Family Focused Practice in Mental Health Care: An Integrative Review

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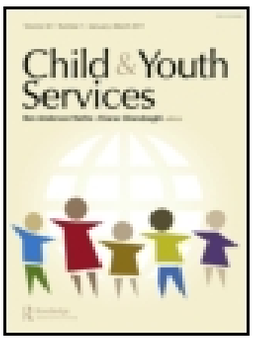

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Family-focused practice in mental health care: an integrative review

Highlights

- In mental health services, family-focused practice is poorly defined concept
- An integrative review was conducted to synthesize evidence in this area
- Six core and inter-related family-focused practices were identified
- Family as defined by its members provides a basis for ‘whole of family’ care

ABSTRACT

While mental health services are increasingly encouraged to engage in family-focused practice, it is a nebulous and poorly understood term. The aim of this paper was to examine and synthesize evidence on the concept and scope of family-focused practice in adult and child and youth mental health care settings. An integrative literature review method was used. Medline, Embase, CINAHL, PsycInfo and Proquest electronic databases were systematically searched for abstracts published in English between 1994-2014. Data were extracted and constant comparative analysis conducted with 40 included articles. Family-focused practice was conceptualised variously depending on who was included in the 'family', whether the focus was family of origin or family of procreation, and the context of practice. As a finding of the review, six core and inter-related family-focused practices were identified: family care planning and goal-setting; liaison between families and services; instrumental, emotional and social support; assessment; psychoeducation; and a coordinated system of care between families and services. While family is a troubled concept, 'family' as defined by its members forms a basis for practice that is oriented to providing a 'whole of family' approach to care. In order to strengthen family members' wellbeing and improve their individual and collective outcomes, key principles and practices of family-focused practice are recommended for clinicians and policy makers across mental health settings.

Keywords: Integrative review; family-focused practice; child and adolescent; adult; mental health services

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INTRODUCTION

Mental illness impacts on more than the individual. Family members, including children, are all affected by a family member's mental illness. Increasingly, governments and service providers across countries are investing in a family-centred, collaborative model of practice (Nicholson et al., 2015). Family-focused practice (FFP) broadens the unit of care provision in mental health services from a narrow focus on the mental health consumer, to the wider family and caregiving system (Foster, O'Brien & Korhonen, 2012). However, there is little consistency in how FFP is defined, and in particular, a lack of integrated knowledge on FFP in mental health services. The lack of conceptual clarity in FFP is also reflected in the terminology employed, where FFP is used interchangeably with 'family-oriented', 'family-sensitive' and 'family-centred'. It is important to note that FFP does not refer to 'family involvement'. Family involvement refers to how adult family members, generally parents, are engaged with organisations in managing an identified issue or concern for a child. Most commonly this is in regard to family involvement in children's learning in schools, although Modlin (2004) highlighted family involvement can include interventions such as parent support groups in children's residential programs.

In this review, FFP refers to how mental health clinicians (e.g. nurses, psychologists, social workers, doctors or occupational therapists) and mental health services respond to other family members when an adult or child has the identified mental health problem. In summary, there is a clear need to examine the concept of FFP across different mental health service contexts (adult and child inpatient or community), in order to provide a framework for clinical

practices between mental health service providers, mental health consumers and their families, and for the purposes of mental health policy and service evaluation.

The term family-focused practice (FFP) originated in the field of paediatrics in the 1950s, where parents campaigned to be included in the planning of their children's medical care (Jolley & Shields, 2009). Accordingly, much of the work in FFP has been conducted in areas such as disability and chronic illness, where the client or consumer is the child (Hoagwood, 2005). In these healthcare fields, core FFP principles are related to placing the consumer and family at the centre of care decisions, respecting the cultural and linguistic traditions of the family, acknowledging that consumers and their families are experts on their own needs, and keeping the relationship between the professional team, consumer and family collaborative, respectful, open and honest (Dunst, Trivette & Hornby, 2007; Mikkelsen & Frederiksen, 2011). MacKean et al. (2012) reviewed similar concepts in child and adolescent mental health services but not adult settings. Using the term family-centred care (FCC), they found improved child and family management skill, increased stability of living situations and improved child and family health and wellbeing as a result of FCC. However, the same depth of research has not been conducted in relation to FFP across mental health services.

A paradigm shift from a traditional, individual model of mental health care toward FFP has slowly gained traction in mental health services over the past decade, as can be ascertained in policies across the US, Australia, Canada, Ireland, the UK and Norway (Nicholson et al., 2015). This has been promoted, at least in part, by repeated research which highlights the benefits of FFP for consumers and their family. In a meta-analysis of 25 studies, Pitschel-Walz, Leucht, Bauml, Kissling and Engel (2001) found that the relapse rate was reduced by 20 percent when

relatives of consumers with schizophrenia were involved in their treatment and care, compared to standard medication treatment. Similarly, Glynn, Cohen, Dixon and Niv (2006) found that FFP was effective in reducing exacerbations in schizophrenia, improving mediation compliance and reducing or eliminating substance abuse. FFP also delivers benefits to the family, with a reduction in subjective burden of care and increased levels of self-care and emotional role functioning (Glynn et al., 2006).

Nevertheless, how FFP within mental health services is conceptualised and subsequently practised is less clear. There are many components of FFP in mental health services documented in the literature but how these relate to each other and promote a consistent set of practice guidelines is currently not available. For example, the Centre for Addiction and Mental Health (2004, p. 3) include "treating clients and their families with dignity and respect" and "openly communicating with clients and families" while the Family Mental Health Alliance (2006) focuses on meeting families' needs, which includes providing education about mental illness and available community services and supports. While noting the proliferation of policies related to family focused practice in child services, Hoagwood (2005) argues that "there are remarkably few studies that have examined experimentally specific modalities of family-based services" (p. 690). In adult services, and in reference to parents with mental health concerns and their children, there have been repeated studies that have highlighted the lack of definitional clarity and theoretical integration in respect to family inclusive practices (Maybery et al. 2014; Maybery, Goodyear & Reupert, 2012; Maybery & Reupert, 2006). While Dempsey and Keen (2008, p. 43) note that family centred care has had an important influence on mental health service philosophy

and orientation, the "family-centred field can best be described as being in an adolescent phase of development" in terms of providing a coherent service and practice delivery model.

The main feature of FFP in mental health services that is commonly presented involves psychoeducation, where information is provided to the family about the consumer's diagnosis, causes, treatment and progress (Lucksted, McFarlane, Downing, Dixon & Adams, 2012). Psychoeducation may also provide an opportunity for family members to manage their stress levels and learn specific skills in helping their relative (Hoagwood, 2005). Others describe FFP in terms of a family member, typically the parent, working as a 'co-therapist' with the professional team, in making treatment and programming decisions for their relative (MacFarlane, 2011). Further elements of FFP include viewing families as a source of information about their relative to supplement assessment and inform treatment options, and acknowledging and responding to the family's caring role and/or how they cope. More recently, discussions of FFP have acknowledged the parenting role and responsibilities for many consumers and highlighted the needs of consumers' children (Reupert, Maybery & Kowalenko, 2012).

