Registered Psychiatric Nurses' Practice with Parents who have Mental Illness, their Children and Families, within General Adult Mental Health Services in Ireland

By

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Notice 1

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Abstract

The overall aim of this study was to investigate Registered Psychiatric Nurses' (RPN) perceptions of their family focused practice (FFP) with parents who have mental illness, their children and families, in general adult mental health services in Ireland. The study sought to measure the extent of RPNs' FFP in acute admission units and community settings and to establish how RPNs' FFP compared with Australian RPNs' FFP. It also sought to identify the significant predictors of RPNs' FFP and to explore the scope and nature of high scoring RPNs' FFP and factors that affected their capacity to engage in FFP.

A mixed methods approach, using a sequential explanatory design, was employed to address the study aims. In Study One a clustered, random sampling approach was used to access 610 RPNs in 12 mental health services in Ireland (practicing within acute admission units and community mental health services). Data was elicited using the Family Focused Mental Health Practice Questionnaire (FFMHPQ) with a 57 percent response rate (n= 346). RPNs' FFP was ranked on the basis of their responses on the questionnaire. RPNs were deemed to be high scoring if they obtained between five and seven on at least three of the six FFP behavioural subscales within the FFMHPQ. In Study Two, fourteen high scoring RPNs, from Study One participated in semi-structured interviews.

Whilst the majority of RPNs in Study One were not family focused, and had lower mean scores than RPNs in Australia, a substantial minority were family focused. Most of the higher scorers were practicing within the community setting. The most important predictors of FFP were skill and knowledge, followed by RPN group (acute versus community setting) and confidence around parenting and children generally. Study Two suggested that high

scoring RPNs' FFP was complex and multifaceted, comprising various family focused activities, principles and processes. Their capacity to engage in FFP was determined by certain enablers and barriers with other results focused on future potential developments in FFP.

The findings have enhanced understanding of RPNs' FFP with parents who have mental illness, their children and families, in the Irish context and internationally. The findings also represent a starting point for future research in this area within Ireland and elsewhere. On the basis of the results, various implications for RPNs' education, practice and policy can be made. It is recommended that national policies be introduced to mandate the identification of service users' parenting status by mental health professionals, including RPNs, on admission to mental health services, and to embed information and support regarding parenting into ongoing care. Furthermore, key enablers, including child and family focused education and time to engage in FFP, should be provided to RPNs, to facilitate the transfer of policy into practice. Future research is required to develop an in-depth understanding of RPNs' FFP in different settings.

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Chapter 1: Background to the Study and Overview of the Thesis

This study sought to examine RPNs' FFP with parents who have mental illness, their children and families, within general adult mental health services in Ireland. A national study, using a sequential, explanatory, mixed methods design was employed. The chapter that follows introduces the reader to the background literature in which the study is situated and chapter two describes the conceptual framework and wider literature that the thesis is based upon. Chapter three further highlights the needs of parents, children and adult family members, the central role of policy in promoting and guiding RPNs' FFP, and why RPNs may play a key role in supporting parents, their children and families. Chapter three also outlines the implications of the conceptual framework and wider literature for RPNs' FFP and reviews empirical literature on RPNs' capacity to implement recommendations sourced from policy and practice in this area. Chapter four details the research design and methods employed in the thesis. Findings of Study One - the quantitative component is presented in chapter five, while chapter six reports the findings of Study Two – the qualitative component. Chapter seven discusses the findings from Study One and Two and the suitability of the Family Model (Falkov, 2012) as a lens for interpreting and discussing the findings. Finally, in chapter eight, the thesis concludes with an overview of the limitations of the thesis and recommendations for the future development of RPNs' FFP, within the context of education, practice, policy and research.

Study Rationale

In Ireland, data from the Health Research Board (HRB) and 2006 Census suggest that approximately 157,201 parents in Ireland experience mental illness (Central Statistics Office, 2006; O'Doherty & Doherty, 2010; Tedstone Doherty, Moran, & Kartalova-O'Doherty, 2008). Mental illness refers to a wide range of mental health conditions and disorders that affect mood, thinking and behaviour. Whilst there is considerable variation in the severity of different types of mental illness/disorders, all can be associated with significant long-term disability. Mental illness may adversely the individual's capacity to cope with daily living, with implications for the individual and their family. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders, personality disorders and addictive behaviours (Morrissey, Keogh, & Doyle, 2008; Tedstone Doherty et al., 2008).

Internationally, it has been estimated that between a fifth and a third of adults receiving treatment from mental health services have children (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009; G. Parker et al., 2008) and that between 10 – 23 % of children live with at least one parent who have a mental illness (Maybery et al., 2009). From these statistics it is clear that a significant number of people, in Ireland and elsewhere, experiencing mental illness, are parents of one or more dependent children.

The needs and issues for parents who have mental illness, their children and families are extensive and have been documented in multiple studies. The research highlights the adverse effects of PMI on children's cognitive, emotional, social, physical and behavioural development (E. D. Barker, Copeland, Maughan, Jaffee, & Uher, 2012; Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012; Beardslee, Swatling, et al., 1998; Rutter & Quinton, 1984). Whilst there are well established links between PMI and poor outcomes for

children, parenthood can also influence parents' mental health (Benders-Hadi, Barber, & Alexander, 2013; Falkov, 2012; Krumm, Becker, & Wiegand-Grefe, 2013; Nicholson, in press). Hence, parents who have mental illness also have their own needs, relating to their parenting responsibilities and their mental illness. Adult family members may also have needs incurred through the demands of caring for their mentally ill relative and by the need to assume additional parenting responsibilities (Diaz-Caneja & Johnson, 2004; Doucet, Letourneau, & Blackmore, 2012; McNeil, 2013).

Multiple randomized trials have demonstrated the benefits of preventative interventions for parents, children and family functioning (Beardslee et al., 2012; Beardslee, Wright, Gladstone, & Forbes, 2007). Moreover, the refocusing of mental health services towards a recovery orientated approach makes consideration of service users' family context and parenting role important (Benders-Hadi et al., 2013; Nicholson, in press). It is becoming increasingly recommended by policy makers and professional organisations (Australian Infant Child Adolescent and Family Mental Health Association [AICAFHMA], 2004; Department of Health and Children [DoHC], 2006; Mental Health and Drug and Alcohol Office, 2010; Royal College of Psychiatrists, 2011; Social Care Institute of Excellence [SCIE], 2005 , 2009, 2011) and by researchers (Beardslee et al., 2012; Cusack & Killoury, 2012; K. Foster, O'Brien, & Korhonen, 2012; Hansson, O'Shaughnessy, & Monteith, 2013; Krumm et al., 2013; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014b; Mordoch & Hall, 2008; Nicholson, in press; Nilsson, Gustafsson, & Nolbris, 2014) that general adult mental health services adopt a whole family approach. Whilst the Irish DoHC (2006) has made recommendations regarding a whole family approach and highlights the importance of mental health professionals addressing the needs of service users' dependent children, these recommendations are based on research conducted in Australia, UK, Canada, USA, Norway,

Sweden and the Netherlands. Policy is often context specific (DoHC, 2006) and needs to be responsive to local needs and workforce and professional training frameworks (Cusack & Killoury, 2012).

Whilst the different professional disciplines (such as RPNs, psychiatrists, social workers, psychologists and so on) should work together to support parents and their children, RPNs are a pivotal member of the workforce to support such families, due to the nature of their role and the high proportion of mental health professionals who are RPNs (Korhonen, Pietilä, & Vehviläinen-Julkunen, 2010; Morrissey et al., 2008). Their role may also allow RPNs to form sustained relationship with parents at a time when parents are likely to be experiencing most difficulties in parenting due to the acute nature of their illness (K. Foster et al., 2012; Houlihan, Sharek, & Higgins, 2013; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2010; O'Brien, Brady, Anand, & Gillies, 2011).

Second, despite the increasing numbers of parents using general adult mental health services (Farrell, Handley, Hanke, Hazelton, & Josephs, 1999; K. Foster et al., 2012; Maybery et al., 2009; Royal College of Psychiatrists, 2011) and evidence that FFP is beneficial (Beardslee et al., 2012; Beardslee et al., 2007; Pihkala, Sandlund, & Cederstrom, 2012a) there is some, albeit limited research that examines and/or explores mental health professionals' (including RPNs) perspectives of their FFP (Devlin & O'Brien, 1999; K. Foster et al., 2012; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Thompson & Fudge, 2005). The evidence base in this area is limited for a number of reasons including: research efforts being focused on how PMI negatively impacts children's well-being (Krumm et al., 2013; Leverton, 2003; Rosenthal, 1970; Rutter, 1989; Rutter &

Quinton, 1984; Werner & Smith, 1992) parents' perspectives of their experiences and needs (Blegen, Hummelvoll, & Severinsson, 2012; Montgomery, Mossey, Bailey, & Forchuk, 2011; Nicholson, in press; Pihkala, Sandlund, & Cederstrom, 2012b) and children's experiences of PMI (Fudge & Mason, 2004; Mordoch, 2010; Mordoch & Hall, 2008; Nilsson et al., 2014). In more recent times, research efforts have predominantly focused on identifying barriers for workers when working with families (Houlihan et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maybery & Reupert, 2006; Rutherford & Keeley, 2009; Slack & Webber, 2008). However, many of these workforce papers have various methodological problems (e.g. small sample, multiple disciplines). Hence, to date, there is limited understanding of RPNs' FFP (Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b); particularly in relation to the nature, scope and extent of RPNs' FFP, in different clinical settings and how and why factors predict, enable and/or impede FFP.

