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Differences Between Irish and Australian Psychiatric Nurses' Family Focused Practice in Adult Mental Health Services

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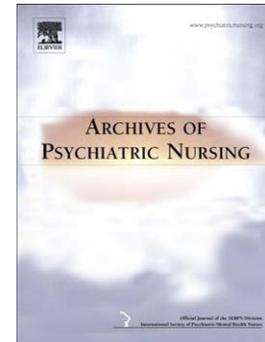
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Differences between Irish and Australian psychiatric nurses' family focused practice in adult mental health services.

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ABSTRACT

Psychiatric nurses' practice with parents who have mental illness, their children and families is an important issue internationally. This study provides a comparison of Irish and Australian psychiatric nurses' family focused practices in adult mental health services. Three hundred and forty three nurses across Ireland and 155 from Australia completed the Family Focused Mental Health Practice Questionnaire. Cross-country comparisons revealed significant differences, in terms of family focused skill, knowledge, confidence and practice. Australian psychiatric nurses engaged in higher family focused practice compared to Irish nurses. The comparative differences between countries may be attributable to differences in training, workplace support and policy.

Key Words: *international comparison, mental health services, parents, psychiatric nursing.*

INTRODUCTION

As a result of improved treatment and policy, individuals with a mental illness are more likely than previously to assume a parenting role (Foster *et al.* 2012 Nicholson, 2014). Consequently, there is a growth in the number of children who have one or both parents who are mentally ill. Two thirds of American adults who have mental illness are parents (Nicholson *et al.* 2015). Elsewhere, it has been estimated that over 20 percent of children live with at least one parent with a mental illness (Maybery *et al.* 2009) and this includes approximately 157,201 parents in Ireland (Grant 2014), while in Australia it is suggested that there are 577,507 families and 1,082,403 children living in families with a parent with a mental illness (Maybery *et al.* 2015).

Whilst parenthood is an important life role (Benders-Hadi *et al.* 2013) parental mental illness (PMI) may adversely impact children's cognitive, emotional, social, physical and behavioural development (Barker *et al.* 2012). Twenty five to 50 percent of children who have a parent with a mental illness will experience some psychological disorder during childhood or adolescence and 10 - 14 percent of these children will be diagnosed with a psychotic disorder at some point in their lives (Beardslee *et al.* 2012). While genetics play an important role in the transmission of mental disorders from parents to children, environmental factors are also critical, as the impact of a parent's illness on children is mediated by impaired parenting capacity and parent-child communication (Hansson *et al.* 2013). Adverse socioeconomic circumstances that often accompany mental illness such as stigma, poverty and isolation are other factors that may adversely impact children (Hansson *et al.* 2013). Conversely, parental responsibilities may also affect parents' mental health and recovery (Cowling & McGorry 2012; Nicholson, 2014). Nevertheless, family focused practice (FFP) has the potential 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).

Thus, focusing on the parent-child relationship provides an ideal opportunity to improve outcomes for children. A systematic review and meta-analysis by Siegenthaler *et al.* (2012) across 13 trials involving over 1000 children found that formal interventions reduced the risk of children acquiring their own mental health disorder by 40 percent. Moreover, several studies suggest that parents, their children and families are more satisfied and find FFP more helpful than other models of practice (Espe-Sherwindt 2008; Gladstone *et al.* 2011; Nicholson *et al.* 2015).

On the basis of such research, recommendations for FFP have been made by Australian policy makers and professional bodies (Australian Infant Child Adolescent &

Family Mental Health Association, 2004). This is also the case in Ireland, where the Irish mental health policy *A Vision for Change* (Department of Health & Children [DoHC] 2006) acknowledges the needs of families where a parent has a mental illness and the important role mental health professionals can play.

The experiences and needs of children of service users must be addressed by the mental health services ... support for families ... must become an integral component of a comprehensive, family-centered approach to mental health provision and adult mental health services should be child friendly (DoHC 2006, p. 29).