Notwithstanding the benefits involved in FFP, there are a number of barriers associated with its uptake. Maybery and Reupert (2006) found that the mental health clinical workforce lack the skills and knowledge to engage effectively and work collaboratively with family members, with clinicians still believing that a consumer's mental health difficulties originated with family members. Another significant barrier is clarity around how FFP might be conceptualised, practised and evaluated (Foster et al., 2012).

While families are important for those with mental health problems (Reupert et al., 2012), there are very few theoretical or practice frameworks that show how families might be included across different mental health treatment settings. Although there are many ways that 'family' can be defined, we align ourselves to Osher and Osher's (2002) concept of family, where a family, and who is included in a family, is defined by its members. This definition acknowledges diverse family relationships that may not necessarily resemble a traditional nuclear family. Specifically for this review, we examine families of *origin*, the family a person is born into and where the family includes the parents of a mental health consumer (child or adult), as well as families of *procreation or choice*, where the family are the children/partner of the consumer, while also noting the inclusion of other family members (such as grandparents, caregivers, and so on).

How FFP might be conceptualised and subsequently practised may relate to the settings from which it is delivered (for example, child or adult mental health services) and similarly, whether the mental health consumer is a child or an adult. For example, how parents/caregivers are engaged and involved by clinicians in the treatment of their child may differ from how parents work with services for their adult offspring. The needs of these different family types may vary and this has potential implications for FFP and how it is operationalised. While the underlying principle of FFP in terms of working *with* and *for* families, rather than *to* families, appears to be consistent across child and adult contexts (Hoagwood, 2005; McFarlane, 2011), there is a notable lack of family-focused practice models driven by conceptual frameworks that may be reliably employed in both settings. Greater clarity on the concept of FFP and its practice in mental health settings will inform future measurement, audit and evaluation of FFP, provide

guidance on the scope of FFP, and inform professional development in the effective practice and provision of FFP.

AIM

The aim of this paper is to examine and synthesize evidence on the concept and scope of FFP in adult and child and youth mental health services in order to advance understanding and implementation of family-focused practice. The research questions framing this review are:

1. How is family-focused practice conceptualised and defined from a mental health perspective in adult as well as child and youth mental health service provision?
2. What are the family-focused practices in adult and child and youth mental health service provision?

METHOD

An integrative review method was employed. This approach uses systematic processes for literature searching and selection, and for data extraction and analysis. An integrative review method allows for inclusion of theoretical and empirical literature and is used for a range of review purposes including concept definition (Whittemore & Knafl, 2005).

Data Sources

Medline, Embase, CINAHL, PsycInfo, and Proquest databases were searched for abstracts (see Table 1).

Insert Table 1 about here.

Inclusion and exclusion criteria

To gain an understanding of the development of FFP over time, peer-reviewed literature published between 1994 and 2014, including empirical, theoretical, and/or discussion papers

focusing on professional practices for children or adults with mental illness in child and youth, or adult mental health settings, were included. Literature reviews, book chapters, and grey literature were excluded. Papers that examined family therapy alone, or family-focused practice for other health conditions, or in other settings, e.g. schools, were excluded.

Screening

Titles and abstracts of 2123 records were reviewed independently by the first three authors against the inclusion/exclusion criteria. Full texts of retained articles were then read and screened, and consensus discussion resulted in 40 articles included for review (Figure 1).

Insert Figure 1

Analysis

Consistent with the integrative review method (Whittemore & Knafl, 2005), data were initially extracted from the 40 articles into a matrix according to the review questions. Constant comparative analysis was used to categorise and group coded extracts, which were iteratively compared and contrasted within and across articles. Key concepts relevant to each question were collated and emergent patterns and themes identified (Patton, 2002). Key concepts and practices related to family-focused practice were also counted to gain an understanding of the contextual use and emphasis of content in the articles (Hseih & Shannon, 2005). In the final process, data were synthesised into an integrated thematic summary of findings.

FINDINGS

The review included 40 articles; *20 empirical research papers, *22 discussion/opinion papers and four theoretical papers (*see Table 2; some papers provided both a discussion of FFP and empirical data). Findings are presented according to the two review questions.

Insert Table 2

Concepts of family-focused practice in adult and child and youth mental healthcare

Twenty-one of the 40 papers described family-focused practice within adult orientated mental health services (hereafter referred to as Adult MH); 19 referred to child or youth orientated mental health services (hereafter referred to as Child MH). The majority of Adult MH publications referred to family of *procreation or choice*, where a parent had mental illness (n = 16); the remainder primarily focused on family of *origin*. In contrast, all but one of the Child MH papers adopted a family of *origin* perspective. Two adult orientated papers included both family of origin and family of procreation (Mottaghipour & Bickerton, 2005; Schmidt & Monaghan, 2012); one youth orientated service included both family types (Miklowitz, Biuckians & Richards, 2006). However, while some Child MH papers mentioned parental mental illnesses (e.g., Miklowitz et al., 2006), the primary focus was on the child at risk of, or diagnosed with, a mental illness or behavioural disorder. The majority of Adult MH papers were from Australia (n = 8/21), USA (n = 4/21) and Finland (n = 3/21) with one paper coming from a non-western country (Samoa; Enoka et al., 2013). The majority of Child MH literature originated in the USA (n= 14/19).

Terms used to describe FFP

There was a plethora of ways to describe FFP, often used interchangeably. While not always clear, some referred to *programs* (n=7; for example, the family-focused case management program [FFCM; Aubry et al., 2000]), *approaches* (n=2; for example, a family-focused approach; Foster et al., 2012), as an *intervention* framework for working with clients and their

families (n=6, see for example, Beardslee's intervention for families where a parent has depression), as a *service* (n=5, e.g. Gross & Goldin, 2008) or as a *model* for how services might work with families (n=9, for example, Mottaghipour & Bickerton's 2005, pyramid of family care). Some terms were used synonymously with FFP; family centred (10/40), family sensitive (4/40), family orientated (n=3) and family inclusive (n=2). These terms recognised the family's pivotal caring role and a concomitant requirement that family be included in services. Nevertheless, there was a lack of clear consensus about the terms and how they were used to describe and define FFP in Adult and Child MH (see Table 2).

Family defined

Integral to the concept of FFP is how 'family' is defined. While a range of definitions of 'family' appeared in the Adult MH literature, there were significant differences in how this was interpreted; this also differed depending on whether the paper assumed a family of *procreation/choice* or *origin* perspective. For example, family of *origin* included definitions of the family restricted to consumers' adult family members (individuals 18 years or older) and who were acknowledged as the primary carers (Aubry et al., 2000; Dausch et al., 2012; Enoka et al., 2013; Mullen, Murray & Happell, 2002). Typically other members were excluded from the FFP focus including dependent children though there was an exception; from a Samoan perspective, Enoka et al., (2013), included siblings, partners and extended family members in their description of family.

