QUEEN'S UNIVERSITY BELFAST

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

Grant, A., Lagdon, S., Devaney, J., Davidson, G., Duffy, J., Galway, K., Perra, O., & Leavey, G. (2018). *A Study of Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland SUMMARY REPORT*.

Document Version:
Peer reviewed version

Queen's University Belfast - Research Portal:
Link to publication record in Queen's University Belfast Research Portal

Publisher rights
Copyright 2018 The Authors

General rights
Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

Open Access
This research has been made openly available by Queen's academics and its Open Research team. We would love to hear how access to this research benefits you. – Share your feedback with us: http://go.qub.ac.uk/oa-feedback

Download date:16. May. 2024

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

SUMMARY REPORT

February 2018

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

This report can be cited as: Grant, A., Lagdon, S., Devaney, J., Davidson, G., Duffy, J., Perra O., Galway, K., Leavey, G., Monds-Watson, A (2018). *A Study of Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland. Summary Report*. Belfast: Queen's University Belfast

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 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 of Main Report 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 of Main Report) and development of a logic model (See p.16 of this report), 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.16 of this report 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.
- Servicer 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? Recommendations of the baseline study include:

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 family focused practice 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 family focused practice. 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.

Contents

Executive Summary 1
Tables & Figures 7
Glossary of Terms 8
Foreword 9
Acknowledgments 10
Part One: Background 12
Prevalence of Parental Mental Illness (PMI) 12
Impact of PMI 12
Family Focused Practice (FFP) and its Benefits 12
Barriers to FFP 13
Enablers of FFP 13
Policy Response to PMI - International Context 13
United Kingdom (UK) Policy and Practice Developments 14
Policy and Practice Developments in Northern Ireland (NI) 14
The Need for Regional Investigation of HSC Professionals' FFP in Adult Mental Health and Children's Services 15
Part Two: Logic Model 16
Part Three: Methodology 18
Research Aims and Questions 18
Research Design 18
Ethical Considerations 18
Quantitative Methodology 18
Validity of FFMHPQ 18
Participants 18
Quantitative Data Analysis 20
Qualitative Methodology 21
Individual Interviews 21
Service User Involvement in Research Design 22
Qualitative Data Analysis 22
Quantitative (Survey) Findings 23
HSC Professionals' Exposure to Parents who have Mental illness and their Children and Extent of Family Focused Practice (FFP) 23
Interdisciplinary Differences in FFP 24
High Scoring HSC Professionals 25
Predicting HSC Professionals' FFP 25
HSC Professionals' Education and Training in Family Focused Practice 27
Qualitative Findings - HSC Professionals 30

HSC Professionals' Perceptions of the Nature and Scope of their FFP 30
Principles 30
Family Focused Activities 31
HSC Professionals' Capacity to Engage in FFP 33
Barriers related to Professionals' Capacity to Engage in FFP 35
Future Potential Developments 37
Qualitative Findings – Service Users 39
Principles (Why professionals should engage in FFP) 39
Family Focused Activities (What Professionals Do) 39
Service Users and Professionals' Capacity to Engage in FFP 41
Barriers related to Service Users' and Professionals' Capacity to Engage in FFP 42
Future Potential Developments 44
Key Messages from the Research and Recommendations for the Future 45
References 48

Tables & Figures

Table 3.1: Completed Surveys by Trust 19
Table 3.2: Professional Disciplines across Adult Mental Health and Children's Services 20
Table 4.1: Summary of Significant FFP Predicators 26
Figure 2.1: Logic Model 17
Figure 3.1: Overview of the Hierarchical Multiple Regression Model 21
Figure 4.1: Adult Mental Health Professionals Training Overview 27
Figure 4.2: Children Services Professionals Training Overview 28
Figure 4.3: Percentage of HSC professionals who have received Family Focused Training 29
Figure 4.4: Percentage of HSC professionals who have received Child Focused Training 29
Figure 5.1: Overview of Two Thematic Networks 30

Glossary of Terms

AMH	Adult Mental Health
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CYPSP	Children and Young Peoples Strategic Partnership
DoH	Department of Health
DV	Dependent Variables
FFMHPQ	Family Focused Mental Health Practice Questionnaire
FFP	Family Focused Practice
FIT	Family Intervention Team
HSC	Health and Social Care
HSCB	Health and Social Care Board
IV	Independent Variable
M	Mean Score
n	Number (i.e. quantity or sum)
NI	Northern Ireland
PI	Principal Investigator
PMI	Parental Mental Illness
SCIE	Social Care Institute for Excellence
SD	Standard Deviation
TFM	The Family Model
UK	United Kingdom
QUB	Queen's University Belfast
WHO	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
January, 2018

Acknowledgments

Principal Investigator Dr Anne Grant (Lecturer, School of Nursing & Midwifery, QUB) and the Research Team;
Dr Susan Lagdon (Research Fellow, School of Nursing & Midwifery, QUB)
Dr John Devaney (Centenary Professor of Social Work at Edinburgh University)
Dr Gavin Davidson (Senior Lecturer, School of Social Sciences, Education and Social Work, QUB)
Dr Joe Duffy (Lecturer, School of Social Sciences, Education and Social Work, QUB)
Dr Oliver Perra (Lecturer, School of Nursing & Midwifery, QUB)
Dr Karen Galway (Lecturer, School of Nursing & Midwifery, QUB)
Professor Gerard Leavey (Director of the Bamford Centre for Mental Health and Wellbeing
Dr Aisling Monds-Watson (Lecturer in Social Work, Ulster University)

We (the project team) would like to express our appreciation to the individuals, groups and services who have supported us in the process of completing this research project.

We would like to start by thanking Mary Donaghy, Think Family NI Lead and the HSCB for commissioning this important piece of research. Many thanks also to each of the Research and Development Office's across the five NI HSC Trusts whose staff were enormously helpful in aiding the progression of this work.

Many thanks also to members of our Research Advisory Committee for your insight, feedback and support throughout the duration of this research study. Thanks also to those service users who helped us to refine our study protocol and particularly service user interview questions.

We would also like to thank each of our Trust Principal Investigators:
Adrian Corrigan (Southern Health and Social Care Trust)
Amanda Mc Fadden (Western Health and Social Care Trust)
Caroline Mc Gonigle (Northern Health and Social Care Trust)
Barney Mc Neaney (Belfast Health and Social Care Trust)
Don Bradley (South Eastern Health and Social Care Trust)

We thank you and your colleagues (Particularly, Mary Connolly David Douglas, Susan Mc Dermott, Deirdre Mahon, Valerie Devine, John Fenton, Lesley Walker, Kerry McVeigh & Michael Murray) for your insight, continued support and assistance during the development and completion of this research study.

We are also indebted to a number of staff from both Adult Mental Health and Children's service across each of the five HSC Trusts and their senior managers. This research was only possible through the support of many individuals who provided advice and information and not least of all, played a key role with regards to communication and advocacy on behalf of the research team to the importance of on-going research activities and research participation.

Most importantly, we would like to thank all of HSC professionals and service users, who have taken part in the study. We are very grateful for your time, insight and overall contribution. Without you this work would not have been possible.

Finally, we would also like to thank our two colleagues from QUB (Dr Peter O'Halloran and Dr Stephen Coulter) who peer reviewed the main report and members of the advisory committee who reviewed the summary report. Thanks also to Dr Adrian Falkov for his advice and insight.

Part One: Background

Prevalence of Parental Mental Illness (PMI): Internationally, it is 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, it is estimated that 10% of mothers and 6% of fathers have mental health problems at any given time (Mental Health Foundation, [MHF] 2016). Percy, Thornton and McCrystal (2008) found that over half of the households surveyed in Northern Ireland (NI) had at least one member who reported problematic use of alcohol. Subsequently Bunting, Ferry, Murphy, O'Neill and Bolton (2013) found that 23.1% of people in NI 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 were between 60,000–75,000 children in NI living with a parent who had mental illness.

