Think family, think relationship

Think Family, Think Relationship: factors influencing stronger professional relationships with parents diagnosed with a mental illness. A qualitative study

ABSTRACT:

This qualitative study explored how professionals and parents with mental illness experience their relationships with each other, what aspects of interaction promote a constructive relationship and the role of wider organisational and systemic factors. A purposive sample of 30 adult mental health and children's services professionals, and 21 parents completed semi-structured interviews. Professionals' transparent, non-judgemental, empathetic and positive approach and ability to form partnerships and to share power with parents were key in building trusting relationships with them. Professionals' capacity to use limited self-disclosure of their own personal experiences (i.e. parenting) enabled them to develop constructive relationships with parents. Equally, important was parents' willingness to form partnerships with professionals and to accept a whole family approach to service delivery. Professionals' limited understanding of mental illness and focus on administration hindered their relationships with parents. An understanding of what constitutes a constructive relationship between professionals and parents and how it develops, may help professionals to reflect upon how they engage parents and to do it well. It may also assist organisations to develop the necessary structures and resources to create the conditions for promoting constructive engagement between professionals and parents.

Keywords: adult mental health services, children's services, mental illness, parents, professional relationships, procedural justice.

Introduction

Internationally it is estimated that 15–23% of children live with a parent with a mental illness (Leijdesdorff, van Doesum, Popma, Klaassen & Amelsvoort, 2017). Across the United Kingdom (UK), it is estimated that 10% of mothers and 6% of fathers have mental health problems at any given time (Mental Health Foundation, [MHF] 2016). Abel et al. (2019) found prevalence of maternal mental illness higher in Northern Ireland (NI) than the rest of the UK; with one in four children aged 0–16 years experiencing maternal mental illness and 53% of children aged 16 having a mother with a common (i.e. depression and anxiety) or severe mental illness (i.e. psychosis). Parental mental illness (PMI) may complicate parents' capacity to meet their children's needs; with resultant impact for the child's cognitive, emotional, social, physical and behavioural development (Bunting et al., 2020; Leijdesdorff et al., 2017). Alternatively, stress from assuming a parenting role may negatively impact parents' wellbeing (Falkov et al., 2020; Hine et al., 2017). If parents perceive that they are unable to cope with their parenting role it may have a profound impact on their mood, self-esteem and self-efficacy, and engender guilt and shame (Montgomery et al., 2011). In addition, parents' awareness of professionals' responsibilities in relation to child protection and perception that their behaviour will be constantly monitored in relation to this creates additional stress (Blegen et al., 2010; Montgomery et al., 2011). Fear of losing custody of their children contributes to parents' distress and further deters them from acknowledging and disclosing their problems and requesting services (Blegen et al., 2010; Nicholson, 2010), which may exacerbate their illness and problems in parenting (Grant et al., 2018a). The need to have their children looked after by others can also make parents vulnerable to experiencing greater depression and anxiety as it may exacerbate their guilt, low self-esteem and negative thinking (Nicholson, 2010). Further adding to parents' difficulties is the range of health and social care (HSC) services that they

may need to navigate to meet their needs and those of their children, as well as a lack of access to early supportive intervention (Afzelius, Plantin and Östman, 2018).

To effectively support parents and their children, HSC professionals are encouraged to engage in family focused practice (FFP) (Grant et al., 2018b). Family focused practice is an approach that focuses upon the family as the unit of attention, as opposed to only working with and addressing the needs of an individual service user alone, whether this is the parent with mental illness, or their child(ren) (Afzelius et al., 2018). The relationship or therapeutic alliance that professionals have with parents is thought to be integral to FFP (Falkov et al., 2020; Grant et al., 2020; Leonard, Linden and Grant, 2020; Pihkala et al., 2012). The therapeutic alliance is characterized by a helpful and trusting relationship (Pihkala et al., 2012) and this can provide both the foundation and process for positive change (Howe, 2010). However, despite an increasing interest in understanding how practitioners can support families when parents have mental illness, there is limited information about how constructive relationships can be developed between professionals and parents, given the complexity of parents and families' needs and service provision itself.