Conversely, when the focus was on the family of *procreation* within adult MH services, children were included in discussions of FFP (e.g. Cowling & Garrett, 2009; Devlin & O'Brien,

1999; Foster et al., 2012; Heitmann, Schmuhl, Reinisch & Bauer, 2012; Hinden, Biebel, Nicholson & Mehnert, 2005; Houlihan, Sharek & Higgins, 2013; Jessop & de Bondt, 2012; Korhonen, Vehviläinen-Julkunen & Pietilä, 2008; Maddocks, Johnson, Wright & Stickley, 2010; Maybery, Goodyear, O'Hanlon, Cuff & Reupert, 2014). Some authors who incorporated both family of *origin* and family of *procreation* included children and other family members (Mottaghipour & Bickerton, 2005; Schmidt & Monaghan, 2012). Overall, those with a family of *procreation* perspective referred to varying family configurations and considered the needs of all family members, including children, partners and spouses, grandparents, and significant others. This was irrespective of whether family members were caring for or were being cared by the consumer.

In the Child MH literature the 'family' was described as a 'system', or an 'ecology of the family' (Lee et al., 2009; Malysiak, 1997). 'Family' also referred to individual members (Lepage, 2005), including siblings (e.g. Furniss et al., 2013; Gross & Goldin, 2008; Young & Fristad, 2007), or siblings and parents (Kilmer, Cook & Palamaro Munsell, 2010). 'Family' also incorporated 'non-professionals' as part of an extended, non-hierarchical collaborative (plus-family) team partnership model that 'wraps around' the child identified as needing services (e.g. Handron, Dosser, McCammon & Powell, 1998). This support was considered informal and provided by significant others identified as important to the family and who acted as unpaid caregivers (e.g. friends, neighbours, coaches) (Kilmer et al., 2010). Allen and Petr (1998) argued that family included whomever the family designates as being in the family.

Family-focused Practice conceptualisations

The concept of FFP in Child MH literature links definitions of 'family' to the mental health care context (e.g. the home or community) and the practice intentions of that environment or anticipated mode of service delivery. For example, Child MH publications from the USA described children considered at risk of 'out-of-home placement'. 'Home' was significant in conceptualizing FFP because 'home based' and 'family-focused' treatment programs described the least restrictive care setting as optimal; FFP occurred in the community (or home) because it was closest to the family's natural supports (e.g. Woolston, 2007). The intention was to avoid an ever-increasing continuum of restrictive (and more costly) environments in which children might be hospitalized or placed in residential care (e.g. Bartlett, Herrick & Greninger, 2006; Lee et al., 2009; Woolston, 2007), and services were directed toward 'preserving' or keeping the family together (Mosier et al., 2001). A day hospital treatment setting for 'psychiatrically ill' infants, toddlers and pre-school children that provided a continuum of flexible care including community and in-patient settings was held to combine the best of both care contexts (Furniss et al., 2013).

An emphasis on family support in the family of *origin* literature was predicated on the goal of reducing primary caregivers' negative impact on consumers' wellbeing, and promoting their capacity to help consumer recovery (Aubry et al., 2000; Dausch et al., 2012). While family involvement was recognised to reduce family members' distress, the ultimate aim of family inclusion was to help the consumer (Mottaghipour & Bickerton, 2005; Schmidt & Monaghan, 2012).

There were a number of principles that underpinned the range of terms used to conceptualize FFP and the notion of 'family', which are shaped by, and shape, their translation in

practice (Table 2). For instance, the Adult MH papers highlighted the importance of familial and community-based care that is individualised, holistic, flexible, transparent, responsive, preventative (e.g., Maybery et al., 2012) and culturally sensitive (Enoka et al., 2013). Thirteen papers explicitly referred to a strengths-based approach that fosters family self-esteem and efficacy as well as resilience (e.g. Foster et al., 2012; Hinden et al., 2005). A number (n = 6) emphasised engaging families in the recovery process (e.g. Mullen et al., 2002), and promoting family resilience through collaborative partnerships (Mottaghipour & Bickerton, 2005). From a family of *procreation* perspective, some authors proposed that children could be indirectly supported through enhancing parents' resilience and capacity to cope (Korhonen et al., 2010a); although most argued that children's needs should be directly addressed by Adult MH services (Cowling & Garrett, 2009; Heitmann et al., 2012; Hinden et al., 2005; Maddocks et al. 2010; Nicholson, 2007).

Family-focused practices in adult and child and youth mental healthcare

In addition to a conceptualisation of FFP, the papers were examined for clinicians' family-focused practices. As a result of analysis, six core and inter-related mental health practices with consumers and their family, across child and adult services, were identified:

1. Family care planning and goal setting;
2. Liaison between families and services including family advocacy;
3. Instrumental, emotional and social support;
4. Assessment of family members and family functioning;
5. Psychoeducation;

6. A coordinated system of care (e.g. wraparound, family collaboration, partnership) between family members and services. See Table 3 for further detail.

Insert Table 3 about here

It is important to recognise that many of these practices are not mutually exclusive. For instance, there was overlap between liaising with other services, advocating for families and providing a coordinated system of care as might be required in a wraparound service for families. Also indicating an overlap amongst practices, Maddocks et al. (2010) defined support in terms of "being present during clients' visits to their children, advocating for clients and providing reassurance" (p. 677). Nonetheless, discrete actions can be identified as distinct dimensions of FFP. The most commonly reported practices were providing instrumental, emotional or social support to the family (21/40) and delivering a coordinated system of care (22/40). The remaining four practices were reported almost equally (between 15 and 17 times). Two practices were more commonly reported in Child MH papers; undertake care planning and goal setting with families (ten times compared to four) and provide a coordinated system of care between and within family members and services (13 times compared to 9). There was little/no different amongst other practices between the two settings.

Family care planning and goal-setting

The practice of care planning and goal setting with families commonly aimed to mobilise a family's resources, including support networks (15/40 papers). While this involved planning for future possible crises, it was more commonly employed to identify what is important for the family in the short and long term. Goals for the family were collaboratively established between clinicians and family members and grounded within a strengths-based approach. The plans were

a means of managing relationships outside of the family including other family members as well as services, thereby meeting the consumer's treatment goals but also the needs of family members. Nicholson (2007) described the importance of setting basic goals for parents with a mental illness, such as creating a safe environment for their children and getting their children to school with the ultimate long term goal of skills building and recovery. Acknowledging the importance of being able to respond to 24 hour family crises, Hinden et al. (2005) also noted the need to collaboratively establish long term targeted outcomes with families that might, for instance, include improved housing, increased employment and decreased hospitalization.

Liaison between family and services

Another commonly reported FFP practice was liaising between the family and other services or informal networks (n=17/40). This also occurred within the one agency; Cowling and Garrett (2009) described how one clinician worked with a parent with a mental illness while another clinician from the same agency worked with the child. Lepage (2005) presented a collaborative approach amongst the clinicians within the one service as well as with other services. Foster et al. (2012) urged clinicians to encourage children and parents to engage with others in their community and liaise with other services as required for the families they worked with, for example, housing organisations. Lee et al. (2009) argued that effective treatment must include "coordination and collaboration among the diverse organizations providing services to the child and the family" (p. 397). Extending this practice, Aubry et al. (2000) suggested that liaison between services involved advocating for appropriate and timely services. Similarly, Devlin and O'Brien (1999) argued that clinicians needed to advocate for parents with a mental illness when dealing with child protective services. Gopalan and colleagues (2014) described the

employment of parent advocates who themselves had previously navigated through the Child MH system and "who could work with families in a different way" (p. 90).

