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## **The impact of organisational factors and government policy on psychiatric nurses family focused practice with parents who have mental illness, their dependent children and families in Ireland**

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## **Abstract**

Government policy and organizational factors influence family focused practice in adult mental health services. However, how these aspects shape psychiatric nurses' practice with parents who have mental illness, their dependent children and families is less well understood. Drawing on the findings of a qualitative study, this article explores the way in which Irish policy and organizational factors might influence psychiatric nurses' family focused practice, and whether (and how) family focused practice might be further promoted. A purposive sample of 14 psychiatric nurses from eight mental health services completed semi-structured interviews in 2013. The analysis was inductive and presented as thematic networks. Both groups described how policies and organizational culture enabled and/or hindered family focused practice, with differences between community and acute participants seen. The need to develop national and international policies along with practices to embed information and support regarding parenting into ongoing care is implicated in this study.

**Keywords:** mental health services, nurses, family focused policy, practice

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It has been estimated that between a fifth and a third of adults receiving treatment from mental health services have dependent children (i.e. under the age of 18) (Maybery, Reupert, Patrick, Goodyear, & Crase, (2009). The needs of parents who have mental illness, their dependent children and families are extensive and have been documented in multiple studies (Beardslee, Solantus, Morgan, Gladstone, & Kowalenko, 2012; Montgomery, Tompkins,

Forchuk, & French, 2006). Hence, policy across several countries (In Australia, the Australian Infant Child Adolescent & Family Mental Health Association, 2014; in the UK, Social Care Institute for Excellence [SCIE], 2011), plus Ireland, recommends that general adult mental health services adopt a whole of family approach (Department of Health and Children, [DoHC] 2006). Family focused practice (FFP) has been defined as an approach that emphasizes the family as the unit of attention, as opposed to working with an individual alone (Mc Gavin, 2013).

While FFP has been extensively explored in pediatric settings (Coyne, Murphy, Costello, O'Neill, & Donnellan, 2013; Mikkelsen & Frederiksen, 2011) and to some extent in adult (Bland & Foster, 2012; Mac Farlane, 2001; Stanbridge & Burbach, 2007) and adolescent mental health services (Hoagwood, 2005; MacKean et al., 2012) there has been limited research regarding FFP in regard to families where a parent, with dependent children, has a mental illness (for a recent review in this area see Foster et al., in press). The increasing focus on FFP for these families results from a growing awareness, from Europe, Australia, Canada and North America, that parenting capacity is a potent and modifiable risk factor contributing to the development of emotional problems in children (Falkov, 2012; Lauritzen, 2014; Nicholson, Wolfe, Wilder & Beibel, 2015; Nicholson et al., 2015).

FFP has the potential to meet the needs of parents whilst providing preventative health care for their children and family members (Bell, 2015; Royal College of Psychiatrists, 2011). 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 (Foster et al., 2012). Other potential family focused practices include collaborating with other services to meet the needs of families and providing information to the family on parental mental illness (PMI), with a view to preventing and/resolving family issues (Liangas & Falkov 2014).

There are several developments in Ireland that aim to support family focused practices, such as policy and organisational change, but how effective these are in translating into practice remains to be seen. Internationally, children who have parents with mental illness are increasingly recognized as a target group for early intervention (SCIE, 2011; Reupert, Maybery, & Kowalenko, 2012). Consequently, various recommendations and guidelines have been made to promote a whole family approach within adult mental health services, in countries such as American, Canada, the UK and Australia (Foster, et al., in press; Nicholson et al., in press). For instance, in the Australian context, practice standards have recently been collaboratively developed for the adult mental health professionals (Maybery et al., 2015). These standards are aligned and operationalized 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 (Maybery et al., 2015). Other countries including Finland, Sweden and Norway have introduced legally mandated and formalized policies that require mental health professionals to work with the family members of their clients, including children (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014). In these countries there is a multi-component, national prevention program where mental health professionals receive training to enable them to engage in FFP) (Solantaus & Toikka, 2006).