An important aspect of FFP with parents who have mental illness, is the issue of power and the possibility of compulsory mental health and/or child protection intervention which has the potential to influence the development and maintenance of positive relationships (Grant et al., 2018a). Power is a complex concept and as Tew (2006) acknowledges, identifying and understanding this complexity can enable the potentially oppressive aspects of power to be addressed and also the positive, productive potential of anti-oppressive practice to be promoted. In the context of limited resources, there are often tensions between statutory duties to protect and therapeutic priorities to support, and many parents have experienced mental health and child welfare services as oppressive and coercive (McKenna, Simpson and Laidlaw, 1999; Smithson and Gibson, 2017). Parents may fear the potential consequences of professional

intervention (Aldridge, 2006) and within families, there may also be complex issues of trust, fear and power (Murphy et al., 2015).

The concepts of power and procedural justice may be helpful to inform how professionals can manage some of the tensions in practice and develop positive relationships. Tew (2006) has discussed power within professional relationships and distinguished between 'power over' and 'power together', suggesting professionals can form more positive partnerships with service users if they focus on engaging service users and working with them, 'power together', rather than asserting 'power over'. This involves professionals and service users working co-operatively to develop and implement agreed plans and willingness by both to accept the potential support and challenge within the partnership. Procedural justice refers to the service user's appraisal of whether the decision-making process concerning treatment was fair and just, whether he or she was included in the process, and whether the decision makers were benevolently motivated (Gallon et al., 2010). The concept of procedural justice also identifies some of the key aspects of promoting the relationship and minimising the perception of coercion and oppression (McKenna, Simpson, Coverdale and Laidlaw, 2001).

To forge a genuine partnership with parents, professionals need to have the motivation and ability to work collaboratively and empathically with the parent (Grant 2014; Ruch, 2018; Tew, 2006) and adopt a family recovery and relationship based approach. The essence of the family recovery approach stems from the ethos of the recovery approach already established in mental health intervention (Roberts and Wolfson, 2004). Built on values of openness, honesty and partnership working "central to applying the recovery approach to the mental health/child protection interface is the promotion of user involvement, partnership working and a commitment to strengths and resilience-based thinking" (Duffy, Davidson and Kavanagh, 2016:45).

This approach to family recovery and to relationship based practice (Coulter et al., 2019) may be promoted through a range of personal attributes such as being flexible, honest, respectful (i.e. of parents' viewpoint and letting them tell their story), trustworthy, confident, warm, interested, transparent and non-judgmental (Grant et al., 2018a). Professionals must also be cognisant of the imbalance in power, authority and resources between themselves and parents and openly and honestly discuss it with parents as part of their partnership, including if they need to confront issues of potential child abuse or neglect (Walsh, 2018). At the same time, they must also be willing to learn from and value parents' perspectives and contribute frameworks of understanding and problem resolution based on their professional training (Beresford and Croft, 2001). This stance may enable parents to feel better able to trust and enter into active partnerships with professionals and reduce their perceptions of coercion; despite professionals' statutory obligations around child protection (Ruch, 2018; Tew, 2006).

Considering the challenges to FFP and centrality of the relationship between professionals and parents, it is important to develop an in-depth understanding of professionals' and parents' perspectives on what constitutes constructive relationships and how they may be enabled and/or hindered. The main aim of the study from which this paper draws was to examine HSC professionals' FFP; the relationship between professionals and parents emerged from our analysis of the data as key to this.

Methods

Design

This paper reports qualitative findings taken from a larger mixed methods study, conducted in NI, that investigated HSC professionals' FFP with families when parents have mental illness (Grant et al., 2018a). The first part of the larger study (not reported here) involved a survey of

all (*n* = 3585) adult mental health and children's services professionals working across the five HSC Trusts. The sample was comprised of 868 professionals, (24% response), working in either adult mental health (nurses, psychologists, psychiatrists and social workers) (*n* = 493) or children's services (social workers) (*n* = 316). The survey sought to identify professionals' perspectives regarding the extent of their FFP and factors influencing this. The findings were supplemented and expanded upon by individual semi – structured interviews, with professionals who had completed the survey (*n* = 30). Parents with a mental illness, in receipt of support from adult mental and/or children's services and who were caring for dependent children (*n* = 21) also participated in interviews. The findings from these fifty-one interviews are reported here with regard to the issue of relationship.

Participants and recruitment

Both professionals and parents were purposively selected from five adult mental health services (Single point of access, Day Hospital, CRHT, Mental Health Services and Addiction Services) and three children's services (Gateway teams, Family Intervention Team [FIT] and 16+ Teams) across the five HSC Trusts. None of the research team had working relationships with the participants.