Instrumental, emotional & social support

Instrumental support included referring a family member to appropriate services and organising practical support for example, transport or child-care (Reupert & Maybery, 2014). Emotional support involved providing empathy and compassion e.g., Bartlett et al. (2006) asserted that clinicians need to "provide emotional support to family members so that they can nurture each other, survive periods of crisis and flourish" (p. 597). Aubry et al. (2000) indicated that 25 percent of the clinician's time was spent providing support which involved "assisting with family relationships, especially those involving the member with severe mental illness, discussing and mediating family difficulties, and helping families to cope with stress" (2000, p. 71). Social support involved broadening a family and consumer's social networks (for example, Foster et al., 2012). Several papers described embedding support within service or treatment (e.g. Gopalan, et al., 2014; Lee et al., 2009; Sin, Moone & Newell, 2007). Sometimes support aimed to empower the consumer or family, for example, the clinician supported parents to solve their own problems, rather than rely on professionals (Lee et al., 2009).

Assessment of family members and family functioning

The assessment of family members centred on 'initial' and/or 'ongoing' assessment practices. The first involved identifying the presence of family (e.g. asking a consumer whether he or she had children at intake, see Foster et al., 2012) as well as assessing the needs of each family member (e.g., Korhonen et al., 2008). Assessment in this instance involved identifying individual and family strengths and/or deficits and the impact the mental illness on family

members, especially children (Cowling & Garrett, 2009). Maybery et al. (2014) suggested that that all clinicians who have contact with parents with mental health challenges should have the skills to assess the impact of the illness on children. Other papers referred more generally to assessment practices for example, Dausch et al. (2012) suggested that FFP involved the following assessment domains; the consumer's diagnosis, the family and consumer's motivation for services, level of functioning/distress, goals and needs, role of the illness, subjective burden and the presence of practical issues.

Papers also included 'ongoing' assessment for determining families' changing needs over time, rather than a static, 'one off' often crisis-driven assessment (see for example Reupert & Maybery, 2014). Mottaghipour and Bickerton (2005) discussed this in terms of a "reassessment of needs" (p. 6). In Child MH, such an approach was consistent with a developmental approach with children. This also acknowledged that parents need to be involved in assessing the child's problems over time (Bartlett et al., 2006).

Psychoeducation for family

Psychoeducation was a commonly mentioned family-focused practice (17/40) and involved a clinician who "teaches the family about [consumer] adolescent [disorder], encourages the [consumer] adolescent to chart his or her mood, provides information about risk and protective factors, such as how psychosocial factors can affect the course of the illness" (Young & Fristad, 2007, p.158). Mullen et al. (as cited in Lepage, 2005, p. 89) note that "families of psychotic youth have a clear desire for information on what is happening... and for clinical guidance on how to best care for the psychotic person." Psychoeducational approaches ranged from awareness raising and general information about the disorder, treatment options and

information on services, through to specific manualised approaches for families (such as Beardslee's 2007 psychoeducation program for parents with depression and their children). Psychoeducation was found to delay relapse, improve family functioning, child wellbeing, communication, coping, and medication adherence, and assist family members to understand and cope with consumers' mental health problems (Beardslee et al., 2007; Miklowitz et al., 2006).

Coordinated system of care for family

Many papers (22/40) described a coordinated system of care, usually focused on a multidisciplinary team approach, which incorporated the family as a key entity within the team, who played a key role in assessment and intervention planning and delivery. Initiatives ranged from 'Wraparound' programs (Handron et al., 1998) to state-wide implementations of a coordinated system of care (Gopalan et al., 2014). These programs were commonly child-centred approaches with an emphasis on family members being active participants in the care of the child. Others described 'Wraparound' as the 'Wave of the Future' (Handron et al., 1998) based on a child-centred team approach that involves parents, the child, teacher, therapist, service co-ordinator, neighbours, friends, extended family doctor or nurse, and potentially social workers and others.

Family members were a key part of this coordinated team approach. This occurred in in adult MH services, "relatives are important to, connected with, and involved in the lives of persons with psychiatric illness, and family involvement is a vital aspect of recovery-oriented comprehensive care" (Dausch et al., 2012, p.7) and child MH services. For example, Lepage (2005, p. 92) argued that the treatment team consists of "the person with the mental illness, the family and clinicians". She continued by indicating that the family "provides the psychiatric

team with pertinent information regarding their loved one…[and assists] in assessment, treatment, recovery and relapse prevention" (p. 92).

DISCUSSION

This review sought to identify how family-focused practice (FFP) was conceptualised and practised in adult and child and youth mental health services. While FFP is reasonably developed in healthcare fields such as paediatrics, it has not been rigorously examined across adult and child and youth mental health services (Hoagwood, 2005; Maybery & Reupert, 2006; McFarlane, 2011). As such, the review comprises an essential first step in interrogating family-focused concepts and practices in mental health. Given the growing evidence base for child and adult family interventions across service settings and diagnostic groups (Glynn et al., 2006), as well as treatment recommendations (e.g. by the National Institute for Clinical Excellence in the UK 2009), it is timely to provide a conceptual analysis and description of pragmatic initiatives and practice in mental health settings, as a basis for greater rigor in policy development and practice.

The review found that FFP was conceptualised variously according who the 'family' consisted of, and more specifically whether the focus was family of *origin* or family of *procreation or choice*, and the context of practice. The problem with lack of conceptual clarity in FFP is that care for families is inconsistent, and family programs and interventions were not founded on comparable principles. 'Family' is a key dimension of the FFP concept and its definition is integral to its practice application. The historical review by Allen and Petr (1998), in particular, demonstrated the significance of defining ''the family' for conceptualizing FFP and that the concept of 'family' is historically, culturally and theoretically contingent.

A key finding from the review was that there are outdated assumptions which ignore temporal and cultural influences and changes in thinking about 'family'. These assumptions led to descriptions of the practice of family as being about a parent, sometimes a parent-child dyad, and often, the mother, who was assumed to be the primary caretaker. This finding needs to be considered in light of the family of *origin* and family of *procreation or choice* constructs, and raises several questions regarding models and practice contexts. If 'family' is viewed through only one lens, then the needs of only some family members are emphasised or addressed in practice. For services using a family of *origin* model (primarily child and youth services), for example, what could be learned from a family of *procreation or choice* model (primarily adult services) about envisioning the whole family differently in respect to FFP? This could, for instance, include viewing children as 'carers' as well as 'consumers' (Gladstone, McKeever, Seeman & Boydell, 2014). The question is whether we can, or should, construct a single concept or framework for FFP in clinical practice, policy and evaluation for both settings.