To develop the psychiatric nursing professions' capacity to engage in FFP, it is important to conceptualise what FFP means for different groups of RPNs and to identify what predicts and enables RPNs' FFP in the first instance. This study will add new knowledge by identifying factors that predict and enable RPNs' FFP, in different settings, and how RPNs, who are most family focused, as measured by the FFMHPQ, (Maybery, Goodyear, & Reupert, 2012a; Maybery & Reupert, 2006), conceptualise FFP. Key findings will inform recommendations that can be used to guide education, practice, policy and research, in both the Irish and International context, with the aim of developing RPNs' capacity to meet the needs of parents who have mental illness, their children and families. Moreover, conceptualisation of FFP will allow development of models and approaches to practice that have utility in different services (K. Foster et al., 2012; Reedtz, Lauritzen, & van Doesum, 2012).

The following sections introduce background literature to the study. The first of these commence by highlighting the prevalence of PMI both in Ireland and elsewhere. The risks and outcomes of PMI for parents, their children and adult family members are then outlined before describing the various dimensions of FFP as it is currently understood, including what FFP should entail and its benefits in reducing negative outcomes for the whole family. Enablers of FFP in the workforce are also detailed. Finally, the study aims and thesis structure are outlined.

Prevalence of Parental Mental Illness

The International perspective. Generally, between 20 to 30 percent of the western world's population experience mental illness (Gould, 2006; Nicholson, Biebel, Williams, & Katz-Leavy, 2004; Parrott, Jacobs, & Roberts, 2008; Tunnard, 2004). Approximately one in four adults, experience a mental illness in a 12 month period (Demyttenaere et al., 2004) with depression and anxiety being the most common presenting problems (Layard, Clark, Knapp, & Mayraz, 2007; O'Doherty & Doherty, 2010).

Increasing numbers of people who have mental health problems are also parents (Falkov, 2012; K. Foster et al., 2012). As a result of improved treatment and rehabilitation, as well as policy and deinstitutionalization (Diaz-Caneja & Johnson, 2004; K. Foster et al., 2012), individuals who are mentally ill have a greater opportunity than previously to assume the parenting role. Consequently, there is also a corresponding growth in the number of children who have one or both parents who are mentally ill (Diaz-Caneja & Johnson, 2004; Gillam, Crofts, Fadden, & Corbett, 2003; Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001). Parenthood is an important life role (Benders-Hadi et al., 2013) and defines adulthood for many (Nicholson, in press; Nicholson & Miller, 2008) and is also

highly valued by society (Krumm et al., 2013; Nicholson, 2010; Nicholson & Miller, 2008). People with mental illness tend to parent at the same rate as people who have good mental health (Falkov, 2012; Nicholson & Biebel, 2002; Nicholson & Miller, 2008) and can be just as motivated to fulfil the parenting role (Diaz-Caneja & Johnson, 2004; Nicholson, 2010; Nicholson & Henry, 2003; Nicholson & Miller, 2008).

However, at the current time, it is difficult for mental health services, in most countries, to provide accurate figures of the number of service users who are parents. Current admission protocols and assessment documentation, utilised by the mental health services in many western countries do not prompt service users to disclose parenting status or mental health professionals to record parenting status (Falkov, 2012; Hansson et al., 2013; Huntsman, 2008; Lee, 2004; SCIE, 2011; Thompson & Fudge, 2005). Moreover, the recording of parenting status does not capture data relating to parents who do not disclose their parenting status due to concerns that their child/children may be removed from their care (Thompson & Fudge, 2005). Nonetheless, ongoing attempts are being made by mental health services to estimate the number of parents with mental illness and the number of children in their care (Falkov, 2012). It is important to determine the number of parents with mental illness (Office for Standards in Education Children's Services and Skills, 2013) because such data will allow service providers to establish if there is a match between population and services provided and assist in making decisions about services, programs, funding and research (Falkov, 2012; Hansson et al., 2013; Lee, 2004). Moreover, when service users' parenting roles are not acknowledged it means that a core aspect of their lives and identities is ignored (Krumm et al., 2013); it also means that the needs of their children can be entirely overlooked (DoHC, 2006; Hansson et al., 2013). This can expose children to

additional hardship, and in a few cases, serious risk of harm (Falkov, 2012; Maybery & Reupert, 2009).

Outside of Ireland initial efforts to approximate prevalence focused on the numbers of mentally ill people (generally with enduring mental illness [EMI]) who are parents, as opposed to numbers of children whose parent has a mental illness. In the UK, over one third of all adults with mental health problems are parents (Tunnard, 2004) and the majority are mothers (G. Parker et al., 2008). It has been estimated that between a fifth and a third of adults receiving treatment from mental health services have children (Falkov, 1998; Farrell et al., 1999; Maybery et al., 2009; Royal College of Psychiatrists, 2011). In Australia, AICAFHMA (2001) proposed that between 29 and 35 percent of people using adult mental health services were women, who had one or more children, aged 18 or less. In separate (2008 and 2009) day audits of their area mental health region, in New South Wales, Howe, Batchelor, and Bochynska (2009) found a consistent 28 percent of clients to be parents. Reupert, Maybery, and Kowalenko (2012), summarised data on prevalence of parents using mental health services and found on average 20 percent of clients to be parents in the Victorian mental health region. In Sweden a one day cross sectional survey of mental health service users found that 36 percent had children under the age of 18 years (Östman & Eidevall, 2005).

In Australia, Maybery et al. (2009) employed three strategies to estimate the number of children with a mentally ill parent. The first approach combined statistics from the Australian Bureau of Statistics (ABS) on mental health and family characteristics studies to establish a population estimate. This suggested that between 21 and 23 percent of children lived with at least one parent with a mental illness (Maybery et al., 2009). The second

approach examined Victorian Mental Health Branch service usage data for the year 2003-2004 and found that 20.4 percent of the patients had an estimated 14,403 children (Maybery et al., 2009; Reupert, Maybery, et al., 2012). The final approach, a cross sectional community study of 701 NSW families, found that 14.4 percent of children had one or more parents who had mental illness (Maybery et al., 2009). In Canada, a study using a population approach estimated that one in six children under 12 lived in the same house with at least one individual who had a psychiatric illness (Bassani, Padoin, Philipp, & Veldhuizen, 2009). This equates to 570,000 Canadian children, less than 12 years of age, and suggested that up to one in five young people lived in families with a parent with a mental illness. In the UK, Cleaver, Unell, Aldgate, and Britain (1999) found that 10 – 15 percent of children lived with a parent who had a mental disorder and 28 percent were the children of lone parents with a mental disorder. Also in the UK, it was estimated that overall two million children lived in households where at least one parent had a mental health problem (Parrott et al., 2008). Based on estimates of prevalence in the UK, Hansson et al. (2013) suggested that there was between 60,000 – 75,000 children in Northern Ireland living with a parent who had mental illness. The Norwegian Institute of Public Health estimated that up to 410,000 children in Norway (37.3 percent) had either one or two parents who had a mental illness (Reedtz et al., 2012). Although estimates of prevalence vary widely, even the lowest of these rates would indicate that parenting is a substantial issue that needs to be addressed among adults with a mental illness (Falkov, 2012; Lee, 2004; Mowbray et al., 2001).

The Irish perspective. Irish data relating to the incidence and prevalence of mental health issues is limited. The largest national survey, on the extent of mental health and social well-being in Ireland, found that major depression was prevalent in six percent of the sample (K. Morgan et al., 2008). The Mental Health Association of Ireland (2001) reported that the

prevalence of moderate to severe depression in the Irish population was four percent and moderate to severe anxiety was 13 percent. Another survey, around the same time, carried out by the HRB, which sought to establish the extent of psychological distress, mental health problems and the use of mental health services, estimated that 12 percent of the population had symptoms of psychological distress/mental illness (O'Doherty & Doherty, 2010; Tedstone Doherty et al., 2008). Most recently, the *Growing up in Ireland* study measured the psychological well-being of parents and found that nine percent of mothers and four percent of fathers were classified as being depressed whilst 14 percent of mothers and six percent of fathers had previously been treated for depression (Nixon, 2012). By extrapolating the HRB figures (12 percent) on the incidence of psychological distress/mental illness to the entire population in Ireland, aged 18 years and over (n = 3,203,814), as determined by the 2006 Census (Central Statistics Office, 2006), it would suggest that around 384,457 individuals were experiencing minor or major psychiatric problems at that time.

