

## REVIEW ARTICLE

# The implementation of family-focused practice in adult mental health services: A systematic review exploring the influence of practitioner and workplace factors

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**ABSTRACT:** *There is increased recognition of the need for greater and more appropriate support to be offered to families in which a parent experiences mental illness and has dependent children. One way of meeting this need is for adult mental health services to take a more family-focused approach. However, there are recognized difficulties in facilitating family-focused practice (FFP). The current review systematically synthesized quantitative and qualitative literature of practitioner perspectives and experiences of FFP in adult mental health settings to identify modifiable factors associated with its successful implementation. Five databases were searched systematically leading to the inclusion and quality assessment of 19 papers, ten of which were quantitative and nine qualitative. Analysis was guided by a narrative synthesis approach. Factors shown to influence FFP functioned at both practitioner and workplace levels and included personal attitudes, beliefs about job role, and perceptions of workplace support. Practitioners who felt that a family-focussed approach was inappropriate or detrimental to service users or outside of their remit as mental health professionals were less likely to adopt this approach. For those who saw the potential benefits of FFP, lack of confidence in their ability to deliver such an approach and lack of training can be barriers, as can lack of support and resources within services. This review highlights the need for actions to boost the awareness of adult mental health practitioners working with parents and to increase their confidence. It also makes the case for broader organizational support if family-focussed practice is to be implemented successfully.*

**KEY WORDS:** *family, mental health services, parental mental illness, parenting, parents.*

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**Declaration Conflicts of Interest:** We declare no conflicts of interest.

**Authorship statement:** All authors contributed to the design of the review and to the analysis and interpretation of findings. HA conducted the initial searches and produced the first draft, and LG critically revised it. All authors are in agreement with the final manuscript.

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Accepted December 17 2020.

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## INTRODUCTION

Serious mental illness (SMI) in parents can have a significant impact on children, affecting their physical and mental health as well as their social and emotional well-being (Bee *et al.* 2014; Schrank *et al.* 2015). Conversely, family relationships, including those with dependent children, can have substantial impacts, both positive and negative, on individuals experiencing mental health difficulties (Barrowclough & Hooley 2003; Glynn *et al.* 2006; Lee *et al.* 2013; Waller *et al.* 2018). A substantial minority of psychiatric patients are parents, with studies revealing that up to 45% are parents to dependent children (Maybery & Reupert, 2018). Support is sometimes lacking for these families, and adult mental health services might have a role to play in improving outcomes for all family members (Bee *et al.* 2014; Reupert *et al.* 2015). A more 'family-focused' approach to mental health services has already been adopted, or is beginning to be, in several countries around the world, primarily in Australia, Finland, Norway, Canada and the Republic of Ireland (Mulligan *et al.* 2019; Reupert *et al.* 2015), reflecting increased recognition of the reciprocal effects of parent and child relationships and emerging evidence that such an approach is beneficial (e.g. Foster *et al.* 2012).

There is a 'lack of definitional clarity and theoretical integration' (p. 131, Foster *et al.* 2016) about what exactly is meant by the term 'family-focused practice' (FFP), a practice which seeks to address the needs of the whole family, not just the parent with mental illness and as such typically involves increased collaboration between adult and child mental health services. Foster *et al.* (2016) conducted a systematic review of the concept and scope of FFP in adult, child, and youth mental health settings and identified six key interrelated components to existing FFP: (i) *family care planning* – involving establishing goals and crisis plans; (ii) *family and service liaison and advocacy*; (iii) *individual and family-focused support*; (iv) *individual and family-focused assessment* – including identifying children and assessing parental competency, mental health impact and mental health literacy; (v) *psychoeducation*; and (vi) *family-focused collaboration*, which encompasses ensuring coordinated support from services to families. Foster *et al.* (2016) recommended four principles to be a starting point for FFP: the belief that 'consumers' families play a pivotal role in their recovery; that consumers and their families can be empowered to address and meet their needs; that it is possible to

support consumers via their family; and that the relationships between clinician and consumer, clinician and family, and between consumer and family members, are key to enabling a "whole of family" approach' (p. 151, Foster *et al.* 2016). Whilst these seem to be relatively straightforward principles in theory, in practice they can be difficult to operationalize and implement.

In a review of the barriers to working with families experiencing parental mental illness as perceived by adult mental health staff and the families accessing these services, Maybery and Reupert (2009) examined 28 papers and identified five themes that appeared to influence practitioners' family-focused approaches. These themes comprised of (i) policy and management, (ii) interagency collaboration, (iii) worker attitude, skill and knowledge, (iv) the client themselves, and (v) the client's family, including their children. The authors emphasized the need to prioritize organizational change in policy and management to successfully implement a family-focused approach within services. Maybery and Reupert's (2009) review was valuable in providing an overview of factors affecting practitioners' family-focused approaches within adult mental health settings. Particular strengths lay in the authors' efforts to capture all relevant studies and include clients' and family members' perspectives but as family-focused practice has increased, more research has been conducted and an updated review is needed. A more recent review by Shah-Anwar *et al.* (2019) synthesized practitioner experiences of FFP in both child and adult settings but focused solely on qualitative reports (nine in total). Conclusions were similar to those of Maybery and Reupert (2009) and highlighted the importance of the organizational context and policies supportive of FFP (theme 1) and clinicians' attitudes, knowledge and practice (theme 2). This review is an important addition to the literature but quantitative studies exploring implementation of FFP were excluded, including a large number conducted since the Maybery and Reupert (2009) review; therefore, a more comprehensive and up-to-date review is timely.

## Aims

The current review sought to synthesize both the quantitative and qualitative literature examining practitioner experiences of the implementation of family-focused practice in adult mental health services systematically with the aim of providing an account of factors that

should be addressed if FFP is to be implemented elsewhere, for example in the United Kingdom. It also aimed to identify the key factors that have been reported to have influenced practitioners' implementation of FFP in adult mental health settings in order to make evidence-based recommendations about how FFP should be implemented in adult mental health services attempting to adopt FFP for the first time. In doing so, this review may inform policy development and service delivery concerning the ways adult mental health services might incorporate family-focused approaches, with the longer term aim of helping families affected by parental mental illness overcome the challenges they face.

## METHODS

### Search strategy and review scope

The search strategy was conducted in line with PRISMA guidance (Moher *et al.* 2009), and a protocol was submitted and registered on the PROSPERO database (CRD42019120756). Search terms were identified from the titles and abstracts of a selection of key papers, using Foster *et al.*'s (2016) review to encompass all FFP-related search terms. An initial pilot search was then undertaken using 'family-focused practice', 'adult mental health practitioner' and 'influential factor' related search terms (see Table 1 for a full list of search terms). An 'influential factor' was defined as any variable that had been examined in relation to its possible impact on the FFP of adult mental health practitioners. The pilot search indicated that influential factors would be better identified through hand-searching as part of the screening process to avoid imposing restrictions and bias by pre-defining search terms. Consequently, five electronic databases (PsycINFO, CINAHL plus, ASSIA, BNI, and Web of Science) were searched using 'family-focused practice' and 'adult mental health practitioner' related search terms only. Both quantitative and qualitative studies published in the English language from database inception until 3 November 2018 were included in order to ascertain a deeper understanding of the influence of factors on FFP whilst synthesizing their quantifiable impact.

It was beyond the scope of this review to incorporate client perspectives or wider organizational issues, as examined by Maybery and Reupert (2009). To better facilitate more targeted recommendations, the current review sought to identify which modifiable practitioner and workplace factors influenced the FFP of

practitioners working in adult mental health services, and determine where this impact was seen. Therefore, the decision was also made to exclude some potentially influential demographic factors (such as age and gender of practitioners; their parental and marital status and geographical location) due to the difficulty of implementing such findings for services.