While family is a troubled concept in the literature, 'family' as defined by its members (Osher & Osher, 2002) forms a basis for practice that is oriented to providing a 'whole of family' approach to care, including adult family members, children, grandparents, extended family and other significant others, and in so doing helps to prevent transmission of mental illness between family members. The 'whole of family' focus can be understood as a means for FFP as a form of preventative intervention, in order to specifically address the impact of intergenerational impact mental illness from parents to children. Aligning ourselves to this concept could go some way to dealing with outdated and restrictive notions of the family. However it needs to be acknowledged that children and young people have differential access to the power and resources to define

themselves as family members in medical contexts (Gladstone et al., 2014). Further, this approach raises questions for FFP in terms of how we involve all members of the family and at the same time not subsume individual members, or individual roles within the family, so that members are disenfranchised as 'family' in significant ways.

The majority of Adult MH papers in the review were from Australia (8/21 papers) and the USA (4/21), while the majority of Child MH literature originated in the USA (14/19). This result raises contextual issues regarding mental health policy initiatives, funding priorities, and cultural conceptualisations and subsequent practices of FFP in mental health services. Nicholson et al. (2015) noted the absence of national policy setting or initiatives for children of parents with mental illness in the USA. In contrast, Australia has both national policies and initiatives (see www.copmi.net.au) that foster FFP in mental health settings for children living with parental mental illness. In comparison, the family-related policy initiatives in the USA have contributed to expanding FFP wraparound practices and evaluating systems of care to develop less restrictive forms of care and preserve families with the ultimate aim of reducing health and welfare costs (SAMHSA, 2004). Further, in cultural contexts where individualised health care and recovery is less robust, family participation in family members' recovery may occur more readily as FFP aligns more closely with cultural expectations (Enoka et al., 2013). The ways of thinking about and implementing FFP therefore, can be influenced by cultural considerations, funding priorities, policy settings and guidelines that promote best practice.

In terms of practice implications, the papers illustrated the relevance of FFP throughout the clinical process, from consumer access/identification and engagement, to assessment, support and management, and review. They also illustrate the relevance of service context and the work

environment in which FFP can occur, as well as the efforts required to tackle ongoing barriers to FFP. The six inter-relating family-focused core practices (Table 3) provide a starting point in defining what approaches and practices could be incorporated in services and delivered by clinicians in partnership with consumers and family members. FFP is everyone's responsibility, regardless of whether it is a child, youth or adult service (Foster et al., 2012). For child and youth mental health clinicians, the defining feature of FFP is the systematic incorporation of parent/carer mental health into a family-focused care plan. Conversely, for adult mental health clinicians, it is an acknowledgement of parenting and child and youth mental health. Importantly, FFP comprises clinicians' willingness, capacity and capability to see the relationship between the primary/referred person and their 'key others'.

CONCLUSIONS

As a way forward in developing a consistent and effective care for families in mental health, and strengthening family members' wellbeing and improving outcomes, the following key principles and practices synthesised from the literature in this review are recommended as a beginning point for further work in the field. They can be used as a foundation to inform the testing of a conceptual framework for FFP applicable across mental health services.

Principles of FFP

Four key principles can be understood to shape FFP including;

1) a belief that consumers' (child or adult) families play a pivotal role in their recovery;
2) that consumers and their families can be empowered to address and meet their needs;
3) that it is possible to support consumers via their family;
4) that the relationships between clinician and consumer, clinician and family, and between

consumer and family members, are key to enabling a 'whole of family' approach.

These principles highlight the crucial importance of clinicians using a process of partnership with consumers and families for better outcomes.

Practices of FFP

The six core and inter-related practices identified in this review (Table 3) form a useful foundation from which to develop further specificity regarding FFP. However, these findings are generated from a review of past practices in mental health and are not necessarily best practice. Accordingly, the practices identified here do not necessarily mean that other practices may not be relevant.

The findings of the review have several implications for mental health clinical practice, education, policy and research. Key stakeholders (such as clinicians and their employers and professional organisations) are recommended to take cognisance of the principles of FFP when working towards adopting a 'whole of family approach' within mental health services. Mental health services need to be informed by a holistic, family and recovery orientated philosophy. To foster and sustain this type of service delivery, it is essential that mental health services have the necessary resources in place, including workforce education programs, FFP policy, practice guidelines and financial resources. Clinical leadership is also central. This is important, particularly in acute mental health settings, where a biomedical and professional-centred approach typically prevails.

By synthesizing available research into FFP in child and adult settings in this review, we have been able to clarify and operationalise clinicians' practice and highlighted key areas for

professional development and service evaluation. Such a framework allows for further testing, research, refinement and advancement.

The review identified several gaps in knowledge regarding FFP that would benefit from further investigation. Research on 'age' as a variable in FFP needs further evidence: for example, day hospital treatment for infants, toddlers and preschoolers (Furniss et al., 2013); and 'early' onset diagnoses such as psychosis (Sin et al., 2007) and bipolar disorder (Miklowitz et al., 2006) where families may be encountering mental health clinicians and services for the first time, and when the consumer is a child, youth or transitioning adult. Other areas include family psychoeducational needs in relation to the differences between developmental- and illness-related behaviors; the need for integrated ways of measuring outcomes of FFP; and examining what it means to collaborate with families as decision makers. Qualitative approaches to take account of families' stories/perspectives that may be based on different assumptions about what is helpful and which may differ from that of professionals, would strengthen investigation. Further research is required to explore whether particular practice settings and professional disciplines should dictate the range of family-focused activities that occur, especially considering the continuum of family-focused practices that exist and the potential differences in the capacity of different healthcare disciplines to engage in FFP (see Maybery et al., 2014).

The findings of this review also highlight a need for further theory development in FFP, so that a shared understanding can be developed around what clinicians currently do, and should do, when working with families. Such a theory would render FFP tangible and enable clinicians to be consistent in their FFP approach. At the same time, in synthesising and unpacking the terms, principles and practices underlying FFP, this review has contributed to the development of FFP

theory for clinicians within adult and child and youth mental health services. However, a consolidation of theory development is still required, particularly around models of intervention and an accompanying efficacy base. Developing a robust theoretical construct of FFP has significant implications for effectiveness of professional practice, adoption of FFP by services, workforce education, and service evaluation.

