Predictors of family focused practice among health visitors: A mixed methods study

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No conflicts of interest has been declared by the authors

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AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [http://www.icmje.org/recommendations/]):

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ABSTRACT

Aims:

To determine what predicts health visitors' family focused practice with mothers who have mental illness. To explore health visitors' experiences of family focused practice and what factors, if any, enable and or hinder it.

Design:

A sequential mixed methods design was employed.

Methods:

In Phase 1, 230 health visitors, in five Health and Social Care Trusts in the United Kingdom were recruited using convenience sampling and completed the Family Focused Mental Health Practice Questionnaire. Three multiple regression models were developed to test whether workload (Model I), professional knowledge (Model II) and health visitors' professional and personal experience (Model III) predicted their family focused practice. In Phase 2, 10 health visitors, who completed the questionnaire, participated in semi-structured interviews to describe their experiences of family focused practice. The data collection of the two phases was conducted from September 2017 - September 2018.

Results:

Model III was significant. While personal experience of parenting was positively associated with family focused practice, length registered as a health visitor and personal experience of

mental illness was negatively associated. Qualitative findings suggested that increasing years of professional experience and personal experience of mental illness enabled health visitors to support mothers and their children, but not other adult family members, including partners. Limited skills and knowledge to support mothers with severe mental illness (i.e. schizophrenia) hindered family focused practice.

Conclusion:

This study advances understanding of how health visitors' professional and personal experiences can influence their family focused practice and highlights the importance of organisations promoting their capacity to support mothers with severe mental illness and to include mothers' partners.

Impact:

A clear understanding of factors affecting health visitors' capacity to engage in family focused practice will help to inform policy, education and practice in health visiting; with potential to improve outcomes for the whole family.

KEY WORDS: barriers, enablers, fathers, family-focused practice, health visitors, mental illness, mothers, nurse, predictors

1 INTRODUCTION

The needs and issues for mothers who have mental illness, their children and families are extensive and have been documented in multiple studies internationally (Beardslee, Solantaus, Morgan, Gladstone & Kowalenko, 2012; Grant et al., 2018; Checchia, Kilian & Becker, 2019; Paulson & Bazemore, 2010; Ruud et al., 2019). However, there is increasing evidence that a whole of family approach to service delivery can reduce the negative impact of maternal mental illness on mothers and their families (Beardslee et al., 2012; Leonard, Lindern & Grant, 2018a; Siegenthaler, Munder & Egger, 2012). On this basis, it is recommended that health visitors engage in family focused practice (FFP) (Department of Health, Social Services and Public Safety, [DOHSS&PS], 2010). However, there is limited understanding of health visitors' FFP, with mothers who have mental illness. Also, to the best of our knowledge no studies have examined factors that predict health visitors' FFP.

2 BACKGROUND

Internationally, rates of maternal mental illness range anywhere from 7.5% in Australia (Buist et al., 2008), to 38% in the USA (Luciano et al., 2014; Nicholson & Meara, 2014). Abel et al. (2019) found that Northern Ireland (NI) had the highest levels of maternal mental illness in the UK; with one in four children, aged 0–16 years, exposed to maternal mental illness and 53% of children over 16 having a mother who has been diagnosed with a common (i.e. depression and anxiety) or severe mental illness (i.e. psychosis).

The needs and issues for mothers who have mental illness, their children and families are extensive and have been documented in multiple studies in Europe, Australia, Canada and the US (Beardslee, Solantaus, Morgan, Gladstone & Kowalenko, 2012; Grant et al., 2018; Siegenthaler, Munder & Egger, 2012). While a mother's mental illness may adversely affect

children's cognitive, emotional, social, physical and behavioural development (Beardslee et al., 2012), it can also affect wellbeing of adult family members, including fathers and partners (Krumm et al., 2019; Paulson & Bazemore, 2010). Motherhood can also jeopardise mothers' mental health (Grant et al., 2018).

Family focused practice (FFP) helps parents, children and other adult family members prevent and/or cope effectively with the difficulties associated with parental mental illness (PMI), (Foster, O'Brien & Korhonen, 2012). Randomised controlled trials have found that structured family focused interventions reduced the risk of children acquiring their own mental health disorder by forty percent (Beardslee et al., 2012, Siegenthaler et al., 2012). On this basis, it is recommended that health visitors engage in FFP to promote optimal outcomes for mothers who have mental illness and their families (Department of Health, Social Services and Public Safety, [DOHSS&PS], 2010).