Impact of Parental Mental Illness: PMI, inclusive of substance use problems, are major public health issues. It is the fact that PMI may negatively impact on 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). Whilst not all children will experience difficulties due to PMI, a significant number will experience cognitive, emotional, social, physical and behavioural problems on a short or long term basis (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). Conversely, parental responsibilities may also negatively affect parents' mental health and recovery (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 (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 et al., 2016; Foster, Whitehead, Maybee & Cullens, 2013; McGavin, 2013). 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 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 illness and, or substance use problems, AND child welfare issues. 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 (Grant, 2014; Nicholson 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; Grove & Reupert, 2017; Grove, Riebschleger, Bosch,

Cavanaugh & ven der Ende, 2017; Grove, Reupert & Mayberry, 2016; Nilsson, Gustafsson & Nolbris, 2014; Reupert & Maybery, 2016). Importantly, FFP has been found to "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). Other research suggests FFP may help to reduce the likelihood that parents will experience a relapse of their mental illness (Pitschel-Walz et al., 2006) or need for hospitalisation for treatment of their mental illness (Hyland, Hoey, Finn & Whitecross, 2008). Health and social care professionals also benefit from engaging in such interventions (Grant, 2014). Toikka and Solantaus (2006) described how using preventive interventions enabled mental health professionals to experience more satisfaction when supporting parents who have mental illness, their children and families. Similarly, Moore et al. (2012) indicated that mental health and social care professionals were able to create stronger alliances with families and experience greater work satisfaction in the process.

Barriers to FFP: Notwithstanding the importance of FFP, international evidence suggests that professionals in adult mental health and children's services experience difficulty in engaging in FFP (Grant, Goodyear, Maybery & Reupert, 2016; Goodyear et al., 2017; Houlihan, Sharek & Higgins, 2013; Maybery, Goodyear, Reupert & Grant, 2016; 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 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, including training, structures and time (Grant et al., 2016).

Enablers of FFP: Enablers to make the workforce more family focused need to be identified for workforce change to occur, but limited research has identified the possible factors that predict and enable FFP (Grant & Reupert, 2016; Halle, 2013; 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; Tchernegovski, Maybery & Reupert, 2017). Instead, long term, multifaceted, implementation strategies, at multiple levels in an organisation, are needed (Grant & Reupert, 2016; Liangas & Falkov, 2014; Proctor et al., 2009; Tchernegovski, Maybery & Reupert, 2017).

Policy Response to PMI - International Context: International policy increasingly recommends that adult mental health and children's services adopt a whole family approach (Foster et al., 2016; Goodyear et al., 2015; Nicholson et al., 2015; Tchernegovski, Maybery & Reupert, 2017). There is, however, wide international variation regarding FFP (Falkov et al., 2016; Grant et al., 2016; Grant & Reupert, 2016). For instance, in the Australian context, practice standards have recently been collaboratively developed for 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 programme where mental health professionals receive training to enable them to engage in FFP (Solantaus & Toikka, 2006). Alternatively, some countries (i.e. Republic of Ireland) have relatively less developed family focused policies in this particular context (Grant & Reupert, 2016).

United Kingdom (UK) 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' which 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 concluded there was a need for improved multi-agency working and policy reform to ensure the needs of an individual and their wider family are met. *Think Parent, Think Child, Think Family,* subsequently developed by the Social Care Institute for Excellence (SCIE, 2009), set out clear guidelines for local authorities to respond to the needs of families when parents have mental illness. (For further information please see Main Report, p.33).

Policy and Practice Developments in Northern Ireland (NI): In NI, during the 2000s, there were a number of small scale initiatives aimed at addressing 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). More recently, The *Champions Initiative* in the Northern HSC Trust area was established in 2009 as a result of the recommendations within the O'Neill Inquiry report (Western Health Social Services Board and Eastern Health Social Services Board, 2008). This initiative identified a Champion in each of the child protection and adult mental health teams to facilitate the interface between the services. Both initiatives were evaluated positively (Davidson et al., 2012; Griffiths et al., 2007).

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. From 2009, in line with international and wider UK developments in FFP and in response to previously noted inquiry reports, [1] *Think Family* has become a priority for the HSCB in shaping the strategic direction of FFP. The overarching aim for Think Family NI, as set out in the HSCB's position paper is "…on improving collaborative working and enhancing understanding of multi-disciplinary roles and responsibilities of all stakeholders working across the Mental

[1] (i.e. 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)

Health and Children's services interface" (HSCB, 2014, p.1). Overall, it was hoped that regional and local initiatives would help to improve the extent to which assessment, planning, treatment and communication in adult mental health and children's services are family focused, thereby promoting greater access to early intervention and family support services (Donaghy, 2014). For information regarding specific initiatives see p.37 - 39 in Main Report.

The Need for Regional Investigation of HSC Professionals' FFP in Adult Mental Health and Children's Services: There is a dearth of international research about system change initiatives integrating mental health and children's services to meet the needs of families and children where a parent has a mental illness (Falkov et al., 2016). There is also an absence of studies comparing FFP across mental health and children's services and limited evaluation of Think Family NI initiatives, with the exception of Davidson et al., (2012). Findings from this study and others 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 *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 were absent (See Main Report, p.35 for further information). Organisational and policy development is often context specific and therefore should be responsive to local needs, workforce and professional training frameworks (Cusack & Killoury, 2012). Moreover, acquiring a good understanding of professionals' perspectives is a crucial element in capacity building for better FFP (Grant et al., 2016). Another fundamental requirement for improving FFP is ensuring that service user and families' voices are also heard and incorporated into education and training as well as service design and delivery (Nicholson et al., 2014). In response to the above, the HSCB commissioned the first independent baseline investigation of HSC professionals' FFP. The remaining sections of this report present an overview of this 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.

Part Two: Logic Model

While the HSCB is to be commended for its commitment to developing a range of initiatives to improve outcomes for parents, their children and families, 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 (See Figure 2.1). 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.

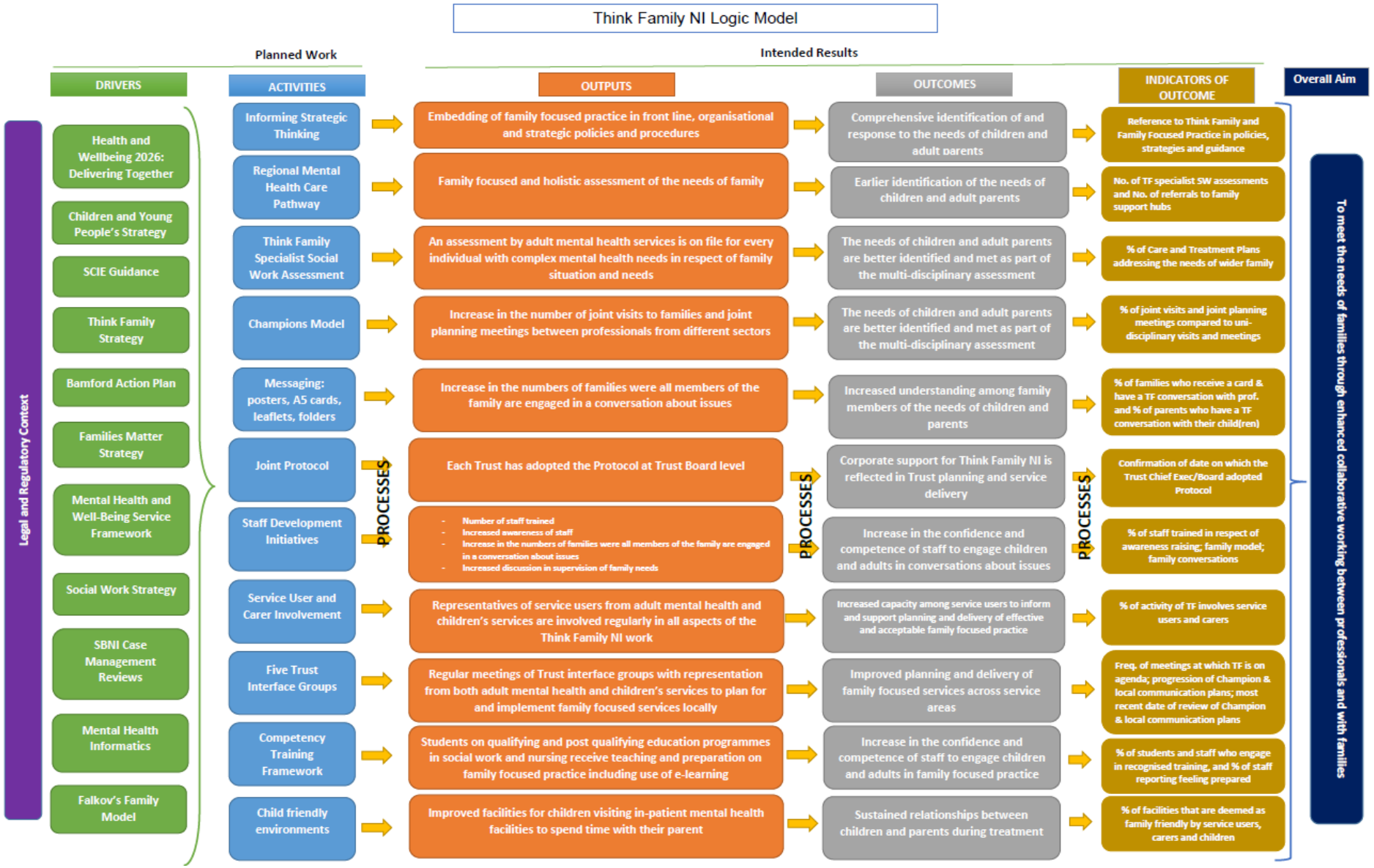
A number of key learning points have arisen from the development of the logic model. During the past eight years Think Family NI has had two distinct external influences. During the initial phase the HSCB was heavily influenced by the Social Care Institute for Excellence's (SCIE) *Think Child, Think Parent, Think Family* work. 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. The domains are illustrated on an A5 checklist card introduced by the HSCB and 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.