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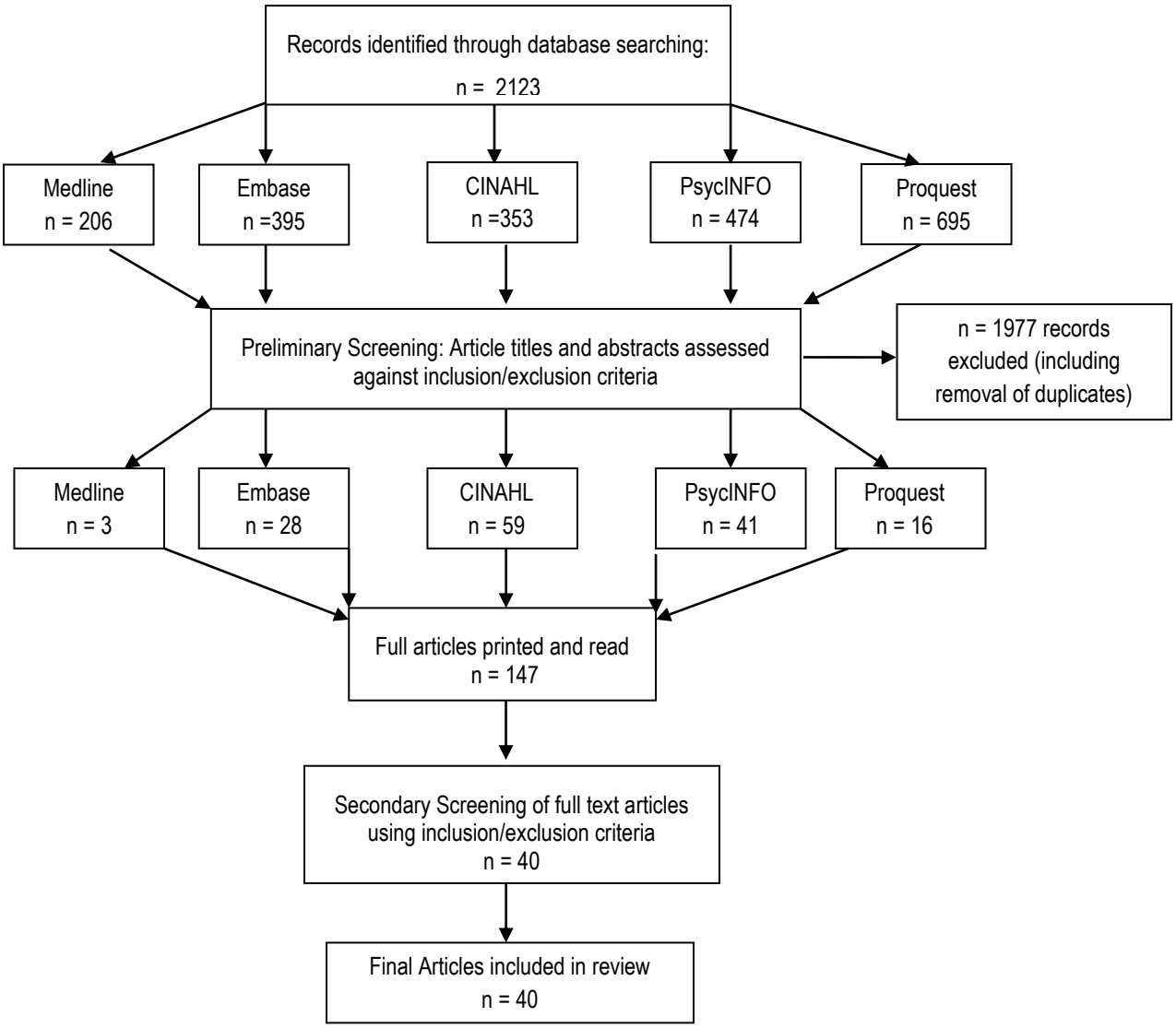

Figure 1: Search and Screening

Table 1: Search terms

Content Area	Subject Headings	Search Terms
1. **Construct**: Family Focused Practice	Family Focused Family Centred	"family focused" OR "family centred" OR "family centred" OR "family sensitive" OR "family oriented" OR "family guided" OR "family friendly" OR "family inclusive" OR "family driven"
AND		
2. **Context**: Professional practice	intervention practitioner professional workforce community mental health	care or practice* OR practitioner OR intervention OR therapy OR treatment OR workforce OR profession* OR "community mental

		health"
AND		
3. **Issue**: Mental illness	Mental health Mental disorders Mentally ill Child of impaired parents	"mental health" OR "mental disorder" OR “mental disorders” OR "mental illness" OR "child of impaired parents" OR "parental mental illness" OR “mentally ill”

Limit to English language and years 1994-2014.

Table 2: Included papers & family-focused practice conceptualisation

Author, Country & Type of paper	**Service orientation**	**Family type**	**FFP Description/Terminology**	**Principles of FFP**
Allen & Petr, (1998); USA Theoretical and historical review of FFP	Children	Family of origin: children with mental health issues and their families	Family –centred service delivery (FCSD): program	Extend current model of FCSD to include: family as unit of attention; informed family choice; family strengths perspective
Anderson et al. (2003); USA Preliminary evaluation of a 'systems of care' project.	Child/ youth: 5-17 years services	Family of origin: parents and their children with mental health issues	Systems of care as a different & non-traditional form of service provision : program	Family centred & culturally competent; involves funding streams of multiple payers [e.g. education, child welfare,

				mental health]; providers strive to support & strengthen natural supports for families
Aubry et al. (2001); Canada Discussion of program and preliminary evaluation using program logic model	Adult	Family of origin: Consumers and their parents	Family focused case management program	Partnership with service users and their families; program developed in collaboration with service users and their families. Autonomy of service user and their families – the family decides if family focused case management is

				relevant and required.
Bartlett et al. (2006); USA Discussion. Presents key principles of 'systems of care' & how model works	Child/youth	Family of origin: parents and their children with mental health issues	Systems of care model	Child & family centre of care Goal to make parent part of child's treatment team with equal status to professional provider; as experts on their own child. Parent partners with advanced practice registered nurse & 'others'. Nurse helps family find 'natural' supports

				including family & community resources Children are involved 'wherever possible' Holistic, culturally competent, child- and family-centred and community based care; Comprehensive wrap-around services; individualized care in least restrictive setting
Beardslee et al., (2007); USA	Child/youth (adolescent)	Family of procreation:	Family- centred preventive interventions	Family psychoeducation

Quantitative evaluation of two public health interventions for parental depression		consumers and their children	for parental depression	intervention goals to promote long term family functioning
Cowling & Garrett (2009); Australia Discussion. Program description.	Adult	Family of procreation: consumers and their dependent children	Child and family inclusive practice	Strengthen and build on parents and children's' capacity to manage and to make sense of their experience; Family centred and child inclusive practice is possible within community mental health services;

				Support provided via child and family inclusive practice program;
Dausch et al.,(2012); USA Family forums held with researchers, administrators and clinicians. Discussion of an intervention framework	Adult	Family of origin: Family defined as relatives, supportive family members of the consumer	Family involvement and services : intervention framework	Family involvement is important for recovery and holistic care Need to provide a variety of services and family choice Empowerment of service user and family to make choices Consumers and family should be given flexibility in service choices Collaboration

				with consumers and family important to identify and to address needs Consumer centred and strengths based
Devlin & O' Brien (1999); Australia Discussion of a mental health model for mental health nursing advocacy	Adult	Family of procreation: adult consumers and their dependent children	Model for mental health nursing advocacy	Advocacy & collaboration Prevention & health promotion Holistic model of service provision Family pivotal as the primary environment of the adult consumer
Enoka et al. (2013); Samoa	Adult	Family of origin:	Mental health care services: a family	Family as active partner in care

