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## **A Study of Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland MAIN REPORT**

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# **A Study of Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland**

## **MAIN REPORT**

**February 2018**

Anne Grant, Susan Lagdon, John Devaney, Gavin Davidson, Joe Duffy, Oliver Perra, Karen Galway, Gerry Leavey, Aisling Monds-Watson

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## Introduction

Parental mental illness (PMI) and, or substance use problems, are major public health issues as they may negatively impact children. Conversely, childrens' experiences and difficulties may impact parents' mental health. Consequently, family relationships should be an important focus for clinicians, managers, researchers and policy makers (Beardslee, Solantus, Morgan, Gladstone & Kowalenko, 2012). There is increasing evidence, within the past 15 years, that Family Focused Practice (FFP) can be beneficial for families, including children, when parents have mental illness and, or substance use problems (Beardslee et al., 2012; Cooper & Reupert, 2017; Siegenthaler, Munder & Egger, 2012).

**For the purpose of this report, FFP refers to interventions which attempt to identify and address the needs of parents and children in relation to child welfare and parental mental health and, or substance use problems. Early intervention to promote family functioning is also key. These interventions may not necessarily be provided to the whole family. In some cases they may be provided to just one person in the family, but the focus has to be on both parental mental health and, or substance use problems AND child welfare issues.**

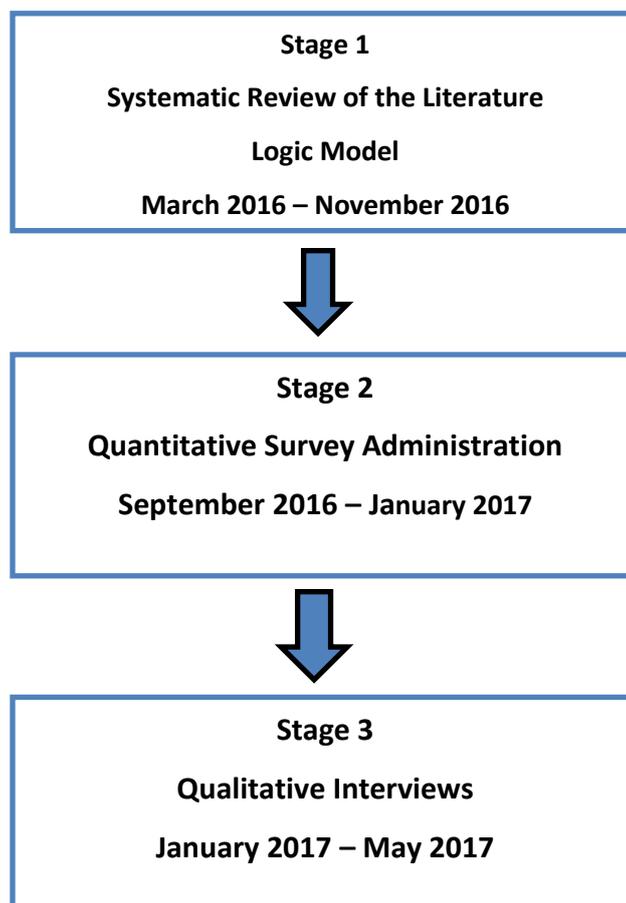
Since the commencement of the Think Family NI programme in 2009 a wide range of initiatives have been developed and implemented, across Northern Ireland (NI), to promote Health and Social Care (HSC) professionals' FFP, in response to families when parents have mental illness and, or substance use problems (See p.37 - 39 of this report for overview of key initiatives). While there is limited information internationally about extent of FFP (Grant, Goodyear, Maybery & Reupert, 2016) and inter disciplinary differences in FFP (Maybery et al., 2014), there is an absence of studies that directly compare FFP across services including adult mental health and children's services. There has also been limited evaluation of Think Family NI initiatives to date.

In 2016 the Health and Social Care Board (HSCB) commissioned Queen's University Belfast (QUB), in conjunction with Ulster University, to conduct a two-year baseline study with three parts. The first part entailed a systematic review of the literature and

development of a logic model. A logic model is a graphical representation of the relationships between the resources, activities, outputs and outcomes of a program of work. A mixed methods study was then conducted in the second and third parts to examine FFP in adult mental health and children’s services from multiple perspectives (i.e. HSC professionals and service users).

Our findings provide evidence on the current state of Think Family NI initiatives and will inform ongoing and future development and evaluation of FFP within the five HSC Trusts. Figure 1.1 provides an overview of stage completion and timelines for the three parts of this project.

**Figure 1.1**  
**Study Stage Completions & Timelines**



This report has three aims, 1) to present contextual information underpinning the wider study as well as key findings from the systematic review, 2) to outline the logic model underpinning Think Family NI and 3) to outline the research design underpinning the HSC commissioned study and to present and discuss key findings. Each of these aims is addressed in three distinct parts of the report.

The first part of the report addresses the first aim and presents the context of the wider project and findings of the systematic review. The first section commences by highlighting the prevalence of parental mental illness (PMI) and substance use problems and their impact on service users and their families, including dependent children. The remaining background sections detail the underlying context to the study including benefits of FFP and related policy and practice developments to promote FFP internationally and in NI. Barriers and enablers of FFP are also detailed. Following on from this, the second part of the report presents the logic model. The process of establishing the logic model entailed scoping out and recording Think Family NI initiatives that have occurred since 2009 to the present day (2017). This information was then used to support the formulation of anticipated outcomes of Think Family NI initiatives and assist with the evaluation of effectiveness and development of refocused aims and future Think Family NI work.

Finally, the third part of the report addresses the third aim and discusses key findings of the mixed methods study. This final part of the report will commence by discussing the research design and methodology. Following on from this, the quantitative survey findings with HSC professionals will be reported. The qualitative findings from semi-structured interviews with HSC professionals and parents who are service users will then be reported. Key findings from the quantitative and qualitative component of the study will then be discussed.

The report concludes with a discussion of the implications of the findings from the study in relation to the future direction of Think Family NI and the steps necessary to consolidate and further develop the progress made to date.

## Table of Contents

<b>Introduction</b> .....	1
<b>Tables &amp; Figures</b> .....	8
<b>Glossary of Terms</b> .....	10
<b>Foreword</b> .....	11
<b>Acknowledgments</b> .....	13
<b>Executive Summary</b> .....	15
<b>Part One: Background</b> .....	22
Prevalence of Parental Mental Illness (PMI) .....	22
Impact of PMI.....	23
Family Focused Practice (FFP) and its Benefits .....	24
Enablers of FFP .....	27
Barriers to FFP.....	30
Policy Response to PMI - International Context.....	32
United Kingdom (UK) Policy and Practice Developments.....	32
Policy and Practice Developments in Northern Ireland (NI) .....	34
The Need for Regional Investigation of HSC Professionals' FFP in Adult Mental Health and Children's Services .....	35
<b>Part Two: Logic Model</b> .....	37
Key Initiatives from the first phase of Think Family NI .....	37
<b>Part Three: Mixed Methods Study of HSC Professionals' FFP</b> .....	42
Research Aims and Questions.....	42
Research Design .....	42
Ethical Considerations .....	43

Achieving Meaningful Service User Involvement in Research Design .....	43
Quantitative Methodology .....	45
Survey Measure.....	45
Reliability and Validity of FFMHPQ .....	47
Participants .....	47
HSC Professionals' Employment and Practice Context .....	48
Quantitative Data Analysis .....	52
Hierarchical Multiple Regression Analysis .....	52
Qualitative Methodology .....	54
Individual Interviews.....	54
Qualitative Data Analysis .....	55
Study Limitations.....	55
<b>Quantitative (Survey) Findings .....</b>	<b>57</b>
Introduction .....	57
HSC Professionals' Education and Training in Family Focused Practice .....	57
HSC Professionals' Exposure to Parents who have Mental illness and their Children and extent of FFP .....	61
Interdisciplinary Differences in FFP .....	65
Comparison of FFP Mean Scores across Trusts .....	68
High Scoring HSC Professionals .....	71

Predicting HSC Professionals' FFP .....	75
Summary of Regression Findings for Whole Sample.....	79
Differences between professionals' FFP in Adult Mental Health & Children's Services .....	82
Barriers and Enablers of HSC Professionals' FFP .....	89
Summary of Survey Findings .....	94
<b>Qualitative Study Findings - HSC Professionals .....</b>	<b>96</b>
Study Sample .....	96
Overview of Findings .....	96
HSC Professionals' Perceptions of the Nature and Scope of their FFP .....	98
Family Focused Activities .....	106
Summary .....	122
HSC Professionals' Capacity to Engage in FFP .....	123
Enablers.....	124
Barriers .....	140
Future Potential Developments.....	159
Summary .....	172
<b>Qualitative Findings – Service Users .....</b>	<b>174</b>
Sample.....	174
Overview of Findings .....	174

Service Users' Experience of HSC Professionals' FFP .....	175
Principles (Why professionals should engage in FFP).....	175
Family Focused Activities (What Professionals Do).....	185
Summary .....	193
Service Users and Professionals' Capacity to Engage in FFP.....	193
Enablers related to Service Users and Professionals' Capacity to Engage in FFP .....	193
Barriers related to Service Users and Professionals' Capacity to Engage in FFP .....	201
Future Potential Developments.....	209
Summary .....	214
<b>Discussion</b> .....	215
Overview of Key Study Findings .....	216
How does FFP in NI compare to the international context? .....	223
Implementation of Think Family NI and Future Direction .....	227
Key Messages from the Research and Recommendations for the Future...	228
<b>References</b> .....	233

## Tables & Figures

<b>Table 3.1:</b> The FFMHPQ subscales	46
<b>Table 3.2:</b> Completed Surveys by Trusts	49
<b>Table 4.5:</b> Mean scores Across Disciplines on FFP Subscales	66
<b>Table 4.6:</b> Mean Scores across Trusts on FFP Subscales	69
<b>Table 4.7:</b> Percentage of High Scorers by Service and Band	71
<b>Table 4.8:</b> Comparisons of Means and SD between High Scoring HSC professionals and Remainder of the Sample	72
<b>Table 4.9:</b> Hierarchical Multiple Regression – Assessing the Impact on the Child	76
<b>Table 4.10:</b> Hierarchical Multiple Regression – Connectedness	76
<b>Table 4.11:</b> Hierarchical Multiple Regression – Referrals	77
<b>Table 4.12:</b> Hierarchical Multiple Regression – Interventions to Promote Parents Mental Health	78
<b>Table 4.13:</b> Hierarchical multiple Regression – Support to Carers & Children	78
<b>Table 4.14:</b> Hierarchical Multiple Regression – Family & Parenting Support	79
<b>Table 4.15:</b> Summary of Significant FFP Predictors	80
<b>Table 4.16:</b> Hierarchical Multiple Regressions for the Influence of new variable ‘Adult / Children’s Services Group: Results for ALL dependant variables	83
<b>Table 4.17:</b> T-Test Comparisons of Adult Mental Health and Children’s Services Professionals on Demographic Variables	84
<b>Table 4.18:</b> T-Test Comparisons of Adult Mental Health and Children’s Services Professionals on FFP Subscales	85
<b>Table 4.19:</b> Children Services Professionals Only: Hierarchical Multiple Regression for All Dependant Variables	88
<b>Table 4.20:</b> Adult Mental Health Services Professionals Only: Hierarchical Multiple Regression for All dependant variables	89
<b>Table 4.21:</b> HSC Professionals’ Views of Barriers & Enablers to Implementing FFP	90
<b>Table 4.22:</b> Awareness of Adult and Children’s Service Joint Protocol by Professional Discipline	92
<b>Figure 1.1:</b> Study Stage Completions & Timelines	2
<b>Figure 2.1:</b> Logic Model	41

<b>Figure 3.1:</b> Professional Disciplines across Adult Mental Health and Children's Services	50
<b>Figure 3.2:</b> Overview of the Hierarchical Multiple Regression Model	53
<b>Figure 4.1:</b> Adult Mental Health Professionals Training Overview	57
<b>Figure 4.3:</b> Children Services Professionals Training Overview	58
<b>Figure 4.4:</b> Percentage of HSC professionals who have received Family Focused Training	59
<b>Figure 4.5:</b> Percentage of HSC Professionals who have received Child Focused Training	60
<b>Figure 5.1:</b> Overview of Two Thematic Networks	98
<b>Figure 5.2:</b> The nature and scope of HSC Professionals' FFP	99
<b>Figure 5.3:</b> HSC professionals' capacity to engage in FFP	123

## Glossary of Terms

<b>AMH</b>	Adult Mental Health
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CYPSP</b>	Children and Young Peoples Strategic Partnership
<b>DoH</b>	Department of Health
<b>DV</b>	Dependent Variables
<b>FFMHPQ</b>	Family Focused Mental Health Practice Questionnaire
<b>FFP</b>	Family Focused Practice
<b>FIT</b>	Family Intervention Team
<b>HSC</b>	Health and Social Care
<b>HSCB</b>	Health and Social Care Board
<b>IV</b>	Independent Variable
<b>M</b>	Mean Score
<b><i>n</i></b>	Number (i.e. quantity or sum)
<b>NI</b>	Northern Ireland
<b>PI</b>	Principal Investigator
<b>PMI</b>	Parental Mental Illness
<b>SCIE</b>	Social Care Institute for Excellence
<b>SD</b>	Standard Deviation
<b>TFM</b>	The Family Model
<b>UK</b>	United Kingdom
<b>QUB</b>	Queen's University Belfast
<b>WHO</b>	World Health Organisation

## Foreword

The Health and Social Care Board (HSCB) has been undertaking regional work with Health and Social Care (HSC) Trusts and in partnership with voluntary sector organisations since the commencement of Think Family work in Northern Ireland (NI). The first phase of the work commenced in 2009 until 2012 as a pilot project, and a wide range of initiatives were developed and implemented. The initial aim for Think Family work focused upon improving collaborative working and enhancing an understanding of multi-disciplinary roles and responsibilities of all stakeholders working across the mental health and children's services interface. The attention in the first phase focused upon improving the systems in place within HSC to become more family focused, and was followed up with a survey of staff and parents to evidence the benefits for families.

Since 2012, Think Family NI has been developed and implemented within a regional action plan under the structure of the Children and Young Peoples Strategic Partnership (CYPSP) (a committee of the HSCB), and reports progress to the Outcomes and Regional chairs group. The major strategic aim of CYPSP is to influence both in the early years of life and at an early stage of difficulty before families and children need more specialised statutory support.

Think Family Northern Ireland (TFNI) became core business for the HSCB from 2012 with a clearer emphasis upon evidencing the benefits family focused practice (FFP) can have for parents with mental health issues and their families.

Using research, service evaluation and an outcome based approach has been a priority component of the second phase of this work. A Strategy for Health and Social Care Research and Development in Northern Ireland (2016-2025) and the HSCB Social work research and continuous Improvement Strategy 2015 – 2020 sets out the commitment to support research, and the use of evidence from this to improve the quality of health and social care and better policy-making within NI.

The Think Family Study, commissioned by the HSCB, is the first of its kind in NI and its findings will have relevance at both a regional and international level. The study, undertaken by Queen's University Belfast, in conjunction with Ulster University, is a partnership approach with HSCB to realising the principles of the Strategy for Health

and Social care research and the Social Work research and continuous improvement Strategy.

The conclusion and findings of the research will support the direction of policy, practice, and education and training both currently and through to the future for health and social care within NI.

I wish to thank the project team for their efforts and commitment in conducting the study and writing the final report, including recommendations for further development of FFP in NI. The study would not be possible without the input of service users in developing the study protocol; or the support of adult mental health and children's services across the five HSC Trusts, who worked tirelessly with QUB to complete the quantitative and qualitative components of the study.

Mary Donaghy

Think Family NI Lead, HSCB

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## Executive Summary

### What is the issue?

Parental mental illness (PMI) and, or substance use problems, are major public health issues as they may negatively impact children. Conversely, children's experiences and difficulties may impact parents' mental health. Consequently, family relationships should be an important focus for clinicians, managers, researchers and policy makers (Beardslee, Solantus, Morgan, Gladstone & Kowalenko, 2012). Based on United Kingdom (UK) estimates, Hansson, O'Shaughnessy and Monteith (2013) suggested that there are between 60,000–75,000 children in Northern Ireland (NI) living with a parent who has a mental illness. **For the purpose of this report when we refer to PMI we are also including parents with substance use problems.**

### What is Northern Ireland (NI) doing about it?

At a broad systems level, initiatives have been introduced in NI to promote Health and Social Care (HSC) professionals' response to families when parents have a mental illness through the promotion of Family Focused Practice (FFP). For the purpose of this report, FFP refers to interventions which attempt to identify and address the needs of parents and children in relation to child welfare and parental mental illness. Early intervention to promote family functioning is also a key component. Foster, O'Brien and Korhonen (2012) and Goodyear et al. (2015), recommend a continuum of family focused activities for HSC professionals when working with service users who are parents. At minimum, professionals should establish the parenting status of service users, ascertain the number and age of children and encourage parents to discuss their family and parenting role during treatment. Other family focused practices include providing appropriate information and resources on PMI and, or parenting to the family, with a view to preventing and resolving family issues from arising (Liangas & Falkov, 2014). Supporting children directly or indirectly (i.e. via supporting parents) to cope with PMI is also key (Grant, 2014). Another component of FFP is to liaise with other services to provide parents and children with additional support as required (Falkov 2012, Goodyear et al., 2015).

From 2009, and in line with international and wider UK developments in FFP and in response to specific inquiry reports (i.e. O'Neill Inquiry, 2008), 'Think Family' has

become a priority for the Health and Social Care Board (HSCB); who shape strategic direction to influence FFP within established forums at Department of Health (DoH), HSCB and HSC Trust level. Since 2012, Think Family NI has been developed and implemented within a regional action plan under the structure of the Children and Young Peoples Strategic Partnership (CYPSP) (a committee of the HSCB), and reports progress to the Outcomes and Regional chairs group. The ultimate aim of Think Family NI initiatives, at a Regional and Trust level, is to improve outcomes for parents, their children and families by establishing a whole family approach to the planning and delivery of services (in line with the SCIE Guide 30, Think Child, Think Parent, Think Family Guidelines, 2011). Overall it was intended that regional and local initiatives would help to improve the extent to which assessment, planning and intervention in adult mental health and children's services are family focused. More specifically, it was anticipated that communication would be enhanced between HSC professionals and families and that as a consequence families will get greater access to early intervention and family support services (Donaghy, 2014). (See p.37 – 39 for further detail of key initiatives).

### **What did we do?**

In 2016 the HSCB commissioned Queen's University Belfast (QUB), in conjunction with Ulster University, to conduct a two-year baseline study to examine HSC professionals' FFP in adult mental health and children's services regionally. The study set out to measure;

- (1) The extent, nature and scope of HSC professionals' FFP
- (2) Factors that predict, facilitate and, or hinder FFP
- (3) How FFP may be further promoted.

In addressing these core areas, the perspectives of both HSC professionals and parents who have mental illness were sought.

#### *The research questions included:*

1. What is the extent of HSC professionals' FFP in adult mental health and children's services with parents who have mental illness, their children and families?

2. What are the significant differences, if any, between HSC professionals' FFP in adult mental health and children's services?
3. What are the significant predictors of HSC professionals' FFP?
4. What is the nature and scope of HSC professionals' FFP?
5. What are parents' experiences of HSC professionals' FFP?
6. What factors, if any, facilitate and, or hinder HSC professionals' FFP? And if so how?
7. How might FFP be further developed in Northern Ireland?

### **How did we do it?**

The first part of the study entailed conducting a systematic review of the literature (see p.26) and development of a logic model (See p.37) in order to present contextual information underpinning the wider project. A logic model is a graphical representation of the relationships between the resources, activities, outputs and outcomes of a program of work. We then conducted a mixed methods study to examine HSC professionals' FFP in adult mental health and children's services from multiple perspectives (i.e. HSC professionals and service users).

This involved administering a survey which was made up of three sections:

- Section one collected information on HSC professionals' demographics (i.e. respondents' Trust and service area).
- Section two included items from the Family Focused Mental Health Practice Questionnaire (FFMHPQ) which is designed to measure professionals' FFP.
- Section three included items which aimed to capture HSC professionals' experience of working with parents. The total final sample of HSC professionals taking part in the current study (number ( $n$ ) = 868) was derived from all five HSC Trusts and included professionals from both adult mental health (number ( $n$ ) = 493) and children's social care services (number ( $n$ ) = 316), (Missing information regarding service area = 59).

We then conducted in-depth interviews with HSC professionals ( $n = 30$ ) and service users ( $n = 21$ ), in adult mental health and children's services, to obtain their perspectives of (1) the nature and scope of HSC professionals' FFP with parents,

who have mental illness, their children and families, (2) enablers and barriers of FFP and (3) future potential developments in FFP.

### **What did we find?**

- While Think Family NI is a widely recognised initiative within some parts of the HSC system, levels of knowledge and understanding of FFP are variable and patchy.
- Overall, survey findings indicate that HSC professionals participating in the current research study and who appear representative of the wider HSC adult mental health and children's social care workforce report low levels of FFP.
- Over a third of HSC professionals recorded high scores on at least three of the six FFP behavioural subscales as measured by the FFPMHPQ. So while the average FFP score is low, there are a large group of HSC professionals who understand and practice in ways which are family focused.
- Those who spend at least some of their time delivering services in the home environment and practicing in community settings, had higher FFP scores than those in acute in-patient settings.
- Think Family Champions also recorded higher FFP scores compared to others, particularly in relation to skills and knowledge of the impact of PMI on children.
- Some differences in the extent of FFP were also noted across disciplines and services. Social Workers recorded higher FFP scores whilst Psychiatrists recorded lower scores.
- Compared to adult mental health services, children's services reported a greater number of higher scores on a number of FFP subscales.
- Across all Trusts, lowest scores were associated with time and workload, indicating the perceived negative impact on FFP of large caseloads and less time for FFP.
- The results of statistical analysis also indicated that the level of skills and knowledge relating to the impact of PMI on children is the most important predictor of both adult mental health and children service professionals' FFP.
- The majority of HSC professionals reported they had not received Family Focused, Child Focused or Think Family training.

- Of those who had received such training, a greater number of adult mental health professionals had received Family Focused training and Think Family training. A greater number of children's service professionals had received Child Focused training. The majority of those who had received Champion's training practiced within the community setting.
- Only 19% of the sample ( $n = 173$ ) are aware of The Family Model (TFM), (Falkov 1998, 2012) and even fewer use it to guide their FFP ( $n = 85$ , 10%). (See p.40 for further detail on TFM).
- Other key reported barriers to FFP included HSC professionals' limited knowledge and skills to support parents who have mental illness (children's services) or children whose parents have mental illness (adult mental health services).
- Parents' fear of temporarily or permanently losing custody of their children was identified by service users and HSC professionals as a further important barrier to HSC professionals' capacity to engage in FFP.
- Service users conveyed the need for recognition of parental status within services and the importance of addressing parenting issues along with mental illness and, or substance use problems, as part of service delivery. Service users also highlighted the stress of PMI on the wider family and the need for greater family supports.
- The relationship that HSC professionals have with parents is crucial to enabling FFP as usually parents can only be effectively supported through a partnership with professionals.
- Individual interviews highlighted the complexities of HSC professionals' FFP, particularly when delivering services to families with multiple adversities.
- HSC professionals and service users emphasised the importance of early intervention and prevention with families in order to mitigate potential adverse impacts of multiple adversities for both parents and children.
- Interviews also highlighted variation in initial family assessments, with focus, depth/ comprehensiveness and family involvement varying across disciplines, sectors and services. In particular, those working within in-patient or clinic based adult mental health services predominantly engaged with parents to identify issues, whilst those working within community based services seemed to actively engage both parents and child(ren) where possible.

- Service users and HSC professionals highlighted the importance of communication and collaborative working, within and across sectors and services (including voluntary services), regarding PMI and substance use problems.
- Service users and HSC professionals suggested that support provided by voluntary services can meet some of the more complex needs of families which may not be addressed by statutory services. The combination of statutory and voluntary service support allows for a holistic approach to treatment.
- A number of organisational enablers of FFP were also identified, including a positive organisational culture towards FFP, support from management and policy and procedures (i.e. UNOCINI and child protection protocols); which aim to encourage family focused approaches to professional practice.
- HSC professionals and service users offered a number of suggestions regarding future developments in FFP, including child and family focused training, improvements within adult mental health and children's services in the availability of psycho-educational resources and support groups for the whole family, including children.
- It was also emphasised, by both service users and professionals that better understanding of service roles and responsibilities among professionals in supporting families when parents have mental illness was important; along with more opportunities to engage in joint working and inter-agency co-operation.
- Service users and professionals also indicated that an improvement to service environments was required so that they are child friendly.
- In developing the logic model it was clear that the initial aim for Think Family NI was focused on improvements in the working of the HSC system. There is an immediate need to assess the impact of these developments on outcomes for the children and parents using HSC services.

**What do we do now? Recommendation of the baseline study includes:**

The HSC Board should develop a Think Family NI Strategy, and consider how this will be taken forward as part of the transitional arrangements for the embedding of Think Family NI within HSC Trusts. In doing so, it would be important to provide an

overarching theory of change and the specific, intended outcomes for the overall strategy, and the associated elements. The new Think Family NI Strategy should include an integrated plan for service development and guidance on how it should be implemented. The new Strategy should also include a governance and performance management framework. This will allow senior managers to monitor the implementation and effectiveness of the various initiatives under Think Family NI. Additionally, each HSC Trust should formally adopt The Family Model (Falkov 1998, 2012) as the basis for future development of Think Family NI. The HSCB should engage in discussions with the bodies that validate qualifying and post qualifying education programmes in Northern Ireland, including the General Medical Council, the Northern Ireland Social Care Council, the Nursing and Midwifery Council and the Health and Care Professions Council to develop a comprehensive approach to multi-disciplinary and uni-disciplinary teaching about The Family Model and FFP for HSC professionals. HSC Trusts should continue to provide regular in-service training on family focused practice and The Family Model to all staff in adult mental health and children's services. This should include both awareness raising and skills development, tailored to the specific needs of different staff groups. Furthermore, Think Family NI Champions are perceived as an important resource for teams, and as such additional professionals should be trained and supported in the role by HSC Trusts. Service users who have had the opportunity to engage with a Think Family Support Worker have perceived this role as a useful resource. As such, further examination of this specialist role would be useful. There is also a need for further development within HSC Trusts of family friendly visiting facilities in in-patient psychiatric facilities. This would support the maintenance of parent, child and family relationships, and facilitate HSC professionals to engage in FFP. A timetable should be developed as part of the new Think Family NI Strategy for when this will be completed. Home visiting is also an important enabler of inclusive assessments and family focused practice and the facilitation of a percentage of home visiting for clinic based professionals would be beneficial. The HSC Board should consider how this can be included in the commissioning of mental health and addictions services across NI. Finally, to inform, support and evaluate Think Family NI, further research should be commissioned by the HSC Board and partners to assist providers in better understanding how many families require help, what types of help are most effective for whom and in what circumstances, and to trial new interventions.

## Part One: Background

### **Prevalence of Parental Mental Illness (PMI):**

Internationally, it has been estimated that between a fifth and a third of adults receiving treatment from mental health services have children (Maybery, Reupert, Patrick, Goodyear & Crase, 2009; Parker et al., 2008) and that between 10-23 % of children live with at least one parent with a mental illness (Maybery et al., 2009). Across the UK is estimated that 10% of mothers and 6% of fathers in the UK have mental health problems at any given time (Mental Health Foundation, [MHF] 2016). Moreover, these estimates suggested that between 50% and 66% of parents with a severe mental illness live with one or more children under 18 (17,000 children and young people in the UK) (MHF, 2016). In terms of parental substance use problems, an important report in 2003 by the Advisory Council on the Misuse of Drugs, estimated that between 200,000 and 300,000 children in England and Wales have one or both parents with serious drug problems. This corresponds to about 2–3% of children under the age of 16. Estimates for Scotland suggest between 41,000 and 59,000 children have a parent with a drug using problem, representing about 4–6% of all children under 16 years (Advisory Council on the Misuse of Drugs, 2003).

In Northern Ireland (NI), Bunting, Ferry, Murphy, O'Neill and Bolton (2013), based on analysis of a large household survey, found that 23.1% of people had experienced one or more mental health problems, including substance use problems, in the previous twelve months. Based on estimates of prevalence in the UK, Hansson, O'Shaughnessy and Monteith (2013), suggested that there was between 60,000–75,000 children in NI living with a parent who had mental illness. Moreover, Percy, Thornton and Mc Crystal (2008), conducted a large scale survey of families in NI and found that over half of the households had at least one member who reported having problems with alcohol. Approximately 10% had at least one member who reported having problems with drugs. It has also been estimated that 40,000 children in NI are affected by parental substance use problems (Public Health Agency & HSCB, 2009). Furthermore, 40% of children on the child protection register and 70% of children who are 'looked after' are using social services due to parental substance use problems. Although not the focus of this review, these issues are often not experienced in isolation and the prevalence and interaction with other factors such as domestic violence, unemployment and poverty also needs to be considered.

### **Impact of Parental Mental Illness:**

According to the World Health Organisation (WHO), mental health can be defined as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (2004, p.11). Mental ill health from this perspective therefore acknowledges the absence of such well-being among individuals. Mental ill health can generally be caused by a number of factors ranging from mental health disorders to substances use problems. Furthermore, an individual’s mental health or substance use problems, can negatively impact their whole family, including dependent children.

Whilst not all children will experience difficulties, due to PMI or substance use problems (Beardslee et al., 2012), a significant number will experience cognitive, emotional, social, physical and behavioural problems on a short or long term basis (Beardslee et al., 2012; Mennen et al., 2015; Reupert & Maybery, 2016). For instance, 25 to 50% of children who have a parent with a mental illness will experience some psychological disorder during childhood or adolescence and 10-14% of these children will be diagnosed with a psychotic disorder at some point in their lives (Beardslee et al., 2012).

While genetics may play an important role in the transmission of mental disorders from parents to children (Bouchard & McGue, 2003), environmental factors are also critical, as the impact of a parent’s illness on children is mediated by impaired parenting capacity and parent-child communication (Hansson et al., 2013). Adverse socioeconomic circumstances that often accompany mental illness and, or substance use problems, such as poverty, domestic violence and isolation are other factors that may adversely impact children (Hansson et al., 2013; Reupert et al., 2016). These are complex dynamic processes and one way to help understand them is to divide them into direct and indirect processes (Manning & Gregoire, 2006).

The direct effects may include genetic factors, development before birth and exposure to their parent’s mental health problems after birth which may impact on attachment and development. The indirect effects may include socio-economic

deprivation, exposure to related issues such as substance use problems, relationship conflict and domestic violence, family breakdown and additional caring responsibilities. It has been estimated that 29% of young carers are looking after a family member with mental health problems (Dearden & Becker, 2004) and it is important to acknowledge the possible complexities and dynamics involved (Aldridge & Becker, 2003). The stigma associated with mental illness and, or substance use problems, may also be an important factor for parents, children and professionals as it may affect many aspects of how people think of and behave towards themselves, others and services (Sartorius, 2007; Davidson, Bunting & Webb, 2012).

Conversely, whilst parenthood is an important positive life role (Benders-Hadi, Barber & Alexander, 2013), parental responsibilities may also negatively affect parents' mental health and recovery (Cowling & McGorry, 2012; Nicholson et al., 2015). Adult family members may also have needs incurred through the demands of caring for their mentally ill relative and, or by the need to assume additional parenting responsibilities (Doucet, Letourneau & Blackmore, 2012; McNeil, 2013).

### **Family Focused Practice (FFP) and its Benefits:**

FFP is a method of care delivery that emphasises the family as the unit of attention as opposed to a Health and Social Care (HSC) professional working with an individual's needs alone (Foster, Whitehead, Maybee & Cullens, 2013; McGavin, 2013). The concept refers to how professionals "respond to other family members when an adult or child has the identified mental health problem" (Foster et al., 2016, p. 2).

During the last two decades the field of paediatrics and to a lesser extent health and social care services, have endeavoured to define the working principles and activities of FFP for practitioners (Espe-Sherwindt, 2008). The literature highlights the importance of caring for parents in the contexts of their families and communities and working with families in an individualised, holistic, flexible, transparent, responsive, preventative, recovery, strengths based and culturally sensitive manner (Grant, 2014; McGavin, 2013; Trowse, Hawkins & Clark, 2013; Ward, Reupert, McCormick, Waller & Kidd, 2017). The literature also focuses on preventive interventions for parents who have mental illness, their children and families in order

to reduce psychological and social risk factors for families and improve strength and protective factors; for instance parenting behaviour, social support and coping skills (Falkov, 2012; Grove, Riebschleger, Bosch, Cavanagh & van der Ende, 2017; Nicholson, Gershenson, Williams & Biebel, 2016). Critical to FFP is the need for professionals to form partnerships with parents and their families and to help parents set and achieve appropriate and realistic goals (Coyne et al., 2013; Grant, 2014; Grant et al., 2016; Nicholson et al., 2015).

Foster et al. (2012) and Goodyear et al. (2015) recommend a continuum of family focused activities for professionals when working with service users who are parents. At minimum, professionals should establish the parenting status of service users, ascertain the number and age of children and encourage parents to discuss their family and parenting role during treatment. Other family focused practices include providing appropriate information and resources on PMI and, or parenting to the family, with a view to preventing and resolving family issues from arising (Liangas & Falkov, 2014). Supporting children directly or indirectly (i.e. via supporting parents) to cope with PMI is also key (Grant, 2014). Another component of FFP is to liaise with other services to provide parents and children with additional support as required (Falkov, 2012; Goodyear et al., 2015).

There is increasing evidence, within the past 15 years, that FFP can be beneficial for families when parents have mental illness and, or substance use problems (Beardslee et al., 2012; Cooper & Reupert, 2017; Moore, Chalk, Vandivere & Scarpa, 2003; Grove Reupert & Maybery, 2016; Grove, Melrose, Reupert, Maybery et al., 2017; Maybery & Morgan, 2015; Marston et al., 2016; Nilsson, Gustafsson & Nolbris, 2014; Reupert, Cuff, Drost, Foster, van Doesum & van Santvoort, 2012). It can “improve outcomes for the parent with mental illness, reduce the subjective and objective burden of care for families, and provide a preventative and supportive function for children” (Foster et al., 2012, p.7). A systematic review and meta-analysis by Siegenthaler, Munder and Egger (2012), across 13 trials involving over 1000 children, found that formal interventions reduced the risk of children acquiring their own mental health disorder by 40 percent. Moreover, several studies suggest that parents, their children and families are more satisfied and find FFP more helpful than other models of practice (Dunst, Trivette & Hamby, 2007; Espe-Sherwindt, 2008;

Gladstone, Boydell, Seeman & McKeever, 2011; Grove, Reupert & Maybery, 2016; Nicholson et al., 2015).

Other research suggests FFP may help to reduce the likelihood that parents will experience a relapse of their mental illness (Espe-Sherwindt, 2008; Pitschel-Walz et al., 2006) or need for hospitalisation for treatment of their mental illness (Hyland, Hoey, Finn & Whitecross, 2008). Psycho educational interventions also improve parents' understanding of their illness, increase the quality of their lives (Rummel-Kluge, Pitschel-Walz, Bauml & Kissling, 2006) and help them to develop stronger relationships with their family (Pitschel-Walz et al., 2006). Moreover, both Davidson (2009) and Van Riper (2001) found that adult family members experienced less stress and better emotional well-being when mental health and social care professionals directly involved and supported them. Health and social care professionals also benefit from engaging in such interventions. Toikka and Solantaus (2006) described how using preventive interventions, including Beardslee's Preventative Family Intervention, enabled mental health professionals to experience more satisfaction and joy when supporting parents who have mental illness, their children and families. Similarly, Moore et al. (2012) indicated that mental health and social care professionals are able to create stronger alliances with families and experience greater work satisfaction in the process. Finally, there are economic benefits of providing good quality parenting support and preventative interventions for the whole family (Moore et al., 2012).

As previously noted, part of the current research agenda included the completion of a systematic review of family focused interventions which address the needs of families affected by PMI and, or substance use problems (for further detail see Technical Report and Appendices, [Appendix O], for systematic review methodology). The main aim of the systematic review was to present an overview of existing research evidence on the effectiveness of FFP based interventions. The most common measured outcomes of studies included in the review tended to involve aspects of PMI and, or substance use problems, and family functioning. Studies which addressed increases in family function note positive improvements on the parent-child relationship, parenting skills, parental stress and coping and family communication regarding mental illness and, or substance use problems. Of those

studies reporting on direct improvements in parental mental health and, or substance use problems, findings note a reduction in mental health symptoms or cessation of substance use problems among parents taking part in an intervention. Most interventions reported some positive impacts on parents' knowledge or awareness of issues associated with mental illness and substance use problems, and increased knowledge of the needs of children. Interventions involving children also report that children improved in areas such as behaviour and emotional functioning, stress reduction and better understanding of parental issues.

Interventions which incorporate a multi-disciplinary approach and include access to more than one service or area of support are noted as effective among families. Opportunities to understand mental illness and, or substance use problems, and how these impact on the parent and child is an important area to address for parents and their children. Community based interventions, particularly those which would ordinarily be clinically based, were reported as favourable among parents particularly those associated with addiction issues. However, this preference for home based treatment was not shared among children who reported that hospitalisation of a parent with a mental illness and, or substance use problem, sometimes provided an opportunity for respite and reduced their stress and worry surrounding their parent.

There is also a range of factors highlighted in the literature on promoting FFP by professionals which reflect the important components of what works for families. These include education, interventions with parents and children together, the importance of support, context and place and facilitating engagement with resources.

### **Enablers of FFP:**

Enablers to make the workforce more family focused need to be identified for workforce change to occur however limited research has identified the possible factors that predict and enable FFP (Aarons, Sommerfeld & Walrath-Greene, 2009; Fixsen, Naoom, Blase, Friedman & Wallace, 2005; Grant & Reupert, 2016; Halle, 2013; Korhonen, Pietilä et al., 2010; Lauritzen et al., 2014). There is a general consensus that whilst policy, guidelines and education are important enablers of FFP none are effective on their own (Grant & Reupert, 2016; Lauritzen, Reedtz, Van Doesum & Martinussen, 2014; Liangas & Falkov, 2014; Royal College of

Psychiatrists, 2011). Instead, long term, multifaceted, implementation strategies, at multiple levels in an organisation, are needed (Aarons et al., 2009; Beardslee et al., 2012; Grant & Reupert, 2016; Halle et al., 2013; Lauritzen et al., 2014; Liangas & Falkov, 2014; Tchernegovski, Maybery & Reupert, 2017).

Scott (2009), suggests that FFP may be enabled within organisations if performance indicators and funding models incorporate a family-centred lens. Others stress the importance of developing family focused policies and guidelines to enable FFP (Coyne et al., 2013; Grant & Reupert, 2016; Korhonen, Pietilä et al., 2010; Lauritzen et al., 2014; Liangas & Falkov, 2014; SCIE, 2009 , 2011). In particular the need to develop and implement standard admission policies and practices is highlighted (Foster et al., 2012; Grant, 2014; Hansson et al., 2013; Krumm et al., 2013; Lauritzen et al., 2014; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Reedtz et al., 2012). Conducive organisational structures and processes, including implementation frameworks (Grant & Reupert, 2016; Lauritzen & Reedtz, 2013; Lauritzen et al., 2014), family focused frameworks (Grant & Reupert, 2016; Korhonen, Pietilä et al., 2010) and recovery and strength based frameworks are also thought to enable FFP (Korhonen, Pietilä et al., 2010; Lauritzen et al., 2014; MacKean et al., 2012; Moore et al., 2012; Reedtz et al., 2012; Toikka & Solantaus, 2006); as is managerial support to translate these frameworks in practice (Coyne et al., 2013; Grant & Reupert, 2016; Korhonen, Pietilä et al., 2010; Lauritzen et al., 2014; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). Provision of the necessary resources, including child and family focused professional development and education have also been highlighted as FFP enablers ( Foster et al., 2012; Grant & Reupert, 2016; Korhonen, Vehviläinen-Julkunen et al., 2010; Krumm et al., 2013; Lauritzen et al., 2014; Liangas & Falkov, 2014; Murphy & Withnell, 2013; Solantaus & Toikka, 2006). Training and education may facilitate professionals to engage in FFP if it promotes their ability to form collaborative partnerships with parents and adult family members (Coyne et al., 2013; Grant & Reupert, 2016; Maybery & Reupert, 2009; Moore et al., 2012; Nicholson, 2010), and to develop knowledge, skills and confidence to address parenting issues (Bell, 2013; Coyne et al., 2013; Grant & Reupert, 2016; Korhonen, Pietilä et al., 2010; Lauritzen et al., 2014).

Opportunity to engage in reflective supervision to consolidate FFP knowledge and skills and to work on areas that need development is also considered important (Grant, 2014; Korhonen, Pietilä et al., 2010; Maybery & Reupert, 2009; Nicholson, 2010; Reupert & Maybery, 2008; Solantaus & Toikka, 2006). Relatedly, interdisciplinary and organisational teamwork and inter-professional practice is required (Brockington et al., 2011; Grant & Reupert, 2016; Seeman, 2013), along with a commitment of all team members to adopt a whole family approach (Grant & Reupert, 2016; Korhonen, Pietilä et al., 2010). Moreover, environmental design that allows close physical proximity of the various disciplines with each other may also facilitate interagency co-operation and thereby FFP (Beck, Weis, Greisen, Andersen & Zoffmann, 2009; Coyne et al., 2013; Grant, 2014; Lauritzen et al., 2014). Availability of services for children and capacity to refer children to these services is particularly important considering professionals may not be able to meet all of the needs of service users' children (Korhonen et al., 2008; Reedtz et al., 2012).

Caring for parents in community settings is also thought to enable FFP as it provides professionals with opportunities to care for parents within their home environments and to observe normal family life (Davies, 2004; Devlin & O'Brien, 1999; Doucet et al., 2012; Grant, 2014, Grant & Reupert, 2016; Jackson & Darbyshire, 2004; Slack & Webber, 2008), to use the case management approach (Khalifeh, Murgatroyd, Freeman, Johnson & Killaspy, 2009; Liangas & Falkov, 2014; Nicholson, 2010; Seeman, 2013), to have sustained contact with parents (Grant & Reupert, 2016; Houlihan et al., 2013; Korhonen et al., 2008; Slack & Webber, 2008), to form partnership with parents (Grant & Reupert, 2016; Scott et al., 2007) and to permit flexibility in service delivery to accommodate parents' needs (Grant & Reupert, 2016; Moore et al., 2012). It is also contended that family friendly visiting facilities, within in-patient settings, may enable FFP by providing an opportunity for children to visit their parents whilst hospitalised and at the same time allow professionals to interact with children (Arney & Scott, 2010; Houlihan et al., 2013; Maybery & Reupert, 2009; O'Brien, Anand et al., 2011; Royal College of Psychiatrists, 2011; SCIE, 2009). Finally, parents, children and families' understanding of the impact of PMI on children's well-being is thought to reduce their resistance to FFP (Falkov, 2012; Maybery & Reupert, 2009) and workforce capacity to provide psycho-educational interventions to parents, children and family members can enable this (Korhonen, Pietilä et al., 2010; Maybery & Reupert, 2009).

Enablers related to professionals' personal attributes may also facilitate their capacity to engage in FFP, despite the existence of organisational barriers (Coyne et al., 2013; Grant, 2014; Lauritzen & Reedtz, 2012; Lauritzen et al., 2014 ). These personal qualities include their own parenting experience (Grant, 2014; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen et al., 2010), positive attitudes towards parents who have mental illness, their children and families (Grant, 2014) and capacity to harness parents' strengths (Grant, 2014; Krumm et al., 2013; Moore et al., 2012), cultural awareness (Falkov, 2012; Moore et al., 2012; Nicholson, 2010) and a willingness and capacity to engage in FFP (Arney & Scott, 2010; Foster et al., 2012; Grant, 2014; Korhonen et al., 2008; Lauritzen et al., 2014; SCIE, 2009).

### **Barriers to FFP:**

Notwithstanding the importance of FFP, and knowledge of what enables FFP, international evidence suggests that professionals in adult mental health and children's services experience difficulty in engaging in FFP (Grant et al., 2015; Houlihan, Sharek & Higgins, 2013; Laletas, Reupert & Goodyear, 2017; Maybery, Goodyear, O'Hanlon, Cuff & Reupert, 2014; Reupert, Williamson & Maybery, 2017). Whilst professionals might want to work with children and other family members they report clear knowledge and skills deficits in relation to (1) working with children, (2) working with service users on parenting issues, and (3) working with the whole family (Grant et al., 2016; Maybery, Goodyear, O'Hanlon, Cuff & Reupert, 2014). Maybery et al. (2014) found clear differences between professional groups, finding that social workers engaged the most in FFP, while mental health nurses performed the lowest. A cross-country comparison by Grant, Goodyear, Maybery and Reupert (2016) has also revealed significant differences in psychiatric nurses' FFP in terms of family focused skill, knowledge, confidence and practice. Australian nurses engaged in higher FFP compared to Irish nurses. The comparative differences between countries may be attributable to differences in training, workplace support and policy.

Professionals may also find FFP challenging because of individual worker, service, family and wider systems barriers to adopting a whole family approach. There is added complexity of working with the family unit rather than the individual service user (Foster, Whitehead, Maybee & Cullens 2013; Goodyear et al., 2015). This usually requires acknowledging the unique and sometimes competing needs of

different family members and active collaboration between professionals, service users and their families (Foster et al., 2015; McGavin, 2013). A lack of liaison between different services (e.g. child protection and adult mental health) is another barrier to working with families (Bellin, Osteen, Heffernan, Levy & Snyder-Vogel, 2011) as is having inadequate resources, structures and time (Grant et al., 2016; Lauritzen, Reedtz, Van Doesum & Martinussen, 2014). Deficits in professionals' attitudes, knowledge and skills have also been identified as barriers to FFP (Davidson et al., 2008; Grant et al., 2016; Houlihan et al., 2013).

Another barrier to FFP is the limited attention in research and practice to conceptualising FFP and relatedly an absence of frameworks identifying key components of effective FFP. Three recent reviews (Acri & Hoagwood, 2015; Foster et al., 2016; Marston et al., 2016) highlight the lack of an agreed definition of FFP and suggest that this can hinder FFP at both an organisational and individual worker level. Foster et al. (2016) reported that, in the context of adult mental health services, "there is little consistency in how FFP is defined, and in particular, a lack of integrated knowledge on FFP in mental health services" (p. 129-130). The lack of conceptual clarity in FFP is reflected in the terminology employed, where FFP is used interchangeably with "family-orientated," "family-sensitive," and "family-centered." Grant et al. (2016) found that a need for theory development in FFP was also identified by mental health nurses in Ireland, so that a shared understanding could be developed around what nurses do when working with families when parents have a mental illness. They concluded that theory would render FFP tangible and measurable and subsequently enable the nursing profession to be consistent in their FFP approach when caring for parents with mental illness who have dependent children. As previously noted, while there is literature on FFP and its working principles in other disciplines, especially paediatrics (Coyne, Murphy, Costello, O'Neill & Donnellan, 2013; Foster et al., 2015; Kuo et al., 2012) there is a paucity of literature on professionals' FFP in adult mental health and children's services in regard to working with parents who have mental illness and their dependent children (Foster et al., 2016). Developing a comprehensive construct of FFP in this particular context has implications for education, adoption of FFP and service evaluation and warrants further investigation.

### **Policy Response to PMI - International Context:**

In response to increasing evidence regarding the needs of families when parents have mental illness and, or substance use problems, and benefits of FFP, and knowledge regarding enablers and barriers to FFP; international policy (i.e. in Australia, America, Finland and Norway) increasingly recommends that adult mental health and children's services adopt a whole of family approach (Lauritzen et al., 2014; Foster et al., 2016; Nicholson et al., 2015). Moreover, as the level and type of need when a parent is unwell is broad and cuts across many services, including adult mental health and children's services, policy highlights the need to look beyond individual services and service providers and to take a broader systems approach in developing a whole family approach to services (Falkov et al., 2016; Nicholson et al., 2015).

Nevertheless, there is wide variation in countries and systems response to recommendations regarding FFP (Falkov et al., 2016). For instance, in the Australian context, practice standards have recently been collaboratively developed for the adult mental health professionals (Maybery et al., 2015). These standards are aligned and operationalised to the core activities of the adult mental health workforce and integrated into the continuum of care and recovery for service users who are parents (Maybery et al., 2015). Other countries including Finland, Sweden and Norway have introduced legally mandated and formalised policies that require mental health professionals to work with the family members of their clients, including children (Lauritzen et al., 2014). In these countries there is a multi-component, national prevention program where mental health professionals receive training to enable them to engage in FFP (Solantaus & Toikka, 2006). Alternatively, other countries (i.e. Republic of Ireland) have relatively less developed family focused policies in this particular context (Grant, 2014; Grant & Reupert, 2016).

### **United Kingdom (UK) Policy and Practice Developments:**

During 2009/10 the Centre for Mental Health estimated the direct cost to Health and Social Care systems for treating mental illnesses in the UK to be 21.3 billion (Centre for Mental Health, 2010). Given such figures and the recognition of potential impacts of mental ill health on families, particularly children, and the wider public response systems; increasing efforts to address PMI has become important for the wider UK

government. Consequently, like Australia, and the Scandinavian countries, over the last fifteen years the UK has made concerted efforts to enhance adult mental health and children's services' response to PMI through policy and practice developments.