It is further recommended that the HSCB 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. (For further information on logic model and key initiatives please see Main Report p.37 - 39).

Figure 2.1 Logic Model



Part Three: Methodology

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.

Research Design:
The study adopted 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, therefore, helps explain and elaborate upon the quantitative results (Creswell & Clark, 2007).

Ethical Considerations:
Ethical approval was granted by ORECNI and Research Governance permission obtained from the five HSC Trusts. Approval from the aforementioned bodies was granted between February 2016 and September 2016.

Quantitative Methodology

Survey Measure:
The survey used in 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. A low score on the FFMHPQ subscales (i.e. less than 5) suggests a reduced family focus and a high score (i.e. 5 – 7) increased family focus. Table 3.1 in Main Report (p.46) shows the subscales along with definitions and an example item from each.

Validity of FFMHPQ:
The FFMHPQ has excellent content and construct validity and good internal subscale reliability (Maybery et al., 2012). As the FFMHPQ was devised for use in the Australian context, it required minor adaption and testing for validity in the NI context (see Technical Report and Appendices for further detail). 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 key stakeholders. To test the validity of the FFMHPQ, outside the Australian context, it was evaluated carefully by a panel of experts and subsequently piloted in the Northern Trust with ten HSC professionals (5 from children's and 5 from adult services) not included in the study. The main changes made to the FFMHPQ involved further refinement to its structure and language.

Participants:
The survey was distributed to approx. 3585 HSC professionals within adult mental health and children's services across the five HSC Trusts (Adult Mental Health, Addictions services, Gateway, Family Interventions Teams (FIT) or 16+ Teams).

However, it was not possible to obtain the precise number of HSC professionals who met inclusion criteria in these service areas from the HSCB. As can be seen from Table 3.1, full survey completion varied between 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. 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).

Table 3.1
Fully Completed Surveys by Trusts

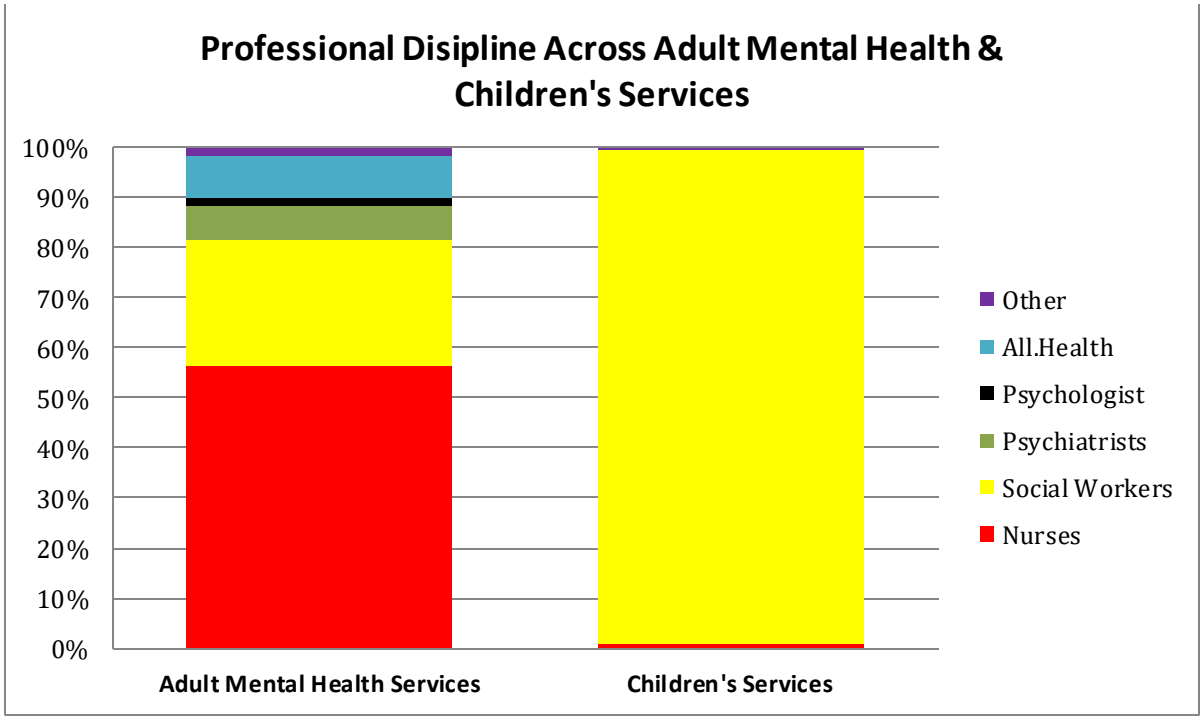
Trust	Number of Completed Surveys n
Belfast	227
South Eastern	163
Western	167
Southern	160
Northern	151
Total	868

The final sample comprised of 868 HSC professionals, a response rate of 24.2%, with *n* = 493 practicing in adult mental health and *n* = 316 practicing in children's services (Missing information regarding service area = 59). Additional information regarding the procedure to access HSC professionals and their sample characteristics is reported in the Technical Report and Appendices.

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 Work (*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%). Table 3.2 provides an overview.