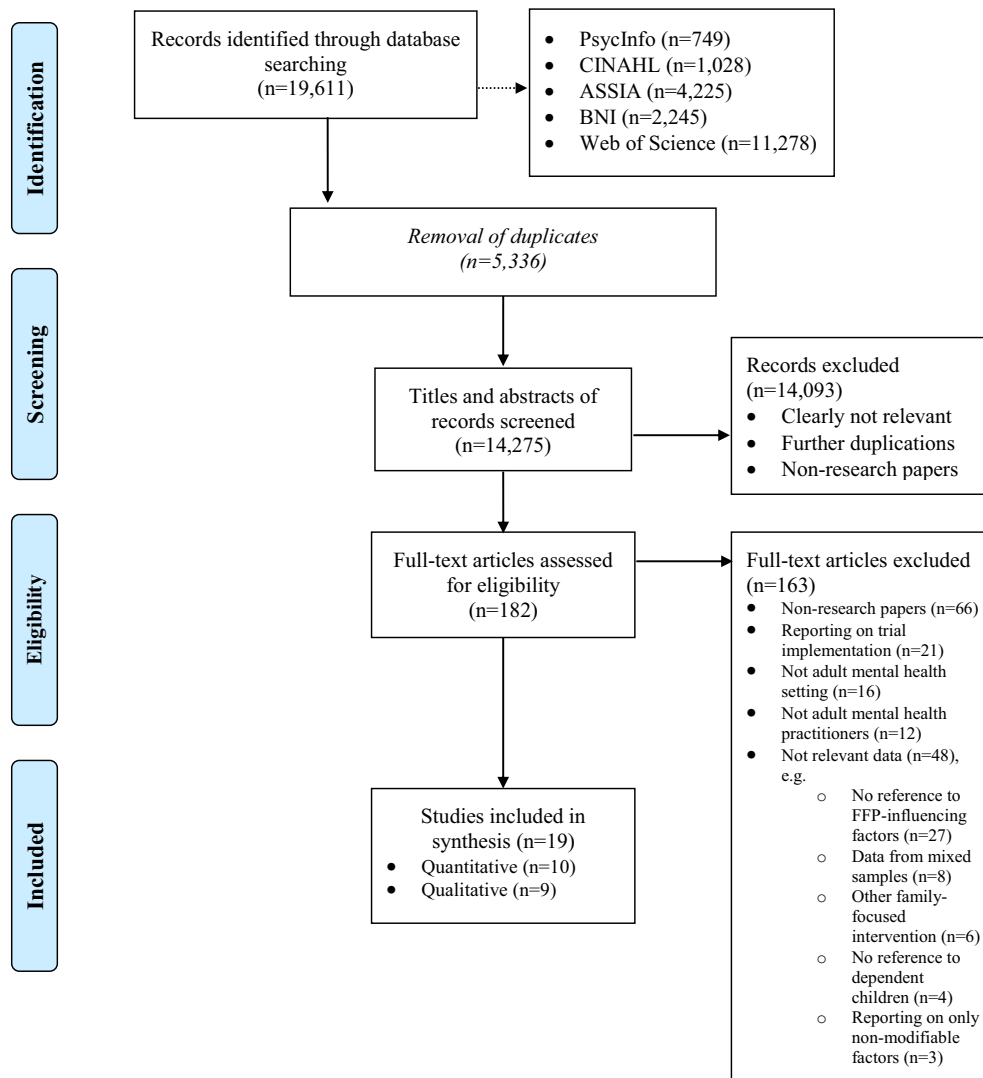
### Inclusion and exclusion criteria

Inclusion criteria for studies reporting on factors influencing FFP were as follows: (i) participants were adult mental healthcare practitioners who worked in adult mental health services, (ii) studies included data on factors that influenced FFP at a practitioner and/or workplace level, and (iii) papers were available in English in peer-reviewed journals.

Exclusion criteria were (i) participants were mental healthcare practitioners working in child, substance use or physical healthcare roles, or occupying a solely managerial, non-clinical position, (ii) studies that described data relating to factors affecting the implementation of a specific short-term intervention or clinical trial relating to family-focused work, (iii) research reporting on specific types of therapy involving families (such as Family Therapy or Family Intervention), and (iv) reviews and/or studies not presenting empirical data, such as opinion pieces and audits.

Studies that included data from a mixed sample (e.g. clients and practitioners) were included if the practitioners' data were presented separately but excluded if they were combined. Whilst papers were included if they explored the impact of factors on FFP following national family-focused policy implementation, studies were excluded if they only examined factors affecting the implementation of specific family-focused interventions or clinical trials (i.e. specific time-limited interventions that did not constitute attempts to adopt FFP more widely). This distinction was made because the focus of the review was on synthesizing evidence on modifiable factors influencing the implementation of FFP within adult mental health services only.

A rater not linked to the study (RF) independently screened the titles and abstracts of 10% of the papers ( $n = 1427$ ). When there was disagreement, this was discussed with the wider team and consensus reached. An interrater reliability score of  $\kappa = 0.77$  was attained, indicating substantial agreement and reasonable reliability. See Table 2 for the full inclusion and exclusion criteria, and Figure 1 for the flow diagram of the search strategy.



**FIG. 1** Flow diagram of search strategy.

### Data extraction and synthesis

The second author (HA) led on assessing eligibility, extracting the data and quality appraising the included articles, consulting with the research team throughout this process. Two published reviews (Foster *et al.* 2016; Maybery & Reupert 2009) were used to guide data synthesis, but it was agreed to diverge from the structures proposed in those papers should the current data extraction and analysis process reveal a different picture.

Data analysis from quantitative and qualitative studies was guided by a narrative synthesis approach (Popay *et al.* 2006) to review and synthesize primarily textual data of multiple studies in order to assimilate findings. Quantitative and qualitative data were initially analysed separately and then combined in the synthesis

process to present a collective narrative of influential factors. Relevant questionnaire data were extracted from the quantitative studies first, and verbatim quotes were then extracted from the qualitative papers. Extracted data were tabulated according to: (i) the factors appearing to influence FFP, drawing on Maybery and Reupert's (2009) review to broadly distinguish between practitioner and workplace factors and (ii) the FFP component the factors seemed to influence, using the categorization proposed by Foster *et al.* (2016) as an initial framework to classify the component of FFP reported being impacted.

### Methodological quality assessment of the included studies

The quality of studies was appraised using reputable appraisal tools that were appropriate for the

methodology of each included study. A 10-item checklist from the Critical Appraisal Skills Programme (CASP 2018) was used to assess the qualitative papers. No appropriate CASP tool existed for the quantitative studies (all utilizing cross-sectional survey designs), and the 21-item Critical Appraisal Checklist for the Appraisal of Surveys tool (Crombie, 2002) was used to appraise these. The quality appraisal rating key proposed by Boland *et al.* (2014) was used. Studies were rated 'high' quality when most of the criteria were met or the paper showed notable methodological strengths, 'adequate' when most of the criteria were met, and 'low' when the study only partially met appraisal criteria. After another external rater (JB) independently appraised over 25% of the included papers, the interrater reliability score of  $\kappa = 0.72$  indicated substantial agreement.

## RESULTS

### Characteristics of included studies

A description of all 19 included studies is provided in Table 3. Most studies were conducted in Australia ( $n = 8$ ) and Finland ( $n = 3$ ). Remaining countries included Norway ( $n = 2$ ), Ireland ( $n = 2$ ), the UK ( $n = 2$ ), Thailand ( $n = 1$ ), and Sweden ( $n = 1$ ). Most countries had introduced national FFP policies except for Thailand, Sweden, and the UK.

Ten studies were quantitative and nine were qualitative, and sample sizes ranged from 6 to 349 participants with a combined sample of 1493. Of the quantitative papers, three reported data from the same Australian sample (Goodyear *et al.* 2017; Maybery *et al.* 2014, 2016), and three papers reported data from the same Finnish sample (Korhonen *et al.* 2010a; Korhonen *et al.* 2008, 2010a). Two qualitative papers published data from the same sample (Tchernegovski *et al.* 2018a, 2018b), hence the 19 studies were drawn from 14 datasets.

The 10 quantitative studies were cross-sectional studies providing self-report survey data. Four (Goodyear *et al.* 2017; Maybery *et al.* 2014, 2016; Tungpunkom *et al.* 2017) used adapted versions of the 'family-focused mental health practice questionnaire' (FFMHPQ) (Maybery *et al.* 2012). Three studies by Korhonen *et al.* (2008, 2010a, 2010b) used a 135-item questionnaire, which was subsequently published as the 'preventive child-focused family work' (PCF-FW) questionnaire (Korhonen *et al.* 2009). The remaining three studies (Houlihan *et al.* 2013; Lauritzen *et al.*

2015; Slack & Webber 2008) used questionnaires developed for their specific research purposes; the latter two of which included open-ended textual responses which were analysed qualitatively.

Eight of the nine qualitative studies used interviews as data collection methods including one focus group (Sjöblom *et al.* 2005), whereas one study (Lauritzen & Reedtz 2013) presented only the qualitative data from a questionnaire, having published the quantitative data in a separate paper (Lauritzen *et al.* 2015).