Family focused practice emphasises the family as the unit of attention as opposed to a health professional working with a mother and her child(ren) alone (Isobel, Allchin, Goodyear & Gladstone, 2019). At a minimum, FFP is about understanding a family's composition and awareness of the needs of the individual within their family structure (Krumm et al., 2019; Maybery et al., 2015) and keeping the needs of family members in mind when supporting service users (Grant et al., 2018; Grant, 2014). Systemic family therapy could be considered as the highest possible level of FFP as it looks at the interrelationships between family members and how these relationships have an impact on individuals within the family (Kendell, Rodger & Palmer, 2010).

Public health nursing is a globally recognised profession, which aims to promote and strengthen the health of individuals, families and communities (Cowley et al., 2013). Health visitors in the UK are registered nurses or midwives with specialist community public health training and experience in child health and health promotion and education (Peckover, 2011.

They receive training in perinatal and infant mental health and can refer directly to general practitioners. They provide a universal service for all families that have children from zero to school age (4 years of age in the UK) (Peckover, 2011). Health visitors are community-based practitioners and make nine visits to a family before a child starts school. However, they also provide more targeted support (weekly or fortnightly visits) to those families identified as having additional needs, including when mothers have mental illness (DOHSS&PS, 2010; Whittaker et al., 2017). Currently, in the UK there are approximately 10,800 health visitors (National Health Service [NHS] Digital, 2018).

Recognising the impact of maternal mental illness on fathers' health and also fathers' health on the family, it is advised that fathers and partners should also be directly involved in health visiting services (DOHSS&PS, 2010). However, while current guidance advises that health visitors look beyond the child in all areas of their practice to consider the family as a whole (Lowe, 2007), research suggests that 'the family' is often mistakenly interpreted as the mother-infant dyad (Bateson, Darwin, Galdas & Rosan, 2017) and that fathers are not sufficiently engaged and supported (Humphries & Nolan, 2015).

There is limited research that specifically explores health visitor's experiences of FFP with families when mothers have mental illness and none examining factors that predict it. In other services (i.e. adult mental health services) and disciplines (i.e. nursing and social work), several important worker and workplace factors that predict FFP have been identified. Goodyear et al. (2015) found that being female, previous receipt of family focused training and working in a rural location predicted FFP. A study of mental health nurses in Ireland found that the most significant predictors of FFP included skill and knowledge, own parenting experience and work setting; with nurses practicing in the health setting exhibiting more FFP than those in acute in-patient units (Grant, Reupert, Maybery & Goodyear, 2019). Tungpunkom, Maybery, Reupert, Kowalenko & Foster, (2017) examined FFP in a multi-

discipline sample (social work, mental health nurses and psychiatry) and found that those who had received training around supporting the family, or working with the family as a whole, were more family focused than those who had not (Tungpunkom et al., 2017). In a similar study incorporating multiple disciplines in NI, time and workload and skill and knowledge were reported as significant predictors of FFP (Grant et al., 2018). None of these studies examined whether the health professionals' personal experience of mental illness or having a family member with mental illness predicted FFP.

Developing a greater understanding of what predicts FFP, would help identify areas for improvement in health visiting and aid health visitors in providing a service which meets the needs of the whole family. Based on the current literature on factors associated with FFP among other professions, we hypothesised that health visitors' workload, greater professional knowledge, skills and personal (i.e. mental illness, parenting) and professional experience would predict FFP. In addition, interviews further explored results from the regression analysis and health visitors' experiences of FFP.

3 THE STUDY

3.1 Aims

The aim of this study was to determine what predicts health visitors' FFP with mothers who have mental illness and to explore health visitors' experiences of FFP and what factors, if any, enable and or hinder it.

3.2 Design

This study used a sequential mixed-methods design (explanatory, complementary, follow-up design) (Creswell & Clark, 2007). Quantitative questionnaire data were collected from 230 health visitors, across all five Health and Social Care Trusts in NI, between September 2017 - January 2018. Qualitative, interviews were conducted between May and September 2018, to further explore and extend on questionnaire results.

