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**Stakeholders' Perspectives of Family-Focused Practice and Engagement in  
a Community Outreach Service: Application of Normalization Process  
Theory**

**And Clinical Research Portfolio**

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Submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology

Institute of Health and Wellbeing  
College of Medical, Veterinary and Life Sciences  
University of Glasgow

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## Table of Contents

Acknowledgements	2
Declaration of originality form	5
Word count declaration	6

### Chapter 1: Systematic Review

Mental health professionals' perspectives of family-focused practice across adult and child mental health settings: A qualitative synthesis	7-34
---	------

Abstract	8
Introduction	9
Methods	11
Results	14
Discussion	25
Conclusions	27
References	30

### Chapter 2: Major Research Project

Stakeholders' perspectives of family-focused practice and engagement in a community outreach service: Application of Normalization Process Theory	35-63
---	-------

Plain English Summary	36
Abstract	38
Introduction	39
Methods	41
Results	45

Discussion	55
Conclusions	59
References	60

## **Appendices**

Appendix 1: Systematic Review	64-71
1.1 Author guidelines – Child & Youth Services	64
1.2 PICo Framework Search Strategy	69
1.3 Walsh & Downe’s (2006) Quality Appraisal Tool	70
Appendix 2: Major Research Project	72-102
2.1 Topic Guide (Clinicians)	72
2.2 Topic Guide (Parents)	73
2.3 Topic Guide (Young People)	74
2.4 West of Scotland Research Ethics Committee Approval Letter	75
2.5 NHS Lanarkshire R&D Approval Letter	76
2.6 Consent form (Clinicians)	77
2.7 Consent Form (Parents)	78
2.8 Consent Form (Young People)	79
2.9 Participant Information Sheet (Clinicians)	80
2.10 Information for staff sheet	83
2.11 Participant Information (Young People)	85
2.12 Recruitment poster for young people	89
2.13 Major Research Project Proposal	90
2.14 Thematic Maps	98
2.15 Contribution of themes from thematic analysis to NPT	101



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## **Chapter One: Systematic Review**

### **Mental health professionals' perspectives of family-focused practice across child and adult mental health settings: A qualitative synthesis**

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## **Abstract**

The shift towards a family-focused approach to practice has been highly endorsed across child and adult mental health services with an increasing policy development and a growing evidence base. The aim of this review was to synthesize the qualitative evidence of professionals' perspectives and experiences of implementing family-focused practice across these settings. Electronic databases were searched up to March 2018 of which 9 articles were included. The synthesis produced two overarching challenges relating to the organisational and system issues of family-focused practice, and the complexity of families' needs. The findings point to a limited evidence of professionals viewing the benefits of family-focused practice and a lack of coherence relating to professionals' investment in family-focused practice. These are discussed within policy and implementation factors.

**Keywords:** Family-focused practice, professionals, parental mental illness

## **Introduction**

There has been a recent global shift towards a family-focused approach to practice within the healthcare system. Family-focused practice (FFP) acknowledges the family as a unit and identifies the needs of the individual seeking support and the family in order to work collaboratively between services and families (Wong, Wan, & Ng, 2016). Mental health disorders have been one of the main causes of overall disease burden worldwide with the effects of mental illness on the family being widely acknowledged. This is particularly evident within the literature surrounding parental mental illness (PMI) whereby up to a third of adults engaging with mental health services have dependent children (Maybery, Reupert, Patrick, Goodyear & Crase, 2009). A family-focused approach to working with young people and their parents has been identified as crucial in changing the outcomes of these families whereby focusing on the wider family and system proves essential for making a positive change and further developing family resilience (Foster, Brien, & Korhonen, 2012). Multiple studies have identified that practices of a family-centred approach reduces relapse rates (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001), reduces the burden of care, and increases emotional regulation for the family (Glynn, Cohen, Dixon, & Niv, 2006).

As a result, there has been an increasing investment in a family-centred and collaborative model of practice to address families' needs and improve the quality of care (Nicholson et al., 2015). This has been promoted internationally with a focus on integrating policy, research and practice. This has been established across various policies and guidelines in order to move away from the individual model of mental health care. For instance, Australia has developed a policy framework for supporting 'Children of Parents with a Mental Illness (COPMI)' ("Framework for mental health services," 2010-2015). This initiative promotes the adoption of FFP within services whereby the strengths and vulnerabilities of parents with mental illness, their children and the wider family are identified in order to provide support for all affected. This framework highlights the important relationships that can impact upon child and parent mental health such as parenting capacity, child development, risk stressors and protective factors. These factors are illustrated within The Family Model (Falkov, 2012) which underpins the family-focused approach to care. It aims to highlight this vulnerable group as a priority for mental health services to promote a family-focused care assessment of the patient and their family.

Other guidelines include the development of specific routine practices in Norway, in which the focus has been on integrated working between child and adult services, as well as increasing professionals understanding of FFP (Lauritzen & Reedtz, 2013). Similarly, across Ireland there has been policy implementation concerning the roles of practitioners and organisations to fundamentally offer support for the whole family via family-focused interventions (Grant & Reupert, 2016). Within the UK, there has been initiatives such as the “Think child, think parent, think family” initiative (Social Care for Institute (SCIE), 2009), and a continuing focus on improving accessible support for children and parents across child and adolescent services in Scotland (The Scottish Government’s Mental Health Strategy, 2017-2027).

The term FFP is used interchangeably across the literature such as family-centred, family-oriented, and family-sensitive, with the overarching theme reflecting the significance of the family. A recent integrative review sought to explore this significance through a review of FFP interventions across adult and child services. They identified several core practices of FFP with clients and their families (Foster et al., 2016). Some of these included family care planning; emotional and social support; psychoeducation and a collaborative care system between the family and services. This has provided a guiding framework for clinicians to consider the implementation of these core practices. Although this recent framework contributes towards defining what FFP may entail, it also reflects a considerable variability in family-focused related practices. What has been defined through the literature is that FFP is understood as more than merely family involvement but rather how professionals directly respond to and engage other family members in support (Foster et al, 2016). In an effort to further define FFP, Leonard, Linden, & Grant (2018) illustrate a continuum of FFP activities in their review, where they rank these activities in accordance with the intensity of family-focused work that professionals engage families in, such as from psychoeducation with the parent to working with the family as a whole.

Despite an increasing awareness for family-focused approaches, there are a number of identified barriers associated with its uptake. Mayberry and Reupert (2009) provide an overview of the barriers that present for the adult mental health workforce to respond to children and families impacted by parental mental illness (PMI). Barriers that were identified to hinder professionals FFP related to issues regarding policy and management; interagency collaboration; and practitioners’ attitudes, skills and knowledge. The inconsistency of policy

and guidelines was highlighted as a prominent barrier in terms of the variations in what should be routinely recorded (e.g. parenting status). Others were in relation to inadequate resources and time for FFP, and demanding workloads (Mayberry & Reupert, 2006; Byrne et al., 2000). They also highlight the limitations in skill and knowledge of clinicians to effectively respond to and ultimately meets the needs of families. This is consistent with research placing more of an emphasis on the experiences of clinicians practice in order to consider how to address these challenges (Tchernegovski, Reupert, & Maybery, 2017). Research is also now exploring the differences across professions and services in implementing FFP (Mayberry, Goodyear, O’Hanlon, Cuff, & Reupert, 2014). This is of particular relevance given the variation in which healthcare professionals conceptualize and practice FFP across differing health settings (Foster et al., 2016). Much of the existing research has predominantly explored the challenges of FFP from mental health nurses’ perspectives (Maddocks, Johnson, Wright & Stickley, 2010), therefore it would be opportune to explore to what extent other professionals’ experiences have been accounted for within the literature.

### *Aims*

As there is an increasing awareness of FFP together with new policy developments, and continuing organisational change across services, the aim of this review was to synthesize the qualitative evidence of mental health professionals’ perspectives and experiences of implementing FFP across child and adult settings. This was examined through evidence relating to the barriers and challenges for the mental health workforce in implementing FFP.

## **Methods**

### *Search Strategy*

Six electronic databases were systematically searched up to 23<sup>rd</sup> March 2018: EBSCO Host – CINAHL, PsycINFO, PsyARTICLES, The Psychology and Behavioural Sciences Collection; Ovid - EMBASE and MEDLINE. Databases were selected based upon their relevance to the research aims and the range of disciplines covered within these databases. Preliminary searches were conducted which helped to generate the final search terms and keywords used. The search terms were framed within the PICO (Population; Phenomena of Interest; Context) framework (see Appendix 1.2). These were categorised into “professionals”, “mental health”, and “family-focused practice”. Search terms from Foster et al. (2016) review served as a

guide. Additional hand searching methods were also employed via the reference lists of articles, previous reviews, and citations.

### *Inclusion and Exclusion Criteria*

Criteria for inclusion consisted of peer-reviewed published studies in English with (i) the focus on mental health professionals' perspectives and/or experiences of implementing FFP, (ii) based within adult mental health or child and adolescent mental health settings, and (iii) professionals' qualitative reports with quotations/ excerpts.

Exclusion criteria were (i) any studies relating FFP for physical health conditions, (ii) FFP specific interventions or projects such as family based interventions or any family specific therapies (e.g. behaviour family therapy), (iii) review articles, editorials or discussion papers, and (iv) any studies where the focus was not exclusively on professionals' FFP.

### *Screening and Selection*

Studies were reviewed in accordance with the eligibility criteria and were initially reviewed by title and abstract. Those studies remaining were then assessed for inclusion by reading the full text article, which determined the final number of included articles for review (see Figure 1).

### *Quality Appraisal*

Quality appraisal was conducted on each study to assess methodological quality and rigor. Walsh and Downe's (2006) quality tool (see Appendix 1.3) provides a comprehensive framework identifying eight key domains: score and purpose; method/design; sampling strategy; analytic approach; interpretation; researcher reflexivity; ethical dimensions; and relevance and transferability. This was employed to critique the papers due to its applicability for qualitative appraisal which can be applied reflexively to identify studies' strengths and weaknesses (Walsh and Downe, 2006).

Two independent raters each reviewed three purposively selected papers. There was agreement between the lead researcher and independent raters on majority of the domains with the exception of design, researcher reflexivity and analysis. For design and analysis, raters differed on the extent to which it was present (i.e. a score of 2) or partially present (i.e. a score of 1). For reflexivity, raters differed on whether it was partially present or absent (i.e.

a score of 0). It was agreed that individual quality ratings of each study would not be reported within this review but rather a focus on the methodological strengths and weaknesses appraised across each of the domains. This would instead provide an initial sense of the relationships and patterns emerging between the individual studies. In addition, the variation of qualitative method and analysis conducted across studies is a key challenge for appraisal (Dixon-Woods, Shaw, Agarwal & Smith, 2004). Thus, it was understood that a descriptive account would better ensure transparency of quality appraisal and to acknowledge the subjective nature of appraising qualitative studies. In this way, scores were not reported as a way of distinguishing those high quality studies from low quality studies, thus reducing the risk of valuable insights being excluded from the synthesis (Dixon-Woods et al., 2007). Additionally, given the limited number of qualitative studies on professionals' FFP it was deemed appropriate to include all those studies identified with an appraisal of their methodologies.

#### *Data Synthesis*

The data from studies were synthesized drawing upon the systemic approach of Noblit and Hare's (1998) method for meta-ethnography. The themes from each study were juxtaposed to identify commonalities and differences. This facilitated the 'translating of studies into one another' to further refine the themes and then synthesizing these using interpretation to produce an understanding of each theme. Data saturation was reached once no new themes emerged and no further discordance or alternative interpretations could be drawn.

An audit trail of both the data extraction and synthesis was recorded to enhance reliability (Mays and Pope, 2000) and were reviewed during research supervision. This also facilitated discussions relating to sources of subjectivity and bias such as the selection of papers that focused predominantly on barriers to FFP as opposed to facilitators, and its influence on the conclusions. However, it was agreed that the scope of this review would focus specifically on the barriers and challenges of a family-focused approach in order to offer a timely review of this area. Other discussions related to the selection of papers from many of the same authors and the risk in offering a potentially subjective view of FFP. However, through preliminary searches it became clear that much of the extant literature was predominantly from the same collaborating authors. The development of a clear search strategy and inclusion criteria assisted to reduce ambiguity around study selection.

## **Results**

The PRISMA flow diagram (see Figure 1) illustrates the review process. A total of 9 studies were included in the meta-synthesis. A summary of these studies can be found in Table 1 which illustrates the initial data extraction method.

### *Meta-Synthesis*

Two overarching themes were identified from the synthesis relating to professionals' implementation of FFP: organizational and system issues, and complexity of families' needs. There were six subordinate themes identified within organizational and system issues, and three subordinate themes within complexity of families' needs. Each were understood as factors through which FFP is implemented and were inferred from both enablers and barriers by professionals. Substantiating excerpts are presented within each theme. It is important to note that participant quotes are italicised while quotes from authors are in plain text. Tables 2 and 3 illustrate the contribution of each study towards the synthesis.

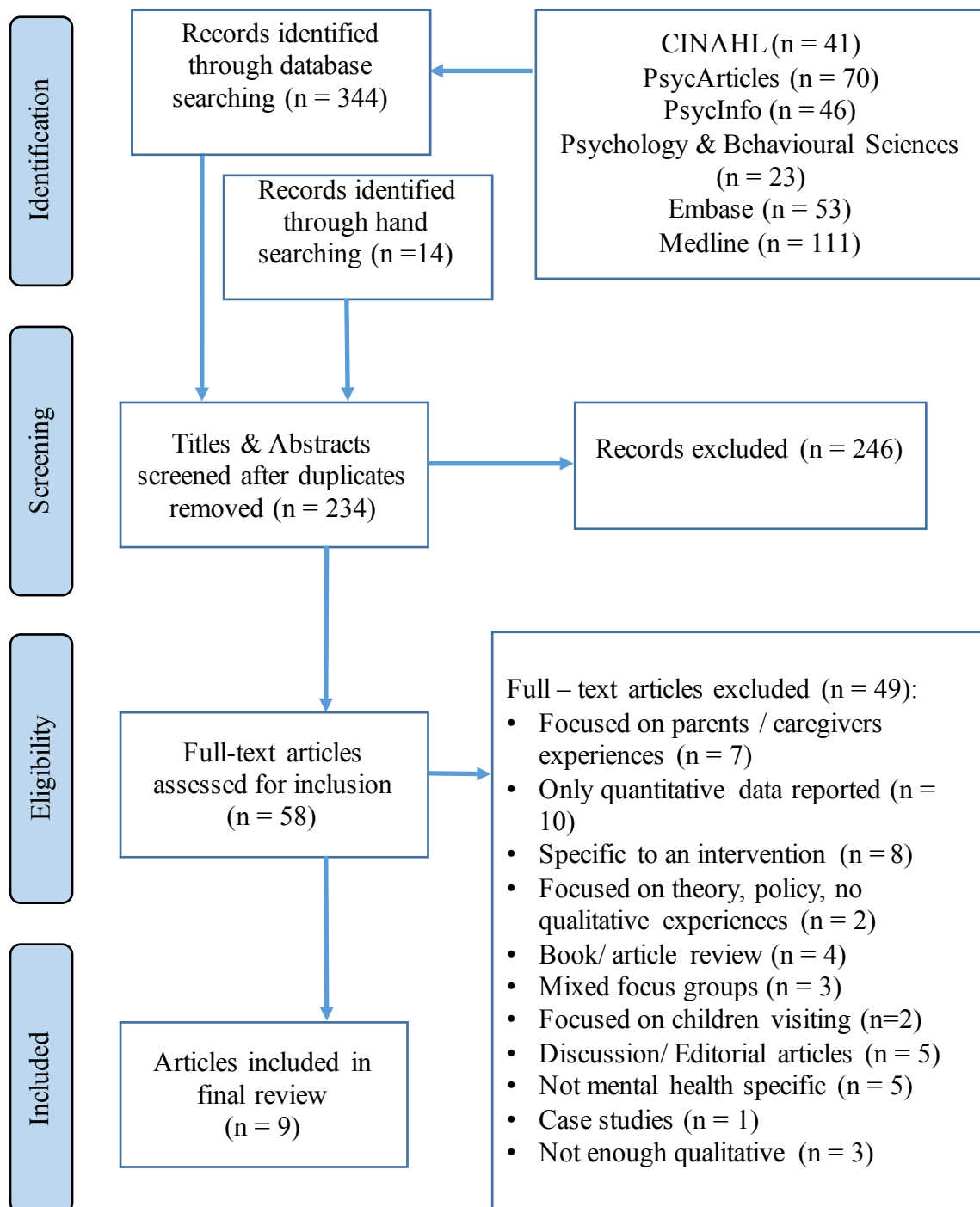


Figure 1. PRISMA Flow Diagram



Table 1. Characteristics of included studies

<b>ID/ Author</b>	<b>Year</b>	<b>Country</b>	<b>Professional group (n)</b>	<b>Mental health disorder</b>	<b>Mental health setting</b>	<b>Qualitative method and Analysis</b>	<b>FFP definition</b>
1. Baker-Ericzen et al.	2013	USA	Therapists (n=26) <sup>b</sup>	Disruptive behaviour problems (DBPs)	Community child mental health	Focus groups; Thematic content analysis	“Parent and child engagement”
2. Wong et al.	2016	Hong Kong	Social workers (n=7)	Mood; anxiety; and psychotic disorders	Adult community mental health	Semi-structured interviews; Constructivist grounded theory analysis	“The family as the unit of care...clients and families as collaborators”
3. Wong <sup>a</sup>	2014	Hong Kong	Psychiatric nurses (n=34)	General mental health	Community psychiatry; psychogeriatric; young people with psychosis; and child development service	Open-ended questions, Focus group and semi-structured interviews; Thematic analysis	“Patient and family as the experts on themselves and involves families as collaborative partners...”
4. Ward et al.	2017	Australia	Mental health practitioners (n=11): (mental health nurses (5), social work (2), social/community welfare workers (2), psychology (1), and occupational therapy (1).	Severe, persistent mental illness and complex needs	Acute inpatient, community services, and private practice	Interviews; Thematic analysis	“acknowledges and addresses the needs of people with mental healthcare needs and their family”