During 2008 the Social Exclusion Unit Taskforce, as part of a wider UK government response to the needs of families, published their first report 'Reaching Out –Think Family'. This report analysed and reviewed current issues faced by many families including mental illness and, or substance use problems, and addressed the then system and services response to such issues. The Taskforce conclude there was a need for improvement if services are to really reach out to families with such complex needs and enable them to overcome their problems. Services need to work together towards a common vision which includes multi-agency working to ensure that the needs of an individual and the needs of their family including children are being met. The report calls for policy reform to include a whole family approach within services in the hope that such an approach will improve the outcomes for all.

Following from this report and in response to research evidence and a number of case reviews, national and local policy developments aimed at improving cross organisational working began to emerge which places greater emphasis on the need to support parents in their parenting role through FFP. Most notably was the Think Parent, Think Child, Think Family Guide developed by the Social Care Institute for Excellence (SCIE, 2009), which set out clear guidelines for local authority response to the needs of families when parents have mental illness. The guidelines make specific recommendations relating to screening, assessment, planning, providing and reviewing care of service users, actions at the strategic level and workforce development and stipulate what practitioners, managers and organisations should do. The guidelines also include four core Think Family principles that are designed to shape service delivery. These include:

- No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities. For

example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.

- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.
- Building on family strengths – practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities. For example, family group conferencing is used to empower a family to negotiate their own solution to a problem (SCIE, 2011).

Between 2009 and 2011, the SCIE worked with five sites in the UK and the five HSC Trusts in NI to implement the recommendations in the guide.

### **Policy and Practice Developments in Northern Ireland (NI):**

In NI, during the past fifteen years there has been a number of small scale initiatives which aimed to address complexities in the interface between adult mental health and children's services. For instance, The Child and Parent Support Service, in the Magherafelt and Cookstown area, aimed to; "provide non-professional personal support; address issues of limited social contact; improve individual self-esteem and functioning; indirectly improve the care provided to the child; and provide support to both children and adults" (Griffiths et al., 2007, p. 126). It was evaluated very positively by the staff and families involved and it was concluded that the project "has allowed professional practice to move away from the somewhat unified structure of separate areas of work and, by focusing on the emotional functioning of the adult, has indirectly helped to address the issue of child development" (p. 133). More recently, The Champions Initiative in the Northern HSC Trust area was established in 2009. This initiative identified a Champion in each of the child protection and adult mental health teams to facilitate the interface between the services. Again this was evaluated positively but there was no control or comparison group included as part of the evaluation (Davidson et al., 2012).

From 2009, and in line with international and wider UK developments in FFP and in response to specific inquiry reports (i.e. Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards [O'Neill Inquiry], Western Health

Social Services Board and Eastern Health Social Services Board, 2008), Think Family has become a priority for the HSCB; who shape strategic direction to influence FFP within established forums at Department of Health (DoH), HSCB and HSC Trusts level. The ultimate aim of Think Family NI initiatives, at a Regional and Trust level, is to improve outcomes for parents, their children and families by establishing a Think Child, Think Parent, Think Family approach to the planning and delivery of services (in line with the SCIE Guide 30, Think Child, Think Parent, Think Family Guidelines, 2011).

**Overall, it was hoped that regional and local initiatives would help to improve the extent to which assessment, planning and intervention in adult mental health and children's services are family focused. Specifically, that communication will be enhanced between HSC professionals and families and that as a consequence, families will get greater access to early intervention and family support services (Donaghy, 2014).**

### **The Need for Regional Investigation of HSC Professionals' FFP in Adult Mental Health and Children's Services:**

A dearth of research exists about system change initiatives worldwide which integrate mental health and children's services to meet the needs of families and children where a parent has a mental illness and, or substance use problem (Falkov et al., 2016). While there is limited information about inter disciplinary differences in FFP (Maybery et al., 2014) there is an absence of studies that directly compare FFP across services including adult mental health and children's services. There has also been limited evaluation of Think Family NI initiatives, with the exception of a study by Davidson et al. (2012) which suggested that the Champions Initiative in the Northern Trust is having a positive impact on interface working. Nevertheless, findings from this study and from initial audits and a sense maker survey with HSC professionals and families suggest a number of barriers impede a whole family approach in both adult mental health and children's services (Davidson et al., 2012; Donaghy, 2014). Moreover, while the SCIE (2012) evaluation of the implementation of their *Think Child, Think Parent, Think Family* guidance found that NI had made more comprehensive and far reaching changes, in relation to their recommendations than

the five other UK pilot sites involved, HSC professionals and service users' perspectives of regional initiatives was not sought.

Organisational and policy development is often context specific and therefore should be responsive to local needs and workforce and professional training frameworks (Cusack & Killoury, 2012) so rigorous, systematic and comprehensive evaluation of Think Family NI initiatives is required. Moreover, acquiring a good understanding of HSC professionals' perspectives is a crucial element in capacity building for better FFP (Grant, 2014; Grant et al., 2016). Another fundamental requirement for improving FFP is ensuring that service user and families' voices are heard and incorporated into education and training as well as service design and delivery (Grant, 2014; Nicholson et al., 2014). In response to the above, the HSCB commissioned the first independent baseline investigation of HSC professionals' FFP.

The first part of this report has presented the contextual information underpinning the wider project. The remaining sections of this report present an overview of the research study including: a logic model of the Think Family NI initiatives, the research questions posed, the mixed methods study employed to address them, the key findings of the research and the implications for research, policy and practice.

Finally, it is important to reiterate that for the remainder of this document the term mental illness is inclusive of substance use problems throughout.

## Part Two: Logic Model

Since the commencement of the Think Family NI programme in 2009 a wide range of initiatives have been developed and implemented. There have been two phases to this work, between 2009-2013 and 2014 – to date. The overarching aim for Think Family NI, as set out in the HSCB's position paper focused "...on improving collaborative working and enhancing understanding of multi-disciplinary roles and responsibilities of all stakeholders working across the Mental Health and Children's services interface" (HSCB, 2014, p.1). While the HSCB is to be commended for its commitment to developing a range of initiatives to take forward this overall aim, it was also timely for the HSCB to reflect on the coherence of these individual pieces of work and their relative contribution to the overall aim of improving outcomes for families. One such mechanism for doing this was the development of a logic model. A logic model is a graphical representation of the relationships between the resources, activities, outputs and outcomes of a program of work. By making explicit the expected relationship between the four key elements of resources, activities, outputs and outcomes, it is possible to assess the alignment between the elements and to measure whether the desired aim is being achieved.

### **Key Initiatives from the first phase of Think Family NI have included:**

- Development and circulation of educational resources to facilitate health and social care professionals and parents to talk to children about parental mental health problems.
- Staff development initiatives including training in family focused practice.
- Development of a regional joint protocol to facilitate joint working between adult mental health and children's social care services.
- Revision and amending of adult mental health screening and assessment tools (including an appendix for Understanding the Needs of Children in Northern Ireland assessment forms – see below), to include a focus on parents and children's needs in relation to parental mental health problems.
- Development of an evidence based appendix to Understanding the Needs of Children in Northern Ireland, to strengthen and reflect upon parental mental health needs more robustly.
- Development of an aide memoire based on The Family Model (TFM) (A5 card), to encourage health and social care professionals to consider the needs of the

whole family when parents have a mental illness and, or problematic substance use.

- Development of role and function of Interface Groups in each HSC Trust.
- Development of the Family and Staff Experience Sense Maker surveys. The methodology used was a qualitative approach which presented the qualitative data for analysis in quantitative format, identifying patterns and trends for analysis.

Since 2012, Think Family NI has been developed and implemented within a regional action plan under the structure of the Children and Young Peoples Strategic Partnership (CYPSP) (a committee of the HSCB) and reports progress to the Outcomes and Regional chairs group. The major strategic aim of CYPSP is to influence both in the early years of life and at an early stage of difficulty before families and children need more specialised statutory support. As one of the eleven regional sub groups under CYPSP, the regional Think Family sub group action plan adopted one of the six high level outcomes 'living in safety and with stability' to drive their work in a partnership approach with SBNI. The Think Family Action Plan was developed using the outcomes of the service user and staff survey completed in 2011.

A number of additional initiatives were introduced within the second phase of the Think Family NI work plan between 2013 – 2015 under three specific themes generated from a Sense Maker survey (undertaken in 2011-2012) in phase one of the Think Family Project with parents and HSC professionals. The aim of initiatives was to improve:

- Communication and information sharing between professionals and families (aim was to develop information leaflets and the joint protocol).
- Access to early intervention family support for children, young people and their families (aim was to develop signposting /referral to hubs by adult mental health staff and ability of family support hubs to pick up on mental health and addictions issues for support).
- The extent to which assessment, planning and treatment is inclusive of a 'whole family' approach (aim was to promote use of the joint protocol in

children's and adult mental health services and to strengthen adult mental health documentation in line with The Family Model approach).

Most recently, ongoing key initiatives to improve services included:

- Development of children and young people's leaflets by Action for Children young carers groups.
- Refinement of A5 cards checklist based on The Family Model (TFM) domains Falkov's (2012) that includes six questions (developed by service users and carers to support the family conversation).
- Introduction of a Think Family Support Worker practitioner in the South Eastern Trust (SET) and Belfast Trust and Western Trust.
- Evaluation of the SET Pilot and Think Family Support worker in SET.
- Commencement of Think Family Social Work Assessment Pilot in partnership with The Social Work Strategy.
- Development of an eLearning resource on TFM, in conjunction with Queen's University Belfast and international partners from Australia and Norway to develop HSC professionals and service users' awareness of the Model and how it may be used in practice.
- Development of the Champions Model in the remaining four Trusts in line with developments in the Northern Trust.

A Champion is a professional who is responsible for sharing knowledge with their teams, ensuring joint working and that the Think Family approach is embedded throughout services. Champions act as a resource to their team regarding the use and understanding of the Regional Adult and Children's Services Joint Protocol, responding to the needs of children whose parents have a mental illness.

Champions also attend multi-agency training sessions pertinent to Think Family working and brief their teams on Think Family NI developments.

The logic model (See figure 2.1) was developed in an iterative fashion, through the Think Family NI lead from the HSCB working with one member of the research team to draft an initial version of the model. This was then considered by the Project Team, refined and circulated to the Advisory Board, refined further and then shared Dr Adrian Falkov, before being finalised. A number of key learning points have arisen from the development of the logic model. During the past eight years Think

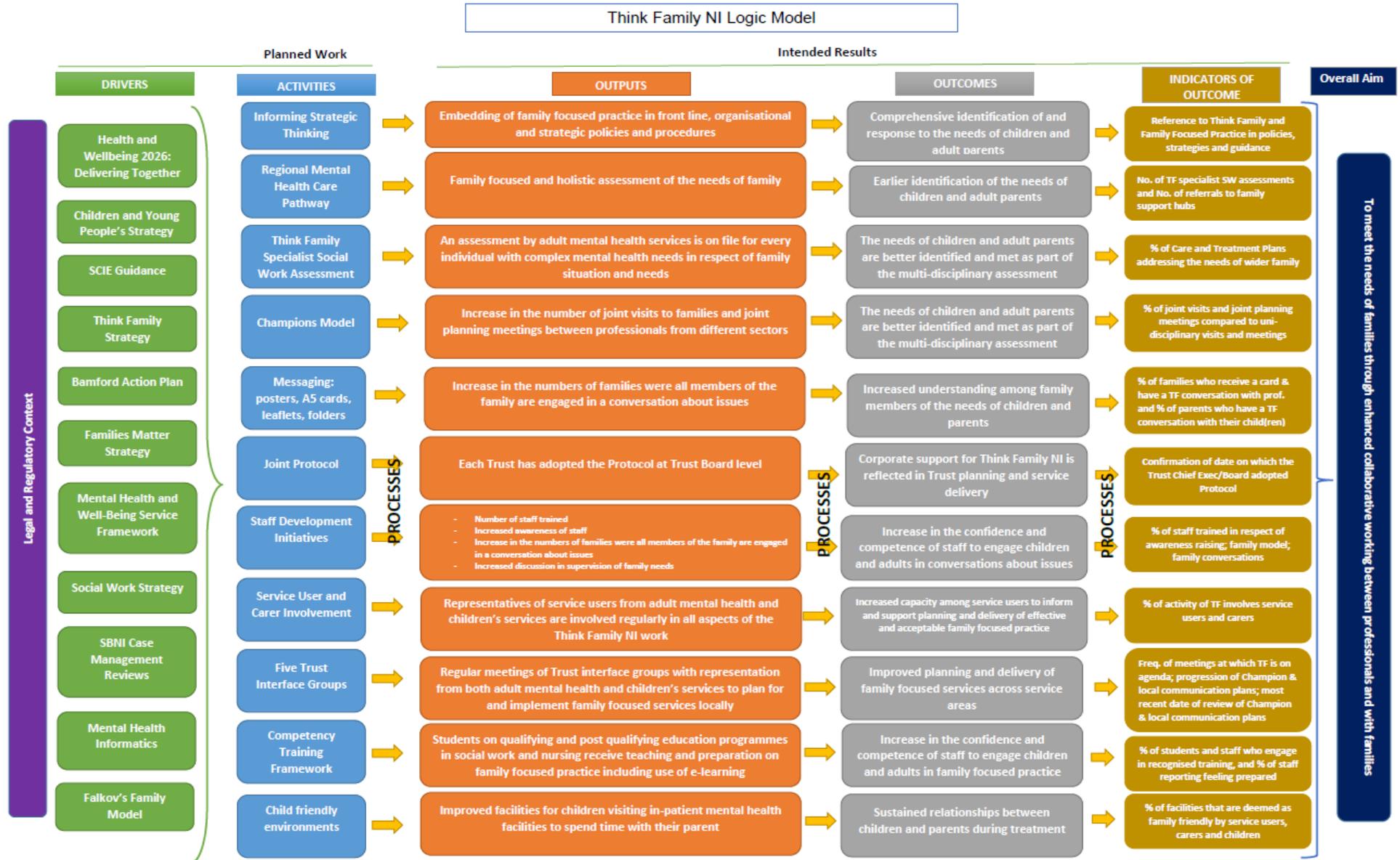
Family NI has had two distinct external influences. During the initial phase the HSCB was heavily influenced by the Social Care Institute for Excellence's (SCIE) *Think Child, Think Parent, Think Family* work (Social Policy Research Unit, 2009). The second key influence has been Dr Adrian Falkov's commissioned consultation and The Family Model (TFM) (Falkov, 1998, 2012), which have been the main theoretical basis for more recent developments. The Family Model can be used as a framework to promote a whole family approach in mental health services as it identifies key elements that professionals should consider when engaging in FFP. The model consists of a visual illustration of six key areas (domains) and interconnecting arrows, which represent key inter-relationships between domains, with six overarching principles (Falkov, 2012). The domains are illustrated on an A5 checklist card introduced by the HSCB. HSC professionals are encouraged to refer to the domains when discussing family issues with service users who have mental illness. Falkov (2012) recommended that health care professionals should consider all domains of TFM if they are to effectively assess and support parents who have mental illness, their children and families.

While some of the earlier initiatives have been refined to incorporate TFM (Falkov, 1998, 2012), some of the original SCIE work is still evident. This is not a substantial issue, as SCIE's model was informed by Falkov's earlier work, but it highlights the challenges faced by HSC professionals who have been seeking, appropriately, to develop family focused approaches in NI based on a developing and growing body of international research and evidence. In developing the logic model it also became clear that the stated overall aim for Think Family NI was more focused on improvements in the working of the HSC system, rather than on the outcomes to be achieved for users of HSC services. As such, it is proposed that the overall aim of Think Family NI be amended to reflect this:

**To meet the needs of families through enhanced collaborative working between professionals and with families.**

The development of the logic model has highlighted the need for the HSCB to continue to work on developing a clearer set of outcome indicators for the various individual initiatives listed in the logic model and to consider how these contribute to the overall aim as stated above.

Figure 2.1 Logic Model



## **Part Three: Mixed Methods Study of HSC Professionals' FFP**

The proceeding sections of the report provide an overview of the study aims and questions and study methodology. The findings are then presented and discussed along with their implications for practice, policy, education and research.

### **Research Aims and Questions:**

The current study set out to measure, (1) the extent, nature and scope of HSC professionals' Family Focused Practice (FFP), (2) factors that predict, enable and, or hinder it and (3) how it may be further promoted. Perspectives of both HSC professionals and parents who have mental illness were sought.

The research questions include:

1. What is the extent of HSC professionals' FFP in adult mental health and children's services with parents who have mental illness, their children and families?
2. What are the significant differences, if any, between HSC professionals' FFP in adult mental health and children's services?
3. What are the significant predictors of HSC professionals' FFP?
4. What is the nature and scope of HSC professionals' FFP?
5. What are parents' experiences of HSC professionals' FFP?
6. What factors, if any, facilitate and, or hinder HSC professionals' FFP? And if so how?
7. How might FFP be further developed in Northern Ireland?

### **Research Design:**

The study design followed the format of a sequential mixed methods design. This involved the collection and analysis of quantitative data followed by the collection and analysis of qualitative data. The qualitative data helped explain and elaborate upon, the quantitative results (Creswell & Clark, 2007). In this way both methodologies complement and extend each other by addressing the research question(s) from different perspectives.

### **Ethical Considerations:**

The study was conducted in accordance with the statement of ethical practice and standards set out by the Declaration of Helsinki and in line with current QUB processes and regulations (Please See:

<http://www.qub.ac.uk/Research/Governance-ethics-and-integrity/Research-integrity/>). The study protocol was approved by ORECNI and Research Governance permission was obtained from the five HSC Trusts. Queen's University Belfast was the acting sponsor of the research and ensured that governance and indemnity procedures were in place. Approval from the aforementioned bodies was granted between February 2016 and September 2016.

In the quantitative component, HSC professionals were informed of the details of the study in online explanatory statements; implied consent was obtained through participation in the completion of the online or hard copy, anonymous questionnaire. HSC professionals were told that their participation in interviews was contingent upon them returning the completed questionnaire and a form with their contact details which was included with their questionnaire. In the qualitative component, prior to commencing the interview, both HSC professionals and parents were invited to complete an informed consent form. Maintaining participants' confidentiality is often a major ethical concern of interpretive research because of the intimate nature of the research (King & Horrocks, 2010), but was maintained through the use of pseudonyms and changing specific contextual details that could possibly reveal the identity of the participant.

### **Achieving Meaningful Service User Involvement in Research Design:**

From the outset, it was important that this research approached service user involvement and engagement in a spirit of openness and meaningful collaboration. At the heart of this was the need to avoid engagement that was tokenistic (Esmail, Moore & Rein, 2015). Service users had to feel that this type of involvement was in line with established good practice (McLaughlin, 2009; Duffy, 2006) and genuinely collaborative (Lathlean et al, 2006; Haggerty et al, 2003; Hanley et al, 2004; Sweeney, 2009; McLaughlin, 2009). Mc Laughlin's definition of this type of collaborative approach seems consistent with our team's endeavours when he remarks: "Collaboration implies a degree of ongoing service user involvement with

an explicit understanding that it is possible to indicate how service user involvement has impacted upon the study” (2009, p.7). Service users were approached and involved as service user representatives in an important advisory capacity working closely with the research team in key aspects of research design. We also worked closely with service user representatives in the design (wording of questions) of interviews to be used with service users. In the latter, a member of the research team worked closely with two people from a service user background where the real focus was on how the interview would be experienced and felt by those service user respondents participating in these. This type of empathic focus is aligned with Beresford’s observations about the particular insights which people with lived experience can bring to research due to their “personal and collective experience of policy, practice and services” (2000, p.493).

The research team’s approach to achieving meaningful and genuine user involvement was also guided by an ethic of care position (Ward & Gahagan, 2012). Originating in feminist philosophy, this approach underscores the: “interconnected principles of attentiveness, responsibility, competence, responsiveness and trust as a requisite for ‘good care’” (Ward & Gahagan, 2012, p.183). In applying these ethics of care/good care principles to collaborative research, the team members were therefore very attuned to issues such as; differing experiences of researchers and service users, differing skills and knowledge, power differences, etc. The research team was therefore mindful about not trying to achieve any sense of “false equality” in working with service users in this research context but more focused on navigating: “a pathway through...our different but equal contributions” (Ward & Gahagan, 2012, p.185). The ethic of care position therefore allowed open discussion within the research process about expert and service user/experiential knowledge that would ultimately and meaningfully recognise the diverse types of expertise that we as a team in our joint endeavours brought to the overall research process (Ward & Gahagan, 2012). The research team’s ethic of care position therefore resulted in: “...a thoughtful and considered nurturing of capacities” (Hugman, 2005, p.69), “...teased out in the context of relationships” (ibid: 71) with user researchers. In practice, this meant that in our research study, service users were involved in managing the research and co-designing research tools (interviews, participant

information and consent protocols) and in proofing aspects of the final report for accessibility.

### **Quantitative Methodology:**

#### **Survey Measure:**

The survey used within the current study consisted of three sections.

- Section one included demographic items (i.e. regarding respondents Trust and service area).
- Section two included items from the Family Focused Mental Health Practice Questionnaire (FFMHPQ) which is designed to measure HSC professionals' FFP.
- Section three included items which aimed to capture HSC professionals' experience of working with parents.

The FFMHPQ was developed by Maybery et al. (2006; 2012) and further refined by Grant (2014). Professionals responded to 14 family focused subscales on a seven point Likert Scale (ranging from strongly disagree to strongly agree). Table 3.1 shows the subscales along with definitions and an example item from each. A low score on the subscales (i.e. less than 5) suggests a reduced family focus and a high score (i.e. 5 – 7) increased family focus. Each of the individual subscales are conceptually distinct from one another but together they measure various dimensions of FFP.

**Table 3.1:****The FFMHPQ subscales, subscale definitions, Cronbach reliabilities and items for current study**

<b>Subscale (alpha reliability)</b>	<b>Subscale Definition</b>	<b>Example item from scale</b>
Support to carers and children ( $\alpha = .46$ ) (DV)	The level of information, advocacy and referral provided to carers and children.	Rarely do I advocate for the carer's and/or family when communicating with other professionals regarding the service user's mental illness
Family and parenting support ( $\alpha = .50$ ) (DV)	Providing resources and referral information to consumers and their families	I provide written material (e.g. education, information) about parenting to service users
Assessing the impact on the child (.59) (DV)	How well the worker assesses the impact of the parent illness on the child/ren	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse
Connected-ness ( $\alpha = .70$ ) (DV)	Workers assessment of parent awareness of child connectedness	I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. peers, school)
Referrals ( $\alpha = .59$ ) (DV)	Referring family members to other programs to.	I refer service user's to parent-related programs (e.g. parenting skills)
Interventions to promote parent's mental health ( $\alpha = .78$ ) (DV)	Workers' interventions to reduce the impact of the service user's parenting role on their mental health	I assess the impact of the service user's parenting role on their mental health
Co-worker support ( $\alpha = .70$ ) (IV)	The support from other workers regarding family focused work	I often receive support from co-workers in regard to FFP
Time and workload ( $\alpha = .66$ ) (IV)	Time or workload issues regarding family focused practice	The workload is too high to do family focused work
Professional development ( $\alpha = .66$ ) (IV)	There are opportunities for professional development regarding working with families	Professional development regarding FFP is not encouraged at my work place
Worker confidence ( $\alpha = .75$ ) (IV)	The level of confidence the worker has in working with families, parents and children	I am not confident working with children of service users
Training ( $\alpha = .76$ ) (IV)	Worker willing to undertake further training	I should learn more about how to assist service users about their parenting and parenting skills
Confidence around parenting and children generally ( $\alpha = .90$ ) (IV)	Confidence around own children	In general I am very happy with my parenting
Skill and Knowledge ( $\alpha = .75$ ) (IV)	Worker skill and knowledge regarding impact of parental mental illness on children.	I am skilled in working with service users in relation to maintaining the well-being and resilience of their children
Workplace Support ( $\alpha = .73$ ) (IV)	The workplace provides support for family focused practice	My workplace provides mentoring to support HSC professionals undertaking FFP

### **Reliability and Validity of FFMHPQ:**

The psychometric properties of the FFMHPQ have been evaluated to confirm validity and reliability (Mayberry et al., 2012). The measure has excellent content and construct validity and good internal subscale reliability (Mayberry et al., 2012). As the FFMHPQ was devised for use in the Australian context, with a variety of professional disciplines (e.g. psychologists, psychiatric nurses, social workers), it required minor adaptation and testing for reliability in the NI context. Accordingly, the Principal Investigator (PI) adapted the language of the FFMHPQ for HSC professionals, practicing within adult mental health and children's services in NI, in consultation with the project team, advisory committee and developers of the original instrument.

The validity of the FFMHPQ outside the Australian adult mental health service context was also established. Validity of the subscales in the NI context was established by a panel of experts, pilot study (Northern Trust), principle FFMHPQ administration and internal consistency reliability indexes. Initially an advisory panel assessed the items in the FFMHPQ subscales for their content validity. Panel members were selected for their expertise in FFP and PMI. All the items to be included were deemed relevant and therefore retained. The final survey including the FFMHPQ was then piloted in the Northern Trust with ten HSC professionals (5 from children's services and 5 from adult services) not included in the study to evaluate the clarity of the questions and their layout. The main changes made to the survey involved further refinement to the structure and language used particularly in relation to section three of the survey.

### **Participants:**

In the development and roll out of the Think Family NI survey we sought to include a wide range of HSC Professionals working across adult and children's services with families where a parent has a mental illness. The survey respondents broadly mirror the relevant workforce which has been the focus of Think Family NI initiatives. The survey was distributed to Approx. 3585 HSC professionals within adult mental health and children's services across the five HSC Trusts (See Technical Report and Appendices for further details). The minimum number of HSC professionals needed to complete a survey ( $n = 878$ ) was determined by various factors, including the size of the population to which results are generalizable to, the results of previous

research and particularly findings from previous use of the FFMHPQ in different populations and the overall purpose of the current study which was to compare two groups of HSC professionals with regard to their FFP. Hence, a two sample comparison of means was used to estimate the overall sample size. We ensured that the characteristics of respondents reflected the population of HSC professionals who fulfilled the inclusion criteria (i.e. HSC professionals working within Adult Mental Health, Addictions services, Gateway, Family Interventions Teams (FIT) or 16+ Teams).

To promote maximum variation and to secure sample access, a principal investigator (PI) for each Trust was identified along with an independent point of contact for the study. A total of 1088 survey questionnaires were accessed by HSC professionals giving a response rate of 30%. However, 119 of these were ineligible based on study inclusion/ exclusion criteria (See Technical Report and Appendices for further details); 48 surveys completed by trainees and support workers and 71 surveys completed by professionals in ineligible service areas (e.g. disability services) were excluded. Due to significant missing information, 101 cases were also removed from the dataset as more than 90% of the survey had not been completed and would not be suitable for inclusion in final analysis. The final sample comprised of 868 HSC professionals, a response rate of 24.2%. Additional information regarding the procedure to access HSC professionals and their sample characteristics is reported in the Technical Report and Appendices.

### **HSC Professionals' Employment and Practice Context:**

As noted, the survey was distributed to the approximate population of HSC professionals, who fulfilled the inclusion criteria, practicing in adult mental health and children's services across the five HSC Trusts ( $n = 3585$ ). However, it was not possible to obtain the precise number of HSC professionals who met inclusion criteria in these service areas from the HSCB. The total final sample of HSC professionals taking part in the current study ( $n = 868$ ) was derived from all five HSC Trusts and included professionals from both adult mental health ( $n = 493$ ) and children's social care services ( $n = 316$ ). Table 3.2 below details the number of professionals from each Trust who completed the survey. Whilst a large sample of HSC professionals was achieved, this does not necessarily mean that those who

participated are completely representative of the population of HSC professionals. As Berg (2009) notes, “non-response bias refers to the mistake one expects to make in estimating a population characteristic based on a sample of survey data in which, due to non-response, certain types of survey respondents are under-represented” (p.3).

As can be seen from Table 3.2, survey completion varied across Trusts. This is most likely reflective of Trust areas and differences in service size. There were a greater number of respondents from the Belfast Trust, followed by Western Trust, South Eastern Trust, Southern and Northern Trust. The Northern Trust has the smallest number of respondents.

**Table 3.2:**

**Fully Completed Surveys by Trusts**

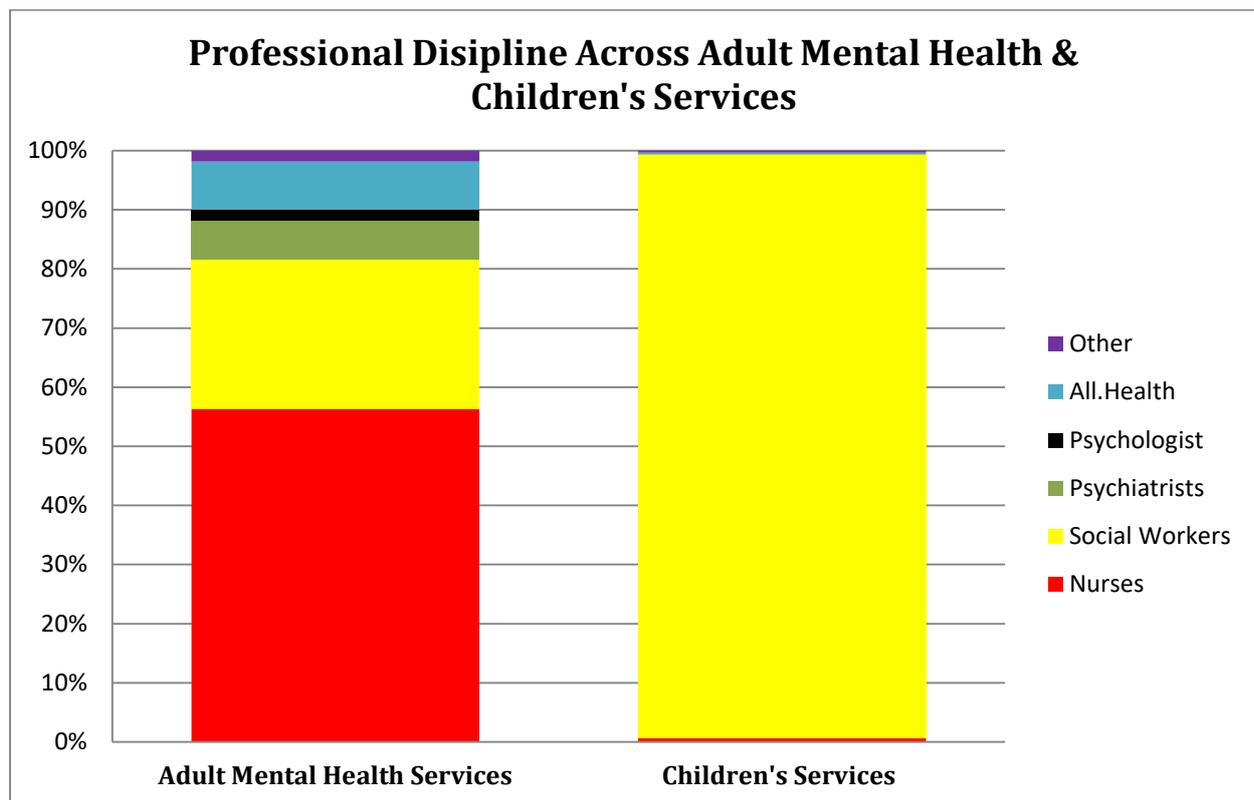
Trust	Number of Completed Surveys n
Belfast	227
South Eastern	163
Western	167
Southern	160
Northern	151
Total	868

Table 3.3 in the Technical Report and Appendices (Appendix J), provides a breakdown of the study sample by Trust, discipline and service area. The largest number of responses were obtained from community mental health teams (28%), followed by family intervention teams (18.1%), acute mental health and addictions in-patient services (9.3%), gateway (9.3%), community addictions teams (6.5%), 16+ (5.3%), crisis resolution home treatment (4.4%) and single point of access (0.9%). Given the variety of titles and terms attributed to different services across each Trust, the survey offered professionals the option to note their service area under a specialist mental health service or other category (15.2%). Such services included for example unscheduled care, Cognitive Behavioural Therapy (CBT) and those working within family centres.

A range of professions across these service areas participated. The most common profession was Social Worker ( $n = 473, 54.5\%$ ) followed by Nurse ( $n = 293, 33.8\%$ ). Other professions included Allied Health professionals ( $n = 44, 5.1\%$ ), Psychiatrists ( $n = 33, 3.8\%$ ), Psychologists ( $n = 12, 1.4\%$ ) and Other, for example, Cognitive Behavioural Therapist ( $n = 13, 1.5\%$ ).

**Figure 3.1:**

**Professional Disciplines across Adult Mental Health and Children's Services**



**Adult Mental Health Professionals' Employment and Practice Context.** Most respondents worked within adult mental health services ( $n = 493$ ); these included Nurses ( $n = 278$ ), Social Workers ( $n = 124$ ), Psychiatrist ( $n = 33$ ), Psychologists ( $n = 9$ ), Allied Health professionals ( $n = 40$ ) and those who selected the 'Other' category ( $n = 9$ ). The most common Agenda for Change Band was band 6 ( $n = 214, 43.4\%$ ), followed by band 7 ( $n = 152, 30.8\%$ ). A few professionals ( $n = 20, 4.1\%$ ) reported at band 8 indicating a managerial role. The mean length of time practicing as a professional was 17 years ( $M = 17.03, SD = 11.01$ ) with the majority of adult mental health professionals currently working on a full time basis ( $n = 427, 86.6\%$ ), with few professionals working part time ( $n = 64, 13\%$ ) or job sharing ( $n = 2, 0.4\%$ ). On

average, professionals worked in their current position for 6.6 years and most worked on day shifts ( $n = 371$ , 75.3%). Most professionals practiced within mixed urban/rural settings ( $n = 211$ , 42.8%) and the rest practiced in an urban area ( $n = 190$ , 38.5%) or rural area ( $n = 90$ , 18.3 %) only.

Overall, 45.3% ( $n = 218$ ) of adult mental health professionals reported spending time each week delivering services within the home environment, most spending between 0 - 40% ( $n = 97$ , 55.1%) followed by 50-100% in the home environment ( $n = 79$ , 44.9%). This wide range most likely reflects the diverse nature of each of the services and service delivery, with 78.7% of adult mental health professional respondents working in a community based setting, whilst 21.3% worked within in-patient services.

**Children's Service Professionals' Employment and Practice Context.** In contrast to adult mental health services, the majority of professionals indicating that they worked within children's services ( $n = 316$ ) reported as Social Workers ( $n = 312$ ), with a small percentage of Nurses ( $n = 2$ ), Allied Health professional ( $n = 1$ ) and 'Other' ( $n = 1$ , Family Therapist). The most common Agenda for Change Band was band 6 ( $n = 182$ , 57.6%), followed by band 7 ( $n = 78$ , 24.7%). A small minority of professionals ( $n = 19$ , 6%) reported at band 8. The mean length of time practicing as a professional was 10.4 years ( $M = 10.04$ ,  $SD = 8.92$ ) with the majority of children's services professionals currently working on a full time basis ( $n = 292$ , 92.4%), with a small minority working part time ( $n = 19$ , 6%) or job sharing ( $n = 4$ , 1.3%).

On average, professionals had worked in their current position for five years. With regards to service location, children's services professionals predominantly worked within an urban setting ( $n = 150$ , 47.5%) whilst 37.7% ( $n = 119$ ) worked within either an urban and rural setting or rural only setting ( $n = 45$ , 14.2 %). Overall, 53% ( $n = 164$ ) of children's service professionals reported spending time each week delivering services within the home environment, with the majority reporting spending between 0- 40% ( $n = 80$ , 70.2%) followed by 50-100% in the home environment ( $n = 34$ , 29.8%). This wide range most likely reflects the diverse nature of each of the services and service delivery.

### **Quantitative Data Analysis:**

The Statistical Package for the Social Sciences (SPSS, Version 24) was used to analyse the quantitative data. This involved the use of descriptive and inferential statistics including ANOVA, MANOVA and hierarchical multiple regression. These methods are used to describe the sample characteristics and to determine the extent of FFP, differences in FFP between services and factors that predict FFP. Outcomes of statistical analysis will be fully discussed in section 'Quantitative (Survey) Findings'.

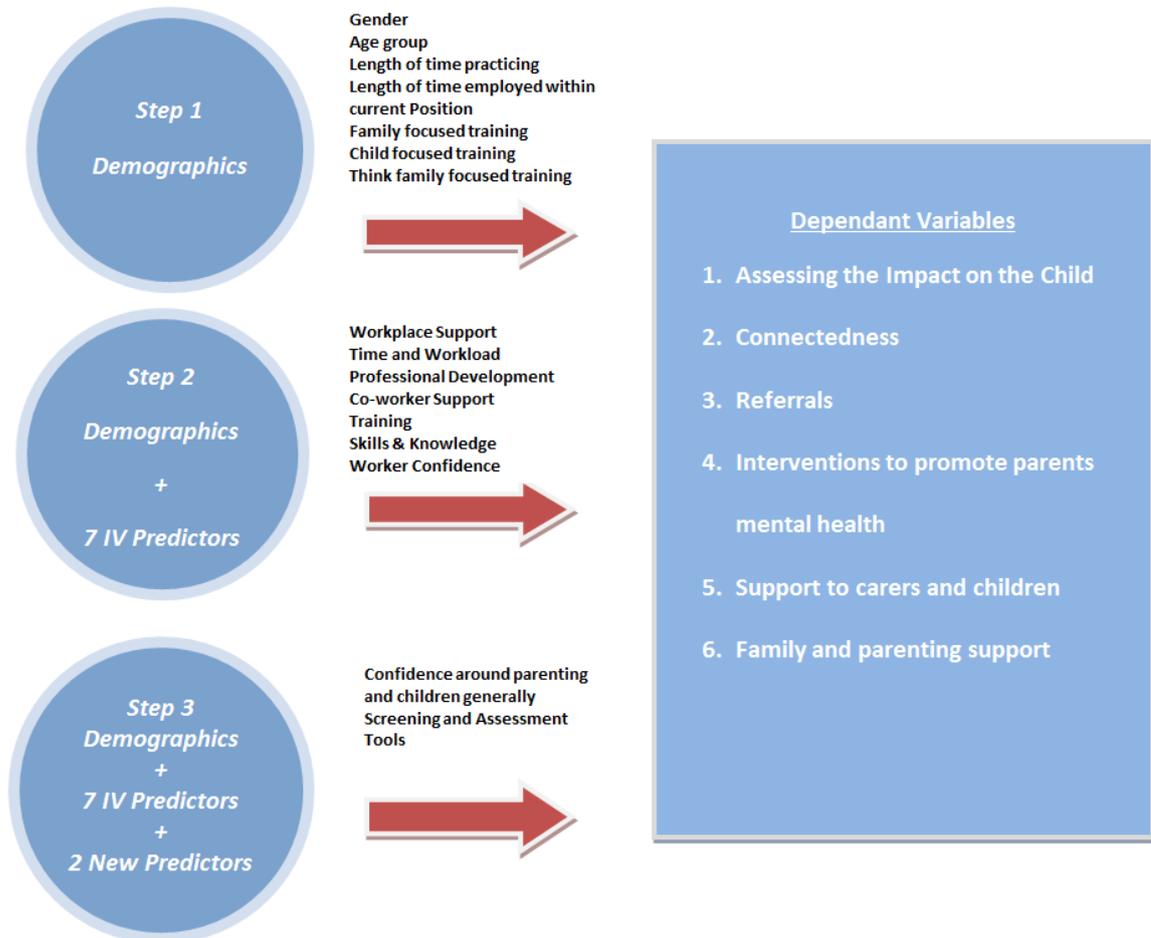
### **Hierarchical Multiple Regression Analysis:**

Hierarchical multiple regression was used to assess how well seven subscales, within the FFMHPQ (section two of the survey), predicted six behavioural subscales measuring family focused activities after controlling for the influence of seven known predictor variables. Six behavioural subscales in the FFMHPQ (*support to carers and children, family and parenting support, interventions to promote parents' mental health, assessing the impact on the child, connectedness and referrals*) were employed in the regressions as dependent variables (DV). In performing the hierarchical multiple regression for each dependent subscale, all demographic variables such as age, gender, length of time practicing, length of time in current experience, family training, child training and Think Family training were entered into block (step) one to control for the effect of these variables. The block of predictors entered at step two included the known predictors (derived in part from a review of the literature). These included seven independent variable (IV), including subscales *workplace support, time and workload, professional development, co-worker support, training, skill and knowledge* and *worker confidence*. Block three included two new predictors that have recently emerged in the literature as potentially important variables. These were *confidence around parenting and children generally* and *screening and assessment tools facilitating FFP*.

The effects of all 16 IV's (comprised of seven IV subscales, seven predictor variables and two IV's that were beginning to emerge in the literature as possible predictors of FFP) on six DV's was measured. The analyses were repeated for each of the six DV's subscales and aimed to determine the significant predictors of the dependent variables. The 16 IV's were entered into regression equations for each of the six

DV's. The variables were entered in three blocks, the order based on previous literature. This order is illustrated in Figure 3.2.

**Figure 3.2:**  
**Overview of the Hierarchical Multiple Regression Model**



## **Qualitative Methodology**

### **Individual Interviews:**

Semi-structured interviews with a subsample of HSC professionals ( $n = 30$ ), in adult mental health and children's services, across all five Trust were undertaken to explore significant findings from the FFMHPQ and systematic review and to expand upon findings in relation to:

- The nature and scope of HSC professionals' FFP with parents, who have mental illness, their children and families.
- Enablers and barriers of FFP.
- Future potential developments in FFP.

HSC professionals indicated willingness to undertake an interview by completing an interview volunteer form which could be found at the end of the FFMHPQ and returning the completed volunteer form to the research team during data collection events or by post, therefore recruitment for the sample was via self-selection. Interviews predominantly took place on Trust premises with a few taking place at QUB. Interviews lasted on average 60 minutes with all HSC professionals completing a consent form before the interview to indicate they understood the purpose of the interview and agreed to take part. With participant permission, all interviews were recorded with a digital audio recorder and subsequently transcribed.

Semi-structured interviews were also conducted with service users ( $n = 21$ ) receiving adult mental health and children's services or a combination of both services from across all five Trust areas. Service users were provided with information about the study and a volunteer form by their key worker. Service users who wished to take part in an interview completed the volunteer form and returned this to the research team via a pre-paid envelope or by consenting for their key worker to pass on their contact information to the research team. Service users who decided to voluntarily participate in interviews were offered the opportunity to meet at a venue suitable to them and to have a person who could support them available should they wish. All service users also provided written consent before the interview began.

The interview schedule was informed by previous literature and the research questions. We explored service users' experiences of HSC professionals' FFP. Interviews provided additional key perspectives to that of HSC professionals in relation to HSC professionals FFP. Interviews focused in particular on service users' perspectives of (1) their needs regarding FFP, (2) experiences of FFP and (3) barriers and enablers of FFP. In addition, key findings from the systematic review were also further explored with service users. Please see Technical Report and Appendices [Appendix F, G & H] for summary of both professionals and service user interview questions (i.e. Topic Guides).

The safety and well-being of service users was a paramount consideration of the research. Service users were also offered a copy of their interview transcript and the opportunity to make any additional comments to elaborate on points they have made. All service users participating in an interview received £30 worth of One-4-All vouchers to acknowledge their time and any expenses or inconvenience caused by their involvement in the research.

### **Qualitative Data Analysis:**

Thematic analysis was used to create core constructs from the qualitative (textual) data through a systematic method of reduction and analysis (Miles & Huberman, 1994). In undertaking the thematic analysis an essentialist, realist perspective was used (Silverman, 2010). In this approach, participants' experiences and motivations were understood in a straightforward way, because a simple, largely unidirectional relationship is assumed between meaning, experience and language (Potter & Wetherell, 1987). Data were analysed first in individual transcripts and then across transcripts. The qualitative data analysis computer software package NVivo 11 was employed to help organise the data and to ensure methodological rigour by establishing credibility, transferability, dependability and confirmability using techniques suggested by Lincoln and Guba (1985).

### **Study Limitations:**

There were several weaknesses with this research that limit the generalizability of the findings. This study provides data about a little studied phenomenon and the design included several important threats to the study's validity. In particular, while

the FFMHPQ had documented validity and reliability in the Australian and Norwegian context (Lauritzen, 2014; Maybery et al., 2012), there was poor reliability of the majority of subscales in the NI context (i.e. most of the subscales had reliabilities greater than .60, with eight subscales greater than .70). This poor reliability may be largely explained by a lack of sensitivity of HSC professionals to FFP and their limited understanding of concepts being measured. Future researchers need to be cognisant that the reliability of a scale in one context may not necessarily transfer to another context and factor this into their study designs. Furthermore, while the first study identified eleven predictors of FFP these only explained between 21.5 percent and 34.4 percent of variance across the six FFP behavioural subscales measured; suggesting that a considerable amount remains unexplained, offering fertile ground for future research.

Additionally, interview data collected here represents a selection of HSC professionals and services users' views of FFP and this may not be a reflection of other HSC professionals' actual practice (Lauritzen et al., 2014). For example, the HSC professionals in Children's services, who participated in this study, practiced in community based services and may have had more of an opportunity to engage with both parents and child(ren). In addition, while the practices of five professional groups are shown here, a further weakness is that not all professional groups operating within the contemporary mental health setting were represented in this study. Occupational therapists and family support workers were not included. These limitations should be noted when generalizing these results to other locations and professions, for example those working within 'Looked After' Children's services. A further limitation of the current study is related to not addressing interrelated issues from the outset, such as domestic violence, although this did arise during interviews with both professionals and service users.

## Quantitative (Survey) Findings

### Introduction:

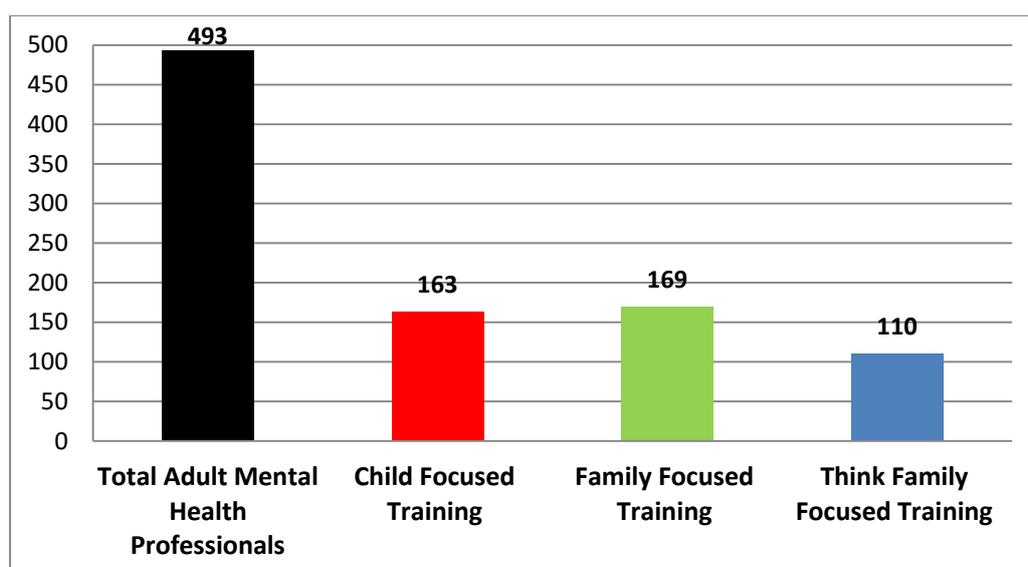
This section of the report presents the findings of a series of analyses designed to further describe the demographic profile of HSC professionals and extent of their Family Focused Practice (FFP) whilst also examining differences, if any, between services (children's social care and adult mental health), Trusts and disciplines in relation to FFP. High scorers' FFP is then examined. Variables that predict HSC professionals' FFP are then reported. Finally, barriers and enablers of FFP are outlined.

### HSC Professionals' Education and Training in Family Focused Practice:

Those who reported that they had received Think Family training were primarily 'Think Family Champions. In relation to adult mental health professionals' education and training, a minority of professionals from across each of the respective disciplines received some sort of family focused (34.3%,  $n = 169$ ), child focused (33.3%,  $n = 163$ ) and Think Family focused training (22.3%,  $n = 110$ ) (See Figure 4.1 below and Tables 4.1 in Technical Report and Appendices [Appendix K], for further detail).