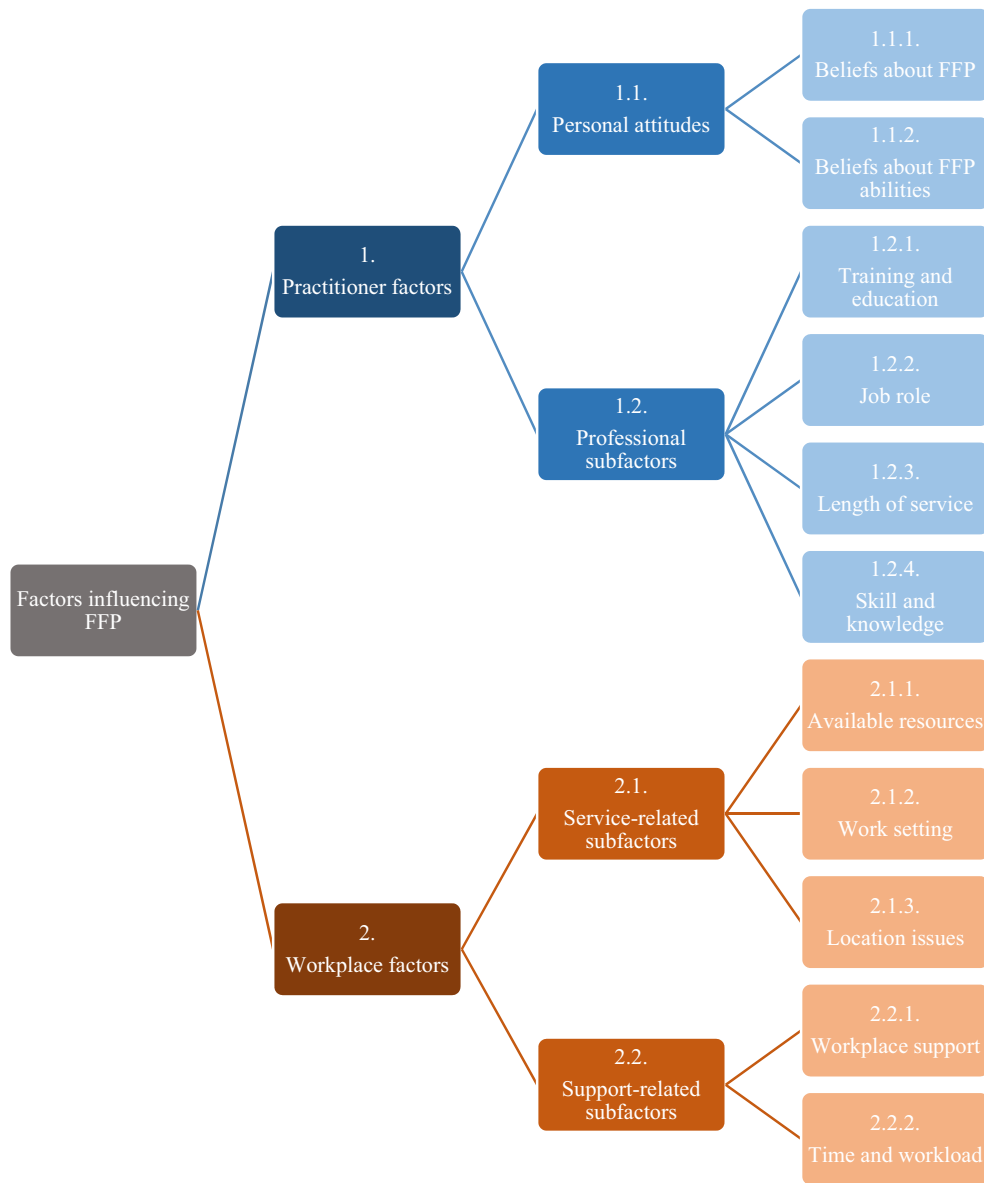
### Methodological appraisal

Quality appraisal revealed three quantitative studies to be 'high quality' (Houlihan *et al.* 2013; Slack & Webber 2008; Tungpunkom *et al.* 2017) and seven 'adequate quality'. Collectively, study strengths lay in the frequent reporting of response rates ( $n = 7$ ), statistical analysis methods ( $n = 9$ ), and in discussions of possible selection bias ( $n = 6$ ). The quality of studies was hampered by null findings either being partially reported ( $n = 5$ ) or omitted entirely ( $n = 4$ ). Inconsistent or inaccurate data reporting was evident, such as variations in the reported sample sizes, mathematical errors in the reported response rates, and data differences between that reported in the text and tables ( $n = 7$ ). Furthermore, as all the quantitative studies were cross-sectional surveys administered to staff to complete, the limitations of self-report questionnaire data were applicable throughout.

Four of the nine qualitative studies were rated 'high quality' (Grant & Reupert 2016; Maddocks *et al.* 2010; Tchernegovski *et al.* 2017, 2018b) and three 'adequate quality' (Sjöblom *et al.* 2005; Tchernegovski *et al.* 2018a; Ward *et al.* 2017). Two studies only partially met appraisal criteria quality standards (Lauritzen & Reedtz 2013; O'Brien *et al.* 2011). The qualitative studies tended to report reasonably rigorous analysis, with two scoring highly in relation to in-depth description of the analytical process (Grant & Reupert 2016; Maddocks *et al.* 2010). However, six of the nine studies did not critically consider researcher influence (Grant & Reupert 2016; Lauritzen & Reedtz 2013; O'Brien *et al.* 2011; Sjöblom *et al.* 2005; Tchernegovski *et al.* 2017; Ward *et al.* 2017) and possible resulting bias is therefore a significant limitation. Detailed quality appraisal ratings are shown in Appendix S1.

### Data synthesis

This review set out to identify which practitioner and workplace factors influenced the FFP of adult mental



**FIG. 2** Diagram of factors influencing FFP of adult mental health staff.

health practitioners and describe which practices they influenced. Practitioner factors included personal attitudes and professional subfactors, whilst workplace factors included service-related and support-related subfactors. The thematic structure of results is illustrated in the following diagram (Figure 2).

The included papers reported data on the influence of factors on family-focused assessment and support practices almost exclusively. Some limited data on family-focused collaboration practices between adult mental health services and other organizations were presented. By definition, however, collaborative practices cannot be wholly influenced by adult mental

health services because they are inherently reliant on relationships with other organizations – organizations which may adopt alternative stances. Hence, we omitted these data from the review in order to present more targeted, workable recommendations. For a full and detailed overview of results, see Appendix S2 showing factors reported to influence FFP.

#### *Practitioner factors*

##### *Personal attitudes*

*Personal beliefs about FFP.* Nine papers reported on the influence of practitioner attitudes and beliefs on

FFP (Grant & Reupert 2016; Lauritzen *et al.* 2015; Maddocks *et al.* 2010; O'Brien *et al.* 2011; Sjöblom *et al.* 2005; Slack & Webber 2008; Tchernegovski *et al.* 2018a, 2018b; Ward *et al.* 2017); eight of which presented qualitative data of broadly good quality. In the only quantitative study (Lauritzen *et al.* 2015), no significant differences were seen between practitioners who did assess whether clients had children and those that did not in terms of their attitudes and beliefs about FFP. However, the eight studies presenting qualitative data offered a different picture in which attitudes and beliefs were reported to have a considerable influence on FFP. Five studies described substantial reservations about taking a family approach, in which practitioners reported that involving children in patient care was inappropriate or detrimental to clients (Maddocks *et al.* 2010; O'Brien *et al.* 2011; Sjöblom *et al.* 2005; Slack & Webber 2008), or that the value of a family-focused approach was overstated (Maddocks *et al.* 2010; Sjöblom *et al.* 2005). Family approaches were also described as being outside the remit of adult mental health work (Grant & Reupert 2016; Maddocks *et al.* 2010; O'Brien *et al.* 2011; Slack & Webber 2008).

Sometimes feels inappropriate in relation to my relationship with the parent, preferable if someone else is involved at that point. (p. 76; Slack & Webber 2008)  
I think she'd still be oblivious to her child walking in front of a fire, but that's not my job to know about. (p. 678; Maddocks *et al.* 2010)

Nevertheless, across these ten studies practitioners also expressed positive attitudes about the benefits of incorporating family approaches. Participants reported that involving children and families increased the likelihood of parents' mental health improving and parents staying well (Maddocks *et al.* 2010; O'Brien *et al.* 2011; Tchernegovski *et al.* 2018a, 2018b; Ward *et al.* 2017).

We all know... that if you don't engage the family meaningfully, peoples' recoveries [are] really limited. (p. 3; Ward *et al.* 2017)

Others described the intergenerational benefits of FFP (Grant & Reupert 2016; Maddocks *et al.* 2010; O'Brien *et al.* 2011; Sjöblom *et al.* 2005; Tchernegovski *et al.* 2018a; Ward *et al.* 2017) and saw an opportunity for 'early intervention' to 'break the cycle' (p. 5; Tchernegovski *et al.* 2018a) as an integral part of their work (Maddocks *et al.* 2010; Sjöblom *et al.* 2005; Ward *et al.* 2017).

*Personal attitudes about ability to practice FFP.* With regard to practitioners' beliefs about their abilities to

take on family-focused approaches, some reported feeling best placed to identify and manage parenting concerns with clients accessing their service (Grant & Reupert 2016; Maddocks *et al.* 2010; Tchernegovski *et al.* 2018a, 2018b).