In Ireland, there are two policy documents which have highlighted the particular needs of children whose parents have mental illness. *Children First: National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs, 2011) explicitly outlines the roles, responsibilities and procedures of mental health and addiction services in safeguarding the interests and well-being of service users' children. It stipulates that many parents, particularly parents who have mental illness may require intensive assessment, support and direct interventions to ensure the safety and well-being of their children and that early action by service providers is very often the best way to protect children and to enable

families to stay together (Hansson, O'Shaughnessy, & Monteith, 2013). The *A Vision for Change* (DoHC, 2006) also reflects the growing awareness that “children whose parents have complex recurrent mental health problems are at risk of developing mental health problems themselves and require sensitive consideration” (DoHC, 2006, p. 89). In relation to adult mental health services the DoHC state:

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-centred approach to mental health provision... (DoHC, 2006, p. 29).

This policy recognizes that long term, multifaceted implementation strategies across organizations are required to enable the translation of family focused policy into practice (DoHC, 2006).

Whilst there is growing evidence that some psychiatric nurses engage in FFP (Grant, 2014; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2010) available data in the Irish context suggest that as a whole psychiatric nurses are not particularly family focused. There are several barriers to FFP emulating from nurses' attitudes, knowledge and skill set, (Houlihan, Sharek, & Higgins, 2013; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008; O' Shea, Sheerin, Canavan, & Russell, 2004) and from parents, children and adult family members who might be reluctant or not available to discuss family issues (Maybery et al., 2015; Maybery & Reupert, 2009). Organizational or systemic factors may also significantly impede FFP (Houlihan et al., 2013). In Ireland and elsewhere the medical model continues to substantially underpin the provision of mental health treatment (Barrington et al., 2011; Nicholson et al., 2015). As this treatment model focuses on individuals and not families, mental health clinicians, including nurses, may not be supported by their organizations to engage in FFP (Nicholson et al., 2015). Houlihan et al. (2013) found that in one mental health service, psychiatric nurses reported relatively low levels of education, knowledge, confidence and practice when caring for service

users' children. Less than 20% of nurses "reported receiving education on how to assess parent-child relationships, talk to children about parents' mental health problem and supporting children" (Houlihan et al., 2013, p.290).

Adult mental health professionals in Australia and Finland also report not having the skills to interact with a service user's children or to address the service users' parenting concerns (Korhonen et al., 2008; Maybery & Reupert, 2009). One study found clear differences between professional groups, finding that social workers engaged the most in FFP, while psychiatric nurses performed the lowest (Maybery, Goddyear, & Reupert, 2014). A lack of liaison between different services (e.g. child protection and adult mental health) is another barrier to working with families (Bellin, Osteen, Heffernan, Levy, & Snyder-Vogel, 2011) as is having adequate resources, structure and time (Lauritzen, 2014). Staff shortages, high workloads and high staff turnover have also been identified as barriers to FFP (Maddocks, Johnson, Wright, & Stickley, 2010).

Previous research has predominately focused on the different FFP barriers, (emulating from the nurse, parent/family and/or organisation). While important, such research has not identified what might promote or facilitate working supportively with families. Identifying organizational enablers, especially those identified by mental health professionals, might be helpful for other services in developing workforce capacity in FFP. Additionally, while there have been other studies that have examined psychiatric nurses' FFP experiences (Davies, 2004; Houlihan, et al., 2013), they do not acknowledge the different organisational environments that psychiatric nurses may work in, such as acute or community settings. Finally, there is limited research and evaluation of services in the Irish context and it is not yet known whether, how and to what extent existing developments in policy and organizational factors may impact on psychiatric nurses' FFP. Policy is often context specific (DoHC, 2006) and needs to be

responsive to local needs and workforce and professional training frameworks (Cusack & Killoury, 2012).

### **Aim/s**

The aim of the study was to identify how current Irish policy and organizational factors may influence psychiatric nurses' capacity to support parents who have mental illness, their children and families, as well as possible differences between psychiatric nurses based in acute and community settings. How FFP might be further promoted was also sought. Specific research questions included:

1. How does Irish government policy influence psychiatric nurses' FFP (if at all)?
2. How do organizational factors in Irish mental health services influence psychiatric nurses' FFP (if at all)?
3. How, if at all, may psychiatric nurses' capacity to engage in FFP, with parents who have mental illness, their children and families, be further promoted?