**Figure 4.1:**

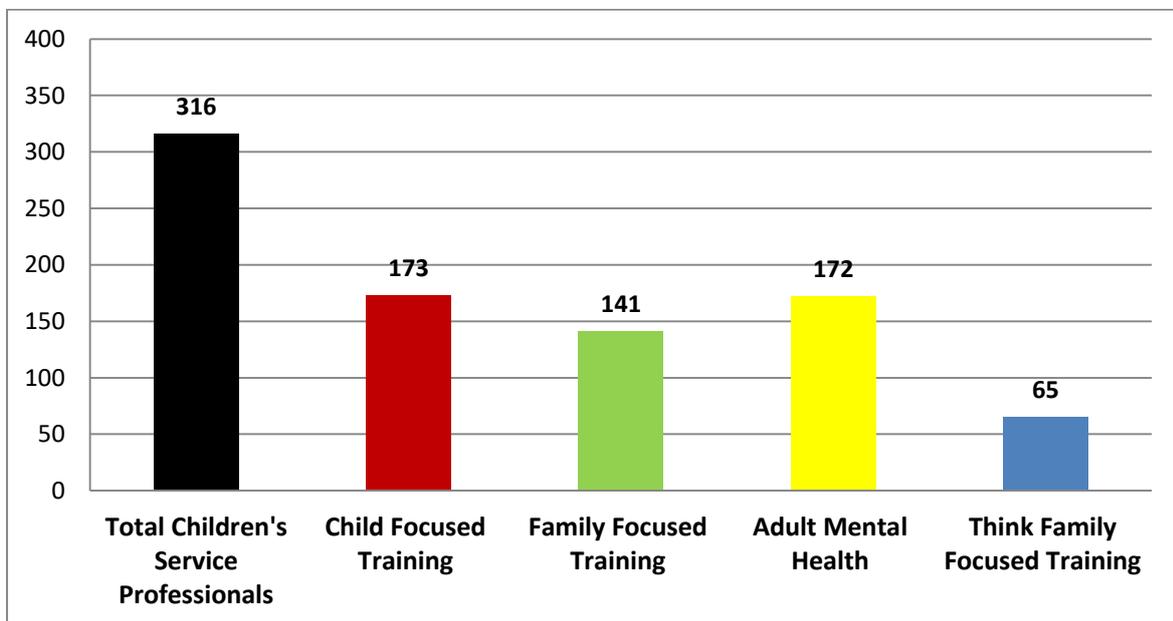
#### **Adult Mental Health Professionals Training Overview**



With regards to children’s services, a greater percentage of professionals had received training. For instance, 44.6% ( $n = 141$ ) had received family focused 54.7% ( $n = 173$ ) child focused and 54.4% ( $n = 172$ ) adult mental health training. However, only a small percentage have received Think Family training (20.6%,  $n = 65$ ). Those who had received training in relation to adult mental health had done so usually during their undergraduate degree and, or on a post qualifying course (See Figure 4.3 below and Table 4.2 in Technical Report and Appendices, [Appendix K], for further detail).

**Figure 4.3:**

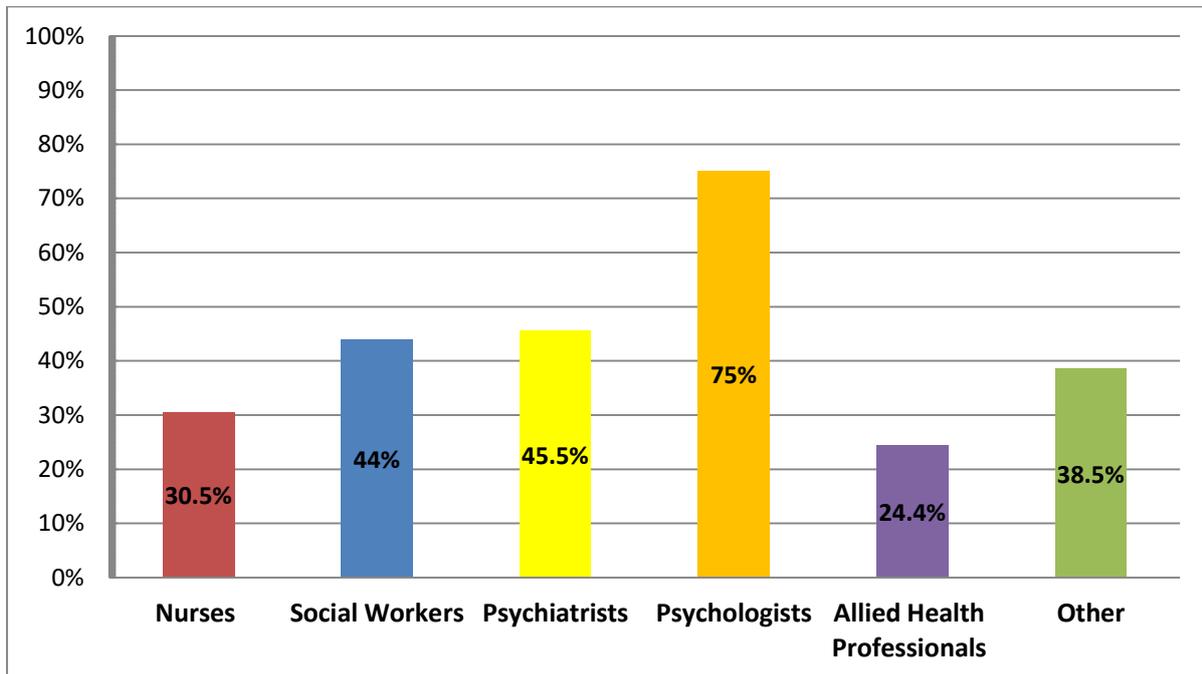
**Children Services Professionals Training Overview**



Across both services (i.e. adult mental health and children’s services) 30.5% ( $n = 85$ ) of Nurses, 44% ( $n = 203$ ) of Social Workers, 45.5% ( $n = 15$ ) of Psychiatrists, 75% ( $n = 9$ ) of Psychologists, 24.4% ( $n = 10$ ) of Allied Health professionals and 38.5% ( $n=5$ ) of ‘Other’, reported having received family focused training.

**Figure 4.4:**

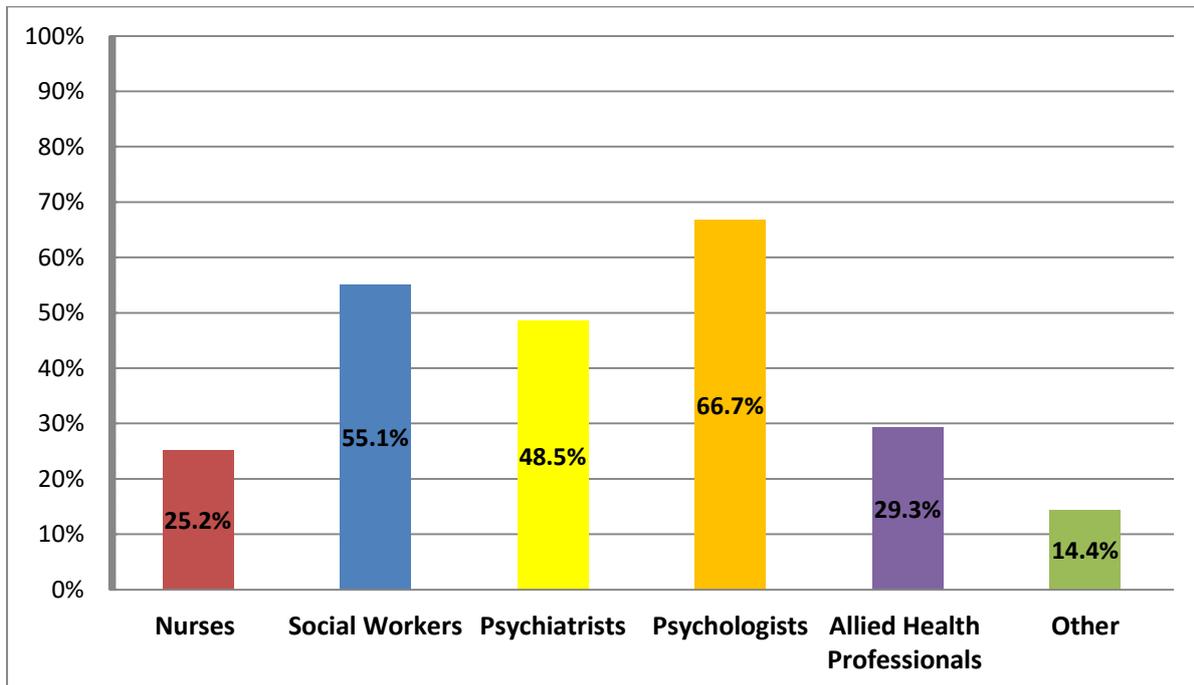
**Percentage of HSC professionals who have received Family Focused Training**



With regards to those who responded to questions relating to child focused training, 25.2% ( $n = 70$ ) of Nurses, 55.1% ( $n = 253$ ) of Social Workers, 48.5% ( $n = 16$ ) of Psychiatrists, 66.7% ( $n = 8$ ) of Psychologists, 29.3% ( $n = 12$ ) of Allied Health professionals and 15.4% ( $n = 2$ ) of 'Other' had received some form of child focused training. Training was provided through a range of courses. Child and family focused training was generally received as result of Trust training including Safety in Partnership, Child Protection and UNOCINI. Additionally, professionals also reported family focused training as a result of Think Family Champions training and both undergraduate and post graduate courses relating to respective disciplines (i.e. Social work, Psychology etc.).

**Figure 4.5:**

**Percentage of HSC Professionals who have received Child Focused Training**



**Summary: HSC Professionals' Education and Training in Family Focused Practice**

Overall, a greater number of adult mental health professionals compared with Children's service professionals had received Family Focused training and Think Family training. A greater number of children's service professionals had received Child Focused training. This perhaps is reflective of the client focus of each respective service but has implications for professionals' capacity in either service to support both parents and their children and other adult family members as a whole. The majority of those who had received Champion training practiced within the community setting. This is unsurprising given that the Champions Initiative (2009) started within the Northern Trust multidisciplinary community mental health teams and in each family and child care team and was later rolled out across the remaining four Trusts. These mental health and child care workers would have attended a series of training and development days.

## **HSC Professionals' Exposure to Parents who have Mental illness and their Children and extent of FFP:**

A number of demographic items were employed to determine the extent of HSC professionals' contact with service users who were parents and their children and extent of their FFP. Mean scores were compared between adult mental health and children's services and between Trusts and across disciplines. As previously noted, whilst a large sample of HSC professionals is included in the current study, this does not necessarily mean that those who participated are completely representative of the general population of HSC professionals.

### ***How many service users do HSC professionals deliver care to?***

As shown in Table 4.3 (Technical Report and Appendices [Appendix M]), 76.5% of HSC professionals ( $n = 664$ ) reported that they were currently delivering direct care to service users, with a majority responsible for between 10 - 40 service users.

### ***How many of these service users are parents?***

Of the 76.5% of HSC professionals delivering direct care to service users, 66.2% ( $n = 575$ ) reported that they deliver some sort of professional service to parents who have a mental illness. HSC professionals indicated that they provide services to on average 19 parents who have mental illness or their children. Seventy one percent ( $n = 615$ ) of professionals also indicated previous experience of providing a service to parents who have mental illness or their children.

### ***How long are service users who are parents involved with services?***

Overall, professionals reported that service users who are parents are generally involved with services for up to, or more than 6 months, particularly within community mental health and family intervention teams. Alternatively, acute in-patient services, addictions services, crisis resolution home treatment and gateway services tend to work with parents for between 1 - 4 weeks (for further details see Table 4.4 in Technical Report and Appendices [Appendix L]).

### ***How often are HSC professionals providing a service to parents who have mental illness?***

33% ( $n = 286$ ) reported caring for parents who have mental illness on a daily basis with the remainder providing services on a weekly ( $n = 221$ , 25.5%) or monthly basis ( $n = 112$ , 12.9%) and a small minority providing services a few times a year ( $n = 58$ , 6.7%). Table 4.3 in Technical Report and Appendices (Appendix M) provides a breakdown by service area. This breakdown of time spent delivering services to parents is most likely reflective of the type of service delivered and the continuation of service delivery through the mental health and substance use care pathway. For example, a service user may spend a number of weeks within an in-patient unit and later transfer to the community mental health team for further home treatment.

Additionally, sixteen percent ( $n = 136$ ) of professionals reported not providing a service to parents who have mental illness with another 4% who were unsure about this ( $n = 35$ ). Further analysis indicates that 54 of these professionals who did not provide services to parents held a managerial position; hence explaining why they reported having no significant direct contact with service users. That said, half of HSC professionals ( $n = 438$ , 50.5%) reported that they had talked to service users who were parents about issues relating to parenting and their mental illness within the week prior to data collection. More than quarter ( $n = 240$ , 27.6%) of HSC professionals also reported face-to-face contact in the past week with children whose parents have a mental illness. However only 15.5% ( $n = 133$ ) had discussed issues relating to PMI.

### ***Are HSC professionals' family focused in their practice?***

Overall, HSC professionals taking part in the current study are not particularly family focused. HSC professionals tended to score between 3-4 on the majority of FFP subscales indicating ambivalence in their capacity to engage in FFP. Lowest scores for the whole sample were in relation to *time and workload* and *family and parenting support*, suggesting HSC professionals perceive that there is little time to engage in family focused work and do not explicitly feel that they provide resources and referral information to service users and their families. Moreover, over half of HSC professionals ( $n = 514$ , 59.2%) recorded higher scores on only two or less of the FFP behavioural subscales.

### ***Are there differences in professionals who are family focused compared to others?***

As previously highlighted, the opportunity to work with families in the home environment is a key enabler of FFP (Grant et al., 2016). Therefore, we conducted a one way MANOVA to explore statistically significant differences between HSC professionals who deliver care in the home environment ( $n = 400$ , 46.1%) and those who do not ( $n = 449$ , 51.7%), in relation to the six FFP behavioural subscales. Results indicate a statistically significant difference ( $F(14, 834) = 3.73$ ,  $P < .001$ ) for five of these subscales, including, *assessing the impact on the child, connectedness, referrals, interventions to promote parents' mental health and support to careers and children*. Those spending a percentage of time in the home environment had higher mean scores on these five subscales; suggesting that they are more family focused than those HSC professionals who do not work in the home environment.

### ***Are Think Family Champions more family focused?***

Compared with the remainder of the sample, Think Family Champions are more family focused. Think Family Champions ( $n = 182$ ) had higher mean scores on all 14 FFP subscales. Result of a one way MANOVA indicated a significant difference between Think Family Champions and the remainder of the sample on all 14 FFP subscales ( $F(14, 831) = 2.77$ ,  $P < .001$ ). Greater significant difference was noted in relation to *skills and knowledge* (i.e. Worker skill and knowledge regarding impact of parental mental illness on children) for Champions ( $M = 4.89$ ,  $SD = 1.02$ ), compared to the remainder of the sample ( $M = 4.50$ ,  $SD = 1.00$ ). Additionally, significant differences are noted in relation to *professional development, connectedness, referrals, worker confidence and support to carers and children*.

### ***Are managers more family focused?***

Managers (i.e. Band 8) ( $n = 45$ ), did record higher mean scores on all FFP organisational and behavioural subscales compared to the remainder of the sample ( $n = 823$ ) with the exception of training (managers  $M = 4.89$ ,  $SD = 1.04$ , remainder sample  $M = 5.61$ ,  $SD = 1.01$ ). This suggests that managers perceive they are family focused and are more positive about the level of organisational support for FFP, including provision of training compared with the remainder of the sample.

We found a significant statistical difference between managers and the wider sample ( $F(14, 853) = 4.24, P < .001$ ) in relation to *workplace supports, time and workload, professional development, assessing the impact on the child, training, skills and knowledge and interventions to promote parents' mental health*. Additionally, comparison of all 14 FFP subscale mean scores among managers within children's services ( $n = 19$ ) vs. adult mental health services ( $n = 20$ ) indicated that children services managers reported higher scores across all FFP subscales. There was a statistical significant difference between these managers ( $F(14, 24) = 3.07, P < .01$ ) in relation to *time and workload, assessing the impact on the child and referrals*.

***Summary: HSC Professionals' Exposure to Parents who have Mental illness and their Children and extent of FFP***

*Overall HSC professionals surveyed are not particularly family focused. Professionals tended to score between 3-4 on the majority of FFP subscales, indicating indecisiveness in their capacity to engage in FFP. Lowest scores for the whole sample were in relation to time and workload and family and parenting support. Across both services those working within the home environment appear to be most family focused; scoring slightly higher on FFP subscales. Higher scoring professional also tend to work within community based settings. The family intervention and community mental health teams had highest reports of interactions with parents, including discussing issues of PMI with parents and children. Champions recorded higher FFP subscale scores than the rest of the sample particularly in relation to skills and knowledge. Managers were more satisfied with the level of organisational support for FFP compared to the wider sample. Compared with managers working within adult mental health, children services managers reported higher scores across all FFP subscales with the exception of 'professional development', 'co-worker support' and 'interventions to promote parents' mental health'.*

### **Interdisciplinary Differences in FFP:**

A review of FFP response scores across disciplines was also undertaken in order to explore any notable differences in the extent of FFP and level of satisfaction regarding organisational support for FFP. Table 4.5 provides an overview of individual disciplines mean scores on the 14 FFP subscales. Given the large representation of Social Workers, these professionals were split by adult mental health and children services. All disciplines scored highest in relation to *interventions to promote parents' mental health* (i.e. professional interventions to reduce the impact of the service user's parenting role on their mental health). Lowest scores across all disciplines were in relation to *time and workload*, followed by *family and parenting support* (i.e. providing resources and referral information to consumers and their families).

### ***Are there differences between disciplines in relation to their FFP?***

In relation to the six family focused behavioural subscales, highest scores were obtained by Social Workers followed by Nurses and Psychologists. Psychiatrists consistently obtained the lowest scores across all FFP subscales and scored lowest on two of the behavioural subscales, including *assessing the impact on the child* and *connectedness*.

### ***Are there differences between Social Workers practicing within adult mental health and children's services?***

There were some interesting differences between adult mental health and children's service social workers. Social Workers within adult mental health services scored higher on *interventions to promote parents' mental health*, *support to carers and children* and *family and parenting support*. Social workers within children's services scored higher on *assessing the impact on the child*, *connectedness* and *referrals*. We found a statistically significant difference between Social Workers within adult mental health and children's services on the FFP subscales ( $F(14, 421) = 10.16, P < .001$ ). We noted differences in relation to *time and work load*, *assessing the impact on the child*, *training*, *connectedness*, *referrals* and *interventions to promote parents' mental health*.

**Table 4.5:****Mean scores Across Disciplines on FFP Subscales**

Subscale	Professional Background						
	Nurse M (SD)	Social Work AMH M (SD)	Social Work Children M (SD)	Psychiatrist M (SD)	Psychologist M (SD)	Allied Health Professional M (SD)	Other M (SD)
Workplace Support	4.18 (1.41)	4.00 (1.46)	4.21 (1.47)	4.06 (1.17)	4.00 (1.31)	3.94 (1.58)	4.56 (1.37)
Time and Workload	3.53 (1.18)	3.39 (1.32)	3.81 (1.37)	2.89 (1.14)	3.09 (1.18)	3.43 (1.32)	4.45 (1.24)
Professional Development	4.57 (1.25)	4.56 (1.39)	4.41 (1.38)	4.46 (0.98)	4.57 (1.14)	4.50 (1.30)	4.69 (0.99)
Co-worker Support	4.46 (1.29)	3.99 (1.46)	4.17 (1.37)	4.67 (1.09)	4.26 (0.90)	4.45 (1.40)	4.34 (1.28)
Assessing the Impact on the Child	3.35 (1.16)	3.71 (1.36)	4.36 (1.16)	3.02 (1.18)	4.15 (0.85)	3.31 (1.29)	3.73 (1.04)
Training	5.33 (1.06)	5.45 (1.11)	5.95 (0.77)	4.76 (1.19)	5.03 (1.02)	5.59 (1.05)	5.07 (0.93)
Skills & Knowledge	4.33 (1.02)	4.79 (1.04)	4.81 (0.93)	4.32 (0.82)	5.09 (0.87)	3.98 (1.10)	5.01 (1.14)
Connectedness	4.72 (1.07)	4.94 (1.22)	5.17 (0.91)	4.45 (0.99)	5.48 (0.75)	4.61 (1.11)	4.80 (1.35)
Referrals	3.97 (1.27)	4.08 (1.36)	4.73 (1.18)	3.45 (1.36)	3.05 (1.47)	3.61 (1.07)	4.38 (0.71)
Interventions to promote Parents MH	5.24 (0.93)	5.35 (0.91)	5.12 (0.86)	5.38 (0.69)	5.45 (0.88)	5.25 (0.92)	5.44 (0.85)
Confidence around Children Generally	6.20 (0.80)	6.23 (0.63)	6.31 (0.56)	6.20 (0.36)	6.29 (0.87)	6.25 (0.65)	6.42 (0.40)
Worker Confidence	4.51 (1.26)	4.94 (1.17)	5.06 (1.01)	4.06 (0.86)	4.58 (1.26)	4.83 (1.13)	4.72 (1.70)
Support to Carers & Children	4.63 (0.76)	4.72 (0.84)	4.62 (0.79)	4.48 (.60)	4.18 (.64)	4.30 (0.93)	4.81 (0.90)
Family & Parenting Support	3.80 (0.90)	3.94 (1.06)	3.77 (0.79)	3.22 (0.85)	3.06 (0.78)	3.38 (0.97)	3.77 (1.02)

Given the overall higher scores among Social Workers, we further explored any differences between Social Workers and all other disciplines on all FFP subscales. Results indicate a statistically significant difference ( $F(14, 853) = 20.1, P < .001$ ) between Social Workers and all other professionals in relation to; *assessing the impact on the child, connectedness, referrals, family & parenting support, time and workload, co-worker support, training, skills & knowledge and worker confidence.*

The finding that Social Workers are more family focused and more positive regarding organisational support for FFP is perhaps unsurprising given the large representation of Social Workers across adult mental health ( $n = 124$ ) and in particular children's services ( $n = 312$ ) within the current study sample. Nevertheless, Maybery et al. (2014) also found Social Workers to be more family focused than other health care professionals.

With the exception of Psychiatrists, all disciplines scored similarly in relation to *training* but this was slightly higher among Social Workers indicating a need and willingness to engage in future FFP training. Interestingly, when asked about *workplace supports* for FFP (i.e. supervision), higher scores came from those represented by 'Other' followed by Nurses and Social Workers.

Those least satisfied with *workplace supports* included Allied health professionals followed by Psychologists and Psychiatrists. That said, Psychiatrists reported higher scores in relation to the perceived support from other workers regarding family focused work; this was followed by Nurses and Allied health professionals. Lower scores for perceived support from other workers regarding family focused work was reported by Social workers followed by Other and Psychologists.

### **Summary: Interdisciplinary Differences in FFP**

Overall, results show that Social Workers followed by Nurses and then Psychologists tend to record higher scores on FFP subscales. Psychiatrists recorded lowest scores on FFP subscales. Differences in FFP scores were also noted between Social Workers within adult mental health and children's services. Social Workers within adult mental health services scored higher on 'interventions to promote parent's mental health', 'support to carers and children' and 'family and parenting support'. Social workers within children services scored higher on 'assessing the impact on the child', 'connectedness's and 'referrals'. Such findings perhaps highlight the different client focus of each service and strengths within these. Scores relating to 'training' indicate that across all disciplines professionals perceive that there is a need and willingness to engage in future FFP training.

### **Comparison of FFP Mean Scores across Trusts:**

The mean scores for each Trust on the 14 FFP subscales were also compared, Table 4.6 provides an overview.

#### **Are there differences in FFP across Trusts?**

While all Trusts recorded high scores in subscales *interventions to promote parents' mental health* and *training* (indicating that they desired more training), all Trusts recorded low scores on all other subscales, irrespective of whether they measured family focused activities or organisational support for FFP. MANOVA indicated that there were some statistical difference across Trusts ( $F = (14, 850), = 2.43, P < .001$ ). Post hoc comparisons indicated that with regard to family focused activities, Belfast and Northern Trust recorded higher scores in relation to *assessing the impact on the child* compared to the Southern Trust ( $P < .05$ ).

**Table 4.6:****Mean Scores across Trusts on FFP Subscales**

Subscale	Belfast	South Eastern	Western	Southern	Northern
	M (SD)				
Workplace Support	4.13 (1.41)	4.44 (1.36)	3.95 (1.49)	4.01 (1.47)	4.27 (1.40)
Time and workload	3.63 (1.26)	3.74 (1.38)	3.82 (1.38)	3.43 (1.20)	3.32 (1.24)
Professional Development	4.54 (1.28)	4.82 (1.30)	4.38 (1.36)	4.30 (1.36)	4.50 (1.18)
Co-worker Support	4.21 (1.31)	4.54 (1.35)	4.19 (1.39)	4.22 (1.41)	4.31 (1.36)
Assessing the impact on the child	3.96 (1.30)	3.71 (1.38)	3.76 (1.29)	3.55 (1.25)	4.00 (1.19)
Training	5.59 (1.30)	5.19 (1.32)	5.80 (.85)	5.52 (.92)	5.78 (.85)
Skills & Knowledge	4.78 (1.05)	4.55 (1.16)	4.47 (.94)	4.44 (.98)	4.69 (.94)
Connectedness	5.05 (1.00)	4.88 (1.14)	4.86 (1.10)	4.85 (.97)	4.94 (.96)
Referrals	4.23 (1.31)	4.18 (1.43)	4.37 (1.27)	4.01 (1.22)	4.38 (1.30)
Interventions to promote Parents MH	5.21 (.86)	5.28 (.99)	5.07 (.98)	5.27 (.88)	5.30 (.77)
Confidence around children generally	6.29 (.64)	6.18 (.79)	6.17 (.98)	6.29 (.70)	6.33 (.50)
Worker Confidence	4.87 (1.16)	4.74 (1.38)	4.75 (1.07)	4.70 (1.17)	4.78 (1.16)
Support to carers & Children	4.69 (.78)	4.62 (.84)	4.71 (.75)	4.56 (.77)	4.49 (.82)
Family & Parenting Support	3.73 (.94)	3.86 (1.02)	3.85 (.94)	3.61 (.90)	3.77 (.97)

The Northern Trust scored higher across all Trust in relation to *interventions to promote parents' mental health* (i.e. professional interventions to reduce the impact of the service user's parenting role on their mental health). That said, Tukey HSD post hoc test indicated that this difference was not statistically significant compared to other Trusts ( $p > .05$ ). The Belfast Trust also scored highest in relation to *connectedness* (i.e. professionals' assessment of parent awareness of child connectedness) but this was also insignificant compared with other Trusts ( $p > .05$ ). The remaining four family focused activities received low scores across all Trusts.

With regard to organisational supports, lowest scores across all Trusts was in relation to *time and workload*, generally indicating that across Trusts, professionals feel there is little time to provide resource to and work with parents and families in a family focused way. Post hoc test indicated that there was a significant difference with regards to *time and workload* scores between the Northern Trust compared with the South Eastern Trust and compared with the Western Trust. The Northern Trust recorded a lower score than all other Trusts in relation to *time and workload*. Both the South Eastern and Western Trusts recorded higher mean scores with regards to this. Lower scores relating to *time and workload* indicate that time and work load is perceived as a major barrier to family focused work.

***Summary: Comparison of FFP Mean Scores across Trusts.***

*Result indicate that across each Trust, professionals perceive that there is not enough time to work with and support parents and their families in a family focused way and that they received limited organisational support to engage in FFP. They also report wider systemic barriers to FFP including limited policy to guide FFP and limited service availability for referrals.*

### High Scoring HSC Professionals:

Although over half of HSC professionals recorded lower scores on the FFP behavioural subscales, over a third ( $n = 354$ , 40.8%) obtained a high score (between 5 - 7 on the Likert Scale) on at least three of the six FFP behavioural subscales. High scorers practiced across all five HSC Trusts, 27.1% Belfast Trust ( $n = 96$ ), 19.2% South Eastern Trust ( $n = 68$ ), 18.9% Western Trust ( $n = 67$ ), 18.9% Northern Trust ( $n = 67$ ) and 15.8% Southern Trust ( $n = 56$ ). Higher scorers predominantly reported as Social Workers ( $n = 225$ , 63.6%) and Nurses ( $n = 100$ , 28.2%) working at either Band 6 ( $n = 170$ , 48%) or Band 7 ( $n = 115$ , 32.5%) and a smaller number reporting as Band 5 ( $n = 27$ , 7.6%) and Band 8 ( $n = 20$ , 5.6%). Table 4.7 provides an overview of the percentage of high scorers by service and Band.

**Table 4.7:**

**Percentage of High Scorers by Service and Band**

	<b>Band 5</b>	<b>Band 6</b>	<b>Band 7</b>	<b>Band 8</b>
Adult Mental Health	11 (12%)	78 (19%)	71 (29%)	6 (13%)
Children Services	16 (17%)	91 (22%)	41 (17%)	10 (22%)
Total	27 (29%)	169 41%	112 46%	16 35%

(Percentage within Band for Total Sample where known,  $n = 791$ )

A large majority of these high scorers reported practicing within community mental health teams ( $n = 105$ , 29.7%), or within family intervention teams ( $n = 73$ , 20.6%), with 68.9% ( $n = 244$ ) reporting that they provide a service to parents with mental illness or their children on a daily or weekly basis. As illustrated by Table 4.8, the group of high scorers had higher mean scores on all 14 FFP subscales when compared with the rest of the sample. This group scored highest in *confidence around children generally* and *interventions to promote parents' mental health*. Lowest scores for this group related to *time and workload* and *family and parenting support*. As previously noted, the ultimate aim of the Think Family NI initiatives is to help improve the extent of which assessment, planning and treatment across services are family focused. An intended outcome of some of the staff development initiatives included increased confidence and competencies of HSC professionals to

work with both parents and children. Findings relating to high scorers suggest that a substantial minority of HSC professionals are able to support service users in their parenting. That said lack of time and high workloads are impacting HSC professionals' ability to engage in other family focused activities, including supporting children.

**Table 4.8:**  
**Comparisons of Means and SD between High Scoring HSC professionals and Remainder of the Sample**

Subscale	High Scorers		Low medium Scorers	
	M	SD	M	SD
Workplace Support	4.45	1.52	3.94	1.32
Time and workload	3.91	1.35	3.37	1.21
Professional Development	4.84	1.34	4.28	1.23
Co-worker Support	4.57	1.40	4.08	1.29
Assessing the impact on the child	4.48	1.28	3.33	1.07
Training	5.63	1.01	5.53	1.03
Skills & Knowledge	5.14	0.88	4.22	0.94
Connectedness	5.62	0.68	4.44	0.96
Referrals	4.97	1.16	3.72	1.15
Interventions to promote Parents MH	5.65	0.64	4.92	0.92
Confidence around children generally	6.31	0.68	6.21	0.66
Worker Confidence	5.21	1.11	4.48	1.14
Support to carers & Children	5.06	0.72	4.31	0.68
Family & Parenting Support	4.16	0.98	3.48	0.82

### ***Are there major differences between high scorers and the remainder of HSC professionals taking part in the study?***

The biggest difference, in the six behavioural subscales, between the high scorers and the rest of the sample related to *referrals* compared to the remainder of the sample. The biggest difference between the high scorers and the rest of the sample on the non-behavioural subscales related to *skills and knowledge*.

One way MANOVA was conducted to investigate if there was a statistically significant difference between high scorers and the remainder of the sample on all 14 FFP subscales. Results indicate a statistically significant difference ( $F(14, 853) = 65.3, P < .001$ ) between the two groups in relation to all FFP subscales with the exception of *training*. Findings reflect some of the core aims of the Think Family NI initiatives which aim to improve professionals' knowledge and understanding of PMI and, or substance use problems, including referrals for specific support needs for families.

29.4% ( $n = 104$ ) of high scorers also indicated that they are aware of The Family Model (TFM) (Falkov 1998, 2012) and 16.9% ( $n = 60$ ) use this model in their work. In contrast only a small number of the remainder of the sample were aware of TFM ( $n = 69, 13.4%$ ) and use this in their work ( $n = 25, 4.8%$ ).

In comparison to the rest of the sample, high scorers also perceived that current screening and assessment documentation (including UNICINI) facilitated their FFP (high scorers  $n = 255, 80.2%$  compared to  $n = 280, 71.4%$ ). A greater number of high scorers also perceived that the Regional Adult and Children's Services Joint Protocols enabled their FFP (high scorers  $n = 164, 80.4%$  compared to  $n = 123, 60%$ ).

### ***Do high scorers work more closely with parents who have mental illness, their children and families?***

Forty two percent ( $n = 64$ ) of high scorers compared with 35.3% of the remaining sample ( $n = 54$ ), reported spending 50% or more in the service user's home delivering services. High scorers also reported spending more face-to-face contact

with children whose parents have a mental illness (high scorers  $n = 144$ , 43.4%) compared to the remainder of the sample  $n = 96$ , 23.3%).

***Summary: High Scoring HSC Professionals.***

*Over a third of professionals recorded a high score on at least three of the six FFP behavioural subscales. Higher scores tended to be Social Workers and Nurses, practicing within community mental health teams or family intervention teams and providing a service to parents or children on a weekly basis. Greatest differences between high scorers and the remainder of the sample was in relation to referrals, confidence around children generally and interventions to promote parents' mental health. Furthermore, high scorers also reported greater skills and knowledge. The ultimate aim of Think Family initiatives is to help improve the extent of which assessment, planning and treatment across services are family focused. An intended outcome of some of the Think Family NI initiatives includes increased confidence and competencies of staff to work with both parents and children. Findings relating to high scorers reflect this. Personal experience of parenting may also help HSC professionals to engage in FFP.*

### **Predicting HSC Professionals' FFP:**

Hierarchical multiple regression was used to assess how well seven subscales (measuring organisational and worker factors) predicted six behavioural subscales (measuring family focused activities) after controlling for the influence of seven known predictor variables. The main aim of using hierarchical multiple regressions were to identify;

#### **What are the key factors (predictors) that predict six key family focused behaviours in a large sample of HSC professionals in NI?**

Prior to conducting multiple regressions, the 14 FFP subscales were judged to be either independent variables/predictors (IV) of FFP or dependent variables/behavioural outcomes (DV) of FFP. Decisions were made in distinguishing between these two groups of variables according to the literature and individual subscale description (Grant 2014; Maybery et al., 2014; Goodyear et al., 2017). In addition, seven IV's were identified from within demographic items in part A and C of the FFMHPQ (see FFMHPQ in Technical Report and Appendices, [Appendix I]). Some of these demographic items were re-coded into dichotomous variables (Yes/No) to allow them to be utilised within the multiple regression model. The order of variable entry was determined in order to allow analyses to demonstrate what the key variables identified in the literature, pilot study and reflected in the FFMHPQ contributed to the prediction of FFP over and above control variables and existing measures (Tabachnick & Fidell, 2007). The final significant predictors for step three within the six DV's are reported in Tables 4.9 to 4.14. Each table reports the significance level, unstandardised (b) and standardised ( $\beta$ ) regression coefficients, standard error (SE b) and R square change ( $\Delta R^2$ ).

#### **What influences HSC professionals' assessment of the impact of PMI on the child?**

In combination, three predictor variables, *Gender*, *Length of Time Practicing* and *Skills and Knowledge* explained 22 percent of the variance in *Assessing the Impact on the Child* ( $R^2 = .219$ , adjusted  $R^2 = .199$ ,  $F = (16, 621) = 10.82$ ,  $p < .001$ ).

**Table 4.9:**

**Hierarchical Multiple Regression for Dependant Variable – Assessing the Impact on the Child**

Significant Predictors	R <sup>2</sup>	b	β	SE b	P (Sig)
<b>Step 3</b>	.219				
Gender (Female)**		-.301	.099	-.110	.002
Length of Time Practicing***		-.568	-.215	.133	.000
Skills & Knowledge***		.414	.330	.054	.000

Note: ΔR Step 1 = .078, ΔR Step 2 = .137, ΔR Step 3 = .004, \* p<.05, \*\* p<. 01, p<.001\*\*\*:

These results suggest that being female and practicing for more than 10+ years (both males and females) are predictors of and have a potential negative effect on the assessment of impact of PMI on the child. Importantly, results also indicate that greater knowledge regarding the impact of PMI on children has a positive effect on professionals' assessment.

**What influences HSC professionals' assessment of parent awareness of child connectedness?**

In combination, five predictor variables including, *Age, Length of time practicing, Co-Worker Support, Training and Skills and Knowledge*, explained 31.8% of the variance in predicting *Connectedness* (R2 = .318, Adjusted R2 = .300, F = (16, 618) = 18.02, p<.001).

**Table 4.10:**

**Hierarchical Multiple Regression for Dependant Variable – Connectedness**

Significant Predictors	R <sup>2</sup>	b	β	SE b	P (Sig)
<b>Step 3</b>	.318				
Age**		.138	.135	.047	.004
Length of time practicing**		-.296	-.139	.100	.004
Co-Worker Support**		.092	.120	.030	.002
Training**		.122	.124	.034	.001
Skills & Knowledge***		.464	.458	.041	.000

Note: ΔR Step 1 = .052, ΔR Step 2 = .262, ΔR Step 3 = .004, \* p<.05, \*\* p<. 01, p<.001\*\*\*

Overall, results indicate that being older and feeling supported by colleagues to engage in FFP, a willingness to undertake training relating to working with parents

and children and having skills and knowledge regarding the impact of PMI on children all have a positive effect on professionals' assessment of parents' awareness of their child's connectedness within wider family and community (including school).

### **What influences HSC professionals' referrals of family members to other programmes?**

In combination five predictor variables; *Workplace Support, Time and Workload, Training, Skills and Knowledge* and *Worker Confidence*, explained 20.4% of the variance in predicting *Referrals* ( $R^2 = .204$ , Adjusted  $R^2 = .183$ ,  $F = (16, 618) = 9.88$ ,  $p < .001$ ).

**Table 4.11:**

#### **Hierarchical Multiple Regression for Dependant Variable – Referrals**

<b>Significant Predictors</b>	<b>R<sup>2</sup></b>	<b>b</b>	<b>β</b>	<b>SE b</b>	<b>P (Sig)</b>
<b>Step 3</b>	.204				
Workplace Support***		.153	.168	.042	.000
Time & Workload***		.128	.128	.039	.001
Training***		.173	.139	.047	.000
Skills & Knowledge***		.281	.218	.056	.000
Worker Confidence*		.098	.087	.047	.039

Note:  $\Delta R$  Step 1 = .028,  $\Delta R$  Step 2 = .175,  $\Delta R$  Step 3 = .001, \*  $p < .05$ , \*\*  $p < .01$ ,  $p < .001$ \*\*\*.

Overall, professionals who think that their workplace provides support (e.g. supervision) for FFP, are more likely to have more time for FFP, greater skills and knowledge as well as confidence for working with families and a willingness to undertake further family training. Professionals are also more likely to indicate that they refer family members to other programs and to feel more positive about collaborating with other professionals to meet the needs of families.

### **What influences HSC professionals' interventions to promote parents' mental health?**

In combination three predictor variables; *Child focused Training, Time and Workload* and *Skills and Knowledge*, explained 25.2 percent of the variance in predicting

*Interventions to Promote Parents' Mental Health*, ( $R^2 = .252$ , Adjusted  $R^2 = .233$ ,  $F = (16, 618) = 13.02$ ,  $p < .001$ ).

**Table 4.12:**

***Hierarchical Multiple Regression for Dependant Variable – Interventions to Promote Parents' Mental Health***

Significant Predictors	$R^2$	b	$\beta$	SE b	P (Sig)
<b>Step 3</b>	.252				
Child Focused Training***		-.289	-.151	.074	.000
Time & Workload*		-.055	-.078	.026	.038
Skills & Knowledge***		.434	.482	.038	.000

Note:  $\Delta R$  Step 1 = .047,  $\Delta R$  Step 2 = .205,  $\Delta R$  Step 3 = .000, \*  $p < .05$ , \*\*  $p < .01$ ,  $p < .001$ \*\*\*:

Results indicate that having more time for FFP and greater skills and knowledge regarding the impact of PMI on children had a positive effect on professionals' interventions to reduce the impact of the service user's parenting role on their mental health. Alternatively, having child focused training had a negative effect.

***What influences HSC professionals' support to carers and children?***

In combination, four predictor variables; *Time & Workload*, *Professional Development*, *Skills and Knowledge* and *Worker Confidence*, explained 34.4 percent of the variance in predicting Support to Carers and Children, ( $R^2 = .344$ , Adjusted  $R^2 = .327$ ,  $F = (16, 618) = 20.27$ ,  $p < .001$ ).

**Table 4.13:**

***Hierarchical multiple Regression for Dependant Variable – Support to Carers and Children***

Significant Predictors	$R^2$	b	$\beta$	SE b	P (Sig)
<b>Step 3</b>	.344				
Time & Workload***		.177	.293	.021	.000
Professional Development *		.065	.106	.026	.014
Skills & Knowledge***		.224	.288	.031	.000
Worker Confidence *		.062	.093	.026	.016

Note:  $\Delta R$  Step 1 = .032,  $\Delta R$  Step 2 = .307,  $\Delta R$  Step 3 = .003, \*  $p < .05$ , \*\*  $p < .01$ ,  $p < .001$ \*\*\*:

Having more time for FFP, greater skills and knowledge of the impact of PMI on children, confidence in working with parents and children and opportunities for professional development regarding working with families all had a positive effect on professionals' perspectives of the level of information, advocacy and referral they provide to carers and children.

### **What influences HSC professionals' family and parenting support?**

In combination five predictor variables; *Child Focused Training, Time and Workload, Co-Worker Support, Training and Skills and Knowledge* explained 21.5 percent of the variance in predicting *Family and Parenting Support*, ( $R^2 = .215$ , Adjusted  $R^2 = .195$ ,  $F = (16, 618) = 10.57$ ,  $p < .001$ ).

**Table 4.14:**

#### **Hierarchical Multiple Regression for Dependant Variable – Family and Parenting Support**

<b>Significant Predictors</b>	<b>R<sup>2</sup></b>	<b>b</b>	<b>β</b>	<b>SE b</b>	<b>P (Sig)</b>
<b>Step 3</b>	.215				
Child Focused Training**		-.217	-.107	.080	.007
Time & Workload***		.099	.134	.029	.001
Co-Worker Support***		.144	.200	.030	.000
Training**		.113	.123	.035	.001
Skills & Knowledge***		.209	.219	.041	.000

Note:  $\Delta R$  Step 1 = .042,  $\Delta R$  Step 2 = .170,  $\Delta R$  Step 3 = .003, \*  $p < .05$ , \*\*  $p < .01$ ,  $p < .001$ \*\*\*.

Overall, results indicate that greater skills and knowledge of the impact of PMI on children, time for FFP, support from colleagues regarding FFP and wiliness for further training related to working with families all had a positive effect on professionals' support for parents and families (i.e. providing resources and referral information to consumers and their families).

#### **Summary of Regression Findings for Whole Sample:**

Eleven of the fourteen FFP IV's were identified as significant predictors, in step three, in one or more of the six multiple regression models and in combination predicted between 20.4 percent and 34.4 percent of variance within the FFP DV's (See Table 4.15 for overview). *Skills and Knowledge* (i.e. Worker skill and knowledge regarding impact of PMI on children) was the single most important predictor as it

was significant in all FFP DVs tested. *Time and Workload* is also important and is a significant predictor of four of the DVs. *Training* and *Co-Worker Support* were significant predictors in three of the FFP DV's. *Length of Time Practicing*, *Child Focused Training* and *Worker Confidence* are also important in that each of them predict at least two of the DVs. *Age*, *Gender*, *Workplace Support* and *Professional Development* were noted as less important predictors, adding to one DV. The two new predictors, *Confidence around Children Generally* and *Screening and Assessment Tools Facilitating FFP*, were not significant predictors within any of the six DVs.

**Table 4.15:**  
**Summary of Significant FFP Predictors**

Dependent	Key FFP Predictor's	Other Factors	Overall variance explained by predictors
<i>Assessing the Impact on the Child</i>	<b>Skills &amp; Knowledge</b>	<b>Gender (Female)</b> <b>Length of Time Practicing</b>	21.9%
<i>Connectedness</i>	<b>Co-Worker Support</b> <b>Training</b> <b>Skills &amp; Knowledge</b>	<b>Age</b> <b>Length of Time Practicing</b>	31.8%
<i>Referrals</i>	<b>Workplace Support</b> <b>Time &amp; Workload</b> <b>Training</b> <b>Skills &amp; Knowledge</b> <b>Worker Confidence</b>		20.4%
<i>Interventions to Promote Parents' Mental Health</i>	<b>Time &amp; Workload</b> <b>Skills &amp; Knowledge</b>	<b>Child Focused Training</b>	25.2%
<i>Support to Carers and Children</i>	<b>Time &amp; Workload</b> <b>Professional Development</b> <b>Skills &amp; Knowledge</b> <b>Worker confidence</b>		34.4%
<i>Family and Parenting Support</i>	<b>Time &amp; Workload</b> <b>Co-Worker Support</b> <b>Training</b> <b>Skills &amp; Knowledge</b>	<b>Child Focused Training</b>	21.5%

Such findings most likely reflect the development and implementation of the Think Family NI initiatives over time. The introduction of the Think Family NI initiatives during 2009-2012 started with awareness raising among professionals through training as well as the circulation of educational resources. This later advanced to the design and implementation of formal protocols and pathways in support of joint working between adult mental health and children's services. Current findings may reflect the length of time some initiatives have been in place in comparison to others, with earlier work much more imbedded within current practice. Furthermore, it is important to consider that without skills and knowledge and the time and resource to engage in FFP, other factors become less important.

***Summary: Predicting HSC Professionals' FFP***

*As expected, the results highlight that skills and knowledge relating to PMI and its impact on children is crucial in enabling HSC professionals' to engage in FFP. Results also indicate that having less time and higher workloads has the potential to negatively impact HSC professionals' capacity to engage in FFP. It is important therefore for HSC professionals' FFP that they are supported by their colleagues in meeting the needs of families and that they have the confidence to work with families including children. The HSCB has invested in training linked to Think Family NI. The findings from the survey support such development opportunities to increase HSC professionals' knowledge, skills and confidence in relation to the impact of PMI and, or substance use problems, and in meeting the needs of family members.*

## **Differences between professionals' FFP in Adult Mental Health and Children's Services:**

This section outlines findings related to differences between professionals' FFP in adult mental health and children's services and more specifically answers the following research question;

### **What are the significant differences, if any, between professionals' FFP in adult mental health and children's services?**

To examine for any differences the above multiple regression was re-run with an additional variable of *adult/children's services* to help distinguish professionals practicing in adult mental health and children's services. The process of setting up building blocks for the hierarchical multiple regression for the two specific groups of HSC professionals practicing within adult mental health services ( $n = 493$ ) and children's services ( $n = 316$ ) followed the same process as the previous multiple regression, however this time with the inclusion of a fourth block. If this inclusion resulted in a significant improvement in the regression equation it would suggest that there were differences between the two groups of HSC professionals' practices. The results from the final step of the six regression analyses are shown in Table 4.16 which summarises the influence of the newly created variable.

**Table 4.16:**

**Hierarchical Multiple Regressions for the Influence of new variable 'Adult / Children's Services Group: Results for ALL dependant variables**

Dependant Variable	R <sup>2</sup>	Significant Predictor	b	β	SE b	P (Sig)
Assessing the Impact on the Child	.220	Adult / Children's Services***	-.235	-.250	.042	.000
Connectedness	.327	Adult / Children's Services*	-.163	-.075	.085	.058
Referrals	.248	Adult / Children's Services***	-.613	-.222	.115	.000
Interventions to promote Parents MH	.289	Adult / Children's Services***	.375	.194	.078	.000
Support to Carers and Children	.362	Adult / Children's Services***	.260	.156	.064	.000
Family and Parenting Support	.222	Adult / Children's Services	.153	.075	.086	.075

Note: \* p<.05, \*\* p<. 01, p<.001 \*\*\*: Adult/Children's Services denoted 2 specific groups of professionals – professionals practicing within adult mental health services and professionals practicing within children's services.

The findings indicate that *adult/children's services* or where professionals practice is generally a significant predictor of FFP. With the exception of *connectedness* and *family and parenting support*, the inclusion of this new variable resulted in significant improvements in the regression equation, suggesting that there were differences between the two groups of HSC professionals' practices. Consequently, a further series of analyses were conducted to examine the differences between the two groups.

Firstly, independent-samples t-test were conducted with the newly created IV (adult/children's services) on mean scores of demographic variables including *age*, *length of experience*, *length of time in current employment*, *number of service users on case load*, *number of parents who have mental illness on case load*. Significant differences across the groups were noted in relation to all demographic variables of interest. Table 4.17 provides an overview.

**Table 4.17:**

***T-Test Comparisons of Adult Mental Health & Children's Services Professionals on Demographic Variables***

Demographic Dependant Variables	Adult Mental Health Service Professionals			Children's Service Professionals			P (Sig)	T – Score
	N	Mean	SD	N	Mean	SD		
Age	488	38.49	10.23	315	42.55	9.48	.000	-5.75
Length of Time Practicing ( <i>Years</i> )	489	17.03	11.01	314	10.04	8.92	.000	-9.86
Length of Time in Current Post ( <i>Years</i> )	491	6.65	6.28	314	4.95	5.28	.000	-3.99
Number of Service Users Delivered Care to	285	48.79	101.69	111	20.09	29.43	.004	-2.92
Number of Parents Delivered Care to	161	28.18	105.66	110	7.13	11.28	.039	-2.07

Note: \* p<.05, \*\* p<. 01, p<.001\*\*\*:

Significant differences between the two groups of professionals were noted in relation to *age, length of time practicing, length of time in current post* and *number of service users delivering care to*. Children's services professionals were on average four years older than adult mental health professionals. That said, adult mental health professionals reported as practicing on average seven years more and in their current post nearly two years longer. Additionally, adult mental health professionals reported as delivering direct care to a higher number of services users, particularly those who are parents with a mental illness.

Such findings are not surprising given the differing roles and responsibilities of professionals relating to PMI across adult mental health services, where the parent is generally the focus of service delivery compared to children's services professionals whose main priority would be the child(ren). These worker related factors can impact on FFP and as such require consideration by organisations when developing and implementing family focused initiatives.

***Are there statistically significant differences in FFP between adult mental health and children’s services?***

Findings suggest that children’s service professionals and adult mental health professionals do differ in their FFP ( $F(14, 794) = 27.01, P < .001$ ). Using independent samples t-test’s we explored the differences in subscale mean scores. Table 4.18 provides an overview; t-tests were conducted for each subscale.