Foster *et al.* (2012) and others (Goodyear *et al.* 2015; Stanbridge & Durbach 2007) recommend a continuum of family focused activities for mental health professionals when working with service users who are parents. At minimum, mental health professionals, including psychiatric nurses, 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 or to family members, with a view to preventing and resolving family issues from arising (Liangas & Falkov 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).

While different professionals should work together to support these families, psychiatric nurses are in a unique position to engage in FFP (Cusack & Killoury 2012; Maybery *et al.* 2014). They are the largest staff group involved in the provision of mental health care and are often the first point of contact for parents who are receiving treatment in adult mental health services (Foster *et al.* 2012). In Ireland, the Nursing and Midwifery Board of Ireland (2014) and Mental Health Commission (2007) urges psychiatric nurses to work with service users within the context of their family. According to Foster *et al.* (2012,

p. 6), in Australia, psychiatric nurses are “among the few groups of health professionals who have direct, frequent, and sustained contact with consumers and families”. The role of psychiatric nurses allows them to form sustained relationship with parents at a time when parents are likely to be experiencing most difficulties in parenting due to the acute nature of their illness (Foster *et al.* 2012) which means they “are in a unique position to evaluate the situation of ...children before problems arise” (Korhonen *et al.* 2010, p. 65).

However, notwithstanding the importance of FFP, evidence suggests that mental health professionals, including psychiatric nurses, experience difficulty in FFP (Houlihan *et al.* 2013; Maybery *et al.* 2014; Maybery & Reupert, 2006, 2009). Whilst mental health professionals might want to work with children and other family members they report clear knowledge and skill deficits in relation to (1) working with children, (2) working with service users on parenting issues, and (3) working with the whole family (Houlihan *et al.* 2013; Liangas & Falkov 2014). They are often unsure how to connect with families and what outcomes to aim for (Maybery *et al.* 2014).

This paper compares and contrasts the FFP of psychiatric nurses in Australia and Ireland. In Ireland, beginning level preparation for psychiatric nursing occurs through specialist pre registration undergraduate degrees. Upon registration, graduates are equipped to practice in a variety of mental health settings (Nursing & Midwifery Board of Ireland 2014). In Australia, undergraduate degrees in nursing are generic in nature and graduates are prepared for practice in a range of areas including mental health services (Clinton & Hazelton 2000). Despite these differences in educational preparation there are similarities in delivery of mental health services. Psychiatric nurses in both countries constitute the largest profession working in mental health services (Cusack & Killoury 2012; Foster *et al.* 2012). While the medical model has historically dominated delivery of mental health services, in recent times services in both countries are endeavouring to adopt a recovery orientated

approach to care (Cusack & Killoury 2012; Maybery *et al.* 2014). In both countries, service users receive treatment for their mental health problems mostly within community mental health services, while those who are acutely unwell are provided with inpatient treatment (Morrissey *et al.* 2008; State of Victoria 2005). Thus, most psychiatric nurses, in Ireland and Australia, practice in community mental health settings.

The definition of FFP in this paper entails working with service users on issues related to parenting with a mental illness, and directly working with, and supporting service users' children (who are younger than 18 years of age) and other adult family members (Grant 2014). The term 'service user' denotes adults, who are also parents of dependent children, and who are receiving public mental health services in either community or acute in-patient settings. The author aligns herself with Osher and Osher's (2002) view 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" (Foster *et al.*, in press). Specifically for this paper, it includes service users' dependent children and other adult family members/significant others who provide supports for parents and their children (i.e. partners, grandparents, siblings).

Drawing comparisons with psychiatric nurses in the Australian and Irish context has the potential to provide an international comparison and benchmark of FFP in each country. Comparing FFP across Ireland and Australia may identify generalised conclusions about FFP in mental health systems valid in more than one country as well as issues that might be specific to one country, and in this way highlight what one country might learn, borrow or adapt from another. Such information may be used by mental health policy makers and used to inform professional development programs in both these countries and elsewhere.

METHODS

Participants

The sample consisted of 155 psychiatric nurses working in adult mental health services across the State of Victoria, Australia and 343 psychiatric nurses working in 12 mental health services across Ireland.