3.3 Sample/participants

In the quantitative component of the study (Phase 1) a convenience sampling approach was used to access the total population of health visitors (N =488) in NI. Inclusion criteria included health visitors who had a caseload, a minimum of six months post qualifying experience and who were permanent members of staff. Health visitors in roles such as the Nurse Family Partnership and those in managerial roles were excluded.

In the subsequent qualitative component of this study (Phase 2), semi-structured interviews were conducted with health visitors. While 35 health visitors agreed to participate ten were selected based on their score on the Family Focused Mental Health Practice Questionnaire (FFMHPQ); high and low scoring health visitors were sought to gain representation from these differing levels of FFP. All ten were recruited and interviewed.

3.4 Data collection

3.4.1 *Quantitative data collection*

The questionnaire designed for phase 1 was disseminated over a five-month period to all health visiting teams and contained three parts; demographic information of the participants; the FFMHPQ (Maybery, Goodyear & Reupert, 2012); and open-ended questions measuring

family focused activities. Demographic information collected included, age, gender, employment basis, parenting status, personal experience of mental illness and previous additional training (i.e. training in mental illness, substance misuse, intimate partner violence, child focused and family focused). The FFMHPQ employed a seven-point Likert-type scale (ranging from one – strongly disagree to seven – strongly agree) to measure five different family focused behaviours (e.g. assessing impact of parental mental illness on children) as well as organisational (e.g. training) and professional (e.g. knowledge) related factors that may have an impact on these behaviours. The original scale contained 45 items consisting of 16 subscales and was developed for mental health professionals in Australia (Maybery et al., 2012). Psychometric information of the FFMHPQ subscales is detailed elsewhere (Maybery et al. 2012), demonstrating that while the measure has good content and construct validity, its reliability is questionable. The third section of the questionnaire, consisted of binary (yes/no) questions regarding family focused activities undertaken by the health visitor, such as 'do you provide support to the partner?' and open - ended questions such as, 'explain how you support partners?'

The questionnaire was disseminated at monthly staff meetings, where the first author was allotted time to introduce the study, answer any questions and allow health visitors the opportunity to complete the questionnaire. Participants could complete the questionnaire in the allotted time or were given the option to complete in their own time and return to the researcher via stamped addressed envelope.

3.4.2 *Qualitative data collection*

Semi structured interviews were conducted with high and low scoring participants, to further explore results from regression analyses and experiences of FFP. Out of the 35 health visitors

who initially agreed to take part in interviews, 10 were interviewed. Participants were asked to discuss how they work with a family, for example, 'do you have contact with partners and if so can you describe this?' Participants were also asked to discuss any barriers or enablers when working with a family; for example, 'what are the current challenges, if any, when working with a mother with mental illness and her family'. The first author conducted all 10 interviews, which were generally 60 minutes in duration.

3.5 Ethical considerations

Ethical approval was granted by a National Health Service Research Ethics Committee (Ref 17/WS/0131). Implied consent was obtained through completion of the anonymous questionnaire and prior to the interview, participants were invited to complete an informed consent form.

3.6 Data analysis

3.6.1 *Quantitative data analysis*

The statistical Package for the social sciences (IBM, 2017) was used to analyse the quantitative data from Phase 1 using descriptive statistics and multiple regression. Three Multiple Regression (MR) models were developed to test our hypotheses. Model I tested whether workload predicted FFP - predictor variables included: service location, caseload size (number of children on caseload), numbers of mothers on caseload with mental illness and frequency of contact with families. Model II tested whether health visitors' professional knowledge and skills predicted their FFP. Predictor variables included; holding a specialist

role and training relating to mental health or the family, including family focused training. Family focused training is training that promotes professionals' capacity to support adult family member's needs.

The final model (Model III) tested health visitors' personal and professional experience as a predictor of FFP. Variables included health visitors' parenting status; personal experience of mental illness; length of time qualified; and duration in current position. Multiple regression analysis was used to assess the relative contribution of each predictor variable on the criterion variable, i.e. total scores on the FFMHPQ. All relevant assumptions of multiple regression were tested and met prior to analysis.