**Table 4.18:**  
***T-Test Comparisons of Adult Mental Health and Children’s Services Professionals on FFP Subscales***

Demographic Dependent Variables	Adult Mental Health Service Professionals ( <i>n</i> = 493)		Children’s Service Professionals ( <i>n</i> = 316)		T-Score	P (Sig)
	Mean	SD	Mean	SD		
Workplace Support	4.10	1.43	4.23	1.47	1.20	.231
Time and Workload	3.45	1.24	3.83	1.38	3.97	.000
Professional Development	4.57	1.28	4.42	1.38	-1.55	.120
Co-Worker Support	4.35	1.38	4.17	1.37	-1.81	.070
Training	5.33	1.09	5.94	.78	9.24	.000
Skills and Knowledge	4.45	1.06	4.81	.93	5.15	.000
Worker Confidence	4.58	1.25	5.06	1.02	5.91	.000
Confidence Around Children Generally	6.21	.73	6.31	.56	2.03	.042
Assessing the Impact on the Child	3.42	1.24	4.36	1.16	10.74	.000
Connectedness	4.77	1.09	5.17	.90	5.63	.000
Referrals	3.93	1.31	4.72	1.18	8.59	.000
Interventions to promote Parents MH	5.30	.90	5.11	.86	-2.94	.003
Support to Carers and Children	4.62	.80	4.62	.79	.120	.904
Family and Parenting Support	3.75	.98	3.78	.92	.346	.729

Note\*  $p < .05$ , \*\*  $p < .01$ ,  $p < .001$ \*\*\*

Table 4.18 highlights that there were significant differences across six of the fourteen variables between the two groups of HSC professionals. It is important to note that difference on professionals’ scores within these particular subscales most likely reflects professionals’ responsibilities and roles within their respective service area. For example, it is unsurprising that children’s service professionals would be more confident in assessing the impact on the child as they work with children more often.

Adult mental health professionals on the other hand within their job role are more likely to be involved in interventions to promote a parents' mental health. Thus it is not surprising they scored significantly higher on this particular subscale.

That said, children's service professionals did score significantly higher in relation to three family focused behavioural subscales including *assessing the impact of the child*, *connectedness* and *referrals*. They also scored significantly higher in relation to professional and organisational factors including *time and workload*, *skills and knowledge*, *worker confidence* and *confidence around children generally*. Such findings suggest that professionals in children's services are generally more family focused than those in adult mental health services.

In terms of the other family focused behaviours there were no significant differences in mean scores between the two groups with regard to *support to carers and children* and *family and parenting support*. Furthermore, no significant differences were also noted on the other organisational factors including in professionals' *workplace support* and *professional development* or *co-worker support*. Such findings support the notion that while professionals in children's services are generally more family focused a certain amount of consistency exists across both adult mental health and children's service in relation to some particular family focused activities and organisational factors that enable FFP. Moreover, differences in HSC professionals' role in either service may affect their capacity to support parents or their children and require consideration by organisations in integrating Think Family NI initiatives.

### ***Are the predictors of FFP different in adult mental health and children's services?***

All regressions were run again but this time the sample was split into adult mental health services professionals only and children services professionals only. It was hoped that in doing so, any differences in significant predictors in professionals' family focused behaviours could be highlighted. The process of setting up the regression models remained the same with the exception of a new variable which represents 'adult mental health training', added to the children's services only regressions. This new addition to children's services only regression is due to the fact that it is expected that adult mental health professionals will have received adult

mental health training; this may not be the case for those working with children services.

### ***What are the significant predictors for children's service professionals' FFP?***

As can be seen from Table 4.19 below, a persistent predictor of all six FFP behaviours among children's service professionals includes *skills and knowledge* relating to the impact of PMI on children. This was the only significant predictor in the final model for *assessing the impact on the child*.

In relation to *connectedness* (i.e. workers' assessment of parent awareness of child connectedness), *family and child focused training* as well as *professional development* opportunities to work with families, all contributed towards this assessment behaviour. *Professional development* also contributed towards professionals' *referral process* (i.e. referring family members to other programs).

*Child focused training* was an important predictor for interventions to promote parents' mental health, whilst *time and workload* as well as *professional development* opportunities to work with families contributed towards *support to carers and children*. *Family and parenting support* was significantly predicted by *co-worker support* (i.e. the support from other workers regarding family focused work) and *professional development*.

**Table 4.19:**

***Children Services Professionals Only: Hierarchical Multiple Regression for All Dependant Variables***

Dependant Variable	R <sup>2</sup>	Selected Main Significant Predictors	b	β	SE b	P (Sig)
Assessing the Impact on the Child	.171	<b>Skills &amp; Knowledge***</b>	.415	.342	.087	.000
		<b>Years Practicing*</b>	-.447	-.178	.215	.039
Connectedness	.335	<b>Family Focused Training**</b>	.331	.178	.123	.008
		<b>Child Focused Training**</b>	-.320	-.172	.116	.006
		<b>Skills &amp; Knowledge***</b>	.410	.431	.060	.000
		<b>Professional Development*</b>	.121	.187	.049	.014
Referrals	.235	<b>Professional Development**</b>	.200	.228	.069	.004
		<b>Skills &amp; Knowledge***</b>	.277	.224	.085	.001
Interventions to promote Parents MH	.254	<b>Child Focused Training*</b>	-.301	-.163	.124	.016
		<b>Skills &amp; Knowledge***</b>	.466	.494	.064	.000
Support to Carers and Children	.320	<b>Time &amp; Workload***</b>	.151	.268	.034	.000
		<b>Professional Development*</b>	.093	.167	.043	.032
		<b>Skills &amp; Knowledge***</b>	.252	.309	.053	.000
Family and Parenting Support	.213	<b>Co-Worker Support***</b>	.170	.241	.051	.001
		<b>Professional Development*</b>	.118	.174	.056	.037
		<b>Skills &amp; Knowledge**</b>	.207	.208	.069	.003

Note: \* p<.05, \*\* p<. 01, p<.001\*\*\*:

***What are the significant predictors for adult mental health professionals' FFP?***

Similar to children's service professionals, *skills and knowledge* relating to the impact of PMI on children was a significant predictor of all six FFP behaviours for adult mental health professionals.

In contrast adult mental health professionals *assessing the impact on the child* was predicted by *number of years practicing* and *worker confidence* in relation to working with families, parents and children. Also, adult mental health professionals' *connectedness* was predicted by *age*, *number of years practicing*, *Think Family training*, *co-worker support* and *training*. *Referrals* were significantly predicted by *work place support* as well as *time and workload*.

Interestingly, gender was noted as a significant predictor of adult mental health professionals' *interventions to promote parents' mental health* (i.e. professional interventions to reduce the impact of the service user's parenting role on their mental health). This may be due to the fact a large majority of adult mental health professionals in the current sample report as female ( $n = 315, 63.9\%$ ).

*Time and workload, training and worker confidence all contributed towards support to carers and children (i.e. the level of information, advocacy and referral provided to carers and children). Significant predictors of family and parenting support were number of years practicing, training including child focused training and also time and workload and co-worker support.*

**Table 4.20:**

**Adult Mental Health Services Professionals Only: Hierarchical Multiple Regression for All dependant variables**

Dependant Variable	R <sup>2</sup>	Selected Main Significant Predictor	b	β	SE b	P (Sig)
Assessing the Impact on the Child	.199	Years Practicing*	-.410	-.153	.175	.020
		Skills & Knowledge***	.385	.327	.070	.000
		Worker Confidence*	.117	.117	.056	.038
Connectedness	.330	Age**	.159	.141	.067	.018
		Years Practicing**	-.354	-.149	.142	.013
		Think Family Training*	.289	.110	.134	.031
		Co-Worker Support***	.157	.197	.041	.000
		Training*	.096	.097	.045	.035
Referrals	.203	Skills & Knowledge***	.506	.484	.057	.000
		Workplace Support*	.131	.143	.055	.019
		Time & Workload***	.219	.209	.054	.000
Interventions to promote Parents MH	.314	Skills & Knowledge***	.254	.204	.074	.001
		Gender**	.233	.119	.088	.008
		Skills & Knowledge***	.450	.510	.049	.000
Support to Carers & Children	.404	Time & Workload***	.222	.344	.029	.000
		Training*	.070	.097	.031	.026
		Skills & Knowledge***	.204	.266	.039	.000
		Worker Confidence*	.080	.122	.031	.012
Family & Parenting Support	.268	Years Practicing**	-.318	-.149	.134	.018
		Child Focused Training**	-.277	-.130	.106	.009
		Workplace Support*	.085	.124	.040	.034
		Time & Workload***	.149	.188	.039	.000
		Co-Worker Support***	.123	.171	.038	.001
		Training***	.161	.182	.043	.000
Skills & Knowledge***	.194	.207	.054	.000		

Note: \* p<.05, \*\* p<. 01, p<.001\*\*\*;

**Barriers and Enablers of HSC Professionals' FFP:**

Additional data was also gathered to further examine HSC professionals' perspectives of barriers and enablers to their FFP through a number of open and closed questions in part C of the survey and in a series of workshops in each Trust (See Technical Report and Appendices for further detail). Table 4.21 provides a summary of the workshop findings.

**Table 4.21:**

***HSC Professionals' Views of Barriers and Enablers to Implementing FFP***

**Barriers Related to Professionals and their Colleagues**

Limited or no knowledge of the Family Model and how to implement/ use in current service

**Organisational Barriers**

Workload pressures and waiting lists (Including voluntary sector)

No support for young carers

Client based work limits involvement with whole family

Confidentiality- rights of the child versus rights of the person

Differences in how adult services and children's services manage and assess risk i.e. Thresholds

Time to implement directives

Lack of interaction with children when working in adult services i.e. Addictions

Lack of time and resource to provide early interventions before issues become problematic

Lack of resource at lower level i.e. availability of voluntary services (These services are subject to funding and thus disappear i.e. FASA, Smiles)

Lack of awareness among statutory services of available voluntary or community services to refer to

GP Referral process – not always suitable or applicable cases for statutory services

Voluntary sector not family focused, services for Child only or Parent only

Availability of voluntary or community services to patients i.e. travel issues for those living in rural areas

No mother and baby units

Time to attend training

**Barriers related to Parents and their Families**

Parents fear and resistance to involve children. They don't want to talk about their children

**Wider Systemic Barriers**

Stigma attached to mental health – Family's do not want others to know about their issues

Stigma attached to family and children's social workers – client perceptions negative

Poor family/ network support for clients

Co-existing problems of alcohol, domestic violence, mental health

**Enablers Related to Professionals and their Colleagues**

(Not Mentioned)

**Organisational Enablers**

Communication to clients regarding professionals roles and aims

Psycho-education intervention for children & parents regarding PMI/ Substance use

Using other professionals knowledge & risk assessment

Being able to support family's through interagency practice

Shared learning and training across services

Shared specialist knowledge and resource

Joined up approaches

Services which share a location, helps build better relationship between services, better communication

Family centres & Family Group Conferences

Addressing the crisis early, investment in early intervention

Opportunity's for joint training/ peer training/ networking

Champions good resource of support and information – that's said onus on you to access, would be better if mandatory protected time for this is provided

Having an opportunity to visit clients at home – gives better idea of circumstances

Co-Location of services / disciplines

Family Hubs

Potential for better outcomes if working collaboratively & Multidisciplinary work

Holistic assessments

Information sharing to get a clear picture for risk assessment

Comprehensive assessments incorporating social, cultural and family history

**Enablers related to Parents and their Families**

Parents cooperation and engagement / Therapeutic Alliance

**Wider Systemic Enablers**

School support structures (Typically better in primary schools)

Parents cooperation and engagement / Therapeutic Alliance

As previously noted, in part three of the survey HSC professionals were also asked a number of questions relating to barriers and enablers of FFP, including what factors or circumstances deterred them from discussing parenting with parents who have mental illness. Most common response included:

- Parent current mental health state
- Lack of training and knowledge to have the conversation
- Lack of time to do so
- Fear of impacting on the therapeutic relationship with the parent

Professionals were then asked what factors and, or circumstances deterred them from discussing issues associated with PMI with children. Most common responses included:

- Children too young
- Parents would not give consent to do so
- Not trained to speak with children

Professionals were also asked about their knowledge of the Adult and Children's Services Joint Protocol (2011) which as previously noted guides service response and encourages interagency collaboration when a parent has a mental illness. 48.3% ( $n = 419$ ) noted that they are aware of the protocol and 36.5% ( $n = 317$ ) noted that they are not aware of the protocol. Across all professional disciplines, only half or less are aware of this important piece of guidance on working together to meet the needs of families.

**Table 4.22:**

**Awareness of Adult and Children’s Service Joint Protocol by Professional Discipline**

<b>Professional Discipline</b>	<b>Aware of Joint Protocol</b>	<b>Not aware of Joint Protocol</b>
Nurses (Missing n = 46)	n = 140 (47.8%)	n = 107 (36.5%)
Social Workers (Missing n = 64)	n = 242 (51.1%)	n = 167 (35.3%)
Psychiatrist (Missing n = 10)	n = 12 (36.4%)	n = 11 (33.3%)
Psychologist (Missing n = 4)	n = 4 (33.3%)	n = 4 (33.3%)
Allied Health Professionals (Missing n = 5)	n = 15 (34%)	n = 24 (54.5%)
Other (Missing n = 3)	n = 6 (46.2%)	n = 4 (30.8%)

*% within Professional Discipline were Known*

Overall, 33.1% (n = 287) perceived that the Adult and Children’s Service Joint Protocol enabled their FFP. While Social Workers were most aware of this protocol, Allied Health Professionals were least aware of it. Professionals who indicated that the protocol enabled FFP suggested that it does so by providing clear guidance, encourages communication across services including information sharing, enables collaborative working and helps ensure clear and consistent care for families where a parent has a mental illness. Those who reported that the protocol does not enable their FFP (n = 122, 14.1%) suggested that a number of improvements to strengthen the protocol could be implemented including; further training and awareness raising of the protocol regarding its purpose and how to implement within particular teams. Respondents also suggested that further opportunity be given to professionals in adult mental health and children’s services to meet and learn from one another including multidisciplinary training. They also indicated the need for more time and resource so that the protocol can be implemented in practice.

All HSC professionals were also asked if current screening and assessment tools/ documentation (including UNOCINI –Appendix 1) facilitates’ professionals to address parents and children’s needs in relation to PMI. 61.6% responded ‘Yes’ (n = 535) while 20.2% responded ‘No’ (n =175). Table 4.23 in the Technical Report and Appendices, (Appendix N), provides a breakdown by professional discipline. Professionals indicated that screening and assessment tools facilitate FFP by

providing guidance for professionals to work with families as a unit. The documentation aids professionals with risk identification and needs assessment of the whole family (parent and child) and to identify strengths and supports. The screening and assessment tools/ documentation also allows professionals to document and share any concerns across services and to consider specific issues such as PMI and any impacts this may be having in relation to parenting capacity and meeting the needs of children.

With regards improvements to screening and assessment tools / documentation, HSC professionals perceived that current documentation prompts them to consider parents' mental health as opposed to also prompting them to consider issues relating to children. Professionals were also asked if they were aware of TFM (Falkov 1998, 2012); 19% ( $n = 173$ ) reported that they are aware of the model, with only 10% ( $n = 85$ ) reporting using the model in their work. Those who use the model within their work do so by adopting associated principles to aid in their assessments (including the impact of PMI on children) and ensure a holistic approach to their practice with families. Finally, professionals expressed the view that TFM (Falkov 1998, 2012) could be incorporated into the documentation to aid with assessment and that further training relating to use of documentation is needed. Furthermore, professionals suggested that documentation could be shorter and more precise.

Finally, HSC professionals generally agreed that they have knowledge and skills in relation to identifying and reporting child protection issues. That said they did not feel that policy and procedures in relation to FFP are clear or that there are enough programmes in which families can be referred to for further support in relation to PMI. Professionals agreed that inter-professional practice is of benefit to professionals, aiding their FFP.

**Summary: Barriers and Enablers of HSC Professionals' FFP**

*33 % of professionals perceived that the Think Family NI Regional Adult and Children's Service Joint Protocol enabled their FFP. Professionals, particularly Social Workers and Nurses, noted that screening and assessment tools are also useful in aiding assessments and that a future improvement to such tools could include incorporation of TFM (Falkov, 1998, 2012) as well as a shorter assessment form. Professionals highlighted that barriers to their FFP include issues such as lack of time and resource as well as limited training and skills and knowledge relating to FFP. Across all Trust areas, professionals noted that policy and procedures in relation to FFP are not always clear and that there are not enough programmes in which families can be referred to for further support in relation to PMI. It is also clear that HSC professionals perceive that opportunity's for future professional development, including inter-sectoral and multi-disciplinary training, is required for effective FFP and optimal services for families.*

**Summary of Survey Findings:**

To conclude, whilst HSC professionals taking part in the current study indicated that they are not particularly family focused in their practice, they highlight that FFP does take place, but that its potential benefits are impacted by a number of key factors. Over a third of HSC professionals recorded high scores on at least three of the six FFP behavioural subscales, indicating that while the average FFP score is low, there are a large group of HSC professionals who understand and practice in ways which are family focused. Professionals who spend a percentage of time delivering services in the home environment scored higher in relation to the six FFP behavioural subscales. Professionals practicing in community settings also had higher mean scores than those in acute in-patient settings. Furthermore, Think Family Champions recorded higher mean scores compared to the remainder of the sample in relation to *skills and knowledge, professional development, connectedness, referrals, worker confidence and support to carers and children*. Some differences in extent of FFP were also noted across disciplines and services. Social Workers recorded higher scores on most FFP subscales whilst Psychiatrists recorded lower scores. Across all Trusts lowest scores related to *time and workload*, indicating the perceived negative impact on FFP as a result of large caseloads. Children services reported as having a greater number of higher means scores on a

number of FFP subscales compared to adult mental health services with the exception of *interventions to promote parents' mental health*, which were higher among adult mental health services.

Multiple hierarchical regressions revealed that 11 IVs predicted HSC professionals' FFP and significantly increased the variance explained within the 6 behavioural FFP subscales. Result of regression for both adult mental health service and children service professionals indicated that a persistent predictor of all FFP behaviours includes *skills and knowledge* relating to the impact of PMI on children. Aside from *skill and knowledge*, the most significant predictors were *time and workload*, *training* and *co-worker support*. Individual multiple hierarchical regressions for children's services and adult mental health services highlighted the important differences in the predictors of professionals' FFP. For those working in adult mental health services, *co-worker support* and *worker confidence* are important for working with families, particularly children. For children's services professionals, *professional development* opportunities to work with families and *co-worker support* were noted as important for *referrals* and *family and parenting support*.

Feedback from professionals relating to barriers and enablers of FFP indicated that more time, training and skills and knowledge relating to PMI is particularly important for FFP. They also perceived that the Regional Adult and Children's Service Joint Protocol enabled their FFP, as well as current screening and assessments tools which were useful during risk assessment and identification of family issues relating to PMI.

The next section of the report will present an overview of findings from individual interviews that aimed to explore professionals and services users' understanding and experience of FFP and factors that affect professionals' capacity to engage in FFP in the first instance.

## Qualitative Study Findings - HSC Professionals

The focus of individual interviews with HSC professionals was threefold: (1) to identify the nature and scope of HSC professionals' Family Focused Practice (FFP), (2) to elucidate the factors that affect their capacity to engage in FFP and (3) to explore how HSC professionals' FFP may be further developed.

### Study Sample:

Thirty HSC professionals who completed the FFMHPQ agreed to be interviewed. Six professionals were invited from each Trust and an attempt was made to get a reasonably balanced number from children's and adult services and to include a mix of disciplines. The majority of HSC professionals were Social Workers ( $n = 21$ ) and practiced across the eight services sampled in the quantitative component of the Study. The majority of the HSC professionals ( $n=19$ ) were practicing in adult mental health services and predominantly in acute in-patient and addictions services. Those HSC professionals practicing within children's services generally worked within family intervention teams (FIT) ( $n = 7$ ). Most HSC professionals were female ( $n = 22$ ) and were parents themselves ( $n = 19$ ). Over half of the HSC professionals had family focused training ( $n = 12$ ) and, or child focused training ( $n = 11$ ).

The number of parents on HSC professionals' caseloads varied between 6 – 80 parents, with some teams reportedly managing 100-180 parents between team members. According to HSC professionals interviewed, each parent had an average of 2 – 3 children. Children's ages and stages of development varied, from babies through to 18 years. The parents experienced a broad range of mental illnesses, varying from the severe and enduring disorders, such as schizophrenia and bipolar affective disorder, through to relatively less severe mental illnesses including post-natal depression and anxiety. Some parents also had a diagnosis of personality disorder and, or substance use problems.

### Overview of Findings:

Those professionals working within adult mental health services and particularly within one Trust (Trust E) in in-patient addictions services, described many examples, contexts and scenarios to illuminate their FFP; suggesting they had more

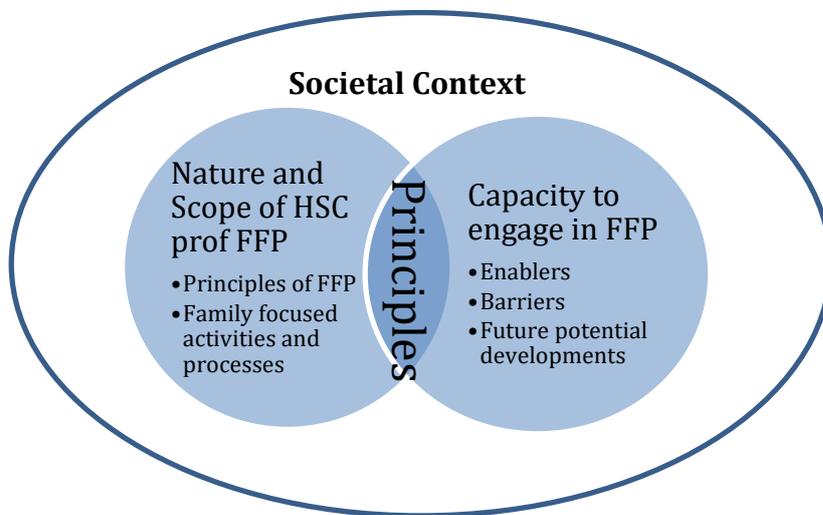
scope than professionals in the other services to engage in FFP. This discrepancy between services was particularly notable in terms of identifying needs of families associated with PMI and in supporting parents.

Major differences were noted with respect to service, work setting, discipline and own parenting experience. For example, professionals who were Social Workers (across both services and particularly in the addictions setting in adult mental health services) and those who were parents themselves and had greater length of work experience, tended to provide more examples of FFP and to talk more freely within the interview. When reporting on subsequent themes, service (i.e. adult mental health or children's service) and discipline is reported for all of the results.

Two global themes emerged from the interviews and were conceptualised as (1) the nature and scope of HSC professionals' FFP and (2) HSC professionals' capacity to engage in FFP (Figure 5.1). Regarding the nature and scope of FFP, professionals described FFP as complex and multifaceted, comprising various family focused principles which were operationalised by a number of activities and processes. Principles reflect *why* HSC professionals engage in FFP while family focused activities capture what they *do* in relation to FFP and process captures *how* they do it. Furthermore, HSC professionals suggested that all components interact and impact upon each other and that family focused activities and processes stem from and are underpinned by FFP principles.

**Figure 5.1:**

**Overview of Two Thematic Networks**



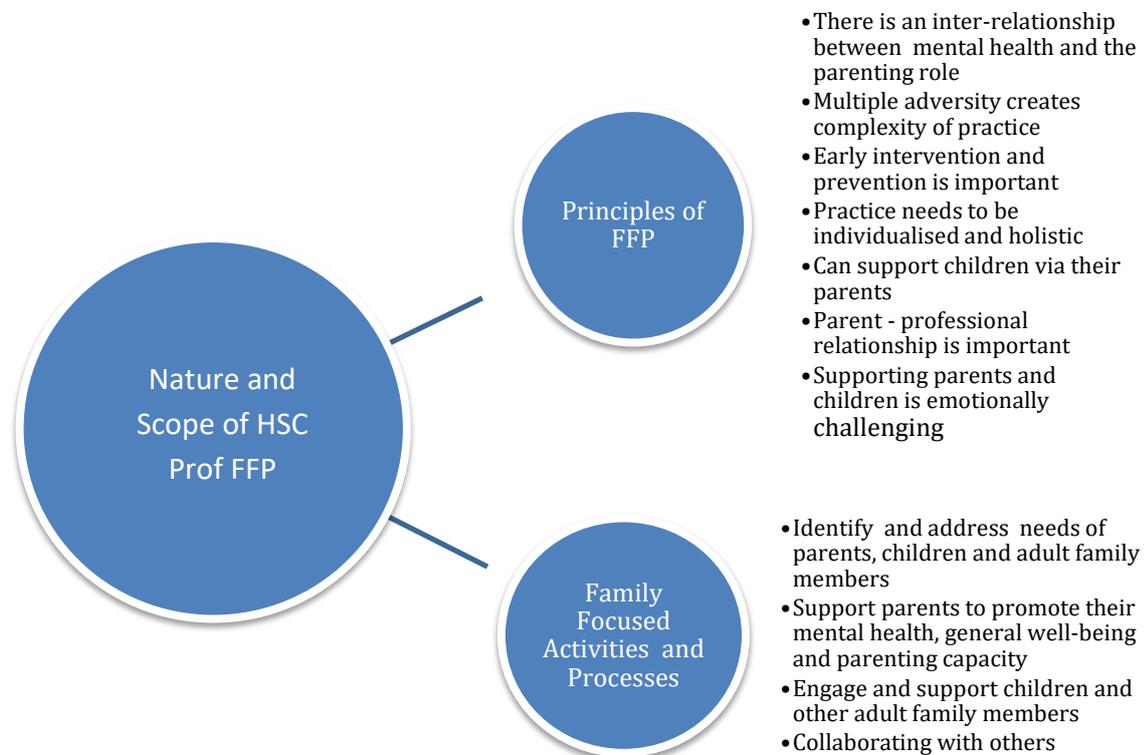
Health and Social Care professionals' capacity to engage in FFP (again see Figure 5.1), was found along three main elements associated with capacity including (1) enablers, (2) barriers and (3) future potential developments. Each of these global themes and their constituent themes are examined in the following sections, with particular attention paid to reporting findings that illuminate HSC professionals' response to key Think Family NI initiatives as outlined in p.37 - 39.

**HSC Professionals' Perceptions of the Nature and Scope of their FFP:**

HSC professionals recounted a variety of principles that motivated and shaped their FFP whilst illuminating the essential family focused activities and processes underpinning their FFP (Figure 5.2) as detailed below.

**Figure 5.2:**

**The nature and scope of HSC Professionals' FFP**



**Principles of FFP:**

The principles described by HSC professionals fell into six broad categories: (1) there is an inter-relationship between mental health and the parenting role, (2) multiple adversity creates complexity of practice, (3) early intervention and prevention is important, (4) practice needs to be individualised and holistic, (5) can support children via their parents and (6) the parent-professional relationship is important.

***The inter-relationship between mental health and the parenting role:***

Part of the early development of Think Family initiatives in NI included further development in strategic thinking particularly the understanding among professionals of the interrelationship between PMI and child development and welfare. All HSC professionals interviewed recognised the inter-relationship between parenting and mental health and specifically that parenting impacts on mental health and

conversely, that mental health impacts on parenting. In the first instance, all HSC professionals recognised the stress of parenting (and particularly parenting young children and adolescents) on parents' mental health. For instance:

Parenting can be the biggest stressor for a parent. They struggle, with the daily role and responsibility, particularly with adolescents or children with special needs. Parents can find it [parenting] too overwhelming and it can bring on depression, anxiety, reliance on substances (P2, Trust D, SW, AMH).

Similarly, P 1 (**Trust A, SW, AMH**) contended "we would see evidence of younger mothers with younger children using substances as a way of coping with their parenting role" while P27 (**Trust E, Nurse: AMH**) suggested "...children can be very demanding for the average parent who doesn't have any mental health problems, never mind a person who...struggles...".

Conversely, all HSC professionals acknowledged that a parent's mental illness may impact on parenting capacity and their children's well-being. Participant 24 (**Trust D, SW, AMH**) reported "there was chaos in the morning time because her mood was low...if she was drinking the night before she wasn't physically ...fit to get up...to cope with the children". Others reported, that children experience "chronic worry, chronic disruption in their lives and take on responsibility beyond their years" (**P7, Trust B, SW, AMH**) and that "we have a number of young people who take on the role of mummy and daddy. I had a young child...in primary school who got mummy up in the morning, got her dressed, got her breakfast, made her own breakfast and ... because it was her job to make sure mummy was ok" (**P30, Trust E, SW, AMH**). In addition, Participant 18, (**Trust D, SW, Children's**) notes:

With mental illness or substance misuse...there may be neglect...physical abuse ...affects on attachment...we have seen children develop anxiety issues, behaviour issues, communication difficulties...With teenagers...drug taking...being sexually adventurous at a very young age. Worst case...the child has to come out of their care, so there is trauma of being removed from everything they know.

Recognition of the impact of PMI on children, including becoming a young carer and the potential intergeneration transmission of mental illness is an important aspect of Think Family NI initiatives, particularly those relating to HSC professionals'

assessment and information sharing between adult mental health and children's services to ensure the support needed is available to families.

### *Multiple adversities create complexity of practice:*

In addition to recognising needs of families related to PMI, a considerable number of professionals ( $n = 11$ ) noted that many families experience multiple adversities which further compound families' difficulties and increase complexity of professionals' practice. For instance, P7 (**Trust B, SW, AMH**) reported "last year...56% of people who walked through our door have significant trauma in their life. So trauma based work is key", while P23 (**Trust D, SW, AMH**) indicated "we see a lot of mummies and daddies who themselves had a poor parenting model in terms of their upbringing. They had lived with domestic violence...drug abuse... childhood trauma through sexual abuse and becoming a parent is when that starts to...unravel". Similarly, others indicated:

I don't think there's any family we would be in that there's one issue...domestic violence and mental illness go hand in hand...there's addiction problems, ...maybe previous abuse and trauma within the family which has led to that, and that's huge because people don't want to open that back up. And that's really difficult to address (**P3, Trust C, SW, Children's**).

### *Importance of early intervention and prevention:*

As previously noted, part of phase two of the Think Family NI work plan includes an aim to improve access to early intervention for families including children.

Professionals within the current study clearly considered and recognised the impact of PMI on parents and their families and the multiple adversities that many families experienced further heightening the need for early intervention and prevention to reduce the impact of crisis. P3 (**Trust, SW, Children's**) indicated that, "professionals need to be in before it gets to the stage where it is completely escalated and you are climbing a mountain to try and help to unpick it". Similarly, P30 (**Trust E, SW, AMH**) suggested "...the more educated services are about... when is a family at risk and... need support...the earlier the intervention and the better the outcomes for parents". Others suggested that they would spend additional time with families where there were additional complexities to try to avert problems arising. For instance, P8 (**Trust, B, Nurse, AMH**) suggested:

...when there is children involved and it is more complex, we...spend a bit more time, putting the efforts in to make sure that everybody feels supported in the family...if you don't put this in now...and the children don't feel supported, then further down the line, it is going to impact and those children will come into mental health services...if they are not supported in their formative years...you have to invest to save.

Early intervention and prevention was also linked with a desire to keep families together. For example, P4 (**Trust A, SW, Children's**) indicated "...our role is to keep families together as best we can and to keep that focus there and early intervention is important", while P30 (**Trust E, SW, AMH**) suggested, "My primary focus would be, where I can, is always to try and keep the family together because...that child wants to grow up in its family home with all the smells... sounds... memories and experiences that they have. Parents want that".

#### *Practice needs to be individualised and holistic:*

Reflective of more recent Think Family NI initiatives which encourage professionals to consider and be inclusive of the needs of the 'whole family', several HSC professionals ( $n = 7$ ) suggested that as all family members are affected by PMI and as each family is unique with varying level of need and complexity, practice needs to be individualised and holistic. For example, P21 (**Trust D, SW, AMH**) suggested "...It really comes down to the supports they have around them, their own backgrounds, their issues...it is very individual... There is not a one size fits all. Every case is different...it really is tailor made". In relation to holistic practice, P 28 (**Trust E, SW, Children's**) indicated, "we use the holistic approach were we look at the person, the social setting, where they are living...if they have kids and how the kids' needs are being met". Additionally, P9 (**Trust B, Nurse, AMH**) reported "It is not all about this... medicalised model of mental illness. It is helping the person see and contextualise themselves within a psycho social framework".

In adult mental health services, being holistic also meant recognising the importance of children for parents; P26 (**Trust E, Nurse, AMH**) indicated "...acknowledging that they are still a parent, even though their child isn't with them...is massive...is a big important part of my work...sometimes that's their [parent] only driver really, is their children", while another suggested "I would look for how the parent feels about their children as a protective factor for them...and...looking for the parent's role with their

children as a strength” (P9, Trust B, Nurse, AMH).

Being holistic also meant acknowledging, involving and supporting other adult family members including parent’s partners. In the first instance, the majority of HSC professionals across both services discussed involving adult family members to get collateral information about parents and, or their children. For example, P2 (Trust A, SW, AMH) indicated, “...we would do our best to try and involve family members, carers and children of a suitable age ...because it is...a real benefit for us to have somebody that’s there in the household and sees, day to day, what’s going on”. HSC professionals also indicated that they involved adult family members in an attempt to maintain child safety. For example, P3 (Trust A, SW, Children’s) indicated “we would also try and involve family and extended family, through family group conferencing. That would be...one of our first ports of call, is to get the wider family involved (P3, Trust A, SW, Children’s).

A few HSC professionals ( $n = 5$ ) acknowledged that PMI affected the whole family, including parent’s partners and their parents and that in this respect adult family members also required support. Participant 2 (Trust A, SW, AMH) reported “It is not just about seeing the individual in front of you, but trying to take into account the whole circle around that person and who is there. Is it kids... partner...grandparents...being impacted?”. Participant 30 (Trust E, SW, AMH) indicated “...for years and years, on an informal basis, grandparents... consistently are that backdrop and that support for mums and dads that are struggling. I am concerned...they are ageing, their health isn’t great...and how do we support them?”.

### *Can support children via their parents:*

HSC professionals and particularly those practicing in adult mental health services also perceived that they could support children via or through the parent by keeping the children in mind. For example, P7 (Trust B, SW, AMH) indicated:

As an adult service we don’t do any direct work with children. But through the parents...we pick up on needs of children...we keep the children’s needs in mind when we are having those conversations. If they are coping better and

supported better, they are going to be in a better position to meet the needs of their kids.

Others reported "...the best way to reduce the damage to kids is reduce the substance misuse. It is about building their [parents] confidence...ability and the need to change in regard to their drinking and drug taking behaviour" (**P7, Trust B, SW, AMH**). Similarly, P30 (**Trust E, SW, AMH**) suggested "if you can help this person with their substance misuse you then will help them in their parenting capacity" and "if...parents are well supported, I would hope that they would do well and their children would do well in the long run" (**P26, Trust E, Nurse, AMH**).

### *The importance of the parent-professional relationship:*

One of the specific themes following the Sense Maker Survey (2011-2012), during phase one of the Think Family NI Initiatives, was the recognition that communication and information sharing between professionals and families is important and should be improved. All HSC professionals within the current study highlighted that the parent-professional relationship is central to their FFP. To support parents and their families, HSC professionals perceived that they needed to be able to challenge parents and to be forthright. Moreover, their emotional connection with parents allowed them to support parents and maintain good rapport. For example, P7 (**Trust B, SW, AMH**) reported "...at the heart of any therapeutic endeavour is a relationship. That ability to connect...you have to earn your right to confront. If you do, then parents think you are doing this because you care. You can raise sensitive issues". To maintain their relationship with parents all HSC professionals indicated that transparency was important. P24 (**Trust E, SW, AMH**) suggested "It is very important to be honest...if parents lose faith in you, you've lost them, so it's very important that you are open and honest and transparent". Similarly, P29 (**Trust E, Nurse, AMH**) indicated, "...it is about trying to work with the person [parent], building that rapport...which is a significantly vital component".

Some characterised the relationship as a partnership focused on supporting parents to help themselves and informed by a strengths based approach. In relation to the partnership approach for example one participant notes "...it is about getting families to understand...that this isn't us coming in as dictators and telling you what to do in your life...we want to do it in partnership...together and try and get the best

outcomes for them and their children” (P21, Trust D, SW, AMH). In relation to importance of using a strengths based approach, P24 (Trust E, SW, AMH) suggested “...you have to look at their strengths, what their resilience levels are...and for me that’s the strength in the family focused approach. It is very much looking at the positive”.

HSC professionals also perceived that a strengths based approach was necessary to encourage parents to work alongside them to improve their and their families’ situation. For instance, “It is very important that that person and their strengths come...through, because that’s what gives them the strength to keep going...the majority of times you have to focus on the positives to bring that parent along on the journey with you, while ensuring the children are safe”.

#### **Summary: Principles of FFP**

*HSC professionals’ responses and discussions relating to principles of FFP reflected many of the core values of Think Family NI initiatives. For instance, HSC professionals are aware of the inter-relationship between mental illness and parenting, specifically; that parenting can be stressful and that mental illness may impact on parenting capacity and children’s well-being. HSC professionals also discussed the complexities of their practice noting that many families experience multiple adversities which further impacts upon families such as trauma history, domestic violence and substance misuse problems. Given some of the complex issues associated with families, professionals recognised the need for early intervention and prevention to reduce further crisis, particularly where children’s needs are concerned. Early intervention and prevention was also linked with a desire to keep families together. HSC professionals discussed the importance of practice needing to be individualised and holistic in order to support not only the parent but other family members that can be affected by PMI and, or substance use problems such as partners and grandparents. In adult mental health services, being holistic also meant recognising the importance of children for parents. Another important FFP principle, particularly for professionals practicing in adult mental health services, was the belief that they could support children via or through the parent by keeping the children in mind. HSC professionals also described the parent-professional relationship as central to FFP. They reported that a positive relationship with parents facilitated more effective support and enabled more open*

### **Family Focused Activities:**

HSC professionals identified four core family focused activities including: (1) identifying the needs of parents, children and adult family members, (2) supporting parents to promote their mental health, general well-being and parenting capacity, (3) engaging and supporting children and other adult family members and finally, (4) collaborating with others.

#### *Identify and address needs of parents, children and adult family members:*

Perhaps one of the most significant aspects of the Think Family NI initiatives includes the improvement of assessments to be comprehensive, family focused and inclusive. The majority of HSC professionals ( $n = 21$ ), most of whom practiced in adult mental health services ( $n = 12$ ), discussed how they acknowledged and identified the needs of parents, children and other adult family members in relation to PMI on initial assessment. However, the focus and depth/comprehensiveness of assessment and extent to which family members, including children, were directly engaged varied depending on discipline and whether HSC professionals were practicing in adult mental health or children's services.

In relation to identifying needs relating to PMI in the initial assessment in adult mental health services, P12 (**Trust C, SW, AMH**) signified:

...there is a part that asks [parents] for the family profile and what children they have caring responsibility for...and to provide detail of the children...but also...it is an opportunity to ask if there's any family and childcare or social services involvement...which... opens up from the outset that we are thinking not just about the person [parent] themselves but as a family...

Alternatively, while HSC professionals in children's services also engaged parents directly to identify impact of PMI they also identified whether parents were currently, or previously, using adult mental health services. Participant 11 (**Trust B, SW, Children's**) indicated "That's one of the ...first things that we would ask a parent...if they are known to mental health services", while P17 (**Trust C, SW, Children's**) reported "...I... find out first of all what exactly the mental illness is, the impact it is likely to have on the parent and on the child". In relation to comprehensiveness of assessment, social workers in both services indicated that they undertook an in-depth assessment of children's needs and family circumstances:

We would ask a range of questions about children's development, if they are meeting their milestones? attend school? have disabilities?, any extra need? or...involved with children's services?, health visitors?...and that would be a full section on finding out about children (**P7, Trust B, SW, AMH**).

While HSC professionals in adult mental health services predominantly asked parents and their partners about the impact of PMI, HSC professionals in children's services actively engaged both parents and children in the assessment process. For instance, in relation to adult mental health services, P1(**Trust A, SW**) indicated "...I would be liaising more directly with the service user...and other parent...to try to gather as much information about the family and the children... especially if the children are particularly young...so direct contact with the child would be quite limited, actually". Alternatively, P17 (**Trust C, SW, Children's**) indicated " "...I would speak with the parent and the child and try to ascertain how the child has been feeling...what they [child] know about the parent's situation...whether they feel that their lives are any different than those of their friends..."

Perhaps reflecting on the strengths of the Adult and Children's Services Joint Protocol all HSC professionals identified collaboration between both services and with wider services and with other adult family members as key to comprehensive assessment of family needs. For instance, in relation to collaborating with other services, P17 (**Trust C, SW, Children's**) indicated:

...I do my best to make contact with any mental health professionals that the parent is involved with...and I would be making contact with the other professionals' involved, like the teachers or the GP to see...if there was any impact on the child's behaviour that was known to them.

All HSC professionals also discussed involving parents' partners and other adult family members in the assessment to get collateral information. For instance, P6 (**Trust A, Nurse, AMH**) suggested, "You get a far better picture if a family member is there...you are seeing a wider picture".

There was also agreement between HSC professionals in both services regarding the need to prioritise assessment of children's welfare and child protection issues in initial and ongoing assessment. This shift in the priority in assessment among adult

mental health professionals towards children is possibly reflective of earlier revisions to adult mental health screening and assessment tools to aid in the understanding the needs of children in NI. For instance, P17 (**Trust C, SW, Children's**) indicated "I would be speaking with the parent to see how the parent was managing and whether...the parent was interacting appropriately or was able to recognise the child's needs apart from...his or her own", while P25 (**Trust E, Psychiatrist, AMH**) signified "We would be thinking very much about safety and if someone [parent] is using substances, who is responsible adult around that child".

In relation to identifying and addressing other less pressing needs of families, five HSC professionals indicated that it was also important to prioritise needs. For instance, P3 (**Trust A, SW, Children's**) suggested:

...a lot of these families are...completely overwhelmed...and if you start to work on everything at once...you can overwhelm these families more. It is about being able to... assess the situation, what's the priority and be realistic about what you can achieve in a reasonable timescale.

The focus of ongoing assessment depended on the HSC professionals 'discipline', with Social Workers in both adult mental health and children's services particularly interested in parents' social circumstances and how they impact parenting and children's wellbeing. For instance, Social Workers in adult mental health services indicated " It is...my job to look at the social needs...that includes housing issues, issues to do with criminal justice...family support...looking at what kind of social support...they require" (**P1, Trust A, SW, AMH**), while P24 (**Trust E, SW, AMH**) suggested that she would:

...very much doing a social history with them...finding how what their own experiences have been from childhood through to adulthood...and in that, what their modelling has been as parents, what they received when they were children and how that has impacted on them and how they parent their own children.

In contrast, the other disciplines in adult mental health services (i.e. Nurses, psychiatrist) were primarily interested in parents' mental illness and it's treatment and how it impacted their daily functioning; including parenting role and how parenting impacted parent's mental health. For instance, P25 (**Trust E, Psychiatrist, AMH**) indicated:

One of the priorities is the clinical side if I am honest. As a doctor...is there something medically that I can offer ...do they need an antidepressant...antipsychotic changed. Then we ...try to look at the wider aspect ... their wider function...how are they supporting their families?...looking at family supports in terms of who is there for them at home to support them, but also who they are expected to support... their ability to parent...if they are using a lot of substances, how are they interacting with the child?

In line with Think Family NI initiative activities for service user and carer involvement, a number of HSC professionals ( $n = 5$ ) also discussed undertaking carers assessments to identify needs of other adult family members. However, these assessments tended to be driven by need to support the carer so that they then would be a position to support the parent. For instance, P2 (**Trust A, SW, AMH**) indicated:

We would also continually offer carer's assessments...it's a big part of our assessment now ...we used to be very focused on the individual, but now it is always the individual and carer...so you are constantly thinking about that now in your practice and making sure any person involved in this individuals [parent] care is being looked after as well. You don't want to see the likes of carer's fatigue set in..., because then the next minute you've got another referral for an individual who is caring for the individual with mental illness... so you need to be mindful of that.

Some HSC professionals ( $n = 5$ ), particularly in children's services, also indicated that they used specific approaches, including family group conferences and safety plans to assess needs of parents and their children and to develop plans of care, when parent's difficulties with mental illness or parenting may impact their children. For instance, P5 (**Trust A, SW, Children's**) suggested, "We are having family group conferences...where the identified co-ordinator is going out to meet individual family members in their own home ...and the social worker and myself will go to those and we would explain what the Trust is worried about".

**Summary: Family Focused Activity - Identify and address needs of parents, children and adult family members**

*The majority of professionals, most of whom practiced in adult mental health (AMH) services, discussed how they acknowledged and identified the needs of parents, children and other adult family members in relation to PMI on initial assessment. This is in line with the aim of Think Family NI initiatives to improve assessment, planning and treatment to be inclusive of the 'whole family'. However, the focus and depth of assessment and extent to which family members, including children, were directly engaged varied depending on discipline and whether professionals were practicing in AMH or children's services. While professionals in AMH services predominantly asked parents and their partners about the impact of PMI, professionals in children's services actively engaged both parents and children in the assessment process.*

*All participants identified collaboration between both services and with wider services and with other adult family members as key to comprehensive assessment of family needs. Professionals also discussed how assessment was an ongoing process and that they are also interested in parents' social circumstances and how they impact parenting and children's wellbeing.*

*A number of professionals also discussed using specific approaches; including family group conferences and safety plans to assess needs of parents and their children and to develop plans of care for parent's difficulties with mental illness or parenting that may impact on their children. Carers assessment was another common approach used to assess family needs and to support them.*

***Support parents to promote their mental health and general well-being and parenting capacity:***

Half of the HSC professionals ( $n = 15$ ) provided various examples of activities that were directly or indirectly related to supporting parents in their mental health, general well-being and parenting capacity. However, it was predominantly four HSC professionals practicing within acute in-patient addictions, in one particular Trust (i.e. Trust E) that discussed this theme in detail. Overall the majority of HSC professionals who discussed supporting parents practiced in adult mental health services ( $n = 10$ ).

In the first instance, it was noted that parents' mental health and well-being were intertwined with their parenting capacity and their relationship with their children. For instance, in relation to reducing the impact of PMI on parenting, P25 (**Trust E, Psychiatrist, AMH**) indicated, " ...our objective is to help the person [parent] reduce or abstain from alcohol...so that they then can fulfil parenting roles...or at least begin to learn what the parenting role should be", while P12 (**Trust C, SW, AMH**) suggested, " ...we support them to explore...how... their substance misuse and ...behaviour...affects their abilities to parent the child".

Alternatively, three HSC professionals intervened to reduce the impact of parenting on parents' mental health. For instance, one participant discussed how she helped reduce the stress of parenting on a father's mental health. P24 (**Trust E, SW, AMH**) indicated:

...he has two kids with autism and is a single parent. One of the kids wouldn't go to school and...he was feeling very dejected...his mental health was low... This gentleman is very anxious because his children are on the child protection register that they are going to be removed...and I am saying to him, your kids are thirteen and fifteen. You physically can't make them get out the door. He rang school with me... He... told the social worker, and I made an appointment for him to see his GP the next morning. And when he was going out the door he says, 'it's like a weight has been lifted'. Small practical things... for me it is...being able to calm him down...take away a bit of the pressure...it is OK to say that you are struggling...need some support...it doesn't mean that they will take your kids from you...

When parents had lost custody of their children, three HSC professionals also discussed their efforts to reduce parents' stress by giving them information about their children. For instance, P26 (**Trust E, Nurse, AMH**) indicated:

...most of the parents that I see, their children already have been removed...They wouldn't have full access but they could be seeing them at...the hubs, or there is supervised access...so it is really about keeping them in the loop...there may have been incidences of...aggression, but even if they can be kept informed of their children's progress... they know their children are OK and safe.

They also provided examples of how they helped parents to address the practical and social aspects of parenting in an attempt to then help parents focus on their mental health needs. For instance, P26 (**Trust E, Nurse, AMH**) suggested:

Have I [parent] enough money to heat the house? Can I feed myself? Can I feed my children? ...those are the real practical things that ...I have to deal with before I can even get them [parent] to have a conversation about their addiction. There might not be enough food, so I am contacting the food bank. There might not be enough beds in the house, so it's contacting one of the charities, can you get some beds?

Four HSC professionals in adult mental health services and one in children's services also intervened to promote parents' confidence and capacity in parenting. In relation to promoting parenting capacity, P7 (**Trust B, SW, AMH**) indicated, "One of the themes we pick up for parents is how do we help parents build their own children's resilience? Another participant described supporting parents to establish boundaries and routines for their children:

...supporting them [parents] to establish...acceptable boundaries and routines within a family home. So just talking about what children need and what is...good parenting...and helping them to re-establish that again...get them to think of it from the bigger perspective...(P29, **Trust E, Nurse, AMH**).

An important outcome of some of the Think Family NI initiatives includes sustaining relationships between children and parents when a parent is being treated in adult mental health services and helping parents to discuss issues relating to PMI with their children. Three HSC professionals reported how they helped parents to promote their relationship with their children by encouraging parents to be emotionally available for their children and by promoting their capacity to explain their illness to them. For instance, P24 (**Trust E, SW, AMH**) suggested that "...parents think because they are physically there that they are parenting...and it is to give them some understanding of being emotionally available for the kids...". In relation to assisting parents to explain the illness to their children, P25 (**Trust E, psychiatrist, AMH**) indicated:

You talk about what their kids would understand. We don't tell them [parents] what to say, we explore with them what do they think they should say and I suppose give a few wee helpful hints. Just like saying mum's not well and she's in because people can help her...get better...having them [child] understand. And also that they will be visiting mum.