(continued)

Table 1. (continued)

<b>ID/ Author</b>	<b>Year</b>	<b>Country</b>	<b>Professional group (n)</b>	<b>Mental health disorder</b>	<b>Mental health setting</b>	<b>Qualitative method and Analysis</b>	<b>FFP definition</b>
5. Grant & Reupert <sup>a</sup>	2016	Ireland	Psychiatric nurses (n=14)	Parents with mental illness	Acute inpatient and community mental health	Semi-structured interviews  Thematic analysis	“The family as the unit of attention as opposed to working with an individual alone”
6. Tchernegovski et al.	2017	Australia	Mental health clinicians (n=11): Psychologists (4), mental health nurses (2), social workers (3), psychiatrist (1), and occupational therapist (1).	Parents with mental illness	Inpatient; outpatient; and community	Semi-structured interviews;  IPA	“extends the focus of care beyond the consumer...”
7. Reupert & Maybery	2014	Australia	Practitioners (n=10): Welfare workers, social workers, and mental health nurses.	Parents with mental illness and/ or substance abuse disorder	Child protection agencies and child mental health	Semi-structured interviews and focus groups  Discovery-oriented approach – inductive analysis	“care that is mindful and responsive to the needs of families...”
8. Reupert et al. <sup>a</sup>	2015	Australia	Primary care clinicians (n=21): Mental health nurses (6), psychologists (7), social workers (6), occupational therapists (1), and GP (1).	Parents with mental illness	Primary care	Focus groups;  Thematic analysis	“recognises the family of the client”
9. Reupert et al. <sup>a</sup>	2017	Australia	Primary care physicians (n=9)	Parents with mental illness	Primary care	Thematic content analysis	“family orientation”

<sup>a</sup> Mixed method study

<sup>b</sup> Study also included families’ perspectives but are not reported

Table 2. Studies contribution to themes relating to Organizational and System Issues

Studies	Sub-Themes					
	Policy & management	Working with services	Staffing issues	Physical setting	Culture	Training needs
Baker-Ericzen et al. (2013)	X	X	X			X
Wong et al. (2016)	X	X			X	X
Wong (2014)	X		X		X	X
Ward et al. (2017)	X		X	X	X	X
Grant & reupert (2016)	X	X	X	X	X	X
Tchernegovski et al. (2017)	X	X			X	X
Reupert & Maybery (2014)	X	X	X			X
Reupert et al. (2015)	X			X	X	X
Reupert et al. (2017)	X	X			X	X

Table 3. Studies contribution to themes relating to the Complexity of Families' Needs.

Studies	Sub-Themes		
	Attitudes, roles & identity	Addressing parenting status & concerns	Knowledge–Practice Issues
Baker-Ericzen et al. (2013)	X		X
Wong et al. (2016)	X	X	X
Wong (2014)	X		X
Ward et al. (2017)	X		X
Grant & Reupert (2016)	X	X	X
Tchernegovski et al. (2017)	X	X	X
Reupert & Maybery (2014)	X	X	X
Reupert et al. (2015)	X	X	X
Reupert et al. (2017)	X	X	X

### *Methodological Review*

There was clear documentation of all studies' scope and purpose. For sampling strategy, interpretation, ethics, and relevance and transferability, there was a clear report of how these were conducted and understood. A particularly good example of the analytical coding process was Grant & Reupert (2016):

“Themes were generated from information...around capacity to engage in FFP...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...” (p.206).

Design was also well reported across studies however for five of the studies, there wasn't a clear exploration of the rationale for their specific qualitative method or why it was appropriate for their study (Grant & Reupert, 2016; Reupert, Maybery, & Morgan, 2015; Wong et al., 2016; Wong, 2014; Ward, Reupert, McCormick, Waller, & Kidd, 2017). Analysis was generally well discussed such as that described in Baker-Ericzen, Jenkins, & Haine-Schiagel, 2013, and Grant & Reupert, 2016. However, there was a lack of "member checking" in three of the studies (Reupert et al., 2015; Baker-Ericzen et al., 2013; Wong, 2014). The main methodological difference that emerged was the lack of evidence of researcher reflexivity which was not evidenced in four of the studies (Reupert et al., 2015; Wong, 2014; Ward et al., 2017; Reupert, Williamson, & Maybery, 2017). There was however some demonstration of the researcher's influence on stages of the research process or evidence of self-awareness and insight by four of the studies (Grant & Reupert, 2016; Wong et al., 2016; Tchernegovski et al., 2017; Baker-Ericzen et al., 2013) with one study discussing the relationship between researcher and participants, however with no further evidence of the other aspects of reflexivity (Reupert & Maybery, 2014). A particularly good example of demonstrating researcher influence and how potential differences were resolved was Wong et al. (2016): "Writing the reflective memo was useful for flushing the matters out, and regular debriefing was conducted during the research process to address potential bias due to personal and professional orientation, and issues of power and social desirability" (p.451).

### ***Organizational and System Issues***

#### *Policy and management*

All studies contributed to policy and management issues within professionals' FFP to some degree (Baker-Ericzen et al., 2013; Wong et al., 2016; Wong, 2014; Ward et al., 2017; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2015; Reupert et al., 2017). Participants identified the significant impact service policies had on their capacity to engage in FFP, with a recurring pattern of professionals feeling the pressures of large caseloads and time constraints. This was depicted by Wong et al. (2016) where work was "oriented towards attainment of output indicators: *"Everybody is trying very hard to achieve impressive statistics...everybody just focuses on numbers...it was impossible to attain the output indicators"* (author and participant quote, p.456). Policy protocols such as documentation and paperwork were also associated with reducing freedom to practice: *"The focus has gotten more off what you're actually doing and [more*

into] being more accountable...like almost proving you're doing the work that you're doing. I don't like that autonomy is taken away from me..." (participant quote, p.860, Baker-Ericzen et al., 2013).

There were however positive reports from psychiatric nurses on "*legislation...from Children's First*" having "enabled FFP" (participant and author quote, p.207, Grant & Reupert, 2016). Overall there was a general consensus that "policy needs to acknowledge the relatively higher workloads for practitioners working with families" (author quote, p.649, Reupert & Maybery, 2014) via management support.

#### *Working with services & agencies*

Given that an important element of FFP involves collaborative working between services and agencies, this was conveyed across six of the studies (Baker-Ericzen et al., 2013; Wong et al., 2016; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2017) as both a challenge and facilitator in delivering FFP. For therapists, there were reports of "services in other agencies or related systems as unsupportive in their care of youth and their families" (author quote, p.860, Baker-Ericzen et al., 2013). This was also depicted by social workers reports of "fragmented and uncoordinated" services: "*What if the clients suffer from emotional disturbance because of parenting issues? Can we really divide the issues into two facets?*" (author and participant quote, p.455, Wong et al., 2016). For mental health clinicians there was specific mention of interagency barriers such as "the low level of response: "*...how much intervention they'll do – don't expect much*" with one clinician attributing this to agency differences: "*different systems [that] are working at cross purposes*" (author and participant quote, p.5, Tchernegovski et al., 2017). There were also references made to the "multiple players" involved in interagency working which can result in "*conflicting advice for families*" (author and participant quotes, p.646, Reupert & Maybery, 2014).

Others were able to draw upon the benefits of interdisciplinary working: "*she [the social worker] was very useful in child protection type issues so we would joint work at times*" (participant quote, p.209, Grant & Reupert, 2016) as well as sharing decision making within multi-disciplinary teams (Tchernegovski et al., 2017). Primary care physicians suggested their approach to families could reflect other models that they currently work with such as the "*shared care model – a bit like we do with obstetrics and pregnancy*" to encourage collaborative working (participant quote, p.333, Reupert et al., 2017).

### *Staffing Issues*

Five of the included studies (Baker-Ericzen et al., 2013; Wong, 2014; Ward et al., 2017; Grant & Reupert, 2016; Reupert & Maybery, 2014) contributed to this theme which closely related to the lack of policy and management as impacting professionals' implementation of FFP. This was attributed to the demands and expectations placed upon clinicians resulting in loss of staff: *"And we've lost some good clinicians that they, they come in and they just feel like they're so bogged down"* (participant quote, p.860, Baker-Ericzen et al., 2013). Staff inconsistencies was also noted as a factor in *"limited teamwork: [There is] different staff every day so there's very little consistency and [this] hinders my capacity in working with families"* (author and participant quote, p.210, Grant & Reupert, (2016).

### *Physical Setting*

Although the physical setting of services was only indicated in three studies (Ward et al., 2017; Grant & Reupert, 2016; Reupert et al., 2015), it was nonetheless an important contributing factor in the differences between community and acute settings. For instance, community settings enabled FFP for some practitioners: *"People are much more comfortable to present to their session with their mum, with their dad, with their partner, with their kids"* (participant quote, p.5, Ward et al., 2017). This was also associated with *"less stigma"* (participant quote, p.360, Reupert et al., 2015) and facilitated collaborative working by *"situating community mental health services within primary care centres and alongside other professionals"* (author quote, p.210, Grant & Reupert, 2016). Acute settings such as hospitals were found to hinder FFP: *"...you're targeted to four patients...and when they've got family members...[you] actually don't get a lot of time..."* (participant quote, p.5, Ward et al., 2017).

### *Culture*

All but two studies (Reupert & Maybery, 2014; Baker-Ericzen et al., 2013) identified the organizational culture of services as determining the level of support for FFP. This was particularly evident within the culture of a biomedical and problem-focused model within acute settings (Wong et al., 2016; Wong, 2014; Grant & Reupert, 2016). One professional related this to the *"hierarchical relationships between psychiatrists and nurses"* as inducing feelings of inferiority: *"It is hard to change the culture...if we want to introduce another intervention approach, the first response we will encounter is "why should I listen to you?"* (author and participant quote, p.216, Wong, 2014). However, this offered an opportunity to instil change: *"the family-centered approach can help build our*

*professional image*” as well as some nurses already seeing shifts in the culture with *“increased dialogue and sharing with colleagues”* (participant quotes, p.216, Wong, 2014).

The theme culture appeared to closely relate to the physical context of services whereby community settings were generally reported to promote a strength-based approach to families. This was indicated by the “structured parenting programmes” for parents (participant quote, p.4, Tchernegovski et al., 2017) and community based professionals valuing home visits which “enabled them to view the family holistically” (author quote, pag.209, Grant & Reupert, 2016). Psychiatric nurses highlighted this advantage of home visiting: *“I think the community perspective is so different to working in an inpatient setting because we see it as it is”* (participant quote, p.210, Grant & Reupert, 2016). Culture also related to how “the patient base was defined” for physicians in Australia in which they are only provided payment for the identified patient and not the family (author quote, p.3, Reupert et al., 2017).

#### *Training needs*

Professionals’ training needs were indicated across all of the studies as essential to facilitating a family-focused approach. Two of the studies (Wong et al., 2016; Wong, 2014) evaluated family-focused training of various professionals in which they “became more aware of the importance of the family context...[and] developed the ability to conceptualize the case from a systemic perspective” (author quote, p.452, Wong et al., 2016). This was reflected in their teams as encouraging collaborative working: “A colleague and I pair up to see family cases. The process is amazing” (participant quote, p.453, Wong et al., 2016).

It was apparent that a lack of training and continuing need for professional development related to the organizational culture in which “a paradigm shift from individual to family oriented and from pathology focused to strengths based” is required (author quote, p.217, Wong, 2014). There were particular training needs identified with those professionals working with PMI indicating a need for “training on working with complex families” (author quote, p.864, Baker-Ericzen et al., 2013) and education on “common experiences of parenting with a mental illness” (author quote, p.6, Tchernegovski et al., 2017). Additional skills training to engage children, parents, and families were also implied: *“to switch from group to individual or from adult to adolescent to child”* (participant quote, p.647, Reupert & Maybery, 2014).

Some clinicians indicated the need for training to outline “what the evidence says” for working with parents and families to allow them to “*put them into practice*” (author and participant quotes, p.333, Reupert et al., 2017). Whilst others identified attendance at training only “if there was a requirement to do so” (author quote, p.360, Reupert et al., 2015). Ultimately, training was conveyed as important for FFP but should depend upon the need of the professional group.

### ***Complexity of Families’ Needs***

#### *Attitudes, roles, and identity*

The development of this theme was contributed to by all of the included studies whereby there was a pattern of professionals’ attitudes towards families as largely impacting upon their engagement in FFP. For instance, “therapists expressed a desire to conduct family-focused therapy but felt constrained by parents’ lack of involvement: “*You have the resistance of parents...you can only do so much work without the family involved*” (author and participant quote, p.859, Baker-Ericzen et al., 2013). This was also echoed by social workers’ attitudes as “*seeing the family is extra work*” (participant quote, p.455, Wong et al., 2016) and primary care clinicians’ whose attitudes presented a “barrier to meeting children: “*Unless they’ve a good reason for children to be involved...why would you involve children?*” (author and participant quote, p.359, Reupert et al., 2015). These issues were in contrast to primary care physicians who “recognised that their role was working with families” (author quote, p.332, Reupert et al., 2017).

Professionals’ roles also appeared to influence the extent to which they were able to adopt a family-focused approach such as some psychiatric nurses who reported “we were it [performing role of social worker]” (participant quote, p.210, Grant & Reupert, 2016) due to a particular lack of social workers in their team. This indicated the often ambiguous roles of professionals’ which leads to the disparity of views on whose role it is to conduct family work: “*is that my job?*” with some identifying their concern of “*doing more damage than anything*” (participant quotes, p.359, Reupert et al., 2015). As such, Tchernegovski et al. (2017) noted the need for “the provision of clear guidelines and role descriptions in regard to family-focused tasks” (author quote, p.7). For psychiatric nurses in particular, their professional identity was viewed as a traditional one where “*therapies should be referred to the clinical psychologists and those with the title of ‘therapists...if we do this [family nursing], at least senior management will not agree with us*” (author quote,



p.215, Wong, 2014). It is evident that much of these attitudes are influenced by the organizational issues and training needs as mentioned.

#### *Addressing Parenting Status and Concerns*

Six of the studies (Wong et al., 2016; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2015; Reupert et al., 2017) made reference to the challenges in identifying parenting status and concerns when engaging in family work. Psychiatric nurses noted “the lack of a formal mandate to identify service users’ parenting status” as a barrier: “*there isn’t anything compulsory or formal in how we reach out to families*” (author and participant quote, p.208, Grant & Reupert, 2015). This was reflected in clinicians’ variation in addressing parenting status in which it was viewed as a standard procedure for some, whilst others “would ‘wait’ for patients to bring up their parenting role, or the child’s needs” (author quote, p.359, Reupert et al., 2015).

Regarding parenting concerns there was a general sense of uncertainty and sensitivity around how to approach this. For example, clinicians acknowledged the absence of the child in their assessment of the family as a barrier: “*you’ve got to rely on what [the parent is] saying*” (participant quote, p.5, Tchernegovski et al., 2017). Four of these studies however conveyed approaches that facilitated their engagement with parents and families such as a strength-based approach (Reupert & Maybery, 2014; Reupert et al., 2015), home visits (Grant & Reupert, 2016), and empathy (Tchernegovski et al., 2017).

#### *Knowledge – Practice Issues*

All studies contributed to this theme with a large emphasis on clinicians’ “feeling overwhelmed” in their response to families’ needs (author quote, p.859, Baker-Ericzen et al., 2013). This was related to the competing needs of families with reports of it being “*tricky*” and “*stressful*” (participant quotes, p.647, Reupert & Maybery, 2014). Psychiatric nurses reported having an increased knowledge on family-focused work following training, however there were questions remaining as to the extent this would “actually be translated into clinical practice”, with their contact with families being limited to advice and information: “*I phoned the families to share information about the client’s diagnosis and treatment plans*” (author and participant quotes, p.215, Wong, 2014). There was particular attention drawn to the importance of developing FFP theory in order “*to identify first what it is we do*” and a need for “*sharing and articulation of information regarding FFP within and between mental health services*” (participant quotes, p.212, Grant & Reupert, 2016).

Essentially the issues emerging within this theme drew closely upon the need for continuing training.

## **Discussion**

This review presents the synthesized qualitative findings of mental health professionals' experiences and perspectives of implementing FFP. Many of the themes drew upon the challenges that professionals' identified in their workplace. The results evidence that there is a significant overlap between challenges of FFP that present within the organization as well as those challenges specific to addressing the complexity of family work. Each of these were strongly found to impact the other and were closely aligned to training needs. As such, there was a strong connectedness between themes of organization, complexity, and training which are proposed as essential components to enable the implementation of FFP.

The themes identified draw close comparisons to Maybery & Reupert's (2009) review in which they conceptualized the barriers to working with families as a hierarchy at which change can be affected at specific points. They acknowledged the foundation of any family-focused service lies within the organizational and managerial support. This was certainly consistent with the findings of the current review where issues with policy and the level of management support directly influenced professionals' capacity to implement FFP. Sub-themes within the organizational context such as interagency working, and staffing were also found to overlap, with each being influenced by the other. This was particularly evidenced from Grant & Reupert's (2016) study in which many of the organizational barriers simultaneously acted as facilitators of FFP. This suggests the close relatedness of these issues and highlights the importance of services to consider these in turn to promote an organisation that is family-focused. These organizational factors have also been documented in earlier studies (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014).