However, similar to other countries, only broad estimates can be made of the number of parents with mental illness and children affected by PMI as there is no Irish wide collection of data to indicate how many adults using mental health services are parents of dependent children (DoHC, 2006; Hansson et al., 2013; Somers, 2007). To obtain approximate numbers of parents who have mental illness the author extrapolated data on family characteristics, obtained from the 2006 Census (regarding number of parents with one or more children under the age of 18), to the percentage of adults in the general population who were experiencing psychological distress. This suggests that within the general population in Ireland at that time, there were approximately 1.3 million parents and that approximately 157,201 of these parents experienced mental illness. Moreover, 22,705 of these parents who had mental illness are thought to be single parents.

As the above figures were based on general population data they provide only a rough estimate of percentage of parents who experience psychological distress/mental illness in Ireland. Furthermore, they provide no information about the percentage of mental health service users in Ireland who are parents. However, from these statistics it is clear that a significant number of people, in Ireland experiencing psychological distress/mental illness, are parents of one or more children under the age of 18. For a number of reasons these estimates are also likely to be conservative. For instance, many people, including parents who have mental illness may be reluctant to disclose their distress or to seek help due to social stigma associated with mental illness (Falkov, 2012; Huntsman, 2008). These figures provide a firm basis for RPNs adopting a whole family approach within general adult mental health services. They also highlight a need for research that examines and explores the nature, scope and extent of RPNs' FFP, in different settings, and factors that affect their capacity to engage in FFP in the first instance.

Risks and Outcomes for Parents who have Mental Illness, their Children and Families

The needs and issues for parents who have mental illness, their children and families are extensive and have been documented in numerous studies (Aldridge & Becker, 2003; Baker & Lees, 2014; Bassett, Lampe, & Lloyd, 1999; Brockington et al., 2011; Cowling, 1999; B. Davies & Allen, 2007; Diaz-Caneja & Johnson, 2004; Doucet et al., 2012; Fudge & Mason, 2004; Handley, Farrell, Josephs, Hanke, & Hazelton, 2001; Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery, Ling, Szakacs, & Reupert, 2005; Montgomery, Tompkins, Forchuk, & French, 2006; Mordoch, 2010; Mordoch & Hall, 2008; Mowbray et

al., 2000; Nicholson, Biebel, Hinden, Henry, & Stier, 2001; J. Nicholson, E. M. Sweeney, & J. L Geller, 1998a; J. Nicholson, E. M. Sweeney, & J. L. Geller, 1998b; Nilsson et al., 2014; O'Brien, Anand, Brady, & Gillies, 2011; O'Brien, Brady, et al., 2011; Reupert & Maybery, 2007, 2009; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004; Stanley, Penhale, Riordan, Barbour, & Holden, 2003). Whilst there are well established links between parents' mental health and their parenting capacity and PMI and poor outcomes for children (Rutter, 1989; Rutter & Quinton, 1984), parenthood can also influence parents' mental health (Baker & Lees, 2014; Falkov, 2012; Krumm et al., 2013; Nicholson, in press; Nicholson et al., 1998a; Royal College of Psychiatrists, 2011). The difficulties experienced by parents with mental illness, in parenting, tend to occur at times of relapse and during acute episodes of illness (Cowling, 1999; Falkov, 2012; Fudge & Mason, 2004; Maybery et al., 2005) and can adversely affect their well-being and that of their children on a temporary and/or on an ongoing basis (Falkov, 2012; J. G. Johnson, Cohen, Kasen, Smailes, & Brook, 2001; Nicholson et al., 1998a; Wals et al., 2001).

Whilst many children do not experience difficulties due to PMI (Falkov, 2012; K. Foster, O'Brien, & McAllister, 2005; Gladstone, Boydell, & McKeever, 2006) many are adversely affected (E. D. Barker et al., 2012; Beardslee, Gladstone, & O'Connor, 2011; Beardslee, Swatling, et al., 1998; Kartalova-O'Doherty, Doherty, & Walsh, 2006; Mordoch & Hall, 2008). Whilst a large body of research suggests that all aspects of a child's development can be affected by the direct or indirect effects of PMI (E. D. Barker et al., 2012; Beardslee et al., 2011; Kartalova-O'Doherty et al., 2006; Lauritzen et al., 2014b; Rutter, 1989; J. A. Smith, 2004) there are indications that exposure to PMI and the resulting disruption may be more harmful to younger children (Falkov, 2012; Hansson et al., 2013). Whilst these effects may be genetic in nature, there is increasing research which suggests that

the intergenerational transmission of mental illness is predominantly environmental in nature, and contributed to by a lack of parenting capacity and ineffective communication between parents and their children (Falkov, 2012; Hansson et al., 2013; Krumm et al., 2013; Morawska, Winter, & Sanders, 2009; Reedtz et al., 2012). Adverse socioeconomic circumstances that often accompany mental illness such as stigma, poverty and isolation are also important factors that can adversely impact on children (Falkov, 2012; Hansson et al., 2013; Nicholson, in press; Nicholson et al., 1998a; Royal College of Psychiatrists, 2011).

A substantial number of children experience a level of psychosocial disorder that is well in excess of that evidenced by children without a parent with a mental illness (Bornstein, 2012; McLaughlin et al., 2012; V. A. Morgan et al., 2012; Rutter, 1989; Rutter & Quinton, 1984; Singer, Tang, & Berelowitz, 2000). Twenty five to 50 percent of children, of parents with a mental illness, will experience some psychological disorder during childhood or adolescence and 10 - 14 percent of these children will be diagnosed with a psychotic disorder at some point in their lives (Aldridge & Becker, 2003; Beardslee, Versage, & Gladstone, 1998; Bornstein, 2012). Similarly, Singer et al. (2000) suggest that psychological difficulties may be found in up to two thirds of children whose parents are known to mental health services. Parents with mental illness themselves report that almost 50 percent of their children have disabilities or difficulties as well (L. T. Barker & Maralani, 1997).

Parents who have mental illness also have their own needs relating to their parenting responsibilities and their mental illness (Doucet et al., 2012; Falkov, 2012; Krumm et al., 2013; Letourneau et al., 2007; Nicholson, in press; Nicholson et al., 1998a; Reupert, Maybery, & Goodyear, 2010). A parent's mental illness and /or adverse living circumstances may cause them to experience considerable difficulty in fulfilling the parenting role

effectively (Aldridge & Becker, 2003; Diaz-Caneja & Johnson, 2004; Falkov, 2012; Hansson et al., 2013; Montgomery et al., 2006). In turn, parenting responsibilities may add to their stress and adversely affect their mental health (Baulderstone, Morgan, & Fudge, 2012; Beardslee et al., 2012; Cowling & McGorry, 2012; Montgomery et al., 2006; Nicholson, 2010). Even though the stressors associated with caring for children and managing their mental illness can be considerable (Diaz-Caneja & Johnson, 2004; Falkov, 2012; Nicholson, in press; Nicholson et al., 1998a; Reupert & Maybery, 2009; Royal College of Psychiatrists, 2011), parenthood is a central and rewarding role in the lives of parents who have mental illness (Aldridge & Becker, 2003; Benders-Hadi et al., 2013; Diaz-Caneja & Johnson, 2004; Montgomery et al., 2006; Nicholson, 2010; Nicholson et al., 1998a). Resuming or maintaining parental responsibilities is a goal that motivates parents who have mental illness, to actively participate with treatment in hospital or to engage with psychiatric services in the community so as to prevent relapse (Korhonen, Vehviläinen-Julkunen, et al., 2010; Krumm et al., 2013; Montgomery et al., 2006; Nicholson, 2010; Nicholson et al., 1998a). Moreover, success or failure as a parent may have profound impact on parents' well-being and recovery (Benders-Hadi et al., 2013; Diaz-Caneja & Johnson, 2004; Nicholson, in press). As such parenthood provides "opportunities for supporting or undermining recovery" (Nicholson, in press, p. 1).

Adult family members (including partners) also have needs (Doucet et al., 2012; Korhonen, Pietilä, et al., 2010; McNeil, 2013; Monahan, Doyle, & Keogh, 2008; Reader, 2002). They may feel overwhelmed and isolated yet struggle to accept help (Doucet et al., 2012; Monahan et al., 2008; Nicholson, in press; Reader, 2002). Risks and outcomes for parents who have mental illness, their children and families, will be discussed in further detail in chapter two and three.