Professionals indicated willingness to undertake an interview by completing an interview volunteer form which could be found at the end of the survey, and returning the completed form to the research team during data collection events or by post. Therefore, recruitment for the sample was via self-selection but the intention was to try to ensure representation across all key disciplines working within the five adult mental health and three children's services, across the five HSC Trusts.

Purposeful sampling was also used to select parents, with dependent children, from the five HSC Trusts who were receiving adult mental health or children's services or a combination of both services. The authors were cognisant that some eligible parents may have decided not to participate due to a fear of negative implications of disclosing their experiences of parenting. Equally, some parents who choose to participate may have done so as they may have thought it would look bad if they refused. Thus it was particularly important to ensure parents understood the aims of the study, safeguards in place and voluntary nature of consent. Each Trust appointed a key contact (at managerial level) who worked with the post doc research fellow (PDRF) to circulate information and instructions about the study to team leads and HSC professionals/key workers. Subsequently, key workers invited parents who met inclusion criteria, including capacity to provide informed consent. No participants approached refused to participate or dropped out.

Data collection

A qualitative study was required because of the paucity of available research examining both professionals and parents' perspectives of FFP. Accordingly, two semi-structured interview schedules were prepared drawing upon a systematic review of the literature on family focused interventions which address the needs of families affected by parental mental health problems and/or substance use problems, and the findings from the survey. Professional interviews focused on the nature and scope of professionals' FFP and enablers and barriers of FFP (see topic guide below for further detail).

Topic guide here

Parents' interviews focused on (1) their needs regarding FFP, (2) experiences of receiving FFP and (3) barriers and enablers of FFP. The interview schedules were shared with an expert

advisory group comprising international academics with expertise on FFP, senior managers of services being evaluated, and users of adult mental health services. Following feedback, the interview schedules were piloted with two professionals and two service users, and final changes made to ensure that the questions were unambiguous, and that the language used was suitable for all participants.

Single interviews with individuals in both groups were conducted between January and May 2017. A female PDRF with experience of qualitative interviewing facilitated the majority of interviews with a minority facilitated by the first author, who has expertise in qualitative interviewing. All participants were provided with a study information sheet prior to interview and service users were asked to contact the PDRF if they wished to participate. Interviews with professionals predominantly took place on Trust premises, whilst service user interviews typically took place within participant's family home. Service users were offered the opportunity to meet at a venue suitable to them and to have a supportive person present should they wish, but none did. They also received £30 worth of high street vouchers to acknowledge their time and any expenses or inconvenience caused by their involvement in the research.

All interviews lasted on average 60 minutes with all respondents completing a consent form before the interview to indicate they understood the purpose of the interview and their agreement to take part. With participant permission, all interviews were recorded with a digital audio recorder and subsequently transcribed. All participants were offered a copy of their interview transcript and the opportunity to make any additional comments to elaborate on points they had made. None of the participants availed of this opportunity to amend their responses and/or provide additional information. Field notes were written after each interview to assist interpretation.

Ethical considerations

Ethical approval for the study was obtained from the Office for Research Ethics Committees Northern Ireland and Research Governance permission was obtained from the five HSC Trusts which provide statutory HSC services across NI (REC Reference 16/NI/0079). Participants gave informed consent.

Data analysis

Thematic analysis was used to create core constructs from the qualitative (textual) data through a systematic method of reduction and analysis (Miles and Huberman, 1994). In undertaking the thematic analysis an essentialist, realist perspective was used (Silverman, 2010). Data were analysed first in individual transcripts and then across transcripts. The qualitative data analysis computer software package NVivo 11 was employed to help organise the data and to ensure methodological rigour by establishing credibility, transferability, dependability and confirmability using techniques suggested by Lincoln and Guba (1985). Each transcript was coded independently by two members of the research team, and any differences were reconciled in conjunction with other members of the research team. When there was a high consensus about the commonality of inductive subjects within the research team, the initial close coding was further consolidated into broader themes, created from conceptual sub themes from the data as a representational strategy.