There's a whole cycle that goes into what we do with families, that gives us a different relationship with people and allows us to make interventions in a different way than the various other professionals that are coming in. (p. 210; Grant & Reupert 2016)

Indeed, negative beliefs about involvement from external services incentivized some practitioners to take a family approach in their work (Lauritzen & Reedtz 2013; Maddocks *et al.* 2010; Tchernegovski *et al.* 2018a, 2018b). The likelihood that involving clinicians from other services (such as children's services) would be perceived badly by parents was highlighted by a practitioner, who consequently reported experiencing a 'really strong motivator for me to raise [the issue], even when it's uncomfortable' (p.384; Tchernegovski *et al.* 2018b).

Nevertheless, even practitioners who reported positive attitudes towards FFP expressed concurrent beliefs about it being difficult. In four studies, practitioners described the risk of FFP adversely impacting their relationship with clients and any developing trust (Lauritzen & Reedtz, 2013; Maddocks *et al.* 2010; Slack & Webber 2008; Tchernegovski *et al.* 2018a).

If they feel that we are involved with the children and that we are part of that decision-making process it can ruin the relationship, and we are trying to build up a good therapeutic relationship to help them move on. (p. 678; Maddocks *et al.* 2010)

[You] take on an authoritarian role instead of a clinician role... you've moved across the line from someone who's trying to help them to someone who's against their will. (p. 5, Tchernegovski *et al.* 2018a)

The tension between being family-focused and person-centred was highlighted in several studies (Maddocks *et al.* 2010; O'Brien *et al.* 2011; Tchernegovski *et al.* 2018a, 2018b; Ward *et al.* 2017). This meant some practitioners considered parenting issues only when raised by the client themselves ('we leave it up to the family to ask about children visiting' – p. 360; O'Brien *et al.* 2011) and could result in FFP being limited to practitioners simply providing a space for their client to 'let off steam' (p. 5; Tchernegovski *et al.* 2018a).

Others highlighted the difficulties of collaborating with families and indirectly assessing family functioning

via parents' accounts (Lauritzen & Reedtz 2013; Sjöblom *et al.* 2005; Tchernegovski *et al.* 2018a, 2018b; Ward *et al.* 2017). Tchernegovski *et al.* (2018b) reported this was particularly pertinent around risk matters – it could be 'very difficult to be clear about predicting issues of safety' when 'you've got to rely on what [the parent is] saying' (p. 385).

Practitioners also spoke about an emotional cost of family-focused work, particularly in terms of the empathic response often invoked when working with parents and children, and felt this could be overlooked (Grant & Reupert 2016; Maddocks *et al.* 2010; O'Brien *et al.* 2011; Tchernegovski *et al.* 2017, 2018a, 2018b).

You can't work with parents unless you've an emotional connection with them and there's a downside to having it [emotional connection]. I don't think that's appreciated and it would be better for us as professionals if it was acknowledged by the organization. (p. 211; Grant & Reupert 2016)

Overall, evidence suggested that practitioners' personal attitudes towards FFP and their ability to use it impacted upon the family-focused approaches they adopted in two main ways. Firstly, the likelihood of practitioners engaging in FFP was closely linked to their beliefs about the benefits of work to their clients and families. Secondly, the extent to which practitioners engaged in FFP was influenced by beliefs about their ability to do such work, but also their beliefs about ways to overcome the inherent, inevitable challenges.

#### *Professional subfactors*

*Family-focused training and education.* Five quantitative studies examined the influence of family-focused training and education on practitioners' FFP (Goodyear *et al.* 2017; Korhonen *et al.* 2008, 2010a, 2010b; Tungpunkom *et al.* 2017), and all five reported some evidence that training positively impacted upon FFP. However, the picture is complicated by two of these studies differentiating between 'family training' and 'child training' but not describing how training differed (Goodyear *et al.* 2017; Tungpunkom *et al.* 2017), and by reporting that 'family training' or 'child training' only influenced certain aspects of family-focused assessment and/or support. The three remaining studies are a series of linked papers reporting data from a single sample (Korhonen *et al.* 2008, 2010a, 2010b) and only report on 'further family education' without providing a description of what this entailed.

Goodyear *et al.* (2017) and Tungpunkom *et al.* (2017) found that practitioners who had undertaken either family training or child training were significantly more likely to assess the impact of parental mental illness on children than practitioners who had not received this training. This result was supported by Korhonen *et al.* (2008, 2010a, 2010b), who reported that participants who had undertaken further family education were more likely to gather information about clients' children and assess family well-being and support networks. Similarly, Goodyear *et al.* (2017) reported that practitioners who had received family training were more likely to assess parents' awareness of their children's well-being as well as offer parenting support, support carers and children, and make referrals for family members. Tungpunkom *et al.* (2017) also found that family-trained practitioners were more likely to support carers and children, but family training was not shown to influence the likelihood of them offering parenting support or making referrals. Child training did not influence the likelihood of practitioners providing parenting support (Goodyear *et al.* 2017; Tungpunkom *et al.* 2017), and Goodyear *et al.* (2017) also found no evidence that it influenced making referrals, offering family support, or assessing parents' awareness of their children's well-being.

The importance of feeling adequately trained in family-focused practice was highlighted in six studies reporting qualitative data (Grant & Reupert 2016; Houlihan *et al.* 2013; Lauritzen & Reedtz 2013; Maddocks *et al.* 2010; O'Brien *et al.* 2011; Tchernegovski *et al.* 2018b). Lack of training was cited in reports of feeling ill-equipped to do family-focused work (Grant & Reupert 2016; Lauritzen & Reedtz 2013; Maddocks *et al.* 2010; O'Brien *et al.* 2011).

I'm not confident at it because I'm not trained in it.  
I'm not qualified to give family-centred care. (p. 678,  
Maddocks *et al.* 2010)

Equally, family-focused training was seen to help practitioners feel more able to engage in FFP (Grant & Reupert 2016; Houlihan *et al.* 2013; Tchernegovski *et al.* 2018b), as highlighted by one practitioner who explicitly stated 'I would like further education in how to deal with questions asked by children' (p. 292; Houlihan *et al.* 2013) and another who felt training made them better able to assist families who were 'stuck in crisis' (p. 384; Tchernegovski *et al.* 2018b).

The evidence therefore suggests that undertaking family-focused training and education has a positive influence on family-focused practice. However, these



conclusions are partly based on the findings reported in quantitative studies with adequate methodological quality (e.g. Goodyear *et al.* 2017; Korhonen *et al.* 2008, 2010a, 2010b; Tungpunkom *et al.* 2017) and five qualitative papers (four of which were rated high quality) asserting the benefits of training for FFP.

*Job role.* Ten studies examined how aspects of job role influenced family-focused practice (Grant & Reupert 2016; Houlihan *et al.* 2013; Korhonen *et al.* 2008, 2010a, 2010b; O'Brien *et al.* 2011; Slack & Webber 2008; Tchernegovski *et al.* 2018a; Tungpunkom *et al.* 2017; Ward *et al.* 2017). Five studies presenting qualitative data reported practitioners seeing FFP as the role of certain professions and not others (Grant & Reupert 2016; Houlihan *et al.* 2013; O'Brien *et al.* 2011; Tchernegovski *et al.* 2018a; Ward *et al.* 2017), as highlighted by a psychologist:

The social workers do a lot of the family work and the doctors might talk to the family for collateral history and things like discharge planning. I'm a bit more one-on-one therapy with the client themselves. (p. 5; Tchernegovski *et al.* 2018a)

This perceived distinction between professions was supported by two high quality quantitative studies. Tungpunkom *et al.* (2017) found that social workers were significantly more likely than psychiatrists, psychologists, and nurses to offer support to family members, whilst psychiatrists were more likely to assess the impact of parental mental illness on clients' children. Similarly, Slack and Webber (2008) reported that social workers were significantly *less* likely than all other mental health practitioners to report that supporting the children of parents with mental health difficulties was beyond their role remit, and care coordinators were significantly *more* likely to support clients' children and assess the need for multi-agency involvement.<sup>1</sup> Intriguingly, this same study found that nurses were significantly more likely than social workers to state that these children should 'always' be offered support.

Across their series of linked papers, Korhonen *et al.* (2008, 2010a, 2010b) reported that factors which had a statistically significant impact on FFP (such as training, length of service, available resources, and workplace support) were seen in registered nurses but not practical mental health nurses (equivalent to healthcare assistants in the UK). This raises the question whether professional seniority may also have an influence on FFP, although Houlihan *et al.* (2013) found no evidence that seniority influenced the way in which

mental health nurses assessed family setup or functioning, offered support, or worked collaboratively with other services.

The results indicating that job type influences FFP were not consistently upheld across studies; for example, Maybery *et al.* (2014) reported mixed results regarding the impact of job role upon aspects of family-focused assessment and support practices. Compared to psychiatric nurses and psychologists, social workers were significantly more likely to offer support to carers and children as well as assess the impact of parental mental illness on clients' children. However, there was no evidence of a significant difference between professions in terms of practitioners offering *parenting* support or assessing the parent's awareness of their child's well-being.