3.6.2 *Qualitative data analysis*

In Phase 2, interviews were audio recorded, transcribed verbatim and subjected to thematic analysis. The six steps involved: (1) familiarisation with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) writing this paper (Braun & Clarke, 2006). Participants were viewed as the 'experiential expert' (Smith et al. 2013, p.64) while exploring the participants own interpretations of their experiences of FFP. NVivo qualitative data analysis software version 10.0 (QSR International, 2012) was used to aid data management.

3.7 Validity and reliability/rigour

While Maybery et al. (2012) established the content and construct validity of the FFMHPQ in Australia, subsequent studies have found varying degrees of reliability within the scale inferring inconsistencies when used across disciplines, services and countries (Grant et al 2019; Grant et al., 2018; Laletas, Goodyear & Reupert, 2018; Lauritzen & Reedtz, 2016;

Tungpunkom et al., 2017). Consequently, an exploratory factor analysis (EFA) was conducted to determine scale validity in the current population of health visitors (Leonard, Linden & Grant, 2018b). The EFA revealed a two-factor solution, consisting of 20 items. These items were combined to produce total scores for each health visitor, with a maximum possible score of 140 and a minimum possible score of 20. This total score was used in analysis of health visitors' FFP.

In phase 2, all transcripts were coded by the first author. All codes were then analysed by the second and third authors, who examined whether there was a coherent and meaningful nature to the codes, referring back to participants' responses where necessary. Methodological rigour was maintained through reflectivity and using a field diary throughout the data collection process (Goodwin & O' Connor, 2006). To ensure credibility during data collection, the researcher bracketed personal assumptions about mothers who have mental illness.

4 FINDINGS

4.1 Sample demographic details

There was a 47% response rate (N =230). All participants were female, with a mean age of 44.31 years (SD 9.35). The mean length in practice was 11 years (SD 9.43), with most in full-time employment (N =130, 57%). Age and employment status in our sample were reflective of the wider health visiting sample in NI, with 52% in full time employment and a third being over 50 years of age (Department of Health, 2018). Health visitors worked in rural (N =73, 32.5%), urban (N =69, 30.3%) and both rural and urban areas (N =86, 37.7%). Reflecting health visitors' varied roles, including specialist positions, caseloads ranged from 20 families

to 333 families. Seventy-seven percent of health visitors were not currently in a specialist position.

For the qualitative interviews, all 10 health visitors were female and three specialised in infant mental health and breastfeeding. Four worked in rural settings, three in urban and three in a mix of urban and rural settings. Seven of the health visitors worked in full-time positions and three in part-time roles. Nine were parents and six had some experience of mental illness, either personally or through a family member.

4.2 Quantitative findings

4.2.1 *Descriptive results*

The sample had a mean FFP score of 102.40 (SD 11.92), with scores ranging from 59 to 140. Further descriptive results are detailed in Table 1.

4.2.2 *Predictors of FFP*

4.2.2.1 Predictors of FFP. Model 1: Workload

We sought to assess whether variables related to workload (e.g. service location, caseload size, numbers of mothers on caseload with mental illness and frequency of contact with families) predicted FFP - model 1 was not statistically significant ($F(6,132) = 1.79$, $p = 0.10$). None of the variables included in model 1 significantly predicted FFP scores (Table 2), thus our hypothesis that workload would predict FFP was not supported.

4.2 2.2 Model II: Health visitors' professional knowledge as a predictor of FFP

There was a non-significant proportion of variance in FFP explained by health visitors' professional knowledge ($F(8,212) = 1.39$, $p = 0.20$). None of the variables included in model II significantly predicted FFP scores (Table 3); again, our hypothesis that health visitors' professional knowledge predicted FFP was not supported.

4.2.2.3 Model III: Health visitors' personal and professional experience as a predictor of FFP

The MR for model III, showed that health visitors' experience explained a significant proportion of variance in FFP scores, ($F(5,202) = 3.79$, $p < 0.01$), with an adjusted R^2 of 0.06. Parental status significantly predicted FFP scores, ($b = .14$, $t(202) = 2.02$, $p = 0.04$) as did length of time qualified ($b = -.20$, $t(202) = -2.22$, $p = 0.02$) and having personal experience of mental illness ($b = -.20$, $t(202) = 2.77$, $p < 0.01$). Duration in current position did not significantly predict FFP (Table 4). As the overall model was significant, results supported our hypothesis that FFP was predicted by health visitors' personal and professional experience.