Interviews with both professionals and parents were considered alongside a range of demographics relating to both the professional or parent and service setting (i.e. adult mental health or children services [or both], and in-patient versus community setting). The importance of relationships emerged as central, so principles of procedural justice were used as a lens to

structure these findings; however, additional aspects important to developing and maintaining constructive relationships, (i.e. organisational and wider context) were also identified.

Results

Participants' characteristics

While the majority of the 30 HSC professionals were Social Workers (SW) (n = 21), there were also seven nurses and two psychiatrists. The majority of the HSC professionals (n = 19) were practicing in adult mental health services and predominantly in acute in-patient and addictions services. Those HSC professionals practicing within children's services generally worked within teams which have responsibility for supporting children who are living with their birth families (FIT), some of whom are subject to a child protection plan (n = 7). Most of the professional participants were female (n = 22), and were parents themselves (n = 19). Over half of the HSC professionals had received training in family focused practice (n = 12) and, or child focused training (n = 11). The number of parents on HSC professionals' caseloads varied between 6 – 80 parents, with some teams reportedly managing 100-180 parents between team members.

In addition, a total of 21 parents (2 males, 19 females) who, at time of data collection, were using adult mental health or children's services (or both) and who had a mental illness, including substance use problems, participated in the semi-structured one to one interviews. Parents were aged between 21– 59 years (Mean age = 38) and had on average three children. The children's age range was between seven months and eighteen years, with some families including older adult children. The majority of parents reported as single (n = 13), with a smaller number married (n = 5) or in a relationship with a significant other (n = 3). Parents were availing of a range of adult mental health services, most notably community mental health

(*n* = 12) and addictions services (*n* = 5). Parents had a range of mental health conditions, from less severe (anxiety) to more severe (i.e. bi polar affective disorder), with the majority (*n* = 8) having dual diagnosis (e.g. eating disorder or personality disorder). Service users reported a range of durations of their mental illness, with some involved with services for six months and others more than ten years. Eight users of adult mental health services also noted involvement with children's services.

Key findings

Participants identified a wide range of issues which are important to their experiences of providing and receiving support. These are organised into two core areas related to 1) relationships between parents and professionals and the influence of professionals on the relationship and 2) influence of organisational and service user/family factors on the relationship

Relationships between parents and professionals and influence of professionals on the relationship

The majority of professionals (*n* = 25) and parents (*n* = 16) discussed the importance of constructive relationships. In the first instance, parents highlighted that in order to be forthright with professionals they needed to feel understood, "[she] just seemed to click with me and I was able to talk to her about how I was really feeling" (SU 3, Trust C, CMHT). Reflecting a key principle of procedural justice, they also expressed the need to feel accepted and not judged negatively, "It is about telling a Mum, if you are feeling like that, don't be ashamed" (SU 1, Trust A. CMHT). Parents felt accepted by professionals who were able to normalise mental illness, "I think it's their attitude towards mental health. How they see it…It makes me feel normal. That's a good word. Yeah, they make you feel normal" (SU 4, Trust E, Addictions) and who were able to convey an understanding of the challenges of parenting with a mental illness.

> … it was the way she presented herself and walked into my home and had respect, and didn't come down on me like a ton of bricks. She spoke to me as a person. And she showed empathy and feelings and respect… for me as a mum… (SU 3, Trust B, CMHT & FIT).

A non-judgemental and positive approach by professionals allowed parents to feel that their involvement in services would be beneficial, "I think it is just positive affirmation and positive feedback and positive suggestions into your home... everything else then falls into place" (SU 2, Trust E, CMHT).

Both groups perceived that a combination of professionals' personal experience (i.e. experience of looking after their own or family members' children) and professional experience enabled them to be empathetic and non-judgemental. As one parent noted:

> Well I think it takes a combination of the right training but also I think life experience is a big help. If you are speaking to someone who has children they can relate so much better. So I think experience and maturity as well as the training, it makes a difference because … it means you feel that the person understands better your situation (SU 3, Trust E, CMHT & Children's Services).