Since all studies except one were rated at least adequate quality, we concluded that some professions may be more likely to take a family-focused approach and/or incorporate certain aspects of FFP into their work. Results suggested that social workers may be more likely than nurses, psychologists and psychiatrists to use a family-focused approach in their work, particularly in terms of offering support. There is also some evidence to suggest that psychiatrists may incorporate more family-focused assessment practices into their work than other professions.

*Length of service in mental health work.* Six quantitative studies examined the impact of practitioners' length of service in mental health work on FFP (Goodyear *et al.* 2017; Houlihan *et al.* 2013; Korhonen *et al.* 2008, 2010a, 2010b; Slack & Webber 2008). Overall, results were mixed. According to Korhonen *et al.* (2008, 2010a, 2010b), practitioners who had 20 or more years' professional experience demonstrated the highest level of family-focused assessment and support practices. In contrast, Houlihan *et al.* (2013) found that practitioners who had been qualified for 10 years or less were more likely to engage in FFP. However, Slack and Webber (2008) reported that length of professional experience was not associated with practitioners' FFP. Similarly, Goodyear *et al.* (2017) noted that experience was not a significant predictor of family-focused assessment, and service-length only explained 1.4% of the variance in a regression model predicting practitioners' provision of family and parenting support. Therefore, the evidence suggests that professional mental health experience might have some impact on family-focused practice, but it is not conclusive at this stage.

*Skill and knowledge.* Two additional quantitative papers of adequate quality investigated the influence of self-reported skill and knowledge around parental mental illness (Lauritzen *et al.* 2015; Maybery *et al.* 2016). Maybery *et al.* (2016) found that self-reported knowledge of the impact of parental mental illness on children was associated with family-focused assessment and support practices. They also determined that confidence in family-focused skills and knowledge was associated with assessment practices. Lauritzen *et al.* (2015) reported a statistically significant difference in favour of participants who *did* assess whether clients had children (compared to those practitioners who did not) and their knowledge of the impact of parental mental illness on children and FFP-related legislation.

These findings were supported in two qualitative papers (Maddocks *et al.* 2010; O'Brien *et al.* 2011) in which participants reported moments when they considered taking a family-focused approach but held back because they did not think they had adequate knowledge.

I often wonder if it would be appropriate for me to see what she was like with the child... but I wouldn't know what to look for. (p. 679; Maddocks *et al.* 2010)

Overall, the evidence suggests that practitioners' perception of their skill and knowledge around parental mental illness influences their FFP, but to date too few studies exist to confirm this.

## Workplace factors

### *Service-related subfactors*

*Available resources.* Nine papers reported data on how having family-focused resources available impacts upon FFP (Grant & Reupert 2016; Korhonen *et al.* 2008, 2010a, 2010b; Lauritzen *et al.* 2015; Maddocks *et al.* 2010; Maybery *et al.* 2016; O'Brien *et al.* 2011; Tchernegovski *et al.* 2017). Resources included workforce availability, physical space for family work, family-focused group programmes, and specialist tools. Studies broadly described how accessible resources helped practitioners shift from being family-minded to enacting FFP, as is illustrated in following quote from a qualitative study rated to be of high quality:

There is impetus to change, but structures to allow this are not in place in services in terms of culture or concrete resources. (p. 208; Grant & Reupert 2016)

Across the five qualitative papers of mixed quality (Grant & Reupert 2016; Lauritzen & Reedtz 2013;

Maddocks *et al.* 2010; O'Brien *et al.* 2011; Tchernegovski *et al.* 2017), participants emphasized that FFP was better enabled by available resources. Two papers highlighted the need for child-friendly rooms within services (Maddocks *et al.* 2010; O'Brien *et al.* 2011), and a further two reported how participants felt a limited workforce hindered their 'capacity in working with families' (p. 210, Grant & Reupert 2016; Lauritzen & Reedtz 2013). Participants also stressed the need for specialist family-focused documentation tools (Grant & Reupert 2016; Tchernegovski *et al.* 2017), particularly regarding assessment where 'it needs to be more formalized' (p. 211; Grant & Reupert 2016).

Indeed, adequate quality quantitative evidence from Lauritzen *et al.* (2015) showed a statistically significant increase in practitioners identifying clients' children *after* a Family Assessment Form was introduced as part of a national family-focused policy implementation in Norway. However, the introduction of this form did not impact on practitioners' FFP beyond identifying whether clients had children. Similarly, Korhonen *et al.* (2008, 2010a, 2010b) reported mixed results regarding any positive impact of family-focused group programmes and resources upon practitioners' FFP. Further adequate quality data from Maybery *et al.* (2016) showed that having clear family-focused policy and procedures in place did not predict participants' assessment or support practices.

Overall, there is reasonable agreement that practitioners identifying whether their clients have children would be enhanced by services implementing tools such as family-focused assessment forms. However, the evidence also indicates that whilst available resources may influence FFP, resources are not enough 'in and of themselves' to ensure a family-focused approach is adopted within services.

*Work setting.* Six papers reported on the influence of work setting (i.e. hospital versus community settings) on FFP (Grant & Reupert 2016; Houlihan *et al.* 2013; Korhonen *et al.* 2008, 2010a, 2010b; Ward *et al.* 2017). Three of the four quantitative papers came from Korhonen *et al.* (2008, 2010a, 2010b) who found some support for the influence of community settings influencing aspects of FFP but reported mixed findings overall. Houlihan *et al.* (2013) also found no evidence of workplace setting influencing practitioners' tendencies to assess family setup, family functioning, and support options.

The two qualitative papers reporting data on work setting presented a slightly different picture (Grant &

Reupert 2016; Ward *et al.* 2017). Both described community practitioners anticipating family involvement (when ‘families wander into the room together anyway’ p. 5; Ward *et al.* 2017) and being more likely to work collaboratively with colleagues from other professions. Being able to see family functioning in the home environment as part of community work was also reported to enhance practitioners’ family-focused assessments.

Being able to go into the home is pivotal in being family-focused – you’re not only working with the service user, but you’re also able to gauge the feelings and interpretations of the family members. (p. 209; Grant & Reupert 2016)

These findings suggest that work setting may have some influence on FFP, with community settings often adopting more of a family approach, especially in terms of assessment. However, this evidence is largely drawn from individual practitioners’ reflections reported in one adequate and one high quality qualitative paper, limiting the extent to which results can be generalized.

*Location issues.* Lauritzen and Reedt (2013) reported one participant describing how working within remote rural locations was a barrier to collaborative practices with family members. This paper only partially met appraisal criteria, and this finding was not supported by two adequate quality quantitative papers which found no significant difference between rural or urban locations and practitioners’ assessment practices or support offered to family members (Goodyear *et al.* 2017; Maybery *et al.* 2016). Collectively, there was minimal evidence to suggest that location issues impacted on FFP.

## SUPPORT-RELATED SUBFACTORS

### Workplace support

Tchernegovski *et al.* (2018a) reported that practitioners conceptualized ‘workplace support’ in relation to FFP as supervision, multi-disciplinary team discussions, informal and formal debrief sessions and specialist consultation meetings. Workplace support was explored in five qualitative studies and only one quantitative study, in which Maybery *et al.* (2016) found some evidence that co-worker support predicted clinicians offering support to parents and families, but not their assessment practices.

However, a richer picture was presented in the qualitative literature in which workplace support was seen

to enhance FFP. Participants described how workplace support facilitated family-focused approaches by offering guidance about the direction of work and providing emotional support (Grant & Reupert 2016; Lauritzen & Reedt 2013; Tchernegovski *et al.* 2018a, 2018b).

Equally, a *lack* of workplace support was also considered a barrier to FFP. Three high quality papers (Grant & Reupert 2016; Slack & Webber 2008; Tchernegovski *et al.* 2017) and one lower quality paper (Lauritzen & Reedt 2013) reported how lack of peer or managerial support obstructed FFP. Practitioners expressed how ‘there needs to be a bigger approach to people as family units and all that that entails’ (p. 211; Grant & Reupert 2016) but described how actions that concerned wider family functioning were often disregarded.

Sometimes it will be discussed in the team meeting and a conclusion drawn that... we don’t have a suitable service for that child or family so it is taken no further. (p. 76; Slack & Webber 2008)

Overall, workplace support had a positive influence on FFP, particularly when practitioners had support from their colleagues as well as management. At this stage, workplace support appeared to have more of an influence on the support that practitioners offered families than their assessment practices.

### Time and workload

Time and workload issues were not investigated extensively throughout the literature. Only two qualitative papers reported participants’ restricted time and heavy workload impacting their FFP because ‘[you] actually don’t get a lot of time’ (p. 5; Ward *et al.* 2017) to ‘do the extra work’ (p. 15; Lauritzen & Reedt 2013). However, the relationships between time and workload issues and FFP were tested in a quantitative study (Maybery *et al.* 2016) which showed no evidence that these issues affected either family-focused assessment or support practices.