Table 3.2:
Professional Disciplines across Adult Mental Health and Children's Services

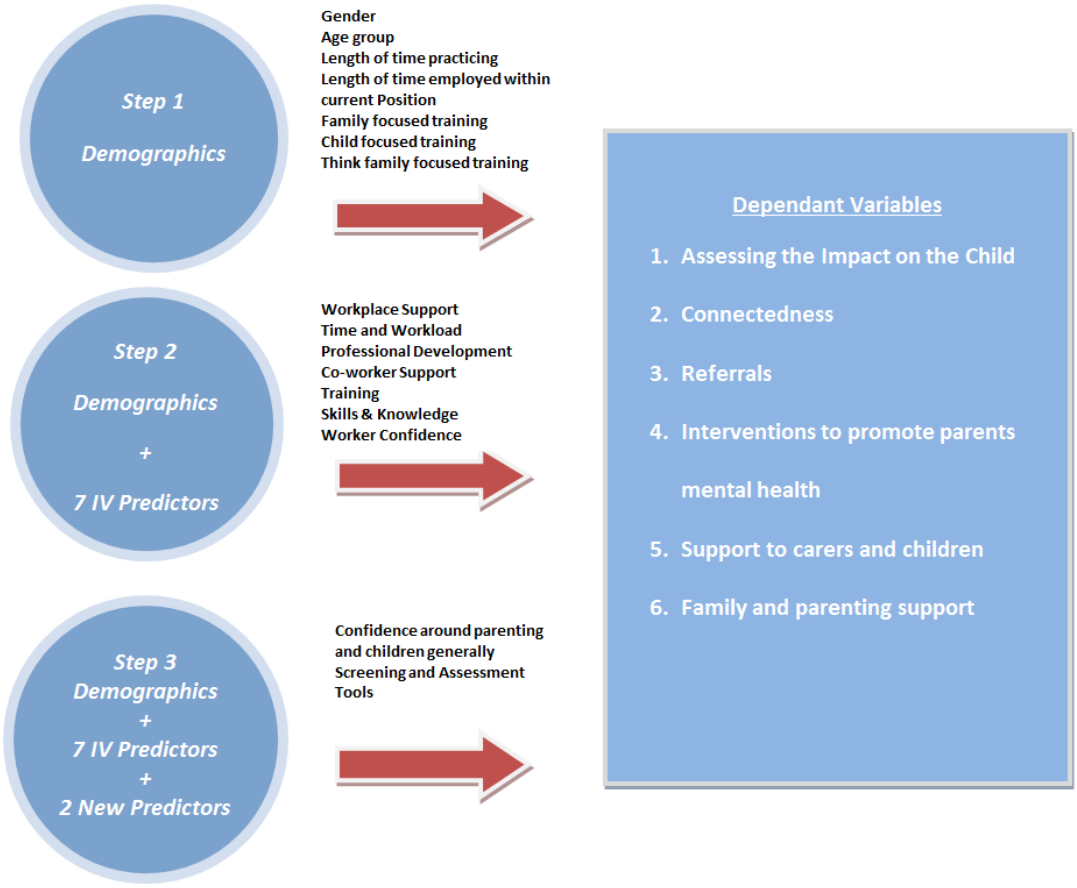


Quantitative Data Analysis:

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.

Hierarchical multiple regression was used to assess how well seven subscales, within the FFMHPQ, 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). The variables were entered in three blocks, the order based on previous literature. This order is illustrated in Figure 3.1.

Figure 3.1:
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 HSC Trusts were undertaken to explore: *The nature and scope of HSC professionals' FFP with parents, who have mental illness, their children and families, enablers and barriers to FFP and future potential developments in FFP*. See further details of Topic Guide in Technical Report (Appendices F, G & H). Recruitment for the sample was via self-selection. Interviews predominantly took place on Trust premises or at QUB. 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 by their key worker. 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 and aimed to explore 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. See further details of the Topic Guide in Technical Report and Appendices, (Appendix F, G & H). 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 provided with the opportunity to make any additional comments to elaborate on points they had made. All service users participating in an interview received vouchers to acknowledge their time and any expenses or inconvenience caused by their involvement in the research.

Service User Involvement in Research Design:
From the outset, it was important that this research approached service user involvement in a spirit of collaboration. Central to this was the need to avoid engagement that was tokenistic (Esmail, Moore & Rein, 2015). Any service users therefore being approached about being directly involved in the research team had to feel that this type of involvement would be real and genuine in line with established good practice in this area (McLaughlin, 2009; Duffy, 2008). The research approach adopted by the team was best described as collaborative (McLaughlin, 2009). Service users were approached and involved as service user representatives in an important advisory capacity working with the research team in key aspects of research design such as the wording of questions for interviews with service users. In the latter, a member of the research team worked closely with two people from a service user background where the focus was on how the interview would be experienced and felt by those service user respondents participating in these.

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).

Quantitative (Survey) Findings

HSC Professionals' Exposure to Parents who have Mental illness and their Children and Extent of Family Focused Practice (FFP) [2]

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.

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%). 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.

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. Over half of HSC professionals (*n* = 514, 59.2%) recorded higher scores on only two or less of the FFP behavioural subscales. 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.

[2] For the purpose of the baseline study findings, when we refer to PMI we are also including parents with substance use problems.

Are there differences in those who are family focused compared to others?

Those spending a percentage of time in the home environment had higher mean scores on five subscales, including; *assessing the impact on the child*, *connectedness, referrals, interventions to promote parents' mental health* and *support to careers and children;* suggesting that they are more family focused than those HSC professionals who do not routinely 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. Greater significant differences were noted in relation to *skills and knowledge* of Champions, compared to the remainder of the sample. Additionally, significant differences are noted in relation to *professional development, connectedness, referrals, worker confidence* and *support to carers and children*. (See Main Report, p.63, for further detail).

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 in Main Report (p.66) provides an overview of individual disciplines mean scores on the 14 FFP subscales.

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 services scored higher on *assessing the impact on the child*, *connectedness* and *referrals*.

Are there differences between Social Workers and other professionals?

Differences between Social Workers and all other professionals were found in relation to; *assessing the impact on the child, connectedness, referrals, family and parenting support, time and workload, co-worker support, training, skills and 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.

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. 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 a mental illness and, or their children on a daily or weekly basis.

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 s*kills and knowledge*. Findings reflect some of the core aims of the Think Family NI initiatives which aim to improve knowledge and understanding of professionals relating to PMI and, or substance use problems, including referrals for specific support needs for families.

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%).

Predicting HSC Professionals' FFP:

Skills and Knowledge was noted as the single most important predictor. Such findings support the critical nature of skills and knowledge relating to PMI and its impact on children as particularly important for HSC professionals' FFP. Results also indicate that having less time and higher workloads has the potential to negatively impact on capacity for 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.

Table 4.1:
Summary of Significant FFP Predicators

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

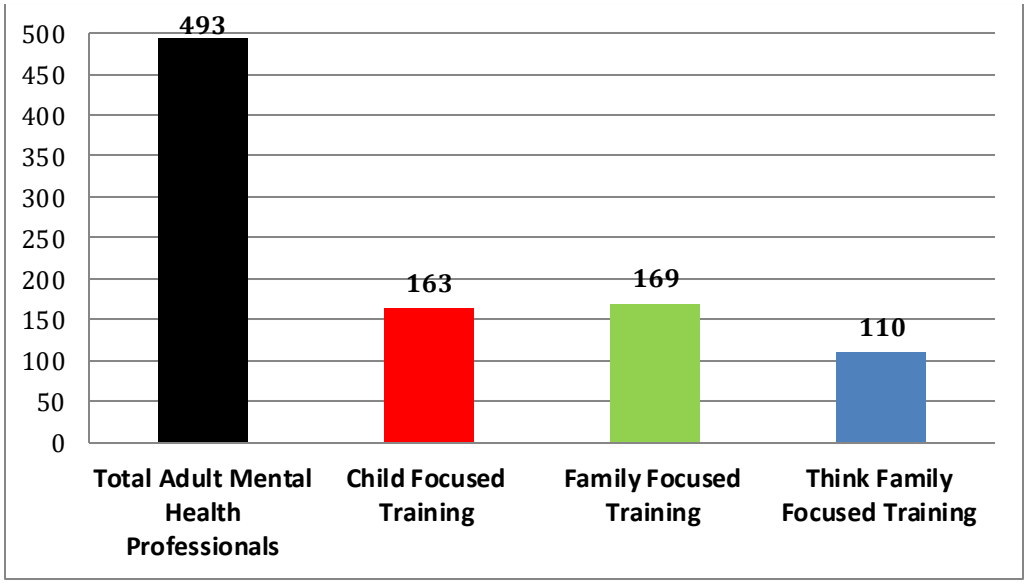
Are the predictors of FFP different in adult mental health and children's services?