Definition of Family Focused Practice

In response to the increasing knowledge about risks and outcomes for families where a parent has a mental illness, various researchers (Gladstone, Boydell, Seeman, & McKeever, 2011; Houlihan et al., 2013; Krumm et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; McNeil, 2013; Mordoch & Hall, 2008; Nicholson, 2010) professional organisations and policy makers (AICAFHMA, 2004; DoHC, 2006; Royal College of Psychiatrists, 2011; SCIE, 2011) have recommended that adult mental health services adopt a whole family approach and that mental health professionals engage in FFP.

Previous literature has described FFP as a paradigm (Hall, 2007), a philosophy (E. J. Brewer, McPherson, Magrab, & Hutchins, 1989; Malusky, 2005), and practice theory (Hutchfield, 1999). The concept has also been operationalised as a model or method of care delivery that emphasises the family as the unit of attention as opposed to a health professional working with an individual alone (Bailey, Raspa, & Fox, 2012; M. J. Foster, Whitehead, Maybee, & Cullens, 2013; MacFarlane, 2011; McGavin, 2013; G. Murphy, Peters, Jackson, & Wilkes, 2011). K. Foster et al. (2012, p. 7) suggest that:

> Family-focused care aims to improve outcomes for the parent with mental illness, reduce the subjective and objective burden of care for families, and provide a preventative and supportive function for children.

Family focused practice entails professionals focusing less on their role as experts and more on their role as collaborators or partners, who work alongside service users and their families (Bailey et al., 2012; Keen, 2007; MacFarlane, 2011; McGavin, 2013; McNeil, 2013; Moore, McDonald, Sanjeevan, & Price, 2012; Nicholson, in press). FFP needs to address the unique and sometimes competing needs of different family members, alongside those of the

designated service user (Bailey et al., 2012; Dunst, Boyd, Trivette, & Hamby, 2002; Kuo et al., 2012). Hence, FFP contrasts to the prevailing professional centred approach, whereby professionals assume an expert role and focus on treating the service users' mental illness without acknowledging and addressing their needs related to their family context (Centre for Addiction and Mental Health, 2004; Dunst, Johanson, Trivette, & Hamby, 1991; MacFarlane, 2011; Nicholson, in press).

The concept of FFP originated in paediatric settings in the 1950's (Coyne, Murphy, Costello, O'Neill, & Donnellan, 2013). However, while FFP has informed service delivery in general adult mental health services, (Bland & Foster, 2012; MacFarlane, 2001; Stanbridge & Burbach, 2007) there has been limited research and literature which has examined and/or explored how the concept has been conceptualised and operationalised with different family configurations (including service users who are parents of dependent children) and by different disciplines, including RPNs (K. Foster et al., 2012; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014). To date, the concept of FFP, in paediatric services and in general adult mental health services, has been coined family centred care (FFC) and has predominantly entailed involving and supporting adult family members who are caring for service users (Bland & Foster, 2012; MacFarlane, 2001; McNeil, 2013; Solantaus & Toikka, 2006). In recent times the concept has expanded within adult mental health services to reflect a growing awareness of the need to address service users' parenting issues and to include and support a range of family members including service users' dependent children (K. Foster et al., 2012; Korhonen, Pietilä, et al., 2010; Mottaghipour & Bickerton, 2005; Nicholson, in press; Reupert et al., 2009; Royal College of Psychiatrists, 2011). With a change in focus and emphasis (to also including children) FFP is referred to as child focused-family nursing (Korhonen, Pietilä, et al., 2010; Korhonen,

Vehviläinen-Julkunen, et al., 2010) family focused approach (K. Foster et al., 2012), family sensitive practice (Liangas & Falkov, 2014; Maybery et al., 2012a) or FFP as is the case in this thesis. The impetus for this change of focus has been the growing awareness that parenting capacity/quality is the most potent and modifiable risk factor contributing to the development of behavioural and emotional problems in children (Lauritzen et al., 2014b; Morawska et al., 2009; Nicholson, in press; Siegenthaler, Munder, & Egger, 2012), and as such, should be a focus of FFP (Biebel, Nicholson, Geller, & Fisher, 2006; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b; Reedtz et al., 2012), within general adult mental health services.

During the last two decades the field of paediatrics and to a lesser extent adult mental health services have successfully defined the working principles and activities of FFP for practitioners (Espe-Sherwindt, 2008). The literature highlights the importance of caring for parents in the contexts of their families and communities and working with families in an individualised, holistic, flexible, transparent, responsive, preventative, recovery, strengths based and culturally sensitive manner (Bailey et al., 2012; Bland & Foster, 2012; Espe-Sherwindt, 2008; K. Foster et al., 2012; MacFarlane, 2011; McGavin, 2013; McNeil, 2013; Moore et al., 2012; Mordoch & Hall, 2008; Seeman, 2013; Trowse, Hawkins, & Clark, 2013; Wright, 2007). The literature about adult mental health services focuses on preventive interventions for parents who have mental illness, their children and families in order to reduce psychological and social risk factors for families and improve strength and protective factors, for instance parenting behaviour, social support and coping skills (Falkov, 2012; Korhonen, Pietilä, et al., 2010; Nicholson, in press; Reedtz et al., 2012). Critical to FFP is the need for workers to form partnerships with parents and their families and to help parents set and achieve appropriate and realistic goals (Bailey et al., 2012; Bland & Foster, 2012; Coyne

et al., 2013; B. H. Johnson, 2000; Korhonen, Vehviläinen-Julkunen, et al., 2010; Kuo et al., 2012; Moore et al., 2012; Nicholson, in press; Wells, 2011).

In addition, researchers are beginning to recommend a continuum of family focused activities for those working with service users who are parents (Berman & Heru, 2005; K. Foster et al., 2012; Maybery & Reupert, 2009; Mottaghipour & Bickerton, 2005; Nicholson, in press; Stanbridge & Burbach, 2007). It is suggested that at the least, all mental health professionals should have a basic family focused skill set (Berman & Heru, 2005; Östman & Afzelius, 2011; Reedtz et al., 2012), to provide a minimum level of care for all families (Mottaghipour & Bickerton, 2005). It is also proposed that RPNs, at the least, and at the outset of a parents' admission to mental health services, should establish if they are parents and encourage parents to discuss their family context; including number of children and any possible issues in caring for them (K. Foster et al., 2012). Thereafter, RPNs should provide appropriate information and resources on PMI and/or parenting to the family or to individual family members, with a view to preventing and resolving issues arising from PMI for parents, their children and family (Baker & Lees, 2014; Falkov, 2012; Korhonen, Vehviläinen-Julkunen, et al., 2010; Liangas & Falkov, 2014; Mordoch & Hall, 2008; Nicholson, in press; Nilsson et al., 2014; Reedtz et al., 2012). As part of this basic family skill set, it has been recommended that RPNs advise parents about effective communication strategies in order to promote parents' relationships with their children (Korhonen, Vehviläinen-Julkunen, et al., 2010; Nicholson, 2010). RPNs should also be able to liaise with other services, to provide parents and children with additional support as appropriate, particularly when children have additional needs beyond understanding and coping with PMI (Falkov, 2012; Gillam et al., 2003; Korhonen, Vehviläinen-Julkunen, et al., 2010; Mordoch & Hall, 2008; Nicholson, in press; Reedtz et al., 2012).

Others have also identified provision of information and support to parents, children and families as an important element of FFP and possible to implement within a basic family skill set (K. Foster et al., 2012; Hosman, van Doesum, & van Santvoort, 2009; Krumm et al., 2013; Maybery & Reupert, 2009; Nilsson et al., 2014; Reedtz et al., 2012; Reupert, Cuff, et al., 2012). Information and support to enhance resilience may be provided through peer support programs (Goodyear, Cuff, Maybery, & Reupert, 2009; Grant, Repper, & Nolan, 2008; Hayman, 2009; Morson, Best, de Bondt, Jessop, & Meddick, 2009; Nilsson et al., 2014; Richter, 2006; Riebschleger, Tableman, Rudder, Onaga, & Whalen, 2009) online discussion support groups (Drost, Cuijpers, & Schippers, 2011; Woolderink et al., 2010) and educational materials; sometimes referred to as biblio-therapy (Tussing & Valentine, 2001). In addition, there are family intervention programs that support both parents and their children (Beardslee et al., 2007; Bühler, Kötter, Jaursch, & Lösel, 2011; Compas et al., 2011; Ginsburg, 2009; Nicholson, Albert, Gershenson, Williams, & Biebel, 2009; Reedtz et al., 2012; Solantaus, Paavonen, Toikka, & Punamaki, 2010; Valdez, Mills, Barrueco, Leis, & Riley, 2011). However, K. Foster et al. (2012) and Falkov (2012) also suggested that at the further end of the continuum, RPNs, with additional education and training in family work, might provide supportive counselling, consumer/family case management, and/or intensive child/family interventions, individually or within a multidisciplinary team.