Some other HSC professionals, while also acknowledging the reciprocal relationship between parenting and mental health indicated that they would not directly support

parents in their parenting but would instead refer parents to an alternative service. Further reflecting key initiatives which aim to promote and encourage communication and information sharing between services to meet the needs of families, P2 (**Trust A, SW, AMH**) notes, "...if we feel that...a parent is struggling in their role as a parent or that ...the role as a parent is affecting their own mental health, we will then get children's services involved. We will make a referral to Gateway and ask for some support for that. And let them take care of that side".

Additionally, two HSC professionals also discussed referring parents to other services to promote their parenting capacity. For instance, P24 (**Trust E, SW, AMH**) indicated "... with his consent [father] we asked... someone in social services...to refer him into...Barnardo's to give him some self-esteem work around parenting and...house rules and sanctions to bring the kids on board".

Finally, a central element underpinning the process of some ( $n = 6$ ) HSC professionals' FFP and particularly Social Workers, was the use of specific interactional approaches and therapeutic interventions to support parents, including person centred counselling, Cognitive Behavioural Therapy (CBT), Solution Focused Therapy (SFT) and, or Motivational Interviewing. For instance, P7 (**Trust B, SW, AMH**) indicated:

...we get competent in...motivational interviewing as a way to talk to people [parents] about change...motivational interviewing gives you a way to structure a conversation. So you use...your core skills, as in any counselling approach...open questions, affirmations, reflective listening and summarising.

Others indicated, "It is often crisis when the parent comes in... to speak to me. I have my qualification in person centred counselling and at those times I really enlist those skills, of... reflective listening" (**P28, Trust E, SW, Children's**) and P3 (**Trust A, SW, Children's**) suggested "...sometimes a solution focused approach is good...in that kind of crisis situation where you are...picking one thing out, because a lot of these families are overwhelmed".

***Summary: Family Focused Activity - Support parents to promote their mental health and general well-being and parenting capacity***

*Some professionals discussed how they support parents to promote their mental health and general well-being and parenting capacity. This support includes reducing parental stress as well as helping parents to address the practical and social aspects of parenting. HSC professionals also discussed referring parents to other services to promote their parenting capacity.*

*Additionally, some professional's FFP, and particularly Social Workers, used specific interactional approaches and therapeutic interventions to support parents and their children, including person centred counselling, Cognitive Behavioural Therapy (CBT), Solution Focused Therapy (SFT) and/or Motivational Interviewing. This suggests that existing resources and expertise can be leveraged by HSC professionals as mechanisms to engage in FFP.*

***Engage and support children and other adult family members:***

The majority of HSC professionals ( $n = 21$ ), across both services, described supporting children and further emphasised the message of some key Think Family NI initiatives for access to early intervention and support for children and families. Support tended to be primarily motivated by a desire to protect children from impact of PMI, as reflected by P15 (**Trust C, Nurse, AMH**) who suggested, "The fact that our first page [of assessment documentation] is a family profile shows our commitment to child protection". However, some ( $n = 5$ ) HSC professionals also suggested that it was important to intervene early as reflected by P3 (**Trust A, SW, Children's**) who suggested "...it is about putting support in there to help children understand PMI...and build their resilience around it, rather ...going down the more critical draconian intervention".

HSC professionals in adult mental health services tended to not support younger children directly but instead referred them to children's services. For instance, P2 (**Trust A, SW, AMH**) indicated "...you do your best to support the family member through...Barnardo's young carers or children's services", while P1 (**Trust A, SW, AMH**) suggested:

We would rarely, to be honest, support children directly; especially if children are younger...Part of the reason for that...is very often children's social services are involved. We typically...work alongside children's services...we will feedback...saying... these are the issues...very often we will defer to the childcare social worker who we would suggest knows the children a lot better...so our direct work with children would be more limited.

Alternatively, while HSC professionals in children's services also tended to refer children to voluntary organisations and community resources there was some evidence that they would also directly support children themselves to cope with PMI. For example, P3 (**Trust A, SW, Children's**) indicated:

...there is community resources that we would refer the children to. The likes of Barnardo's young carers would be a big service in terms of helping them [children] understand their parent's mental illness and how that impacts on them...and the family...I suppose some social workers would do one to one work with the child.

Some HSC professionals ( $n = 7$ ) across both services and particularly in addictions, described directly supporting older children through helping to inform them about PMI. For instance, P18 (**Trust D, SW, Children's**) suggested, "One of the families I am involved quite a lot with the children, just talking through with the older children about their mum's mental health and what impact that might have on them and their fears for their own mental health in the future etc.". Similarly, in adult mental health services, HSC professionals at a parent's request, met with older children to establish what they knew about their parent's mental illness and to help them understand it. For example, P14 (**Trust C, Psychiatrist, AMH**) indicated "if the parent was to say that their child was distressed or worried...and they wanted information...we have...met with the older children to explain". Two HSC professionals also indicated that they provided children with information if they observed that they were affected by PMI. For instance, P 8 (**Trust B, Nurse, AMH**) suggested:

We have...age appropriate... leaflets, the Think Parent, Think Family, Think Child...and gave them to twin girls...You could see the impact that mum's illness had on them and one of them in particular was very clingy...and made a comment to me, our mummy is doing much better today. I did sit with them and...said...it's OK. Sometimes mums and dads get sick and sort of explained to them that sometimes your brains get tired and needs some time out...and it's a bit like having a chest infection or cold...it does get better in

time...I was trying to simplify it that there was nothing they were doing wrong...and that dad was there for them to talk about it if they were worried.

Three HSC professionals also discussed supporting older children in their relationships with their younger siblings. For example, P24 (**Trust E, Nurse, AMH**) indicated “You could have kids who are...looking after their younger siblings. I worked with her [older child] to give her advice and support in how to support her sister [younger child], but also how to be a sister and not a mum”. Five HSC professionals also indicated that with parent’s permission they would speak with older children in their parents’ company. For instance, P 24 (**Trust E, SW, AMH**) indicated, “I’m trying to give parents insight that ...children may be frightened... I would bring the kids as well...and we would have the conversation together...and we would say what’s it like for you? Mum has given permission today for you to talk about that”.

Six HSC professionals also described how they encouraged parents to explain their illness to their children themselves so as to reduce children’s concerns. For instance, P4 (**Trust A, SW, Children’s**) indicated:

The key thing for the kids is when they have the conversation with their parent, because I could talk to them and they mightn’t believe me. When they hear it from mummy or...daddy and it makes sense...it doesn’t worry them and that is the key for the child...or young person...to understand...in a child appropriate way...what is going on, so we encourage parents to talk to their children.

In addition, HSC professionals discussed how they engaged and supported adult family members to care for the mentally ill parent and the children in the family. For example, P5 (**Trust A, SW, Children’s**) indicated “we would try to engage a family member...either to support the parent or to provide kinship care to a child while we try to work with a parent towards getting the help they need”.

A few HSC professionals ( $n = 7$ ), also discussed how they endeavoured to support adult family members to meet their own mental health needs. “...our next step is how do we help family members get the message that there is help for you in your own right? ...we ran a workshop for adult family members...we have a weekly family

support group and have written a self-help book for families”. Similarly, others suggested:

...the other parent will contact us and we will have a meeting with them...it's a carer's appointment. We would discuss any issues with regards to their role as a parent...their own mental health and seeing whether they feel supported or is there anything in addition they need. The carer's assessment would look at other roles that are affected by their caring role and that would be their parenting role in addition to looking after someone with mental health difficulties. Because it is the impact that it has on the whole family network, not just on the person with the mental health issues. (**P8, Trust B, Nurse, AMH**).

A number of HSC professionals ( $n = 7$ ), also discussed supporting grandparents to meet their emotional needs and practical needs associated with caring for their grandchildren. For instance, P30 (**Trust E, SW, AMH**) indicated:

I would meet with...grandparents on a regular basis. I am there for emotional support for the grandparent. I am there if they have any problems. If you are asking them to do it [take care of grandchildren], you need to ensure you are empowering them and that you are providing them with support. So I will always make myself available. And in fact...this team is excellent at doing that. ...we will make phone calls on their behalf, we will speak to other agencies if we feel they need other support, we will talk to them about financial issues. It is that practical, emotional support that you can offer.

***Summary: Family Focused Activity - Engage and support children and other adult family members***

*Some professionals gave examples of how they addressed the key Think Family NI improvement aims such as early intervention and family support. HSC professionals discussed engaging and supporting children and other adult family members, including referring to respective services and to voluntary organisations and community resources. Some professional also described how they encouraged parents to explain their illness to their children.*

### *Collaborating with others:*

Perhaps indicative of the on-going Think Family NI initiatives which aim to improve communication and collaboration within and across services, the final and most discussed component of FFP, involved HSC professionals collaborating with colleagues within and outside of their services, (both statutory and voluntary) to support parents and their children. Just over half of the HSC professionals ( $n = 17$ ), though predominantly social workers ( $n = 14$ ) discussed this activity and most were from adult mental health services ( $n = 11$ ). Some HSC professionals in adult mental health services described collaboration as key to supporting families. For instance, P21 (**Trust D, SW, AMH**) indicated, "...in terms of mental health services...there has been a huge shift in the way of working...it seems to be a lot more partnership working between us [adult mental health] and community mental health, between us and primary care".

However, collaboration between adult mental health and children's services primarily occurred when child protection concerns arose. For instance, P27 (**Trust E, Nurse, AMH**) suggested:

...we are very closely linked in with our health visitor colleagues and with childcare as well if there has been an issue at all...if there are any risks or any thoughts of life not worth living, then a UNOCINI is completed and the child is referred to childcare for assessment to the Gateway team. It is important that liaison exists between all the agencies.

Similarly, P30 (**Trust E, SW, AMH**) suggested, "...if concerns are significant... and requires a child protection plan to be put in place...our gateway service would convene...an initial child protection case conference meeting where one of ourselves would meet the Family Intervention team". Nevertheless, a couple of HSC professionals indicated that collaboration didn't always occur due to child protection issues. For instance, P20 (**Trust D, SW, AMH**) suggested, "I would consult with Gateway quite a lot even though we may not refer to Gateway, because...the concerns aren't there... and they would give me guidance in terms of childcare".

Collaboration and referral was also driven by a perception, that adult mental health professionals were not best placed to directly address needs of children related to PMI. For instance, P25 (**Trust E, Psychiatrist, AMH**) suggested, "We primarily work

with parents. We are an adult service, so we are not...engaging with younger children... If a teenager is struggling...we'd refer into counselling...but we wouldn't be offering it ourselves directly".

HSC professionals in adult mental health services also indicated that prior to referring service users' children or parents to outside services that they would obtain parent's consent. For instance, P2 (**Trust A, SW, AMH**) indicated, "If we do find that they are open [parent] to children's service, we would liaise with children's services to inform them that the parent has come through and what the reasons are, with the parent's consent". However, some HSC professionals noted that if parents did not give consent and there were child protection concerns, they would refer children regardless due to their obligation to protect children's wellbeing, as reflected by P1 (**Trust A, SW, AMH**) who indicated:

We would make parents aware at the start of our assessments that anything they do disclose...in relation to children...we have a duty to pass [refer]...on. Further down the line, if they aren't...open to children's services, and we feel that there is a need...and feel that a parent is struggling in their role as a parent...or that the role as a parent is affecting their own mental health, we will then get services involved.

HSC professionals also indicated that they would seek advice from colleagues in children's services about the appropriateness of making a referral for service users' children to community supports and particularly if children's services were already involved with the family. For instance, P1 (**Trust A, SW, AMH**) suggested, "We...have a service...that provides emotional support for children...very often I will defer to children services to decide whether children should be referred to that service...particularly if they are already involved in the family's care".

Collaboration between adult mental health and children's services was also seen as a way to facilitate professionals to address gaps in discipline and service specific knowledge and skills. For instance, P5 (**Trust A, SW, Children's**) suggested, "We have a mental health champion in our team who has been working quite closely with the mental health champion in the community mental health team and so we are developing those networks in terms of mental health and understanding how childcare teams work and vice versa". Similarly, P11 (**Trust B, SW, Children's**)

suggested, "...we usually invite mental health professionals...to meetings and they are able to give us a clear understanding of what is going on for this parent in terms of their mental health" and P21 (**Trust D, SW, AMH**) indicated:

We have weekly visits...I might do one and they [children's service] will do the next week and we will talk about what we have seen, what we have heard, so I am getting knowledge about their mental health and about bipolar disorder and depression...and they are getting the safeguarding, the working with families...that sort of knowledge...so we are both learning something from it".

HSC professionals in adult mental health services, in particular, also discussed collaborating with colleagues within their own services so that their colleagues could support parents and their children with issues related to PMI, particularly more complex issues, rather than they themselves getting involved. For instance, P25 (**Trust E, Psychiatrist, AMH**) indicated:

Would it be me specifically doing work with them? [parent or child]. ...I would be specifically going to the Child and Family Practitioner and saying...their family life is struggling...we are thinking about the impact that their substance misuse has on the child and the other partner...we obviously want to keep the family network together and I would be asking the Child and Family Practitioner to do specific ...more intensive work...because she has a lot of skill and I see the positive outcomes.

HSC professionals also described collaborating with a wide array of other statutory services including child and adolescent mental health services (CAMHS), General Practitioners (GP) and health visitors to develop an understanding of the services they provide and get their perspective on the parent's and child's circumstances and issues and also to update them about the parent and family. For instance, P5 (**Trust A, SW, Children's**) suggested, "we will talk to health visitors, GPs, social workers", while P5 (**Trust A, SW, AMH**) indicated:

...in terms of supporting them ... we will talk to GPs and say, I am working with this mummy, I don't know what she's telling you but this is what I am observing on visits...I contact the health visitor, particularly if there's young kids involved, to find out how they have found the individual [parent] when they have gone out. Are they aware that we are involved?...is the other thing...It has been quite reassuring...to be able to find out from the health visitors that, ok, mum is struggling...around mental health, but actually is very protective at home (**P5, Trust A, SW, AMH**).

Four HSC professionals also noted that they collaborated with the educational sector. For instance, P11 (**Trust B, SW, Children's**) suggested "We would have schools who would...notify us if they notice a dip in mum or dad's mood when they are leaving the child off to school or if they [child] are not on time in school".

HSC professionals in both services also described collaborating with a wide array of non-statutory services to support both parents and children. For instance, in relation to supporting parents, P5 (**Trust A, SW, Children's**) suggested:

...there's a big emphasis on engaging in families better with our partners... the likes of Action for Children and Women's Aid. Network Personnel as well have been providing a really good family support service. And it is linked very much to educational training for parents and trying to help parents who are interested in coming off benefits and coming into work.

Referral to a wider array of non-statutory/voluntary services was identified as particularly important by HSC professionals for families with multiple adversities. P5 (**Trust A, SW, Children's**) indicated, "...there's a threshold in terms of statutory intervention,...we would work with families where the situation is a lot more complex and if we feel...that it would be better for them as a family to be working with one of the voluntary agencies...we will explore that with them".

HSC professionals also indicated that they referred families to other services when they perceived that they could not meet specific needs themselves. For instance, P8 (**Trust B, Nurse, AMH**) suggested "...it is about signposting to the people who might be able to help... and identifying whether things are above your remit...you would send them on to ...someone who has more experience". Some HSC professionals also described how they engaged in joint working for example:

I would be involved with family and childcare services, the Pharos project [Barnardo's project]...and we would work quite closely together in sessions, we... would have a family session that includes the kids and myself and the Pharos worker. So that is really important...ties it's all up very nicely, because the family unit is brought together (**P24, Trust E, SW, AMH**).

Joint working was identified as particularly important when families had complex problems. For instance, P21 (**Trust D, SW, AMH**) suggested:

It is a...complex case...mummy is in and out of hospital quite a bit...we do more or less composite report writing, we do joint assessment... joint home visits... joint individual work with children...when we are explaining to the child about...psychiatric hospital and what that all means. So I was there to take the lead in doing the work with the child and then the mental health worker was there if they had any questions that maybe I wouldn't be able to answer. So the joined up working in that has been brilliant...as it was outside my scope of knowledge in terms of this woman's mental health and the complexities of it.

***Summary: Family Focused Activity - Collaborating with others***

*Phase two of the Think Family NI work aimed to improve communication and information between professionals and families. The final and most discussed component of FFP involved professionals collaborating with colleagues within and outside of their services (both statutory and voluntary) to support parents and their children. For example, professionals in AMH services described collaboration as key to supporting families. That said, collaboration between AMH and children's services primarily occurred when child protection concerns arose. Collaboration and referral was driven by a perception among some, that AMH professionals were not best placed to directly address needs of children related to PMI. Nevertheless, collaboration between AMH and children's services was seen as a way to facilitate professionals to address gaps in discipline and service specific knowledge and skills.*

**Summary:**

The purpose of this section was to outline the nature and scope of HSC professionals' FFP as reported by a range of disciplines but particularly social workers in adult mental health and children's services. Notwithstanding the complex nature of HSC professionals' FFP and drawing on the various themes emerging from the data, there is evidence that the majority of HSC professionals interviewed perceive they are engaging in FFP by endeavouring to support parents and to a lesser degree their children and other adult family members. This is particularly evident by those practicing within addictions services in one particular Trust. This was also evident through participants' accounts of collaborating with other services to support parents and their families, particularly when families had complex needs

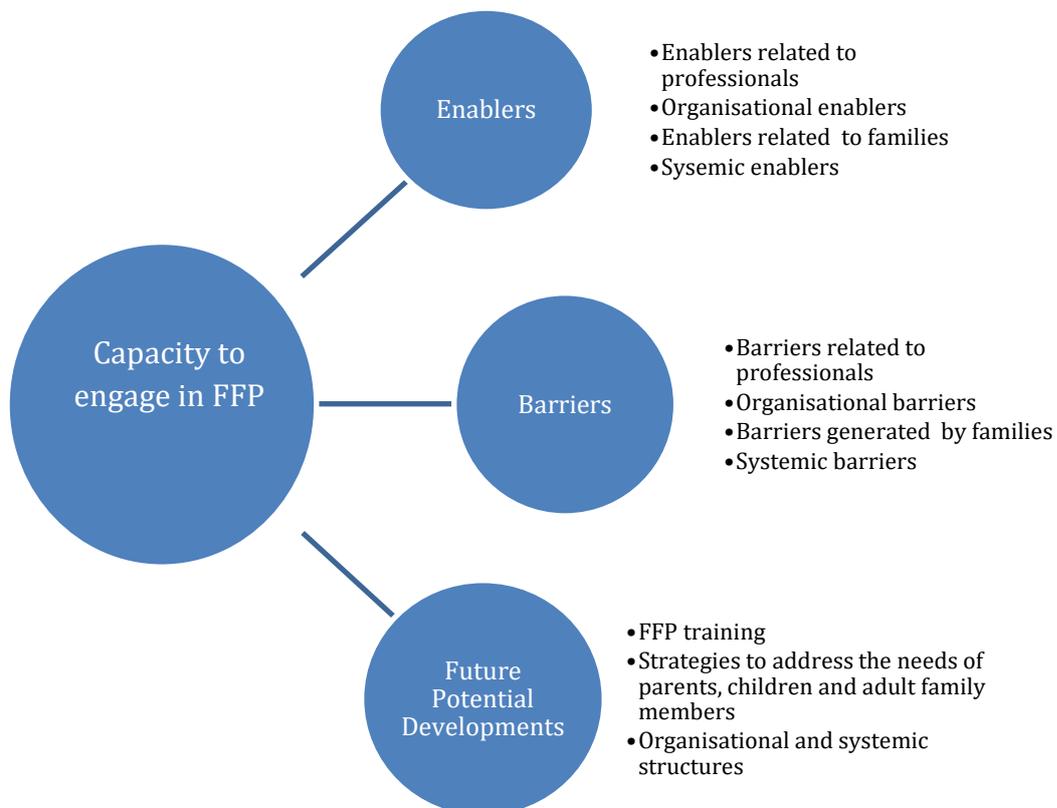
or where there were child protection concerns. Having elicited HSC professionals' views on the nature and scope of their FFP, their capacity to engage in FFP is now discussed.

### HSC Professionals' Capacity to Engage in FFP:

Three main components associated with HSC professionals' capacity for FFP included (1) enablers (2) barriers and (3) future potential developments in FFP (Figure 5.3). Generally, an equal number of barriers and enablers of FFP were identified by HSC professionals. There were several suggestions across both groups regarding FFP promotion such as FFP training, strategies to address the needs of parents, children and adult family members and systematic structures to support FFP.

**Figure 5.3:**

**HSC professionals' capacity to engage in FFP**



**Enablers:**

HSC professionals identified a wide array of FFP enablers, within four areas, related to (1) HSC professionals themselves, (2) the organisation as a whole, (3) parents, children and adult family members and (4) wider systemic enablers.

***Enablers related to HSC professionals:***

The majority of HSC professionals ( $n = 20$ ) identified a variety of factors related to themselves and, or their colleagues that enabled FFP, most of whom practiced in adult mental health services ( $n = 13$ ). Whilst some of these factors are of a more interpersonal nature they may affect HSC professionals' capacity to engage in FFP and responsiveness to the Think Family NI Initiatives.

Early key Think Family NI Initiatives aimed to further focus assessments around the needs of parents and their children. HSC professionals reported that their own understanding of effective parenting is of central importance in enabling their FFP. For example, P28 (**Trust E, SW, Children's**) indicated:

...it is my own upbringing, my own experience of parenting and being parented...I was very fortunate. I had a very loving and caring home...was encouraged at school...access to all my resources. I...understand how important that was for me.

Furthermore, for many ( $n = 11$ ) the skills, knowledge and attitudes to engage in FFP was developed through caring for their own children and to a lesser extent, caring for other's children. For instance, nine HSC professionals suggested that being a parent enabled them to empathise with parents. Participant 11 (**Trust B, SW, Children's**) suggested, "I myself as a parent, understand what other parents go through in terms of trying to manage their children daily and I have no mental health issues. So for them I know it could be so much more frustrating", while P.8 (Trust B, Nurse, AMH) indicated, "...I have children of my own...I have experience as a mummy... getting across [to parents] that things are ok and it is ok to feel sad. So normalising for them". Similarly:

I have children...I know what it is to be a parent...when you come from an understanding of the stresses, the difficulties, the pressure that it involves being a parent, without the added mental health, isolation, lack of support,

depression, substance misuse, domestic violence...it is very difficult in its own right without any of that... (**P30, Trust E, SW, AMH**).

Being a parent also helped HSC professionals to engage with parents as they were able to use limited personal self – disclosure discreetly. For instance, P8 (**Trust B, SW, Children’s**) notes; “I would say...obviously I am aware of professional boundaries and all, but I would talk about myself...I think as more like a mummy...just to reassure them [parent] and there are times I struggle. And that’s normal.” Others indicated that personal experience of caring for children developed their insight into needs of service user’s children. For instance, P29 (**Trust E, Nurse, AMH**) suggested:

I think when you are a parent yourself you can view it from that perspective...what if you were in that situation? What is needed? ...if they...have children...the same age as your own children you think about how you would deal with a situation...what could be going on for that child...it is impossible to block your own experiences in life out...but it would be using it in a positive way (**P29, Trust E, Nurse, AMH**).

Two HSC professionals also indicated that experience as an aunt or uncle was also beneficial. For instance, P28 (**Trust E, SW, Children’s**) indicated, “I know a lot of my colleagues are excellent practitioners and maybe they aren’t parents but maybe they are aunts or uncles and they have good skills, very very good with the family focused area...they have experience”.

Life experience, associated with age, was another FFP enabler that facilitated some HSC professionals to engage in FFP and in particular to support children, for example, P8 (**Trust B, Nurse, AMH**) indicated:

...from my own experience as a child living with a parent with a mental health problem. My mummy would have went through periods of psychotic depression ...I can remember what that felt like and how uncertain everything felt whenever mummy was unwell...So I know the impact it has...and how frightened you can feel...so I feel comfortable talking to the children.

Some HSC professionals also discussed drawing on their own personal experience of adversity to empathise with and to support parents. For instance, P26 (**Trust E, Nurse, AMH**).indicated:

...My own personal experience of living in a house...with...abuse ...living with a husband who had mental health problems...and realising that unless you speak out nobody is really going to help you. So it is those sort of things... It has been an experience and when you come out the other side...because I think... parents see all of those crises as the dark, dark times and things will never change...But me...coming out the other side.

HSC professionals' attitudes to FFP and the need for holistic care was another major enabler and very much reflective of The Family Model (Falkov, 1998, 2012) integrated approach. With regard to holistic practice, P2 (**Trust E, SW, AMH**) suggested, "You've got to think about your client and the wider household who is there... the wider circle and how they are all being impacted". In relation to recognising the importance of FFP, P26 (**Trust E, Nurse, AMH**) indicated:

I am a newcomer to mental health. Previously I worked in A&E...there would have been addictions and mental health issues...just patching people up and sending them on... you could see there was work that needed to be done...And I always used to think to myself, if I ever got the chance I would really put 100% into this. Family work would be something that I would be very interested in...I see the role for it.

HSC professional confidence and previous experience was also noted as a key enabler for FFP. P13 (**Trust C, SW, AMH**) suggested, "If you are confident in your role and what you do...that helps. And I think my...confidence in working with families and childcare colleagues has grown and I'm able to forge really good relationships with people in different teams to go to for advice".

In relation to professional experience, P26 (**Trust E, Nurse, AMH**) indicated, "as time goes on, you understand it better. Just working with it more" and P 7 (**Trust B, SW, AMH**) indicated, "I worked in a family centre in West Belfast for a lot of years and...was working with troubled families on the child protection register and you saw that need [for FFP]. Other HSC professionals indicated that being aware of the impact of PMI on the whole family was crucial to being family focused. For instance:

...for me...it is about...having a really good understanding of the impact of ...severe and enduring mental illness, what is that likely to mean in respect of their parenting capacity... the impact on children of living in that environment...how that impacts on their social, emotional, psychological and physical development (**P30, Trust E, SW, AMH**).

From this perspective professionals understanding of the needs of families and confidence in working with families and across services, has important consequences for professionals' ability to engage in collaborative working in order to support families, something which is reflective of the intended outcomes of staff development activities associated with Think Family NI initiatives.

***Summary: Enablers Relating to Professionals***

*A large number of professionals identified personal factors related to HSC professionals and their colleagues that enabled FFP. These factors may impact on professionals' capacity to engage in FFP and their responsiveness to Think Family NI initiatives and hence require consideration by organisations. Professionals highlighted that their awareness of the importance of effective parenting enabled their FFP. Some also indicated that they developed skills, knowledge and attitudes to engage in FFP through caring for their own children and to a lesser extent, caring for family and friend's children. For example, a number of professionals suggested that being a parent enabled them to empathise with parents and to develop insight into the needs of parents and this knowledge helped them to undertake family assessments. Furthermore, professional attitudes to FFP and the need for holistic care were also highlighted as important enablers as well as professional's confidence to engage in FFP. Some professionals also indicated that being aware of the impact of PMI on the whole family was crucial to being family focused.*

***Organisational enablers:***

The majority of HSC professionals ( $n = 24$ ), provided numerous examples of organisational enablers that promoted their and their colleagues' FFP. This was particularly the case in two Trusts where all HSC professionals provided detailed examples of organisational enablers for FFP. With regard to common organisational enablers across both services, the importance of a positive organisational culture was repeatedly emphasised. In the first instance, seven HSC professionals noted that services were becoming more family focused. For instance:

...we are bringing the family work more into the service. Now we are actually seeing the work and our colleagues are sharing it with us and we are hearing it very much at our team meetings...I don't know about other Trusts but

certainly here... way back whenever there was an in-patient facility, those families were looked after, but whenever that in –patient facility went away, it [FFP] seemed to be less on the radar. But now it [FFP] is very much on the radar (**P26, Trust E, Nurse, AMH**).

A positive organisational culture stemmed from the adoption of a holistic and family-centred philosophy perhaps reflecting the on-going Think Family NI planned work activities which aim to inform strategic thinking, for instance:

I think everybody wants to...provide a service that is holistic and that takes into consideration all parts of the family, not just the client [parent] but their immediate family because that can be a big protective factor for the person [parent] to have their children ...well cared for and for them to have the support” (**P2, Trust A, SW, AMH**).

Some HSC professionals ( $n = 6$ ) specifically indicated that the Think Family NI initiatives promoted HSC professionals’ capacity to engage in holistic practice, “I suppose it is just trying to look at the family holistically ...before the mental health champion model and the Think Family and joint training between mental health staff and childcare staff, we...worked more in silos”, while P7 (**Trust B, SW, AMH**) indicated “I think the introduction of the Think Family agenda...the assessment proforma. These assessments are just tools but they do incorporate quite a bit about families and looking at peoples’ experiences in a holistic way”, Relatedly, P8 (**Trust B, Nurse, AMH**) suggested:

...the parents did allow me to have the conversation with the children. And that’s what the Think Parent, Think Family initiative is. You know to have that short conversation with children if parents will allow you, just to...reassure the children they are not doing anything wrong...and if you are worried about your mummy or daddy, or whatever, have a chat with your daddy.

Organisational policy and protocols also helped to promote a positive organisational culture, albeit with a focus around child protection. For instance, P21 (**Trust D, SW, AMH**) indicated, “...through Safety in Partnership we are trying to focus more on the child”, while P28 (**Trust E, SW, AMH**) suggested, “...the different protocols that the Trust has on childcare and we have clear guidelines on how to work and how we operate and how we...express any concerns at meeting, through the UNOCINI”. Relatedly, P24 (**Trust E, SW, AMH**) indicated, “we...drew up a policy document...on

effective communication between both services [adult mental health and LAC]...to prepare for case conferences” and P30 (**Trust E, SW, AMH**) suggested:

...we work with families at a child protection level...we have obligations in that respect. There are statutory responsibilities that we have...we do have regional policies and procedures...so we can have an intense level of involvement with families and with children, where you build really good, positive relationships, albeit that initially for a lot of families you are there as a child protection social worker.

Working alongside colleagues engaged with Think Family NI initiatives and who were family focused also enabled HSC professionals to engage in FFP, for instance, P24 (**Trust E, SW, AMH**) indicated:

...I would be involved in the Think Family Northern Ireland initiative. We also had a Champions group...within our Trust...where it was family and childcare senior practitioners and team leads and ourselves for...the last five years. And we met four times a year. That was driven very nicely with myself and the head of family and childcare services. It is back to relationships as well, it really is.

Teamwork and improvements to ongoing clear communication within and between services was also a key enabler of FFP; although again, particularly discussed in relation to child protection issues. For example, P24 (**Trust E, SW, Children’s**) stated, “And a lot of our strengths are built on the success of relationships, it really is. Long gone are the days when you sat in an office on your own. You have to get up and out and meet people”, while P28 (**Trust E, SW Children’s**) indicated:

Teamwork together achieves more...our team is a close knit team and we share our experiences, good or bad or indifferent with each other and that’s a great way of protective practice and helping us through our daily routine of work. On a day to day basis we are discussing the person’s case...any childcare concerns that have been flagged up during the team handovers...speaking to the child protection nurses and gateway. So there is a lot of multidisciplinary work going on...

Other HSC professionals perceived that the interdisciplinary nature of the teams enabled FFP as they were able to draw on other areas of expertise in supporting parents and children. For example, P6 (**Trust A, Nurse, AMH**) indicated:

Our team is that good that we could...ask advice...discuss with any of the social workers...cases... [and ask], do you really think I need to do that? Because I don't know if...that is appropriate or not? And they [social worker] will say straight away what they think.

Similarly, P2 (**Trust A, SW, AMH**) suggested, "...in a multidisciplinary meeting we discuss our assessments...any issues we have". Relatedly, P18 (**Trust D, SW, Children's**) suggested:

You would have really good relationships with other professionals. We have really good co-working between health visitors and the family centre and social workers. We really trust each other. You would feel supported with them...you would be showing a united front...singing of the same page.

Perhaps facilitated by the implementation of the Adult and Children's service Joint Protocol, others suggested that opportunities and a willingness for colleagues to learn about the various roles of the different services and professional disciplines enabled FFP. For instance, P29 (**Trust E, Nurse, AMH**) suggested, "...the door is open for anybody within childcare to...spend a day with us in mental health...it is only in doing so that you have a better appreciation of each other's working role, of each other's ability and restrictions and their working role to support a family unit".

Capacity to engage in joint working was also a key enabler of FFP. For instance, in relation to learning from colleagues from a different discipline and service, P18 (**Trust D, SW, Children's**) suggested:

They [mental health colleagues] had a completely different take on mental health and substance misuse than I did. They were able to look at it...more vertically...from bottom up all the way through...This is how it affects...people. This is what we do. This is how we manage it...they are embedding a different kind of approach.

Another participant described the benefit of joint working in stressful situations, "...the situation gets very, very stressful in one home...we normally go in pairs, so we can have that peer support and we can discuss how difficult it is" (**P28, Trust E, SW, Children's**), while P21 (**Trust D, SW, AMH**) discussed the benefit of joint visits in complex situations and when they had gaps in expertise:

I am outside of my scope of knowledge in terms of this woman's mental health and the complexities of it...the community mental health team...has taken it on because it is such a complex case, and the joined up working...it just wouldn't have worked any other way.

Joint working was also a helpful way for the different disciplines to aid communication with parents and between disciplines and to allow a consistent approach with parents:

...quite often the parent will tell the social worker one thing and their mental health worker something completely different...joint visits with mental health professionals can reduce...miscommunication or misunderstandings. With joint visits, they [parents] can see that we are coming from the same place...very beneficial for some parents" (**P4, Trust A, SW, Children's**).

Supervision was another form of teamwork that promoted FFP. For instance:

...supervision with the team lead...anything that you...want a bit of clarity...it does no harm to...get a bit of advice and make the onward referral...it is about the communication within the team...professional supervision...from more senior practitioners in the team and asking questions and they would be able to direct you in the right way in what to do next (**P2 Trust A, SW, AMH**).

Support from senior colleagues was also integral to effective teamwork, "...senior members...have been very, very supportive of my role...there's particular people that I would give great credit for where I am and how I got to where I am and the knowledge that they continue to allow me to glean from them" (**P24, Trust E, SW, AMH**). Similarly, P26 (**Trust E, Nurse, AMH**) suggested:

...when the family piece came up, I had spoken to my team leader and said...this is something I...could do with a fair bit of support. I would never have taken it on had I not known that I could do it...give it 100%. I felt confident...supported and that was literally why I did it.

Some HSC professionals also indicated that effective leadership from managers promoted FFP. "We have had really good managers...who are very family focused...because otherwise it wouldn't have pulled together, they have had a bit of foresight in terms of seeing where services are likely to go" (**P25, Trust E, Psychiatrist, AMH**). Similarly, P2 (**Trust A, SW, AMH**) suggested, "...I have noticed that the team leads are pushing it [FFP] a lot more and saying, be mindful of

families". Relatedly, P30 (**Trust E, SW, AMH**) reported "The Trust are excellent at promoting engagement in training...from the director level down. We would get any reports that are out there and that would inform our knowledge base. Any new services...all those things are absolutely made available to us".

Following from some of the Think Family NI staff development initiatives, training was also very significant in promoting FFP for 12 HSC professionals. For instance, and specifically in relation to Think Family training, P5 (**Trust A, SW, Children's**) indicated, "...I think...the...Think Family and family focused training and all of that help people to be more in tune with that [FFP]. Relatedly, others suggested:

I have to say the Think Family training that I would have went on was actually like light bulb moments. Gosh...maybe that's why such and such is happening...and from that...I would be a bit more conscious of family relationships and how that impacts on mental health and how mental health affects relationships as well (**P9 Trust B, SW, AMH**).

Reflective of the positive organisational culture towards FFP and Think Family NI strategic thinking, some HSC professionals also indicated that their Trust encouraged a wide array of training that could inform FFP. For example, P30 (**Trust E, SW, AMH**) indicated:

I have to say the Trust is excellent...There's an excellent social services training team. Excellent training resources. In the last year I got on a number of training courses. There's lots of training and it is very much person centred...Each individual [professional], through their appraisal and...their training needs...would be identifying to their manager, this is something I would need a wee bit more work on...I did...training on effective assessment and promoting outcomes...around parenting capacity...and mental health...and substance misuse. If you want training it is available.

Some HSC professionals in adult mental health services indicated that training helped their colleagues in children's services to better understand mental illness and support parents. For instance, P19 (**Trust D, SW, AMH**) suggested:

...in fairness, childcare has come round to...Not all childcare social workers in the past were totally negative of mental health, but there was quite a few. I suppose it was lack of knowledge on their part. And now with a ...bit more

training and ...information about what mental health actually is, how we work, they are more willing to work alongside the client and ourselves.

Joint training was identified as particularly helpful in promoting FFP:

...we had a training day...and we had addiction services and as many representatives from family and childcare across the Trust and it was an amazing day...just to here the difference views. We are coming from adult services; they are coming from children's services and to here the pressures and ...the stressors...and the things that could be done better. And the simple things that we miss sometimes...so that was a really important day and I would like to duplicate that again and again (**P24, Trust E, SW, AMH**).

Whilst not directly related to the Think Family NI initiatives but rather promote professionals' capacity to engage in FFP through joint working, six HSC professionals noted that sustained working relationships between adult mental health and children's services were facilitated by having a common base (i.e. service located in the same building). For instance, P4 (**Trust A, SW, Children's**) suggested, "I think the proximity of the mental health team, because they are literally 200 yards away, so I think that aids the relationship", while P11 (**Trust B, SW, Children's**) indicated, "I think because we have the mental health team within our office we are also very lucky. There is nothing missed". Another participant indicated:

...it works well for that knowledge base...I can scoot sown and ask this person about that. And it is good to build relationships...we share a tea room. It is good that you can just build those connections. I suppose I never really thought about it being a colocation, but it...definitely... does have its advantages (**P21, Trust D, SW, AMH**).

Similarly, having a number of mental health services located within the one building also enabled communication between the various services. P24 (**Trust E, SW, Addictions**) suggested:

I work with adult mental health...primary mental health, support and recovery...we all glean information and support from each other...our relationships...would be very good, because we work out of the centres that these other teams are based in, so you would get to know people through coffee, or just in the front reception or the secretaries which are a mind of information. So you get to know people very well.

Some HSC professionals indicated that colleagues in other specialist positions or roles, including, the Think Family Support Worker (previously Think Family

Practitioner), Safe Guarding Nurse and Think Family Champion also enabled their FFP; particularly through developing their awareness of the impact of PMI on children and by enhancing their capacity to engage in inter agency practice. A number of HSC professionals ( $n = 5$ ), from one particular Trust, highlighted how the Child and Family Practitioner played a central role in promoting their FFP. For instance, P26 (**Trust E, Nurse, AMH**) indicated:

...that was a new area for me [supporting parent in parenting]. I...was guided by...our child and family practitioner...she...is from a social work background. That element really does give you a lot of support because she makes herself available, particularly if there's UNOCINIs.

Similarly, others suggested:

We...have the Child and Family Practitioner who is brilliant, absolutely brilliant and...I would get a lot of information from her because she would be quite involved...with some of the other services that are available in the community and she is specifically trying to do some of the work with the family (**P25, Trust E, Psychiatrist, AMH**).

Sometimes having that Think Family, Think Child practitioner coming on board is brilliant, because they can explain it in a way...that brings in the whole support aspect as opposed to...we could potentially be going into the courtroom or whatever" (**P10, Trust B, SW, Children's**).

In relation to the Safeguarding Nurse, P6 (**Trust A, Nurse, AMH**) indicated, "we...have...a safeguarding nurse...and he is good...we can go and discuss with him", while P28 (**Trust E, SW, Children's**) suggested, "...we can express our concerns to...child protection nurses...They are very, very good, to have at the end of the phone...she emailed me a copy of our discussion and concerns and that was an excellent way of...recording my concerns about the plan. That was a very, very effective way of seeing work in progress".

In relation to the Think Family Champion role a number of HSC professionals ( $n = 7$ ) conveyed how through promoting interagency practice, champions promoted FFP. For instance, P17 (**Trust C, SW, Children's**) suggested "to a large degree...the champion model... is about getting people to know each other. Getting people to know where the services are...understanding about what those

other services offer...what the referral systems...and processes are and how to get people through there". Relatedly, others indicated:

We have a childcare champion in the team, so if you feel there's any issue around childcare, you would always run it by your childcare champion and say...do you think this ...warrants a referral to Gateway? Do you feel...there's any support I could be giving this parent or the children?...they [champion] would be your expert in that area to get advice from P2 (**Trust A, SW, AMH**).

We have a mental health champion in our team who has been working quite closely with the mental health champion in the community mental health team, and so we are starting to develop those networks in terms of mental health understanding how childcare teams work and vice versa. And that's been really helpful (**P5, Trust A, SW, Children's**).

Four HSC professionals, primarily in specialist positions, also mentioned how using family focused frameworks (i.e. The Family Model (Falkov 1998, 2012) enabled FFP as it encouraged them to be holistic, to consider needs of whole family and to be strengths based:

...the family model [TFM]... we would use that as well...that's just circulated around the team...very, very impressed with it. It ties in very well with UNOCINI and with our assessment form as well. When you really get used to using it, it is very simple...Sometimes we focus in addiction services, so much on the addiction that you don't think about the impact on the family...and what are their strengths?. Well we are very focused on it [family] now. You have to draw on what these people...strengths...resilience levels are, what the family support is, what the impact is on them. And for me that's the strength in the family focused approach (**P24, Trust E, SW, AMH**).

Relatedly, P21 (**Trust D, SW, AMH**) indicated, "...the A5 cards, most of us have them taped...on our walls...we have them there just as a reminder if we are talking to...service users...just keep that [family]...at the forefront of your mind".

Finally, six HSC professionals described the importance of home visiting as an enabler that was specific to the community setting. Home visiting from this perspective can be perceived as a key enabler towards professionals' capacity to engage with Think Family NI initiatives, particularly those associated with family focused assessments. For example, P28 (**Trust E, SW, AMH**) indicated, "...toddlers

would be at home, so it is a very good way of seeing how the person is coping...with their family and how they are interacting with their families too”.

Reflecting on some of the key FFP principles identified by professionals relating to the importance of the parent-professional relationship, some HSC professionals also perceived that home visits enabled them to have a more relaxed and equal relationship with parents, “the home environment...is the most comfortable environment for any of us. So it would be the best place to carry out that work” (**P9, Trust B, Nurse, AMH**). Relatedly, P25 (**Trust E, Psychiatrist, AMH**) indicated, “I do think its [home visiting] is useful. It...provides you with a more relaxed environment that is...more in the patient’s [parents] control...you have a bit more flexibility and it is a bit more natural”. In relation to benefits of home visiting for children, P9 (**Trust B, SW. AMH**) suggested, “...that is their...safe zone...it brings it [service] to them. It would hopefully be more engaging, less intimidating, less threatening. To take a child out of their home environment into a clinical area ...that is destabilising to some degree...so...home is a safe environment and an appropriate environment...the best place to do some of those pieces of work”.

### **Summary: Organisational Enablers**

*Professionals identified organisational enablers of FFP. These included a positive organisational culture, stemming from the adoption of a holistic and family-centred philosophy associated with Think Family NI strategic thinking. Some professionals specifically indicated that the Think Family NI initiatives promoted HSC professionals' capacity to engage in holistic practice. Furthermore, teamwork, multidisciplinary working and ongoing clear communication within and between services were also highlighted as a key enabler of FFP. Sustained working relationships between services were said to be facilitated by having a common base. Furthermore, home visiting was perceived as a key enabler of professionals' capacity to engage with Think Family NI initiatives, particularly those associated with family focused assessments. Capacity to engage in joint working and support from management were also noted important as well as organisational policies and protocols promoting a positive organisational culture. Training was also very significant in promoting FFP, specifically Think Family training. Some professionals also indicated that colleagues in other specialist positions or roles, including, Think Family Support Worker, Safe Guarding Nurses and Think Family Champions enable FFP; through developing awareness of the impact of PMI on children and by enhancing capacity to engage in inter agency practice.*

### **Enablers related to families:**

To a much lesser extent, HSC professionals ( $n = 5$ ) discussed enablers related to families. Parents' receptivity to adult mental health professionals collaborating with children's services enabled HSC professionals FFP and the ability of professionals to engage with Think Family NI initiatives such as communication and information sharing between professionals and families. For example, P2 (**Trust A, SW, AMH**) reported "...when parents are happy for you to liaise with children's services and work with you it does work well". Parents' willingness to work with HSC professionals to address family issues also further enabled HSC professionals to work with and include other family members. For instance, P3 (**Trust A, SW, Children's**) suggested, "You normally find by the time we get to a family group conference, it is actually quite easy and families, nine times out of ten are more than willing to come on board and help their families out".

### **Summary: Enablers Related to Families**

*A few professionals also identified some enablers related to parents. For example, parents' receptivity to adult mental health professionals collaborating with their colleagues in children's services enabled FFP and the ability of professionals to engage with Think Family NI initiatives such as communication and information sharing between professionals and families.*

### **Wider systemic enablers:**

Some HSC professionals ( $n = 10$ ) also identified a number of systemic factors that enabled their FFP. HSC professionals suggested that developments in policy enabled their FFP and specifically around child protection:

...we do have regional policies and procedures...Safeguarding children is an important one. There are statutory responsibilities that we have...we do have obligations in that respect...so we can have an intense level of involvement with families and the children, where you build really good, positive relationships (**P29, Trust E, Nurse, AMH**).

Relatedly, P27 (**Trust E, Nurse, AMH**) suggested, "The regional policy is important and all staff would be encouraged, as training comes up, to avail of it", and P7 (**Trust B, SW, AMH**) indicated, "One of the things that the Hidden Harm strategy clearly tells us is the best way to reduce the damage to kids is reduce the substance misuse...so it is building the person' [parent] capacity...to change".

Discipline specific requirements to keep knowledge and skills updated also enabled FFP " from a nursing point of view and social work as well, there is an onus for people to ensure that they have adequate training throughout...so that they can revalidate or register. And the childcare interagency working is one of those things which is paramount" (**P27, Trust E, Nurse, AMH**).

Availability of additional community supports for referral was also important; Family support hubs were identified as key:

...referring them on to family support hubs gives them [parents] that extra...longer support... I like the family support hubs because it is about the

parent and it is about the child...if focuses on how can we support this family? A lot of voluntary, statutory and community agencies attend those. They are very collaborative...there is a discussion...with all the services...would that work?...and services...offer to do a piece of work on that...And that is then needs led...so very focused on the family (**P30, Trust E, SW, AMH**).

Other community supports also played a role in enabling HSC professionals' FFP:

If you have a child under four and in an area of need, you have Sure Start...a great initiative coming from infant mental health, how we get kids off to the best start. There's family nurse partnerships, there's new parenting projects, health visitors...a range of supports to help parents in that early...stage (**P7, Trust B, SW, AMH**).

Similarly, P23 (**SW:AMH**) suggested, "...if people have the confidence and resilience to use the supports that are available within the community...it can really help families...the parent and toddler groups and the women's centre...there is quite a lot of voluntary services...". Barnardo's was identified as particularly helpful, in supporting parents:

...we have protecting parenting assessments. Barnardo's are excellent...will come and they will give an honest and true interpretation of how families are engaging...that works really, really well because families know, this is what's expected, this is what I am doing well, this is what's not working well" (**P30, Trust E, SW, AMH**).

Five HSC professionals also suggested that communication with schools also enabled their FFP, "I think schools play a good part...the schools would...notify us if they notice a dip in mum or dad's mood when they are leaving the child off to school. Or if they are not on time in school" (**P11, Trust B, SW, Children's**). Relatedly, P30 (**Trust E, SW, AMH**) indicated, "Schools will attend [case conferences] religiously. They are brilliant".

Other statutory services were also identified as facilitating HSC professionals' FFP, including Child and Adolescent Mental Health Services, "The CAMHS team...would be providing a service to children and young people and they offer the family therapy service as well...that offers a good opportunity to talk through...family dynamics and all that kind of stuff" (**P5, Trust A, SW, AMH**).

### ***Summary: Wider Systemic Enablers***

*Systemic enablers such as existence of community supports for referral and policy development were also noted as important for FFP, particularly those around child protection which support adult mental health professionals to consider the impact of PMI on children (i.e. Hidden Harm)*

### **Barriers:**

Notwithstanding that just over a third of HSC professionals in this study were identified as high on the FFMHPQ and those who were interviewed were able to discuss their FFP to varying degrees, numerous barriers to FFP were identified by all HSC professionals. Similar to enablers, barriers fell within four areas, including barriers related to HSC professionals, the organisation as a whole, barriers emanating from parents, children and, or adult family members and the wider systemic barriers.

### ***Barriers related to HSC professionals:***

Whilst HSC professionals identified skills and knowledge relating to understanding PMI was an important enabler for their FFP, both adult mental health and children's service professionals discussed issues relating to lack of knowledge and expertise around PMI. Although a core aim under phase two of the additional Think Family NI initiatives included improvement to assessment, planning and treatment to be more inclusive of the 'whole family', one HSC professional makes clear their feeling that addressing parenting as part of mental health assessment is not part of their role; "Well I think that adult psychiatrists do not see parenting as part of their role...It is not their business. They are too busy... actually their job is to deal with the mental health issue that is presented in front of them and not to consider the children. I think that is a huge issue" (**P3, Trust C, Psych, AMH**). However, given the multi-disciplinary culture so imbued in child and family social work, psychiatrists will be asked for a view on parenting which this HSC professional viewed as quite challenging given the individualised focus of the role on the adult parent:

.... social workers ask the treating psychiatrist for some feedback on the diagnosis and how it might impact on parenting. And the psychiatrists present as if they have absolutely no knowledge. I couldn't comment because I have

no direct observation of the parenting. And that ... I think that is an issue that consultant psychiatrists do not see this as their issue. They are frightened of it **(P3, Trust C, Psych, AMH)**.