### **Research Design**

Sequential mixed methods design was employed. Quantitative, questionnaire data were collected first to identify participants, and then qualitative, interview data were obtained to explain and elaborate initial results. The nature of the research questions and the strengths of the mixed methods design guided the selection of a mixed methods approach (Creswell & Clark, 2007).

Participants were identified using the Family Focused Mental Health Practice Questionnaire (FFMHPQ) which employs a seven point Likert Scale (ranging from strongly disagree to strongly agree) to measure different family focused behaviors e.g. providing support to children (Maybery, Goodyear, & Reupert, 2012). The original version of the FFMHPQ was developed for the Australian context, for various professional groups (e.g. nurses, psychologists, social workers) and in this study modified for the Irish context. Psychometric information of the FFMHPQ subscales is detailed elsewhere (Maybery et al., 2012) however the measure has excellent content and construct validity and generally good internal subscale reliability (Maybery et al., 2012).

In the initial questionnaire study, 610 psychiatric nurses in 12 Irish mental health services were surveyed (practicing within acute admission units and community mental health services) with a 57 percent response rate (n= 346). The questionnaire was disseminated by Directors of Mental Health Nursing, Clinical Nurse Managers and the lead author.

## Participants

The majority of participants in the initial questionnaire study were female (n = 247, 71.4%) with most aged between 21- 64, and an average age of 39.02 (SD = 9.64). Most worked within acute admission units (n = 194, 56.1%) while the remainder worked in community mental health services (n = 152, 44%). Average years of experience as a registered psychiatric nurse (RPN) was 14.4 years (M = 10, SD = 10.81).

Potential interview participants were identified by their high scores on the FFMHPQ. Other inclusion criteria included having current or recent (within the last 12 months) experience of caring for parents who have mental illness and those currently working as a registered nurse in either acute in-patient or community settings. Participants also indicated a willingness to



undertake an interview as volunteered at the end of the FFMHPQ. High scorers included those who scored between five and seven on at least three of the six FFP behavioral subscales (DVs) (seven being the maximum) in the FFMHPQ and were selected to establish whether and to what extent policy and organizational factors influenced FFP.

On this basis, a purposive sample of 14 psychiatric nurses in acute and community settings, in eight Irish mental health services were engaged. Nine of the 14 participants were female; ten worked in community mental health nurses (CMHN) and four in acute admission units.

#### Interview data collection

The interview schedule was informed by previous literature and the research questions and included questions around enablers that might impact on psychiatric nurses' capacity to engage in FFP (e.g., what policies, if any, have influenced your work with families? What organizational factors have influenced you, if at all? What might help you and your colleagues in working with parents, their children and family?). As each transcript was analyzed before undertaking the next interview, the schedule was slightly changed to incorporate important areas as they arose. Interviews ranged from forty five minutes to one and half hours with the average interview lasting one hour. With participant permission, all interviews were recorded with a digital audio recorder and subsequently transcribed.

#### Ethical considerations

Ethical approval to conduct the study was provided by the relevant university committees and from participants' organizations. Participants were informed of the details of the study in explanatory statements; they were told that their participation in interviews was contingent upon them returning the completed FFMHPQ and a form with their contact details which was included with their FFMHPQ. Prior to commencing the interview, the participants were invited to complete an informed consent form. Maintaining participants' confidentiality is often a major ethical concern of interpretive research because of the intimate nature of the research (King & Horrocks, 2010) but was maintained through the use of pseudonyms and changing specific contextual details that could possibly reveal the identity of the participant.

#### Interview Data analysis

Thematic analysis was employed to create core constructs from the textual data through a systematic method of reduction and analysis. The author employed an essentialist, realist perspective which focuses on participants' experiences, meanings and realities as they report it (Braun & Clarke, 2006). In this approach, participants' experiences and motivations were understood in a straightforward way, because a simple, largely unidirectional relationship is assumed between meaning, experience and language (Potter & Wetherell, 1987). Data were analysed first in individual transcripts and then across transcripts.