The principles, activities and interventions that comprise FFP demonstrate that parents, children and adult family members may be supported in various ways (Fitzgerald & Galyer, 2007; Forman et al., 2007; Korhonen, Vehviläinen-Julkunen, et al., 2010; Moore et al., 2012). Taking cognisance of the existing literature on FFP, the definition, as operationalised in this thesis, entails RPNs working with service users around issues related to parenting with a mental illness. It also entails directly working with and supporting service

users' children (those who are younger than 18 years of age) and other adult family members. The conceptualisation of FFP will be re visited in chapter three when discussing the implications of Falkov's (2012) Family Model and wider literature for RPNs' FFP.

Benefits of Family Focused Practice

A substantive body of evidence suggests that parents, their children and families are more satisfied and find FFP more helpful than other models of practice (Dunst, Trivette, & Hamby, 2007; Espe-Sherwindt, 2008; Gladstone et al., 2006; Gladstone et al., 2011; Nicholson, in press; Van Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008). Moreover, there is increasing evidence, within the past 15 years, that FFP can be beneficial (Beardslee et al., 2012; Drost et al., 2011; Hayman, 2009; Moore et al., 2012; Mottaghipour & Bickerton, 2005; Nilsson et al., 2014; Pihkala et al., 2012a; Reupert, Cuff, et al., 2012; Reupert & Maybery, 2011; Solantaus et al., 2010; Van Doesum & Hosman, 2009). A systematic review and meta-analysis by Siegenthaler et al. (2012) found across 13 trials involving over 1000 children that formal interventions reduced the risk of children experiencing mental health problems themselves by 40 percent. Many of the current interventions are informed by Beardslee's family intervention *Family Talk*; as it is one of few family-based methods, developed for preventive practice for children of parents with mental illness, with proven benefits (O'Connell, Boat, & Warner, 2009). Beardslee's *Family Talk* aims to reduce the likelihood of children experiencing mental health problems as a result of PMI by: (a) promoting children's psychosocial resilience and other protective factors, (b) initiating communication and promoting understanding of PMI in the family, (c) promoting effective parent/child and family interactions, (d) reducing stigma and increasing social

network support for all family members and (d) strengthening parents in their role as caretaker (Beardslee et al., 2007; Solantaus & Toikka, 2006).

Other research suggests FFP may help to reduce the likelihood that parents will experience a relapse of their mental illness (Espe-Sherwindt, 2008; Mottaghipour & Bickerton, 2005; Pitschel-Walz et al., 2006) or need for hospitalisation for treatment of their mental illness (Hyland, Hoey, Finn, & Whitecross, 2008). Psycho educational interventions also improve parents' understanding of their illness, increase the quality of their lives (Rummel-Kluge, Pitschel-Walz, Bauml, & Kissling, 2006) and help them to develop stronger relationships with their family (Metsch et al., 1995; Pitschel-Walz et al., 2006). Moreover, both Davidson (2009) and Van Riper (2001) found that adult family members experienced less stress and better emotional well-being when mental health professionals directly involved and supported them. Mental health professionals also benefit from engaging in such interventions. Toikka and Solantaus (2006) described how using preventive interventions, including Beardslee's *Preventative Family Intervention*, enabled mental health professionals to experience more satisfaction and joy when supporting parents who have mental illness, their children and families. Similarly, Moore et al. (2012) indicated that mental health professionals are able to create stronger alliances with families and experience greater work satisfaction in the process. Finally there are economic benefits of providing good quality parenting support and preventative interventions for the whole family (Moore et al., 2012).

Enablers and Predictors of Family Focused Practice

Enablers to make the workforce more family focused need to be identified for workforce change to occur however limited research has identified the possible factors that

predict and enable FFP (Aarons, Sommerfeld, & Walrath-Greene, 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Halle, Metz, & Martinez-Beck, 2013; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b). There is a general consensus that whilst policy, guidelines and education are important enablers of FFP none are effective on their own (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014a; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Royal College of Psychiatrists, 2011). Instead, long term, multifaceted, implementation strategies, at multiple levels in an organisation, are needed (Aarons et al., 2009; Beardslee et al., 2012; Halle et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014).

Scott (2009) suggests that FFP may be enabled within organisations if performance indicators and funding models incorporate a family-centered lens. Others stress the importance of developing family focused policies and guidelines to enable FFP (Coyne et al., 2013; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; SCIE, 2009 , 2011). In particular the need to develop and implement standard admission policies and practices is highlighted (K. Foster et al., 2012; Hansson et al., 2013; Krumm et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Mordoch & Hall, 2008; Reedtz et al., 2012). Conducive organisational structures and processes, including implementation frameworks (Lauritzen & Reedtz, 2013; Lauritzen et al., 2014b), family focused frameworks (Korhonen, Pietilä, et al., 2010; Korhonen, Vehviläinen-Julkunen, et al., 2010), and recovery and strength based frameworks are also thought to enable FFP (Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Lauritzen et al., 2014b; MacKean et al., 2012; Moore et al., 2012; Nicholson, in press; Östman & Afzelius, 2011; Reedtz et al., 2012; Toikka & Solantaus, 2006); as is managerial support to translate these frameworks in practice (Coyne et al., 2013; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b; Maybery

& Reupert, 2009; Toikka & Solantaus, 2006). Provision of the necessary resources, including child and family focused professional development and education have also been highlighted as FFP enablers (K. Foster et al., 2012; Korhonen, Vehviläinen-Julkunen, et al., 2010; Krumm et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; N. Murphy & Withnell, 2013; Östman & Afzelius, 2011; Toikka & Solantaus, 2006). Training and education may facilitate mental health professionals to engage in FFP if it promotes their ability to form collaborative partnerships with parents and adult family members (Coyne et al., 2013; Korhonen et al., 2008; Maybery & Reupert, 2009; Moore et al., 2012; Nicholson, 2010), and to develop knowledge, skills and confidence to address parenting issues (Bell, 2013; Coyne et al., 2013; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b; Maybery & Reupert, 2009).

Opportunity to engage in reflective supervision to consolidate FFP knowledge and skills and to work on areas that need development is also considered important (Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Maybery & Reupert, 2009; Nicholson, 2010; Reupert & Maybery, 2008; Toikka & Solantaus, 2006). Relatedly, inter-disciplinary and organisational teamwork and inter-professional practice is required (Brockington et al., 2011; Darlington, Feeney, & Rixon, 2005; Korhonen et al., 2008; Maybery & Reupert, 2009; Seeman, 2013) along with a commitment of all team members to adopt a whole family approach (Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Toikka & Solantaus, 2006). Moreover, environmental design that allows close physical proximity of the various disciplines with each other may also facilitate interagency co-operation and thereby FFP (Beck, Weis, Greisen, Andersen, & Zoffmann, 2009; Coyne et al., 2013; Lauritzen et al., 2014b). Availability of services for children and capacity to refer children to these services is particularly important considering mental health professionals may not be able to meet all of

the needs of service users' children (Korhonen et al., 2008; Nicholson, in press; Reedtz et al., 2012).

Caring for parents in community settings is also thought to enable FFP as it provides mental health professionals with opportunities to care for parents within their home environments and to observe normal family life (A. Davies, 2004; Devlin & O'Brien, 1999; Doucet et al., 2012; Jackson & Darbyshire, 2004; Slack & Webber, 2008), to use the case management approach (Khalifeh, Murgatroyd, Freeman, Johnson, & Killaspy, 2009; Liangas & Falkov, 2014; Montgomery et al., 2006; Nicholson, 2010; Seeman, 2013), to have sustained contact with parents (Dearing, 2004; Hauck, Rock, Jackiewicz, & Jablensky, 2008; Houlihan et al., 2013; Korhonen et al., 2008; Slack & Webber, 2008), to form partnership with parents (Daro, 2009; Gomby, 2005; Scott et al., 2007) and to permit flexibility in service delivery to accommodate parents' needs (Moore et al., 2012). It is also contended that family friendly visiting facilities, within in-patient settings, may enable FFP by providing an opportunity for children to visit their parents whilst hospitalised and at the same time allow mental health professionals to interact with children (Arney & Scott, 2010; Houlihan et al., 2013; Maybery & Reupert, 2009; O'Brien, Anand, et al., 2011; Royal College of Psychiatrists, 2011; SCIE, 2009). Finally, parents, children and families' understanding of the impact of PMI on children's well-being is thought to reduce their resistance to FFP (Falkov, 2012; Maybery & Reupert, 2009) and workforce capacity to provide psycho-educational interventions to parents, children and family members can enable this (Korhonen, Pietilä, et al., 2010; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maybery & Reupert, 2009).