Concurring with parents, some professionals (n = 10) described how experience of parenting enabled their capacity to empathise with parents and to normalise their difficulties. One professional, (SW 1, Trust B, Children's Services) suggested, "I myself as a parent, understand what other parents go through in terms of trying to manage their children daily and I have no mental health issues. So for them I know it could be so much more frustrating", while another indicated, "I have experience as a mummy…getting across to [parents] that things are ok and it is ok to feel sad. So normalising for them" (Nurse 2, Trust B, AMH). Conversely, having limited or no experience of parenting was perceived by both groups as hindering development of constructive relationships. For example, a parent indicated,

> I think it is very hard for somebody that doesn't have kids and doesn't understand the stresses to come in and make a judgement call… you should do this, this, this and this,

> because that's going to make your children better and it is going to keep them safe, They [professionals] are following something out of a text book when they don't actually know, because they don't have kids themselves (SU, 6, Trust E, Addictions).

Professional's understanding of the impact of PMI was also crucial to supporting both parents and their children. For instance:

> …for me…it is about…having a really good understanding of the impact of …severe and enduring mental illness, what is that likely to mean in respect of their parenting capacity… the impact on children of living in that environment...how that impacts on their social, emotional, psychological and physical development (SW 7, Trust E, AMH).

Some parents (n = 12), particularly those with experience of children's services, perceived that professionals who had limited knowledge of mental illness and its impact on parenting were less willing and able to support them; leaving parents feeling misunderstood, judged, unheard and unsupported. For instance:

> I don't understand how social workers are put into their jobs, most of the people that they are working with have addictions and mental health problems, but they have no training in it. It doesn't make any sense… but then that's where they would say they are not your social worker, they are the child's social worker. And I have had that said to me so many times. If I try to speak anything about it they will cut you off and say, I am not your social worker. I am the child's social worker. But I'm the child's mum… (SU 5, Trust E, Addictions & CMHT).

When parents perceived that professionals did not understand them, excluded them and/or judged them; they in turn were reluctant to engage: "they need to be assessing the needs of the home. Not in a bad way or not in a critical way… when you get somebody that is criticising, you don't want that person in with you because they are only chipping away at your self-esteem even more" (SU 2, Trust E, CMHT).

Reflecting another key principle of procedural justice, professionals' honesty regarding intentions to support parents' families was also identified as important by both groups. For parents it provided a sense of security and perhaps control:

> I am always a great believer of people speaking the truth. And people namby pambying round facts just takes longer for them to sink in. Somebody had to be honest with me and

> say, you need to wake up for you and your kids. Which is what she [PROFESSIONALS NAME] done and she was right (SU 6, Trust E, Addictions).

To further increase parent's sense of control, both groups also identified the importance of parents being actively involved in services. The following parent describes how a professional engaged them in their recovery plan and provided a certain amount of control within this:

> She gives you the tools to make the decisions for yourself. She doesn't make the decisions for you, which I think is the totally wrong thing to do anyway. She comes up with all these suggestions and puts them into perspective. And there is always somewhere to go with it, you know, depending on your personality and what you want. (SU 2, Trust E, CMHT).

Similarly, another parent indicated,

> [PROFESSIONALS NAME] was the first person to teach me that if you are living with issues of alcohol misuse and mental health you can parent. How do we manage it? She was the first person to really make me feel like this. You don't have to lose your child. You can parent and deal with this at the same time and I am going to show you how (SU 5, Trust E, Addictions & CMHT).

Influence of organisational and parent/family factors on the relationship

Throughout interviews, the majority of parents (n = 19) and professionals (n = 24) also highlighted various organisational and parent/family factors which they perceived as relevant towards developing constructive relationships and to more or less effective practice.

In relation to organisational factors, irrespective of setting in which services were delivered, both groups, and particularly parents, indicated that the majority of professionals spend too much time on administration and do not make time to fully understand the needs of parents and their families; with a few parents (n = 4) reporting that some professionals relied on records to make decisions: "she [professional] hadn't sat down across a table from me. If that woman would just give me ten minutes of her time... see me for ten minutes, as a human being, rather than just what she sees written about me on paper" (SU 5, Trust E, Addictions &

CMHT). Coinciding, and further highlighting a focus on administration, other parents contended, "…don't think they have the time. They definitely don't have the time to sit and actually talk to you and find out what is going on. It is basically, you know, a five-minute conversation and then like two hours of writing what's happened" (SU 6, Trust E, Addictions) and, "they just want to know, right, what paperwork have I to do for this child or where's this child going, blah, blah, blah. They are not actually taking the time to…to form any sort of relationship (SU 5, Trust E, Addictions & CMHT).