For both adult mental health and children's service professionals, skills and knowledge relating to the impact of PMI on children remained the most significant predictor of all six FFP behaviours. For those working in adult mental health services, *co-worker support* and *worker confidence* are important for working with families, particularly children. For children service professionals, *professional development opportunities* to work with family's and *co-worker support* was noted as important for *referrals* and *family and parenting support*.

HSC Professionals' Education and Training in Family Focused Practice:

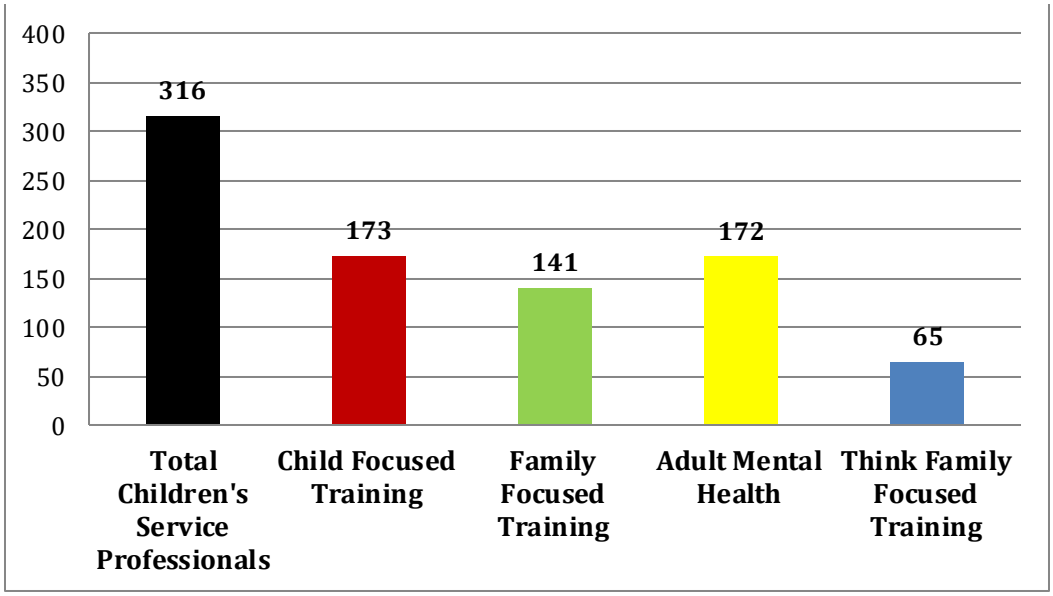
Those who reported that they had received Think Family training were primarily Think Family Champions. In relation to adult mental health professionals' education and training, a minority of professionals from across each of the respective disciplines received some sort of family focused (34.3%, *n* = 169), child focused (33.3%, *n* = 163) and Think Family focused training (22.3%, *n* = 110) (See Figure 4.1 below and Table 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 54.5% (*n* = 172) adult mental health training, but 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 or on a post qualifying course (See Figure 4.2 below and Table 4.2 in Technical Report and Appendices, [Appendix K] for further detail).

Figure 4.2:
Children Services Professionals Training Overview



Overall, a greater number of adult mental health professionals, than children's service professionals, had received Family Focused training (adult mental health, *n* = 169, Children's service, *n* = 141) and Think Family training (adult mental health, *n* = 110, children's service, *n* = 65). A greater number of children's service professionals had received Child Focused training (adult mental health, *n* = 163, children's service, *n* = 173) (see figures 4.3 and 4.4 for overview of training by professional discipline). Such findings are perhaps reflective of the client focus of each respective service but have implications for professionals' capacity in either service to support both parents and their children and other adult family members as a whole.

Figure 4.3:
Percentage of HSC professionals who have received Family Focused Training

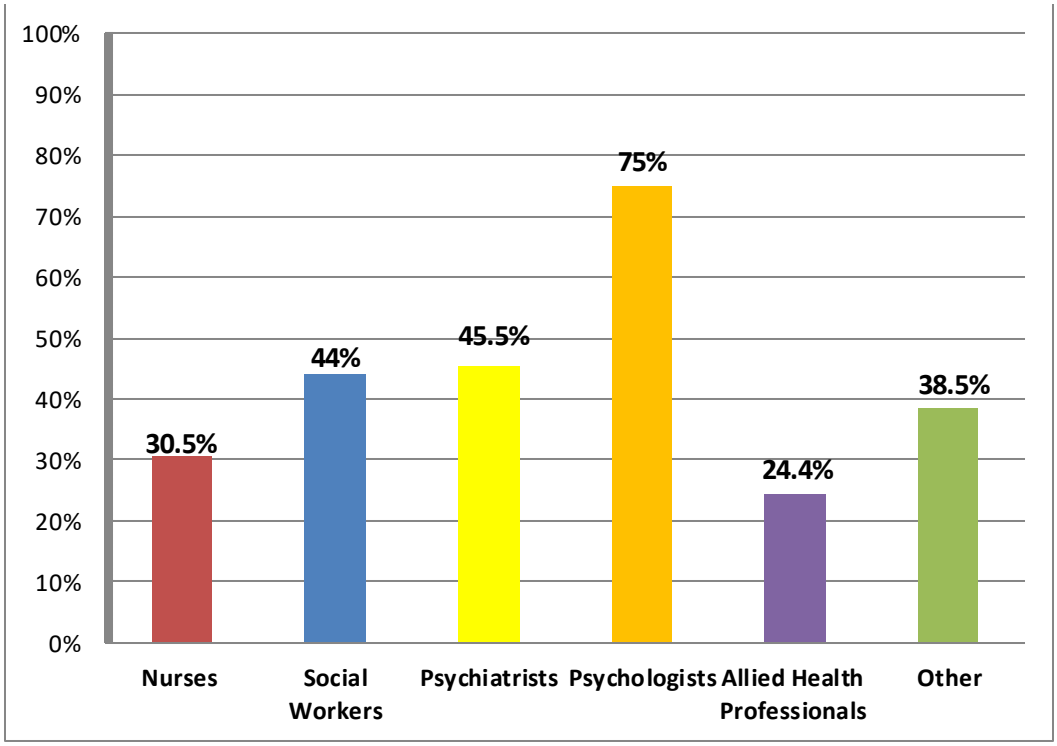
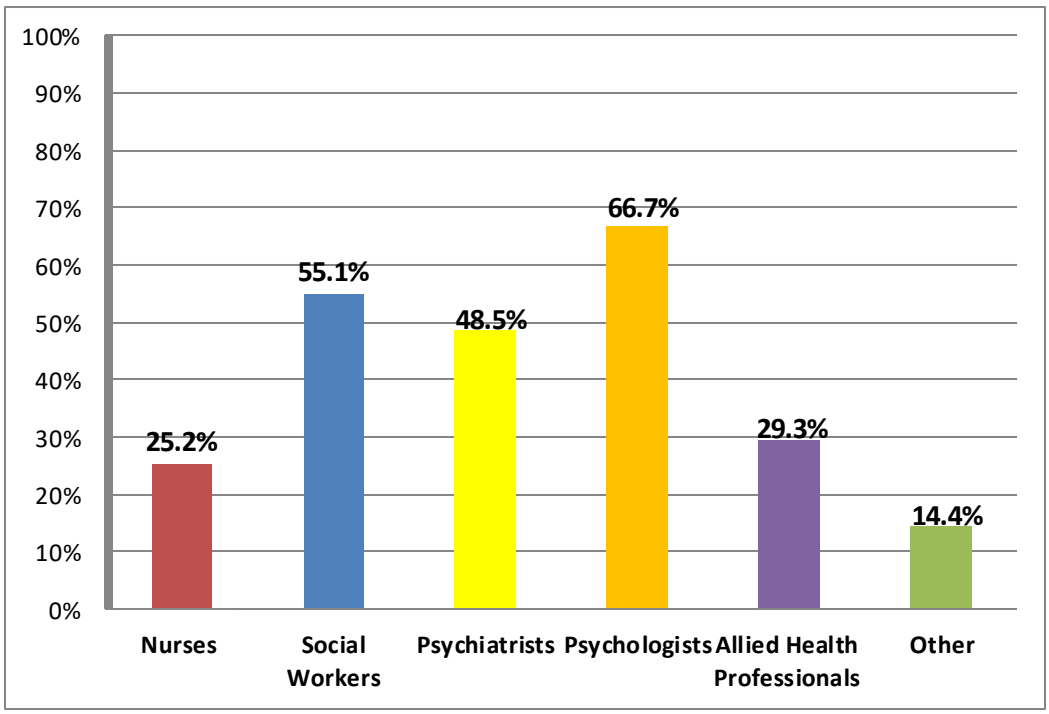