Themes were presented as thematic networks which "...are web-like illustrations that summarize the main themes constituting a piece of text" (Attride-Stirling, 2001, p. 385).

Essentially thematic networks systematize the extraction of: (1) lowest – order premises evident in the text (basic themes): (2) categories of basic themes grouped together to summarize more abstract principles (organizing themes): and (3) super-ordinate themes encapsulating the principle metaphors in the text as a whole (global themes) (Attride-Stirling, 2001, p. 388).

In the current study thematic networks were established by initially developing basic themes and working inwards toward a global theme. Themes were generated from information provided by participants around capacity to engage in FFP. Specifically, information that was important to the research questions and emphasized within and across interviews comprised the presenting themes. Once the basic themes were created, they were categorized according to the underlying story they were telling; these become the organizing themes. The organizing themes were reinterpreted in light of their basic themes and “were brought together to illustrate a single conclusion or super-ordinate theme that became the global theme” (Attride-Stirling, 2001, p. 385). This global theme incorporated subthemes that captured participants’ perspectives of those things that impacted on FFP and future potential developments in FFP; providing insight into the organizational and policy related factors that enabled this group of psychiatric nurses to engage in FFP. Themes were illustrated by participants’ quotations, where participants are identified by number (e.g. P1 is participant one) and setting (cmhn is community mental health nurse).

## Rigor

The researcher conducted all 14 interviews. The strategies employed to maintain methodological rigor coincide with best practice in conducting qualitative research (King & Horrocks, 2010) and included the following strategies. Journal entries were made throughout the research process, and reflected the lead author’s interaction with the text and possible interpretive assumptions. For example, the author’s familiarity with psychiatric nursing may have caused her to ascribe or assume certain meanings to participants’ words or jargon, behaviors, and decisions. Additionally, the lead author identified aspects of practice or issues not raised by other participants (negative cases) and explored these further in subsequent

interviews. The lead author discussed these negative cases and assumptions with a fellow researcher in regard to emerging themes. Finally, two weeks after their interview, participants were invited to review their individual interview transcript and invited to delete any information they believed to be potentially identifiable, add anything they considered to be relevant and/or change anything they considered to be inaccurate.

## **Results**

There was a range of participant demographics in terms of length of experience as a psychiatric nurse, time in current position, grade and educational and professional qualifications (Table 1). Over half of the participants had received family focused training (n = 8) and/or child focused training (n = 9).

*Insert Table 1 around here*

Figure 1 illustrates the global theme that emerged surrounding psychiatric nurses' capacity to engage in FFP. Three main components associated with psychiatric nurses' capacity for FFP included (1) enablers (2) barriers and (3) future potential developments in FFP.

*Insert Figure 1 around here*

Organizational enablers for FFP

Participants identified specific policy which enabled FFP, i.e., "...the legislation...from *Children First* has made us...broaden what we're taking on...It's measures like that that make things more concrete" (P 13:acute). Similarly, P 8 (cmhn) reported:

With ...changes in...legislation...and *Children's First* training.... you're ...becoming more...family orientated...it's more...a rounded view of what's going on...with the children...is there any risk...things like that...

Others suggested "...if we suspect the child is being neglected...under the Child Welfare Act we have a responsibility ...to report it" (P 14: acute) and "there is a mechanism in the service to report suspected child abuse" (P 10: acute).

Simultaneously, the lack of a formal mandate to identify service users' parenting status upon admission to mental health services was a barrier. Participant 12 (cmhn) contended "...there isn't anything...formal...in how we reach out to families". Others indicated "It's not something that is...there in black and white that you have to ask them" (P 7: acute) and "psychiatric nurses are aware that...there is a need to involve children and adult family members and there is impetus to change but structures to allow this are not in place... in terms of culture or concrete resources" (P 2: cmhn).