The issue of feeling deskilled, inexperienced and inadequate in knowledge relating to the impacts of PMI for either parent or child came across from both mental health and child care professionals respectively in regard to their FFP. The following quotes from a social worker in the field of addictions aptly sums up the core issues:

I suppose you are wanting to think about the children, certainly, but being... having the resources and the skill set to actually do the best service to the children from our end of things, we might... we maybe don't see ourselves in the best position for that. We would like to, but maybe don't have the training for that.

An overly prolonged focus by adult mental health professionals on trying to help with the mental health issues was also expressed by the following HSC professional to have a detrimental effect on the children:

Well I think that sometimes professionals who are engaging specifically with the parents, leave it quite late before they will recognise that the children in the household are being either put at risk or may have support needs. And that in itself can delay any supports going to the children and can certainly, I think, make our job more difficult with the children **(P6, Trust C, SW, Children's)**.

Another social worker in children's services however took the view that having insufficient knowledge on mental health issues was also a disadvantage: "I suppose where we probably lack sometimes in knowledge is a real knowledge of what our parents are experiencing and how their mental illness impacts on them. We probably don't have that" **(P3, Trust A, SW, Children's)**. Such views further support the need for continued staff development initiatives as proposed by the Think Family NI work plan activities (See logic model, p.41).

### **Summary: Barriers related to HSC Professionals**

*Whilst HSC professionals identified that skills and knowledge relating to understanding PMI was an important enabler for their FFP, issues relating to lack of knowledge and expertise around PMI were also discussed. Adult mental health professionals in particular shared the view that assessment of parenting can be quite challenging given the individualised focus on the adult parent. Additionally, children's services HSC professionals also expressed the view that having insufficient knowledge on mental health issues was also a disadvantage towards understanding the needs of parents and how their mental illness impacts on them. Such views further support the need for continued staff development initiatives as proposed by the Think Family NI work plan activities.*

### **Organisational Barriers:**

Professionals identified a range of organisation barriers which included issues with service structures, policy and ways of working, communication and joint working and resources (including time); and training.

Whilst revisions and amending of adult mental health screening and assessment tools included a focus on assessing the needs of parents and children in relation to PMI, one of the main organisational barriers to FFP that was identified in terms of service structures was simply the separation of child care, mental health and addictions services. Those working in adult services repeatedly stated that they often did not have direct contact with children. "I suppose because we are an adult service, we are not getting the opportunity to see the children, because we don't have any direct contact with them." (**P1, Trust C, SW, AMH**). This was mainly because they consider the focus of their service was on the needs of the adult. "So it is a difficult one, because then you are seeing that individual, you are not actually seeing the child and your role isn't for... it is mainly for that person." (**P2, Trust A, SW, AMH**). Similarly, another HSC professional noted:

Our perspective is very much the adult and I mean that's quite a big failing in the way our service, our psychiatric services are set up, this compartmentalised ... CAMHS, children and adolescents, and then the adult

psychiatry, rather than maybe thinking of a family model of psychiatry (**P3, Trust C, Psychiatrist, AMH**).

If there was a need for intervention with the children identified, those in adult services explained that it would not tend to be their role to address those needs. “if it was direct work with children I would be seeking advice from gateway. I wouldn’t be saying, well let’s discuss this with them. I wouldn’t be doing that.” (**P5, Trust C, SW, AMH**). The potential problems with having separate structures were acknowledged.

I think sometimes professionals can work in their own silos and say we work with adults, therefore the children aren’t our responsibility. And that can be dangerous. It also... you know, people if they are working in their own silos, they don’t have very good relationships with family and childcare services or with other mental health services (**P1, Trust E, SW, AMH**).

Although Think Family NI initiatives aim to improve communication and information sharing between HSC professionals, it was suggested alternative approaches could be explored. “it is something we would maybe need to look at...where we stand in terms of children under 18 within the household, and what we can do to support them.” (**P2, Trust A, SW, AMH**).

Within adult mental health services the separate structures between in-patient and community services were raised as further barriers. “Whenever the mum was in hospital. We found a lot of barriers, a lot of difficulties with mental health hospital staff. And I think things just hadn’t moved on compared to what it had in the community, with the community staff. And it was quite difficult.” (**P4, Trust D, SW, AMH**). These difficulties may overlap with resourcing and training issues, for example P3 noted, “we see the first presentations of new admissions coming into the wards, some with childcare needs, and we have no skills, knowledge and resource that we could then use.” (**P3, Trust D, SW, AMH**). Such views perhaps reflect that whilst Think Family NI initiatives devised to inform strategic thinking and embedding of FFP in front line, organisational and strategic policy and procedures, this have not been adopted/ implemented across all services, particularly acute in-patient services.

In addition to the main issue of separate service structures presenting barriers to FFP, there were also a number of more specific service structures which were highlighted as potential barriers. The first was the perceived lack of services for

children who provide care for a parent or parents with mental health problems. “I think there needs to be more services for children who have a parent with a mental health illness, because they kind of don’t fit. You know, you have the young carers, but they kind of don’t fit in their either, although some can...” (P4, Trust A, SW, Children’s). Additionally, whilst Think Family NI work involved the improvement to facilities to be more family and child friendly environments, some HSC professionals expressed the view that some adult services tended not to be family friendly environments. This included how accessible services were in terms of child care facilities and design, especially within more clinical settings for example:

And then the fact that if you do have young children, some people will struggle to get children to be looked after to come to an appointment. It is OK if they are babies. It is harder if they are toddlers, you know, and you are trying to get into some type of therapeutic work with them, but you can’t when a toddler is present because they are so active and running round (P6, Trust A, Nurse, AMH).

“Well the only clinics that we have, that we run here, are Clozapine clinics or Depot clinics and you know what they are. You know, children don’t need to see their mum or dad getting bloods done every week or fortnight or monthly, or getting injections and things. You wouldn’t want your children seeing you getting injections for anything. So it is not something that is encouraged, really (P4, Trust E, Nurse, AMH).

Issues associated with policy and ways of working were also highlighted as organisation barriers. Ways of working within some adult mental health services which are regarded as the accepted way to practice or part of the organisational culture result in barriers to engaging other family members, particularly children. A Social Worker in adult mental health services reported “It is unusual for us to have any direct contact with children. It is discouraged that service users would bring children to appointments” (P1, Trust C, SW, AMH). There also did not seem to be the expectation that those working in adult services would be working with, or even meeting the relevant children. “I haven’t, to date, experienced a time where family and childcare have asked us to come and meet with a child.” (P1, Trust C, SW, AMH). In addition to lack of family/ child friendly facilities, another factor in the accessibility of services was when they were open. “I am just wondering would the fact that we are Monday to Friday, nine to five, hinder that? (P6, Trust A, Nurse, AMH).

Additionally, the lack of direct contact with children within the familial context added a further difficulty for some mental health professionals in attempting to provide assessments and judgements on the impact of mental illness on parenting. At such times, what is relied upon is how parents report their feelings and thoughts as the following quote highlights:

Because we don't do home visits, we don't get to see the children with the parents or the interaction that is going on. We have to look for concerns purely from what we are hearing. People talking about their children, talking about their interaction and how their body language is when they are talking about their children and how involved they are with their children (P4, Trust C, Nurse, Comm Addictions).

Furthermore, even when participants were more inclusive there seemed to be some uncertainty about working with the whole family further suggesting that the Think Family NI ethos surrounding this has perhaps not reached some services:

Well I certainly wouldn't be talking to the children at all about does mummy do this or how does mummy make you feel?... I have no problem in bringing children into the assessment, because I know that life is like that and I am fine with that. I don't know what the policy is on that. I don't if we are allowed or not allowed. But I certainly wouldn't feel that... I would be afraid to do that, because I wouldn't know if that was right. I wouldn't know if I was doing it right. I wouldn't know if it was the right terminology. I wouldn't know if I would upset the client. So I wouldn't do it, you know (P6, Trust A, Nurse, AMH).

As previously noted, working within the service user's home environment is perceived by HSC professionals as an important enabler to their FFP. Conceivably then is the additional barrier to FFP noted by HSC professionals that service users are only seen in service settings:

Because we don't do home visits, we don't get to see the children with the parents or the interaction that is going on. We have to look for concerns purely from what we are hearing. People talking about their children, talking about their interaction and how their body language is when they are talking about their children and how involved they are with their children (P4, Trust C, Nurse, AMH).

Although participants expressed willingness to work across structures there were some policy and practice issues which were also reported as hindering FFP such as

time and notice needed before being able to attend case conferences. For instance, P6 (**Trust A, Nurse, AMH**) suggested “whenever we are asked to go at three weeks’ notice to LAC reviews that are cancelled the day prior and we juggle our whole entire diary round and then, to be honest, you don’t get to go to them. Another indicated:

We do attend family and childcare case conferences and child protection meetings...The problem being we are not given enough notice to attend. The Government dictates that we must give six weeks’ notice to cancel any patient appointments. And also we need six weeks’ notice of a family and childcare case conference or child protection meeting (**P4, Trust C, Nurse, AMH**).

Additional policy and practice issues that were repeatedly identified were the different approaches to assessment. As one adult mental health professional noted, “The assessment is primarily around their mental health and it depends what’s raised because of that, but you don’t specifically ask about parenting unless it may come up as part of a mental health assessment” (**P5, Trust C, SW, AMH**).

There was also a concern that the forms used were not very user friendly:

The UNOCINI, I think the UNOCINI is a very repetitive document and we have new print formats... we’ve been rolling out what’s called Blue Screen and the print of it is horrendous. So to give to any parent, whether you would have mental health difficulties, learning disability, it is a horrendous document and quite often we have to say, flick to page 12 and that’s where you really need to read. Because the first pages are the demographics, then your visits are all laid out on a page and that maybe runs on to three pages, then your significant events. It is not an easy document to read (**P4, Trust A, SW, Children’s**).

Another participant expressed a more general concern about the amount of time involved in completing the relevant forms:

The systems of documentation, paperwork, is weighing every practitioner right across the health service down. I think collectively we should be exploring the need to reduce that bureaucracy. Streamline it to keep our focus on our interactions, rather than on the documentation (**P1, Trust B, SW, AMH**).

A possible solution was suggested which was to attempt to bring the assessments from different services into one joint, or even shared, format:

... when we go to meetings, you know, you will have the social work reports there, which is UNOCINI. Then you maybe have a report from the community mental health teams. Sometimes you might also have a report from community addictions team. And you have this parent coming in who is already probably up to high dough because they are going into a meeting with social workers about their child, and they are already going, oh my goodness, what's the outcome of this going to be? And then you are putting in front of them this wealth of information. Sometimes information repeated... One document for the whole family and all their needs... you are going into a meeting with three or four different reports ... you want to make sure the family can read it **(P3, Trust A, SW, Children's)**.

The next set of issues which were identified by participants as presenting barriers to FFP were around communication and joint working. Whilst previously HSC professionals identified the benefits of joint working across adult mental health and children's services when there is good communication and positive organisational culture towards FFP; issues involved with the complexity of joint working, the pressure on time and possible difference between services can also act as barriers. Some of the issues of complexity involved the number of people and perspectives that could be involved. "We had the community mental health, we had various... there was foster placement, there was a health visitor... trying to think off the top of my head who all was there. But there were so many different views on what would be best for the children" **(P4, Trust A, SW, Children's)**.

The pressure on time, especially in crisis situations, was also identified as a barrier. As one HSC professional noted; "we need to get better at that too, sharing reports before the meetings, but sometimes you don't, particularly if it is crisis and you've called an urgent meeting" **(P3, Trust A, SW, Children's)**. Similarly, HSC professional P1 states; "And you do tend to find within the mental health sector, the more pressurised workers get, the less focus they have on that networking. So you have to keep that at the forefront in your mind" **(P1, Trust B, SW, AMH)**.

The demanding and busy nature inherently characteristic of current health and social care was also recognised as a barrier for doing creative Think Family work. The following HSC professional underscores the everyday nature of these types of pressures by saying; "the whole thrust of the service was assessing people, progressing people through an assessment, treating them, discharging them.

Assess, treat, discharge” (**P5, Trust C, SW, AMH**). Furthermore, this HSC professional goes on to describe the fundamental challenge in achieving FFP by saying: “I don’t see how you can be a social worker for adults and a social worker for children and do any of them particularly well” (**P5, Trust C, SW, AMH**).

There were also perceived tensions of differences in perspective which impacted on communication; for example, one adult mental health professional stated; “the social workers would be ringing us and asking us well how did we find their mental health? Can they look after a child? How do I know if someone can parent a child or not? Do you know what I mean? It is very much put on you. It should be a joint thing” (**P2, Trust B, Nurse, AMH**). Conversely, one children’s’ service professional reported how on edge about working with their adult mental health professional colleagues as they were seemingly unapproachable with regards to PMI issues:

We would always be edgy if we had to approach mental health professionals. We would always be thinking, what way are they going to work with us? Are they going to listen to us? We would always be careful about how we would be talking to them so that we didn’t say anything ... You will always sound extremely supportive and extremely unjudgemental and all that, because otherwise you will get their back up. You would be worried you’d get their back up and then you wouldn’t get any cooperation from them, because they would circle the wagons (**P1, Trust D, SW, Children’s**).

Regarding the underscored difficulties in information sharing at a professional level another HSC professional states that; “We are often finding at the minute that they are asking for updates on the service user’s work with us and involvement, but often we are not getting regular updates from them” (**P1, Trust C, SW, Addictions**). One participant suggested that the reduced level of face to face, or even telephone contact, between services may contribute to these barriers:

We are all in a world, a faceless world of emails, where you don’t even hear another professional’s voice. Quite often all communication is via email. And to have that person’s name, that voice, that face, you can say look, what’s the situation going on here? How can we support each other? That basic kind of interaction of professionals can only produce better outcomes, I think, for families we work with (**P6, Trust E, Nurse, AMH**).

A possible solution was proposed which was to have a regular time for services or teams to come together. “I always felt that it would be good for mental health to

maybe provide a slot, you know, where social services could maybe come. Whatever it was, once a month and discuss a case where the psychiatrist would be there as well.” (P6, Trust D, SW, AMH). One participant concluded by stating that; “we can’t carry on having problem children and problem parents and having them kind of segregated off into services that don’t really talk to each other” (P3, Trust C, Psychiatrist, AMH).

Many participants, across services and teams also identified issues regarding resources, especially the pressure on their time, as the main barrier to their capacity to engage in FFP:

I think at the minute the pressures of all the services, family and childcare, addiction, mental health... it is hard for us to come together. It is often more telephone contact. I think that’s because of the demands and under resourcing, lack of staff to be able to go out and meet and attend case conferences or family and childcare workers coming to us to maybe meet with a parent (P1, Trust C, SW, AMH).

This was further distilled by one participant who simply stated that “Time is the biggest constraint, without a doubt.” (P3, Trust A, SW, Children’s). This meant that even completing the routinely expected tasks within services was proving difficult. “Yeah, well when the case transfers to us initially we try to have an initial planning meeting. Because of the volume of work in the area that we are working, it can be difficult to do that all of the time” (P5, Trust A, SW, Children’s).

Additional issues of resource also involve the pressure to see as many service users as possible:

You know, constant patient after constant patient. You know, there isn’t any thinking time. It is all about just seeing a person, a problem... that’s what it is called, a problem, and fixing that problem if you can and getting shot of them as fast as possible. That’s the culture that we are in. It is terrible. It is not really about thinking beyond the person in front of you to the family. That would be seen as, that’s the responsibility of CAMHS or social services (P3, Trust C, Psychiatrist, AMH).

Furthermore, the inability to engage with families within the home environment where professionals feel a more comprehensive assessment can take place is said to be further hindered by few numbers of staff available for such assessments; as HSC

professional P1 stated; “And that’s again a resource led... you know, partly a resource led issue, with not enough staff and time to go round and meet people in their own environments, in their homes.” (P1, Trust C, SW, AMH). All-in-all, lack of time and resource is perceived as a major barrier towards engagement in FFP and without this many of the Think Family NI initiatives, particularly those associated with the improvements towards a ‘whole family’ approach to assessment, planning and treatment, may not be feasible under current systemic working conditions. For example; specifically discussing the Champions initiative it was reported that resource pressures reduced the opportunities to fully engage in that role; “both services are so crises driven that it’s really hard to completely devote your time to that role and implement it. Really, really difficult” (P3, Trust A, SW, Children’s). Also, whilst the existence of the Champions Model is recognised as a positive development, the following HSC professional expressed that it had a potentially deskilling impact on other professionals who rely on Think Family Champions to engage and respond to family related issues rather than engaging with FFP themselves:

I think also confidence in staff is a real issue. And although the champion model is great, it absolutely is great, I think sometimes then other members of the team think, oh this isn’t my level of expertise so I’ll not go there. This is for the champion and I’ll just go to them. Rather than actually thinking, I have the same skill set as the champion. I can probably do this myself (P3, Trust A, SW, Fam Support).

Possible barriers were also identified in both pre-qualifying and post-qualifying professional training. In terms of pre-qualifying training it was suggested that working with the family was not sufficiently emphasised:

unfortunately, our nurse colleagues feel that they are not best trained or don’t understand enough about the childcare system for there to be liaison there. So that’s why social work would be often pulled in for that (P2, Trust D, SW, AMH).

“realising the impact that parental mental illness does have on children and families. And the struggles as well that carers have in managing someone with a mental illness and then having to look after the family as well, just as if everything is normal. That is tremendous pressure... I know whenever I was a student there wasn’t an awful lot of training at university level with regards to the impact (P2, Trust B, Nurse, AMH).

Another HSC professional expressed that lack of confidence in one's own skills sometimes results in the tendency to think about always referring on rather than engaging with FFP:

Referring kids on, as I say, there's plusses and minuses for it. What I hear a lot, and even when I talk to people and talk to other professionals... I am not trained to do that...it is about being confident. You are just talking to another person at a different level...as I said, at times it is more appropriate for me to do the work than it is to keep referring on to someone else. So that's something I think that there is a gap in **(P1, Trust E, SW, Addictions)**.

All Think Family NI initiatives aimed to increase staff awareness of the needs of families regarding PMI as well as increase numbers of staff trained; separate service structures were also mentioned in relation to training as the required skills to work with the whole family were sometimes not available. "The fact that the services just aren't set up across children and adult services to think about the family as a unit. That there isn't the range of psychological supports, or people that would be quite skilled at working with this group **(P3, Trust C, Psychiatrist, AMH)**."

Additionally, the issue of resources was also identified as being important regarding training; "There's huge pressures on people when they work in a clinical setting to get away to be able to do training." **(P1, Trust E, SW, AMH)**. Overall, the main perspective on training was the need for more of it on FFP. "I think there needs to be a greater understanding, perhaps, that substance misuse and mental health issues do affect the wider family" **(P1, Trust A, SW, AMH)**. "A lot of children's services don't understand the mental health role...We can't force a service on someone; until they actually want to engage it is not going to work for them" **(P2, Trust A, SW, AMH)**.

### **Summary: Organisational Barriers**

All HSC professionals identified a range of organisational barriers. Some perceived that adult mental health service structures result in professionals often not having direct contact with children. This lack of contact impacts on the professional's ability to make an assessment on the needs of the child. Furthermore, although Think Family NI initiatives aim to improve communication and information sharing between HSC professionals, such contact is generally through a referral only process rather than a collaborative approach to FFP. HSC professionals also commented on the difference in family focused approaches within community based services versus acute in-patient facilities. Such views perhaps reflect that Think Family NI initiatives and related organisational and strategic policy and procedures have not yet been adopted or implemented across all services. Additionally, whilst Think Family NI initiatives aim to encourage the development of child friendly facilities, some HSC professionals perceived that the acute in-patient and clinic based service environment and design was not appropriate for children accompanying or visiting their parents.

An additional barrier to FFP noted by HSC professionals was when service users are only seen in service settings making comprehensive, family inclusive and holistic assessments difficult. HSC professionals also shared concerns that assessment forms used are not very user friendly, quite lengthy and can involve duplication as each service will complete them. HSC professionals also identified the complexities of joint working, the pressure on time and possible differences between services as acting as barriers. The demanding and busy nature of current health and social care was recognised as a barrier for doing creative Think Family work. Lack of time and resource is also perceived as a major barrier towards engaging in FFP. Although an important aim of Think Family NI initiatives was to increase professional awareness of the needs of families regarding PMI as well as increase numbers of professionals trained in FFP, professionals still conveyed that there is a need for more training and time to participate in such training.

### *Barriers emulating from parents, children and, or adult family members:*

The challenges presented by having to live with an enduring mental illness were of themselves viewed as a barrier in being able to appreciate the needs of children:

Some folks with mental illness, mental health difficulties, are entirely just preoccupied with what's going on in their own head and they are not really capable... to think about another person as a separate being, or have deficits in their empathy. And the child, in some folks, unfortunately is just an appendage, a burden, a problem, another difficulty that they have to manage” **(P3, Trust C, Psychiatrist, AMH)**.

This HSC professional also added that for some individuals the service being offered is perhaps not the right type of support needed: “There are some people that are keen to work with us, but sadly they are just so damaged. We actually don't have any treatment to help them.” For example, some HSC professionals discussed the increasing numbers of families within their service dealing with multiple adversities impacting HSC professionals' capacity to engage in preventative work, for example:

... when I started eight...years ago, we would have done a lot more preventative work,...because thresholds have changed...anything we are getting in the door is so much more complex...a case came to me recently where there's mental health, ...domestic violence...neglect of the children...historical allegations of sexual abuse...that's just the tip of the iceberg with one family. So there's a huge amount of complexity in that **(P4, Trust, SW, Children's)**.

The reluctance of service users to share information about the extent of their problems was also recognised by the following Addictions Nurse: “Sometimes people refuse to allow us to get collateral history. So we can only go by what they say” **(P4, Trust D, Nurse, Community Addictions)**. The negative perception towards child care Social Workers and the concomitant fear of their children being taken into care was recognised as an obstacle towards achieving trust and building the therapeutic relationship between parent and professional which was previously highlighted as a key principle underpinning professionals FFP. As one social worker in community addictions describes:

.... whenever I am meeting with the service user and I suggest meeting with the family, they can become quite defensive and are very often reluctant for me to speak to the family. And I think there's a whole range of different reasons for that. One of them is I think that they hear the term 'social worker'

and if there's children involved, they think the worst and think, he's going to take my children off me (**P1, Trust A, SW, AMH**).

This sense of fear and lack of trust can pose a real barrier for professionals trying to gather information to build towards a comprehensive and family inclusive assessment:

The big issue, which I suppose I have already touched on, is the reluctance for parents to engage with us whenever we are trying to find out any kind of information about their parenting capacity, their abilities, how their substance misuse impacts them. Whenever you initially have that discussion with parents, I find in most occasions, they become very, very defensive. They assume the worst is going to happen. And it can be really, really difficult to get a clear picture of what's going on (**P1, Trust A, SW, AMH**).

Interestingly, the following quotes from an adult community mental health nurse underscore the involvement of child protection social workers as actually having a positive impact in encouraging parents to cooperate as this was seen as a 'requirement':

...there have been loads of families... but again it is very difficult to get them to engage in any support unless there is stipulation from social services...unless it is child protection, you can't get them to engage in support. And that's the difficulty. And I would imagine that most practitioners find that difficulty. Because whilst there's limited resources out there, but they are still there, but unless you get parents' consent, there's nothing you can do (**P2, Trust B, Nurse, AMH**).

Additionally, HSC professionals reported their frustration that, at times, even when needs were identified and services were available service users, for a range of reasons, could be reluctant to use them. "The whole issue around consent now is going to be a significant challenge for us all, particularly in family support cases, because we need consent from parents to work with them at a family support level. And if they don't want our intervention, they don't have to accept it" (**P5, Trust A, SW, Children's**). Nevertheless, HSC professionals expressed their willingness and desire to work in a more family focused way. "I would definitely like to have more time to be speaking to families" (**P1, Trust A, SW, AMH**).

Stigma associated with mental illness was also regarded as a negative factor impacting on being able to adopt a more progressive approach to family work. The following social worker makes this point clearly: “An obstacle we always have is the parent themselves don’t always want the rest of the family to know how difficult things are for them. And I suppose they kind of feel there is a stigma and they don’t want their family to know. And that would be our obstacle” (**P3, Trust A, SW, Fam Support**).

This stigma was also evident in parents not wanting their information shared with other professionals: “...sometimes parents are reluctant to give consent for us to talk to GPs or talk to their mental health professionals because they are worried about how they may be viewed” (**P4, Trust A, SW, F&CC**).

This sense of reluctance about other professionals being involved was also manifest in how parents themselves deterred their children from being open with any professionals they came into contact with:

It turned out that these children had major issues engaging because mum’s interpretation of social services was that if she... if they were involved too much that they would take her children away. So, she had encouraged the children not to talk to any professional and that included the teachers. And there was a stony silence between the teachers and the children (**P4, Trust E, Nurse Manager, AMH**).

This sense of fear was all pervading and operated as a serious obstacle towards more engaged practice as the following HSC professional remarked: “it really is a fear of letting people in the door. What are they going to see? What are they going to say? Is my child going to be removed? So there is that attitude” (**P4, Trust D, SW, AMH**).

Minimising behaviour on the part of parents was also felt to be problematic as the following HSC professional remarks: “You find a lot of people will minimise, completely minimise the impact it is having and it will be ... sometimes it will be, well you know, I only drink after seven and my children are in bed” (**P6, Trust A, Nurse, Comm Addictions**). This type of minimising could also be expressed in denial that a mental health issue actually exists as the following HSC professional observes: “I

would have parents on my caseload, who would totally deny they had mental illness, even though we can see it, they've been assessed. And they are saying, you know, I am only depressed but that's not mental illness. We do get a lot of that" (P5, Trust B, SW, F&CC). This lack acknowledgment by parents regarding mental illness and associated impacts supports the need for Think Family NI educational resource for understanding PMI not only for children, but perhaps for parents also.

***Summary: Barriers Emulating from Parents, Children and, or Adult Family Members.***

*HSC professionals also discussed barriers relating to families, including lack of engagement with services, particularly reluctance towards children's service involvement. Additionally, professionals reported that there are increasing numbers of families dealing with multiple adversities which further impacts upon capacity to engage in preventative work and being able to provide the right type of support to families.*

***Wider systemic barriers:***

"The father who was looking after the children kept saying, the left hand doesn't know what the right hand is doing, whenever the mum was in hospital" (P4, Trust D, SW, AMH).

The above quote underscores a fundamental and on-going challenge in achieving meaningful collaborative working between adult mental health and children's services. Similar observations were made by a psychiatrist from experience of the CAMHS service suggesting improvements to collaborative approach. The following quote makes this point:

And what you tend to find is that the child has either been.....focused on as the source of the problem within CAMHS and the adult has been focused on as maybe the source of the problem, but the services aren't really meeting to address how the parent's behaviour is impacting on the child, or the child's behaviour is impacting on the parents. And we don't really have a lot of those, very few in my experience, meetings where two teams would sit down to discuss a particular family (P3, Trust C, Psychiatrist, AMH).

Furthermore, the impact of insufficient resources included direct impact on the availability of services and decision making processes. “there is a long waiting list for primary care. And then they will do their assessment and then it’s another maybe nine week waiting list” (**P4, Trust D, SW, AMH**). This professional goes on to say:

Waiting lists are very difficult. We are all at the mercy of these waiting lists and in childcare, family and childcare we set up plans usually within timeframes...We might have to make huge decisions about a family in terms of, is that child going to be LAC, is that child going to be adopted? Things like that. And we have set up a plan for a parent... you need to do this, you need to do that, and then there’s a nine month, twelve month waiting list (**P4, Trust D, SW, AMH**).

The issue of funding was also recognised as being both central but equally detrimental to some aspects of FFP. One HSC professionals observed that the Think Family NI initiatives currently in place were positive but dependent on on-going funding:

I think they are great when they are backed up with resource, but if they are not resourced, if it is another add-on to the team, then ... it’s what we do anyway. The fact that our first page is a family profile shows our commitment to child protection. It is part and parcel of our practice. But to include children in our work increases the risk to the children, so we have to be very balanced and very aware to do no further harm (**P4, Trust C, Nurse, AMH, Comm Addictions**).

The detrimental aspects of the funding and resource issues were also linked to the tendency for funding to be short term for some family focused type initiatives, for example:

It is how we help workers across our sector have a good, clear view of what services are out there. You know, because that’s a challenge in itself. It is a forever changing world. New services come up all the time. Other services, short term funding, change. So how you help practitioners keep a clear view of what services, and the referral pathways into those services (**P1, Trust B, SW, Addictions**).

A similar observation was made by another HSC professional about the short term and precarious nature of funding and how this was an impediment to FFP:

Now if that came up in an interview I would probably be having a conversation with ... about what is available in the area, because a lot of them are tier two and it's not the same groups in each area and their funding can be short-term and it disappears for a while and then they will come back and then they might be called something different. So it does get a wee bit mucky (**P2, Trust E, Psychiatrist, Addictions**).

This HSC professional also made some suggestions about addressing these challenges:

One of the difficulties is, non-recurrent funding that a lot of these groups get...If we had a more ... if we had a tier-two service that was available for families, and specifically children, that we knew had good governance arrangements that was suitable for us to refer into, we would use it. But we are always a little bit more uncomfortable about using these sort of voluntary organisations that are changing all the time. You don't know what the standard delivery is. And I suppose you don't want to do more harm. It puts you off putting referrals in. So that actually would help if we had, I suppose, standardised services available that weren't just going to disappear in April because the funding runs out (**P2, Trust E, Psychiatrist, Addictions**).

The resourcing of other services was also highlighted as creating barriers to meeting the needs of families. "the services that we have to offer can maybe be somewhat limited. And that can be a real problem. Because you are having a discussion with families, and then at the end of the discussion, maybe the range of services on offer are limited" (**P1, Trust A, SW, AMH**). "When I first started here we had a raft of services and those have, over the years, just diminished very quickly" (**P4, Trust A, SW, Children's**). Although one HSC professional did have a more positive perspective on the availability of other services:

There's loads of different other agencies out there. There is a hub referral so if we need to go in there. There's different agencies we can link in with and liaise with. There's different family members we can link in to support families as well. Family group conferencing, different things, community referrals too, without having to go. So it is about all that. It is developing that knowledge and spreading that out among other professionals and utilising it (**P6, Trust E, N, AMH**).

This section on wider systemic barriers commenced with a parent's plea for services to be better connected and joined up. This service user perspective however must also be contextualised within a system where there are fundamental challenges

faced by professionals in achieving practice and outcomes where children are protected. As one HSC professional states:

I would say that the system doesn't necessarily facilitate us working together in a Think Family approach. I think that the system is very much geared towards risk aversion and avoiding... and that sort of sense of corporate responsibility and corporate accountability (**P3, Trust, B, SW, AMH**).

**Summary: Wider Systemic Barriers**

*Finally, professionals discussed some of the wider systemic barriers such as lack of collaboration with and resources relating to additional statutory services including CAMHS and primary care services; with resultant delays in assessment, planning and treatment. The issue of funding was also recognised as being both central and detrimental to aspects of FFP. Think Family NI initiatives currently in place were perceived as positive but dependent on on-going funding.*

**Future Potential Developments:**

Three ways to develop FFP further were identified, including (1) FFP training, (2) strategies to address the needs of parents, children and adult family members and (3) organisational and systematic structures to support FFP.

**FFP training:**

Although a core activity of Think Family NI initiatives includes staff development initiatives, over half of the HSC professionals ( $n = 18$ ) reported that in order to develop HSC professionals' capacity to engage in FFP they required further training. In the first instance some HSC professionals outlined a number of needs that training programmes should address including information regarding (1) importance of FFP and how to integrate Think Family NI initiatives, (2) impact of mental illness on parents and (3) practical skills to engage in FFP.

Regarding training on importance of FFP, P20 (**Trust D, SW, AMH**) indicated, "...I have been to the the...Think Family conference and it was excellent...professionals need to be aware of what it [FFP] is all about and what it means and how it can change our practice...and how our focus needs to be more holistic". Regarding

training on how to integrate Think Family initiatives, P24 (**Trust E, SW, AMH**) indicated in relation to The Family Model (TFM),

...when you can see the diagram...and put a case example around it...and talk about the different areas of peoples' lives...it will help professionals realise that that's how they are working with every day...but probably didn't realise...I think professionals will see where they fit, where they can go next, where it (TFM) overlaps, what's missing and start to embed it into their practice.

Four Social Workers also suggested that training regarding the impact of mental illness on parents would be beneficial particularly for those working within children's services. For instance, P17 (**Trust C, SW, Children's**) suggested, "...we do need to have much more of an understanding...and knowledge about how particular conditions can manifest themselves...I want to know how these things are going to impact on family life... on relationships...and what the needs of the child are", while P3 (**Trust A, SW, Children's**) suggested, "...that's a real big gap...we are not the experts so we don't really...fully understand mental illness...to the same level as we should...we need to be skilled up...more in that".

A number of HSC professionals ( $n = 8$ ) indicated that training should be interdisciplinary in nature so that professionals can learn about each other's roles and how to communicate across services better. For example, P24 (**Trust E, SW, AMH**) suggested:

I would like training to be.... really multidisciplinary...where you have the opportunity to learn together. I think that's really important. That it shouldn't be...segregated...a lot of our team through this process with Queen's [QUB conducted interdisciplinary workshops] have really got their eyes opened. We had addiction services and ... many representatives from family and childcare across the Trust and it was an amazing day...just to hear the difference views. We are coming from adult services; they are coming from children's services and to hear the pressures and ...the stressors...and the things that could be done better...so that was a really important day and I would like to duplicate that again and again...A lot of the...nurses...family and childcare teams...are saying that there needs to be more time to speak to each other...train together...build relationships.

Further emphasising the need for training and association between training and opportunities for relationship building, P28 (**Trust E, SW, Children's**) stated:

“...often we speak to social services on the phone...having further training...would be very, very important and it would help develop and strengthen those ties”.

Similarly, P29 (**Trust E, Nurse, AMH**) suggested:

...there needs to be a channel of communication and greater joined up training...so that childcare and mental health social workers and staff can come together...that's vital. I would have seen a lot more of that years ago. You would have had the training where you would have had a fifty- fifty ratio of mental health joined with addiction and family and childcare. And that has not been as evident in more recent years... Because of emails...we have become a faceless profession. We don't communicate the way we would have done five years ago. I know it's time constraints and getting people out of their posts for a day...but I think the benefits are significant.

Some ( $n = 4$ ) HSC professionals also perceived that family focused training should be mandatory and ongoing and particularly for younger professionals. In relation to mandatory training, P28 (**Trust E, SW, Children's**) suggested, “... training could be mandatory so we could be updated to childcare concerns...”. Relatedly and further emphasizing the need for ongoing training, P23 (**Trust D, SW, AMH**) indicated, “...it [training] needs to be continually revisited...currently it [focus on PMI] is flavour of the month...but it needs to be kept up there”. Finally, some HSC professionals also indicated that face to face training could be supplemented by online training, “I think e-learning would support...specific days...formal conferences...eLearning is great in terms of supporting and revising” (**P26, Psychiatrist, AMH**).

### **Summary: Future Developments - FFP Training**

*Professionals described a number of areas where they felt that capacity for FFP could be promoted or improved, much of which is reflective of the key initiatives and activities proposed by the Think Family NI work plan. This suggests that currently many of the proposed initiatives are not being sufficiently integrated in services. Training was seen as an important area to be addressed.*

*Specifically training programmes should include information regarding the importance of FFP and how to integrate Think Family NI initiatives, impact of mental illness on parents and practical skills to engage in FFP and specifically to have structured conversations with parents around parenting with mental illness. Professionals also suggested that training should be inter-disciplinary in nature so that professionals can learn about each other's roles and how to communicate across services better. A number of professionals also felt that family focused training should be mandatory and ongoing, and particularly for less experienced professionals. Some also suggested that face to face training could be supplemented by online training.*

### **Strategies to address the needs of parents, children and adult family members:**

As previously noted, phase two of Think Family NI initiatives emphasises the need for further improvement to access to early intervention and family support for parents, children and their families. Participants within the current study unanimously agree with this need for improvement with the need to focus on early intervention repeatedly made. Participant 2 (**Trust A, SW, AMH**) indicated, "...we need to look at early intervention to stop the cycle from continuing on...", while P24 (**Trust E, SW, AMH**) indicated:

A lot of the people I work with are the complex cases. It would be nice to work with people at a preventative level, rather than a reactive side... Occasionally I can work with people preventatively, but it's very occasional. The majority of them are very down the line by the time they get to where I am. They are within the court process, LAC process.

In agreement, P4 (**Trust A, SW, Children's**), suggested, "my thing would be about prevention. So about getting work in there in the early stages to try and prevent any

emotional harm...I don't think there's enough...early prevention". Relatedly, but also highlighting a need for a range of services, P7 (**Trust B, SW, AMH**) suggested, "...we need to try to develop a continuum of services...and values that continuum so that it is not just all intensive work; that the earlier preventative work equally has a role".

Fifteen HSC professionals provided examples of what early intervention may comprise. In the first instance, a few discussed the importance of developing specific supports for families when parents have mental illness within adult mental health services as opposed to just referring children and parents to children's services and to voluntary services. For instance, P21 (**Trust D, SW, AMH**) indicated:

...I know in the voluntary sector there's ...organisations that provide education...and therapeutic work... for children...if their parent has mental illness, but I think within the... Trust we really should be leading the way...We should...have the provision here... where we can be saying to families...we have a specific team... a range of professionals...with training and expertise...for parents with mental health problems...that can come in and do some work with you.

Others described the importance of developing support groups for parents, particularly younger parents and for their children. In relation to supporting parents, P24 (**Trust E, SW, AMH**) indicated:

I think there is a real gap for young mums...parents to come together... for mums to share...to know that they are not the only one...There is a lot of stigma attached to it [mental illness]. So it is very important that we have those...information support networks for parents where they can meet together and not feel stigmatised...blamed...villainised.

Furthermore, whilst one of the early key Think Family NI initiatives involved the development and circulation of educational resource to aid HSC professionals to talk to children about PMI some HSC professionals also highlighted discuss the importance of developing resources to help children understand PMI. For instance:

I think a big component of children's needs is education...about what mental illness is and how it affects mum or dad. A mental illness is a hidden

illness...there is no injury...no cuts...bandage and it is hard for them [children] to understand. There is limited amount of resources to do that...for younger children you could use activity based resources...some book work...that is fun...something that helps them to bring out what they see as the changes in mummy or daddy, so that they can put it on paper and it becomes real for them and less of a taboo (**P29, Trust E, Nurse, AMH**).

Some HSC professionals also indicated that it would also be helpful for services to assist parents to explain their mental illness to their children, "...we...need to get better at engaging parents...involve them and say...there's a wee book here that you can talk to your child about".

HSC professionals also noted that it was important to develop supports for young carers. For example, "they [young carers] are taking... on a caring role so we would use Barnardo's Young Carers...to try to support them. I still think...there's more to be done...and we've more to look at, to be able to offer children growing up in those circumstances" (**P5, Trust A, SW, Children's**).

Additionally, although one of the key Think Family NI activities involved improvement to facilities to create more child friendly visiting environments, this has not been adopted in some Trust services and is seen as an important future development; as one HSC Professional notes:

...my current base is an old hospital ward. It is not the most inviting place. You wouldn't want to bring a parent and a young person into a building where you have someone who is seriously unwell. We need somewhere that is family friendly and you know they are going to be at ease with you and not just frightened (**P2, Trust A, SW, AMH**).

***Summary: Future Developments - Strategies to Address the Needs of Parents, Children and Adult Family Members***

*Professionals also discussed future potential strategies to address the needs of parents, children and families. These included the need to focus on early intervention and prevention as well as developing specific supports for families when parents have mental illness within services as opposed to just referring. Some examples included support groups for parents, educational resources for children regarding PMI and family friendly areas. While a number of key Think Family NI initiatives already address and support some of these recommendations, professionals proposing the development of these resources, for example to explain PMI to children, raises queries as to whether current resources are accessible to all HSC professionals for distribution.*

***Organisational and systemic structures:***

Organisational and systemic changes were required to support FFP. Ten HSC professionals suggested that going forward there is a need for more effective interdisciplinary, interagency and inter sectoral collaboration to jointly address the needs of parents and their children; in the recognition that FFP is intense and complex work and as such requires input from various disciplines and services.

Nine HSC professionals noted the importance of developing specialist positions within teams that equip post holders to specifically focus on supporting families when parents have mental illness and to act as a resource for all other professionals across both services. For instance, P2 (**Trust A, SW, AMH**) suggested, "...it would be good if we could have someone in our team...who is trained in different techniques...family focused therapies...and they were able to role it [FFP] out within the team...or you could do joint appointments with that person". Relatedly, others noted the importance of further developing existing roles, such as the Child and Family Practitioner, Champion Model and Family Support Worker. In relation to the latter, P24 (**Trust E, SW, AMH**) suggested, "...the role I work [Child and Family Practitioner] is a fantastic role...I would love to see it duplicated across the Trusts...I would love people to invest in what we do, because it really...works", while, P25 (**Trust E, Psychiatrist, AMH**) indicated,

...we could easily use two Child and Family liaison officers/Practitioners...because it really does make such a difference...she [Child and Family Practitioner] does time limited intervention...very intensive work...So another one would be good...and not just sitting in isolation...but that is part of your team...

HSC professionals also discussed the need to support further development of the Champions Model, “I think it is early days because it [the Champions Model] is still ongoing, to help those champions feel equipped and skilled and competent. I just did a training session...for the champions...Got a great conversation of not only how kids are affected by substance misuse, but how can we help them” (**P7, Trust B, SW, AMH**), while P29 (**Trust E, Nurse, AMH**) indicated, “...the family focused champions...that is rolling out but it is about bringing that forward”.

Others discussed the importance of increasing the numbers of Family Support Workers who could help social workers to support families. For instance, P6 (**Trust A, Nurse, AMH**) suggested “...I would like the family support worker back. I did think that it was fantastic and I do struggle to get to LAC reviews and it upsets me that I can't advocate for my patients” while P3 (**Trust A, SW, Children's**) indicated:

Social workers have to deal with crisis...which creates so much work for them...and takes them away from families with less pressing needs but who may need support. ...I have one band four social work assistant...she is able to do work with the child or parents...as she is not caught up in that crisis...we need more of that (**P3, Trust A, SW, Children's**).

As previously note by HSC professionals as a key enabler, eleven HSC professionals also noted the importance of more collaboration within and between services in general and in particular opportunities to engage in increased joint working. For instance, P30 (**Trust E, SW, AMH**) indicated:

I would like adult mental health services...addictions services to commit to being part of that plan to commit to attending those meeting and to work collaboratively. That doesn't mean just being on the end of the phone, giving information, it means being prepared to sit down with families, with us, and saying here's where we are.

Focusing on the benefits of joint working, P3 (**Trust A, SW, Children's**) indicated:

...so this person who is completely overwhelmed by whatever is going on, either their mental illness, child stresses, then has two different appointments with two different professionals that day, to tell the same story...and then possibly get conflicting advice. I do think that needs to be more joined up. I think joint visits would help immensely. There's one message for parents and both the parents and child's needs are being met there and then. It would also be useful if community mental health professionals could come along to the family group conference and do one family plan that will meet parent's needs and child's needs.

Others noted how joint visits could help either service deal with gaps in knowledge:

...we are not the experts, so we don't...fully understand mental illness...to the...level we should...we need to be skilled up...more in that...and community mental health team... aren't skilled in terms of working with children. I would love joined up practice...visits...to help parents understand how their mental illness is impacting on the child, but also then for the child to understand mum or dad's illness (**P3, Trust A, SW, Children's**).

Some HSC professionals identified various ways in which joint working could occur.

For instance:

...we could ask someone from the mental health team to come to a team meeting...to give us some knowledge around it [mental health] that we know signs to look out for, approaches, ways of working cases differently. What does this [mental illness] mean about parenting? This is an area we do find difficult...and that's where the co working actually needs to happen whenever we are trying to identify, can this parent, parent? So it is really important that we do work together (**P21, Trust D, SW, AMH**).

I think you should have one mental health worker in a childcare team. Somebody who is always there and that expertise is always there...And vice versa...a childcare worker in the mental health team that can be used for their expertise... as staff confidence is a real issue (**P3, Trust A, SW, Children's**).

Expanding further upon how joint plans could be formulated, P3 (**Trust A, SW, Children's**) suggested:

...I think...if we had monthly meetings...with all the professionals at it and bringing along case examples... and you are saying this is the crisis the family is on, what is everybody doing here and is there anything additional we need to do or is there anything less we need to do, to focus on one thing...we have things like MARAC in terms of domestic violence...something like that.

Others suggested that another way to promote collaboration was for professionals to visit other service areas to find out more about services offered and to develop effective working relationships with colleagues in those services. For instance, P15 (**Trust C, Nurse, AMH**) indicated, "I think it would be a very good idea for...members of our service to spend...two or three weeks... with a family and childcare social worker, going...to people's houses, seeing family development, seeing the perspective from family and childcare social work". Likewise, P5 (**Trust A, SW, Children's**) suggested how professionals in children's services could also benefit by spending time in adult mental health services to develop insight into their colleagues practice context:

I think it would be a good project to swap roles for a day or a week ...that...'walk in my shoes' scenario...Even to go for a day to each other's place of work in a very planned and supportive way and to be able to say, oh I understand how this works (**P5, Trust A, SW, Children's**).

Following on from this, six HSC professionals indicated that it would be good to have opportunities for sharing information with other colleagues across Trusts. For instance, P24 (**Trust E, SW, AMH**) indicated "...it would be nice if we could have...joined up working across all the Trusts...more often...it would be nice if we all could come together more often". Some HSC professionals ( $n = 6$ ) also noted the importance of being flexible:

...doing family work...would not worry me at all. So I think we need to keep our minds very open as practitioners that...we can't just stay in one area and be deskilled in something else. So it is about attitudes and if we have a proactive team and we are willing to move on and learn different elements of the service (**P26, Trust E, Nurse, AMH**).

Relatedly, others suggested:

There needs to be more shared tools so that we are not just thinking, well that's their expertise so I'm not touching that and vice versa. That you have the tools there that you can go out and do it there and then if somebody isn't available, rather than leave it (**P3, Trust A, SW, Children's**).

...it's not one person's responsibility... not one discipline's responsibility...If they [children] are not going to engage with Family Smiles and things like that, you might be the one person that those children are going to be in contact with. So I think you use that opportunity when you have it (**P8, Trust B, Nurse, AMH**).

Five HSC professionals also highlighted that to be able to engage in FFP, including effective collaboration that more time was required, "...if I didn't have to spend as much time on administration...it would free me up...to give...parents more quality time" (**P10, Trust B, AMH**). Similarly, P8 (**Trust B, Nurse, AMH**) suggested "...it helps...if...management are supportive...giving you the time to do things [FFP]".

Seven HSC professionals also highlighted the need to integrate Think Family NI initiatives and evidence based interventions into practice. Regarding Think Family NI Initiatives, P20 (**Trust D, SW, AMH**) indicated, "I just think the whole Think Family Initiative needs to be out there more and staff should be educated on it within their local areas", while P21 (**Trust D, SW, AMH**), suggested:

I think some of our nursing colleagues need to be brought on board...probably through some of our team building days...team meeting...where some of the Think Family team could come down and speak to them...give an outline of what the project is about...use scenarios to get the team to think of cases they are working with...and try to get peoples' [professionals] minds back to Think Family again and again.

Others highlighted the need for further research to inform development of initiatives. For example, in relation to exploring children's needs, P25 (**Trust E, Psychiatrist, AMH**) indicated:

...we need information about what kids need. It shouldn't be about us telling families or telling children what they need. I think it needs to come up the other way. In terms of training...it needs to be directed by that [children's needs]. We [professionals] obviously have our specific need that we might feel we would like to learn...more about, but that's obviously no use it that's not the same as what a family needs...one really important aspect is that we could be meeting in the middle somewhere.

In relation to examining benefits of existing interventions for children, P7 (**Trust B, SW, AMH**) indicated:

...an area of further development is...what can we do to build protective factors and how do we build them?...kids get the short intervention... Steps to Cope...does it raise kid's resilience? The early evidence is saying, yes it does and significantly. So how do we help keep building that evidence base? So we do need to keep exploring building that evidence base. What is going to help

these kids? The more we get a better picture of it and continually offer it...we could make a bit of a difference.

Finally, in relation to systemic structures, some HSC professionals discussed the importance of sustaining existing voluntary services that could be used to refer family members to. For example, P6 (**Trust A, Nurse, AMH**) suggested, "I think that when we had the supportive families project going that was so good. Now that it is not here I feel that it should be. I feel that if we had that there would be absolutely nothing more we could offer". Relatedly, P24 (**Trust E, SW, AMH**) indicated:

...the other thing that I think we are very guilty of...in Northern Ireland...we are very stop, start, stop. We will get an initiative, we will go hell guns on it, but then something new will come down the block and people will say, ...now we need to do that but they will forget all about the work that's gone on for the last couple of years.