The organizational culture and physical setting of services also appeared to be closely interrelated whereby community settings advocated a more family-sensitive approach than acute inpatient units. The benefits depicted by professionals within community services is consistent with a recent review exploring health visitors' FFP in which they convey the importance of home visiting as facilitating a whole family approach (Leonard et al., 2018). Importantly, their review emphasized the links between limited resources and poorly

specialized training as hindering FFP. These findings were reflected within the current meta-synthesis whereby professionals' capacity to engage in FFP related to a need for continuing training and professional development skills. This was viewed as particularly influential in promoting collaborative and interagency working, and changing the organizational culture towards FFP, as well as a shift towards holistic and strength based approaches.

Training needs were also associated with the complexity of families' needs. There were a range of issues that emerged which pertained to the ambiguity around professionals' roles as influencing their attitudes towards working with families. This was further embedded within policy and system related factors such as the need for clearer guidelines and role descriptions together with training. This is also in keeping with Maybery & Reupert's (2009) hierarchy of needs.

Issues around addressing parenting concerns were understood within the context of a lack of policy (e.g. no routine identification of parenting status) and clarity on how to respond to families' needs alongside the practical skills required to match the need. Thus with initiatives focusing on the importance of a family approach, these findings further support the need to consider enactments of FFP. This reflects a wider implication upon government policy to act upon this. The knowledge-practice gap that was evident also supports the literature on the need for formalised FFP specific practice guidelines (Foster et al., 2016).

### *Strengths and Weaknesses*

The included studies were based within four different countries where variation is likely to occur in the practices adopted within mental health services as well as in the interpretation of FFP, mental health, and contextual issues such as the organizational settings. However, the fundamental aim of this review was to explore different professions' implementation of FFP, thus given that there has been an international emphasis on promoting FFP, it was relevant to include those studies. Nonetheless, it was deemed a strength of the synthesis that FFP was understood similarly across the studies.

The inclusion criteria facilitated the systematic selection of studies enabling clear theoretical generalisations to be produced in keeping with the aims of meta-ethnography (Pope, Mays, & Popay, 2007). Arguably the inclusion and exclusion criteria acted as a false dichotomy given the challenge of distinguishing between FFP interventions versus implementation of professionals FFP. However as Foster et al. (2016) review already

explored the range of FFP interventions, we sought to focus on FFP implementation at a broader level.

The reviewer was also aware of interpretations being naturally influenced by an existing knowledge and familiarity of FFP, however supervision ensured the synthesis process was as transparent and reflective as possible. Similarly, this encouraged an awareness of the variety of epistemologies and qualitative methods employed across the studies and their contribution to the interpretation.

### *Implications and Conclusion*

The findings from this review point to a wider issue of FFP in which services should consider incorporating each of the above themes into their practice as a way of addressing the array of challenges that professionals' experience in implementation. The findings highlight that in order to tackle these barriers, there must be a response to identify to what extent the needs of each of the connecting themes can be realistically met. Maybery & Reupert's (2009) hierarchy on addressing low level factors in the first instance, such as organizational support building up to addressing workforce attitudes, knowledge and skill, is an essential framework that should be utilised across mental health services. However, the findings from the current synthesis seek to place an equal emphasis on each of these factors when considering professionals enactment of FFP. Furthermore, future research should seek to develop these models by differentiating between various mental health professions as has been initiated by Maybery et al. (2014). Future research should also continue to seek input from service users and their families to incorporate their views and experiences of family-focused input across a range of FFP activities as highlighted (Leonard et al., 2018). Regarding policy, it is intended that the current review draws attention to the lack of policy advocating FFP across the UK in particular. Although there has been an increasing focus on developing initiatives within Northern Ireland with much success (Grant et al., 2018), there is limited research evidence of this elsewhere.

What was particularly striking from the synthesis was the limited evidence of professionals viewing the benefits of FFP which was not reflected across professionals' attitudes. Many of the professions expressed their concerns around whose responsibility family work is. These views allude to professionals lacking a sense of shared expectations and outcomes and perhaps raises the question as to why professionals should invest in FFP, and Why FFP is worth the resource and effort. Further, although this review sought to identify the barriers and challenges in implementation of FFP, there is still little emphasis on the

facilitators of FFP across the literature. It is evident that the ongoing challenges to implement family-focused care have been widely acknowledged, and in efforts to address this a number of drivers behind developing preventive interventions have been outlined. These include a need for greater empirical evidence, policy and legislative support, leadership, and capacity (Falkov et al., 2016). This integrated approach is therefore likely to better inform stakeholders of the value of investing in the implementation of FFP. Exploring stakeholders' involvement through implementation models may also be warranted.

A further understanding of the benefits of FFP together with a consideration to supporting professionals' competencies and level of knowledge will better reflect their needs as well as the needs of families. Research has begun to identify and make these links explicit through the development of a comprehensive logic model (Grant et al., 2018) in which distinct associations are made between the resources, activities, outputs, and outcomes of a family-focused initiative in Northern Ireland. It is clear from this model that much work is being undertaken to make clear the processes for implementing FFP across services and to provide clarity around what is expected of the workforce. This logic model (Grant et al., 2018) recognises the need for a focus on expected outcomes for meeting families' needs rather than solely focusing on how system improvements can be made. It is therefore hopeful that the development of FFP specific models will assist to establish standards of practice across mental health services.

Nonetheless, with the evidence for FFP largely dominating within Northern Ireland and Australia, much of what can be understood of FFP is therefore drawn from a particular care delivery model of practice. This naturally has implications for the wider implementation of FFP internationally and points to a greater need to consider implementation within mental health service contexts in the UK.

To the authors' knowledge, this is the first qualitative review looking specifically at mental health professionals' experiences of FFP across adult and child mental health settings. From the synthesis, there was a clear association between the organization, the complexity in meeting families' needs, and professionals' training needs, all of which combine to facilitate FFP. This study contributes to the existing literature by focusing the attention on the needs of mental health professionals to deliver effective FFP. There exists a significant challenge in FFP becoming embedded within services but it is intended that the growing

literature on the benefits of FFP together with the development of FFP guidelines and identifiable short and longer-term outcomes will assist the implementation process.

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## **Chapter Two:**

### **Stakeholders' perspectives of family-focused practice and engagement in a community outreach service: Application of normalization process theory**

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## **Plain English Summary**

### **Introduction**

Recent years has seen an increase in literature on the effectiveness of a family-focused approach to supporting children and families impacted by parental mental illness (Foster et al., 2016). In recognition of this, a number of initiatives have been underway to develop policy and framework in order to highlight the vulnerabilities associated with these families (Falkov et al., 2016). A number of barriers present for professionals to meet the needs of this population which identify a need to further understanding of implementation processes to effectively meet clinician, user, and family's needs.

Research could benefit from addressing major stakeholders' perspectives (i.e. users and their families) of a family-focused approach to their treatment, together with an exploration of factors deemed important for engagement in therapeutic support. Thus, an understanding of the implementation processes of family-focused practice could provide valuable insights into the coherence of views across stakeholders to inform routine practice.

### **Methods**

Mental Health Clinicians, parents and young people from a specialist community outreach mental health service were invited to participate in focus groups and interviews to explore multiple stakeholder perspectives of family-focused practice. Factors considered important for engagement were also explored. Data was first analysed using thematic analysis (to identify themes that were data-driven). Framework analysis using Normalization Process Theory (NPT) was then used to map the emerging themes onto a theoretical framework (NPT) that conceptualized the implementation process. Ethical approval was granted and the study was conducted at one NHS site and across home settings.

### **Results**

Common themes across stakeholders included the value of a family approach to meeting the needs of parents and young people. Other themes included the importance of understanding parental mental illness, and the benefits of an outreach approach as facilitating FFP and engagement. The application of NPT conveyed coherence and participation around stakeholders' investment in FFP which was evidenced by clinicians' enactments (e.g. the family model, systemic working, outreach approach). However, there

was variability in the level of family-focused practice received by users, relating to organisational and policy issues.

## **Conclusions**

A family-focused approach is highly endorsed by stakeholders with reported benefits for all. The findings have clinical relevance for the implementation of FFP across services. Future research identifying expectations of support to facilitate implementation should be explored.

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## **Abstract**

This qualitative study explores stakeholders' perspectives of family-focused practice and engagement factors in a community outreach service for children and their families affected by parental mental illness. Participants included mental health clinicians, and parents and young people who were receiving input from the service. Data for clinicians were gathered via two focus groups (n=8) and semi-structured interviews were conducted for parents (n=4) and young people (n=5) aged 13-16. Analysis included an inductive and iterative thematic approach and a deductive framework approach using Normalization Process Theory to explore the implementation of family-focused practice within the service. Results indicated coherence of views across stakeholders regarding the benefits of a family approach, with clinicians' application of the family model as enabling family-focused practice, and families' participation indicating an overall investment in a family approach. Stakeholders endorsed the community outreach approach however clinicians' appraisal of this was both an enabler to a family approach and a barrier in terms of demands and expectations. Factors for engaging families were also found to be embedded within a family approach and facilitated engagement and an understanding of needs.

**Keywords:** Family-focused practice, stakeholders, implementation, normalization process theory

## **Introduction**

There has been an increasing concern that mental health services seek to address the needs of children and young people where parental mental health (PMH) difficulties are prominent (Cooklin, 2013). Within the UK this was highlighted through the *'Think Child, Think Parent, Think Family'* initiative (Social Care Institute for Excellence (SCIE), 2009)) which addresses the practical, professional and organizational challenges of meeting these families' needs. It acts as a policy guideline for professionals working within child services. The outcomes from this focused on the complexity of both the parent and child's needs relating to a whole family working approach, addressing both the child's needs whilst acknowledging the parental responsibility of the adult. Earlier changes in policy have highlighted the need for improvement in these services that will enhance community inclusion (Davidson & Roe, 2007). This has been ongoing within governmental approaches (The Scottish Government's Mental Health Strategy, 2017-2027) which highlight the need for service integration and inclusion. However, there are a number of challenges that present in meeting the needs of parents with a mental illness and their families. Those families affected by parental mental illness (PMI) have been found to be among the most vulnerable with an increased likelihood of experiencing social isolation, and lower psychological and physical health (Reupert & Mayberry, 2007). With more recent initiatives within Northern Ireland (Grant & Reupert, 2016) and internationally (Nicholson et al., 2015) which have placed an emphasis upon a family-focused approach to practice, there presents opportunities to explore in what way services are responding to families experiencing difficulties with PMI. In this context, family-focused practice (FFP) is understood as the response of professionals to both the parent and child's needs.

### *The impact of Parental Mental Illness*

The emotional, social and practical support provided by parents plays a significant role in the child's emotional, psychological and behavioural development. As parenting is often complicated by the adult's mental health difficulties, therefore often these developmental needs are interrupted having implications for their future mental health and development (Falcov, 1998). A key factor for good mental health and psychological resilience is determined by the strength of the parent-child relationship (Falcov, 2012). Studies have highlighted additional challenges with children experiencing high levels of anxiety, and a sense of blame, guilt and isolation (Weir & Douglas, 1999; Cooklin, 2013). A challenge therefore presents for services to respond to both the child and parent's unmet needs by drawing upon a family approach. In this way, there must be recognition for the family as a



whole which requires a multi-faceted approach. The family model (Falco, 2012) provides a model of practice which considers the adult and child's mental health and development, and the associated parenting and family relationships. It takes into account the social and cultural factors as well as the formal and informal support systems available to the family. In order to promote resilience, there must be a network of support around families which extends to the responses of professionals (Cooklin, 2010, 2013).

### *Engagement*

Parents with mental illness and their children are one of four groups most likely to have difficulty in their needs being recognised by services (SCIE, 2009), thus understanding families' engagement needs can assist services to effectively respond. Understanding users' intentions and expectations can serve to facilitate this engagement. Wright, Callaghan, & Bartlett (2011) found level of engagement as determined by themes of contact, dialogue, transformation and a shared understanding. Engaging children in particular is highly dependent upon parents and there have been a number of parent and family factors associated with parent engagement specifically, including expectations, motivation and perceived barriers (Nock, Ferriter & Holmberg, 2007). Engagement in this context is therefore understood as factors that assist families to therapeutically engage and seek support from services.

### *The role of stakeholders*

A joint working approach between services and families requires collaboration between all individuals involved to facilitate an effective response. Normalization Process Theory (NPT) is a theoretical framework which seeks to understand the implementation of new practices within healthcare by exploring mechanisms that promote or inhibit the enactment of a practice (May et al., 2009). This is understood within four constructs of NPT: coherence (i.e. attitudes of stakeholders); cognitive participation (i.e. willingness and involvement in implementation); collective action (i.e. service enactments); and reflexivity (i.e. evaluation and appraisal) (Hazell, Strauss, Hayward, & Cavanagh, 2017). NPT focuses on the interaction between group processes rather than on one individual group at a time. This encourages analysis across multiple stakeholder perspectives, particularly those involving a collaborative working approach between stakeholder groups such as professionals and service users (MacFarlane & O'Reilly-de Brun, 2012). NPT is particularly relevant to the aims of this study as the primary focus of NPT is to understand the different stakeholder groups involved which enable the normalisation of an intervention. In this way, it provides a clear and consistent framework in which to

determine the factors that enable and hinder the successful implementation of a complex intervention, as well as to enhance its implementation potential (Murray et al., 2010). Utilising NPT in this context will draw attention to what extent the research evidence for a family approach translates into clinical practice in a child and adolescent mental health service.

### *Aims*

This qualitative study aimed to explore multiple stakeholder perspectives of FFP and engagement factors in a community outreach mental health service for children and parents affected by PMI. To understand how these factors are implemented and become embedded into practice, NPT was applied. This provided a framework for exploring implementation and normalization processes across stakeholder groups (Murray et al., 2010). NPT acknowledges the interactions across groups and thus was utilized to investigate coherence of views and actions in relation to the implementation of FFP.

### *Research Questions*

1. How is a family-focused approach encompassed within the service?
2. How do factors for engaging parents and young people fit within FFP?
3. Can stakeholders' perspectives of the implementation of FFP be understood within a NPT framework?

## **Methods**

### *Design*

This exploratory study adopted a qualitative design. Focus groups were conducted with clinicians and semi-structured interviews were completed with parents and young people. Topic guides for each participant group were generated prior to the commencement of recruitment and were reviewed during research supervision to facilitate the relevance of stimulus questions and accessibility of language across the groups (see Appendices 2.1-2.3). Thematic analysis was utilised as a realist method to report the experiences, meanings and the reality of participants (Braun & Clarke, 2006). The focus of the study was purposely broad in order to elicit meaningful themes and to enhance data richness. Framework analysis using NPT as a deductive approach extended the analytical process to evaluate the processes of implementation within practice.

It is important to note that the development of the study design was initiated in consultation with clinicians of the child and adolescent mental health service (CAMHS) during which their priorities reflected a need for an evaluation on factors for engaging families affected by PMI. During this consultation, there also emerged a unique strength of the service being their family approach to supporting young people. These are reflected in the study aims.

### *Ethical Considerations*

The study was reviewed by the West of Scotland Research Ethics Committee (17/WS/0241) and sponsored by NHS Lanarkshire Research and Development Department (L17066) (see Appendices 2.4-2.5). Written informed consent was obtained prior to each clinician focus group and parent and young person interview where confidentiality and anonymity were explained (see Appendices 2.6-2.8). Capacity to consent was assessed by the main researcher and the referring clinician along with assent from their parent (in accordance with the Scottish Children's Research Network guidance on obtaining informed consent, 2012). All participants under 16 were assessed as competent to consent.

### *Participants and Recruitment*

#### *Clinicians*

Clinicians working within the Tier 3 CAMHS (for young people who are affected by their parent or family member's mental illness) were recruited following a presentation explaining the study purpose. They were provided with an information sheet detailing the purpose of their participation (see Appendix 2.9) as well as an information sheet detailing the inclusion criteria for participation of young people and parents on their caseload (see Appendix 2.10). Clinicians were informed that their participation would not negatively impact their position within the service. Two focus group dates were scheduled so as to accommodate for clinicians' capacity to attend. Thus two clinician focus groups (n=8) were conducted. The demographics for each individual clinician were not reported due to the potential for this to effectively de-anonymize participants. Clinicians consisted of child and adolescent mental health clinicians from a range of backgrounds such as mental health nursing and family therapy (n=4); clinical psychologists (n=2); and child and adolescent psychotherapists (n=2). Clinicians length of experience within the service ranged from 6 months to 16 years (median= 7.5 years). Age of clinicians ranged from 30 to 51 (median= 43.5 years), and included 5 females and 3 males.

### *Parents and Young People*

Parents and young people were recruited from mental health clinicians within the service who in the first instance provided potential participants with an information sheet (see Appendix 2.11). A recruitment poster (see Appendix 2.12) was also placed in the waiting room and circulated to clinicians. Verbal consent was obtained prior to their details being passed for further discussion with the researcher. Inclusion criteria for parents consisted of (i) the parent receiving input from the service for their mental health difficulties which are impacting upon their child, (ii) have a good level of stability in their presentation as deemed by the service, (iii) have capacity to consent and (iv) English speaking. Young people's inclusion criteria comprised (i) age 12-18 years, (ii) receiving input from the service for their mental health which is being affected by their parent's mental illness, (iii) have a good level of stability in their presentation, (iv) deemed competent to consent, and (v) English speaking. Parents and young people were eligible to participate at any stage of their treatment with assurances that their participation would not negatively impact their current or future treatment. They also did not have to be recruited from within the same family. Only two of the parent participants had young people whom also participated.

A purposive sampling method was employed for the parent and young people interviews until sufficient saturation was reached (i.e. approximately the same number of participants across each group). Thus four parent (n=4) and five young people (n=5) semi-structured interviews were completed (see Table 1).