Participants also identified other organizational enablers, though most were specific to the community setting. The organizational culture in community settings was promoted by the adoption of a holistic and family-centred philosophy and prevention. For instance "...our team philosophy...is ...orientated to families and to ensuring that we don't see little Johnny in ten years' time" (P 6: cmhn). The majority of community participants (n = 7) reported that collegial and managerial support was important by providing direction and resources to engage in FFP. For instance, "It does help...if colleagues and management are supportive...and give you... the resources that you need...to drive out family focused services..." (P 8: cmhn).

Teamwork and drawing on the expertise of other disciplines in supporting parents and children was another enabler, for example, P 9 (cmhn) reported “she [the social worker] was very useful in child protection type issues... so we would joint work at times”.

All community participants described how conducting home visits enabled them to view the family holistically. For instance, “being able to go into the home is pivotal in being family focused... you’re not only working with the service user [parent] but you’re also able to gauge the feelings and interpretations of the family members...” (P5: cmhn). Others described the importance of home visits in obtaining accurate assessments;

You can see a mum on her own when the children have gone out of the house and... she’s making it out to be rosy... you could go back the next evening when the children are in and there’s chaos...it’s a good learning curve for me as well as for the mum to see how she is managing (p4: cmhn).

Home visits were not always planned, “...there’s so much you see that you’re not probably meant to see and particularly if you go in unannounced” (P 11: cmhn). Some participants also implied that their colleagues in the acute setting were disadvantaged by not being able to undertake home visits, “...the community perspective is so different to working in an in-patient setting because we see it as it is...” (P12: cmhn).

Working with parents over an extended period of time was another FFP enabler:

...I’ve been with them all along when their children have been very small...and some of these children are now having children... there’s a whole cycle that goes into what we do with families, that gives us a different relationship with people and allows us to make interventions in a different way than...other professionals that are coming in... (P11: cmhn).

There were also physical FFP enablers including situating community mental health services within primary care centres and alongside other professionals, (e.g. social workers) which meant that “...I can stick my head in the door and have a laugh but at the same time... have good detailed conversations” (P 9: cmhn).

## Organizational barriers for FFP

Notwithstanding that participants were identified as high on the FFMHPQ, a number of organizational barriers to FFP were identified, particularly in the acute setting. Most barriers originated from participants' organizations (i.e. managers and colleagues) and the organizational culture e.g. "the service itself would say refer [children] to the social work team [because] we're not really equipped to deal with it" (P 14: acute). The problem focused approach within the acute setting was another barrier; "unless there was a risk...it probably wouldn't be integrated with the person's care plan...it is more firefighting than working from the very start with the parent in case something happens" (P 14:acute).

Some community psychiatric nurses noted that staff shortages and inconsistencies resulted in limited teamwork, for example, "...since the recession... [there is] different staff every day... very little consistency... [this] hinders my capacity in working with families" (P 13: acute). A lack of social workers was particularly problematic as participants saw their contribution as valuable to FFP; P 6 (cmhn) suggested "we've only [had] a social worker linked in with this team for the last two months. Before that we were it [performing role of social worker]". Participants in both settings noted a lack of FFP training "within the organization...management...would encourage us to...do Children's First training ... its mandatory but...they can't release the staff to do it ..." (P13: acute).

## Future potential developments in FFP

Several ways were identified that might further promote FFP. All acute participants (n = 4) and half of the community participants (n = 5) argued that in order to promote psychiatric

nurses' FFP, child focused training was required, at the undergraduate and in-service level. In relation to undergraduate education, P7 (acute) reported "...you're not taught how to look at...if that person's experiencing difficulty with family or...children...it would be important for undergraduates to have that in their education". There were also suggestions as to what in-service education should entail, e.g., "we need information about building competency to manage complex family and parenting issues, how to put the family at the center of care and recovery, how to refer to family services, how to utilize voluntary sector supports" (P 2:cmhn).