Figure 4.4:
Percentage of HSC professionals who have received Child Focused Training

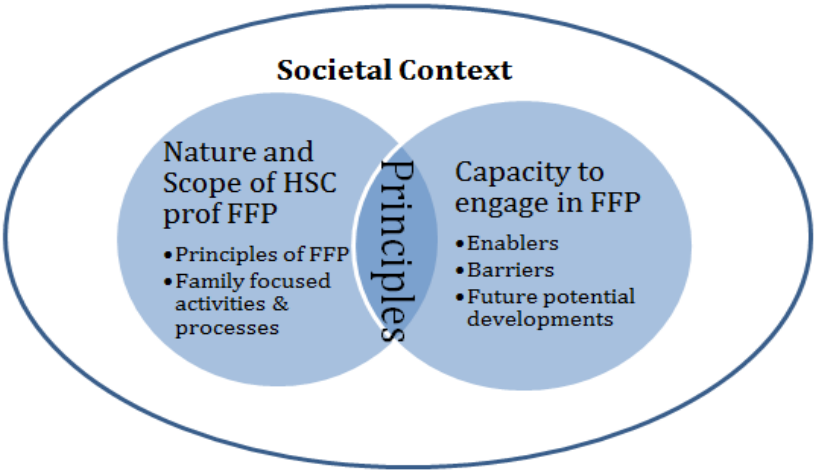


Qualitative Findings - HSC Professionals

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

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 section.

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

Principles (Why professionals need to do what they do):

HSC professionals recounted a variety of principles that motivated and shaped their 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 health 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 use problems. The following professional highlights these issues.

> ***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).***

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, 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 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 communication.

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.
(4) Collaborating with others.

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. The following quote illustrates this point.

> ***…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 (Trust C, SW, Children's).***

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 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 when parent's difficulties with mental illness or parenting 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

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, as the following respondent highlights.

> ***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? (Trust E, Nurse, AMH).***

Additionally, some professionals and particularly social workers used specific interactional approaches or 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

Some professionals also gave examples of how they addressed the key Think Family NI improvement aims such as early intervention and family support. For instance, 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 professionals also described how they encouraged parents to explain their illness to their children. The following quote highlights these issues.

> ***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 (Trust A, SW, Children's).***

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, as the following respondent remarks.

> ***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 (Trust D, SW, AMH).***

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 perceived they engaged 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 professionals' 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:

Enablers related to HSC 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. For instance, 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 friends' children. For example, a number of professionals suggested that being a parent enabled them to empathise with parents and develop insight into their needs which helped with family assessments.

Furthermore, professional attitudes to FFP and the need for holistic care were also highlighted as an important enabler as well as professionals' confidence to engage in FFP. This reflects Think Family NI initiatives that aimed to promote professional development in these areas. Some professionals also indicated that being aware of

the impact of PMI on the whole family was crucial to being family focused as the following quote highlights.

> ***…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).***

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 sharing the same workplace as is highlighted by the following professional.

> ***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 (Trust D, SW, Children's).***

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 as it helped professionals to observe parents' and children's normal daily lives. 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 and specifically Think Family training. Some professionals also indicated that colleagues in other specialist positions or roles, including, Think Family Support Workers (previously Think Family Practitioner), 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, as is evident from the following quote.

> ***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 se 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).***

Enablers related to families

A few professionals also identified some enablers related to parents. For example, parents' receptivity to AMH professionals collaborating with their colleagues in children's services enabled FFP***. "When parents are happy for you to liaise with***

children's services and work with you it does work well" (P2, Trust A, SW, AMH).

Wider systemic enablers

Systemic enablers, such as existence of community supports to refer families to families and policy development, were also noted as important for FFP. In relation to policy development, particularly those around child protection, P7 ***"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"*** **(P7**,***Trust B, SW, AMH).***

Barriers related to Professionals' Capacity to Engage in FFP:

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 related to HSC professionals, the organisation as a whole, emulating from parents, children and, or adult family members and wider systemic barriers.

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 and family issues can be quite challenging given the individualised focus on the parent. Additionally, Children's services HSC professionals also expressed the view that 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***. "I suppose where we probably lack sometimes in knowledge is a real knowledge of what our parents are experiencing and how the mental illness impacts on them. We probably don't have that" (P3, Trust A, SW, Children's).***

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 professionals' 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 services as highlighted by the following professional,

> ***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).***

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. ***"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).***

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 professionals' 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

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 on capacity to engage in preventative work and being able to provide the right type of support to families.

> ***…. 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).***

Wider systemic barriers

Finally, professionals discussed some of the wider systemic barriers such as lack of collaboration with, and resource 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 recurrent funding. ***"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).***

Future Potential Developments:

FFP training

Professionals described a number of areas where they felt that capacity for FFP could be promoted or improved upon, 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 and that specific training programmes should include information regarding;

- The importance of FFP and how to integrate Think Family NI initiatives
- Understanding the impact of mental illness on parents
- Practical skills to engage in FFP and specifically to have structured conversations with parents around parenting with mental illness.

The following respondent highlights the challenges involved.

> ***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" (Trust D, SW, AMH).***

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

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 need to develop educational resources to explain PMI to children, raises queries as to whether existing educational resources are adequate or are accessible to all HSC professionals for distribution. The following quote highlights these points.

> ***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).

Organisational and systemic structures

Professionals commented on future organisational and systemic changes needed 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. The following respondent makes this particular point.

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).

Relatedly, others noted the importance of further developing existing roles, such as the Think Family Support Worker, Champions Model and 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.

Qualitative Findings – Service Users

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 (*n* = 21) described the complex and multifaceted nature of experiencing mental illness and, or substance use problems, 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 and, or substance use problems). Service users' perceived that in response, HSC professionals undertook a variety of activities that were underpinned by a number of principles.

Principles (Why professionals should engage in FFP):

Similar to professionals, service users are aware of the interrelationship between mental illness and, or substance use problems, 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. The following quote emphasises service users' views that knowledge and understanding of PMI among the whole family is an important enabler for coping with these issues.

> ***… 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 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. In this context, children and families can also be supported via the parent. Reflective of professionals' views, service users discussed the importance of the parent-professional relationship as they believed that without this 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 the service users was the most difficult part of the interview for service users. 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 are presented here.

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 were listened to as the following quote highlights.

> ***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).***

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.

> ***… 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).***

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's 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.

> ***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).

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 included updating respective services on the families' circumstances and reducing the burden on families to repeat their story and engage separately with children's services. Service users also remarked 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 For instance;

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).

Service Users and Professionals' Capacity to Engage in FFP:

Enablers Related to HSC professionals and their Colleagues

Service users suggested that professionals' life and work experience enabled 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 enable 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.

… 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).

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 as is evidenced from the following respondent.

> ***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).***

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 cooperation of the service user and their family, including children, the 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. ***"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).***

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.

> ***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 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 (SU 3, Trust E, CMHT & F&CC).***

Barriers related to Service Users' and Professionals' Capacity to Engage in FFP:

Barriers generated by professionals and their colleagues

Service users reported a number of barriers generated by professionals and their colleagues, some of which included, lack of empathy and little understanding (particularly from childcare professionals) regarding PMI. This is reflective of the findings from the previous section relating to future recommendations for development of FFP 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.