Table 1. Parents and Young Peoples Demographic Information

<b>Participant*</b>	<b>Age (years)</b>	<b>Gender</b>	<b>Length of input</b>	<b>Mental Health</b>
<b>Parents</b>				
Claire	50	Female	7 years	Schizophrenia/ BPD
Jill	45	Female	5 years	PD/ Anxiety/ Depression
Mary	34	Female	2 years	Anxiety/ Physical health
Amanda	42	Female	3 years	Bipolar/ ADHD
<i>(Mean)</i>	<i>(43)</i>		<i>(4.3)</i>	
<b>Young People</b>				
James	14	Male	2 years	Anger
Laura	13	Female	4 years	Anxiety
Scott	15	Male	5 years	Anxiety
Aiden	15	Male	3 years	Anxiety
Charlotte	16	Female	5 years	Anxiety/ Low mood
<i>(Mean)</i>	<i>(14.6)</i>		<i>(3.8)</i>	

\*Pseudonyms

### *Procedure*

Each focus group consisted of four clinicians, lasting 1.5-2 hours. Focus groups with clinicians encouraged participants to interact with one another thereby limiting interaction with the facilitator (a method particularly suited for exploratory discussions and increases the validity of participants' perspectives (Morgan, 1997)).

Separate focus groups for parents and young people were initially proposed, however due to the logistical difficulties in access to the clinic for these families as well as many participants' reported anxieties around partaking in focus groups, individual semi-structured interviews were sought. These difficulties were anticipated at the proposal stage (see Appendix 2.13) and therefore had formerly been approved by ethics. Additionally, there were difficulties in clinicians recruiting parents and young people due to a number of issues such as ambivalence about participating in a research study, not feeling well enough to partake, and feelings of participation being an additional stress. These issues are reflected in the small participant numbers. Interviews were conducted via home visits across Lanarkshire. Interview duration ranged between 12-54 minutes (mean=34.2). Interviews enabled parents and young people to provide their perspectives in familiar settings to them which is likely to have reduced their inhibitions.

### *Data Analysis*

Interviews were audio recorded and transcribed verbatim. An inductive and iterative thematic process was first adopted so as to generate themes with a strong association to the data itself (Braun & Clarke, 2006). Transcribing and checking the accuracy of transcripts allowed the researcher to become familiarised and immersed in the data. Initial codes were generated from the entire dataset at a semantic and explicit level. Extracts of the data were coded inclusively so as to keep the context surrounding the extracts (Bryman, 2001). Each focus group and interview was analysed separately using a comparative process of the codes across each transcript (Glaser & Strauss, 1967). The second level of coding involved collating the codes and grouping them within potential broader themes. Thematic maps representing this refocusing of data are shown in Appendix 2.14, in which themes and subthemes were finalised. Analysis was facilitated by an analysis software package, NVivo (version 11.0).

Ritchie & Spencer's (1994) framework analysis model was then adopted utilising NPT as a theoretical model. The emergent themes from thematic analysis were mapped onto NPT constructs (coherence; engagement; collective action; and monitoring). This involved an

iterative process moving between the emergent themes and NPT constructs to ensure the mapping process reflected this specific study setting and context (MacFarlane and O'Reilly-de Brun, 2012). Overlap of themes between the constructs were noted and ensured that the NPT framework enhanced an overall understanding of stakeholders' perspectives.

### *Reflexivity*

Researcher reflexivity was maintained through the recording of each analytic stage in the researcher's analysis logbook. Any discrepancies in the analysis were discussed during research supervision to increase the validity of themes as coherent and representative of each stakeholder group. The lead researcher acknowledged her role as a trainee clinical psychologist with experience across CAMHS teams. This simultaneously offered a valuable perspective in terms of understanding participants, whilst acting as a disadvantage in terms of the assumptions that may have been drawn. This relates to the shared language with participants and familiarity with the service which may have informed the researcher's preconceptions about what themes are likely to occur. In an effort to address this, the researcher made explicit her role and profession and asked participants not to assume her level of understanding of CAMHS. None of the participants were clinically known to the researcher. As the study was designed in consultation with clinicians, this could be argued as a strength to the study design, yet also a challenge to reflexivity.

## **Results**

The themes and corresponding subthemes from each stakeholders' perspective are illustrated in relation to FFP and factors deemed important for engagement. Tables 2 and 3 present a summary of the emerging themes and subthemes from thematic analysis. Salient points within these are described below.

Table 2. Clinicians themes and sub-themes

Stakeholder Group	Theme	Sub-theme
Clinicians Perspectives	Enablers of FFP	<ul style="list-style-type: none"> <li>• The Family Model</li> <li>• Community Outreach Approach</li> <li>• Systemic Working</li> </ul>
	Barriers of FFP	<ul style="list-style-type: none"> <li>• Outcomes &amp; lack of awareness</li> <li>• Community Outreach Approach</li> <li>• Structure of Adult Services</li> </ul>
	Factors for engaging Parents	<ul style="list-style-type: none"> <li>• Understanding PMH</li> <li>• Non-Judgemental Approach</li> </ul>
	Factors for engaging Young People	<ul style="list-style-type: none"> <li>• Child-Centred Approach</li> <li>• Understanding their parent's MH</li> </ul>

Table 3. Parents & Young Peoples themes and sub-themes

Stakeholder Group	Theme	Sub-Theme
Parents Perspectives	FFP	Level of family involvement
	Engagement Factors	<ul style="list-style-type: none"> <li>• Understanding the parent and child</li> <li>• Bringing a sense of calm</li> <li>• A family approach</li> </ul>
Young Peoples' Perspectives	FFP	Level of family involvement
	Engagement Factors	<ul style="list-style-type: none"> <li>• Being listened to</li> <li>• Community Outreach Approach</li> <li>• Support for the family</li> </ul>

## MENTAL HEALTH CLINICIANS

### 1) Enablers of FFP

#### *The Family Model*

Clinicians made references to the family model (Falkov, 2012) as an approach that they utilised in their practice with families. They discussed the different elements that were fundamental in their assessment process of families as those which are embedded within the family model:

*“we kinda look at the adult with the mental ill health...we look at the child’s [mental health] and development, and then the third part processes [such as] the child’s and parent’s relationship. And so really it is a family approach”* (Clinician (C)6, page (p.)4, (line)114).

Clinicians adopted the family model within their practice as a way of incorporating all potential factors impacting upon *“the dynamics and functionality of a family”* (C6, p4,117). They also described the value of this model to empower the family: *“You’re investigating both where are the stressors and protectors in the families”* (C6, p.7,246) and *“...it is actually accepting the expertise of the family”* (C4, p18,648).

#### *Community Outreach Approach*

Clinicians drew on the advantages of a community outreach approach which enables them to practice in a family-focused way. They expressed the value of gaining an experience of a family’s overall level of functioning within their home environment *“...It’s almost that in-vivo rather than in-vitro type, we’re actually getting an experience of that”* (C4, p.14,501) and the resulting impact this has on the family’s ability to transfer skills. This was highlighted through the difference between clinic appointments and home visits: *“...and when they take that back it gets lost, but if you’re in there and actually taking them through and the child through it, there’s something a bit more viable for the family”* (C4, p.14,506).

Clinicians also stated the significance of the community approach in accessing families whom are otherwise missed. They expressed this through powerful descriptions such as *“hidden children”* (C4, p.15,560) and *“hidden families”* (C6, p.1,18). They related this to the challenges (e.g. financial, rural) that families face in accessing the general clinic based approach across CAMHS and adult services. This appeared to form the remit of the service *“...to find out about these hidden families, in terms of families who do or don’t make the clinic, and therefore children who are unseen...and what our remit was in how we work...”* (C6, p.1,18).

#### *Systemic Working*

*“The systemic approach”* (C4, p.28,1062; C6, p.12,430) was viewed as enabling clinicians to draw upon other resources to encourage a family approach – *“...so whether that be adult mental health clinicians supporting a parent, engaging with school staff, you know, just*



*trying to find those supports...*” (C7, p.7,236). Professionals considered the role that they offer within multi-agency working. They discussed the value of their role in *“keeping the child at the centre”* (C2, p.19,720) and to assist professionals to reflect, particularly when the parent’s mental health consumes the system:

*“...things get quite caught up with the parent’s mental health, and I find that a lot with parents of very young children because health visitors and social work are naturally concerned about the parental mental state, but actually what you’re trying to highlight is this is the experience for this child while this mother is in this state...”* (C2, p.6,218).

## **2) Barriers of FFP**

### *Outcomes and lack of awareness*

Although clinicians identified the benefits of the family model, there was discussion around the difficulty of measuring outcomes for families: *“It’s not as simple as symptom reduction, its relational work”* (C7, p.28,989). This was related to clinicians fears around the sustainability of their work – *“...because it’s so much of a financial ballgame...and services can fold”* (C6, p.25,896). Clinicians were thus aware of their need for *“an evaluation...and an evidenced based feel”* about their work (C6, p.25,893). There was an overall evidence of commitment from clinicians to consider how they evidence *“slightly open-ended outcomes”* (C5, p.28,992) due to the long-term work with families: *“...because it’s difficult doesn’t mean it’s not doable...it’s about moving forward with it”* (C2, p.28,995). This was also related to the lack of awareness of this population group and clinicians want to act upon this: *“we’re not on the fancy government strategy...we have a responsibility to raise the profile of these families and make people more aware”* (C1, p.26,986).

### *Community Outreach Approach*

The community outreach approach was also described as exposing clinicians to the chaos existing within many of the families: *“We get caught up in actually almost the family’s functioning because it’s community based”* (C4, p.12,451). Professionals expressed feeling *“quite vulnerable as a worker to what happens in the family”* (C2, p.12,447) and having an awareness of professional boundaries and roles – *“...their boundaries are very diffuse...it’s very easy as a clinician to get drawn into something that actually isn’t your role”* (C2, p.15,537).

The outreach approach posed a challenges in terms of the demands and expectations placed upon clinicians, such as waiting time targets and the impact of travelling on caseload and admin demands - *“you’re not really getting your notes up to date”* (C8, 21.763). Overall this was described as a *“vulnerability”* (C8, p.18,642) for the team to *“protect”* (C3, p.16,585) what it is they do but community work was also viewed as outweighing these issues – *“in terms of engagement and flexibility and availability for families, it’s something that we’ve just came to accept”* (C6, p.22,771).

#### *Adult Services Structure*

Clinicians recognised the disparity in the structure of CAMHS and adult services as a barrier to engaging with families where they described having repetitive conversations around service roles – *“there’s a role for adult mental health to kinda manage the mental health bit [of parents]”* (C4, p.20,741). They also expressed a lack of referrals from adult services, however with an acknowledgement that adult clinicians do not have opportunities to see the child: *“It sounds like there is negativity towards them but quite often they’re not seeing children, so the representation of the child eh is a descriptive one from the parent...they’re seeing the parent unwell on their own”* (C3, p.28,1056).

### **3) Factors for engaging parents**

#### *Understanding of PMH*

Clinicians described the importance of connecting with the parent via an understanding of their mental health. This involved understanding the impact on their parenting by *“externalising the parents...letting them see that they are a person beyond their illness”* (C3, p.23,875). This was understood as a crucial element for engagement: *“...when they hear those words, they hear that kind of level of-of support, in terms of understanding, eh it’s usually the hook that gets them engaged...”* (C5, p.18,632)

#### *A non-judgemental approach*

Professionals made countless references to adopting a non-judgemental approach, with them recounting instances of parents worries around judgement – *“you’re gonna judge me, you’re gonna give me a hard time for, you know, I’ve failed because of my mental illness”* (C1, p.23,871). This was linked to the importance of trust for families, which one clinician’s description of families as *“suspicious families”* (C6, p.17,588).

#### **4) Factors for engaging young people**

##### *Child-Centred Approach*

Clinicians related engagement with young people as centred around that of the child – “*a consistent adult who is interested in them and wants to know about them...*” (C3, p.21,792). This was viewed as encouraging engagement and offering them “*a secure attachment that holds them at the centre*” (C4, p.22,815).

##### *Understanding their parent’s mental health*

Communicating an understanding of the parent’s mental health to the young person was understood to facilitate “*...an experience of somebody else thinking about my mum or dad...*” (C3, p.23,850). Young people were viewed by professionals as having loyalties to their parents which was described as both a “*barrier*” (C4, p.21,766) and “*strength*” (C3, p.17,636). Professionals utilised this as a way of engaging with young people and reducing responsibility: “*...somebody else is you know, making sure that I’m getting this right (laughs) and no it’s not my job, so I think a reassurance that you’re looking out for their parent aswell...*” (C3, p.23,850).

## **PARENTS**

### **1) Family-focused Practice**

#### *Level of involvement with the family*

Parents reported variability in how involved they felt with the support their child received. They reported more of a focus on support for their child or children rather than for them as the parent – “*as I say, it was more for [Scott]*” (Claire, p.2,80), and “*He wasnae really assigned to me, it was the children*” (Jill, p2,.88). Parents generally described receiving feedback about their children – “*Yes, he would feedback and that with me...*” (Claire, p.5,222) which they attributed to feeling involved with their child’s difficulties.

One parent described her difficulties as having impacted upon feedback sessions with the clinician – “*...we’ve not actually managed to get a meeting in because a lot of things have changed, obviously me and my husband aren’t together anymore...*” (Mary, p.3,93). This illustrated the complexity of engaging in family work for this parent.

Three out of the four parents described receiving individual support – “*He was good to offload to*” (Jill, p.2,.88) as well as having joint sessions with both the parent and children – “*we would sit together and if the kids didn’t want to talk in front of us that was fine...*” (Jill, p.6,254).

Although parents reported the focus of input being predominantly for the child, it was understood that they were content with this – “*I was very happy to sit back, because there wasnae anthing he did that wasnae good for the child*” (Claire, p.6,235). On the contrary, one parent did report feeling that her mental health was unaccounted for: “*...and he never really took my health into it, he always took me as just a normal person*” (Amanda, p8,340).

## **2) Factors for engagement**

### *Understanding the parent and child*

Parents generally expressed feelings of being understood. For instance, one parent discussed the importance of the clinician addressing her illness and the impact it was having on her children – “*...and he was there to make that understood too, like your illness has got to that level where it does impact on the kids but you’re not necessarily meaning to do it...*” (Jill, p.10,466). This parent made particular reference to her problems not being “*burdened*” (p.4,174) onto her kids in the same way as she experienced as a child.

Parents also reported benefits from the clinician understanding their children – “*... when [Scott] started to understand how he felt, you know, there was a positive progress from it because you could see he was getting better...when that was happening I could start to get better*” (Claire, p.1,20). There was also an indication that an understanding of the young person and the parent resulted in an overall better understanding between the family – “*we all had the same thoughts, as a family, but it was about putting them together*” (Jill, p6,249).

### *Bringing a sense of calm*

For two of the parents, there was reference made to the sense of calm that the clinician brought into their environment. Parents identified “*the relaxed approach*” (Claire, p4,147) as important for engaging their children: “*He was the stable one, he was quite eh peaceful...he wasn’t the madness to what they were used to*” (Mary, p.9,399).

However, one parent identified the level of chaos that she had experienced as having impacted upon her engagement with the clinician: *“I have like bipolar, I have l-loads of things, and I’ve only just been diagnosed with ADHD, and trying to deal with this and different doctors meetings, court cases, [Aiden], it was just all too much”* (Amanda, p.3,99).

#### *A whole family approach*

Regardless of parents experiences of support, they each identified the importance of a family approach. They indicated that *“listening to both”* (Amanda, p8,353) (i.e. the parent and child) was an important quality for meeting their needs. They further identified with the relief that is associated with there being support for both family members – *“the whole family, and that’s what it’s about because he [clinician] didn’t just treat eh my son, he helped me aswell and when I knew he was ok, my mental health was fantastic...so, the whole family benefits”* (Claire, p7,304).

One parent who expressed her lack of experience of a family approach identified this as problematic in meeting her needs – *“...and I think he probably was listening, but he wasnae listening to what my issues were, it was probably [Aiden’s] issues more”* (Amanda, p.8,355).

## **YOUNG PEOPLE**

### **1) Family focused Practice**

#### *Level of family involvement*

The level of family-focused input also tended to vary between young people. Four of the five young people described their parent receiving support but that the focus was primarily on themselves. Parents’ receiving support was viewed positively – *“...she likes the fact that like it’s not just for me, it’s like she’s included aswell”* (Laura, p.13,375). One young person described this as – *“she gets a better understanding of things”* (Charlotte, p.9,387). However, one young person described his support as being solely focused on him with no input with his parent or other family members.

Some young people experienced having joint sessions with their parent with this being positive – *“I quite liked it”* (Scott, p.2,58). Clinicians facilitated communication between the parent and young person – *“...and put it in her point of view and put it in my point of*

view” (Aiden, p.3,123) as well as assist the parent to understand the impact of PMH on the young person. One young person described her support as inclusive of her siblings – “...he’ll talk to them like as if they’re pals like, so they’re being included aswell” (Laura, p.13,387). Contrary to the family-focused approach, one young person valued the separation from her family that her sessions provided:

*“like he’s a separate thing from my friends and my family and his purpose is for me to like sort of talk about the big things that are bothering me, or rant about little things, it’s just really nice to have that”* (Charlotte, p2,90)

## **2) Factors for engagement**

### *Being listened to*

Each of the young people discussed the value they felt in – “...someone that’s actually listening” (Jack, p.5,216). One young person spoke of the significance of the clinician remembering his discussions from previous weeks that he had never formerly experienced: “...he was always paying attention because, ehm, he would come in one day, I’d tell him something and a couple of weeks later he’d still remember it...and usually people forget, don’t really care” (Jack, p.4,180).

### *The community outreach approach*

The community outreach approach enabled discussions within a familiar environment – “I can get more things off my chest because I’m more relaxed” (Laura, p.15,442). This young person expressed feelings of – “intimidates like people like me” (p.14,434) when referring to a clinic setting, while another young person experienced feelings of being “triggered” (Charlotte, p4,175) when recalling her father having been in the hospital for his mental illness. She made further references to the reality of her experience and its association with a clinic environment: “It can become a little too real if you actually need to step into one of those places...it’s kinda like a big wakeup call about what you’re actually going through, so that can be a bit triggering” (Charlotte, p.4,180).