However, participants pointed out that information and education alone was insufficient. Five participants alluded to the need for concrete and systemic strategies to address the needs of parents, children and adult family members, necessitating a fundamental philosophical change in services: For instance "...at a very basic level there needs to be...a bigger approach...to people as family units and all that that entails...that it's not just the person coming through the door, ...it is the whole ...system" (P11: cmhn). The need to provide early intervention to service users' dependent children was repeatedly made with some participants suggesting that psychiatric nurses should talk to children about PMI and their own mental health for example, "We need to let kids know that it's ok to link in with services and get... help ...if they are ever seeking help they'll know how to do it..." (P 7: acute). To enable this fundamental philosophical change in services, the majority of community participants (n = 6) and one acute participant highlighted a need for collaborative work with other mental health professionals. Colleagues and managers' acknowledgement of the emotional challenges of engaging in FFP was also considered important in enabling participants' FFP.

...you can't...work with parents unless you've an emotional connection with them...there's a downside to having it [emotional connection]...I don't think that's appreciated... it would be better for us as professionals... ...if it was acknowledged...by the organization... (P 11: cmhn).



Further systemic or organizational changes were required to support FFP, as reflected by P 6 (cmhn) “It needs to be more formalized...that if there is children ...you have to tick a box to say you sat down and had a chat with the children with the parent’s consent”.

Some participants (n = 5) suggested that there was a need for FFP theory development, “we need to identify first what it is we do...and debate...what nurses should be doing” (P 14: acute). Some (n = 4) perceived that psychiatric nurses need to communicate what they are doing in relation to FFP, “sharing and articulation of information regarding FFP within and between mental health services” (P1: cmhn) and “we need to make what we do tangible” (P 3: cmhn).

## **Discussion**

This study sought to explore whether organizational developments and policy in Irish mental health services impact on psychiatric nurses’ FFP and how FFP might be further promoted. Interviews from high scoring psychiatric nurses found that policy and organizational structure has promoted FFP in many ways, though much more could be done.

The findings suggest that organizational developments and government policy may effectively promote psychiatric nurses’ FFP, at least within the context of the Irish system. 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) suggest that no single strategy is effective on its own. Instead, the translation of policy to practice needs to be promoted through long term, multifaceted, implementation strategies, at multiple organizational levels (Lauritzen et al., 2014).

Psychiatric nurses suggested that recent legislation from *Children’s First* (DCYA, 2011) enabled FFP, as it made their responsibilities surrounding child safety more concrete.

This policy motivated psychiatric nurses to learn about the impact of PMI on children and helped to focus their attention on the family context. The accompanying guidelines also facilitated mechanisms within general adult mental health services to report suspected child abuse. The importance of relevant policy resonates with previous research (Lauritzen et al., 2014; Toikka & Solantaus, 2006).

However, this study highlights the need for more comprehensive family focused policy than *Children First*, in terms of prevention and early intervention, as opposed to only reacting to child welfare difficulties when or if they arise. These findings regarding the need for more comprehensive policies in Ireland are also relevant for other countries in their efforts to develop a whole family approach in adult mental health services. Policies that focus mental health professionals' attention and resources primarily on child protection may reduce scope to engage in early intervention that aim to prevent problems arising in the first instance (Nicholson et al., 2015). Relatedly, existing policies and guidelines in Irish mental health services might be reviewed and amended, to ensure that explicit reference to families are made, and managed through local clinical governance structures.

As existing child training in Ireland has a dominant focus on child protection, future training might focus on the capacity of mental health professionals to work with children and families in a strengths based, early intervention manner, aligned with Nicholson et al., (2015) recommendations regarding developing organizational capacity in the USA and Goodyear et al., (2015) recommendations in Australia. Nonetheless, applying child protection policy in this area can be problematic for nurses' relationships with parents and the manner in which nurses work with parents and children (Doucet, Letourneau & Blackmore, 2012; Khalifeh et al., 2009). For example, parents may be reluctant to disclose their parenting role and any concerns they are experiencing as parents, for fear of losing access to their children (Nicholson et al., 2015). Hence, training needs to also consider how nurses might maintain relationships with

parents and families in circumstances where there are potential and/or actual child protection issues. The findings of this study also illustrate the importance of introducing policies that mandate practice change. Unlike in some Scandinavian countries, (Lauritzen, 2014), in Ireland there is no national and legal obligation to translate recommendations in *A Vision for Change* into practice. The implementation of the Health Service Executive's recruitment embargo and the public service moratorium from 2009 to date may further compound these problems (Barrington et al., 2011). Again, the findings resonate with other countries, including Australia where "changing political agendas that tend to be crisis rather than prevention focused is a significant challenge" (Nicholson et al., 2015).