They are making judgements on something that they know nothing about" (SU 5, Trust E, Addictions & CMHT). Similarly, another service user remarks, ***"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).***

Organisational barriers

Service users 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 service users' minds most likely reflects the disjointed approach by some services with regards to PMI as is seen from the following quote,

> ***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).***

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.

> ***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).***

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.

> ***...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).***

Future Potential Developments:

Service users also suggested how they and their families could be further supported by HSC professionals. Overall, service users perceived that they required more knowledge and understanding of their own mental illness and, or substance use problems, to enable them to work in partnership with professionals and to better cope with PMI. Service users also indicated that it is equally important that HSC professionals help their children to understand (in an age appropriate way) PMI and how to live with this in order to protect them against intergenerational transmission of mental illness.

Service users also 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 with 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 as is evident from the following quote.

> ***...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).***

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[3]), 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 collaboration and a holistic approach towards service delivery, the findings do suggest that this strategy is not effective on its own 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

[3] 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.

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.

References

Beardslee, W. R., Solantaus, T. S., Morgan, B. S., Gladstone, T. R., & Kowalenko, N. M. (2012). Preventive interventions for children of parents with depression: *International Perspectives. Medical Journal of Australia Open, 1*(Suppl 1), 23-25. doi: 10.5694/mjao11.11289

Bellin, M. H., Osteen, P., Heffernan, C., Levy, J. M., & Snyder-Vogel, M. E. (2011). Parent and health care professional perspectives on family-centered care for children with special health care needs: are we on the same page? *Health & Social Work*, *36*(4), 281-290.

Berg, N. (2009). *Non-response bias. Encyclopedia of social measurement* 2: 865–873. Kempf-Leonard, K., ed. London: Academic Press

Bunting, B.P., Ferry, F.R., Murphy, S.D., O'Neill, S.M., & Bolton, D. (2013). Trauma associated with civil conflict and posttraumatic stress disorder: evidence from the Northern Ireland study of health and stress. *Journal of Traumatic Stress*, *26(1),* 134-141.

Campbell, P. (2001). The role of users of psychiatric services in service development—influence not power. *The Psychiatrist, 25(3), 87-88.*

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.

Coyne, I., Murphy, M., Costello, T., O'Neill, C., & Donnellan, C. (2013). A survey of nurses' practices and perceptions of family-centered care in Ireland. *Journal of family nursing*, *19*(4), 469-488.

Cusack, E., & Killoury, F. (2012). *A vision for psychiatric/mental health nursing: A shared journey for mental health care in Ireland*. Office of the Nursing & Midwifery Services Director.

Davidson, G., Bunting, L., & Webb, M.A. (2012). *Families experiencing multiple adversities: A review of the international literature*. Barnardo's Northern Ireland

Donaghy, M (2014). *Think Family Northern Ireland*. Barnardos Childlinks, Issue 2, pp.19-25.

Donaghy, M. (2016). Chapter 22 Think Family, Northern Ireland in Diggins, M. (2016). *Improving practice and working together across health and social care parental mental health and child welfare work.* Learning from success: The Pavilion Annuals.

Duffy, J. (2008). Looking out from the middle: User involvement in health and social care in Northern Ireland. London. Social Care Institute for Excellence (SCIE). Available at https://www.scie.org.uk/almost-there

Esmail, L., Moore, E., & Rein, A. (2015). Evaluating patient and stakeholder engagement in research: moving from theory to practice. Journal of comparative effectiveness research, 4(2), 133-145.

Falkov, A. (1998). *Crossing bridges: training resources for working with mentally ill parents and their children, Reader-for managers, practioners and trainers*. Department of Health.

Falkov, A. (2012). *The Family Model Handbook: An integrated approach to supporting mentally ill parents and their children*. Hove, East Sussex: Pavilion.

Falkov, A., Goodyear, M., Hosman, C. M., Biebel, K., Skogøy, B. E., Kowalenko, N., ... & Re, E. (2016). A systems approach to enhance global efforts to implement family-focused mental health interventions. *Child & Youth Services*, *37*(2), 175-193.

Foster, K., O'brien, L., & Korhonen, T. (2012). Developing resilient children and families when parents have mental illness: A family-focused approach. *International Journal of Mental Health Nursing*, *21*(1), 3-11.

Foster, K., Maybery, D., Reupert, A, Gladstone, B., Grant, A.,Ruud, T., Falkov, A & Kowalenko, N (2016). Family-focused practice in mental health care: an integrative review. Child and Youth Services. Volume 37, 2.doi:10.1080/0145935x.2016.110408

Foster, M. J., Whitehead, L., Maybee, P., & Cullens, V. (2013). The parents', hospitalized child's, and health care providers' perceptions and experiences of family centered care within a pediatric critical care setting: a metasynthesis of qualitative research. *Journal of Family Nursing, 19*(4), *431-468*. doi: 10.1177/1074840713496317

Goodyear, M., Hill, T. L., Allchin, B., McCormick, F., Hine, R., Cuff, R., & O'hanlon, B. (2015). Standards of practice for the adult mental health workforce: Meeting the needs of families where a parent has a mental illness. *International Journal of Mental Health Nursing*, 24(2), 169-180.

Goodyear, M., Maybery, D., Reupert, A., Allchin, R., Fraser, C., Fernbacher, S., & Cuff, R. (2017). Thinking families: A study of the characteristics of the workforce that delivers family-focussed practice. *International journal of mental health nursing*, 26(3), 238-248.

Grant, A & Reupert, A. (2016). The Impact of organizational factors and government policy on psychiatric nurses' family-focused practice with parents who have mental Illness, their dependent children, and families in Ireland. *Journal of Family Nursing*, 22: 199-223. doi:10.1177/1074840716643770

Grant, A., (2014). *Registered psychiatric nurses' practice with parents who have mental illness, their children and families, within general adult mental health services in Ireland*. PhD thesis, Monash University, Melbourne.

Grant, A., Goodyear, M., Maybery, D., & Reupert, A. (2016). Differences between Irish and Australian psychiatric nurses' family-focused practice in adult mental health services. *Archives of Psychiatric Nursing*, *30*(2), 132-137.

Griffiths, H., Boland, V., Gilliland, D., McKernan, B., & Shields, L. (2007). An Evaluation of the Child and Parent Support Service within the Magherafelt and Cookstown Area. *Child Care in Practice*, *13*(2), 125-135.

Grove, C., & Reupert, A. (2017). Moving the field forward: Developing online interventions for children of parents with a mental illness. *Children and Youth Services Review*, 82: 354-358. http://dx.doi.org/10.1016/j.childyouth.2017.10.003

Grove, C., Reupert, A., & Maybery, D.J. (2016). The perspectives of young people of parents with a mental illness regarding preferred interventions and supports, *Journal of Child and Family Studies*, 1 – 10. http://dx.doi.org/10.1007/s10826-016-0468-8

Grove, C., Riebschleger, J., Bosch, A., Cavanaugh, D., & van der Ende, P. (2017). Expert views of children's knowledge needs regarding parental mental illness, *Children and Youth Services Review*, 79: 249-255. Accessed online at http;//dx.doi.org/10.1016/j.childyouth.2017

Halle, T. (2013). *Applying implementation science in early childhood programs and systems.* A. Metz, & I. Martinez-Beck (Eds.). Baltimore: Paul H. Brookes Publishing Company.

Hansson, U., O'Shaughnessy, R., & Monteith, M. (2013). *Maternal mental health and poverty: The impact on children's educational outcomes*. Northern Ireland: University of Ulster.

Health and Personal Social Services (Northern Ireland) Order 1972. … *Commencement*

Hidden Harm: Responding to the needs of children of problem drug users. ACMD, 2003. http://www.drugs.gov.uk/publication-search/acmd/hidden-harm?view=Binary

Houlihan, D., Sharek, D., & Higgins, A. (2013). Supporting children whose parent has a mental health problem: an assessment of the education, knowledge, confidence and practices of registered psychiatric nurses in Ireland. *Journal of Psychiatric and Mental Health Nursing, 20*(4), 287-295.