Young people valued the various settings that clinicians used – “like you can come out or you can go a drive” (Laura, p.14,437). Schools were also frequently used as a setting for appointments.

### *Support for the family*

Three of the young people indicated the need for a family approach to support their needs – “*can’t just focus on the kid and then let the parent sit there and watch...it’s about focusing on both, keeping an eye on all of them*” (Aiden, p.7,298). Two of them also expressed a need for liaising with the family more to assist their understanding of PMH and the young person’s mental health - “*maybe like one could be sort of talking to the confused ones about the illness a bit more...maybe offer some like knowledge there*” (Charlotte, p.7,317).

The family was identified as – “*whoever the main relationship is like with the person that they’re seeing...*” (Charlotte p.7,323) and a need to make them “*aware of triggers*” (Charlotte, p.8,328) to better inform their understanding. There was a lack of willingness described for their parent to engage in support due to their own experiences with services – “*he has a lot of prejudice against those types of jobs...*” (Laura, p.7,372) highlighting the challenge of supporting those intergenerational issues.

### **Normalization Process Theory**

Figure 1 illustrates the application of NPT (see Appendix 2.14 for contributions of themes to NPT constructs). There was 55% agreement between the author and independent rater (NX) on the mapping and interpretation of themes. Disagreements mainly concerned the overlap of themes between the coherence and participation constructs (for e.g. differentiating the value of a family approach from willingness for family involvement). These were discussed and revised leading to 100% agreement.

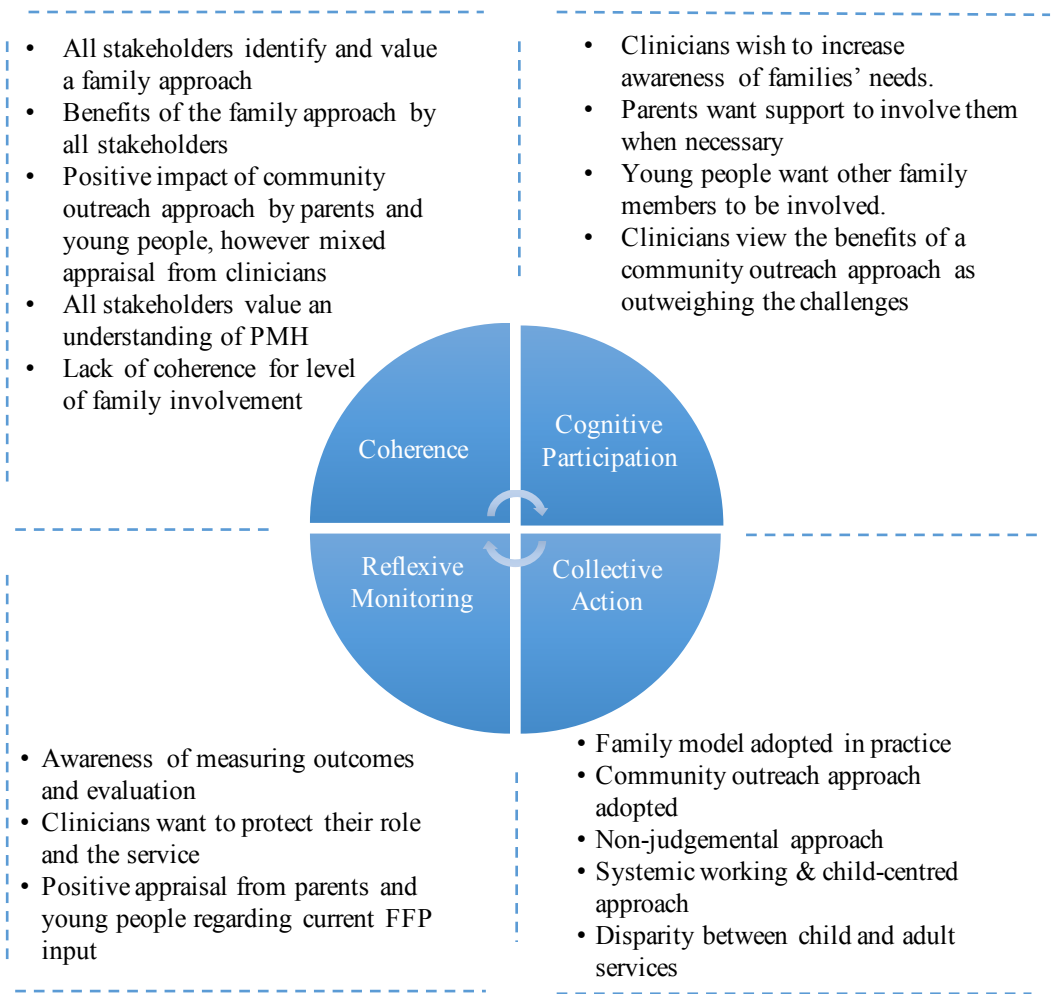


Figure 1. NPT Model

## Discussion

This study sought to identify stakeholder perspectives on the implementation of FFP and factors for engaging families affected by PMI. These were framed within NPT to inform an understanding of implementation processes. The research aims will be discussed overall and will focus on the contribution of NPT. The analysis revealed a number of factors that enabled clinicians' capacity to engage in FFP. Of key importance was clinicians conveying the usefulness of the family model as encouraging a family approach. This echoes Falkov's (2012) recommendations for professionals to consider the model's domains in their assessment and support for families. These findings are reflective of current initiatives which are driving the FFP agenda to promote clinicians' adoption of the family model in their practice (Grant et al., 2018). Parents and young people also valued a family approach as important for meeting their needs. This coherence of views (see Figure 1) was rooted in all stakeholders understanding the benefits of the family approach, as consistent with previous studies (Reupert & Maybery, 2007). This coherence resulted in high levels of



participation from stakeholders in which they indicated their willingness and involvement in a family-oriented approach to treatment. Although one young person valued the separation from family that support offered her, she still identified with a need for support also being available for her family. Thus there were high levels of participation from stakeholders. The high levels of coherence and participation therefore indicated stakeholders' investment in FFP which resulted in clinicians' enactment of the model to implement FFP.

Coherence of stakeholders' views regarding the benefits of the community outreach approach were significant in facilitating FFP. Research supports a community approach as shifting the paradigm from individual to family-oriented (Grant & Reupert, 2016). However, the simultaneous challenges within the context of organizational issues such as demands, expectations, and role ambiguity that presented for clinicians hindered FFP. These are longstanding issues as indicated in previous reviews (Maybery & Reupert, 2009). These issues were attributed to clinicians' desire to protect their role (i.e. reflexivity) within the wider context of government policy and austerity of cuts and lack of funding. Therefore, despite the mixed appraisal of the community approach, clinicians reported high participation for this as enabling access to this vulnerable population. Thus the community approach as a collective action for FFP influenced parents and young peoples' high positive regard towards it. This is in keeping with the literature on community settings enabling opportunities for sustained relationships (Priebe, Watts, Chase, & Matanov, 2005) and a comprehensive understanding of the family context (Grant & Reupert, 2016). This was suggestive from the length of service input parents and young people had received.

Stakeholders coherence of valuing an understanding of PMH was an essential component of FFP and engagement. From the findings, enacting a non-judgemental approach was understood as enabling clinicians to demonstrate an understanding of the parent and relates to the vulnerability attached with families experiencing the challenges of PMH (Reupert, Maybery, & Kowalenko, 2012). This may have influenced clinicians' motivation to measure treatment outcomes and evaluate their practice (illustrating their reflexivity) and corresponds with a need to evidence their practice and raise awareness in order to inform government policy and identify clear outcomes (Grant et al., 2018), as discussed in chapter one. This is consistent with the continuing development of key strategies to implement FFP globally (Falkov et al., 2016).

The lack of coherence regarding the level of FFP received by users was certainly evidenced in the variable levels and activities of FFP enacted by clinicians. These activities ranged from parents receiving feedback regarding their child's progress; individual support for the parent; joint sessions with the parent and child; facilitating communication between the parent and child; and communicating with other family members during visits. These findings are consistent with the wider issue on how FFP is enacted across services. A model identifying stakeholder (i.e. consumer, family, and practitioner) roles indicated a key enactment of the practitioner and consumer relationship is to discuss the extent of family members' involvement (Reupert et al., 2018). Thus, clinicians should seek to assess the appropriate level of FFP in accordance with families' expectations and needs.

Despite the variability, parents and young people both reported benefits for the other receiving support. Therefore, appraisal for FFP was relatively high with the exception of one parent who did not feel her mental health was considered. This is consistent with the literature surrounding the benefits of FFP for families affected by PMI (Foster, O'Brien, & Korhonen, 2012; Foster et al., 2016).

This variability of FFP may also be understood in relation to the systemic working that clinicians reported as enactments of a family approach. Although this enabled FFP, clinicians also attributed this to their role in keeping the child at the centre of their work, which they also viewed as important for engaging young people. This resonated with young people's reports of being consistently listened to, and both patient groups highlighting the focus of support being mainly on the young person. This is a significant finding relating to the culture of CAMHS whereby the focus has historically been on the child's presenting difficulties, thus raises a fundamental issue concerning the shift towards a family-focused approach and to what extent clinicians can embed this within their practice. This was further influenced by clinicians' awareness of the disparity between child and adult services and its barrier to collaborative working for families (Foster et al., 2016).

There presents an important issue relating to the variability of how FFP was enacted which reflects a wider issue on a greater need for empirical evidence for the efficacy of FFP. The contrary approaches in how a family approach may be practiced across services suggests confusion around how to enact this in practice which has been recognised across the literature (Charles, Reupert, & Maybery, 2016). This links to many of the challenges associated with implementation such as increased role ambiguity as a result of CAMHS

services providing a level of care to more than the individual child (i.e. parents with mental illness and their families). Others include resource allocation, and capacity for family work against the current demands within services such as increasing waiting lists. This perhaps creates a risk of the possible dilution of service focus and raises a number of implications concerning the endorsement and sustainability of family-focused work in meeting families' needs. There requires careful thought and consideration into the successful implementation of a family approach to care which is evident from the increasing collaboration of leading researchers within this area who are seeking to collectively expand the evidence base and development of FFP. Perhaps focusing the attention on the efficacy of FFP would better inform the implementation process.

#### *Methodological Strengths and Limitations*

A limitation could be inferred from the heterogeneity of the sample in that the findings from parents and young people reflect only those individuals who were willing to be interviewed. This may affect the generalizability to other families affected by PMI. Although clinicians' perspectives are reflective of one service, this was viewed as a study strength which created an opportunity for the researcher to exclusively access the stakeholder groups of this unique service.

Further, interview questions were purposefully broad in nature to elicit a wide range of themes, thus a challenge presented in forming a coherent narrative from participants that reflected similar themes, yet not losing the individuality of their shared experience. Perhaps using the NPT framework to generate a more structured interview guide with respect to the four components of NPT would have further facilitated this process.

The thematic analysis of the data in the first stage ensured that the data was not forced into predetermined constructs had NPT been used on its own, and was a method employed previously (MacFarlane & O'Reilly-de Brun, 2012). The application of NPT was viewed as a strength in terms of the value it added in determining the factors that enable a family-focused approach in practice. Still, it is important to note that NPT should not limit our interpretations of FFP to the defined NPT constructs, with a risk of minimising the initial thematic analysis. Instead, it is argued that the application of NPT further captured stakeholders' perspectives within an implementation context. The analytic process was considered a particular strength within the context of understanding implementation processes of FFP and how factors of engagement can be enacted to facilitate this.

### *Clinical Implications and Conclusion*

The findings highlight the complexity around implementing FFP within a framework that takes account of multiple stakeholder needs. It is evident that stakeholders are invested in a family approach, but how clinicians enacted FFP was variable. For this to become embedded within the service, it would seem appropriate to consider how clinicians could actively incorporate FFP specific models into their practice (Reupert et al., 2018). Clarity on outcomes indicative of FFP are also required, as well as understanding stakeholders' expectations of family support. Nonetheless, stakeholders' acknowledgement and understanding of a family approach is considered as a contribution to the evidence base in advocating the family model as a framework underlying FFP. Thus, the service should seek to further embed this model within their practice by routinely utilising this in their work with families. For instance, Grant et al. (2018) outline current initiatives to improve FFP which include the development of a checklist based on the family model and an eLearning resource for professionals and users. Each of these work to enhance collaborative working between stakeholders and are areas for consideration for the service.

Family-focused specific practices have recently been outlined (Foster et al, 2016) and are proposed as a starting point to assist services to gain clarity and define how they practice with families. These should be discussed in partnership with stakeholders to encourage integration and empowerment of families. Identifying practice guidelines will seek to strengthen and protect the service's capacity to meet users' needs.

It is intended that the NPT framework effectively contributed towards an understanding of the implementation processes of FFP, highlighting the strong connectedness between each of the constructs. It also allowed us to explore how factors for engaging families can facilitate FFP. Although the NPT model explores the level of coherence of stakeholders views as influencing the enactment of FFP, it is important for this not to draw away from the benefits of hearing individual experiences and promoting individuality. Therefore, efforts to balance the coherence of views whilst retaining individual differences should be considered in future research exploring stakeholder perspectives. Though these were service specific, it is hopeful that this model will contribute to the expanding literature on FFP with families affected by PMI. Future research should continue to evaluate implementation processes at the different stages of implementation.

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### Appendix 1.3: Walsh & Downe (2006) Quality Appraisal Tool

**Table 4** Summary criteria for appraising qualitative research studies.

Stages	Essential criteria	Specific prompts
Scope and purpose	Clear statement of, and rationale for, research question/aims/purposes	<ul style="list-style-type: none"> <li>• Clarity of focus demonstrated</li> <li>• Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing</li> <li>• Link between research and existing knowledge demonstrated</li> </ul>
Design	Study thoroughly contextualised by existing literature	<ul style="list-style-type: none"> <li>• Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both</li> </ul>
	Method/design apparent, and consistent with research intent	<ul style="list-style-type: none"> <li>• Rationale given for use of qualitative design</li> <li>• Discussion of epistemological/ontological grounding</li> <li>• Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology)</li> <li>• Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims</li> <li>• Setting appropriate</li> </ul>
	Data collection strategy apparent and appropriate	<ul style="list-style-type: none"> <li>• Were data collection methods appropriate for type of data required and for specific qualitative method?</li> <li>• Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail?</li> <li>• Was triangulation of data sources used if appropriate?</li> </ul>
Sampling strategy	Sample and sampling method appropriate	<ul style="list-style-type: none"> <li>• Selection criteria detailed, and description of how sampling was undertaken</li> <li>• Justification for sampling strategy given</li> <li>• Thickness of description likely to be achieved from sampling</li> <li>• Any disparity between planned and actual sample explained</li> </ul>
Analysis	Analytic approach appropriate	<ul style="list-style-type: none"> <li>• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory)</li> <li>• Was it appropriate for the qualitative method chosen?</li> <li>• Was data managed by software package or by hand and why?</li> <li>• Discussion of how coding systems/conceptual frameworks evolved</li> <li>• How was context of data retained during analysis</li> <li>• Evidence that the subjective meanings of participants were portrayed</li> <li>• Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance</li> <li>• Did research participants have any involvement in analysis (e.g. member checking)</li> <li>• Evidence provided that data reached saturation or discussion/rationale if it did not</li> <li>• Evidence that deviant data was sought, or discussion/rationale if it was not</li> </ul>
Interpretation	Context described and taken account of in interpretation	<ul style="list-style-type: none"> <li>• Description of social/physical and interpersonal contexts of data collection</li> <li>• Evidence that researcher spent time 'dwelling with the data', interrogating it for competing/alternative explanations of phenomena</li> </ul>
	Clear audit trail given	<ul style="list-style-type: none"> <li>• Sufficient discussion of research processes such that others can follow 'decision trail'</li> </ul>



Table 4 (continued)

Stages	Essential criteria	Specific prompts
	Data used to support interpretation	<ul style="list-style-type: none"> <li>• Extensive use of field notes entries/verbatim interview quotes in discussion of findings</li> <li>• Clear exposition of how interpretation led to conclusions</li> </ul>
Reflexivity	Researcher reflexivity demonstrated	<ul style="list-style-type: none"> <li>• Discussion of relationship between researcher and participants during fieldwork</li> <li>• Demonstration of researcher's influence on stages of research process</li> <li>• Evidence of self-awareness/insight</li> <li>• Documentation of effects of the research on researcher</li> <li>• Evidence of how problems/complications met were dealt with</li> </ul>
Ethical dimensions	Demonstration of sensitivity to ethical concerns	<ul style="list-style-type: none"> <li>• Ethical committee approval granted</li> <li>• Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants</li> <li>• Evidence of fair dealing with all research participants</li> <li>• Recording of dilemmas met and how resolved in relation to ethical issues</li> <li>• Documentation of how autonomy, consent, confidentiality, anonymity were managed</li> </ul>
Relevance and transferability	Relevance and transferability evident	<ul style="list-style-type: none"> <li>• Sufficient evidence for typicality specificity to be assessed</li> <li>• Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies</li> <li>• Discussion of how explanatory propositions/emergent theory may fit other contexts</li> <li>• Limitations/weaknesses of study clearly outlined</li> <li>• Clearly resonates with other knowledge and experience</li> <li>• Results/conclusions obviously supported by evidence</li> <li>• Interpretation plausible and 'makes sense'</li> <li>• Provides new insights and increases understanding</li> <li>• Significance for current policy and practice outlined</li> <li>• Assessment of value/empowerment for participants</li> <li>• Outlines further directions for investigation</li> <li>• Comment on whether aims/purposes of research were achieved</li> </ul>



## Appendix 2.1: Focus Group Topic Guide for Clinicians

### Setup:

- Consent forms signed and copies retained.
- Room arranged to ensure ease and comfort with chairs in a circle around a table.
- Digital audio recorder checked and functioning.
- Stationary available such as flipchart paper and pens should participants wish to use these.
- Refreshments available for participants.