Discussion: developing a culturally appropriate mental health service in Samoa		including partner, siblings and extended family of adult consumer	focused model	provision Family focused community MH care Partnership model of mental healthcare Family focused model of mental health care
Foster et al., (2012), Australia Discussion of family focused approach for mental health nurses	Adult	Family of procreation: adult consumers and their dependent children	Family focused approach	Focus on families Identify family strengths and vulnerabilities Prevent problems in children Build individual and family resilience
Furniss et al., (2013); Germany	Child – infant, toddlers & pre-school	Family of origin: parents and	Program within psychiatry	Multidisciplinary, developmentally & family-

Discusses a psychiatric day treatment program for infants, toddlers and pre-schoolers and their parents	children & parents/siblings	their children with non-transient mental illness		oriented approach Refers to 'family psychiatry' as involving parents in treatment of psychiatrically ill children; presumes psychopathology of one family member affects mental health of others; thus family member included as important contextual factor for treatment of index patient; other caregivers can participate

				where required; pre-school siblings of index
Gopolan et al. (2014); USA Implementation study of program for children with oppositional defiant disorder or conduct disorder.	Child/youth 7-11 yrs.	Family of origin: parents and their children with behavior disorders	4 R's and 2Ss for the Strengthening Families Program treatment program;	Core treatment components based on empirically supported family-level influences on disruptive behavior disorders incorporating treatment strategies from behavioral parent training and family therapy evaluation reported; Working with entire families

				effective because all members part of the process Developed in collaboration with families of youth with disruptive behavior disorders and mental health providers
Gross & Goldin, (2008); UK Discusses principles in practice for working with children and	Child/youth	Family of origin: parents and their children with mental health tissues	Services embedded in an Inpatient Child & Adolescent Mental Health facility	Partnership with parents features include: mutual respect; rights to information; accountability; competence and value accorded to each individual's

families.				input; power shared; decisions made jointly; roles respected and backed by legal and moral rights, being willing to learn from families; & avoiding a culture of blame To think systemically, using the idea of the family-plus-unit as a complex system, & that the process of an inpatient admission creates a

				new set of interconnected relationships for child, family, and staff group interwoven together
Handron et al., (1998) USA Historical overview of wraparound services & political, economic, practice implications and theoretical discussion	Child/youth	Family of origin: parents and their children with mental health tissues	Wraparound process model	Strengths based, family orientation that focuses on uniqueness of each child and family; individualized and flexible services used to define: 1. A philosophy of service provision; 2. A unique mechanism to

				plan & implement services; 3. New mechanisms to gain funding across agencies to support shared services; preference to refer to complex need rather than 'illness' Combining traditional and non-traditional services - intensive care in home and communities; a set of policies, practices & steps to meet

				individualized concerns of child and family with complex needs; Child and family are expert on their lives/needs; vs. services designed by professional assumption; Wraparound described as a philosophy of a child-driven and family-driven service provision
Heitmann et al., (2012); Germany Discussion of	Adult	Family of procreation: consumers and their dependent	Family-centred care	Discusses family-centred philosophies [ie. Systems of Care and practice

program development		children		models [i.e. wraparound] – idea is to support family to help child make gains; Family system is important for helping child with disorder
Hinden et al., (2005); USA Case study design within a qualitative framework; data obtained from interviews with parents, service providers, and from family file	Adult	Family of procreation: consumers and their dependent children	Family centred program	Focus on strengths and trust between provider and family; Focus on effective communication, collaboration and partnership between parent and provider Strengths based

records				approach
Houlihan et al., (2013); Ireland Quantitative surrey with mental health nurses	Adult	Family of procreation: consumer and their dependent children	Family focused care	Nurses and services need to be both child and family focused.
Jessop & de Bondt (2012); Australia Discussion of a consultation service by child/youth staff to adult mental health services	Adult	Family of procreation: consumer and their dependent children	Family centred Family sensitive	Collaboration between services critical Strengths based approach
Kilmer et al. (2010); USA	Child/youth	Family of origin: families of	Family- focused, family-centred care	System of Care philosophy with wraparound as

Discussion; identifies discrepancies between conceptualization and practice; of family centred care		children with mental health issues		main practice model; to help families engage their broader communities and connect with informal or natural community supports, not just professionals Child &Family Team (CFT), composed of family members, professionals from community agencies, and informal supports
Korhonen et al., (2008); Finland	Adult	Family of procreation;	Family centred care	Preventative approach

Quantitative survey of psychiatric nurses		consumers and their dependent children		Collaboration
Korhonen et al., (2010a) ; Finland Quantitative survey with psychiatric nurses	Adult	Family of procreation: adult consumers and their children	Family centred care; Family orientated approach; Family orientated care methods	Prevention approach Collaboration Identifying parenting status and supporting parents to develop parenting skills can promote recovery FFP is a multi-professional issue
Korhonen (2010b) ;	Adult	Family of procreation:	Family centred care; Family orientated care	Family orientated care methods

Finland Quantitative survey with psychiatric nurses		adult consumers and their children		support nurses in the recognition of clients' parental responsibilities; including identifying parental status, support for parent's wellbeing, support for parenting in the therapeutic milieu, and fulfilling parental duties.
Lee et al., (2009); USA Reports on a feasibility trial of intervention	Child/youth	Family of origin: parents and their children with severe emotional	Integrated family and systems treatment [I-FAST]: intervention	I-FAST assumes: (1) effective treatment of a child or adolescent necessitates

effectiveness		and behavioral problems		treatment of the family system, (2) families are resilient and have strengths & resources to achieve client change, (3) effective treatment must include coordination and collaboration among the diverse organizations providing services to the child and the family, and (4) effective treatment is built

				upon training and retaining staff with expertise in providing home-based family services Integrates common elements of system theory & strategic family therapy; expanding treatment system beyond the individual to multiple embedded systems, & expanding therapeutic alliance across

				numerous individuals & systems
Lepage (2005); Canada Discusses two interventions employed in rural northern communities	Child/youth	Family of origin: parents and children diagnosed s with a first episode psychosis	Partnership Model and the Family Consultation Model	Collaboration with the family's local resources an essential component of the Partnership Model; as well as formation of complementary roles between the patient, the family and the mental health professionals through teamwork Family considered a rich

				resource of information and insight into the ill member's problems, as well as an equal partner in the health care team; Family Consultation provided on an as-needed basis and tailored to the families' specific needs, learning styles and time schedules.
Maddocks et al., (2010); UK	Adult	Family of procreation: consumers and their	An integrated model of care	Family centred care approach obliges the practitioner to