Thus, time and workload issues did not influence the FFP of adult mental health practitioners; however, this has not been investigated extensively. It also is possible that time and workload barriers to FFP did not materialize due to wider sampling biases in which more family-minded practitioners took part in research into FFP.

## DISCUSSION

This review sought to identify the key modifiable factors influential in the family-focused practice of adult

mental health practitioners and highlight where these factors have their impact. Nineteen studies were included and analysed to determine which practitioner and workplace factors seemed to influence family-focused assessment and support practices. Although more work is clearly needed to firmly establish the links between practitioner and workplace factors and FFP, and to confirm which of these factors have the greatest impact on FFP, we were able to draw some tentative conclusions about the factors which might be most relevant to the adoption of FFP within adult mental health services.

The review found that personal attitudes, beliefs about job role, and perceptions of workplace support appeared to have a notable impact on practitioners' FFP. It is not surprising that the likelihood of practitioners engaging in FFP was closely linked to beliefs about the benefits of such work as well as beliefs about practitioners' ability to overcome the inherent challenges involved. This finding is supported by Foster *et al.*'s (2016) review in which the authors emphasized the dependence of FFP on 'clinician's willingness, capacity, and capability to see the relationship between the primary/referred person and their "key others"' (p. 150; 2016). Similarly, some professions were more likely to take a family-focused approach and/or incorporate certain aspects of FFP into their work. Social workers were more likely than nurses, psychologists, and psychiatrists to use a family-focused approach in their work, particularly in terms of offering support, whilst psychiatrists incorporated comparatively more family-focused assessment practices into their work. Perceived workplace support from colleagues as well as management had a positive influence on FFP, particularly on support offered to families by clinicians.

Mixed results were noted regarding the influence of family-focused training and education, length of service in mental health work, self-reported skill and knowledge and available resources. As was emphasized in qualitative interviews, family-focused training and education positively impacted FFP. Similarly, practitioners' perceptions of themselves as skilled and knowledgeable about issues relating to parental mental illness seemed linked to the increased use of family-focused approaches. Evidence showed some impact of practitioners' length of service on FFP, but overall results were not consistent. It is possible that perceived skill and knowledge, effects of training, and length of service are interrelated and may act as confounding variables. Furthermore, the mixed results might also reflect the changing priorities within services in

different countries, perhaps with newer staff being more likely to take FFP on board. Having available resources better facilitated FFP, albeit there was a recognition that such resources might not be sufficient in ensuring that family-focused approaches were adopted within services. Overall, the relatively few studies that contribute to the findings outlined here were of mixed quality, as is common in under-researched areas. Nevertheless, preliminary evidence suggests family-focused training, length of service, self-reported skill and knowledge and available resources are worthy of further investigation in order to determine their respective influence on FFP.

In contrast, there was minimal indication that practitioners' FFP was influenced by work setting (hospital versus community settings), location issues (rural vs urban locations) or time and workload issues. However, none of these factors have been investigated extensively. It is also possible that time and workload barriers to FFP are more subject to sampling biases than other factors, in which more family-minded practitioners tend to take part in research into FFP and are less likely to report time and workload issues as hindrances. Future research incorporating more diverse samples might tell a different story.

This review supports findings from Maybery and Reupert (2009) in that FFP is hindered by inadequate provision of resources, restrictive ideas about job role, negative beliefs about FFP and perceived lack of individual skill and knowledge of workplace support. However, findings from the current review offer a different perspective about possible solutions to that illustrated in Maybery and Reupert's hierarchy diagram (p. 789) which proposes that 'higher level activities [i.e. practitioner factors] will only be successful if they build on lower factors embedded in the organisation' (p. 788). The current review highlights that many of the factors influencing FFP were fundamentally about practitioners' perceptions, with personal attitudes, perceived workplace support, self-reported skill and knowledge all impacting FFP. There was some evidence that more service-based factors were insufficient 'in and of themselves' (e.g. available resources) or were not seen to have an influence on FFP (e.g. work setting and location issues), but there was insufficient data to draw a firm conclusion. More work in this area is required.

Focusing efforts on practitioner factors that work at the level of the individual may be pivotal in encouraging more family-focused approaches. Contrary to Maybery and Reupert's (2009) proposal, boosting FFP in adult mental health services might be better

conceptualized as a reciprocal process between individual practitioner factors and wider workplace systems, rather than as a linear, hierarchical process.

In contrast to the six-component definition of FFP presented by Foster *et al.* (2016), the current review highlighted that research on the FFP of adult mental health practitioners had focused primarily on assessment and support practices, with some examination of collaborative working. The remaining three practices (i.e. psychoeducation, family planning and goal-setting, and family-service liaison) were either not investigated within the 19 papers identified or were referred to but were better subsumed under the overarching components of assessment and support. The fact that Foster *et al.* (2016) included papers recruiting from child as well as adult mental health settings might explain this discrepancy. Nevertheless, this finding is important because it indicates a clear two-stage process for practitioners aiming to incorporate more FFP into their work: to start implementing family approaches, practitioners firstly should assess whether the adults accessing their service are parents, and then secondly, they need to consider ways in which the wider family might be supported.

In terms of how best to focus efforts to encourage FFP within adult mental health services, the following targeted, evidence-based recommendations are proposed. To begin with, there needs to be an attitude shift on three levels: firstly, in terms of a formulation-based understanding of the reciprocal impact of parenting and mental health stressors; secondly, the resulting importance of taking a family approach in adult health work which includes consideration of any children; and thirdly, a reassertion of practitioners' capability not only to do this kind of work, but to offer unique skill and expertise from an adult mental health perspective. Such shifts in attitudes could be achieved by the inclusion of clear FFP targets within policy and associated training offered across the different professional backgrounds that typically comprise a multi-disciplinary team to emphasize that FFP is not just the remit of particular professions, as well as ensure that workplace support and responsibility around FFP is shared across the team. When personal attitudes, beliefs about job and perceptions of workplace support are more closely aligned with the principles of family-focused approaches, the introduction of basic resources, such as family assessment forms, may help

**TABLE 1:** Table of search terms:

Database (and platform)	PsycINFO (OVID); CINAHL plus (EBSCOhost); ASSIA and BNI (ProQuest); and Web of Science (Clarivate)		
Key search categories	'Family-focused practice' (n = 25)	'Adult mental health practitioner' (n = 13)	'Influential factors' (n = 24)
Search terms	Child focused family nursing OR child-focused family nursing OR family-centred OR family cent?red OR family-centred care OR family driven OR family focus OR family-focus OR family-focused OR family-focused care OR family-focused practice OR family focused practice OR family friendly OR family guided OR family inclusive OR family orientated OR family oriented OR family sensitive OR family sensitive practice OR family support OR parent-based interventions OR support for parents OR support needs OR supporting children OR supported parenting	Adult psychiatric practice OR adult psychiatry OR community mental health OR mental health institutions OR mental health nurses OR mental health organizations OR mental health professionals OR mental-health professionals OR mental health services OR mental health workforce OR psychiatric nurses OR psychiatric services	Attitude* OR barrier* OR characteristics OR confidence OR education OR enabler* OR experience OR practitioner characteristics OR factors OR institutional support OR knowledge OR lived experience OR personal characteristics OR personal experience* OR professional attitude* OR professional experience* OR policy OR practice* OR skill OR skills OR training OR views OR workplace OR workplace support

**TABLE 2:** *Inclusion and exclusion criteria:*

Review question	What influences the family-focused practice (FFP) of staff working with parents in adult mental health services?	
	Inclusion	Exclusion
Who / Population	Mental healthcare practitioners/clinicians working in adult mental health services For example, to include: Mental health nurses, psychologists, social workers, doctors, occupational therapists, etc. Include papers reporting on findings from mixed sample if subgroup findings are reported separately (i.e. can isolate data relating to adult mental healthcare practitioners)	Mental healthcare practitioners/clinicians working in child mental health services Mental healthcare practitioners/clinicians working in services specifically targeting drug/alcohol misuse only Physical healthcare practitioners/clinicians Mental healthcare professionals who are not practising clinicians, for example in managerial role only
What / Intervention	Influential factors – practitioner and workplace For example, to include: Practitioner – attitudes/views; confidence; education/knowledge/training; experience (lived/personal; professional); practice/skills; etc. Workplace – workplace support; time and workload issues, etc. Will include papers exploring or reporting on factors that influence FFP following national FFP policy implementation	Influential factors influencing the implementation of a specific intervention/clinical trial relating to family-focused work
How	Included papers will explore or report on factors that influence family-focused practice (FFP defined below; associated terms listed in ‘Search strategy’ above)	Research exploring or reporting on: ‘Family therapy’ (i.e. type of therapy) ‘Family-focused therapy’ (i.e. therapy for young adults with bipolar disorder and/or psychosis) ‘Family Intervention’ (i.e. where ‘parents’ are parents of adult child experiencing mental health difficulties) Papers presenting comparative findings if one of the comparison groups is not an adult mental health setting (e.g. physical health practitioners vs mental health practitioners), <i>unless the data is reported separately for each group</i>
Where / Setting	Adult mental health services, to include community and inpatient settings	Child or youth mental health services Physical healthcare settings Mental health services specifically targeting drug/alcohol misuse only
Study design	All research study designs, that is both quantitative and qualitative Included papers must report on either quantitative or qualitative data which have been analysed by an established quantitative/qualitative methodology	Opinion pieces; reviews; audits.
Dates	No dates specified	Not applicable
Language	Articles written in English language	Non-English language articles
Peer reviewed	Articles from peer-reviewed journals	Articles from journals not peer reviewed

to boost practitioners’ FFP. The current state of the literature on FFP indicates that these resources would need to prompt practitioners to identify whether their clients are parents of dependent children and remind them to enquire as to the type of support the parent might need, in addition to that of their family members. However, underpinning these shifts at the service and practitioner levels is the need for national policies to stipulate the inclusion of FFP which go beyond the recording of service users who are parents, for organizations to mandate and promote FFP, and to support their staff to achieve it. As Tchernegovski *et al.* (2017)

report, the embedding of FFP practices is reliant on wider organizational factors such as reporting systems, meeting structures, and supervision.