### Introductions and Welcome:

- Reminder of the purpose of the focus group
- Expected timings & rules
- Explanation of my role as facilitator and to not make assumptions about what I know.

### Stimulus Questions:

#### *Referral pathway*

1. Tell me how someone gets referred to the service?
2. Who is the first point of contact for the child, parent, family? What's the process?

#### *Family-Focused Practice*

3. How do you work with families? What does that look like?
4. How do you respond to their needs?
5. Do you work with external family members too? Siblings? Grandparents?
6. Would you say your work is family-focused?
7. Do you feel that the workplace supports your work with families? In what ways does it or doesn't it?
8. How do you come together as a team to make sense of the various approaches that you work with?
9. How do you make decisions as a team?
10. How do you formulate as a team?
11. Do you feel that there are any issues for these families that you would like to respond to but feel like you aren't able to?

#### *Outreach approach*

12. What does an outreach service mean to you?
13. In what ways does an assertive outreach mental health service facilitate the work you do?

#### *Engagement*

14. What factors are important for you when engaging children, young people, parents, families?
15. What things make engaging these families easy? Difficult?
16. Anything that gets in the way of you providing input?
17. What do you think facilitates their engagement?
18. What do you think hinders their engagement?

#### *Values*

19. What do you think children & young people value/ don't value from the service?
20. What do you think parents value/don't value from the service?

#### *Improvements*

21. Are there any changes to the service that have been beneficial for you? Or have facilitated your work?
22. Any changes you would like implemented?
23. Any other comments you would like to make about any aspect of what we have discussed? Or perhaps haven't discussed that you would like to add?

## Appendix 2.2: Interview Topic Guide for Parents

### Setup:

- Consent forms signed and copies retained.
- Room arranged to ensure ease and comfort with chairs in a circle around a table.
- Digital audio recorder checked and functioning.

### Introductions:

- Reminder of the purpose of the interview
- Expected timings
- What to do in case of any distress.

### Stimulus Questions:

#### *Referral pathway:*

- Tell me how you first got referred to the service?
- Was it just yourself or other family members?

#### *Engagement/ Support:*

- How have staff made you feel?
- What sort of things do staff do to support you?
- Have there been any positives/ negatives of engaging with the service for you?
- Are there particular things that you have liked/ disliked about your treatment?
- Are there things that have made it easier/ difficult for you to engage with the service?
- Are there any things that get in the way of you engaging with the service?
- What do you think could make your experience more positive?
- Do you feel that the staff helping you has a good understanding of your needs?
- How do they show/ communicate that to you?

#### *Family-Focused Practice:*

- Would you say the support you received was focused on you and your family?
- What does family-focused support mean to you? Is it important?
- Do you feel involved with decisions that are made about your mental health/ wellbeing? (or child's mental health)
- Do you feel that you have been able to have a say/ express your opinion/ ask questions?
- Are there times when you don't feel able to do that?

#### *Important for other families:*

- What do you think would be helpful for parents/families in similar situations to you?
- In what ways do you think parents and young people could be better supported?

#### *Values:*

- What do you value about the service?
- What do you think young people value about the service?
- What sort of things do you think they would like support with?
- Do you think there is anything staff could do better to understand your needs?

## Appendix 2.3: Interview Topic Guide for Young People

### Setup:

- Consent forms signed and copies retained.
- Room arranged to ensure ease and comfort with chairs in a circle around a table.
- Digital audio recorder checked and functioning.

### Introductions:

- Reminder of the purpose of the interview
- Expected timings
- What to do in case of any distress.

### Stimulus Questions:

#### *Service related:*

- Tell me how you first got referred to the service?
- Was it just yourself or other family members?

#### *Engagement/ Support:*

- How have staff made you feel?
- What sort of things do staff do to support you?
- What things have you liked/ disliked about the service?
- What things have you found helpful/ unhelpful about the service?
- Anything that got in the way of you engaging with the service?
- Did you feel that the staff member(s) helping you had a good understanding of your difficulties?
- How did they show/ communicate that to you?

#### Values:

- What do you value about the service?

#### *Family-Focused Practice:*

- Would you say the support you received was focused on you and your family?
- What does family-focused support mean to you? Is it important?
- Is there anything your parent/ family found helpful about the support you received?
- In what ways do you think your parent/ family was supported or would like to be supported?
- Did you (and your family) always feel involved with decisions that were made about your mental health?
- What did that look like?
- Did you feel that you were able to have a say/ express your opinion/ ask questions?
- Were there times that you didn't feel able to do that?

#### *Important for other young people:*

- What do you think would be helpful for young people in similar situations to you?

## Appendix 2.4: West of Scotland Research Ethics Letter

**WoSRES**  
*West of Scotland Research Ethics Service*



Miss Sadia Shah  
Trainee Clinical Psychologist  
Institute of Health and Wellbeing  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
G12 0XH

**West of Scotland REC 4**  
Research Ethics  
Clinical Research and Development  
West Glasgow Ambulatory Care Hospital  
Dalnair Street  
Glasgow  
G3 8SJ  
(Formerly Yorkhill Childrens Hospital)

Date 7 December 2017  
Direct line 0141 232 1808  
E-mail [WoSREC4@ggc.scot.nhs.uk](mailto:WoSREC4@ggc.scot.nhs.uk)

Dear Miss Shah

**Study title:** The experiences of engagement in a community mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician  
**REC reference:** 17/WS/0241  
**IRAS project ID:** 233521

The Research Ethics Committee reviewed the above application at the meeting held on 1 December 2017. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net) outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### **Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

## Appendix 2.5: NHS Lanarkshire R&D Approval Letter

NHS Lanarkshire Research & Development: Management Approval Letter

Project I.D. Number: L17066



Miss Sadia Shah  
Trainee Clinical Psychologist  
Institute of Health and Wellbeing  
Gartnavel Royal Infirmary  
1055 Great Western Road  
Glasgow  
G12 0XH

R&D Department  
Corporate Services Building  
Monklands Hospital  
Monkscourt Avenue  
AIRDRIE  
ML6 0JS

Date 29<sup>th</sup> January 2018  
Enquiries to Elizabeth McGonigal,  
R&D Facilitator  
Direct Line 01236 712445  
Email [elizabeth.mcgonigal@lanarkshire.scot.nhs.uk](mailto:elizabeth.mcgonigal@lanarkshire.scot.nhs.uk)

Dear Miss Shah

**Project title: The experiences of engagement in a community mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician**  
**R&D ID: L17066**

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
Dr Stephanie Hunter	Clinical Psychologist	Local Collaborator	Coathill Hospital

As you are aware, NHS Lanarkshire has agreed to be the Sponsor for your study. On its behalf, the R&D Department has a number of responsibilities; these include ensuring that you understand your own role as Chief Investigator of this study. To help with this we have outlined the responsibilities of the Chief Investigator in the attached document for you information.

## Appendix 2.6: Consent Form (Clinicians)



### CONSENT FORM

Identification number for this study: L17066

**The experiences of engagement in a community parental mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician.**

Chief Investigator: **Sadia Shah**

Please initial box

1. I confirm that I understand the nature of the study proposed, having read and understood the information sheet provided. I have had opportunity to ask questions, and am satisfied with the answers I received.
2. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time. Should I wish to withdraw, I understand that I can do so without giving reason, and without my medical care or legal rights being *affected*.
3. I agree to take part in the study.
4. I agree that you may audio-record tape sessions as required.
5. I agree that fully anonymised quotations may be used in publications and other materials arising from the study.

---

Subject Name	Date	Signature
..... Researcher	... / ... / ..... Date	..... Signature
.....	... / ... / ..... Date	..... Signature

1 copy for participant; 1 copy for researcher

## Appendix 2.7: Consent Form (Parents)



Institute of Health  
& Wellbeing

### PARENTS CONSENT FORM



Identification number for this study: L17066

#### **The experiences of engagement in a community parental mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician.**

Chief Investigator: **Sadia Shah**

Please initial box

1. I confirm that I understand the nature of the study proposed, having read and understood the information sheet provided. I have had opportunity to ask questions, and am satisfied with the answers I received.
2. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time. Should I wish to withdraw, I understand that I can do so without giving reason, and without my medical care or legal rights being *affected*.
3. I agree to take part in the study.
4. I agree that you may inform my general practitioner, keyworker and psychiatrist of my involvement in the study.
5. I understand that my medical notes and data collected during the study may be looked at by individuals from the research team where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.
6. I agree that you may audio-record tape sessions as required.
7. I agree that fully anonymized quotations may be used in publications and other materials arising from the study.
8. I would like to receive a copy of the study results.

---

Subject Name

Date

Signature

.....

... / ... / .....

.....

Researcher

Date

Signature

.....

... / ... / .....

.....

1 copy for participant; 1 copy for researcher; 1 copy for GP notes



## Appendix 2.8: Consent Form (Young People)



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### CHILDREN/ YOUNG PEOPLE CONSENT FORM

Identification number for this study: L17066

**The experiences of engagement in a community parental mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician.**

Chief Investigator: **Sadia Shah**

Please initial box

1. I understand the research project and understand the information sheet provided. I was able to ask questions and I am happy with the answers.
2. I understand that it is up to me whether I take part in the study, and I understand that I can stop taking part at any time if I want to without giving a reason. I understand that my care will stay the same and won't be affected.
3. I agree to take part in the study.
4. I agree that you may let my general practitioner (GP), keyworker and psychiatrist know about my involvement in the study.
5. I understand that my medical notes and data collected during the study may be looked at by others in the research team when necessary to. I give my permission to these people to look at my information.
6. I am happy for you to audio-record the focus group or any other interviews.
7. I am happy for my own words to be used in the final written report as long as these are made anonymous (i.e. nobody will be able to tell that it was you that said it).
8. I would like to receive a copy of the study results.

---

Subject Name	Date	Signature
.....	... / ... / .....	.....
Parent/ Guardian	Date	Signature
.....	... / ... / .....	.....
Researcher	Date	Signature
.....	... / ... / .....	.....

1 copy for participant; 1 copy for researcher; 1 copy for GP notes



## Appendix 2.9: Participant Information Sheet (Clinicians)



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### **What is the purpose of this research?**

This research project is investigating staff and service users' experiences of engaging within the Reach Out Service. The Reach Out Service offers support to families who are affected by difficulties associated with parental mental health. The purpose of this study is to explore how service users and staff engage within the service. This will be from the perspective of the parent, child or young person, and staff working in Reach Out.

The project will run a focus group discussion in order for your views to be shared. Hearing about your experiences of what's been helpful and/or unhelpful in relation to the care and support you provide for these families is extremely important and valuable. This in turn will help facilitate improvements in the care that the Reach Out Service provide to families in order to better meet their needs, as well as to consider the systems currently operating within the service.

### **Who is eligible to take part in the study?**

We would like to invite all mental health professionals working within the service to participate. Any new staff members must have worked for the service for at least a minimum of 2 months at the time of participation. This is to ensure they have had a sufficient orientation to the service and its users, as well as familiarity with the general service system.

Mental health professionals will include Clinical Psychologists, Psychiatrists, Social Worker, Occupational Therapists, Psychiatrist Nurses, or other child and family workers.

### **What does participation in this research involve?**

Participating in this research will involve contributing to a focus group discussion which will be led by one researcher. The focus group will be audio recorded with a digital recorder. The group discussion will focus on staff members' experiences of engaging with the Reach Out Service exploring their perspective of service users incentives as well as barriers to engaging with the service.

It is expected the focus group discussion will take approximately 1- ½ hours and will take place within the Reach Out Service based at Coathill Hospital.

### **Other relevant information**

The project aims to involve parents and young people who have been affected by difficulties associated with parental mental health. The project will also involve staff who are currently working within the service in order to explore their experiences of working in the service. This will allow for multiple perspectives to be explored and understood.

The research project is being conducted by NHS Lanarkshire and the University of Glasgow and will fulfil part of the requirements for the completion of the Doctorate of Clinical Psychology course for the main researcher.

### **Do I have to take part in this research project?**

No, participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, that is also ok. You have the right to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information Sheet and Consent Form to sign, and you will also be given a copy to keep.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your employment with the service or other services within NHS Lanarkshire.

**What are the potential benefits of taking part?**

We cannot guarantee or promise that you will receive any benefits from this research. However, you might find it helpful for you to be able to share your views on your experiences of the service.

**What are the potential disadvantages of taking part?**

It is the responsibility of the group facilitator to ensure that the focus group is run in a respectful way that will allow participants to express their thoughts on the topics in a safe and confidential environment. However, it is possible that someone may communicate things in a way that may upset others. In this instance, the facilitator will take appropriate action and offer you the opportunity to speak with the facilitator following the discussion.

Participants will also be provided with an opportunity to discuss any questions relating to the topic of interest separately on a one-to-one basis, should they feel they were unable to express their views within the focus group.

**What if I withdraw from this research study?**

You can withdraw from the study at any time. You do not have to provide a reason and it will have no affect on your employment. If you do withdraw from the study, any personally identifiable information about you will be destroyed. However, anonymised data already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected by the research team up to the time that you withdraw will form part of the research project results. If you do not want them to do this, you should choose not to participate in the study.

**What happens when the research project ends?**

The results of this research project will be written up in the form of a report and it is anticipated that the results of this project will be published and/ or presented in a variety of forums. In any publication and/ or presentation, information will be provided in such a way that participants cannot be identified, except with your permission. We will take quotations directly from the focus group, however you or your family will not be identifiable based on these quotations.

**What will happen to the information I give you?**

Your contributions to the focus group and demographic information (e.g. age, gender, duration of employment etc) will be collected. The focus group will be audio-recorded and this and the demographic information will be stored on a password protected computer. Any paper files will be stored securely within the Reach Out Service based at Coathill Hospital. No identifying details will be stored with the audio recording of the focus group. The audio recording will only be accessible by the main researcher and two supervisors for the purpose of the coding of responses of group participants.

**Can I speak to someone who is not involved in the study?**

Yes, you can speak to Dr Kim Barry, Specialist Clinical Psychologist, who is not involved in the study and can answer questions or give advice about participating in this study. You can contact her on: 01698 269 651.

## What will happen if there is a problem or if I want to make a complaint?

If you have any concerns about the study or the way it is conducted, or if you want to make a complaint about any aspect of the research, please contact the main researcher, Sadia Shah, Trainee Clinical Psychologist.

The normal NHS complaint mechanisms will also be available to you.

If you would like to take part in this project, please contact me and we can arrange a time and place to meet to discuss the project. You can contact me by:



Telephone: 01236 703010 (Reach Out Team)



Email: [s.shah.1@research.gla.ac.uk](mailto:s.shah.1@research.gla.ac.uk)

If you have any questions you can contact me, but you can also contact my supervisors:

### **Dr Stephanie Hunter:**

Clinical Psychologist  
Hamilton & Clydesdale CAMHS  
194 Quarry Street  
Hamilton  
ML3 6QR  
email: [Stephanie.hunter@lanarkshire.scot.nhs.uk](mailto:Stephanie.hunter@lanarkshire.scot.nhs.uk)

### **Professor Andrew Gumley:**

Professor of Psychological Therapy  
University of Glasgow  
Institute of Health & Wellbeing  
Gartnavel Royal Hospital  
G12 0XH  
email: [Andrew.gumley@glasgow.ac.uk](mailto:Andrew.gumley@glasgow.ac.uk)

**Thank you for taking the time to read this information sheet**

## Appendix 2.10: Information for Staff



Identification Number for this project: L17066

### **The experiences of engagement in a community parental mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician.**

**Chief Investigator:** Sadia Shah, Trainee Clinical Psychologist

I am recruiting parents and children/ young people who have an experience of parental mental health and are experiencing a range of difficulties associated with this. The purpose of this study is to investigate their perspectives of engaging within the service exploring any incentives and barriers to their engagement. This will contribute towards the main objective of the study which is to investigate multiple stakeholders' experiences of engaging within the service. This will be from the perspective of parents, young people and staff.

Please see the inclusion/ exclusion criteria outlined below. If you know of any parents or young people receiving/received treatment from the Reach Out team and are eligible to take part, I would be most grateful if you would provide them with a participation information leaflet. For any young people that are identified as eligible, I would be grateful if you would also provide them with a letter to their parent/ guardian outlining the details of the study.

If any parents and/or young people express their interest to take part and are agreeable to being contacted to discuss the study, then please seek their permission for their contact details to be forwarded to me.

#### **❖ Inclusion criteria for Parents: eligible for participation if they:**

- Are currently receiving or have received treatment within the service
- Are experiencing mental health difficulties have/are impacting upon the child/ young person as well as experiencing difficulties themselves
- Have a good level of stability as assessed by their keyworker and the chief investigator to participate in the study
- That participation will not negatively impact their own treatment within the service
- Have capacity to consent

#### **❖ Inclusion criteria for Children/ Young People: eligible for participation if they:**

- Are currently receiving or have received treatment within the service
- Are aged between 12-18 years old (inclusive)
- Present with a range of emotional, psychological or behavioural difficulties as a result of a parent or family member with a mental health problem(s)
- Have a good level of stability as assessed by their keyworker and the chief investigator to participate in the study
- That participation will not negatively impact their own treatment within the service

#### **❖ Exclusion criteria for Parents and children/ young people: will not be eligible for participation if:**

- They do not meet the inclusion criteria above
- Children < 12 years old
- They are unable to provide informed consent or have their parent/ guardian provide informed consent
- They are currently participating in an existing research study

**Please note:** Young people will be assessed as competent to consent by the staff member they are working with and by the chief investigator. This must be recorded in their clinical casenotes that their participation in the study was discussed and that they are deemed to be competent. For young people aged 12 to 15 years, it is also best practice to obtain consent from the parent/guardian which must also be recorded.