Qualitative interview study with mental health nurses		children		view the client as part of ta family and their assessment and any interventions must consider them in this position. Therefore treatment goals and interventions should be directed with a view to changing the whole family Acknowledgeme nt of strengths and needs of all family members. Integrated model of care that applies a person

				centred and family centred approach in tandem Centred on supporting parent
Malysiak (1997); USA Examines theoretical underpinnings of wraparound model	Child/youth	Family of origin: parents and their children with serious emotional disturbance	Wrap around model; Ecological strengths enhancement	Strengths based, family focused ecological process emphasizing individualized services in least restrictive setting appropriate to child's needs; engaging families natural strengths as decision making participants; parent

				involvement, unconditional care, building and maintaining normative lifestyles, culturally competent
Maybery et al., (2012); Australia Development and psychometric testing of instrument to measure FFP	Adult	Family of procreation; consumers and their dependent children	Family sensitive practice; Family focused practice,	14 subscales that summaries 49 items reflecting organizational and worker factors such as skill and knowledge about the impact of PMI on children and worker confidence Family sensitive

				responses can span a broad spectrum of practice from identifying clients who are parents and referring to relevant support services to providing in-depth and long term family therapy.
Maybery et al. (2014); Australia Quantitative survey research with variety of	Adult	Family of procreation; consumers and their dependent children	Family focused practices; Family sensitive; Family inclusive; Family centred	Importance of collaboration between professionals and parents and families and between services

professional groups				
Miklowitz et al., (2006); USA Discusses a treatment model and presents data from treatment study	Child/youth	Family of origin and procreation: parents and their children with early-onset t bipolar disorder; also acknowledges that parents may have their own disorder	Family focused treatment (FFT) model	The reciprocal influences of a child's biological and psychological functioning, stage of cognitive, social, and emotional development & the family, cultural, and medical context in which symptoms are expressed, Need for integrated treatment; rely on extra-familial

				resources **i**ncluding mental health treatment, extended family, and community supports. A manualized psychosocial intervention consisting of psychoeducation, communication training, and problem-solving skills training
Mosier et al. (2001); USA Discussion and quantitative	Child/youth	Family of origin: parents and their children with mental health issues	Family preservation services (FPS): intervention	The rationale underlying this approach involves having treatment goals driven by

evaluation of an in-home program for 4-17 year olds				parental & child perceptions of what is important; and (a) provide intensive intervention, (b) deal with the family as a unit, (c) provide services primarily in the home, (d) provide services based on need rather than on service categories, and (e) provide intensive services on a short-term basis.

				FPS similar to wraparound principles
Mottaghipour & Bickerton (2005); Australia Theoretical discussion of FFP	Adult	Family of origin and procreation: consumers and their parents and children	Family work; Pyramid of family care; Model of family care	Collaboration with families Partnership with parents – different levels of intervention negotiated over varying timeframes
Mullen et al., (2002); Australia; Description and evaluation (both qualitative and	Youth	Family of origin: adults of consumers (young adults) experiencing first	Family intervention	Families play a major role in promoting service users' recovery and preventing relapse

quantitative) of family intervention		psychotic episode		Nurses have a central role in providing family interventions Early intervention important
Nicholson (2007); USA Discussion of FFP in relation to families where a parent has a mental illness	Adult	Family of procreation; consumers and their dependent children	Family centred; Strengths based approach	Helping parents can help children Parenting is an important and fulfilling life role Strengths based approach (builds natural supports) Partnership process with services Parents will be successful if given right

				supports Prevention important to prevent or reduce likelihood of intergenerational transmission of mental illness
O' Brien et al., (2011); Australia Qualitative interview study with acute setting staff	Adult	Family of procreation; consumers and their dependent children	Family focused services; Family friendly services	Nurses have a responsibility to support and understand clients in their parenting role as part of overall care
Pierpont & McGinty, 2004; USA. Discussion and evaluation of	Children & youth	Family of origin: children with mental health issues and their	Family orientated program based on Systems of Care	Child centred Family focused Community based Culturally competent

treatment program		families		
Reupert & Maybery (2014); Australia Qualitative interviews with mental health practitioners	Adult	Family of procreation; consumers and their children	Family sensitive practice or approach	Strengths based approach Partnership between parents and practitioners pivotal Families have complex needs so need for interagency co-operation Need to balance competing needs of children & parents Family sensitive practices important given the needs of parents, children

				& wider family FFP can stop or reduce intergenerational transmission of mental illness
Schmidt & Monaghan (2012); USA Description of family support service	Adult	Family of origin and family of procreation	Intensive family support service	Structures of service driven by individual family choice Collaborative process based on trust Focus of intervention is determined by the family's concerns Strengths based competence of family recognised

				Promotes recovery
Sin et al. (2007) ; UK Discusses the process for developing a service for carers of a young adult with first episode psychosis	Child/youth	Family of origin: parents and their youth with early onset psychosis	Early Intervention in Psychosis service	Services developed to address carers' needs for knowledge, skills and support to cope with their caring roles & situation, from stressful beginnings of a potentially long caring journey
Woolston, (2007); USA Discusses intensive in-	Child/youth	Family of origin: parents and their children with severe	The Intensive In-Home Child & Adolescent Psychiatric Service (IICAPS): approach	Combines elements of medicalized treatment with system-of-care

home child/youth family-focused approach.		emotional disturbances		principles that place a high value on authentic parent involvement and attention to youth and family strengths; Focus on four critical domains: child, family, school & environment, and other systems Family members are considered equal partners in all aspects of treatment
Young & Fristad, (2007); USA	Child/youth	Family of origin: children with	Four programs presented: Family-focused treatment (FFT);	Describes four programs based upon a

Discusses four family programs		bipolar and their families	RAINBOW Program; Multi-family psychoeducation program s(MFPG); Individual family psychoeducation (IFP)	psychoeducation format & a cognitive-behavioral foundation Goals to increase adherence to medication & delay recurrence of mood episodes; enhance adolescents' knowledge of illness; enhance communication and coping skills; & minimize the psychosocial impairment; and incorporate both parents and

				children as active partners in the management of bipolar disorder

Table 3: Family–focused core and inter-related practices and descriptions

Core practice	Description
1. Family care planning & goal setting	Clinicians conduct care planning including collaboratively establishing crisis/care plans with families and assisting family members to set goals both in relation to the individual's recovery and also in relation to improving family members' mental health and wellbeing.
2. Liaison between family & services including advocacy	Liaison between families and services. Advocacy involves acting, speaking or encouraging actions with services to achieve better outcomes for families.
3. Instrumental, emotional & social support	Instrumental support involves the clinician referring a family member to another service, and organising practical support e.g. transport or child-care. Emotional support involves showing empathy and compassion to family members. Social support involves empowering families and encouraging individuals and families to expand social networks and improve their connections with others.

4. Assessment of family members & family functioning	Assessment ranges from basic questions that aim to ascertain family relationships for example, at psychiatric intake asking, 'Do you have children?' through to assessing parenting competency and/or family circumstances, the impact of a family member's mental illness on other family members, and level of mental health literacy in all family members.
5. Psychoeducation	Psychoeducation aims to improve family members' mental health literacy and may focus on education about mental illness, treatment including information about medication, and improving the understanding of mental illness and wellbeing. It ranges from informal discussion through to manualised, evidence-informed family interventions.
6. Coordinated system of care between family & services	Clinicians provide a coordinated system of care (e.g. family collaboration, family-service partnership) with family members and clinicians and other service providers (e.g. education providers). Commonly this coordinated system of care involves a wraparound that encompassed partnerships between families and service

	providers in a constructive and synchronised manner. It ranged from a general approach (coordinating the various services - the 'system' - involved with a family) through to specifically defined type of service (e.g. 'Wraparound') with clear operating parameters and model of care. Collaborating with family members is a critical component of this.