4.3 Qualitative findings

Health visitors described the nature and scope of their FFP and identified enablers and barriers to adopting a whole of family approach to service delivery.

4.3.1 Theme 1: Nature and scope of health visitors' FFP

Health visitors' FFP largely consisted of supporting the mother and child, with partners' needs seen as secondary. Health visitors reported primarily supporting partners to understand the mothers' mental illness as opposed to also addressing their needs: "*we involved him in the conversation to understand where her frustration are and how she is feeling*" (SHV3). While health visitors described an array of activities to directly support mothers, their main activity included listening to the concerns of mothers during visits. These visits were a time for the health visitor to solely focus on the mother, as this health visitor described: *"we offer listening visits… it's not about coming out and weighing the baby and all of that there. It's about coming out specifically to talk to the mummy. Or to let her talk to you about her feeling."* (NHV8).

Health visitors supported the child mainly through mother focused parenting interventions, including provision of advice and physically showing mothers how to interact with their child in an appropriate way: *"I would say you know em try and get down and talk to your baby and interact with him and stimulate, because the baby feels your anxiety"* (NHV1). Furthermore, health visitors recognised that they needed to look beyond the baby, when considering the needs of children within a family. Most inquired about the well-being of older children and offered support as illustrated in the following quote:

> *I would generally ask how's everybody coping with the new baby, because you could have someone with older children who have autism or whatever and if they baby is crying they just can't deal with that, or cope with that. So sometimes you have to put support in there for the older child with a new baby in the house* (NHV8).

4.3.2 **Theme 2: Professional and personal experience that enabled health visitors' FFP**

Health visitors described how increasing years of professional experience and, to a lesser extent, personal experience of postnatal depression enabled their FFP.

Health visitors with increased years of professional experience reported having more confidence in asking about mental health, recognising signs of mental illness and implementing strategies to support the mothers' mental health. In turn this confidence led to increased skills and professional judgement to identify mothers' needs and to communicate effectively with them. For example, professional experience helped health visitors to develop effective questioning techniques for enquiring about mental health. As one health visitor stated, *"I suppose with experience you do start to generally word it in a way that you think awk god I'm a bit concerned about you, you're not your usual self today, you know what questions to ask."* (SEHV4).

Those with extensive practice experience also described enhanced skills such as observation; gut feelings; and professional judgement which aided them in unmasking mother's deteriorating mental health and allowing them to intervene more effectively. In homes where concerns may not have been obvious, health visitors with extensive experience described being able to see past the mask that mothers portrayed. As one health visitor stated: *"I thought there is something not right here and I can see it in her. And eventually then she just broke down"* (NHV1). The ability to identify those at risk of mental illness meant that health visitors were able to intervene early and stop the mothers' mental health from deteriorating further. As one health visitor highlighted; *"there are ladies who maybe are not PND but I think are on the verge of it, maybe have had a really bad experience with breastfeeding. And I would be giving them extra visits. I just don't want them going over the edge"* (SEHV2). Health visitors also used observation to read 'in-between the lines' and build a deeper picture of the family. Observation severed as a method of assessing relationships and bonds, particularly between mother and baby:

Well I just watch. Are they picking them up (child) or even when I'm doing examinations and stuff there are mums that would just be completely standing off, whereas it would be more instinctive for ok mum……But I suppose if someone is very low. They just don't respond to that" (SEHV2).

Some health visitors also disclosed how personal experiences of postnatal depression enabled their FFP. They indicated that this personal experience allowed them to empathise and have a deeper understanding of the experiences and needs of mothers with postnatal depression, *"I suppose it's my forte because I experienced postnatal depression myself, so I think it's one of the things I would be more in-tune with" (SEHV4).* While personal experience of mental illness was believed to promote more compassionate care towards the mother, health visitors did not discuss how this experience developed their practice with other family members, including partners.