Enablers related to mental health professionals' personal attributes may also facilitate mental health professionals' capacity to engage in FFP, despite the existence of

organisational barriers (Coyne et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen & Reedtz, 2013; Lauritzen et al., 2014a, 2014b). These personal qualities include their own parenting experience (Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010), positive attitudes towards parents who have mental illness, their children and families (Nicholson, in press) and capacity to harness parents' strengths (Krumm et al., 2013; Moore et al., 2012; Nicholson, in press), cultural awareness (Falkov, 2012; Moore et al., 2012; Nicholson, 2010) and a willingness and capacity to engage in FFP (Arney & Scott, 2010; K. Foster et al., 2012; Korhonen et al., 2008; Lauritzen et al., 2014b; SCIE, 2009; Toikka & Solantaus, 2006).

The current study aims to examine the core components of RPNs' FFP. This includes RPNs' capacity to engage in FFP and whether there are factors that predict, impede and enable FFP and the manner in which FFP is operationalised or enacted. It is anticipated that such information will have relevance for the field of implementation science as "the work of nurses and other professionals is a vital 'bottom-up' component in effective care for children and families" (K. Foster et al., 2012, p. 6) and the processes employed by organisations to implement FFP are as important as FFP itself (Aarons, Hurlburt, & Horwitz, 2011; Lauritzen et al., 2014b). By identifying predictors and enablers, and how they may impact on FFP, mental health service managers and funding bodies may be informed as to how to implement and sustain a whole family approach within adult mental health services in Ireland and elsewhere (Curran, Mukherjee, Allee, & Owen, 2008; Lauritzen et al., 2014b; Mildon & Shlonsky, 2011). This information may help inform development of initiatives that allow mental health professionals to identify service users' parenting status and embed parenting roles into continuing treatment and care (Krumm et al., 2013; Lauritzen et al., 2014b; Maybery & Reupert, 2009).

Chapter 2: Conceptual Framework

This chapter outlines the conceptual framework employed in this study. Initially outlined is an overview of the Family Model (Falkov, 2012) and this is followed by a discussion of the Model's six domains. The chapter concludes by highlighting the relevance and integration of the Family Model into the current study.

Overview of the Family Model

The Family Model was developed by a child and adolescent psychiatrist, Dr Adrian Falkov. Originally developed in 1998 (Falkov, 1998), the Model was subsequently modified in response to its application in various practice contexts. The latest developments in the Model were published in a family handbook in 2012 (Falkov, 2012). The Family Model provides a conceptual framework to support the implementation of FFP within general adult mental health services and is comprised of six domains and that can be used by mental health professionals, including RPNs, to consider the parent, the child and the family, as a whole, when assessing the needs and planning care packages for families where a parent has a mental health problem (Falkov, 2012). It is proposed that each domain is influenced by every other domain, highlighting the relevance of a systems and developmental approach to assessment and intervention (see Figure 2.1). It is suggested that the Family Model can be used by researchers as a conceptual framework to guide their investigations of mental health professionals' FFP (Falkov, 2012).

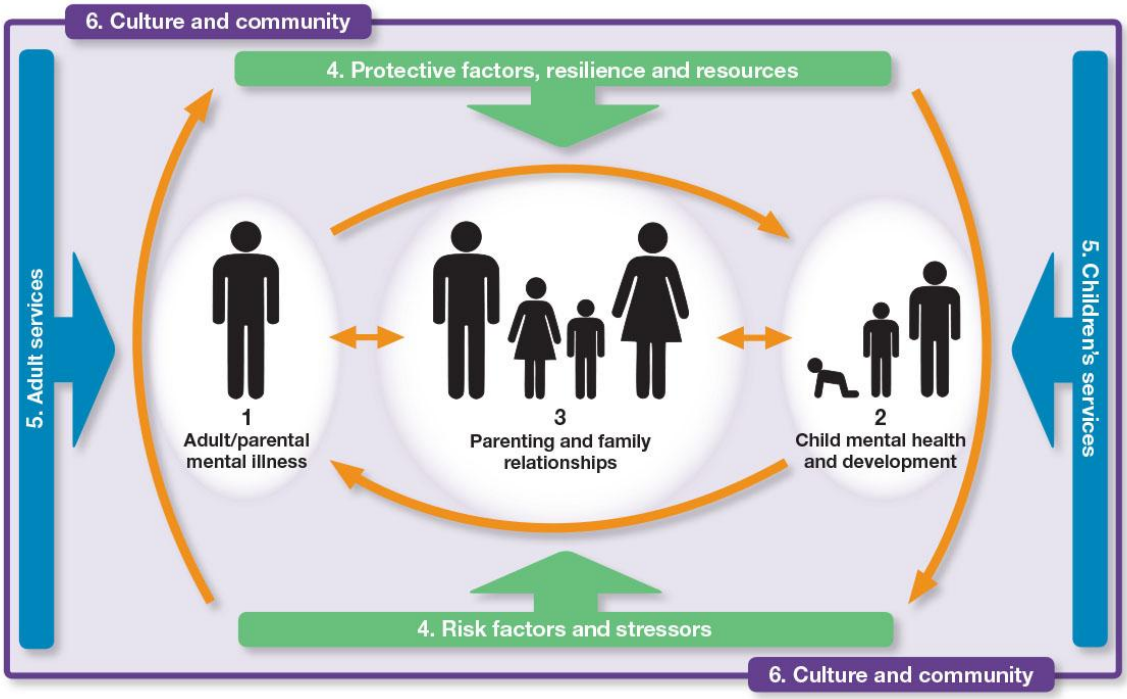


Figure 2.1: Falkov's (2012) Family Model

The six domains illustrate how the mental health and well-being of the children and adults in a family, where a parent is mentally ill, are intimately linked. For example:

1. Adult/parental mental illness (domain 1). PMI can negatively impact children's development, mental health and safety (an adult/parent-to-child influence) (domain 1 → 2).

2. Child mental health and development (domain 2). Children, especially those with behavioural, emotional or chronic physical difficulties, can precipitate or aggravate mental health problems in their parents/carers (a child-to-parent influence) (domain 2 → 1).

3. Family relationships and parenting (domain 3). Growing up with a mentally ill parent can adversely affect the quality of an individual's adjustment in childhood and in adulthood, including the individual's transition to parenthood (a childhood-to-adulthood lifespan and family influence) (1 → 3).

4. Risk factors and stressors as well as protective factors, including available resources (domain 4). Negative circumstances (poverty, lone parenthood, social isolation, stigma) can adversely affect both parents and children's mental health and generate resilience (an environment-to-family influence).

5. Services for children and adults (domain 5). The quality of contact/engagement between individuals, families, practitioners and services is of central importance to the overall outcome for all family members (a service-to-family influence).

6. Cultural influences and broader social and community networks (domain 6). The above principles and their relationships with each other occur within a broader social network encompassing cultural and community influences (a broader, more distal, environment-to-family influence) (Falkov, 2012).

The following section discusses the six domains with due reference to other relevant research. It should be noted that due to its direct relevance to this thesis domain 5 (services for children and adults) is the final domain discussed in this chapter.

Discussion of Domains with Reference to Key Literature

Adult/parental mental illness (domain 1). Children, who have a parent with a mental illness have an increased risk of developing mental illness through genetic

transmission (Caton, Cournos, Felix, & Wyatt, 1998; Falkov, 2012; Lauritzen et al., 2014b; Reupert & Maybery, 2007; Royal College of Psychiatrists, 2011). However, the symptoms of mental illness may also reduce a parents' capacity to parent (Beardslee, Swatling, et al., 1998; J. G. Johnson et al., 2001; Nicholson, in press; Rutter & Quinton, 1984; Wals et al., 2001), with adverse effects for children's well-being (Brockington et al., 2011; Maybery et al., 2005; Royal College of Psychiatrists, 2011; Singleton, 2007). When the parent's coping mechanisms are exceeded by the demands of the mental illness they may be unable to meet their children's needs especially during acute episodes (Khalifeh et al., 2009; Nicholson et al., 1998a; Rutter & Quinton, 1984; Wals et al., 2001).

The extent of the impact of PMI on children is not determined solely by their parent's diagnosis, but also by the level of their parent's insight, behaviour and functional ability which can vary depending on the type of illness parents have (Aldridge & Becker, 2003; Falkov, 2012). Research on attachment disorganisation has found potential effects of specific severe mental illnesses on parenting. Severely depressed parents and those with schizophrenia and personality disorders may be least interactive with their children and attentive to their needs (Brockington et al., 2011; Campbell et al., 2012; Fletcher et al., 2012; Nicholson, 2010; Nicholson & Henry, 2003; Nicholson & Miller, 2008). In a small number of cases, parents with these conditions may also cause their children grievous bodily harm (Reder, McClure, & Jolley, 2000). Moreover, it is estimated that 42 percent of children subject to care proceedings have a parent who has enduring mental illness (Cleaver et al., 1999). Parental behaviours, such as threat of abandonment and suicidal attempts can be emotionally abusive, while thought disorders, such as delusions and hallucinations, may cause aggression directed to children and an overreaction to stress, and may lead to an increase in the risk of physical abuse for the child (Falkov, 2012; Reder & Duncan, 1999).