I appreciate your support with the recruitment of this study and if you or anybody else wishes to speak with me in connection with my research or would like further information, please contact me via email ([s.shah.1@research.gla.ac.uk](mailto:s.shah.1@research.gla.ac.uk)) or telephone (07976255548).  
Many Thanks,

**Sadia Shah**  
**Trainee Clinical Psychologist**  
**University of Glasgow / NHS Lanarkshire**  
**Supervisors:**  
Professor Andrew Gumley (University of Glasgow)  
Dr Stephanie Hunter (NHS Lanarkshire)

## Appendix 2.11: Participation Information Sheet (Young People)



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& Wellbeing



### **YOUNG PEOPLE WITH A PARENT EXPERIENCING MENTAL HEALTH PROBLEMS** **Share your views of the Reach Out Service!**



#### **What is the research about?**

I would like to speak with young people aged 12-18 years old who have a parent or family member experiencing mental health difficulties. I am really interested in your needs and the needs of your family. Children and young people's views are extremely important and valuable. Hearing about your experiences of being supported by the Reach Out team can help other people in health services focus on matters that are important to you and your family. I am really interested to hear your views on what support has helped you and your family and what has been less helpful to you.



#### **Why am I being asked?**

You have a parent or family member with an experience of mental health difficulties and so I would really like to meet with you and ask you some questions about what that is like and what sort of things the Reach Out team have helped or not helped you with. I would be really keen to hear you tell me about your experiences.

#### **What will happen if I take part?**

*Before you agree to take part:*

1. If you would like to take part, we will first meet to have a short conversation (approximately 10-15 mins) so that I can answer any questions you may have for me.
2. We will arrange a time and place to meet that is convenient for you (i.e. health centre, hospital, school/college).
3. When we first meet we will talk about the project and I will give you a consent form to sign. This makes sure that you understand the project and have agreed to take part. This also gives you time to think about it and chat to a family member or someone you trust before you make a decision.

*After you have agreed to take part:*

4. Taking part in this project will involve you sharing your views and experiences in a small group discussion. This group will have no more than 4-6 people in it and will meet only once.



5. The group discussion will be led by one researcher who will ask the group some questions about their experiences of coming to the Reach Out team, the things you have liked and disliked about the Reach Out team, and what sort of things have been helpful or unhelpful to you and your family.
6. During the group discussion, you will have the chance to share your opinion of matters that are important to you with other young people in your age group.
7. The researcher will try to ensure that the group is a friendly and warm place for you to feel comfortable in sharing your experiences.
8. The discussion will be audio recorded. This is to make sure I do not miss anything.

### **What if I don't want to speak about my personal experiences?**

The group discussion will be managed by one researcher who will make sure that you only talk about the things you feel comfortable to talk about. This means that you don't have to speak about any personal experiences that may be upsetting for you.

If you do feel upset at any point during or after the discussion, you will be able to take a break at any point, speak with me, or speak with other relevant people who are supporting you should you wish to.

If you feel that you haven't been able to speak in the group, you may also be offered to speak with the main researcher separately on a one-to-one basis to discuss the topic.

### **How long will it take?**

The group discussion will last between 1 – 1 ½ hours and we will take a short break in between for some tea and biscuits!



### **Where will it take place?**

The group discussion will take place within the Reach Out team at Coathill Hospital.

### **Do I have to take part?**

No, it is entirely up to you whether you wish to take part. If you decide to take part and later change your mind that is also ok. You can stop taking part at any stage of the project, even if that is before, during or after our discussion.

It might also be a good idea for you to speak with an adult that you trust (such as a family member, keyworker) to help you make your decision. It might also be helpful for you to show them this Participant Information Sheet. The support you receive now or in the future by the Reach Out team or other staff in NHS Lanarkshire will not be affected in any way.

### **What will happen to the information I give you?**

After our discussion, I will type up the conversation onto a computer and the recording will be deleted from the recording device. The typed version will be kept securely and will be made anonymous. This means that nobody will be able to connect the information to you, apart from me. If you tell me something that makes me think that you are unsafe or in any harm, then I will need to share this information with other relevant people.

Any information that contains your name or contact details will be stored securely within the Reach Out team and this will be destroyed safely after the project has been written up. When the project is written up, it will not contain any information that could potentially identify you. This means that anybody reading the final project report will not be able to tell that you were involved. I may include your direct words but these will not be linked directly to any information about you.



### **What are the potential benefits of taking part?**

- Although talking about your experiences might be difficult, it may also be helpful for you to do. You will potentially have the chance to meet with other young people who have had similar experiences to you, which you might also find helpful.
- Most importantly you will be able to have your voice heard and share your opinion of matters that are important to you. This will also help other young people and families with similar experiences. This project will help make improvements to the support families receive which is incredibly important to us.



- You will also receive a certificate of participation that you may be able to use to contribute towards gaining awards such as the Duke of Edinburgh or towards gaining hours towards voluntary work.



- Travel costs will also be reimbursed to you.



### **What are the potential disadvantages of taking part?**

- Talking about your experiences might be difficult and you may become upset, however you will be able to speak with the main researcher and other relevant staff supporting you. You will also not be asked about any personal experiences, and will only be encouraged to speak about that which you feel comfortable to talk about.

If you would like to take part in this project, please contact me and we can arrange a time and place to meet. You can contact me by:



Telephone: 01236 703010 (Reach Out Team)



Email: [s.shah.1@research.gla.ac.uk](mailto:s.shah.1@research.gla.ac.uk)



You can also inform the staff member you are working with and I will get back to you.  
If you have any questions you can contact me, but you can also contact my supervisors:

**Dr Stephanie Hunter:**

Clinical Psychologist  
Hamilton & Clydesdale CAMHS  
194 Quarry Street  
Hamilton  
ML3 6QR  
email: [Stephanie.hunter@lanarkshire.scot.nhs.uk](mailto:Stephanie.hunter@lanarkshire.scot.nhs.uk)

**Professor Andrew Gumley:**

Professor of Psychological Therapy  
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**Thank you for taking the time to read this information sheet**



## Appendix 2.12: Recruitment Poster for Young People



### WHO?

Young people aged 12-18 years who has a parent or family member experiencing mental health problems.

### WHAT?

This is part of a research project looking at young people's experiences of coming to the Reach Out Team and what that has been like for you. Young people's views are extremely important to us and we would really like to hear about your needs and the needs of your family.

### WHERE?

We can arrange to meet you at a time suitable for you such as a health centre, hospital or school/ college.

### HOW?

If you might be interested please speak to your clinician to find out more details, or you can contact Sadia Shah, Trainee Clinical Psychologist on: [s.shah.1@research.gla.ac.uk](mailto:s.shah.1@research.gla.ac.uk) or 07976255548. 😊

## Appendix 2.13: Major Research Project Proposal



Institute of Health  
& Wellbeing

### **DOCTORATE IN CLINICAL PSYCHOLOGY**

### **SUBMISSION COVER PAGE**

**Matriculation Number:** 1108451

**Name of Assessment:** MRP Proposal

**Title of Project:** The experiences of engagement in a community mental health outreach service for children and families affected by parental mental health: Perspectives from the parent, child and clinician

**Date of Submission:** 28/09/17

**Version Number:** 3

**Word Count, including reference list (excluding appendices):** 3,092  
(maximum word count is 3,000)

## **Abstract**

### *Background*

Research has highlighted that mental health services seek to address the needs of families affected by parental mental health. Those families affected have been found to be the most socially isolated with poorer psychological and physical health. Examining processes of engagement across stakeholder groups within community settings is lacking, with there often being ambiguity around service user needs.

### **Aims**

This qualitative study will investigate stakeholder's experiences of engaging within an outreach service for children and parents affected by parental mental health. This will be explored from the perspective of clinicians, parent and/or family member, and the child.

### **Methods**

Participants will be recruited from the outreach service with parents and children experiencing mental health difficulties related to parental mental health. Children will be aged 12 – 18 years old. Staff will comprise of a range of professions. Focus groups and supplementary interviews will be conducted and thematically analysed using framework analysis methods informed by normalisation process theory and logic modelling.

### **Applications**

This is a unique study which explores key stakeholder's perspectives with the aim to bridge the gap between the child, parent, and staff on processes of engagement. This will facilitate improved outcomes within this population group.

*(Word count: 197)*

## **Introduction**

There has been an increasing concern that mental health services seek to address the needs of children and young people where parental mental health difficulties are prominent (Cooklin, 2013). Within the UK this was highlighted through the '*Think Child, Think Parent, Think Family*' (2009) initiative which acts as a policy and implementation guideline for professionals working within child services. Earlier changes in policy have highlighted the need for improvement in these services that will enhance community inclusion (Davidson & Roe, 2007). This has been ongoing within governmental approaches (Scottish Government's Mental Health Strategy, 2012-2015) which highlight the need for service integration and inclusion. Those families affected by parental mental health specifically have been found to be among the most vulnerable with an increased likelihood of experiencing social isolation, and lower psychological and physical health (Reupert & Mayberry, 2007).

An important aspect in the recovery of mental health in children is the emotional, social and practical support provided by parents. However, parental mental health difficulties act as a barrier in providing those, impacting significantly on the emotional, psychological and behavioural aspects of a child's development (Falcov, 1998). A challenge therefore presents for services to respond to both the child and parent's unmet needs by drawing upon a family approach. In this way, there must be recognition for the family as a whole which requires a multi-faceted approach. The family model (Falcov, 2012) has become well embedded within child services and provides a model of practice which considers the adult and child's mental health and development, and the associating parenting and family relationships. It takes into account the social and cultural factors as well as the formal and informal support systems available to the family.

There has been much focus placed on promoting children's psychological resilience to the mental health difficulties faced by these families (Cooklin, 2013). In more recent literature, it is suggested that the negative effects exhibited by the child as a result of their parent's mental health are significantly associated with the responses of key figures in the child's life. This includes the parent and family members and extends to the behaviour and responses of professionals too (Cooklin, 2010; 2013). With reports of a well-established link between parental mental health and its impact on children (Royal College of Psychiatrists report, 2011), research should focus on these interactions between families and services to better meet their needs.

### **The Role of Stakeholders**

There have been efforts to identify and consider the impact of key stakeholders involved with these families. How services and parents respond in supporting a child to understand their parent's mental health can consequently prevent mental health difficulties occurring in later life. This has been conveyed through studies placing the focus on the child's thinking whereby they stress the importance of the child's rights in gaining this understanding of parental mental health (Cooklin, 2010; 2011; 2013). Much of this work draws upon the joint working approach between families, mental health services, and social care. In this respect, it is through the engagement of multiple stakeholders where further insight into the barriers that present in community based services for these families can be provided.

An exploratory study investigating treatment barriers in community outpatient mental health services communicate the value of learning from the perspectives of multiple stakeholders (i.e. therapist, parent and youth) (Baker-Ericzen et al, 2013). They identify similar themes across stakeholder groups of dissatisfaction, lack of involvement, and feeling overwhelmed with the complexities of families' needs. However, they offered differing opinions on the underlying causes of these, with parents attributing it to feeling excluded, and therapists reporting parents' lack of involvement as a key factor in treatment engagement.

The social care for excellence report (2009) highlights the challenges for staff being that they require more effective leadership in being able to work jointly. It also includes the views of the family who report wanting more practical support, with young people reporting a need to have somebody that they can share their experiences with and understand their parent's mental health. Through this approach, all stakeholders involved are acknowledged. Such findings convey the benefits of exploring multiple stakeholder perspectives in order to consider the barriers that may be present and to inform more effective service delivery.

### **Engagement**

In considering the practical priorities that families have expressed support for, the focus on adopting an assertive outreach model within services has developed widely across the UK. However, there are inconsistencies relating to its effectiveness, with there being a variation in how it is implemented within services (Fiander et al, 2003). In order to address these, studies have begun to focus specifically on the concept of engagement (Gillespie et al, 2004, Wright et al, 2011). This itself has brought its own challenges in relation to how the term engagement is understood and defined. Wright et al (2011) suggests a failure on services in acknowledging engagement as a process. They explore this from the perspective of service users and practitioners in which emerging themes from their analysis include contact, dialogue, transformation, and a shared understanding as significant determinants of their level of engagement.

Other qualitative studies have also looked more closely at some of these themes. For example, studies have addressed the 'therapeutic relationship' (Farrelly & Lester, 2014) in which it was

recognised that there was a lack of clarity between stakeholders' roles which often lead to ambiguity around service user needs. Further evidence highlights the barriers that present in which service users report experiencing a lack of involvement in their treatment, rather they were more informed about decisions (Farrelly et al, 2015).

With regard to assertive outreach, the literature appears to place an emphasis on identifying the processes of engagement. The development of a trusting relationship as well as the time and commitment that an assertive outreach approach enables staff to deliver, has been regarded as significant in service users' views of engagement (Priebe et al, 2005). It is therefore relevant to explore these processes within complex parental mental health.

## **Aims**

This qualitative study will aim to investigate stakeholder's experiences of engaging within an assertive outreach service for children and parents affected by parental mental health. This will be explored from the perspective of the child and young person; the parent(s); and clinicians working within the service. This will be conducted through focus group discussions.

## **Methodology**

### **Plan of Investigation**

#### ***Participants***

Participants will consist of the following three stakeholder groups in which the inclusion and exclusion criteria for each group are defined:

#### *(i) Parent or Family Member*

The parent or family member(s) will currently be receiving treatment within the service; experiencing mental health difficulties which are impacting upon the young person, as well as themselves; have a reasonable level of stability in their presentation; and have capacity to consent.

#### *(ii) Child and/or Young Person*

The child or young person will currently be receiving treatment within the service; aged between 12-18 years; presenting with a range of emotional, psychological or behavioural difficulties as a result of a parent or family member who has a mental health problem(s); and have a reasonable level of stability in their presentation.

Participants will be excluded if they are below the age of 12 as it is considered that this will present a set of challenges in modifying interview and focus group techniques and questions in accordance with the child's linguistic and cognitive ability (Gale, 2006). This has been assessed as out with the feasibility of this study. Exclusion also extends to those who do not speak English.

#### *(iii) Clinicians*

All clinicians working within the service will have the opportunity to participate. This will consist of the clinical team manager; child and family workers (including psychiatric nurses, social workers, occupational therapists); clinical psychologists and a locality paediatric psychiatrist.

### **Recruitment Procedures**

#### ***Reach Out Team***

Participants will be recruited from within the '*Reach Out Team*' within NHS Lanarkshire's Child and Adolescent Mental Health Services. The team provides a Tier 3 service for children and young people (aged 0-18 years old) where there is a significant impact on their wellbeing as a result of

mental health difficulties experienced by a parent(s), carer(s), or other close family member. The team operate a community assertive outreach service in order to promote a de-stigmatising environment where families can access mental health support.

#### *Eligibility and Consent*

A presentation will be delivered to staff whereby they will be asked to consider families on their caseload who meet the inclusion criteria. Staff will also be provided with leaflets detailing this information, as well as separate leaflets for parents and children for staff to handout. A poster will also be placed in the service waiting room. Families who wish to participate will then meet with the main researcher whereby they will be provided with a full description of what the study entails. This information will be in both verbal and written formats. Informed consent to participate will be obtained from all three participant groups. For children and young people, competency to consent will be assessed by the main researcher and will be obtained from the child and parent/guardian in accordance with the guidance on obtaining informed consent for clinical research in children and young people under the age of 16 (Scottish Children's Research Network (ScotCRN)).

#### ***Research Procedures***

A total of five focus groups will be conducted separately for each stakeholder group in order to obtain unbiased responses of their engagement with the service. Focus groups for children will be further organised to reflect defined age groups:

- (i) Group 1: Clinicians
- (ii) Group 2: Parents/ Family member
- (iii) Group 3: 12 – 13 years old
- (iv) Group 4: 14 – 15 years old
- (v) Group 5: 16 – 18 years old

A secondary option of participating in a supplementary individual interview will potentially be offered to children under 16 years old who may be less able to openly share their perspectives within the focus group. This will be based on the researcher's judgement of engagement within the focus groups. In this way, convergence of themes across both focus group and interview data can enhance data richness (Lambert & Loiselle, 2008). Demographic details for each participant will also be collected. Focus groups and interviews will be audio recorded, transcribed and anonymised before being imported onto N-VIVO (qualitative software package version 7) for analysis. A provisional schedule of topic guides for each stakeholder group will facilitate exploratory discussion (Appendix 1).

### ***Justification of Sample Size***

All five focus groups will be structured having 6-8 participants per group (max n= 40). A purposive sampling method aimed at parents and children representative of eligible families engaging within *Reach Out* will be recruited until sufficient saturation is determined. This sampling procedure will ensure recruitment of participants reflecting both diversity and heterogeneity. All clinicians working with the service (n= 8) will be approached by the main researcher to participate.

### ***Data Analysis***

Data will be analysed using the Framework Method of analysis (FA) informed by an existing framework (Normalisation Process Theory (NPT), see appendix 2) which will allow for a deductive approach to be applied. FA is considered most appropriate for analysis of interview data where commonalities and differences within the data can be identified (e.g. coherence across stakeholder's experiences). It provides a systemic model on which the data can be mapped providing more structure than other qualitative analysis methods (Gale, Heath, Cameron et al, 2013).

Thematic analysis will also be utilised which will be informed by an inductive coding process in order to limit the potential for any themes being left undetected or reframed under the NPT framework approach. Identifying themes will be based on the researcher's judgement which will involve an element of both flexibility and rigidity around how these will be determined (Braun & Clarke, 2006). The analytical five stage model (Ritchie & Spencer, 1994) will be adopted to facilitate analysis (see Appendix 1). Logic modelling will also be utilised in the analysis process whereby a specific logic model framework will help to consider and evaluate the emerging themes in the data (see appendix 1).