4.3.3 **Theme 3: Deficits in knowledge and skill**

Health visitors also discussed factors that hindered their FFP and insufficient knowledge and skills to support mothers who had severe mental illness and multiple adversities (i.e. s domestic violence) were key. This resulted in apprehension and uncertainty as to how to support these mothers and reluctance by some to address needs associated with mental illness. For example, (NHV8) indicated, *"Then we start going into bipolar and personality disorder and things like that. I would really feel out of my depth and sometimes I can feel like I don't know if I should be going in there. And offering advice and support".* Similarly, others stated, "*They can say something and I would be thinking right, I can't give you the answer because that's a specialist a*rea" (SHV3) and "*I am not trained to do that. I feel like I can*

listen, but that's about it" (SEHV2). This perception of being unable to support mothers effectively resulted in many health visitors withdrawing their input when mental health services became involved.

Not seeing support for fathers as within health visitors' remit further hindered FFP. Some health visitors were of the opinion that if the partner was present they would involve them, otherwise they would not actively seek to engage with them. These views stemmed largely from viewing the mother as the primary carer and thus the primary focus of support. As this health visitor stated: "*we wouldn't see them (partners) not unless they are those families that are on the child protection register and of course then you may have to be visiting and talking to your daddy more because of the circumstances*" (SHV6).

5 DISCUSSION

The aim of this study was to determine what predicts health visitors' FFP with mothers who have mental illness and to explore their experiences of FFP and what factors, if any, enable and or hinder it. Multiple regression revealed that health visitors' professional and personal experience was a significant predictor of FFP, with time qualified, personal experience of mental illness and parental status significantly predicting FFP scores. While increasing years qualified and personal experience of mental illness had a negative association with FFP, qualitative findings illustrate how health visitors drew on these experiences to engage in FFP. However, they primarily engaged mothers with postnatal depression and their children as opposed to also supporting mothers with severe mental illness and other family members, including partners. Based on the continuum of family focused activities (Leonard et al., 2018a), health visitors engaged in low levels of FFP. As previously discussed, while, partners should be directly supported by health visitors (DOHSS&PS, 2010), others have also found

that 'the family' is often mistakenly interpreted as the mother-infant dyad (Baldwin, 2015; Bateson et al., 2017; Humphries & Nolan, 2015). At the centre of FFP is the concept of family and the way health visitors conceptualise the family and roles of members within it influences their FFP. Findings of this study suggest that health visitors' perceptions of the family were based on stereotypical gender roles, such as fathers as the bread winners and mothers as carers, which led to them viewing partner's needs as secondary to that of mothers and children. Having a female-centric health visiting system has been suggested to reinforce the feminine nature of care (Bateson et al., 2017; Page et al., 2008). Therefore, if health visitors' FFP is to move beyond the mother – infant dyad to encompass partners, their conceptualisation of the family and fathers' roles must be challenged. More males could also be recruited into the profession.

In relation to engaging and supporting mothers, health visitors in the present study did not attribute one particular experience to promoting their capacity to engage them; instead they perceived that an accumulation of both personal and professional experience helped to construct their professional identity and practice. With regard to professional experience, health visitors highlighted how increasing years of professional experience developed their confidence and professional judgement which they used to support mothers' mental health and parenting through early intervention. Health visitors discussed using their 'gut feelings' (or intuition) to support their decision making, including estimating the number and duration of health visits that would provide optimal support for particular mothers. The use of intuition in nursing practice is a frequently discussed topic and has been linked to enhanced clinical judgment, effective decision making and crisis aversion (Smith, 2007; Turan, Kaya, Ozsaban & Ozdemir Aydin, 2016). Increased years of experience have also been associated with increased capacity to use intuition in practice (Turan et al., 2016) and to engage in FFP (Grant et al., 2019; Korhonen, Vehvilainen-Julkunen, Pietila, 2010).