The Australian sample consisted of ninety-two (59%) females and 61 (39%) males with an average age of 44.2 years of age (SD : 9.3 years). The average length of time in their working role was 7 years, 4 months (SD = 7 years) and the average length of time working in mental health was 16 years, 11 months (SD = 10 years). Most participants practiced on a full time basis (n = 120, 77.4%) and just over half were in an urban location (n = 84, 54.2%). A large group (n =61, 39.4%) had attended a form of family-focused training that included training in family focused interventions and/or family therapy, and 27 participants (17.4%) had attended child-focused training that included child development education and/or child protection protocols.

In Ireland, the majority of participants were female (n = 247, 71.4%) and aged between 21- 64, with an average age of 39.0 (SD = 9.64). The majority practiced on a full time basis (n = 306, 88.4%) and were in an urban location (n = 229, 66.2%). A minority (n =54, 15.6%) had family training that included training in family focused interventions and/or family therapy. Whilst a minority had also received child training (n = 51, 14.7%) this was restricted to instruction in *Children's First* guidelines and their responsibilities in relation to child protection. The mean length of experience as a psychiatric nurse was 14.4 years (SD = 10.8) and the mean length of time in current position was 4 years (SD = 5.58).

The Irish and Australian samples of psychiatric nurses were also somewhat different in terms of worker characteristics; the gender composition of each sample was found to be significantly associated with country of origin ($\chi(1) = 5.865, p < .05$), with the Irish sample including a higher proportion of female participants, as compared to Australia. The Australian sample also reported a significantly higher mean age ($t(487) = 5.649, p < .001$), significantly more time in current role ($t(209) = 2.970, p < .01$), and in years working in mental health ($t(489) = 2.498, p < .05$). There were also significant associations with country of origin for type of employment with Irish nurses more commonly working full-time ($\chi(1) = 7.473, p < .01$), and a greater proportion of Australian nurses were located in rural areas compared to Irish nurses ($\chi(1) = 6.542, p < .05$). Significant associations were found between country of origin and previous family focused training with Australian nurses more commonly reporting previous family focused training ($\chi(1) = 35.953, p < .001$). No differences were seen in child focused training between the two countries.

Instrument

The Family Focused Mental Health Practice Questionnaire (FFMHPQ) developed by Maybery *et al.* (2012) was employed. Participants responded to the 11 family focused subscales on a seven point Likert Scale (ranging from strongly disagree to strongly agree) is used. Table 1 shows the 11 subscales along with definitions and an example item from each.

Table 1

The FFMHPQ subscales, subscale definitions and items.

Subscale	Subscale Definition	Example item from scale
Support to carers and children	The level of information, advocacy and referral provided to carers and children.	I don't provide information to the carer and/or family about the service user's medication and/or treatment
Engagement issues	The opportunity for engagement with family members	Many service users do not consider their illness to be a problem for their children
Assessing the impact on the child	How well the worker assesses the impact of the parent illness on the child/ren	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse
Skill and knowledge	Worker skill and knowledge regarding impact of parental mental illness on children.	I am skilled in working with service users in relation to maintaining the well-being and resilience of their children
Service availability	There are programs to refer families to.	There are no parent-related programs (e.g. parenting skills) to refer service users to
Connectedness	Workers assessment of parent awareness of child connectedness	I am able to determine the level of importance that service users place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)
Referrals	Referring family members to other programs	I do not refer children of service users to child focused (e.g. peer support) programs (other than child and adolescent mental health)
Time and workload	Time or workload issues regarding family focused practice	There is no time to work with families or children
Family and parenting support	Providing resources and referral information to consumers and their families	I regularly have family meetings (not therapy) with service users and their family
Worker confidence	The level of confidence the worker has in working with families, parents and children	I am not confident working with service users about their parenting skills
Training	Worker willing to undertake further training	I should learn more about how to assist service users about their parenting and parenting skills

A low score in a particular subscale suggests a reduced family focus and a high score increased family focus. Psychometric information of the 11 subscales is detailed in a paper published in the Archives of Psychiatric Nursing (Maybery *et al.* 2012). The measure has

excellent content and construct validity and generally good internal subscale reliability (Maybery *et al.* 2012).