The findings of the current study suggest that 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 of 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 to the core activities of the adult mental health workforce and integrated into a continuum of care for service users who parents of dependent children (Goodyear et al. 2015). The authors suggest that developing practical and realistic practice standards are essential for change to occur.

Many psychiatric nurses, especially those in community settings, described various organizational enablers that promoted FFP, including a holistic, family focused philosophy framed by prevention and early intervention and collegial and managerial support. This finding is similar to that found by others, regarding the importance of a family focused organizational culture (Korhonen et al., 2010; Lauritzen, 2014; Nicholson et al., 2015). Additionally, the present study suggests how family focused philosophy within these community settings made

it easier for psychiatric nurses to address parenting on a routine basis; it conveyed to them and their colleagues that families were important and that parenting and family related issues needed to be factored into service users' care. This organizational support meant that the time required to engage in FFP was sanctioned, planned and accommodated by psychiatric nurses and their managers. The interdisciplinary nature of the community mental health teams and encouragement and support from managers reinforced this positive organizational culture and sharing of information and skills. The importance of collaborative team work is consistent with international literature on inter-professional practice and its significance in predicting FFP (Lauritzen et al., 2014; Grant, 2014). The findings of the current study are relevant in helping organizations in Ireland and elsewhere to understand how particular aspects of organizational cultures can be developed and/or harnessed to promote FFP. The findings also illustrate how recommendations regarding FFP in Ireland and elsewhere can be translated in practice through various activities, principles, processes and philosophies.

Community psychiatric nurses perceived that home visits enabled FFP. Care in the context of family life is an important principle underpinning FFP (Kuo et al., 2012) with previous researchers also highlighting the benefits of home visits with this target group (Olds 2002; van Doesum et al., 2008). The current study adds to these studies by explicating how home visiting promotes FFP, by allowing psychiatric nurses to forge relationships with parents, their children and adult family members, to observe normal family life and to address parenting and children's needs. Home visits also provide psychiatric nurses the opportunity to obtain objective information about the parents' capacity to cope with their parenting role and to assess children's needs (directly and indirectly). Working with parents in the home enabled psychiatric nurses to detect PMI symptoms early, and identify potential difficulties in parenting, the parent-child relationship and children's mental health and development. According to those interviewed here, the collaborative relationship between psychiatric nurses

and parents enabled parents to see home visiting as a supportive measure rather than intrusive. Thus, home visiting activities may shift the paradigm from an individual to family orientated approach, particularly when psychiatric nurses intentionally use home visits to work with parents around child and family related issues. As home visiting was regarded as a potential process for the implementation of FFP, training programs and professional organizations might conceptualize and/or standardize how home visiting may be used by psychiatric nurses when engaging in FFP.

Another organisational enabler in community settings was the opportunity to work with parents over a sustained period of time, an approach also found by others (Hauck, Rock, Jackiewicz, & Jablensky, 2008; Slack & Webber, 2008). According to the participants interviewed here, sustained contact allowed psychiatric nurses to develop deep and authentic relationships with parents, to obtain comprehensive information about parents and their wider family context and to sometimes work with families across generations. In addition, community psychiatric nurses suggested that sustained contact with parents, when they were both well and unwell, enabled them to obtain a complete picture of parents' capacities, including strengths. Such a finding highlights the need to develop structures and mechanisms to allow adequate time for partnerships to be forged with parents and their families.