Hyland, M., Hoey, W., Finn, M., & Whitecross, F. (2008). *Reducing 28-Day Readmissions – Project Report. National Mental Health Benchmarking Project*. A joint Australian, State and Territory Government Initiative. Retrieved from https://www.amhocn.org/sites/default/files/publication_files/28day_readmit_final_report_14112008.pdf

IBM Corp. Released 2016. *IBM SPSS Statistics for Windows, Version 24.0.* Armonk, NY: IBM Corp.

Lauritzen, C., Reedtz, C., Van Doesum, K. T., & Martinussen, M. (2014). Implementing new routines in adult mental health care to identify and support children of mentally ill parents. *BMC Health Services Research*, *14*(1), 58.

Liangas, G., & Falkov, A. (2014). Use of structured clinical documentation to identify patients' parental concerns and their childrens' wellbeing. *Community Mental Health Journal*, *50*(6), 646-655.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry* (Vol. 75). Beverly Hills, CA: Sage.

Marston, N., Stavnes, K., Van Loon, L. M., Drost, L. M., Maybery, D., Mosek, A., ... & Reupert, A. (2016). A content analysis of Intervention Key Elements and Assessments (IKEA): What's in the black box in the interventions directed to families where a parent has a mental illness? *Child & Youth Services*, *37*(2), 112-128.

Maybery, D, Goodyear, M, Reupert, A, Grant, A (2016). Worker, workplace or families: What influences family focused practices in adult mental health? *Journal of Psychiatric and Mental Health Nursing*, 23, 163–171.

Maybery, D. J., Reupert, A. E., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of parental mental illness in Australian families. *The Psychiatrist*, *33*(1), 22-26.

Maybery, D., Goodyear, M., & Reupert, A. (2012). The family-focused mental health practice questionnaire. *Archives of Psychiatric Nursing, 26*(2), 135-144. doi: 10.1016/j.apnu.2011.09.001

Maybery, D., Goodyear, M., O'Hanlon, B., Cuff, R., & Reupert, A. (2014). Profession differences in family focused practice in the adult mental health system. *Family process*, *53*(4), 608-617.

Mayberry, D., Reupert, A., Nicholson, J., Göpfert, M., & Seeman, M. V. (2015). Are we there yet? Developing a conceptual framework for understanding families where a parent has a mental illness. *Parental Psychiatric Disorder: Distressed Parents and Their Families*, 365-370.

McGavin, C. (2013). Colleen's story: Reflections on the concept of "patient and family centered care". *Journal of Family Nursing, 19*(4), 418-430. doi:10.1177/1074840713496114

McLaughlin, H. (2009). Keeping service user involvement in research honest. *British Journal of Social Work*, *40*(5), 1591-1608.

McNeil, S. (2013). Understanding family-centered care in the mental health system: perspectives from family members caring for relatives with mental health issues. *Social Work in Mental Health*, *11*(1), 55-74.

Mennen, F. E., Pohle, C., Monro, W. L., Duan, L., Finello, K. M., Ambrose, S., ... & Arroyo, W. (2015). The effect of maternal depression on young children's progress in treatment. *Journal of Child and Family Studies, 24(7), 2088-2098.*

Mental Health Foundation, (2016). *Fundamental facts about mental health*. Available at: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage.

Moore, T. G., McDonald, M., Sanjeevan, S., & Price, A. . (2012). *Sustained home visiting for vulnerable families and children: A literature review of effective processes and strategies*. Parkville, Victoria: Murdoch Childrens Research Institute and The Royal Children's Hospital Centre for Community Child Health. Retrieved from http://www.rch.org.au/uploadedFiles/Main/Content/ccch/resources_and_publications/Home_visiting_lit_review_RAH_processes_final.pdf.

Nicholson, J., Reupert, A., Grant, A., Lee, R., Mayberry, D., Mordoch, E., ... Stavnes, K. (2015). The policy context and change for families living with parental mental illness. In A. Reupert, D. Maybery, J. Nicholson, M. Gopfert, & M. V. Seeman (Eds.), *Parental Psychiatric Disorder: Distressed Parents and their Families.* 3rd ed., 354-364. London: Cambridge University Press.

Nicholson, J., Wolf, T., Wilder, C., & Biebel, K. (2014). *Creating options for family recovery: A provider's guide to promoting parental mental health.* Systems and Psychosocial Advances Research Center Publications and Presentations. 702. http://escholarship.umassmed.edu/psych_cmhsr/702

Nilsson, S., Gustafsson, L., & Nolbris, M. J. (2014). Young adults' childhood experiences of support when living with a parent with a mental illness. *Journal of Child Health Care. doi: 10.1177/1367493513519296*

NVivo Qualitative Data Analysis Software, (2017). QSR International Pty Ltd. Version 11.

Parker, G., Beresford, B., Clarke, S., Gridley, K., Pitman, R., Spiers, G., & Light, K. (2008). *Technical report for SCIE research review on the prevalence and incidence of parental mental health problems and the detection, screening and reporting of parental mental health problems*. (Report No. 2247).

Percy, A., Thornton, M., & McCrystal, P. (2008). The extent and nature of family alcohol and drug use: findings from the belfast youth development study. *Child Abuse Review*, *17*(6), 371-386.

Pitschel-Walz, G., Bäuml, J., Bender, W., Engel, R. R., Wagner, M., & Kissling, W. (2006). Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. *The Journal of Clinical Psychiatry*, *67*(3):443-52.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London, UK: Sage.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*(1), 24-34.

Reupert, A., & Maybery, D. (2016). What do we know about families where a parent has a mental illness: A systematic review. *Child & Youth Services*, 37(2), 98–111.

Reupert, A., Drost, L.M., Marston, N., Stavnes, K., Loon, L., Charles, G, Mosel, A., & Solantus, T. (2016). Developing a shared research agenda for working with families where a parent has a mental illness, Child and Youth Services, 37:2, 194-209. doi:10.1080/0145935X.2016.1104105

Reupert, A., Maybery, D., & Morgan, B. (2015). The family-focused practice of primary care clinicians: a case of missed opportunities. *Journal of Mental Health*, 24(6), 357-362.

Reupert, A., Williamson, C., & Maybery, D. (2017). How family orientated are primary care physicians? *Journal of Child and Family Studies, 26(1), 329-335.*

Silverman, D. 2010. *Doing qualitative research*, 3rd, London: Sage

Siegenthaler, E., Munder, T., & Egger, M. (2012). Effect of preventive interventions in mentally ill parents on the mental health of the offspring: systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(1), 8-17.

Social Exclusion Unit Taskforce (2008). Reaching out: think family, London, Cabinet Office.

Social Policy Research Unit, University of York. Social Care Institute for Excellence. (2009). *Think child, think parent, think family: A guide to parental mental health and child welfare.* London: Social Care Institute for Excellence (SCIE).

Solantaus, T., & Toikka, S. (2006). The effective family programme: Preventative services for the children of mentally ill parents in Finland. *International Journal of Mental Health Promotion*, *8*(3), 37-44.

Tchernegovski, P., Maybery, D. J., & Reupert, A. E. (2017). Legislative policy to support children of parents with a mental illness: revolution or evolution? *International Journal of Mental Health Promotion, 19(1), 1-13.* Doi:10.1080/14623730.2016.1270847

Toikka, S., & Solantaus, T. (2006). The effective family programme II: Clinicians' experiences of training in promotive and preventative child mental health methods. *International Journal of Mental Health Promotion, 8(4), 4-10.*

Toner, H., McMahon, M., Harper, S., Devlin, M., Harris, C., & Hogan, T. (2008). Independent review report of agency involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their children.

Van Doesum, K. T., & Hosman, C. M. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: II. Interventions. *Australian e-Journal for the Advancement of Mental Health*, *8*(3), 264-276.

Western Health and Social Services Board & Eastern Health and Social Services Board, (2008). Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards, Madeleine and Lauren O'Neill, [O'Neill Inquiry]. Available at https://www.rcpsych.ac.uk/pdf/Independent%20Inquiry%20Report.pdf