As the FFMHPQ was devised for use in the Australian context, with a variety of professional disciplines (e.g. psychologists, psychiatric nurses, social workers), it required minor adaption and testing for reliability in the Irish context. Accordingly, the term ‘consumer parent’ was changed to ‘service user’ and the word ‘worker’ was changed to Registered Psychiatric Nurse (RPN).

The validity of the FFMHPQ outside the Australian adult mental health service context was also established. Reliability and validity of the subscales in the Irish context was established by a panel of experts, pilot study, principle FFMHPQ administration, and internal consistency reliability indexes. Initially an advisory panel assessed the items in the FFMHPQ subscales for their content validity. Panel members were selected for their expertise in FFP and PMI. All the items were deemed relevant and therefore retained. The FFMHPQ was then piloted with ten psychiatric nurses from a mental health service not included in the study to evaluate the clarity of the questions and their layout. The main changes made to the FFMHPQ involved an explanation of the term ‘dependent children’ as it was considered that some psychiatric nurses in Ireland might be unsure as to what this term meant. Overall there was poorer reliability of the majority of subscales in the Irish context (i.e. most of the subscales had reliabilities greater than .60, with 2 subscales greater than .70). Consequently eight of the subscales were modified (by reducing items within them) which increased their reliability.

Procedure

Ethical approval to conduct the study was provided by participants' organisations and the relevant university committees. The Australian recruitment method involved distributing the FFMHPQ to participants in either online or in hard copy formats via managers. Implied consent was obtained through participation in the completion of the anonymous questionnaire. In Ireland, Directors of Mental Health Nursing invited participants across each region in 12 mental health services. Questionnaires were made available to participants in hard copy format only and returned anonymously.

Data analyses

Means and standard deviations (SD) were calculated for each of the 11 subscales compared. Independent t-tests and chi-square statistics were calculated to compare the demographic variables and subscale ratings across countries.

RESULTS

Psychiatric nurses in Australia scored higher in all of the FFP subscales than psychiatric nurses in Ireland (see Table 2 below). The exception was training, where participants in Ireland had a slightly higher mean score ($M = 5.89$, $SD = 1.05$) than psychiatric nurses in Australia ($M = 5.54$, $SD = 1.06$), suggesting that both groups, and in particular psychiatric nurses in Ireland, perceived that they would like more child and family focused training. All subscales with the exception of engagement were rated significantly different depending on whether nurses were from Australia or Ireland. Generally psychiatric nurses in Australia neither agreed or disagreed (a rating of 4) or slightly agreed (a rating of 5) with the items of the 11 subscales and psychiatric nurses in Ireland slightly disagreed (a

rating of 3) or neither agreed or disagreed (a rating of 4). These results indicate that Australian nurses engage in more FFP than Irish nurses.

Table 2

Comparison of M and SD between psychiatric nurses in Ireland and Australia on 11 FFP subscales.

Subscales	Irish		Australian		Statistical analysis		
	M	SD	M	SD	<i>t</i>	df	<i>p</i>
Time & workload	3.23	1.52	4.52	1.22	10.007	360.1	.000
Family and parenting support	3.60	1.11	4.46	1.07	8.054	493.0	.000
Worker confidence	4.08	1.35	4.35	1.26	2.145	496.0	.032
Support to carers and children	4.58	1.01	5.39	0.84	9.239	345.1	.000
Engagement Issues	4.33	1.02	4.39	0.91	0.642	495.0	.521
Assessing the impact on the child	3.10	1.43	4.04	1.08	8.007	487.0	.000
Training	5.89	1.05	5.54	1.06	-3.444	494.0	.001
Skill and Knowledge	3.89	1.23	4.34	0.99	4.319	360.7	.000
Service availability	4.28	1.60	5.08	1.18	6.176	368.9	.000
Connectedness	4.50	1.31	4.84	1.10	2.984	325.2	.003
Referrals	3.21	1.55	4.73	1.15	11.850	354.1	.000

Note. Irish psychiatric nurse n = 343, Australian psychiatric nurse n = 155

The biggest difference between the two countries was related to time and workload, provision of referrals for family members, assessing the impact on the child, and service availability. The lowest means, in the Irish context, were found in assessing the impact on

the child ($M = 3.10$, $SD = 1.43$), referrals ($M = 3.21$, $SD = 1.55$), time and workload ($M = 3.23$, $SD = 1.52$) and family and parenting support ($M = 3.60$, $SD = 1.11$).