In relation to parent/family factors, parents' readiness and willingness to engage with services was also identified by some professionals (n = 5) and the majority of parents (n =17) as key to enabling constructive relationships. For example, in terms of readiness to engage, one parent indicated, "… well I've tried everything. Anything that has been suggested I've went for it and done it" (SU 4, Trust E, Addictions), while a professional indicated "…when parents are happy for you to liaise with children's services and work with you it does work well" (SW 2, Trust A, AMH).

The majority of professionals (n = 24) and parents (n = 17) also identified a number of barriers generated by parents/families that hindered development of a constructive relationship. Most prominent of these was parents' fear of losing their children if children's services become involved with their family. This fear reduced parent's capacity to be forthright about their difficulties in parenting and resulted in some delaying or not asking for help when needed:

> See the thought of losing your kids, and I have always said this out loud to social services, to [PROFESSIONALS NAME] … that fear has to be taken away. Because I spent so long being afraid to be completely honest and ask for the help that I needed, because I felt that I was going to lose my son (SU 5, Trust E, Addictions & CMHT).

This sense of fear was all pervading and operated as a serious obstacle towards more engaged practice as the following professional remarked: "it really is a fear of letting people in the

door. What are they going to see? to say? Is my child going to be removed? (SW 1, Trust D, AMH) while another indicated,

> The big issue, is the reluctance for parents to engage with us whenever we are trying to find out any kind of information about their parenting capacity, their abilities, how their substance misuse impacts them. Whenever you initially have that discussion with parents, I find in most occasions, they become very, very defensive. They assume the worst is going to happen (SW 1, Trust A, AMH).

Discussion

In our investigation of HSC professionals' FFP, with parents who have mental illness, the importance of constructive relationships was repeatedly identified. Both professionals and parents agreed that relationship based practice were embodied by a genuine partnership; and was essential in enabling professionals to overcome parents' fears of fully engaging with services as well as allowing the needs of their family members, including children to be addressed. Others have also found that relationships are key to FFP (Grant et al., 2018a; Grant, 2014). While FFP is underpinned by a constructive relationship between professionals and parents, the relationship can also be used by professionals as a mechanism to support parents and their families and to promote positive change (Coulter et al., 2019; Grant, 2014; Shah-Anwar, Gumley and Hunter, 2019). However, as previously noted, it is widely recognised that many parents may experience mental health services and child welfare services as oppressive and coercive (McKenna et al., 1999; Smithson and Gibson, 2017) and that professionals experience tensions between their statutory duties to support parents and to also protect and support their dependent children (Ward et al., 2017). As previously noted, the concepts of power and procedural justice may be helpful to inform how professionals can manage some of these tensions in practice and develop positive relationships. The current study suggests that despite these tensions it is possible for professionals to form constructive relationships with

parents. According with principles of procedural justice, constructive relationships were characterised by professionals' honesty regarding the need to address parenting, a non-judgemental, empathetic and positive approach and capacity to work in partnership with parents to address the needs of both parents and their children. Furthermore, this study suggests that constructive relationships are enabled by factors primarily related to professionals, in conjunction with their organisations and to some extent by parents and the wider system. This highlights that no matter what initiatives (i.e. policy) and strategies (i.e. implementation frameworks and action plans) organisations develop to promote FFP, parents need to feel understood, listened to and actively involved, and that professionals need to be aware of the importance of this and enabled to develop constructive relationships and to adopt a relationship based practice approach.

We argue that while existing models of relationship based practice are helpful they need to be expanded to see the multiplicity of relationships within any encounter. Family focused practice has challenged professionals to move beyond dyadic approaches to practice, to see the individual within the network of relationships which service users have with significant others in their lives, principally any partner they may have and children – in essence, that practice is both family focused and relational and at least acknowledges the complex wider context.

Applying what Duffy et al. (2016) describe as a *family recovery approach* to the child protection and mental health interface may help to ensure that practice is both family focused and relational. It may also help address some of the fears and mistrust that service users have expressed in this study and reduce tensions that professionals experience in supporting parents while protecting their children. Family recovery builds on the core tenet of recovery in mental health itself, which Slade (2009) describes as being personal, focused as such on getting on with one's life, alongside the mental health issues being experienced. Previously, we proposed

that a family recovery approach entails both family support and meaningful engagement with everyone involved to offer "a more effective means of protecting children, through its inherent focus on a whole family perspective, where risk is assessed and managed in a spirit of collaboration, empowerment, partnership and openness" (Duffy et al., 2016:45). This type of approach, however, will call for introspection and reflexivity by workers particularly against an occupational context characterised by over regulation, risk aversion and pre-occupation with a child protection orientation (Munro, 2010; Jones, 2014; Parton, 2014). The child's welfare is central to a family recovery approach, positioning this in a balanced way alongside an important focus on providing support to parents to help them meet their children's needs. The focus on the paramountcy of the child is therefore not compromised but realistically envisioned through a whole family systems approach to intervention.