Three HSC professionals indicated that existing services should be standardised and equally available to families across Northern Ireland. For example, P8 (**Trust B, Nurse, AMH**) indicated:

...more support...there are some areas that don't have access to the likes of SureStart and it depends on your postcode...just to say that because someone lives in Lisburn doesn't mean that...they are...better off than someone...living in Twinbrook. We would have patients living in...Lisburn who wouldn't have access to that [SureStart] and that's inequality. The supports should be accessed for everybody.

Relatedly, P25 (**Trust E, Psychiatrist, AMH**) suggested:

...we have these little areas of excellence, but they sort of float around without any real coordination. So it is kind of pulling together the services but also making them standardised...so that it is not just that...you go to the (TRUST NAME) Trust you get this, but...if you went twenty minutes up the road you either would have got nothing or a very different service. So I think it is not unreasonable to have an expectation that we have a bit more standardisation of services.

Expanding upon need for wider availability of family support services, P26 (**Trust E, Nurse, AMH**) indicated, "we need ...more tier two services...as many staff in tier two as there is in tier three... because they are at the coal face and there is a lot of families in crisis out there".

Four HSC professionals also indicated that existing services could consider the needs of parents more as opposed to focusing primarily on children's needs. For example, in relation to Family Support hubs, P30 (**Trust E, SW, AMH**) indicated:

...the last time I was at the family support hub...there was talk about mental health being more proactive in sitting in the hub, which would be an excellent idea. Because I think initially it would have been very child focused, so you had education welfare, CAMHS,...all those organisations that worked with children...it would be very, very good to then look at services that can work with parents...and that's where your mental health, your addiction service or someone from that would be excellent.

Others indicated that families need to be aware of services provided by family support hubs, "...it is important that the family support hubs... let families know that they are out there, and this is what they can do" (**P30, Trust E, SW, AMH**). Four HSC professionals highlighted the importance of schools further supporting parents and children, "I would like to see primary schools doing a lot more work about positive parenting. I know they have different programmes...like Roots of Empathy...I don't see why that type of thing could not be developed in the school but on specific issues [PMI]" (**P29, Trust E, Psychiatrist, AMH**). Relatedly, P30 (**Trust E, SW, AMH**) indicated:

School is a huge issue here. These kids are going to school daily, or not. So school has a big role to play in identifying that there are issues at a very early stage. And that's where schools can refer families to the family support hub. So they don't need to come to us at that stage, necessarily... So to me it is schools recognising at a very early stage, because we will not see those kids until somebody tells us about them. So I think we have to be confident that those people who see those children on a daily basis, feel comfortable enough to lift the phone and say look, can I get some advice please.

***Summary: Future Developments - Organisational and systemic structures***

*Professionals commented on future organisational and systemic changes required to support FFP. A number of professionals suggested that going forward there is a need for more effective interdisciplinary, interagency and inter sectoral collaboration in the recognition that FFP is intense and complex work and as such requires input from various disciplines and services. For example, some suggested a need to appoint a specialist professional within teams who could specifically focus on supporting families and act as a resource for all other professionals across both services. Relatedly, others noted the importance of further developing existing roles, such as the Champions Model and Think Family Support Worker. Moreover, professionals welcome opportunities for joint working across services and Trusts, with suggestions such as professionals visiting other service areas to find out more about services offered and to develop effective working relationships with colleagues in those services. Finally, professionals also highlighted that to be able to engage in FFP, including effective collaboration, more time is required and existing voluntary services need to be sustained so that they can be used to refer family members to.*

**Summary:**

In this section of the report, the findings of the qualitative component with HSC professionals have been presented and two global themes were identified in the process. These included (1) The nature and scope of HSC professionals' FFP and (2) HSC professionals' capacity to engage in FFP. The first global theme suggests that HSC professionals view their FFP as being comprised of three central elements including (1) family focused activities, (2) principles and (3) processes. Although all three elements are connected they are distinct and illuminate what HSC professionals do in relation to FFP, why they do it and how they do it.

The second global theme was concerned with HSC professionals' capacity to engage in FFP which was described in terms of enablers and barriers to FFP and future potential developments. Generally, there were a balance between enablers and barriers to FFP and many of the enablers derived from HSC professionals' personal attributes such as own parenting experience and life experience.

Collaboration within and between services was identified as a key organisational

enabler. The community setting was also important, primarily due to opportunities to observe normal family life during home visits.

Barriers to FFP fell within four areas, including barriers related to HSC professionals, the organisation as a whole, barriers emulating from parents, children and adult family members and the wider systemic barriers. HSC professionals identified that skills and knowledge relating to understanding PMI was important for their FFP. Insufficient knowledge on mental illness and associated parenting issues was perceived as a disadvantage towards understanding the needs of parents, children and their families. Furthermore, lack of engagement with children within adult mental health settings impacts on professionals' ability to assess the needs of the child(ren). Additionally, HSC professionals noted that within some services, service users are only seen in service settings making comprehensive, family inclusive and realistic assessments difficult. Complexities of joint working, the pressure on time and possible difference between services were also highlighted as important barriers.

In addition, there were suggestions for future potential developments within three areas including FFP training, strategies to address the needs of parents, children and adult family members and organisational and systemic structures. Again these suggestions emerged as a consequence and response to identified barriers to FFP.

## Qualitative Findings – Service Users

### Sample:

A total of 21 parents (2 male, 19 females) who, at time of data collection, were using adult mental health or children's services (or both) and who had a mental illness, including substance use problems, participated in a semi-structured one to one interviews. Service users were aged between 21– 59 years (Mean age = 38) and had on average three children. The children's age range was between seven months and eighteen years, with some families including older adult children. The majority of service users reported as single ( $n = 13$ ), with a smaller number married ( $n = 5$ ) or in a relationship with a significant other ( $n = 3$ ).

Service users were availing of a range of adult mental health services, most notably community mental health ( $n = 12$ ) and addictions services ( $n = 5$ ). Ten service users reported as experiencing depression with four service users reporting with postnatal depression. Other diagnosis included personality disorder, bi-polar disorder, eating disorder and anxiety with four service users also reporting issues with addiction. Eight service users reported dual diagnosis such as depression/ anxiety, depression/ alcohol dependency and eating disorder/ personality disorder. Service users reported a range of durations of their mental illness, with some involved with services for six months and others more than ten years. Eight service users also noted involvement with family and childcare services. Services being availed of were typically situated within both urban and rural areas with a small few rural services predominantly from the Southern Trust.

### Overview of Findings:

Service users reported with mixed emotions with regards to service experience, particularly when children's services were involved. Service users discussed a number of examples, contexts and scenarios to describe their experiences of services, including facilitators and barriers relating to those experiences. Whilst terminology such as Family Focused Practice (FFP) was not easily recognised by service users, the need for and benefits of FFP for families was discussed at length by service users.

Similar to professionals' interviews, service user interviews were considered alongside a range of demographics relating to both the service user and service setting (adult mental health or children services [or both], and in-patient versus community).

Two global themes emerged from the interviews with service users and were conceptualised as (1) Service users' experience of professionals' FFP and (2) Service users and professionals' capacity to engage in FFP. Service users described the complex and multifaceted nature of experiencing mental illness, its impact on children and other adult family members as well as additional external factors adding to the difficulties associated with such an experience (i.e. social stigma of being a parent with a mental illness). Service users' perceived that in response, HSC professionals undertook a variety of activities that were underpinned by a number of principles.

Service users perceived that their capacity and that of professionals to engage in FFP depended on three main elements including (1) enablers, (2) barriers and (3) future potential developments. Each of these global themes are examined in the following sections, with particular attention paid to reporting service users' perspectives of HSC professionals' response to key Think Family NI initiatives.

### **Service Users' Experience of HSC Professionals' FFP:**

#### **Principles (Why professionals should engage in FFP):**

The principles described by service users fell into five broad categories including (1) the inter-relationship between mental health and the parenting role (including the impact of PMI on children and wider family), (2) supporting children and families via their parents, (3) the importance of the parent-professional relationship, (4) the needs of parents, children and families and (5) practice needs to be individualised and holistic and parents' family contexts are part of this.

#### ***The inter-relationship between mental illness and the parenting role:***

In the first instance, and similar to HSC professionals, service users recognised the inter-relationship between parenting and mental illness; specifically that parenting

impacts on mental health and conversely, that mental illness impacts on parenting. For instance, in relation to the stress of parenting on their mental illness, service users 5 indicated:

Like there's only fourteen months between the two of them, so it is quite hard and quite demanding. But I keep telling myself it is going to get better. It is going to get easier. It is going to get better. But it will eventually. It is just hard now because they are going through that wee stage. But it will get better **(SU 5, Trust A, CMHT)**.

Likewise, another service user notes:

.... I can understand how a parent actually breaks. Because when you already are suffering with mental health issues and you have that added pressure and stress of a child... and I find your coping skills to be able to discipline a child and things like that, go out the window. Because I think you almost ... to relieve your own stress, you give the child anything, to stop the white noise **(SU 2 Trust E CMHT)**.

A number of service users ( $n = 9$ ) also acknowledged the impact of mental illness on their children, particularly the bond between parent and child. As one service user noted "...although I looked after my daughter, met all her physical needs... I remember saying to my health visitor; I can't talk to my baby. I just felt as if I got her bathed and fed and it was just... I was almost like a robot" **(SU 3, Trust E, CMHT & F&CC)**. Service user 2 also recalls feeling emotionally unavailable for their children; "when I was here, even though I was physically here, mentally I wasn't here and emotionally I wasn't here for the kids in the sense of I was totally disengaged. I wasn't mentally or emotionally available to them" **(SU 2 Trust E, CMHT)**.

Service users also expressed the view that their mental illness had a major impact on their parenting capacity. Parents reported that they are perhaps more 'on edge' or impatient with their children:

...if I am having a bad day I would find I am more on edge and if the kids do something silly that you would be more inclined to go, stop it! And they are not doing anything wrong. And it is just them playing in their normal day. And you get quite stressed out doing simple tasks and the kids are then... they are sort of on edge because you are on edge, doing simple tasks like **(SU 4, Trust B CMHT)**.

In the same sense another service user notes that “if you are feeling low and you’ve no energy or you just feel like you can’t cope, it definitely comes off on the children” **(SU 2, Trust A, CMHT)**.

Service users also shared their feelings and concerns about the emotional and social impact of their mental illness on their children. Some service users described situations relating to their mental illness which would have been perceived by their children as traumatic, such as parents being detained under the Mental Health Order or children being removed from the family home due to child protection concerns. Service user 1 stated that, “I now have a twelve year old who saw her mum being dragged away three or four times in an ambulance. So it is quite scary for them.... I have said that is not a good experience for me and it was certainly not a good experience for my children” **(SU 1, Trust A, CMHT)**.

Similarly, another service user recalls the upset experienced by their children due to a kinship placement:

... they were upset obviously because they wanted to be with me. Going to my sister’s is ... her way of dealing with the kids is actually entirely different to mine, and obviously my daughter was extremely upset because she wanted to come and be with mum **(SU 3, Trust B, CMHT & FIT)**.

Service users also shared concerns regarding the potential for the intergenerational transmission of mental illness. For example, service user 2 notes; “my depression has rubbed off on my kids” **(SU 2 Trust C Home Treatment & Children’s Services)**. Service User 1 also stated “I think she [daughter] needs to talk to somebody because I can see myself in her, and I can see her anxieties and I can see her behaviours and I am putting them down to the whole attachment issues with her mum not being there when she was younger” **(SU 1, Trust A, CMHT)**. Such views further highlight the need for better integration of existing Think Family NI initiatives which aim to improve access to early intervention.

Furthermore, the wider impact of mental illness on the family unit and family relationships was also highlighted. As one service user states “as a whole the family is very fragmented at the minute” **(SU 4, Trust A, CMHT)**. Additionally, service users

perceived that other adult family members have also been affected by PMI through stress and worry for the service user and upset to normal daily life. One service user stated that “with my mental health I have found that I brought my mum down quite a lot. And she is starting to get back on her feet and I am maybe having a bad day and I will phone her. And then I get her into a tizzy and get her upset” (**SU 4, Trust B, CMHT**). Service user 3 also explains how her mental illness and need for support impacted her parents, both emotionally and in terms of resource:

Well it left my parents and my family, they were just completely consumed by it, you know. I know my parents couldn't sleep. I think my father actually cried, and I had never seen him crying. My mum and dad, you know, full time jobs at that time, and I think actually my mum... she was a teacher... she took early retirement because then she just felt that I needed support. So she retired, I think, earlier than she was planning to. So it has, it has taken its toll on them (**SU 3, Trust E, CMHT & F&CC**).

In other cases, service users discussed how their children have also taken on the role of young carers impacting their own development including educational attainment. One service user describes how her daughter has taken on household responsibilities including caring for younger siblings; “she takes over the house. She looks after me. She looks after [PARTNERS NAME]. She gets [PARTNERS NAME] out to work. She gets the kids out to school. And I know that I have done that to her”. (**SU 2, Trust C, Home Treatment & Children's Services**). Service user 5 also admitted that “I wanted to sort of keep her home because I've two wee ones, a three and two, so if anything goes wrong, she is old enough nearly to know what to do. She had missed a few days off school” (**SU 5, Trust A, CMHT**). The impacts of PMI on children and the wider family support the need for a ‘whole family approach’ to assessment, planning and treatment.

### *The needs of parents, children and families:*

Throughout the interviews and in conjunction with the impact of PMI on parents, children and their families, service users also made reference to their perceptions of needs. Reflecting on their experience of PMI and services, service users highlighted that first and foremost knowledge of their mental illness is important for parents:

It's like anything really. It is like... I have to be able to understand the elements and how everything all fits together and how it all works together, before I can

do anything. Because it's just above my head. It is like skipping. I can't skip, because I can't get into my head ... I have to understand it a bit more technically, I think, before I am able to sort of cope with it **(SU 2, Trust B, Addictions)**.

Service users also noted that understanding mental illness is important for service user's children. Discussing the need to recognise signs and symptoms of being unwell, service user 4 notes:

...like the dishes aren't being done. The washing's not being done. These are all my sort of tell-tale signs of what's going on and how I am going downhill. Or she hasn't had a shower in a week, or washed in a week, or whatever. You know, that's all my tell-tale signs. My child wouldn't pick that up because he doesn't know what to look out for **(SU 4, Trust B, CMHT)**.

Furthermore, services users reported that recognition of parental status and support with parenting are important components of sustained recovery. Speaking about meeting with professionals regarding mental illness, one service user recalled how she had to remind professionals of her parental status; "I did say when I was sat in these meetings, I said, you know, I am sitting here and none of you know how this feels like. Because you are all professional people. I am a parent" **(SU 3, Trust B, CMHT & FIT)**.

Another service user highlighted how living with an addiction further impacted on parenting confidence, highlighting the need for encouragement and reassurance with regards to the parenting role, she stated that "...parenting is a major issue... living with a parent with addiction and just a complete shambles of a mother, my biggest fear is being a crap mum. And thinking that you are unable to cope and unable to look after your children is such a horrible feeling" **(SU 4, Trust E, Addictions)**. Speaking about what she needs from professionals, service user 1 states that "It is about telling a mum, if you are feeling like that, don't be ashamed" **(SU 1, Trust A. CMHT)**.

One service user also felt that a positive approach by professionals towards parenting is more helpful and provokes a better response from service users towards service involvement, particularly with regards to children's services;

They need to be assessing the needs of the home. Not in a bad way or not in a critical way... when you get somebody that is criticising, you don't want that

person in with you because they are only chipping away at your self-esteem even more. I think it is just positive affirmation and positive feedback and positive suggestions into your home... Try and focus on the positive that everything else then falls into that **(SU 2, Trust E, CMHT)**.

Service users also indicated that knowledge of services and how to navigate services is an important element of support and recovery for the whole family; “I don’t know what’s out there. This is my problem. I don’t know what is out there... people don’t know what services are out there. And that’s all they ask you when you are depressed and your mind is blank. What do you want? I don’t know what I want” **(SU 2, Trust C, Home Treatment & Children’s Services)**. Service User 5 suggested that “people don’t know anything about the services if they have never used them. And maybe all it takes is one person to just guide you into them” **(SU 5, Trust E, Addictions & CMHT)**.

Furthermore, service users also acknowledged the need for early intervention for both the parent and child in order to negate future crisis “if the problem is dealt with as best as possible the younger they are, then the better it is for him. Or for any child growing up” **(SU 3, Trust A, CMHT & F&CC)**. One service user suggested that the consequence of such issues not being identified sooner is that “it starts to affect your life... if it is costing you jobs or affecting your kids, affecting your family, you know... that’s where you are at crisis point. If you don’t get the right help at that time, you know, that’s how people end up losing their lives to it”, **(SU 5, Trust E, Addictions & CMHT)**.

#### ***Supporting children and families via the parent:***

Similar to professionals, service users also perceived that children and even other adult family members can be supported via the parent. As one service user suggested, “...if I am well, then they are well. You know, because whatever I do, or my moods, or my reactions, all reflect on their moods and reactions” **(SU 2, Trust E, CMHT)**.

As previously noted, service users acknowledge the inter-relationship between parenting and mental illness and with this in mind feel that when they are supported and their needs are met they are better able to cope with daily life; “If you are being treated for something, obviously it is going to make you better at everything in your

life. Your job, parenting, every aspect. If it is not... same as untreated alcoholism. It has a ripple effect on everything in your life” (**SU 5, Trust E, Addictions & CMHT**).

Additionally, one service user suggests that the right type of support for the parent within adult mental health services could mediate the need for support from children’s services with regards to the needs of children:

...when I am better, everything is better. They are better, my husband is happier, the house is better, you know, everything is better whenever I am better. So everything has a knock on effect. Even if children’s services isn’t involved with adult services, getting the right adult services in place can help make everything better (**SU 6, Trust E, Addictions**).

### *The importance of the parent-professional relationship:*

Similar to reports by professionals, across all Trusts, service users ( $n = 16$ ) discussed the implications of having a therapeutic relationship with the professional in which they are in contact with. Service users reported that having this relationship allows parents to be honest and ask for help and support when it is needed. For example, service user 3 notes that the professional “just seemed to click with me and I was able to talk to her about how I was really feeling. And that was great and I thought she was brilliant. But also very supportive if I needed anything done”, (**SU, Trust C, 3 CMHT**).

When this relationship between the service user and professional does not exist, parents were left feeling uncomfortable, judged and unsupported. One service user recalled that because “...it wasn’t comfortable...I couldn’t have opened up to her. So I am glad anyway she did discharge me, because it would have been a waste of my time going to her... I wouldn’t have been able to sit down and open and tell her how I feel. (**SU 2, Trust C, Home Treatment & Social Services**). Likewise, service user 4 notes “I didn’t really have a good relationship with one person in particular. And that is very hard because you are in crisis (**SU, 4, Trust A, CMHT**).

Service users also highlighted that having a good rapport with the professional and the professional having a good sense of the service user was important for parents to feel understood and for professionals’ assessments of parents to be more

accurate; "...I felt I really clicked with her. And I felt she really knew what was going on inside my head. And that really helped me, because there was nobody else I felt that knew how I felt," (SU 3, Trust E, CMHT & F&CC). Likewise, service user 3 noted:

And like building up good relationships so that the person can talk to you. Like because that's such a change. See if they come in and it's a bad day, and they know it's a bad day, not even mentioning that. Just ask how they are or whatever, but notice that it is just a bad day. But like if they have a good relationship with them then they will obviously recognise the bad day quicker or whatever (SU 3, Trust A, CMHT & F&CC).

This common understanding between parent and professional resulted in parents being more receptive to support being offered and a willingness to engage with services, for example speaking about courses suggested by the professional:

...when she said to me about WRAP, she said you will really enjoy it. Because you sort of get to know each other. You get a feel for each other. And she said to me, you would really enjoy it. And I am very trusting of [NAME OF PROFESSIONAL]. If she tells me something and she thinks I am going to enjoy it, I trust I will enjoy it... (SU 2, Trust E, CMHT).

Similarly, another service user decided to engage with recovery when this relationship with the professional existed:

And all of a sudden it kind of twigged. Do you know what I mean? There's someone who is not sitting there judging me. There is someone actually sitting there talking to me, showing empathy, obviously, to the state I was in. And I think if it hadn't have been for her, I think I probably would have carried on (SU 3 Trust B, CMHT & FIT).

***Practice needs to be individualised and holistic and parents' family contexts are part of this:***

Similar to professionals, a number of services users also discussed the need for a parent's history, circumstances and individuality to be considered as part of service response. For instance:

...they shouldn't focus on the bad points there and then. They should try to get down to the nitty gritty, to the individual person...Understanding what is going on, and what has gone on in the past... use that as a tool to where you

are today. But, you know, have a little bit more understanding and awareness of why people end up using...service users **(SU 3, Trust B, CMHT & FIT)**.

Furthermore, similar to HSC professionals, service users discussed the complexities of their situations. Issues such as domestic violence, history of childhood abuse, dual diagnosis, lack of wider family supports and single parenthood were noted as further affecting mental health. One service user discussed how initial service engagement had only dealt with part of the problem resulting in continual relapse:

Over the years, because of my misuse of alcohol I would have been referred to the addiction services first, you know, and I would have always said to them I need help with my mental health as well, because it was always... I would have relapsed with alcohol and then I could have went a year or a year and a half without it, but my mental health deteriorated and I wasn't getting support for that. And that's what always led me back, then, to the misuse of alcohol **(SU 5, Trust E, Addictions & CMHT)**.

Given some of these aforementioned complexities, service users perceived that, it is important for professionals to gain a good understanding of everything that's influencing the services users' mental illness and parenting is part of this. As one service user commented, "I don't think it is even brought up much about how parents cope with an addiction, I really don't. It is hard enough when you are normal... I have an addiction and I have depression, you know what I mean?" **(SU 1, Trust E, Addictions & Children's Services)**.

### **Summary – Principles of FFP**

*Similar to professionals, service users are aware of the interrelationship between mental illness and its impact on parenting. Service users also shared their concerns about the emotional impact of PMI on children, and the potential for intergenerational transmission of mental illness; further highlighting a need for the Think Family NI initiatives which, as previously noted, aim to improve access to early intervention and support for families.*

*Service users also highlighted the stress of PMI on the wider family and the need for greater family supports. Service users reported that knowledge and understanding of PMI among the whole family is an important enabler for coping with PMI.*

*Service users also noted the need for recognition of parental status within services and the importance of addressing parenting issues along with mental illness as part of service delivery. In this context children and families can also be supported via the parent.*

*As a final note and also reflective of professionals' views, service users discussed the importance of the parent-professional relationship as without this parents feel they cannot be forthright with professionals about their needs. This is particularly important given that some service users reported the complexities of their situation including domestic violence. Such insight is important for further improvements to Think Family NI initiatives.*

### **Family Focused Activities (What Professionals Do):**

It is important firstly to note that the section of the interview which addressed professionals' family focused activities with service users was the most difficult part of the interview for service users. Perhaps unsurprising, service users were not generally aware of the specific activities in which professionals had engaged in with them. Rather such activities were identified by the researchers throughout the interview and noted as such. Four core family focused activities will be reviewed including: (1) identifying the needs of parents, children and adult family members, (2) supporting parents to promote their mental health, general well-being and parenting capacity, (3) engaging and supporting children and other adult family members and finally, (4) collaborating with others.

#### ***Identify and address needs of parents, children and adult family members:***

A small number of parents ( $n = 5$ ), particularly those availing of community mental health services, recalled professionals asking questions relating to parental status and any needs the children might have during initial assessments; as one service user recalled, "we talked and we talked about the kids I had in the house and things like that. And we went into things. And she had to ask me about the kids and did they need support" (**SU 2, Trust E, CMHT**)

Another service user also reflected on their initial assessment when transferring from one Trust to another and how the level of detail and opportunity to discuss any issues was positive as they were listened to;

I first came up from (LOCATION) and she did an initial assessment of my full family... my full history and things. And it was good to be listened to, particularly going from one Trust to another Trust, or one service to another service. It was good to actually have that opportunity (**SU 3, Trust C, CMHT**).

#### ***Summary: Family Focused Activity - Identify and address needs of parents, children and adult family members***

*A small number of parents ( $n = 5$ ), particularly those availing of community mental health services, recalled professionals asking questions relating to parental status and any needs the children might have during initial assessments. The opportunity to discuss any issues was viewed as positive as parents felt listened to.*

### *Supporting parents to promote their mental health, general well-being and parenting capacity:*

A greater number of service users ( $n = 18$ ) were able to provide examples as to how they were supported with not only their mental illness but also within their parenting role. A number of service users ( $n = 5$ ) described how they were encouraged by adult mental health professionals to take time to recover and focus on themselves:

I am sort of learning to have time, because I was twenty four hours basically on call all the time, so I never really had the chance to do anything. So having that wee time, then, to go to a class or to do something for myself... I used to feel guilty. And then it was learning that it wasn't guilt to take time out, even from the kids. And they were told then that I needed my time on my own as well **(SU 2 Trust A, CMHT)**.

Some service users noted how professionals helped them to understand their mental illness and addressed coping strategies within this:

...there are things that I have learned that I do, but I would never have linked it together with like anxiety and stuff. Do you know just things and you are like, flip, I didn't know. So it is insightful. It is really good...I would notice things. I would pick up on anxiety... not anxiety but wee things I am doing ...like I would recognise more the things happening with my body, whereas I wouldn't have in the past **(SU 3, trust A, CMHT & F&CC)**.

Service users also provided examples of how they were supported at a practical level with things such as medication, parenting skills and childcare support, particularly from adult mental health services. For example, service user 4 notes; "my wee support worker comes out and she will take the child away so I get an hour to myself to go and get a shower, bath, or do a bit of housework, or whatever I want to do. Or lie down for an hour. So I do find that that service is really helpful". **(SU 4 Trust B, CMHT)**. Another example of such support provided by adult mental health services for a single father includes; "They got me in touch with somebody to come and show me how to like look after my home and my child and so on, and give me different ways of doing it" **(SU 1, Trust B, Addictions)**.

More generally, service users reported that aspects of parenting were discussed and helpful suggestions made by some professionals:

I am made aware of everything that's available. I've been offered parenting classes and told about all the services, you know like Orana and day classes, playgroups... I even got a list of playgroups and stuff when the two younger ones were younger and stuff. You know, suggestions of things to do. I don't know what it is. It's just... they are just great **(SU 4, Trust E, Addictions)**.

...we talked about different issues, you know in your life, like your work, like your parenting, like your every day to day life; getting up, getting washed, getting ready, getting dressed, and like your motivation and stuff. And so she supported me through those life matters, and financially as well **(SU 4, Trust C, CMHT)**.

Three service users also recalled how Think Family Support Workers encouraged parents to speak to their children about PMI and provided reading resources to help explain PMI to their children, for example one service users notes; "I met [PROFESSIONALS NAME] and she was giving me leaflets on how to explain, how to talk with children" **(SU 1 Trust C, CMHT & Children's Services)**. Another service user recalls "it's what I was advised, basically. Advised by the Think Family coordinator [currently known as Think Family Support Worker] and by my social worker to talk to him ....the mental health team have made me think how important it is that he knows what is going on" **(SU 3, Trust C, CMHT)**.

One service user also described how she learned from the Think Family Support Worker how to speak to her son in a child friendly way and to have confidence to do so; "...with [CHILDS NAME] she taught me how to speak to [CHILDS NAME] about it in a child friendly way. Just tell him mummy can't drink, it makes her sad...She helped me, gave me the confidence to talk to [CHILDS NAME] about things and not be the elephant in the room" **(SU 5, Trust E, Addictions & CMHT)**.

The service user went on to say:

[PROFESSIONALS NAME] was the first person to teach me that. If you are living with issues of alcohol misuse and your mental health, relapse is going to happen so how do we manage it? She was the first person to really make me feel like this. You can parent. You don't have to lose your child. You can parent and deal with this at the same time and I am going to show you how **(SU 5, Trust E, Addictions & CMHT)**.

Some service users also indicated that HSC professionals endeavoured to form partnerships with them to help them to help themselves. For instance, (SU 1)

suggested, “So if I went in not well she would have said to me, what are you not doing that’s making you unwell at this minute in time? And we would have went through it together. So that core knowledge between the two of us was really helpful” (SU 1, Trust A, CMHT). Another service user also gave an example of how the professional engaged them in their recovery plan and provided a certain amount of control within this:

She gives you the tools to make the decisions for yourself. She doesn’t make the decisions for you, which I think is the totally wrong thing to do anyway. For me, I think it is like being told, right, you need to do this, you need to do that and you need to do that. She doesn’t. She comes up with all these suggestions and puts them into perspective. And there is always somewhere to go with it, you know, depending on your personality and what you want. There is that many options that there’s always one that you can choose (SU 2, Trust E, CMHT).

Furthermore, professionals’ honesty regarding intentions to support the service user’s family was appreciated by service users as it provided a sense of security and perhaps control:

I am always a great believer of people speaking the truth. And people mamby pambying round facts just takes longer for them to sink in. I think you are safer being brutally honest and, you know, even if it takes you like a day or a week to actually let that sink in, it will eventually sink in. Somebody had to be honest with me and say, you need to wake up for you and your kids. Which is what [PROFESSIONALS NAME] done and she was right (SU 6, Trust E, Addictions).

***Summary: Family Focused Activity - Supporting parents to promote their mental health, general well-being and parenting capacity***

*Service users noted how professionals tried to engage children and family members and discuss their needs relating to PMI. Others recalled how professionals encouraged service users to take time to recover and understand their mental illness and how to better cope with this. Professionals had provided services users with advice regarding practical everyday activities and also advice around parenting including speaking with children about PMI. Some service users also indicated that HSC professionals endeavoured to form partnerships with them to help them to help themselves. Furthermore, professionals' honesty regarding intentions to support their family was appreciated by service users.*

***Engaging and supporting children and other adult family members:***

A number of service users also reported how professionals had spoken with children about parental mental illness ( $n = 6$ ). Evidence of communication and joint working between services was highlighted by one service user who spoke about a Think Family Support Worker in adult mental health services working alongside a children services professional in order to address PMI and explore the emotional needs of the children. The professional engaged with the children on multiple occasions ensuring that the children understood the subject being discussed:

[PROFESSIONALS NAME] from Think Family came out, but she came out with the social worker on both occasions. And she talked to the kids about emotions and, you know, she had them wee figures from some film... what was this one and what was that one and how does that emotion make you feel, and all this? And then she says that mummy had borderline personality disorder. And she went through and made it more exciting than it sounds! You know, mummy's illness has three names to it. And she talked away. And then she came back... left some books... well they picked some of these books and we went through some of them. And she came back about a month, maybe a month and a half later and was talking to them again. And sort of went over what do you remember ... basically what she told them the last time  
**(SU 2, Trust B, Addictions).**

With regards to professionals' attempts to engage with other family members, six service users recalled occasions where professionals engaged or tried to engage

and support adult family members. Some service users recalled how professionals (both adult mental health and children's services) spoke with adult family members such as partners and parents of the service user in order to offer support, provide insight and update on treatment progression. Speaking retrospectively about children's services one service user notes:

We always talked about it and he [husband] always had the opportunity to talk. When the social services came out to the house it would have been open and honest conversations. When I was in hospital they still would have come out and I don't know what they talked about. I didn't ask. So he was receiving support... **(SU 1, Trust A, CMHT).**

And later speaking about adult mental health services the same service user recalls; "They would have rang my husband and they always kept him informed as to what was going on. If I was going against treatment they would have rang him and said look, we have had to do this because such and such. So they kept him informed. They were really supportive" **(SU 1, Trust A, CMHT).**

Service users also recognised and appreciated professionals' efforts to be family inclusive; "They did offer, yesterday, to hold a family meeting with the wider family circle, but just with my circumstances I am not that keen on that. But for some people that may work well. And it is obviously something they offer" **(SU 4, Trust A, CMHT).** Furthermore, another service user notes; "She also tried to include my family as well. She would have asked if my mum wanted to come in on an appointment or...you know, she always tried to. That's one thing about [PROFESSIONALS NAME]; she has always been a great family advocate. It is a family matter" **(SU 5, Trust E Addictions & CMHT).**

**Summary: Family Focused Activity - Engaging and supporting children and other adult family members**

*A number of service users reported how professionals had spoken with children about PMI. Evidence of communication and joint working between services was highlighted by one service user who spoke about an adult mental health Think Family Support Worker working alongside children services professionals in order to address PMI and explore the emotional needs of the children. Service users recognised and appreciated professionals' efforts to be family inclusive and recalled occasions where professionals engaged or tried to engage and support adult family members. Some service users recalled how professionals (both adult mental health and children services) spoke with adult family members such as partners and parents of the service user in order to offer support, provide insight and update on treatment progression.*

**Collaborating with others:**

One of the more frequent activities among professionals recalled by service users related to collaborative working. Thirteen service users noted that they had been referred to either another statutory service or to a voluntary service with regards to their specific needs or the needs of their children. Speaking about being involved with one service, but having access to others, one service user notes, "...well me working with [PROFESSIONALS NAME] with the adult mental health, it is not just one person. You are sourcing other units. You are sourcing outwards all the time. I find... and that's a big thing I noticed, you know (**SU 2, Trust E, CMHT**). Another service user explains how the professional they worked with also addressed other complex needs relating to the parent through the referral process; "She linked in with Nexus for me because I was abused myself as a child. She has linked in with an awful lot of service for me, for the kids, you know, for help and support" (**SU 2, Trust B, Addictions**).

Four service users also commented on professionals' multidisciplinary working and the benefits of this for parents including updating respective services on family's circumstance and reducing the burden on families to repeat their story and engage separately with children's services; "So like with them linking in with each other and stuff, like I am not doing two sets of work for two different times and all that there. So

it is good that they all link in and they are not overwhelming me with stuff too” (SU 3, Trust A, CMHT & F&CC).

Furthermore, service users indicated that multidisciplinary meetings allowed for adult mental health professionals to advocate on behalf of the parent with regards to parenting capacity, given that they spend more time with the parent as a service user:

I would be lost without them, you know, because they are able to... they are the ones that are seeing me on a weekly basis... they are the ones that give me confidence. If I didn't have them then ... and social services wouldn't know what to think either, because they can't be there to... So it is important that they work closely together. But I have definitely found, especially this time dealing with the FIT team... they are very much connected now and in contact with each other and working together (SU 5, Trust E, Addictions & CMHT).

***Summary: Family Focused Activity - Collaborating with others***

*Reflecting on some of the Think Family NI initiatives which promotes collaboration, communication and continued support, a majority of service users recalled how professionals referred them and in some cases their children and family members, to other services. These services included those within the voluntary sector in order to meet the specific needs of the family. Service users also commented on professionals' multidisciplinary working and the benefits of this for parents. Benefits include updating respective services on families' circumstances and reducing the burden on families to repeat their story and engage separately with children's services. Service users also felt that multidisciplinary meetings allowed for adult mental health professionals to advocate on behalf of the parent with regards to parenting capacity given that they spend more time with the parent as a service user.*

**Summary:**

The purpose of this section was to outline service users' experience of professionals' FFP. Notwithstanding the complex nature of FFP, and drawing on the various themes emerging from the interviews, in the main, service users perceive that professionals are endeavouring to engage in FFP by supporting parents, their children and other adult family members in line with Think Family NI initiatives. Much of the evidence for this has been derived from reflections of adult mental health service users, especially those service users engaged with community mental health and addictions services and who have had contact with a professional practicing in a specialist position such as the Family and Child Care Liaison Officer or Think Family Support Worker. Also of note, service users were less able to describe examples of professionals' FFP than professionals were. Furthermore, whilst service users attempted to provide examples of activities in which professionals engaged in with them, these did not always match with the needs of parents, children and families, as described by the service users themselves. Having elicited service users' views on their experience of professionals' FFP, their capacity and that of professionals to engage in FFP, will now be discussed.

**Service Users and Professionals' Capacity to Engage in FFP:**

Three main components associated with service users and professionals' capacity to engage in FFP from the view of service users included (1) enablers, (2) barriers and (3) future potential developments in FFP. Service users highlighted differences between adult mental health and children's services within areas such as understanding of mental illness and how this interlinks with parenting. Furthermore, those who had experience of both adult mental health and children's services identified more enablers and barriers given their insight and ability to compare services. Service users also provided several suggestions regarding promotion of FFP such as FFP training, improvements to systematic structures to support FFP and strategies to address the needs of parents, children and adult family members.

**Enablers related to Service Users and Professionals' Capacity to Engage in FFP:**

Service users, and particularly those within the community setting, identified a wide array of FFP enablers. Enablers fall within four core areas related to professionals,

the organisation as a whole, enablers related to parents and families themselves and wider systemic enablers.

### *Enablers Related to HSC professionals and their Colleagues:*

Service users reflected on a number of enablers related to HSC professionals. Perhaps unsurprising, service users reported that professionals' experience, including life experience and work experience enable FFP. As one service user noted:

Well I think it takes a combination of the right training but also I think life experience is a big help. I have found in the past, if you are speaking to someone that has been married or has children or whatever, they can relate so much better, I feel. So I think experience and maturity as well as the training, it makes a difference because ... it means you feel that the person understands better your situation (**SU 3, Trust E, CMHT & F&CC**).

Some services users also commented on the comfort in knowing that professionals understood and acknowledged the stressful nature of parenthood. For example, speaking about an adult mental health Social Worker, service user 5 notes "I think she has a wee niece or something that she minds. And she came and talked to me about that, saying... acknowledging the difficulties of having children" (**SU 5, Trust E, Addictions & CMHT**). Similarly, one service user noted that it was important when a professional speaks to parents as both a service user and a parent; "... it was the way she presented herself and walked into my home and had respect, and didn't come down on me like a ton of bricks. She spoke to me as a person. And she showed empathy and feelings and respect, nearly, for me as a mum..." (**SU 3, Trust B, CMHT & FIT**).

Services users also discussed the importance of interpersonal skills among professionals such as honesty, empathy and attitude towards parents:

I think she is totally honest with you. She will not tell you something to make you feel better...but she has empathy with you. And she talks in plain talk...It is very relaxed and it is very comfortable... And so comfortable in your own skin when you are with her that you feel you can offload. She is just so approachable. And she genuinely wants to help. And she genuinely is honest about things and she puts things into perspective (**SU 2, Trust E, CMHT**).

Normalisation of mental illness was also an important enabler for service users; “I think it’s their attitude towards mental health. How they see it...It makes me feel normal. That’s a good word. Yeah, they make you feel normal” (**SU 4, Trust E, Addictions**).

Reflecting on the needs of parents, children and families, as previously identified by service users, and the importance of the parent-professional relationship, it is unsurprising that attributes of professionals such as knowledge, understanding and attitude are important enablers for service users both in establishing a relationship with a professional and feeling comfortable to engage with services. Organisations need to be cognisant of how professionals’ personal circumstances can affect FFP and responsiveness to Think Family NI initiatives.

***Summary: Enablers Related to HSC Professionals***

*Service users identified that professionals’ life and work experienced enabled their FFP. Service users remarked that professionals who were parents themselves were more understanding and acknowledged the difficulties associated with PMI. As previously noted, this understanding of the inter-relationship between mental illness and parenting among professionals may aid professionals’ assessment of the needs of both the parent and child(ren). Organisations need to be cognisant of how professionals’ personal circumstances can affect FFP and responsiveness to Think Family NI Initiatives.*

***Organisational enablers:***

Throughout interviews, a large number of service users ( $n = 19$ ) also highlighted organisational enablers which they perceived as beneficial towards meeting the needs of parents, children and families.

As mentioned by professionals, during the review of FFP activities, multidisciplinary working within and across services is an important activity relating to FFP and one which has been vigorously promoted through Think Family NI initiatives. This is also considered by service users as an enabler. Reflecting on adult mental health and children’s services working together, service user 5 notes that “it is important that

they work closely together. But I have definitely found, especially this time dealing with the FIT team, that they are very ... they are very much connected now and in contact with each other and working together". The service user goes on to say that "Well it makes me, obviously, less fearful and more confident when I see that. Obviously then it helps the situation because that's how we come to decisions with everybody sort of on board at the same... you know... sort of heading in the same direction" (**SU 5, Trust E, Addictions & CMHT**).

Service users also commented on the usefulness of child friendly visiting facilities within in-patient units and flexible service delivery within community settings as important enablers for parents and their children. One service user who had experience of an in-patient unit talked about their child visiting the unit and making use of the family visiting facilities:

I seen her once a week, every Friday. So for about an hour or two hours, so I did. So it was great seeing her there and it wasn't too bad, even though I wasn't well, it was great to see her. And I don't think she was afraid or anything... It was lovely. It was all painted with Mickey Mouse and Disney characters and SpongeBob..." (**SU 4, Trust C, CMHT**).

Flexible service delivery was also appreciated by service users; for example, speaking about a home visiting appointment, service user 4 stated that "...they do understand that I am a parent and they have to work round it and they will try and organise it. Like my CPN nurse will organise it round the child's sleeping pattern". (**SU 4, Trust B, CMHT**). Additionally, home visiting was also noted as an enabler for both the family and the professional. Speaking with regards to service delivery for children, one service user remarked that the home environment was more appropriate for children:

The kids could have went to the centre, you know, but me as a parent, I wanted to make them feel as comfortable as possible and to me their own home environment was the best place for them to be, to have this strange person coming in and trying to teach them about stuff, and everything else (**SU 3, Trust B, CMHT & FIT**).

Furthermore, another service user also highlighted that service delivery within the home environment allows professionals to observe normal daily life, aiding the

identification and accurate assessment of the needs of parents, their children and families. As one service user noted; "...I think that you can't assess what is going on in somebody's home, especially with young children, until you come into that home **(SU 2, Trust E, CMHT)**.

A further organisational enabler reported by services users related to continuity and availability of services, particularly adult mental health services. Service users feel relief in knowing that support is available if needed:

But the psychiatrists have all been very supportive and listening to me, you know. And obviously you don't see the psychiatrist that frequently. But they have all said to me, like even one of the older ones who is about to retire recently, he said to me, phone up anytime and speak to me... And the two consultants who I have been under since he left have said the same thing to me. If you are having bother, you either phone through your social worker or directly to the consultant's secretary. And some of them have phoned me back if I have had queries about medicine or if I haven't been feeling particularly well or whatever. It is just like a lifeline at the end of the phone, you know **(SU 3, Trust C, CMHT)**.

Eight service users who had been involved with adult mental health services for a number of years also discussed the systemic improvements of services over time. One service user noted that services had improved with regards to support for parents:

Sixteen years ago...felt like a failure as a parent. People's going to think I am crazy that I can't look after my kids. That was a big worry. If I am in hospital and people think I am sick that I can't look after my kids. I have a fear of children's social services due to childhood, like. But recently the past few years, I understand it better and I appreciate the help and the services that I have now are not like the services sixteen years ago. They are more supportive than what they were then **(SU 4, Trust E, Addictions)**.

Service user 6 also reported that adult mental health services are more considered and inclusive of children than before:

...nobody actually sat down with my kids and asked them how they were. They were making all these judgement calls, but nobody actually sat down and said to them, how are you? How's your mummy? Or find out is your mummy sick or find out what they were thinking or feeling at the time, or how

does that make you feel?...Which looking back, you know, shocks me like. But again, times have moved on. I know it's only six years but things have moved on so quick in six years and policies change and things happen (**SU 6, Trust E, Addictions**).

**Summary: Organisational Enablers**

*Organisational enablers such as professionals' multidisciplinary working and collaborative working across adult mental health and children services were also regarded as important enablers for service users. This collaborative working reflects the Think Family NI approach to meeting the needs of the whole family through joint working, communication and information sharing among adult mental health and children's service professionals. Service users also remarked that flexible service delivery, including service delivery within the home environment, is an important enabler for parents to be able to engage with FFP. Home visiting was also highlighted by HSC professionals as an enabler to their FFP as it allows for real life assessment of need and provides an opportunity to build a rapport with the service user in a more relaxed environment.*

**Enablers related to parents and families:**

During interviews a number of service users ( $n = 16$ ) also alluded to enablers related to families themselves which enhance them and their families' receptivity to professionals' efforts to engage in FFP. Some of these enablers relating to both the parent and family were also reflected within professionals' interviews. For example, service users' readiness and willingness to engage with services was identified as key by both groups. For instance, "we have tried quite a few things, but I mean ... well I've tried everything. Anything that has been suggested I've went for it and done it" (**SU 4, Trust E, Addictions**).

Additionally, service users' motivation to recover was also cited as an important enabler. For some service users, motivation was typically the result of being a parent and wanting to recover for their children; "I am better going on something because I want to be one hundred percent there for my wee girl" (**SU 3, Trust A, CMHT & F&CC**). Similarly, another service user notes:

But in a way I think it is positive because it is my two kids that keep me here. And it is my two kids that get me up every morning and have that routine. If I didn't have that routine, I don't know where I would be or without them I don't know where I would be. Because I genuinely... I do look forward to... if I have been out for the day and them two is away, whenever I come home I am like, oh I can't wait to see the kids (**SU 4, Trust B, CMHT**).

Service users also indicated that their self-awareness, knowledge of own mental illness and knowledge of services was important for help seeking and recovery; "My experience hasn't been an overall negative experience, because I would say I am one of the lucky ones in the services. Where I have been able to advocate for myself. I have been able to, over time, learn tools to keep me well" (**SU 1, Trust A, CMHT**).

***Summary: Enablers related to parents and families***

*Service users also acknowledged that their own motivation to recover and willingness to engage with services and professionals is an important enabler towards engagement with FFP. Without the co-operation of the service user and their family, including children, HSC professionals' capacity to engage in FFP is reduced. Organisations should be mindful of this and endeavour to raise service users' awareness of benefits of FFP.*

***Wider systemic enablers:***

Service users also discussed wider systemic enablers such as support from partners and families; "I am totally supported within my own home and within a lot of family members and friends. You know that's there" (**SU 2, Trust E, CMHT**). Two service users also indicated that support relating to employment and having supportive employers is greatly beneficial; "...my boss is brilliant as well. She is really into recovery and mental health. So she has been very, very supportive and if I go through a difficult time I would pick up the phone and ring her" (**SU 1, Trust A, CMHT**). Additionally, support from peers regarding mental illness allowed service users to feel understood through shared experience:

...my friend, they are able to help me a lot because their head works the same way. I think they have overcome a lot of their problems, if you know what I mean. Obviously not them all, but they have overcome them, so they

are able to help me because of through their own experience (**SU 2, Trust B, Addictions**).

Additionally, some service users also discussed support provided by voluntary organisations as a result of a professionals' referral as an enabler. In this sense, voluntary organisations allow for the specific and sometimes complex needs of the parent and their children to be met and typically run alongside statutory service delivery. Examples of such services include Barnardo's, Women's Aid, Sure Start, and GEM's. Speaking about services provided by Sure Start addressing mental illness, parenting support and support with the bond between parent and child, service user 4 states:

That there was organised through my health visitor. She had organised that for me. And then my CPN nurse wrote a wee referral letter to try and get the days up, because I have a support worker from Sure Start who comes out once a week to help. And like Sure Start has been really, really good at helping. I went to a group called Mellow Babies for mums who have mental health issues, and it didn't matter where on the spectrum you were, everybody was as one, if you know what I mean. And they look after the kids for so long and then they involve the kids with you. So I found that really helpful (**SU 4, Trust B, CMHT**).

One service user suggests that it is the combination of support from both statutory and voluntary services, in conjunction with systemic supports, which sustain recovery for parents with mental illness:

But having all those supports in place has enabled me to continue living in my own home, not to have gone under, not to have ended up back at my parents' house with my three children, unable to function. Whereas with that support in place, I am able to function day to day. I don't rely heavily on my parents. They are very good and my family are very good, but I like to be independent and I am able to be, because I have that support. And I know, at any time, I can make a phone call and I can speak to someone. I can speak to someone in Women's Aid twenty four hours a day, and also I can get in touch with the mental health services at any time too. So it has allowed me to continue and to be able to function and to be able to get out there and have friendships and have sort of a normal, day to day life (**SU 3, Trust E, CMHT & F&CC**).

Two service users also discussed their experience with HSC Recovery Colleges and the benefits of understanding mental illness and having a space for shared experience. One service user notes that; "you know, you go in there and you know,

you realise everybody is going through something very similar to yourself. So you don't feel weird or odd" (**SU 2, Trust B, Addictions**).

***Summary: Wider Systemic Enablers***

*Support from family and peers were also considered as a significant support for service users. Service users also reported that the support provided by voluntary services was instrumental towards recovery as voluntary services can meet some of the more complex needs of service users which may not be addressed by statutory services. The combination of statutory and voluntary service support allows for a holistic approach to treatment.*

**Barriers related to Service Users and Professionals' Capacity to Engage in FFP:**

Although service users described professionals' family focused activities, as well as enablers of FFP, they also identified a number of barriers to FFP. Similar to enablers, barriers fell within four core areas including (1) barriers related to professionals and their colleagues, (2) the organisation as a whole, (3) barriers emanating from parents, children and, or adult family members and (4) wider systemic barriers.

***Barriers generated by professionals and their colleagues:***

A number of service users reported that some of the professionals which they engaged with, particularly children's service professionals, lacked the interpersonal skills needed in order to establish a relationship with the parent and assure the parent that their family mattered. Speaking about the lack of empathy portrayed by one professional, service user 5 stated:

They would tell you themselves they have to be kind of cold to do their job, which I think is very sad. They would say, for them to be able to do their job, they have to kind of have no emotions towards you. So there you have people making major decisions on what's going to happen in your life, but they have the shutters down. They don't want to know really what's going on with you at all. They just want to know, right, what paperwork have I to do for this child or where's this child going, blah, blah, blah. They are not actually taking the time to talk to the person ... you know... to form any sort of relationship (**SU 5, Trust E, Addictions & CMHT**).