DISCUSSION

This study sought to compare FFP of Irish and Australian psychiatric nurses. Results indicate that while both samples were not particularly family focused, substantial differences exist amongst psychiatric nurses in the two countries; with Irish psychiatric nurses generally scoring less than Australian psychiatric nurses on the majority of the eleven family focused subscales.

While both the Australian and Irish sample obtained their lowest scores in the subscale 'assessing the impact of PMI on the child' this was also the subscale that recorded the most difference between the two groups, with the Irish sample scoring considerably lower than the Australian sample.

Others have suggested that psychiatric nurses may experience more difficulty in assessing children's needs and working with children, than other family focused activities (such as supporting parents and adult family members (Liangas & Falkov 2014; Thompson & Fudge 2005). In Ireland, Houlihan *et al.* (2013) suggested that the lack of education on child- and family-focused practices may explain psychiatric nurses' low levels of self-reported, knowledge, skills and confidence in supporting service users' children. However, in Sweden, Östman and Afzelius (2011) found that even those mental health professionals who are trained to work with service users' children may also experience difficulties, unless training is extensive. Difficulties in working with children may persist if training is minimal as mental health professionals in adult psychiatry have historically focused on the needs of

adult service users and obtained little experience in working with service users' children (Falkov 2012). Generally professionals from adult settings have limited or no background in child development and assessment and this can reduce confidence and capacity to work with children (Toikka & Solantus 2006).

The findings in this study extend our understanding of the importance of child and family focused training by providing tentative evidence that a lack of appropriate training (in terms of extent and scope), particularly in Irish mental health services compounds nurses' difficulties in engaging and supporting service users' children. While the Australian sample reported less difficulty in assessing children's needs they also reported more child focused training and significantly more family focused training, compared to the Irish sample. Moreover, the Australian sample also generally reported higher levels of worker confidence and significantly higher levels of skill and knowledge than the Irish sample. The significantly higher score for the subscale training (between agree and strongly agree), in the Irish sample signifies that psychiatric nurses in the Irish context identified a greater need for further child and family focused training; perhaps reflective of their low scores in skill and knowledge and in most of the family focused behavioural subscales.

The current study also highlighted that the Irish nurses experience additional barriers to FFP, than the Australian sample. For instance, Australian psychiatric nurses on average neither agreed nor disagreed that they had the necessary time to work with children and to do family focused work whereas psychiatric nurses in Ireland slightly disagreed. In relation to service availability, Australian psychiatric nurses on average neither agreed nor disagreed that they had sufficient services (i.e. parenting programmes and family therapy) to refer parents and children to while Irish psychiatric nurses disagreed. Whilst existing research highlights the existence of time and service availability as barriers to FFP (Lauritzen *et al.* 2014; Maybery & Reupert 2009) the current study provides tentative evidence that different

countries experience these barriers to FFP in varying degrees. Moreover, the study also indicates that the extent to which psychiatric nurses experience barriers may impact FFP.

The findings are perhaps unsurprising that the Australian sample reported greater levels of FFP, worker confidence, skill and knowledge, family focused education and fewer barriers than the Irish sample. As previously noted, in Australia there has been substantial investment in developing mental health professionals' FFP (Australian Infant Child Adolescent & Family Mental Health Association, 2004). Several policy initiatives exist that aim to promote a whole of family approach in the workforce, such as the Victorian Families of Parents with Mental Illness (FaPMI) strategy (Goodyear *et al.* 2015; Victorian Government 2007). Thus the results of the present study tentatively demonstrate the effectiveness of policy initiatives in promoting a family focused organisational approach. However, it should be noted that the Australian results, while higher than the Irish sample, are still are not optimal in terms of high family focused knowledge, skill and practice. Thus, it could be argued that while policy might encourage FFP, it is not sufficient on its own, a finding aligned with recent Norwegian research (Lauritzen 2014).