Qualitative findings also suggested that health visitors drew on their personal experience of mental illness to support mothers; although primarily with mothers who had postnatal depression. Others have also found that professionals, including health visitors draw on their personal experiences of mental illness to help them empathise with and respond to mothers (Oates, Drey, & Jones, 2017; Waugh, Lethem, Sherring, & Henderson, 2017). As expertise by experience has become an increasingly valued element of service design and delivery professionals are increasingly encouraged to reflect on their own personal experiences and challenges of managing mental ill health to empathise with and to better engage service users (Oates et al., 2017). Additionally, this study highlights that caution must be taken when assuming shared experience, such as mental illness, will automatically lead to better support for mothers with a variety of mental illness and all members of the family, including fathers. As previously noted, the regression (model III) findings indicate that health visitors' personal experience of mental illness is negatively associated with FFP and qualitative findings highlight how health visitors only use it to support mothers who have postnatal depression. Moreover, our qualitative study only included ten health visitors.

While multiple regression in the present study also reveals that health visitors' professional knowledge, (including family focused training and training in mental illness) model II, was not a significant predictor of FFP, qualitative findings support our hypotheses that it is important. In interviews, health visitors described feeling overwhelmed and apprehensive when working with mothers who had severe mental illness due to their diverse range of needs, which they felt ill equipped to deal with. While there is no reference to health visitors' capacity to support mothers with severe mental illness in the literature, the findings do coincide with a study conducted by (Grant et al., 2018), who found that limited knowledge of severe mental illness hindered social workers' capacity to support mothers in children's services. Most (N =200, 87%) of social workers in the current study also had no training to

support mothers, beyond those with perinatal mental illness. While others have also found that limited skill and knowledge and training hinder mental health professionals' capacity to engage in FFP (Grant et al., 2019; Maybery et al., 2016; Tungpunkom et al., 2017), this study suggests that health visitors have different needs in relation to training than other professionals. For instance, while they may have knowledge and skills to support children, they have deficits in knowledge and skill in relation to supporting mothers with severe mental illness. The importance of training in mental illness is also underscored by health visitors' frequent exposure to mothers who have mental illness and their families and their recommended role in timely referral to specialist services when additional support is required (Department of Health, 2014).

Additionally, only 9% of health visitors had received family focused training. Given limited family focused training, it is also not surprising that health visitors did not directly engage and support fathers and partners. These findings also call into question why so few health visitors are receiving family focused training, considering recommendations in policy surrounding family focused training (DOHSS&PS, 2010) and awareness of benefits of this type of training in promoting professionals' FFP (Grant & Reupert, 2016; Isobel et al., 2019).

5.1 Limitations

While the study identified four predictors of FFP, these only explained 6% of the total variance, suggesting that a considerable amount remains unexplained, offering fertile ground for future research. Further research should build on this work to validate the findings and to determine any additional predictors of health visitors' FFP. Furthermore, the FFPMHQ is a self-report tool and was thus subject to social desirability bias. While efforts were made to minimise this (e.g. participation was anonymous), the possibility of its influence exists. Our

sample size comprised 47% of the total available population of health visitors in NI. While this is lower than we might have liked our sample still met the underlying assumptions for multiple regression. Moreover, it was not possible to examine response bias.

6 CONCLUSIONS

While health visitors drew on their personal experience of postnatal depression and increasing years of professional experience to engage in FFP, their activities were at the lower end of the family focused continuum. They primarily focused on supporting the mother and the child via the mother and had minimal or no contact with partners. Furthermore, health visitors' limited understanding and skills to support mothers to cope with needs associated with severe mental illness further hindered FFP. This suggests the need for training programmes, particularly for less experienced health visitors, to develop their capacity to effectively support mothers with varying types of mental illness and their partners. There is also a need to challenge existing gender roles and conceptions of the family in training. Recruitment of males into health visiting might also help to redress the exclusion of fathers from health visitors' FFP. Further research could identify additional predictors of health visitors' FFP and how they can be facilitated to more effectively support partners.

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Table 1. Descriptive results