A reflexive account of the data collection and analysis will be recorded via a research log which will allow assumptions to be discussed with other researchers. External supervision by an experienced qualitative analyst may also be sought to facilitate guidance and understanding.

### ***Setting and Equipment***

Focus groups and interviews will be conducted within the service based at Coathill Hospital and within community settings across NHS Lanarkshire sites. Digital audio recording equipment and a transcriber will be utilised for recording and analysis purposes.

### **Health and Safety Issues**

#### ***Researcher and Participant Safety Issues***

Appropriate safeguarding issues will be in place when conducting interviews and focus groups (see Appendix 3 for details).

### **Ethical Issues**

All ethical issues have been considered and are outlined in the health & safety form (see Appendix 3).

Ethical approval will be obtained from the Research & Development Department within NHS Lanarkshire. An application will also be made to the local NHS research ethics committee.

### **Financial Issues**

A review of potential expenditure has been considered and detailed (see appendix 4).

### **Timetable**



An application to the relevant ethics department will be made following approval of the proposal with recruitment procedures anticipated to commence September/ October 2017.

### **Practical Applications**

It is intended that by exploring key stakeholder's perspectives of engaging with a community outreach service will aim to bridge the gap between the child, parent and staff on processes of engagement within the Reach Out service. This will inform better practice and improve outcomes within this population.

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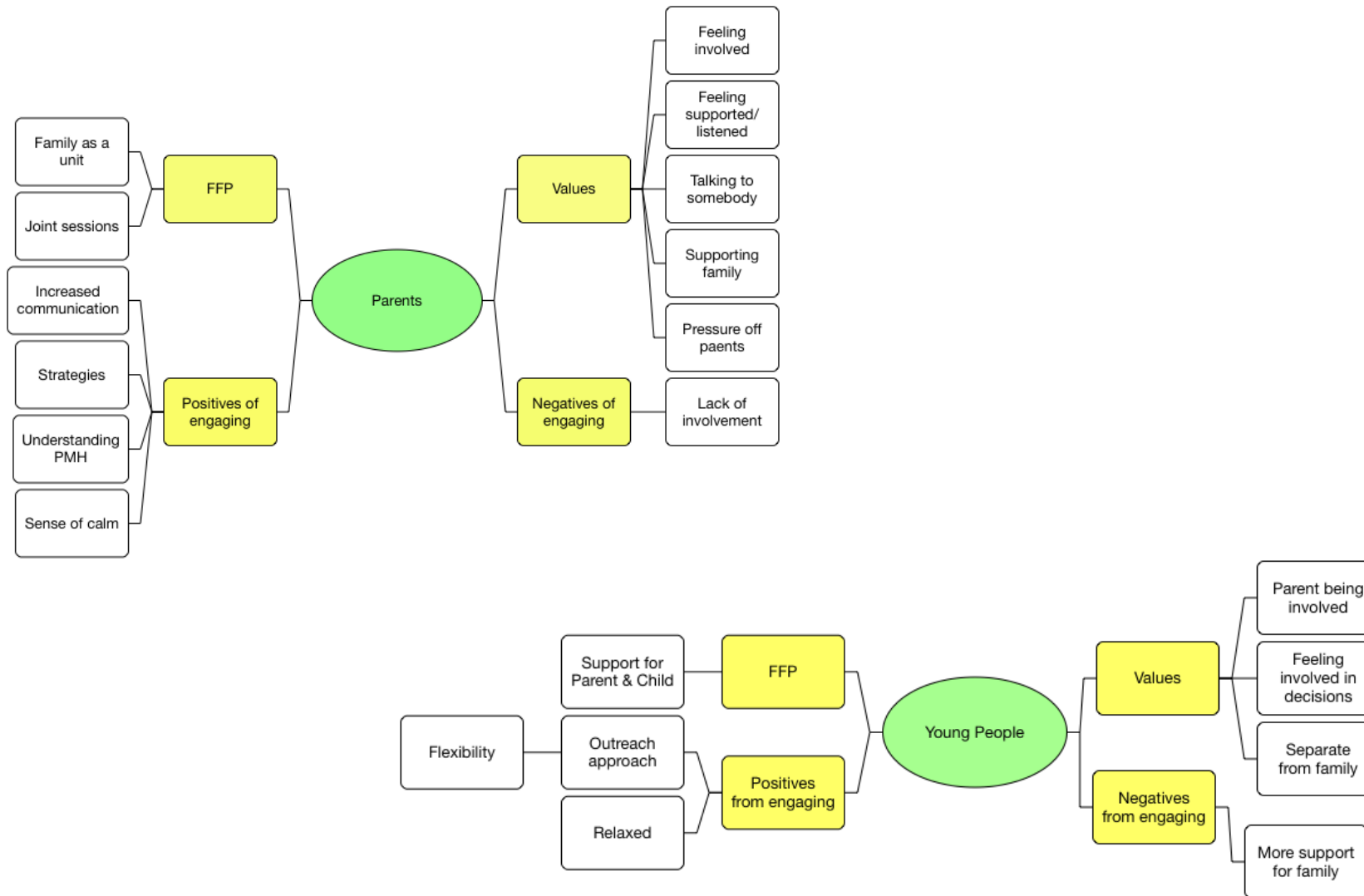
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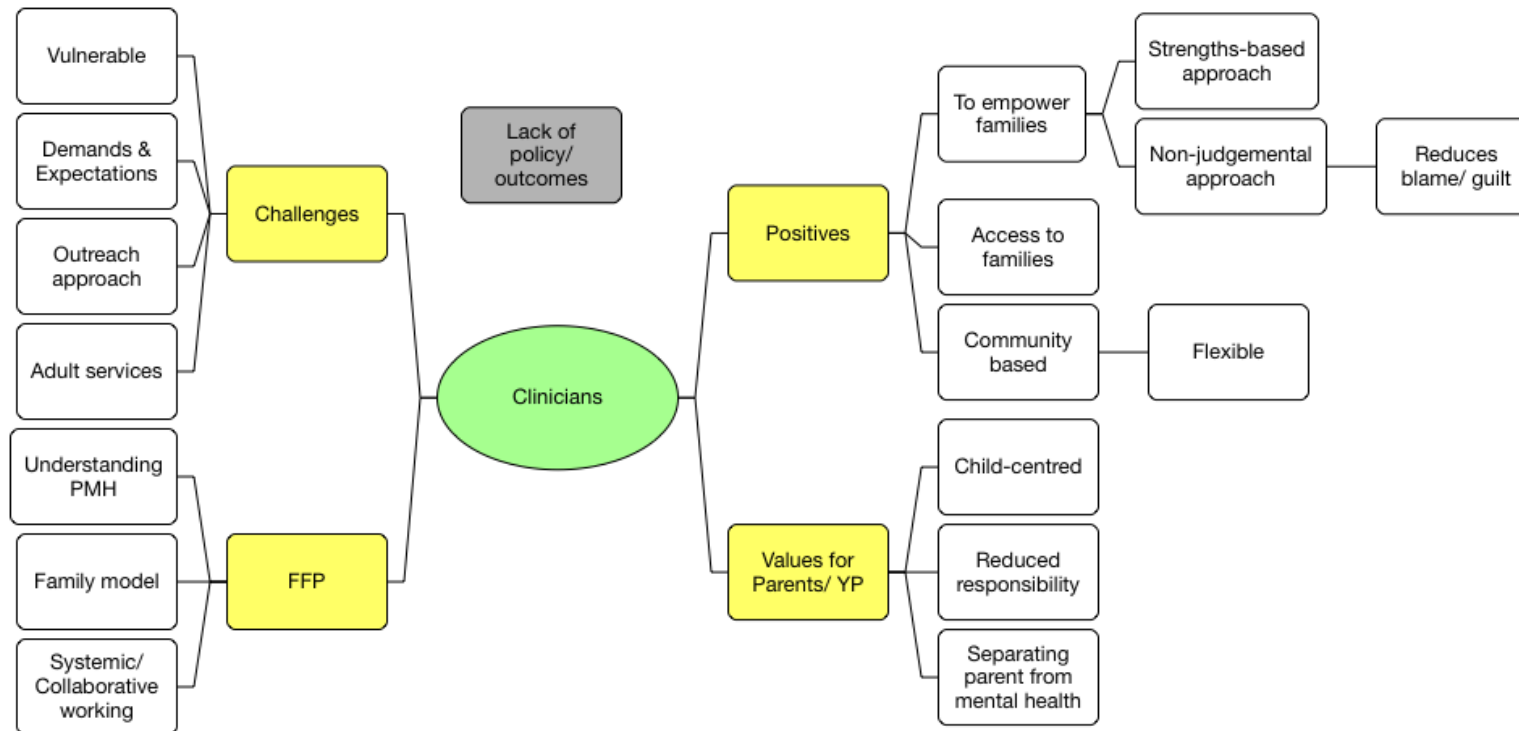
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## Appendix 2.14: Thematic Maps

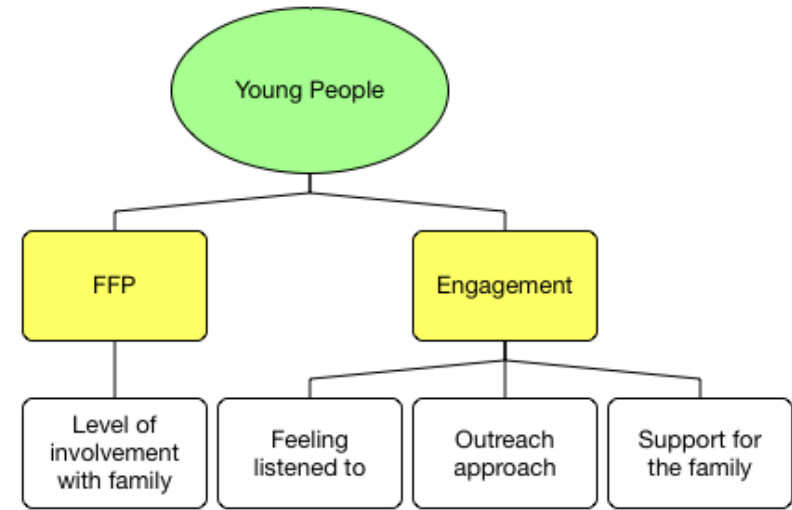
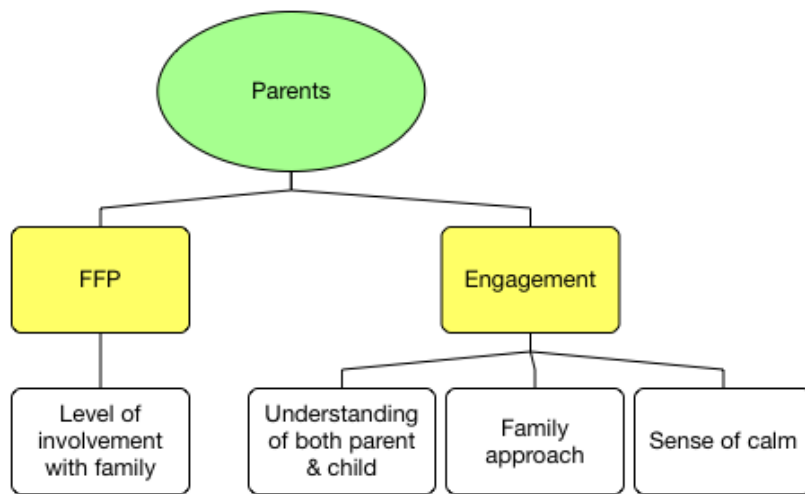
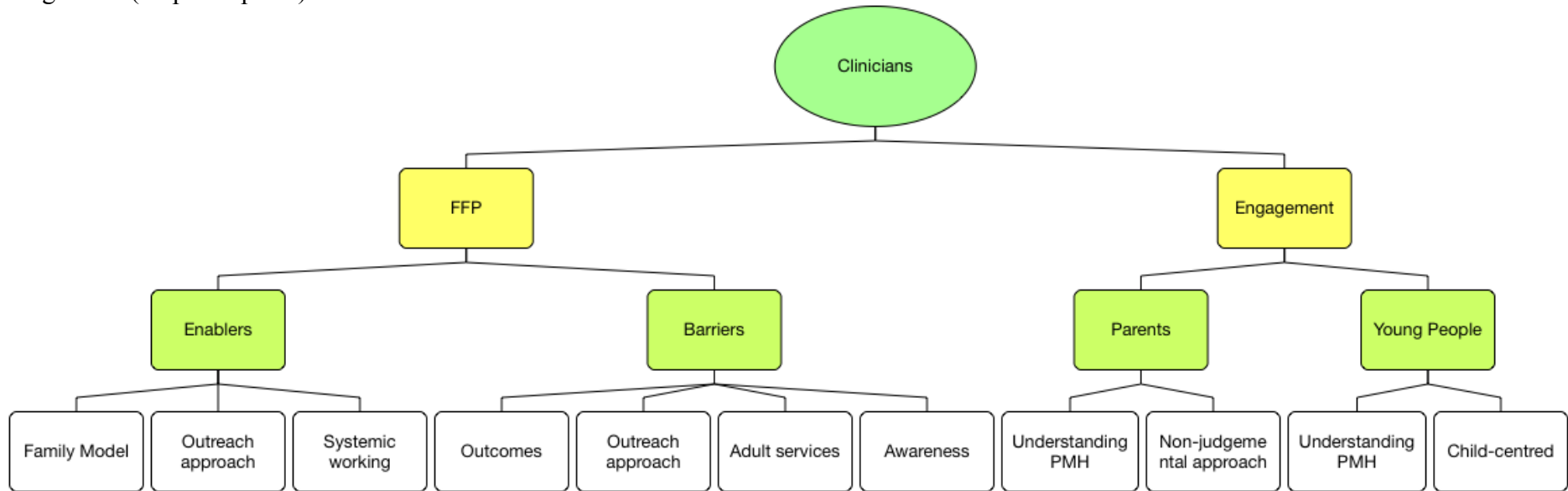
### Stage One (Parents & Young People)



## Stage One (Clinicians)



Stage Two (all participants)



## Appendix 2.15: Contribution of themes from thematic analysis to NPT

Each table reflects the contribution of themes that emerged from thematic analysis towards NPT constructs. The stakeholder perspective is indicated in brackets.

**Table 1. Coherence**

Thematic analysis themes	NPT
<ul style="list-style-type: none"> <li>The family model (clinicians)</li> <li>A family approach (parents)</li> <li>Support for the family (young people)</li> </ul>	All stakeholders identify and value a family approach
<ul style="list-style-type: none"> <li>Understanding the parent &amp; child (parents)</li> <li>A whole family approach (parents)</li> <li>Level of family involvement (parents)</li> <li>Level of family involvement (young people)</li> <li>Support for the family (young people)</li> <li>The family model (clinicians)</li> </ul>	Benefits of the family approach by all stakeholders
<ul style="list-style-type: none"> <li>Community outreach approach (clinicians)</li> <li>Bringing a sense of calm (parents)</li> <li>Community outreach approach (young people)</li> </ul>	Positive impact of community outreach approach by parents and young people, however mixed appraisal from clinicians
<ul style="list-style-type: none"> <li>Understanding PMH (clinicians)</li> <li>Understanding their parent's MH (young people)</li> <li>Understanding the parent and child (parents)</li> </ul>	All stakeholders value an understanding of PMH
<ul style="list-style-type: none"> <li>Level of family involvement (parents)</li> <li>Level of family involvement (young people)</li> </ul>	Lack of coherence for level of family involvement

**Table 2. Cognitive Participation**

Thematic analysis themes	NPT
<ul style="list-style-type: none"> <li>Outcomes and lack of awareness (clinicians)</li> </ul>	Clinicians wish to increase awareness of families' needs.
<ul style="list-style-type: none"> <li>Understanding the parent and child (parents)</li> <li>A whole family approach (parents)</li> </ul>	Parents want support to involve them when necessary
<ul style="list-style-type: none"> <li>Support for the family (young people)</li> </ul>	Young people want other family members to be involved.
<ul style="list-style-type: none"> <li>Community outreach approach as an enabler and barrier (clinicians)</li> </ul>	Clinicians view the benefits of a community outreach approach as outweighing the challenges

**Table 3. Collective Action**

<b>Thematic analysis themes</b>	<b>NPT</b>
<ul style="list-style-type: none"> <li>• The family model (clinicians)</li> </ul>	Family model adopted in practice
<ul style="list-style-type: none"> <li>• Community outreach approach as an enabler (clinicians)</li> </ul>	Community outreach approach adopted
<ul style="list-style-type: none"> <li>• Non-judgemental approach (clinicians)</li> </ul>	Non-judgemental approach
<ul style="list-style-type: none"> <li>• Systemic working (clinicians)</li> <li>• Child-centred approach (clinicians)</li> <li>• Being listened to (young people)</li> </ul>	Systemic working & child-centred approach
<ul style="list-style-type: none"> <li>• Structure of adult services (clinicians)</li> </ul>	Disparity between child and adult services
<ul style="list-style-type: none"> <li>• Level of family involvement (parents)</li> <li>• Level of family involvement (young people)</li> </ul>	Variability in level of FFP

**Table 4. Reflexive Monitoring**

<b>Thematic analysis themes</b>	<b>NPT</b>
<ul style="list-style-type: none"> <li>• Outcomes and lack of awareness (clinicians)</li> </ul>	Awareness of measuring outcomes and evaluation
<ul style="list-style-type: none"> <li>• Outcomes and lack of awareness (clinicians)</li> <li>• Community outreach approach as a barrier (clinicians)</li> </ul>	Clinicians want to protect their role and the service
<ul style="list-style-type: none"> <li>• Understanding the parent &amp; child (parents)</li> <li>• Level of family involvement (young people)</li> </ul>	Positive appraisal from parents and young people regarding current FFP input

Note:

PMH = Parental Mental Health

MH = Mental Health

FFP = Family-focused practice