However, research also supports the view that severity and chronicity of the parent's diagnosis is more important than diagnosis (Aldridge & Becker, 2003; Falkov, 2012). Mental illness can also vary in terms of its frequency, duration, severity, length of episode and reoccurrence (Falkov, 2012; Somers, 2007). A temporary and minor illness handled by a GP is likely to be much less disruptive to family life than a severe and chronic psychotic illness requiring lengthy treatment from community mental health services or repeated hospitalisation (Falkov, 2012; K. Foster et al., 2005).

Whilst a parent's mental illness may affect their parenting capacity, children can also experience difficulties as a consequence of psychosocial disturbance, socioeconomic disadvantage, unsettled living situations and stigma that may occur as an indirect effect of PMI (Brockington et al., 2011; Gladstone et al., 2011; McLaughlin et al., 2012; Nicholson et al., 1998b; Nilsson et al., 2014; M. M. Silverman, 1989; Social Research Unit, 2013). Moreover, PMI has different effects on children depending on the parents' diagnosis, children's stage of development, resilience, supports, other stressors in children's lives and their attitude and understanding of PMI (Aldridge & Becker, 2003; Falkov, 2012; Nicholson, 2010; Schepman et al., 2011). These factors will be further discussed in domain four in relation to risk factors and stressors.

Child mental health and development (domain 2). Whilst parenthood can promote a parent's recovery (Benders-Hadi et al., 2013; Biebel et al., 2006; Nicholson, in press; Nicholson et al., 2009) it can also negatively affect the parent's illness in a number of ways (Cowling & McGorry, 2012; Hauck et al., 2008; Krumm et al., 2013; Maybery et al., 2005; Nicholson, 2010; Pihkala et al., 2012a). From the moment mentally ill mothers conceive their children they experience a unique set of challenges which can exacerbate their mental illness

(Hauck et al., 2008; Hogg, 2012; Nicholson et al., 1998a; Rutherford & Keeley, 2009; Wan, Moulton, & Abel, 2008). Mothers who have PMI have higher rates of unplanned pregnancies (Burr, Falek, Strauss, & Brown, 1979; Miller, 1990; Miller & Finnerty, 1996; Ritsher, Coursey, & Farrell, 1997; Seeman, 2013; Zemencuk, Rogosch, & Mowbray, 1995), spontaneous miscarriages, stillbirths, and induced abortions (Coverdale, Turbott, & Roberts, 1997) than mothers who do not have mental illness. They may also fail to avail of pre natal care due to fears regarding custody loss (Miller & Finnerty, 1996; Mowbray, Oyserman, Zemencuk, & Ross, 1995). Furthermore, psychotic denial of pregnancy happens with greater frequency in women who have previously lost custody of children (Miller, 1990; Miller & Finnerty, 1996). Mentally ill mothers may also decide to stop taking medications during pregnancy in an effort to protect their babies (Nicholson et al., 1998a) and experience a relapse of their mental illness as a consequence (Empfield, 2000). Giving birth or commencing child rearing may also trigger the onset of illness for parents who are vulnerable. Postnatal depression and psychosis are examples affecting mothers, but fathers may also become ill as a result of the stress and role changes around the time of the birth of a child (Doucet et al., 2012).

The period following the birth of a child is characterised for many mothers by low spirits, low confidence and little energy, but for mothers with pre-existing mental health problems a relapse of their mental illness may be experienced (Hansson et al., 2013; Nicholson et al., 2001; Seeman, 2013), particularly if they receive insufficient support. Beyond the postnatal period, many parents with mental illness are subjected to increasing stress as they experience particular challenges in managing their illness in the context of their daily lives (Bunting & Galloway, 2012; B. Davies & Allen, 2007; Hansson et al., 2013; Marryat & Martin, 2010; Nicholson, 2010). Parents who have mental illness experience the

normal stresses and challenges of parenting along with additional stressors related to juggling the demands of their mental illness and their parenting role (Doucet et al., 2012; Nicholson, 2010; Nicholson et al., 1998a; Reupert & Maybery, 2011; Seeman, 2013). 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 (Nicholson, in press).

Many parents who have mental illness may also have children who have physical, emotional or behavioural issues (Kilmer, Cook, & Palamaro Munsell, 2010; Swartz et al., 2005; Vidair et al., 2011). In these situations a vicious process exists whereby a parent's mental illness impacts on their children's well-being and then children's additional needs impact further on the parent's mental health (Falkov, 2012; Nicholson et al., 1998a). Many of these children will require appointments with treatment providers and therapy and/or medication (Falkov, 2012). Having to juggle the demands of managing their own mental illness and additional responsibilities of managing their children's problems can further heighten the risk of parents' relapse (Falkov, 2012; Nicholson et al., 1998a; Nicholson et al., 1998b). Furthermore parents may feel blamed or responsible for their children's difficulties, whether they fall within the range of 'normal', or are extreme enough to require special attention (Falkov, 2012; Nicholson et al., 2001; Nicholson et al., 1998a) and this further compounds their difficulties.

Parents may also neglect their own mental health in an effort to meet children's needs. For example, parents may have difficulty in attending appointments or using day care services, due to a lack of social support and child minding facilities, and therefore delay seeking help until a full blown crisis develops (Diaz-Caneja & Johnson, 2004; Nicholson, 2010; Nicholson et al., 1998a). A parent's treatment, such as psychotherapy, may also require

time and monetary resources that impact on other household needs. Therefore in an attempt to meet their children's needs, parents may sacrifice their own well-being, by ceasing their medication and failing to attend appointments and services (Nicholson et al., 1998a; Nicholson et al., 1998b). Parents may also avoid hospitalisation for their illness, even when necessary, because they do not know what will happen to their children while they are in hospital (Falkov, 2012; Nicholson et al., 1998a). They may also feel that they are a 'bad parent' for focusing on their own needs (Nicholson, in press).

Family relationships and parenting (domain 3). As PMI may affect family relationships and parenting, it may also jeopardise the development of a bond between parents and their children with long term effects for both parties (Falkov, 2012; Mordoch & Hall, 2008; Nicholson, in press; Nicholson et al., 1998a). Whilst parents' symptoms may affect their capacity to have a positive relationship with their child(ren), other aspects of their illness may also interfere with family relationships and parenting, including parents' recurrent and sustained admission to hospital (Diaz-Caneja & Johnson, 2004; Nicholson, in press; O'Brien, Anand, et al., 2011; J. A. Smith, 2004). "For children, hospitalisation is considered one of the most stressful aspects of coping with a parent's mental illness" (H. Sivec & Masterson, 2009, p. 1) and can lead to significant subsequent difficulties in parents' relationships with their children (Diaz-Caneja & Johnson, 2004; O'Brien, Anand, et al., 2011). As a consequence of a parent's hospitalisation, up to 37 percent of children may experience sleep disturbance and a decline in their school work (H. Sivec & Masterson, 2009). If parents are hospitalised for an extended period children may also experience confusion, social withdrawal, frustration and sustained anxiety (Mordoch & Hall, 2008; H. Sivec & Masterson, 2009). Absence of a care giver for extended periods of time may also

make a child vulnerable to attachment disturbances (Falkov, 2012; O'Brien, Anand, et al., 2011; Rutter & Quinton, 1984). If the child is very young (under 3 years old) when the first separations from an attachment figure occur, or if there are several separations in which the parent is replaced by different carers each time, the child's vulnerability may be increased (Falkov, 2012; Rutter & Quinton, 1984). Although some children may not show obvious signs of distress during their parent's hospitalisation (H. Sivec & Masterson, 2009), symptoms and concerns can occur later, when the child is older (Falkov, 2012; O'Brien, Anand, et al., 2011). This is especially true if parents have frequent relapses and long and multiple periods of hospitalisation and/or children have to go into foster care because they have no relatives to look after them (Bassett et al., 1999; Nicholson et al., 1998a; Rutter & Quinton, 1984). This effect is mediated somewhat if the other parent is a strong positive influence during these difficult times (Falkov, 2012; Judge, 1994; Mordoch & Hall, 2008; Nicholson et al., 1998a).

Even if parents are not hospitalised, an inability to have sustained emotional engagement with their young children can still affect children's adjustment in childhood and adulthood (Falkov, 2012; Rutter, 1989). Lack of emotional engagement of the parent, with their children, may hamper children's ability to regulate emotions and interact socially (Nicholson et al., 1998a; Rutter, 1989). This may then have effects on children's capacity to form supportive relationships throughout the course of their lives with long term effects for their mental health and well-being (Falkov, 2012; Nicholson, in press; Rutter, 1989).