This review is limited by the fact that all included studies used questionnaires or interview methods, and as such are subject to the inherent bias of self-report data. By including only English language studies published in peer-reviewed journals, we also need to acknowledge possible language and publication biases. Nevertheless, a strength of this review lay in including both quantitative and qualitative studies which meant we were able to gather a deeper understanding of the

research topic whilst synthesizing the extent of the influencing factors. As such, we have been able to present evidence-based recommendations drawn from new research which can be used to target efforts by focusing on identified factors known to influence

implementation of family-focused approaches in adult mental health settings.

This review highlights the need for further, high quality research, particularly in relation to what training in FFP would need to involve for it to be effective,

**TABLE 3:** Table of study characteristics:

No.	Author, year, location, and title	FFP policy	Sample characteristics	Recruitment setting	Measures and analysis	Quality rating
Quantitative studies						
1.	Goodyear <i>et al.</i> (2017). Australia 'Thinking families: A study of the characteristics of the workforce that delivers family-focused practice' Aim: Determine what key practitioner characteristics can predict FFP in MH services	Yes	No: 307 Gender: 189 female, 111 male Age: 41.3 years (mean), 21–64 years (range) Profession: Psych. nurses (155); Social workers (52); Psychologists (43); Occ. Therapists (17); Psychiatrists (15); Carers/Consumer consultants (4); Medical officers (3) Other profs (13); (Missing data NS) MH sector experience: 12.8 years (mean); 0–42 years (range) Experience working with children: 8.94 years (mean); 0–31 years (range)	10 adult mental health services across Victoria, Australia Rural (142) Metropolitan (165)	Questionnaire survey: family-focused mental health practice questionnaire (FFMHPQ) (Maybery <i>et al.</i> 2012) Regression analysis	Adequate
2.	Tungpunkom, Maybery, Reupert, Kowalenko and Foster (2017). Thailand 'Mental health professionals' family-focused practice with families with dependent children: a survey study' Aim: Investigate the attitudes, knowledge and practices of Thai MH workforce	No	No: 349 Gender: 296 female; 53(?) male Age: 42.0 years (mean); 23–60 years (range) Profession: Psych. nurses (295); (Other details NS) MH sector experience: 18.7 years (mean); 0–49 years (range) Experience working with children: 3.2 years (mean); 0–37 years (range)	Inpatient settings (207) (Other details NS)	Questionnaire survey: family-focused mental health practice questionnaire (FFMHPQ) (Darryl Maybery <i>et al.</i> 2012) – translated for Thai MHPs Means, SDs and ANOVAs with post hoc tests	High
3.	Maybery <i>et al.</i> (2016). Australia 'Worker, workplace or families: What influences family-focused practices in adult mental health?' Aim: Examine individual and workplace factors that predict FFP in adult MH agencies	Yes	As above (same sample as Goodyear <i>et al.</i> 2017)	As above (same sample as Goodyear <i>et al.</i> 2017)	Questionnaire survey: (FFMHPQ) (Maybery <i>et al.</i> 2012) Regression analysis	Adequate

(Continued)

TABLE 3: (Continued)

No.	Author, year, location, and title	FFP policy	Sample characteristics	Recruitment setting	Measures and analysis	Quality rating
4.	Lauritzen, Reedtz, Doesum and Martinussen (2015). Norway 'Factors that may Facilitate or Hinder a Family Focus in the Treatment of Parents with a Mental Illness' Aim: Examine factors that facilitate and/or hinder FFP in MH workforce	Yes	No: 219 Gender: 166 female; 52 male; (Missing data NS) Age: Majority: 30–50 years Profession: Detail NS; sampling frame of general nurses, psych. nurses, psychologists, psychiatrists + special teachers MH sector experience: NS Experience working with children: NS	Psychiatric clinic of large university hospital in northern Norway; also runs decentralized clinics throughout region 16 outpatient and inpatient clinics	Survey questionnaire (not specified) Means, SDs, independent t-tests + Cohen's d	Adequate
5.	Maybery, Goodyear, O'Hanlon, Cuff and Reupert (2014). Australia 'Profession Differences in Family-focused Practice in the Adult Mental Health System' Aim: Examines how professional groups compare re family work in MH services	Yes	As above (same sample as Goodyear <i>et al.</i> 2017)	As above (same sample as Goodyear <i>et al.</i> 2017)	Questionnaire survey: (FFMHPQ) (Maybery <i>et al.</i> 2012) Means, SDs, ANOVAs + post hoc analyses	Adequate
6.	Houlihan, Sharek and Higgins (2013). Ireland 'Supporting children whose parent has a mental health problem: an assessment of the education, knowledge, confidence and practices of registered psychiatric nurses in Ireland' Aim: Examine nurses' knowledge, confidence + practice re child's support needs	Yes	No: 114 registered psych. nurses Gender: 90 female; 24 male Age: Mean: NS; 20–55+ (range) Profession: Staff nurse (68); CNM I or II (19); CMHS (18); CNS (9) MH sector experience: Mean: NS; 0–21+ years (range)	Hospital (63) Community (47) (Missing data NS)	Survey questionnaire with some qualitative response questions Mixed – Quantitative: frequencies, percentages, t-tests, ANOVAs + Kruskal–Wallis tests Qualitative: Open questions on questionnaire – thematic analysis	High
7.	Korhonen, Pietilä and Vehviläinen-Julkunen (2010a). Finland 'Are the children of the clients visible or invisible for nurses in adult psychiatry? A questionnaire survey' Aim: Examine interaction nurses have with clients' children + predictors	Yes	No: 331 Gender: 216 female; 91 male Age: 20–60 years (range) Profession: MH nurse (88); Registered nurse (222) (Missing data NS) MH sector experience: <5, >20 years (range) Experience working with children: NS	Inpatient unit (243) Outpatient unit (68) (Missing data NS)	Survey questionnaire <i>Later published as preventive child-focused family work (PCF-FW) questionnaire</i> Frequencies, percentages, means, SDs, Kruskal–Wallis tests and Mann–Whitney U-tests	Adequate

(Continued)



TABLE 3: (Continued)