Professionals' capacity to be emotionally responsive, open and honest is critical in helping service users to accept and process difficult decisions (Smith et al, 2011). Allied to this, Buckley et al's research (2011) found that service user negativity was neutralised when there was a quality relationship between social workers and families. This is not, however, without practice challenges and the need for professionals to exercise self-awareness and reflexivity will be crucial to work in more partnership-based ways with service users. The *macro context* (Duffy and Collins, 2010) of professionals' practice must also be recognised and, within this, the potential for managerialism to create a more challenging occupational culture for values based practice to flourish. If professionals do not critically reflect on how their practice is negatively impacted by the 'compliance, tick-box, proceduralised and regulated culture' typifying managerialism, (Trevithick, 2014:302), relationship-based practice with service users will not flourish. It is only by placing an emotionally responsive relationship-based practice at the centre of service delivery that managerialism can be humanised (Trevithick, 2014: 307). This type of humanising approach will help bring the emotional

dimension that Munro (2011) calls for to the heart of practice and thus reduce professionals' over-reliance on records and administration and a lack of time to engage parents that was observed negatively by the service users in this research. In turn this deeper connection may also help professionals better understand the impact of parent's mental illness on them and their family.

Finally, this study also highlighted that professionals' capacity to draw upon their personal experiences, and particularly parenting was important in enabling constructive relationships, based on principles of procedural justice. Others also highlight the relevance of professionals' personal experiences, including parenting, for their practice (Grant et al., 2018b; Kwan and Reupert, 2019; Korhonen et al., 2010). The current study found that while professionals were able to draw upon their parenting experience to better understand parents' challenges they were also able to use limited self-disclosure to obtain credibility with parents and to offer them practical advice. On this basis, educational programmes could encourage critical reflection on parenting experience, so that it can inform how professionals engage parents who have mental illness. Also, considering that those without parenting experience were less able to afford parents procedural justice, it is also important that educators consider how to support professionals without parenting experience to gain commensurate knowledge. Educators could encourage professionals who are not parents to draw on their experiences of caring for a family member or friend's children, as well as reflecting on their experiences of being parented. The sharing of personal experience may also help professionals, irrespective of parenting status, to learn from each other and to dispel attitudes that first-hand parenting experience is essential to understand and assist parents to cope with their challenges in parenting. Such approaches could add to the growing call for more reflective practice within mental health across the range of professions often involved with individuals and their family,

enhancing a social, rather than medical perspective on understanding and responding to mental illness (e.g. Graham, 2000; Park-Taylor et al., 2009).

To our knowledge this is the first qualitative study to explore what constitutes a constructive relationship between HSC professionals and parents who have mental illness and factors that enable and hinder it with reference to theoretical constructs of power and powerlessness, and principles of procedural justice and relationship based practice. Inclusion of both professionals and service users in multiple services is a strength of this study. However, not all professional groups operating within the contemporary mental health setting were represented in this study. Occupational therapists and family support workers were not included. These limitations should be noted when generalizing these results to other locations and professions, for example those working within 'Looked After' Children's services. Finally, we had hoped to recruit 30 service users but were not able to. However, saturation was met for both samples.

Conclusion

This study developed an understanding of what mentally ill parents need from professionals to be able to build trusting relationships with them and how professionals can manage the tension inherent in both supporting parents and protecting their children. It also added to the literature on relationship based practice. An understanding of what constitutes a constructive relationship between professionals and parents, how it develops and the importance of the wider context, may help professionals to reflect upon how they engage parents and to do it well. It may also assist organisations to develop the necessary structures and resources to promote constructive engagement between professionals and parents. For example, training and supervision can afford professionals time to reflect on their relationships with parents and to address issues of power and powerlessness more effectively within daily practice.

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