IMPLICATIONS AND RECOMMENDATIONS

Based on the results of this study and previous research several implications can be drawn. Undergraduate and post registration educational programmes in both Australia and Ireland need to promote family focused knowledge, skills, attitudes and competencies to support parents who have mental illness, their children and families. Child focused training is particularly important considering that only a minority of psychiatric nurses in both countries had previous child training and reported particular difficulties in identifying and assessing children's needs and in working with children. As existing child training in both countries had a dominant focus on child protection, future training could also focus on assisting mental

health professionals to work with children and families in a strengths based, early intervention manner; in line with Nicholson et al. (2015) recommendations regarding developing organisational capacity in the USA.

Practices consistent with FFP need to be reflected in national practice standards and key performance indicators for Irish psychiatric nurses. An inclusive consultation process in Ireland, involving all stakeholders, including parents and young people, might be undertaken to investigate what a whole family approach might look like, in adult mental health services. In the Australian context, practice standards have recently been collaboratively developed for the adult mental health professionals (Goodyear *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 of dependent children (Goodyear *et al.* 2015). The authors argue that developing practice standards that provide practical and realistic expectations of the workforce within the context of their existing role is essential for a change in family focused practices.

Finally, while there is a general consensus that policy, guidelines and education are important enablers of FFP the findings of this study and others (Lauritzen *et al.* 2014; Liangas & Falkov 2014) highlight that none are effective on their own. The translation of policy to practice needs to be supported and promoted through long term, multifaceted, implementation strategies, at multiple organisational levels (Halle *et al.* 2013; Lauritzen *et al.* 2014). Relatedly, existing policies and guidelines could be reviewed and amended, to ensure that explicit reference to families are made, as managed through local clinical governance structures. Time could also be provided to enable psychiatric nurses to engage in FFP; particularly in Ireland where nurses (including those who were most family focused) generally perceived that they had insufficient time to engage in FFP. As Irish nurses also reported more limited availability of services than Australian nurses, additional support

services for parents (i.e. parent support groups) and children (i.e. children's peer support groups) might also be developed.

LIMITATIONS OF THE STUDY

While the FFMHPQ had documented validity and reliability in the Australian context (Maybery *et al.* 2012) there was poorer reliability of the majority of subscales in the Irish context. Given the large number of statistical tests conducted, caution should also be used in interpreting the results for some of the subscales. All subscales, with the exception of worker confidence, would still maintain a statistically significant difference if we were to control for familywise error. It should also be noted that the data reported here represents psychiatric nurses' self-reported views of their FFP and this may not be a reflection of their actual practice. Observational research might be conducted to provide other data regarding the extent and type of psychiatric nurses' FFP including the perspectives of family members.

It is also acknowledged that this study may not be comparing like with like (i.e. Irish and Australian psychiatric nurses have different undergraduate preparation and practice in different organisations). This is illustrated in the differences found in the sample demographics between the two countries.

CONCLUSION

While the reader should be cognisant of the above study limitations it should also be kept in mind there are considerable benefits from such cross country comparisons. The current study shows significant differences in psychiatric nurses' FFP in the Irish and Australian context. This raises important questions about international variations in

psychiatric services in regard to family focused practice. Have the differences arisen due to different policy and organisational directives underpinning FFP in adult mental health services? Are there important nurse training differences and can each country learn from the other? Can other countries, including European countries, Canada and the USA reflect on International differences in FFP and consider their own country specific issues in implementing a whole family approach in line with findings of the current research? The extent of psychiatric nurses' FFP in either country underscores the importance of both countries and others developing family focused guidelines, resources (including training) and policies within organisations to enable psychiatric nurses to engage in FFP.

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