Similarly, another service user noted;

I think they themselves need to try to be a bit more empathetic, because if they are not empathetic and they do not understand the situation they are just coming in to do a job, and that's quite obvious with some people. They are there to do a job and that's it. They don't give a shit about the person sitting in front of them (**SU 1, Trust A, CMHT**).

Some service users expressed the view that children's services professionals did not have a good understanding of mental illness and how this related to parenting; "They are making judgements on something that they know nothing about" (**SU 5, Trust E, Addictions & CMHT**). Additionally, service users also indicated that lack of work and life experience, including own parenting experience, had an impact on professionals' understanding, skills and knowledge relating to PMI:

I think it is very hard for somebody that doesn't have kids and doesn't understand the stresses to come in and make a judgement call on how somebody that has mental health problems, with kids... because it is hard enough having children on your own and then throw in mental health on top. You know, I think it is very hard for somebody from the outside looking in to say, well you should do this, this, this and this, because that's going to make your children better and it is going to keep them safe, when they have no idea because they don't... They are following something out of a text book when they don't actually know, because they don't have kids themselves (**SU 6, Trust E, Addictions**).

One service user reported after encountering some professionals that "It just felt like no matter what I done it wasn't good enough" (**SU 6, Trust E, Addictions**).

Parenting seemed to be undermined by children's service professionals with one service user stating that "I do my best and sometimes I don't think social services... it is as if they are waiting on you slipping up, you know" (**SU 1, Trust E, Addictions & Children's Services**). Service user 2 also recalled "Like I had crap social workers back then that would have just been on top of me for anything whatsoever. Like any decision I made as a parent was undermined. This is the way it is done in the book, so this is the way you have to do it. And it doesn't work that way. Every child is different" (**SU 2, Trust A, CMHT**). Furthermore, parental status was not always recognised by adult mental health professionals, one service user also notes that "They should be able to understand that it is a mother. It is not just an adult that has mental health issues, it is a mother" (**SU 4, Trust B, CMHT**).

### **Summary: Barrier Generated by HSC Professionals**

*Service users reported a number of barriers generated by professionals, some of which included a lack of empathy and little understanding (particularly from childcare professionals) regarding PMI. This is reflective of findings from the previous section relating to future recommendations by child care professionals which highlighted the need for further training in understanding PMI. Service users also perceived that professionals who had less work experience or parenting experience had less understanding, skills and knowledge to help them cope with effects of PMI than those professionals with more years of experience and who were parents themselves.*

### **Organisational barriers:**

There was a notable similarity between service users' perspectives regarding organisational barriers. Most notable among these was issues relating to continuity within services and waiting lists for support. Service users reported on the short period of time spent with some support services due to service demands, for example:

We could have continued on there, and I think it would have been useful, but we only had a certain number of weeks. Which, at the time I remember thinking we could have done with more. And even the girls, the social workers there, said they would have liked to work on. But at that time they were getting more and more cases where child protection was an issue, whereas in our case there was no issues with the children's safety (**SU 3, Trust E, CMHT & F&CC**).

Some service users reported that professionals did not take the time to engage with them or to understand their circumstance, relying on records to make judgment calls:

She hadn't sat down across a table from me. I used to say to [PROFESSIONALS NAME], if that woman would just give me ten minutes of her time. Would she not just see me for ten minutes, as a human being, rather than just what she sees written about me on paper? (**SU 5, Trust E, Addictions & CMHT**).

...before she met me, she read about my past and about my abuse. So she had her mind made up before she met me. And because she had her mind made up, she didn't want to hear what I had to say. (**SU 2, Trust D, CMHT & LAC**).

Lack of time for professionals to get to know parents and understand family circumstances was perceived as an issue of time and resource; "...don't think they have the time. They definitely don't have the time to sit and actually talk to you and find out what is going on. It is basically, you know, a five minute conversation and then like two hours of writing what's happened" (**SU 6, Trust E, Addictions**).

Service delivery was also highlighted as problematic if a professional was unavailable, leaving parents feeling vulnerable; "...but I think whenever she is off, it seems to be worse, my mental health...but sometimes I am feeling like I haven't seen her in three weeks and I am starting to get really upset and she's not coming out" (**SU 4, Trust B, CMHT**). Support from some adult mental health services was also described in some cases as intermittent:

I will see you again in another couple of weeks. I panicked. She seen the panic on my face. And I went, what am I supposed to do without anything for the next three weeks? What am I supposed to do with myself? How am I supposed to be resilient and not drink and still be isolated within my own home? And she had said to me, well look, I'll try and get it a bit sooner (**SU 2, Trust E, CMHT**).

Others reported on the long waiting lists to gain access to support services. For instance, "It just takes a long time. These things are proposed but it takes a long time. There's a waiting list. You know" (**SU 1, Trust E, Addictions & Children's Services**) and "... I just think there's a terrible lot of waiting lists in the Trust for everything (**SU 2, Trust C, Home Treatment & Children's Services**). One service user spoke about the need for family support; "... it has been mentioned for so long...Just sorting out the family therapy, who it comes from, or being able to access it quickly when it is needed. Because we have needed it for a while now and it hasn't been available (**SU 4, Trust A, CMHT**). Similarly, service users also highlighted a lack of follow-up after support had been promised; "but if you want to go down the line of social services offering me help and all, they promised me the world, and nothing (**SU 2, Trust C, Home Treatment & Children's Services**).

Services users who had experience of children's services also described such services as 'child focused'; "They were coming in to see the children and it was the

children and not me (**SU 3, Trust B, CMHT & FIT**). Additionally, another service user noted:

I don't understand how social workers are put into their jobs, most of the people that they are working with have addictions and mental health problems, but they have no training in it. It doesn't make any sense... but then that's where they would say they are not your social worker, they are the child's social worker. And I have had that said to me so many times. If I try to speak anything about it they will cut you off and say, I am not your social worker. I am the child's social worker. But I'm the child's mum... (**SU 5, Trust E, Addictions & CMHT**).

The service user went on to say:

They are coming out to assess how things are. They are coming out to do their check-ups and it is always, it is about the kids and I understand that. That's their job, which I have been reminded of many times. But, you know, they just don't seem to have... it doesn't seem to be part of their job to include the parent as an individual. And I know they are coming up against all sorts of people and it is not an easy task. They are doing the best they can and they have to safeguard themselves. But I do believe people have to be given the chance to be treated fairly and listened to (**SU 5, Trust E, Addictions & CMHT**).

Service users also discussed that in some cases there was no recognition of parental status with regards to mental illness and little to no engagement with families. For example, one service user noted that "... there has been nothing of that like your needs as a parent who has mental health issues. I haven't been offered any help at all. I've gone out and sought and tried to educate myself (**SU 4, Trust C, CMHT**). Furthermore, a lack of recognition and facilitation for parenting responsibilities and family commitments was also highlighted as an issue for some service users. For example, one service user could not engage with services due to child care issues:

I have no one. Like my family, my mum's not very well. She has a lot of disabilities and stuff. And my youngest won't go to anybody. She is very strange. And I have no one to take my wee one. And they are asking, can you not bring her to the appointments. And you are like, but if I don't bring her to the appointments, I can't come (**SU 4, Trust B, CMHT**).

As a final note with regards to organisational barriers, it is important to mention that throughout interviews the majority of service users who had experience of both adult mental health and children's services discussed their experiences as almost

discrete. This separation in the service user's mind most likely reflects the disjointed approach by some services with regards to PMI; "There's no connection, you know. Like adult services deals with the parent and children's services deals with the children and children's services tells the parent what to do. But there's no connection between the two" (**SU 5, Trust E, Addictions & CMHT**).

**Summary: Organisational Barriers**

*Service users also highlighted a number of organisational barriers to FFP, including lack of time and resource impacting professionals' ability to engage with parents and families and also lack of continuity within and across services. Service users reported that long waiting lists for support means that parents and families are not getting the help they need when they need it. Throughout interviews the majority of service users who had experience of both adult mental health and children's services discussed their experiences as almost discrete. This separation in the service users mind most likely reflects the disjointed approach by some services with regards to PMI.*

**Barriers generated by parents and families:**

The majority of service users ( $n = 17$ ) were able to identify barriers relating to themselves, their children and adult family members which impact on professionals' FFP. Most prominent of these was the fear amongst service users of 'losing their children' if children's services become involved with their family. This fear resulted in some services users delaying or not asking for help when needed:

See the thought of losing your kids, and I have always said this out loud to social services, to [PROFESSIONALS NAME] ... that fear has to be taken away. Because I spent so long being afraid to be completely honest and ask for the help that I needed, because I felt that I was going to lose my son (**SU 5, Trust E, Addictions & CMHT**).

Service users also noted that even when services become involved and offered support, parents, their children and other adult family members did not wish to engage with services. Speaking about support offered to the wider family, service user 6 notes:

They have offered, you know, offered my partner a carer's assessment and all. And he didn't want any of that. He just didn't want any of that. They did offer support to my mum and my sister and all, but again they didn't want any of that. So that was their choice. But it was offered (**SU 6, Trust E, Addictions**).

Similarly, service users, particularly parents of teenagers, also noted that whilst professionals offered to discuss mental illness and support the family in this, their children did not wish to take part:

As I say offering of family days to come in and do different things and although the sort of teenagers don't want to really. They are quite OK doing their own thing. Like the wee fella goes, I don't need any help. And I goes, it's not for you, it was for me. But he wasn't really bothered. But they were offered that chance to come in and talk, you know, while I was here and stuff (**SU 2, Trust A, CMHT**).

Service users themselves also admitted to not continuing to engage with services or availing of the support offered:

I haven't stayed with anybody long enough. I can't blame the professionals. I start to feel better and then I feel as if I don't need to talk. And then I can be grand for maybe up to another year or a year and a half, and then I would dip again and I need everybody, and why did nobody help me? (**SU 2, Trust C, Home Treatment & Children's Services**).

...she did keep telling me about the family centre and the family clinic. I refused to go because I said, I can't have people telling me how to be a mum when I am struggling enough knowing what it is like to be a mum myself. So I didn't bother with that (**SU, 1, Trust A, CMHT**).

Three service users also noted that when help and support was offered, they were too unwell to benefit from this. When one service user was asked about professionals supporting them with their parenting role they replied; "I don't think they knew how to address an issue with a mum who constantly doubted herself. And when I first got unwell it took a long time to try and bring me out of it. I mean I received ECT and stuff like that. So address my needs as a parent? I think I was my own worst enemy in that. They probably did but I wasn't taking any of it in (**SU 1, Trust A, CMHT**). Another service user was also asked if they found the support regarding parenting useful, they responded that "I suppose it depends how low the

mood is, you know. Sometimes it wouldn't help anyway. You do have an element of thinking, what can they do for me?" (**SU 4, Trust A, CMHT**).

***Summary: Barriers Generated by Parents and Families***

*Service users acknowledged barriers generated by themselves and their families including not engaging with services when support is offered due to fear of losing children.*

***Wider systemic barriers:***

Service users also conveyed during interviews that wider systemic barriers such as lack of family support, being a single parent and the social stigma of mental illness, as well as misconceptions about services, all act as barriers towards recovery and ability to engage with services. Speaking about being a single parent, one service user noted; "I am the mother and the father, you know. I am everything, and it is very, very hard like. Very hard" (**SU 1, Trust E, Addictions & Children's Services**). Similarly, another service user indicated that the stress of being a single parent and trying to manage a family alone resulted in adverse coping in the form of alcohol:

I found myself into this position of having to, you know, reach to alcohol to try and relax or to try and... you know, everybody's got their own coping mechanisms to what they do. But to be on their own and to have to try and deal with the situation and not to have a second person there to support each other (**SU 3, Trust B, CMHT & FIT**).

Service users also highlighted that the stigma surrounding mental illness and how this related to parenting, deterred helping seeking by service users:

...then you are thinking of the stigma and the shame and the embarrassment of one, being an alcoholic, and two, of being mentally disabled almost, to a point. And there still is a stigma around mental illness. And it is a shame...And because I am from this area, everyone knows what you are going in there for. So to be seen to go in there, everyone knows what you are going in there for. So it was a case of that put you off asking for help... (**SU 2, Trust E, CMHT**).

Service users felt that generally, society does not understand PMI creating a sense of judgment towards parents with mental illness and, or substance use problems:

So I do find that whenever you do have mental health issues, that people look at you differently because you are a parent, and they judge more (**SU 4, Trust B, CMHT**).

People take one look at you and think there is nothing wrong with you. Because they can't see a broken leg or a wheelchair or whatever they think you are fine, you know (**SU 3, Trust C, CMHT**).

The system needs to change and it is like a stigma on mental health. And it needs to change. Like see this stigma that... if you have anything wrong with you, mentally ill, you can't parent. That is so wrong. Because do you know what? I know I am a damn good mother (**SU 2, Trust D, CMHT & LAC**).

...well having a mental health illness doesn't make you any different than anybody else. Do you know what I mean? Like it doesn't... it is just a label, I think. It doesn't define you. I am still the same person. It's still me. I would talk to my friends who are parents and we would still have the same issues over kids and like trying to get them to bed and trying to get them to eat their dinner (**SU 4, Trust C, CMHT**).

A further extension to issues of stigma identified by service users related to social services. Service users described how there is a general misconception that children's services professionals are there to remove children from the family home, resulting in parents not wanting to engage with children's services, particularly social work professionals. For example, one service user stated, " There is still that great fear of social services, and once you mention social services, because if they come in and see something wrong they are going to take this child away from me (**SU 2, Trust E, CMHT**)".

#### **Summary: Wider Systemic Barriers**

*Service users discussed some of the wider systemic barriers to engaging with HSC professionals' FFP, including lack of family support, being a single parent and stigma of PMI. Furthermore, stigma associated with 'social services' involvement also has negative impact on service user's help seeking relating to fear of losing children.*

#### **Future Potential Developments:**

Future potential developments, as identified by service users, will now be discussed. Future developments were described under three main themes including (1) strategies to address the needs of parents, their children and families, (2) systemic and organisational structures and (3) training.

### *Strategies to address the needs of parents, their children and families:*

Perhaps unsurprising, given consistent issues identified with regards to the understanding of PMI, services users suggested that it is important that children and other adult family members be educated on mental illness and associated issues. One parent reported the importance of this in relation to early intervention for children:

I think children should be more aware from a young age about people being sick or, you know, that it's not their fault the way the parent is. I suppose there is a big huge chance that history is going to repeat itself, definitely. So children need to be aware, and I would be very adamant about that there, from an age that they can understand (**SU 1, Trust D, CMHT**).

Following from a similar line of thought, one service user also suggested that adult mental health professionals could engage children and address the impact of PMI and their emotional needs:

Even for the kids to sit down... somebody to ask the kids, you know, how do you feel when mummy is stressed? Or how do you feel when mummy goes to bed for a week at a time? It would be interesting for me, because I have never asked them that. Or I have never heard what they think. And it would maybe be interesting for me to find out how they feel (**SU 6, Trust E, Addictions**).

Service users also suggested that services should be more family inclusive; "Just keeping the emphasis on the family and just, as I say, meet with the family as a whole regularly" (**SU 4, Trust A, CMHT**). Furthermore, "people need to be more aware of the services that are there" (**SU 2, Trust D, CMHT & LAC**). For example;

...you should have access to be able to say there's a wee group, its run by, you know, family services. It is a wee group where single parents with children or two parent families and they meet up and the children can play and engage with each other and they are not isolated because they have a common ground there (**SU 2, Trust E, CMHT**).

Three service users indicated that they would also benefit from courses on parenting skills as a way of supporting their parenting capacity; "I think if you have mental health issues and/or an addiction, I think parenting classes are a must. Because I think you need to relearn, you know (**SU 2, Trust E, CMHT**). Additionally, some services users reiterated the need for childcare support and respite for parents with

mental illness, particularly those with less wider family support who may need some assistance in order to attend appointments. Service user 2 (Trust D) suggests:

if social services are to be involved with a family regarding a parent having mental health, put support in. put a family worker in a couple of mornings a week. See if the parent has the likes of therapy or has a counselling session, put a family worker in if there's no wider support and if there's a child that needs watched. Tell them to take the child to the park for an hour and let the parent go to the therapy **(SU 2, Trust D, CMHT & LAC)**.

### ***Systemic and organisational structures:***

As part of the Think Family NI work plan, improvements have been proposed to create child friendly facilities in order to help sustain relationships between children and their parents during treatment. Service users indicated that it was important for both in-patient units and day clinics to portray a more family friendly environment; "it is a completely depressing atmosphere, you know. Even a bit of music in the background or something would be nice **(SU 3, Trust C CMHT)**. Also with regards to attending appointments, a childcare facility on site was suggested by one service user; "so I find that if there was some sort of way of the kids being minded. If there was like a crèche or a childminder or something in the facility, so you can go right, there's the child for an hour till I go and do this" **(SU 4, Trust B, CMHT)**.

Service users also reported that in future, adult mental health and children services should work collaboratively with the family; "I personally believe that they all need to start working together to give parents a better chance" **(SU 2, Trust D, CMHT & LAC)**. The service user later went on to suggest that;

There's nothing stopping a social worker going and even say once a month, meeting with the mental health team, with the client, to say right, this is what she is working on and this is what she is not working on. This is where she is going to struggle and this is where we think she will need help. Keep it together and work together **(SU 2, Trust D, CMHT & LAC)**.

Furthermore, two service users from Trust E also discussed issues of time and resource relating to service delivery such as length of time in service and constancy in service delivery:

This period of time where you have six weeks with somebody or eight weeks with somebody, that is really of very little value because you need to have someone there even if you are not seeing them...maybe you are only seeing them once a month, but it needs to be an ongoing thing. Because mental health is something... You might feel OK today, you might be back to square one tomorrow, so you need to have that ongoing support. And... it needs to be consistent (**SU 3, Trust E, CMHT & F&CC**).

Additionally, service user 5 also notes:

...all you ever hear from them is that they have no time and are short staffed. And that's totally understandable. So the only thing that would ever probably improve the services would be more staff and more training. And including the parent... the reason why they have to work on risk management is because they don't have the time to assess the situation right away (**SU 5, Trust E, Addictions & CMHT**).

Whilst both services users highlighting the issues of time and resource came from Trust E, it can be inferred from all interviews that the issue of time and resource is a salient issue for both professionals and services users across all Trust areas.

### *Training:*

Ten service users also indicated that future training for professionals is needed across both adult mental health and children services. Training from service users' perspective should address improvements in communication with families and sensitivity towards PMI; "They just need to learn about... especially with somebody who is going through really bad patches with mental health, they just need to learn how to approach people properly without making them stressed even more (**SU 5, Trust A, CMHT**). Furthermore, "Training wise, I think it is about offering more support to the people, the families that are involved, and signposting them to peer services. Knowing what is out there for those people who are going through that" (**SU 1, Trust A, CMHT**). Additionally, "children's services need more training in mental health" (**SU 4, Trust E, Addictions**), and "I think the mental health team do know about addictions, but I don't think there's as much known as needs to be known. I think there's a lot there that they don't know" (**SU 1, Trust E, Addictions & Children's services**).

**Summary: Future Potential Developments – Service Users’ Perspectives**

*Overall, service users perceived that knowledge and understanding of their own mental illness and, or substance misuse is important for parents to engage in FFP and to better cope with PMI. Service users also indicated that it is equally important that children also understand (in an age appropriate way) PMI and how to live with this in order to protect against intergenerational transmission. This could perhaps be facilitated by adult mental health professionals. Service users noted the importance of services and professionals being family inclusive and the potential benefits of supporting service users with parenting i.e. via parenting skills classes. Service users also perceived that services should be family friendly and flexible with regards to children in order to allow for appointment attendance. Furthermore, service users indicated that collaborative working within adult mental health and children’s services would enable FFP and better meet the needs of families. Finally, service users noted that future training for professionals should promote their capacity to understand and respond to PMI.*

**Summary:**

The purpose of this section was to outline issues associated with service users and professionals' capacity to engage in FFP from the service user perspective. Enablers were generally reflective of many of the principles and activities reported by service users, for example the importance of the parent-professional relationship was dependent upon attributes of the professional and willingness to engage by the service user. Service users also indicated that collaborative working by adult mental health and children's services assured a more holistic approach which is reflective and recommended as part of the Think Family NI work plan. Furthermore, wider family support being available and the inclusiveness of families by services were also noted as important enablers towards holistic care. A further enabler was associated with professionals' recognition of the interrelationship between parenting and mental illness and the need for support with parental capacity, particularly support provided via voluntary services.

Conversely, barriers relating to capacity to engage in FFP related not only to professionals and services but also service users themselves. For example, a number of service users indicated that their own unwillingness to engage with services, negated professionals' attempts to engage in FFP. This unwillingness stemmed from a number of factors, most notably the misconception and negative view of children's services causing fear towards involvement. Additionally, service users also perceived that there is a disconnect between some adult mental health and children's services and a lack of knowledge and skill relating to mental illness among children services professionals. More generally, service users report that a stigma surrounding mental illness and parenting capacity currently exists, creating a barrier to working with services as a parent with mental illness and impacting on service users' confidence to ask for help when needed. Despite some of these impediments, service users did indicate that without support from adult mental health and, where relevant, children's services, their current recovery and family circumstances would have been more difficult.

## Discussion

Northern Ireland's (NI) Health and Social Care (HSC) leaders and policy makers recognise that parental mental illness (PMI) is an important societal and public health issue. At a broad systems level, initiatives have been introduced across NI to promote systemic working and HSC professionals' family focused practice (FFP); in response to families when parents have mental illness and, or substance use problems. As previously noted, the overarching aim of Think Family NI, as set out by the Health and Social Care Board (HSCB), is to improve collaborative working and enhance understanding of multi-disciplinary roles and responsibilities across both adult mental health and children's services with regards to PMI. Furthermore, the adoption of Think Family principles, as set out by SCIE (2009) guidelines, aimed to inform strategic thinking towards FFP in front line, organisational and strategic policy and procedures.

The logic model (see p.37 of this report) illustrates the connections between influential theory/ work on the development of the Think Family NI programme's activities and the programme's intended and desired outcomes and reflects the efforts of the HSCB to promote a whole family approach by services. These service improvements are intended to improve outcomes for service users but the focus of research and evaluation has mainly been on practice and so there is still more research needed to explore the impact on families. The findings of this project include qualitative data from service users which provide some indications of the impact on families and could help inform the design of further outcomes focused research.

This section will summarise and review key quantitative and qualitative findings in relation to (1) the extent, nature and scope of HSC professionals' FFP, (2) factors that predict, enable and, or hinder it and (3) how it may be further promoted. We will then conclude with key messages and recommendations derived from the current study and suggestions for future research.

### **Overview of Key Study Findings:**

Overall, HSC professionals participating in the current research study appear representative of the wider HSC adult mental health and children's social care workforce, with the study findings indicating low levels of FFP. While, the study identified clear examples of good practice in line with Think Family NI initiatives; including family engagement, inclusive assessments and collaborative working in order to support the needs of parents, children and other family members, there were variations in the extent of HSC professionals' FFP across disciplines, sectors and services. Findings and insight generated from in-depth interviews with both HSC professionals and parents who have mental illness, illuminate the nature, scope and complexities of FFP and the enablers and barriers which influence the degree to which a 'whole family' approach to practice is appropriate and achievable.

Firstly, survey findings highlighted that whilst the vast majority of adult mental health and children's service professionals had engaged with parents and children in the week prior to the survey, only half had addressed issues relating to parenting and mental illness and less than a quarter had discussed PMI with children. Not addressing issues related to PMI appears to be associated with setting and role. For example, social workers across both sectors, working within community based settings and those who spent more time with families in the home environment, tended to score higher on FFP behavioural subscales; including those associated with assessment, interventions to promote parents' mental health, support to careers and children, and referrals. Relatedly, service users who received services within the community setting, and particularly within the home environment, were more able to describe their experience of FFP than those in acute in-patient settings.

Opportunities to care for parents in the home environment may afford professionals with greater opportunities for contact with family members, including children (Grant & Reupert, 2016). Greater contact with families has been highlighted in the literature as an important enabler of FFP as it allows professionals the opportunity to engage with the 'whole family' and observe normal daily life, making assessment more accurate and inclusive (Grant, 2014; Grant & Reupert, 2016). The preference towards home treatment was also voiced by a number of service users during interviews, as they explained that home treatment is not only better for accurate

professional assessment but also for parents and children with regards to childcare needs and reduced anxiety for children who otherwise might attend clinic based appointments with their parents which are not always perceived as family friendly.

Additionally, over a third of HSC professionals obtained high scores on at least three of the six FFP behavioural subscales, indicating that while FFP is generally low, there are a large group of HSC professionals who understand and practice in ways which are family focused. This was further reiterated during interviews with both HSC professionals and service users who provided examples of family focused activities with families. This signifies that a number of HSC professionals are endeavouring to address the inter-relationship between parenting and mental illness within aspects of their practice. Overall, professionals practising within children's services had higher mean scores across five of the six FFP behavioural subscales, including assessing the impact on the child, than professionals in adult mental health services. That said, survey findings also indicate that adult mental health professionals tended to score higher in relation to interventions to promote parents' mental health. Such findings reflect respective professional roles and skill sets relating to working with either the parent or child and supports the benefits and need for joint working among sectors and services to meet the needs of the whole family.

It is of note that Think Family Champions recorded higher mean scores across a number of subscales, compared to the remainder of HSC professionals, in relation to their skills and knowledge, professional development, connectedness, referrals, worker confidence and support to carers and children. This may reflect that Champions tend to be more involved in the training and resources associated with Think Family NI initiatives. These findings suggest that when HSC professionals engage with Think Family NI initiatives and adopt associated principles, including considering the whole family and understanding the inter-relationship between parenting and mental illness, workforce capacity for FFP is improved. This is further exemplified by results of individual regression analysis for both adult mental health and children service professionals. Regression results indicated that the most important predictor of all FFP behaviours was skills and knowledge relating to the impact of parental mental illness on children. That said, under half of adult mental health and children's service professionals taking part in the current study reported

receiving family focused or Think Family training, and only 33% of adult mental health professionals had received some form of child focused training. The need for further family focused training for HSC professionals was highlighted throughout interviews, by both HSC professionals and services users, as well as being a significant predictor of a number of FFP behaviours as indicated by regression analysis.

Additionally, time and workload, and co-worker support were also significant predictors of HSC professionals' FFP. The time to work with families inclusively is likely to be interconnected with support from other professionals regarding family focused work as well as capacity to do so. HSC professionals reported varying caseloads across both adult mental health and children's services and indicated that larger caseloads appear to reduce capacity to engage in FFP. Moreover, individual regression analysis for children's service professionals indicated that professional development opportunities to work with families as well as co-worker support were important for referrals and family and parenting support (i.e. providing resources and referral information to consumers and their families). As previously mentioned, the focus of a number of Think Family NI initiatives includes improvements to collaborative working across sectors and services to meet the diverse needs of families. Those who scored higher on FFP behavioural subscales perceived that the Adult and Children's Services Joint Protocol (2011) enables their FFP by providing clear guidance on service response and encouraging interagency co-operation. That said, many professionals, particularly Allied Health professionals, are not aware of this protocol whilst others feel that better integration and application of the protocol is needed within individual services. Moreover, whilst The Family Model (TFM) (Falkov 1998, 2012) underpins many of the Think Family NI initiatives aimed at improving HSC professionals' assessment, planning and treatment, the vast majority of HSC professionals report a lack of knowledge of TFM and how to use it to guide their FFP.

Individual interviews also highlighted many of the underlying principles of FFP, and importantly, the complexities associated with mental illness, parenting and additional associated adversities including domestic violence. Both HSC professionals and service users discussed the inter-relationship of many of these issues and the

potential impact on children and other adult family members, supporting the need for a holistic approach to HSC policies, procedures and practice regarding PMI.

Moreover, similar to the existing literature (Devaney & McConville, 2016; Davidson, Devaney & Spratt, 2010), both HSC professionals and service users emphasised the importance of early intervention and prevention with families in order to mitigate such potential adverse impacts on parents and children. Service users reported the benefits of early intervention and prevention efforts by stating that when parents are supported and children are engaged and their emotional needs are being addressed, there is better potential to reduce intergenerational transmission of mental illness.

Evidence of the success of family focused early intervention methods were highlighted in the systematic review of the literature that informs Part One of this report. Key components of effective interventions included, (1) psychoeducation (including increasing knowledge around either mental health problems or substance use problems), (2) direct treatment and support for mental health and, or substance use problems, (3) addressing parenting behaviour and child risk and resilience, (4) family support and functioning, including family communication and (5) working to improve access to or engagement with community supports and services.

Interventions which incorporate a multi-disciplinary approach and include access to more than one service or area of support were also noted as effective for families.

Aspects of these aforementioned key components were evidenced during individual interviews with both HSC professionals and service users with regards to family focused activities. Moreover, as previously noted in Part One of this report, Foster et al. (2012) and Goodyear et al. (2015) recommend a continuum of family focused activities for HSC professionals when working with service users who are parents.

Evidence of inclusive assessments with parents varied according to survey findings, and during individual interviews with focus, depth/ comprehensiveness and family involvement varying across disciplines, sectors and services. In particular, those working within in-patient or clinic based adult mental health services predominantly engaged with parents to identify issues, whilst those working within children's services seemed to actively engage both parent and child(ren) where possible. It is important to note that children's services included within the current study were community based services thus providing professionals with greater opportunity to

engage both parents and child(ren). During interviews, HSC professionals highlighted the importance of communication and collaborative working within and across sectors and services (including voluntary services), regarding PMI assessment and response, stating that joint working is the key component to supporting families; again a point well recognised in the literature (Brockington et al., 2011; Grant & Reupert, 2016; Seeman, 2013). Nevertheless, during interviews both HSC professionals and, to a more limited extent, service users discussed professionals' wide ranging attempts to support parents to promote their mental health, parenting capacity and family relationships, including talking to parents and educating them about PMI, and encouraging parents to explain PMI to their children and family members.

Additionally, interviews also highlighted that HSC professionals and service users value voluntary sector involvement with regards to meeting the needs of families. The availability of specialist support services and programmes is particularly useful when families have complex and multifaceted issues. As previously noted, the needs of families are complex and diverse and require both an individual and holistic response at times. Additionally, HSC professionals' high workloads and time constraints can impact on their capacity to address and respond to some of these needs. The interplay between both historic and current issues for families creates a challenge for professionals who are expected to provide short term interventions to address presenting issues within a context of reduced resources and rising demand for services (NSPCC, 2017). Voluntary services fill this gap by offering additional and niche supports to families. However, such services are highly dependent on funding to support their continued operation, making their ongoing availability uncertain. Nonetheless, voluntary sector involvement in relation to PMI is an important resource for both adult mental health and children's services and recognised in the literature as such (Morris, 2008). The recent development of Family Support Hubs in NI may provide an important avenue for support in relation to PMI that does not require statutory children's services involvement.

HSC professionals and services users also discussed a number of additional factors related to professionals themselves which also facilitate FFP. Firstly, HSC professionals' interpersonal skills and attitudes towards FFP is an important enabler

in working with the whole family. This is supplementary to services users' willingness to engage with HSC professionals' FFP. Service users found engagement with FFP easier when a HSC professional understood PMI, normalised and acknowledged the difficulties associated with PMI and were able to engage in limited self-disclosure of their own parenting experience. Similarly, HSC professionals perceived that knowledge of PMI, particularly the impact of mental illness on parenting and potential impacts on children, is important in developing their confidence to support parents and children and that often this knowledge is developed through their own experience of parenting.

HSC professionals also discussed a number of organisational enablers which help facilitate their FFP. This included a positive organisational culture towards FFP, support from management, and policy and procedures which aim to encourage family focused approaches to professional practice. Survey findings indicated that managers across both adult mental health and children's services perceived current organisational supports more positively than other HSC professionals. This discrepancy in the views of organisational supports towards FFP is an important finding. It demonstrates that perhaps Think Family NI strategic thinking has been adopted at more executive levels, but support for this is not being embedded or reinforced in practice. Additionally, social workers were also more positive regarding support for FFP compared to their colleagues from different disciplines. Maybery et al. (2014) suggested that such differences can be accounted for as a result of role constraints. It is not always seen as the clinician's role to provide services for family members and consequently there may be inadequate resources allocated, including time to engage in FFP.

An additional organisational enabler identified by HSC professionals related to developments in policy, specifically those relating to child protection. Such policies enforce statutory responsibilities across adult mental health and children's services, providing clear guidance and expectations regarding professional response. For example, HSC professionals described how the UNOCINI assessment process enabled FFP, as it made their responsibilities surrounding child safety more concrete and it also meant that parents felt required to engage in discussions surrounding parenting and children's well-being. Although as previously noted, knowledge and

skills deficits regarding working with the parent and, or child(ren) can be a major barrier to FFP (Grant & Reupert, 2016), creating a significant challenge for professionals to be able to implement such policies within practice.

Furthermore, both HSC professionals and service users reported that it is generally apparent that adult mental health professionals have little knowledge of the needs of children whilst child care professionals lack understanding of mental illness. This lack of understanding reflects back to issues associated with time, training and resource within HSC services to engage in FFP. Additionally, ambiguous role definition and responsibilities regarding work with families and the confidence to work with different family members, may mean that HSC professionals defer responsibility for either the parent or the child(ren); leaving respective assessment and needs to be addressed by their professional counterparts. This separation is particularly apparent between in-patient and community based services. To reduce this separation both HSC professionals and service users suggested that professionals have regular opportunities to engage in multidisciplinary training opportunities which emphasises HSC professionals working together and with the whole family.

Professionals and service users also highlighted the importance of the parent-professional relationship in relation to FFP. Without this relationship, the opportunity to engage in FFP may be hindered. HSC professionals and services users acknowledged the challenges associated with service users' engagement, including fear of losing children and stigma of PMI. Lack of social awareness regarding both mental illness and intended function of services relating to this, create difficulties for the parent-professional relationship, service user engagement and accurate assessment, planning and treatment. Additionally, service users also highlighted the importance of recognition of their parental status by HSC professionals, noting that they are both a person with a mental illness and a parent with responsibilities and that these two things can impact upon one another and impact on their children. Greater awareness of PMI is needed in order to reduce feelings of shame and guilt among parents as well as educating children in order to build towards effective coping and resilience.

Finally, HSC professionals and service users offered a number of suggestions regarding future developments in this area, including improvements within adult mental health and children's services in the availability of psycho-educational resources and support groups for the whole family, including children. It was also emphasised that better understanding of service roles and responsibilities among professionals in supporting families when parents have a mental illness was important, along with more opportunity to engage in joint working and inter agency co-operation. Improvements to service environments, so that they are child friendly, was also identified as important for parents and their children.

### **How does FFP in NI compare to the international context?**

The barriers to FFP highlighted within the current study are not unique to NI, with similar issues noted within the existing international literature (Grant et al., 2016; Grant & Reupert, 2016; Grove et al., 2017; Lauritzen et al., 2014; Reupert et al., 2017). The results regarding the extent of FFP are also consistent with previous studies which have illustrated that different professional disciplines within mental health services tend to exhibit different levels of FFP. For example, Maybery et al. (2014) also found that social workers were most family focused. Clear skill, knowledge, and confidence differences are indicated between the professions and require consideration by organisations in developing initiatives to promote FFP. In the case of social workers, working with families has traditionally been seen as a particular area of expertise of this profession and therefore it could be expected that they report more activity in this area than the other professions.

Furthermore, consistent with previous findings of qualitative studies, different professional disciplines will also have varying learning needs in relation to working with families where a parent has a mental illness (Whitham, Eddy, Maybery, Reupert & Fudge, 2009). Maybery et al. (2008) suggest that these differences can be accounted for by considering that the discipline of the professional will result in differing levels of contact with families. This was certainly apparent within the current study given that those working in community based settings report most family focused whilst those working in in-patient settings, and who have less contact with families, report as being least family focused. Care in the context of family life is an important principle underpinning FFP, with previous researchers also highlighting the

benefits of home visits (Grant, 2014; Grant & Reupert, 2016; Kuo et al., 2012; Olds 2002; van Doesum et al., 2008). Working within the home environment provides opportunity for professionals to observe family dynamics, address parenting and intervene to promote family functioning when and where appropriate (Grant & Reupert, 2016; Korhonen et al., 2010). With this in mind, it is important for professionals and policy makers alike to consider how we might facilitate clinic based professionals and their service users to engage with FFP.

Additionally, professional background has been linked to training needs regarding FFP. For example, Whitham et al. (2009), employing a Delphi research methodology, also state that different professionals report different learning needs. Similar to the current study, they found that social workers knew most about families and carers but needed to know more about parenting and child development with regards to adult mental health; a finding similar for nurses. Psychologists, on the other hand, needed to know more about supporting families. Moreover, both Grant (2014) and Korhonen et al. (2008) suggested that those with least education and training experience more barriers to FFP than those who have more training.

Conversely, what we do know from the current study findings is that professionals who have taken part in specialist training relating to working collectively and with the whole family (i.e. Think Family NI Champions) report as being the most confident in their FFP. Following an earlier evaluation of the Champions Model in NI, Davidson et al. (2009) concluded “The findings from the evaluation suggest that the Champions Initiative is having a positive impact on interface working” (p.168). That said, the authors also noted that “having an identified Champion increases the risk that other members of the team may think that the Champion carries responsibility for interface issues rather than the whole team” (p.168). With this in mind it is important to consider a more structured approach to sharing knowledge between and across sectors and services as well as opportunities for multidisciplinary training and promotion of inter-agency co-operation. The Champions Model lends itself as a potential framework in which to further promote such activities within and across adult mental health and children’s services.

Time and workload was also found to be a significant predictor of professionals' FFP. The time to work with families inclusively is seemingly limited, with HSC professionals reporting varying case-loads across both adult mental health and children's services. An over stretched workforce is not unique to the NI HSC system. For example, research reviewing the experience of mental health nurses in the UK report staff shortages, high workloads and high staff turnover as being identified as barriers to FFP by these professionals (Maddocks, Johnson, Wright & Stickley, 2010). As highlighted by Lauritzen et al. (2014) and Grant and Reupert (2016), having adequate resources, structure and time is important for HSC professionals' capacity to engage in FFP.

Current findings from this study, regarding the extent of FFP and organisational supports for FFP, are also similar to those reported by Grant (2014) who addressed nurses' FFP in Irish mental health services. Grant (2014) notes that nurses' capacity to engage in FFP was determined by their knowledge and skills and working in community settings. However, in comparison to Grant (2014), HSC professionals in the current study were more family focused than nurses practicing in Irish mental health services. This is perhaps unsurprising considering there are limited initiatives in Irish mental health services, in comparison to the NI context, to promote professionals' FFP (Grant 2014; Grant & Reupert, 2016). That said, compared with other researchers who have measured the extent of professionals' FFP within the Australian context, (Maybery et al., 2009; Maybery et al., 2014), the NI sample scored lower on all FFP subscales, excluding training. This is to be expected considering Australian health and social services have introduced family focused initiatives over the last 25 years.

This comparison in the extent of FFP between NI and elsewhere provides tentative evidence that organisational support for FFP can increase the extent of HSC professionals' FFP. For instance, Toikka and Solantaus (2006) suggested that the Effective Family (EF) Programme in Finnish mental health services have enabled mental health professionals to support both parents and their children by providing training, resources and managerial support for FFP. Additionally, the availability of specialist support services and programmes is important for both professionals and service users regarding complex and multifaceted issues. As Maybery and Reupert

(2009) note, it is problematic for workers to start talking about family issues and children when there was a lack of appropriate and adequately staffed services to refer them on to. Referral networks and pathways within and outside of services also need to be clearly defined, within strong service partnerships, considering professionals may not always be able to meet all the needs of parents, their children and families (Reedtz et al., 2012).

Moreover, the question of how to effectively support children whose parents have a mental illness is also important and strikes at the core of what constitutes FFP. As discussed during the introduction of this report, Falkov (2012) suggests that just as a parent's mental illness impacts on children, there is also a "child to parent" influence, where the child's behaviour and emotional state impacts on the mental health of parents. This means that even if a parent's mental illness is treated and their parenting capacity supported and enhanced, his or her children's own mental health issues might continue to adversely impact on family life and on the mental health of the parent. Internationally efforts are being made to equip professionals to engage both parents and their children to support them to cope with PMI. For example, the Finnish Let's Talk about Children, VERTTI peer groups for children and their parents or Childs Talk in Norway are three such models that might assist in this regard (Lauritzen et al., 2014; Reedtz et al., 2012; Söderblom & Inkinen, 2005). These psycho-educational interventions are designed to promote parenting and child development through improving understanding of a child's needs and children's understanding of PMI. A core aim of such interventions is to prevent children's mental health problems from occurring in families with PMI by promoting family and child (ren') strengths and resilience through knowledge and understanding (Cooper & Reupert, 2017; Grove, 2017; Grove & Reupert, 2017; Solantaus et al. 2010). Whilst The Family Model (Falkov, 1998, 2012) promotes similar aims regarding improvements for parents and children, currently, there are no such training and interventions offered within NI HSC services. It is important moving forward that children are acknowledged by HSC professionals as active family members who can be affected by, and have an effect on PMI, and supported by HSC professionals accordingly.

Hence, organisational readiness for FFP as previously highlighted, is a necessary pre requisite for HSC professionals' FFP (Grant & Reupert, 2016; Halle et al., 2013; Lauritzen et al., 2014; Maybery & Reupert, 2009; Reedtz et al., 2012; Trowse et al., 2013; Ward et al., 2017) and the processes employed by organisations to implement FFP are crucial (Aarons et al., 2011; Curran et al., 2008; Grant & Reupert, 2016; Lauritzen et al., 2014; Moore et al., 2012). The broader legislative and policy backdrop to adult social care in NI is, however, disparate consisting of diverse pieces of legislation, dating back to 1972, arguably lacking in both thematic connection and individualised focus. As a result, there have been calls for NI to address this issue with a more consolidated and single piece of legislation (Duffy, Basu, Davidson & Pearson, 2016). By contrast, the legal and policy frameworks for children and families is more unified and recognisable, with The Children (NI) Order 1995 being the primary piece of child care law affecting all children and families in NI. Northern Ireland also has a firmly established rights based context shaping social work practice through both the United Nations Convention on the Rights of the Child (1989) and the Human Rights Act (1998) (Duffy & Collins, 2010), and an overarching cross-Government strategy for children and young people (OFMDFM, 2006).

### **Implementation of Think Family NI and Future Direction:**

The inquiry into the deaths of Madeline and Lauren O'Neill in 2008 and subsequent inquiry into the deaths of the McGovern/McElhill family in June 2008, brought into focus deficits in the working relationship between mental health services and children's services in NI; suggesting that the way in which these services worked together needed to improve. The commencement of the Think Family NI programme in 2009 was part of the response, introducing a wide range of initiatives. There have been two phases to this work, between 2009-2013, and 2014 – to date.

The theory of implementation science highlights the conditions under which a new policy or programme are most likely to be successfully implemented to meet their stated objective. The necessary stages involve:

- An agreed articulation of the outcome being sought, the method to be followed to achieve this, and the process of measuring whether activity is leading to the desired outcomes.

- A clear implementation strategy that sits alongside the strategic plan, with robust governance and performance measurement structures to ensure the stated outcome is being achieved, and to identify early any unintended or unanticipated consequences.
- Action to embed the new practice or policy into the structures, policy and culture of any host organisation.
- Periodic independent evaluation of whether the policy or programme is achieving its stated aim.

While this evaluation was not commissioned to provide a process evaluation, nevertheless, a number of key findings have emerged about the successes achieved and challenges encountered in developing and implementing Think Family NI. Allied to this is the wider context within which health and social care services are being delivered in NI. The current configuration of HSC Trusts came into being in April 2007, the most significant reorganisation of such services since 1974. Within a relatively short time period the new organisations had to deal with the impact on public finances of the financial crisis that began in 2008, and is still being felt today. As such, much has been achieved by Think Family NI, in spite of these wider systemic challenges. However, there is some evidence from this evaluation which highlights that Think Family NI would benefit from a period of reflection in order to ensure that as it moves forward, within a changing HSC landscape, that the structures to ensure that the initiative delivers better outcomes for greater numbers of children and their parents are in place.

### **Key Messages from the Research and Recommendations for the Future:**

The development and implementation of Think Family NI is to be commended for its ambition and the many initiatives that have been developed. This is in no small measure due to the leadership of the Health and Social Care Board (HSCB), and more recently the Children and Young People's Strategic Partnership (CYPSP) (a committee of the HSCB). In addition, the successes achieved to date have been supported by the drive of the Think Family NI Lead. However, at the outset, there was a lack of an overall theory of change (logic model) to guide development of Think Family NI, and HSC Professionals who were interviewed reported that individual initiatives have been developed and implemented in a way that appeared

fragmented. This is unsurprising given the lack of a Think Family NI strategy from the outset. The imperative to move straight to action is not unusual within public services, especially when attempting to respond to significant adverse events (the O'Neill and McGovern/McElhill inquiries, 2008<sup>1</sup>), but is also a significant weakness in moving forward in the longer term. The current overarching Action Plan, which guides Think Family NI, was last updated in April 2016, and it appears timely that this evaluation was commissioned to reflect on progress to date, and next steps.

The findings of this study suggest that while Think Family NI is a widely recognised initiative within some parts of the HSC system, the knowledge and understanding of Family Focused Practice (FFP) is more piecemeal. There are encouraging findings that indicate that some of the Think Family NI initiatives have supported FFP, in particular in relation to community versus in-patient services; children's sector versus adult mental health sector; and the social work profession versus other professional groups. However, there remains a large proportion of the workforce across all professions, services and sectors who display low levels of family focused awareness and practice. This is evident from feedback from both HSC professionals and, more significantly, users of services. Family focused practice is least embedded within adult mental health in-patient services. This requires consideration of whether different approaches are required for these particular settings, where staff have significant contact with the adult patient, but much less contact with other family members.

Family members report that HSC professionals who understand FFP are able to support the family as a unit as well as individually. Professionals who do practice in a family focused manner report that multi-disciplinary training, agreed protocols related to child protection and inter agency working, and the availability of Think Family Champions have supported their understanding and practice in this area. Whilst the Adult Mental Health and Children Services Joint Protocol aims to promote

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<sup>1</sup> Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards [O'Neill Inquiry], Western Health Social Services Board and Eastern Health Social Services Board, 2008; Report of Agency Involvement (Independent Review) with Mr.A McElhill, Miss E McGovern and their children – the Toner Report, 2008.

collaboration and a holistic approach towards service delivery, the findings do suggest that this strategy is not effective to embed FFP and is hindered by a number of multi-level organisational and systemic barriers, including the co-occurrence of multiple adversities experienced by families when PMI is present. There is an established body of literature highlighting the impact on parenting of multiple adversities both in carer's own backgrounds, alongside their current situation (Davidson, Bunting & Webb, 2012). This requires professionals to look beyond the specific issue for which they are engaged with family members, to better understand the dynamic interplay between a range of both proximal and distal stressors, and to provide support and services that address this wider range of needs. Finally, study findings emphasise the importance of building on existing initiatives and strengthening links between policy and practice. Moreover, the gap between the wider system and frontline practice highlights the need for better integration of both with implications for current and future initiatives. The translation of policy to practice needs to be supported and promoted through long term, multifaceted, implementation strategies, at multiple organisational levels (Grant & Reupert, 2016; Halle et al., 2013; Lauritzen et al., 2014).

**With this all in mind, it is proposed Think Family NI is further strengthened by the following recommendations:**

1. The HSC Board should develop a Think Family NI Strategy and consider how this will be taken forward as part of the transitional arrangements for the embedding of Think Family NI within HSC Trusts. In doing so it would be important to provide an overarching theory of change and the specific, intended outcomes for the overall strategy, and the associated elements.
2. The new Think Family NI Strategy should include an integrated plan for service development and guidance on how it should be implemented.
3. The new Strategy should also include a governance and performance management framework. This will allow senior managers to monitor the implementation and effectiveness of the various initiatives under Think Family NI.

4. Each HSC Trust should formally adopt The Family Model (Falkov 1998, 2012) as the basis for future development of Think Family NI.
5. The HSCB should engage in discussions with the bodies that validate qualifying and post qualifying education programmes in Northern Ireland, including the General Medical Council, the Northern Ireland Social Care Council, the Nursing and Midwifery Council, and the Health and Care Professions Council to develop a comprehensive approach to multi-disciplinary and uni-disciplinary teaching about The Family Model and family focused practice for health and social care professionals.
6. HSC Trusts should continue to provide regular in-service training on family focused practice and The Family Model to all staff in adult mental health and children's services. This should include both awareness raising and skills development, tailored to the specific needs of different staff groups.
7. Think Family NI Champions are perceived as an important resource for teams and as such additional professionals should be trained and supported in the role by HSC Trusts.
8. Service users who have had the opportunity to engage with a Think Family Support Worker have perceived this role as a useful resource. As such, further examination of this specialist role would be useful.
9. There is a need for further development within HSC Trusts of family friendly visiting facilities in in-patient psychiatric facilities. This would support the maintenance of parent, child and family relationships, and enhance staff in their FFP. A timetable should be developed as part of the new Think Family NI Strategy for when this will be completed.
10. Home visiting is an important enabler of inclusive assessments and FFP and the facilitation of a percentage of home visiting for clinic based professionals would be beneficial. The HSC Board should consider how this

can be included in the commissioning of mental health and addictions services across NI.

11. To inform, support and evaluate Think Family NI, further research should be commissioned by the HSC Board and partners to assist providers in better understanding how many families require help, what types of help are most effective for whom and in what circumstances, and to trial new interventions.

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