Another enabler was being in close physical proximity (being located in the same building) to other services, as it enabled collaboration. Others also suggest that environmental design may facilitate interagency co-operation and thereby FFP (Coyne et al., 2013; Lauritzen, 2014). In this study, it was found that close physical proximity to different services promoted collaboration for nurses. Similarly, easy access to other services within the same building enabled psychiatric nurses to get to know staff on an informal basis, which enabled ready access and collaboration with these services in a formalized manner.

Despite all participants engaging in FFP, a number of organizational barriers were

identified, especially in acute settings. These barriers resonate with other research across multiple professional groups, settings and countries (Lauritzen et al., 2014; Grant, Goodyear, Maybery, & Reupert, in press; Rutherford & Keeley, 2009) as well as research that focused specifically on psychiatric nurses (Houlihan et al., 2013; Korhonen et al., 2010; O'Brien, Brady, Anand, & Gillies, 2011). These barriers were primarily caused by a lack of policy, teamwork, family and/or child focused training, time and resources and use of a problem focused approach. This finding confirms the role of organizations in promoting or impeding FFP and has relevance for development of a whole family approach in Ireland and internationally.

Suggestions for further promoting FFP included maintaining a focus on parents as well as children and adult family members, similar to the recommendations of others (Falkov, 2012; Lauritzen et al., 2014; Nilsson, Gustafsson, & Nolbris, 2014). In this study, psychiatric nurses suggested that there should be separate peer and professional led support groups and interventions available for different family members. Child and family focused education at the undergraduate level and post registration were other suggestions made. Others have also urged for FFP training for nurses and other mental health professionals (Lauritzen et al., 2014, Liangas & Falkov, 2014), suggesting that the lack of family focused training opportunities is not unique to Ireland.

A need for theory development in FFP was also raised by psychiatric nurses, so that a shared understanding could be developed around what psychiatric nurses do when working with families when parents have a mental illness. According to participants, theory would render FFP tangible and measurable and subsequently enable the nursing profession to be consistent in their FFP approach when caring for parents with mental illness who have dependent children. While there is substantial literature on FFP and its working principles in other disciplines, especially pediatrics (Coyne et al., 2013; Foster, et al., 2015; 2015; Kuo et al., 2012) there is a paucity of FFP literature in regard to working with parents who have mental

illness and their dependent children (Foster et al., in press;). Developing a comprehensive construct of FFP in this particular context has implications for education, adoption of FFP and service evaluation and warrants further investigation.

### Limitations

This study represents the views of 14 psychiatric nurses who were classified as being family focused and who were available and willing to be interviewed; this may or may not be generalizable to others. For instance, nurses who are not particularly family focused may identify additional and different organizational and policy factors that impact on the way they work, or do not work with families. In order to investigate the direct impact of policy, we could have interviewed (or surveyed) nurses before and after introduction of FFP policy. Nonetheless, the current findings provide direction to further examine FFP enablers. The findings may act as an impetus for change within Irish adult mental health services in line with developments elsewhere.

### Conclusion

This study contributes to the existing literature by highlighting how organizational and policy developments impact on psychiatric nurses' FFP. Whilst *Children's First* guidelines and a positive organizational culture, particularly in community settings, enable FFP, the findings suggest that policy alone is not sufficient to promote workforce change, particularly in acute settings. In line with mental health services in other countries such as Finland, Norway and Australia, practice guidelines and policies might be developed and implemented in relation to parents who have mental illness, their children and families. Policies may need to stipulate

that parenting status is identified on admission, along with steps to support service users' children. Such measures may enable a systematic documentation of service users' parenting status nationally, data which might be used to guide resource allocation and training. As home visiting enabled FFP, community services might be further developed in line with recommendations in *A Vision for Change* (DoHC 2006). Referral networks and pathways within and outside of services also need to be clearly defined, within strong service partnerships.

The translation of policy to practice needs to be actively promoted. Given that inter-professional practice and teamwork enabled FFP in community settings, evidenced based, interdisciplinary education in FFP may be delivered to various mental health professionals at the under and postgraduate level. Such education might incorporate principles of best practice and provide psychiatric nurses with the skills and knowledge beyond that provided through existing *Children First* training (see for example, Reupert & Maybery, 2011).

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