		Family Focused Practice Score
	n	***Mean (SD)***
Age Group		
25-38	74	103.45 (9.29)
39-50	77	102.54 (11.70)
51-66	72	102.32 (13.64)
Missing	0	
Length Registered		
>1-4	75	103.01 (11.04)
5-15	69	103.69 (10.06)
16-35	73	101.19 (14.07)
Missing	0	
Service Location		
Rural	70	101.31 (11.69)
Urban	67	102.70 (10.62)
Rural and Urban	85	102.94 (13.11)
Missing	0	
Caseload Size		
20-200	58	104.93 (10.75)
201-253	57	102.74 (12.08)
254- 333	54	99.59 (11.31)
Missing	0	
Percentage of mothers on Caseload with a mental illness		
1-7.5	95	101.86 (12.45)
8-15	72	104.28 (10.99)
15.50-100	17	104.94 (9.11)
Missing	0	
Specialist home visiting position		
Yes	52	103.54 (12.10)
No	169	102.15 (11.88)
Missing	0	
Training Substance misuse		
Yes	88 (38%)	104.57 (11.71)
No	141 (62%)	101.04 (11.89)
Missing	0	
Training Intimate partner violence		
Yes	91 (40%)	104.66 (11.47)
No	138 (60%)	100.90 (12.02)
Missing	0	
Training perinatal mental illness		
Yes	169 (72%)	102.50 (12.19)
No	60 (26%)	102.12 (11.18)
Missing	0	
Training pre-existing mental illness (e.g. bipolar)		

Yes	29 (13%)	104.96 (10.14)
No	200 (87%)	102.40 (12.14)
Missing	0	
Training Think Family Initiative		
Yes	10 (5%)	105.00 (11.41)
No	219 (95%)	102.28 (11.95)
Missing	0	
Training child focused		
Yes	171 (75%)	102.79 (11.64)
No	58 (25%)	101.25 (12.75)
Missing	0	
Training family focused		
Yes	21 (9%)	107.95 (10.66)
No	208 (91%)	101.86 (11.92)
Missing	0	
Home visitors experience of mental illness		
Personal	42 (19%)	97.58 (11.41)
Family member with mental illness	85 (37%)	104.29 (10.30)
None	92 (40%)	102.70 (13.00)
Missing	10 (4%)	
Home visitors' parenting status		
Parent	200 (87%)	102.79 (11.73)
Not a parent	29 (13%)	99.71 (13.03)
Missing	0	
Frequency of Contact with family		
Daily or weekly	118 (52%)	104.76 (11.00)
Monthly or yearly	100 (43%)	100.63 (10.68)
Missing	11 (5%)	
Discuss mental illness with mother		
Yes	203 (89%)	103.27 (11.10)
No	20 (8%)	97.88 (13.66)
Missing	6 (3%)	
Contact with children		
Yes	190 (83%)	103.34 (11.01)
No	38 (17%)	96.97 (14.53)
Missing	1	
Contact with partner		
Yes	186 (83%)	103.32 (11.28)
No	40 (17%)	97.78 (13.10)
Missing	0	
Provide support to partner		
Yes	172 (75%)	104.08 (11.29)
No	48 (21%)	97.49 (12.53)
Missing	9 (4%)	

Table 2. The unstandardized and standardised regression coefficients for variables entered into model 1

Variable	B	SE B	β
Rural Location	.12	2.31	0.00
Urban Location	.84	2.39	0.03
Caseload size	-.03	.01	-0.16
Total mothers with mental illness on caseload	.02	.08	0.02
Daily or weekly visits	3.35	1.97	0.15

Note: Model 1 was not statistically significant (F(6,132) = 1.79, p = .10)

Table 3. The unstandardized and standardised regression coefficients for variables entered into model II

Variable	B	SE B	β
Specialist position	-0.98	1.93	-0.03
Substance misuse training	2.76	1.75	0.11
Domestic violence training	2.47	1.82	0.10
Perinatal mental illness training	-1.09	1.92	-0.04
Existing mental illness training	-0.10	2.60	-0.00
Child focused training	-0.10	1.93	-0.00
Family focused training	5.36	3.02	0.13
Think family training	-0.88	4.03	-0.01

.

Note: Model II was not statistically significant ($F(8,212) = 1.39$, $p = 0.20$)

Table 4. The unstandardized and standardised regression coefficients for variables entered into model III

Variable	B	SE B	β
Family member with mental illness	1.14	1.78	0.05
Personal experience of mental illness	-6.05	2.1	-0.20**
Being a parent	5.06	2.51	0.14*
Length registered	-0.25	0.10	-0.20*
Length in current position	0.23	0.14	0.15

*p < 0.05. **p <0.001.

Note: Model III was statistically significant ($F(5,202) = 3.79$, $p < 0.01$), with an adjusted R^2 of .06.