No.	Author, year, location, and title	FFP policy	Sample characteristics	Recruitment setting	Measures and analysis	Quality rating
8.	Korhonen <i>et al.</i> (2010b). Finland 'Do Nurses Support the Patient in His or Her Role as a Parents in Adult Psychiatry? A survey of Mental Health Nurses in Finland' Aim: Determine nurses' support (+ related characteristics) of clients' parental responsibilities	Yes	As above (same sample as Korhonen <i>et al.</i> 2010a)	As above (same sample as Korhonen <i>et al.</i> 2010a)	Survey questionnaire <i>Later published as preventive child-focused family work (PCF-FW) questionnaire</i> Frequencies, percentages, means, SDs, Kruskal–Wallis tests and Mann–Whitney <i>U</i> -tests	Adequate
9.	Korhonen <i>et al.</i> (2008). Finland† 'Do nurses working in adult psychiatry take into consideration the support network of families affected by parental mental disorder?' Aim: Examine nurses' activities re support network of families with parents with mental illness	Yes	As above (same sample as Korhonen <i>et al.</i> 2010a)	As above (same sample as Korhonen <i>et al.</i> 2010a)	Survey questionnaire <i>Later published as preventive child-focused family work (PCF-FW) questionnaire</i> Frequencies, percentages, means, SDs, Kruskal–Wallis tests and Mann–Whitney <i>U</i> -tests	Adequate
10.	Slack and Webber (2008). UK† 'Do we care? Adult mental health professionals' attitudes towards supporting service users' children' Aim: Explore attitudes of MHPs re support needs of MH service users' children Included in Maybery and Reupert (2009) review†	No	<i>No:</i> 91 <i>Gender:</i> NS <i>Age:</i> NS <i>Profession:</i> Nurse (40); Psychologist (4); Occ. Therapist (10); Health-care assis. (5); Social worker (12); Psychiatrist (9); MH worker (11) <i>MH sector experience:</i> NS <i>Experience working with children:</i> NS	Community mental health team (43) Assertive outreach team (9) Day services (13) Home treatment team (4) Inpatient settings (22)	Cross-sectional survey questionnaire with some qualitative response questions Mixed – Quantitative: frequencies, percentages, chi-squared tests, Fisher's exact test + one-way ANOVA Qualitative: pattern coding for analysis of additional comments)	High
Qualitative studies						
1.	Tchernegovski <i>et al.</i> (2018a). Australia 'Adult mental health clinicians' perspectives of parents with a mental illness and their children: single and dual focus approaches' Aim: Examine MH clinicians' perspectives to parents working with + their children	Yes	<i>No:</i> 11 <i>Gender:</i> 8 females, 3 males <i>Age:</i> 39.3 (mean) <i>Profession:</i> Psychologist (4); Social worker (3); MH nurse (2); Psychiatrist (1), OT (1) <i>MH sector experience:</i> 8.4 years (mean); 0–9 years (range) <i>Experience working with children:</i> 3.9 years (mean), 0–9 years (range)	<i>Setting:</i> Community (4) Outpatient (4) Inpatient (3) <i>Geography:</i> Regional (4) Rural (3) Suburban (4)	Semi-structured interviews Interpretive Phenomenological Analysis (IPA)	Adequate

(Continued)

TABLE 3: (Continued)

No.	Author, year, location, and title	FFP policy	Sample characteristics	Recruitment setting	Measures and analysis	Quality rating
2.	Tchernegovski, Reupert and Maybery (2018b). Australia 'How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study' Aim: Examine MH clinicians' experiences + strategies when working with parents	Yes	As above (same sample as Tchernegovski <i>et al.</i> 2018a)	As above (same sample as Tchernegovski <i>et al.</i> 2018a)	Semi-structured interviews IPA	High
3.	Tchernegovski, Maybery and Reupert (2017). Australia 'Legislative policy to support children of parents with a mental illness: revolution or evolution?' Aim: Examine MH clinicians' experiences of FF legislation affecting practice	Yes	<i>No:</i> 11 <i>Gender:</i> 8 female; 3 male <i>Age:</i> 39.2 (mean) <i>Profession:</i> Psychologist (3); Social worker (5) MH nurse (3); <i>MH sector experience:</i> 10.2 years (mean) <i>Experience working with children:</i> 6.4 years (mean); (Range: NS)	<i>Setting:</i> Community (4) Outpatient (1) Rehabilitation (1) Across units (3) Crisis (1) Intake (1) <i>Geography:</i> Regional (4) Rural (1) Suburban (6)	Semi-structured interviews IPA	High
4.	Ward <i>et al.</i> (2017). Australia 'Family-focused practice within a recovery framework: practitioners' qualitative perspectives.' Aim: Explore practitioners' understandings of FFP within recovery framework	Yes	<i>No:</i> 11 <i>Gender:</i> 8 female 3 male <i>Age:</i> 47 (median) <i>Profession:</i> MH nursing (5) Social work (2) Social/community welfare (2) Psychology (1) Occ. Therapy (1) <i>Years working in MH with families:</i> 6 years (median) 0.5–30 years (range)	Public acute care services (4) Public community services (5) Private practitioners (2)	Semi-structured interviews Thematic analysis	Adequate
5.	Grant and Reupert (2016). Ireland 'The impact of Organizational Factors and Government Policy on Psychiatric Nurses' Family-Focused Practices with Parents Who Have Mental Illness, Their Dependent Children, and Families in Ireland' Aim: Explore way Irish policy influenced nurses' FFP and how FFP might be promoted	Yes	<i>No:</i> 14 psychiatric nurses <i>Gender:</i> 9 female 5 male <i>Age:</i> 39 (mean of original sample) <i>Profession:</i> 10/14: community mental health nurses' <i>MH sector experience:</i> 14.4 years (mean of original sample)	Acute admission units (4) Community (10)	Semi-structured interviews Thematic analysis	High

(Continued)

TABLE 3: (Continued)

No.	Author, year, location, and title	FFP policy	Sample characteristics	Recruitment setting	Measures and analysis	Quality rating
6.	Lauritzen and Reedtz. (2013). Norway 'Support for Children of Service Users in Norway' Aim: Investigate whether lack of identification by healthcare workers of children of adult mental health service users was related to negative staff attitudes and organizational barriers to FFP	Yes	No: 219 Gender: NS Age: NS Profession: staff and leaders of wards carrying out intervention MH sector experience: NS Experience working with children: NS	Regional Norwegian hospital	Open-ended responses to items within a survey questionnaire (not specified) Framework analysis	Low
7.	O'Brien, Brady, Anand and Gillies (2011). Australia 'Children of parents with a mental illness visiting psychiatric facilities: perceptions of staff' Aim: Understand experiences of staff when children visit inpatient MH facilities	Yes	No: 9 Gender: NS Age: NS Profession: Nurses (3); Psychiatrists/Registrars (2) Social workers (2); Occ. Therapists (2) Experience on unit: All participants worked for 1+ years	Acute inpatient mental health facility	Semi-structured interviews 'Qualitative exploratory research framework'	Low
8.	Maddocks, Johnson, Wright and Stickley (2010). UK 'A phenomenological exploration of the lived experience of mental health nurses who care for clients with enduring mental health problems who are parents'	No	No: 6 Gender: NS Age: NS Profession: Mental health nurses (6) MH sector experience: 1+ years (no other detail) Experience working with children: within last 3 years (no other detail)	Two long-term residential wards	Semi-structured interview IPA	High
9.	Sjöblom <i>et al.</i> (2005). Sweden 'Nurses' view of the family in psychiatric care' Aim: Examine nurses' view of the family in psychiatric care	No	No: 20 Gender: 10 female; 10 male Age: NS Profession: Registered nurse (7); Further trained, enrolled nurse (10); Enrolled nurse (3) MH sector experience: 7–27 years (range) Experience working with children: NS	'Psychiatric ward with facilities caring for eight short-term adult patients admitted for involuntary treatment under the Psychiatric Involuntary Care Act'	Focus group discussion guide Focus group (not otherwise stated)	Adequate

Missing data within the table were not reported by original paper; this is indicated by 'NS' ('not stated').

†Inclusion in Maybery and Reupert's (2009) review.

and how this could best impact practice. Researchers should focus on identifying the most effective way of using training to boost practitioners' skill and knowledge in order to increase the likelihood of family-focused approaches being incorporated. Research should also investigate whether there is an underlying

component underpinning perceived skill and knowledge, impact of training, and length of service in order to more directly and efficiently instigate FFP. Future research should also focus on developing available resources for adult mental health services, which would help in facilitating practitioners' assessment practices

and the support they can offer when meeting with clients accessing their services. Longitudinal studies are also required to examine the impact of influential factors on FFP over time to help ensure that efforts to incorporate more family-focused approaches in services can be sustained.

## CONCLUSION

The factors most consistently found to influence the family-focussed practice of adult mental health practitioners were personal attitudes, beliefs about job role, and perceptions of workplace support. Other factors are also likely to impact FFP, but further research is needed to ascertain what these are and how they influence FFP. In order to increase understanding of the interplay of parenting stressors and the reciprocal impact upon mental health, efforts need to be made to enhance practitioners' knowledge and confidence around FFP. Enhanced competency can be achieved via specific, family-focused education and training, but also at an individual team level through discussions about job role and remit. Such service-development discussions could involve ascertaining whether certain professions lend themselves to leading on certain aspects of FFP, with the explicit understanding that being able to incorporate family-focused approaches is fundamental to working with adults with mental health difficulties. Similarly, increasing opportunities for workplace support is integral in facilitating FFP – this needs to be at both a managerial and colleague/peer level, and can include more formal sessions, such as supervision and multi-disciplinary team discussions, as well as more informal exchanges, such as debrief sessions and frequent consultation.

## Relevance to clinical practice

The current review offers updated, targeted, evidence-based recommendations about how efforts to encourage FFP in adult mental health services might best be applied. These findings can be used to inform policy development and service delivery, as well as the direction of future research, and in doing so contribute towards helping overcome the challenges faced by families affected by parental mental illness.

## FUNDING

None.

\*

\* Indicates a wildcard search.

## Note

<sup>1</sup> This paper did not specify the differences in role between care coordinators and social workers – in the UK, many social workers are also care coordinators.

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## SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's website:

**Appendix S1.** Quality appraisal ratings of included studies\*.

**Appendix S2.** Table of all factors reported in relation to their influence on FFP\*.