Children who are abused and/or neglected by their parents may also experience more long term effects of PMI. The 'survival skills' that abused children may develop in order to cope with the trauma of victimization may also mitigate against healthy functioning when

they are adults (Falkov, 2012; Nicholson, 2010; Rutter, 1989). For example, children exposed to repeated trauma, such as physical abuse, may learn to depend on denial, avoidance or withdrawal to deal with stress (Nicholson, 2010; Rutter, 1989). Therefore as adults, they may have difficulty in establishing relationships characterised by trust and intimacy (Falkov, 2012; Nicholson, in press; Nicholson et al., 2001; Rutter & Quinton, 1984). Adults who were victimized as children may also resort to substance abuse in an attempt to erase their painful childhood memories (Nicholson, 2010; Nicholson et al., 2001). Others will also experience depression and anxiety and may have feelings of low self-esteem, guilt, and shame (Harris & Landis, 1997; Nicholson, 2010; Read & Bentall, 2012; Rutter & Quinton, 1984). Consequently, adult children of parents with mental illness, who have been abused, may have difficulty trusting their own assessments of their children's needs and their ability to meet them (Nicholson, 2010; Nicholson et al., 2001). They may also have unrealistic expectations regarding their children's development or behaviour, and may not know how to stimulate their children's development through play (Nicholson, 2010; Nicholson et al., 2001). Their children's developmental stages or ages, or their particular experiences, may also remind them of unpleasant times in their own past, and may trigger flashbacks, or contribute to their anxiety or depression (Nicholson, 2010; Nicholson et al., 2001). Adult children, of parents with mental illness, may also be unable to establish a physically and emotionally safe home environment for their children if they have never experienced a safe home environment themselves (Nicholson, 2010). If they have been disempowered by their victimization experiences they may also have difficulty advocating for themselves or their children (Nicholson, 2010; Nicholson et al., 2001).

Risk factors and stressors as well as protective factors, including available resources (domain 4). Many families who have a parent who is mentally ill will experience

various risk factors that stem from the indirect effects of mental illness and these compound their difficulties. For instance, many parents who have mental illness are also dealing with struggles related to marital discord, lone parenting, poverty, stigma and social isolation (Baker & Lees, 2014; Bassani et al., 2009; Nicholson, 2010; Nicholson et al., 1998b; Reupert & Maybery, 2007). As a consequence of poverty, many parents and their families also experience housing and transport problems (Falkov, 2012; Nicholson, 2010; Nicholson et al., 1998a), substance abuse, health problems and crime victimization (Harris & Landis, 1997; Nicholson, in press; Nicholson et al., 1998b; Ritsher et al., 1997; Sands, 1995).

Individual risk or stress factors, on their own, do not necessarily have a serious effect on parenting capacity or children's mental health. However, some parents with mental health problems will face multiple adversities (Falkov, 2012; Nicholson et al., 1998b). Risk factors are also cumulative – the presence of more than one increases the likelihood that the problems experienced and impact on the child and parent will be more serious (Falkov, 2012; Keyes et al., 2012; Nicholson et al., 1998b). Risks, stressors and vulnerability factors of each family member interact with the protective factors and resources available to each of them (Falkov, 2012; Nicholson, in press; Nicholson et al., 1998b). Risks can also change over time and create acute problems. For example, parents' hospitalisation can represent a significant crisis in terms of family life. Everyday routines are disrupted, other adults are overstretched, and both parents and children often feel worried and powerless (Falkov, 2012; Nicholson, in press; Nicholson et al., 1998b). In general, whilst all children may be affected by PMI, younger children are particularly vulnerable and less able to cope (Falkov, 2012; Mordoch & Hall, 2008).

The experience of adversity can also lead to development of resilience in parents with mental illness, their children and families (Aldridge, 2011; Falkov, 2012; Nicholson et al., 1998b; Schepman et al., 2011; Walsh, 2011). Hence, the presence of mental illness does not in itself preclude effective parenting nor are all children of parents, who are mentally ill, adversely affected (Falkov, 2012; Reupert et al., 2010; Rutter & Quinton, 1984). This also means that not all children in the same family will be affected in the same way (Beardslee, Versage, et al., 1998; Gladstone et al., 2006).

Whilst it may not be possible to readily change adversities that families experience (i.e. adverse socioeconomic circumstances), promoting and supporting protective factors, such as social supports, can help reduce the negative impact of a parent's mental illness on them and their children (Falkov, 2012; K. Foster et al., 2012; Mordoch & Hall, 2008; Nicholson, 2010; Nicholson et al., 1998b). Promoting children's coping skills also appear to reduce their risk of negative outcomes (Beardslee, Versage, et al., 1998; Gladstone et al., 2006). Information and understanding about PMI can assist children to cope with PMI and accompanying stigma (Beardslee et al., 2012; Pihkala et al., 2012a; Punamaki, Paavonen, Toikka, & Solantaus, 2013; Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009). Secure attachments between parents and their children are also an important factor in promoting children's resilience (Falkov, 2012; Mordoch & Hall, 2008; Nicholson, in press; Nicholson et al., 1998b; Ritsher et al., 1997). The presence of another well parent can be beneficial to the development of children's self-esteem and social skills (Falkov, 2012; Mordoch & Hall, 2008; Nicholson, in press; Nicholson et al., 1998b; Schuff & Asen, 1996). Other trusted adults, whether family members, family friends or people known from other aspects of the child's life, can be equally important in fulfilling some of the functions that would otherwise have been performed by the parent with the mental illness (Falkov, 2012;

Mordoch & Hall, 2008; Nicholson, in press; Nicholson et al., 1998b). It is also contended that support from mental health professionals may also be an important protective factor for parents who have mental illness, their children and families (Baker & Lees, 2014; Falkov, 2012; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Nicholson, in press; Royal College of Psychiatrists, 2011). This indicates that there can be important ramifications regarding how an RPN responds to parents when they are receiving mental health services. This will be further considered when discussing services for adults and children (domain five).

Cultural influences and broader social and community influences (domain 6). While domain six is distinct it is also closely related to domain four (risk and protective factors) and hence the discussion of this domain is situated before domain five. Moreover, like the other domains, it also requires consideration within services for children and adults (domain 5). Domain six reflects a central principle of FFP, as discussed in the wider literature, in that it illuminates the importance of recognising that all families are unique and require culturally competent services (recognising and accommodating cultural diversity; (Bailey et al., 2012; Moore et al., 2012).

In line with the existing literature, domain six contends that interaction between factors in parents and children's immediate family/community environment and the societal landscape influences their development and well-being (Bornstein, 2012; Bronfenbrenner, 1979; Charles, Stainton, & Marshall, 2009; Falkov, 2012; Nicholson, 2010). In essence:

> … parents do not parent and children do not grow up in isolation, but in multiple contexts, and one notable context of parenting and child mental health is culture…cross cultural comparisons show that virtually all aspects of parenting children are informed by culture (Bornstein, 2012, p. 258).

Therefore any attempt to improve the life of families, children and parents, in families affected by PMI, must be based on a good understanding of the child and parent within the

family and its environment (Bronfenbrenner, 1979; Charles et al., 2009; Falkov, 2012; Nicholson, 2010). Of particular importance is the influence of stigma, racism and poverty on families' well-being (Falkov, 2012; Nicholson, 2010) and mental health professionals' awareness of these issues and their subsequent attempts to address or at least acknowledge them in the light of the stressors facing the family (Nicholson, 2010). Also important is mental health professionals' capacity and activities in promoting a range of family, neighbourhood and community supports to the family and helping parents to capitalise on their strengths (Falkov, 2012; Nicholson, 2010).

Services for children and adults (domain 5). Another key component of the Family Model, and of particular relevance for this study, is that "the quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members" (Falkov, 2012, p. 16). The far reaching consequences of PMI for parents with mental illness, their children and families, make it imperative for mental health professionals to enquire about parental status when adults seek help from general adult mental health services (K. Foster et al., 2012; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Nicholson, 2010; Reiss, 2011; Reupert, Maybery, et al., 2012; Singleton, 2007) and factor this into ongoing care.

Aside from the recognised impact of PMI on parents, children and adult family members, various other reasons have been presented as to why adult mental health services should address service users' parenting roles. Seeman and Göpfert (2004, p. 11) contended that as adult mental health services have "statutory responsibility for treating parents with mental illness, considerations for the well-being of the children of the parent fall squarely within the psychiatric remit". They further suggest that:

> Knowing whether patients are parents is…critical for primary prevention in psychiatry, for more profound understanding of the patient, and for optimal intervention. It is also crucial for a number of legal/ethical reasons and for humanitarian reasons, so that services can work together to promote a better quality of life for the whole family (Seeman & Göpfert, 2004, p. 12).

Similarly, others have argued that a parent's admission, to mental health services, presents a unique opportunity for prevention of problems for all family members that must not be missed, particularly as these families may have no contact with other services (Liangas & Falkov, 2014; Maybery & Reupert, 2006; Östman & Eidevall, 2005). Mental health professionals have an opportunity to engage children about their experiences of PMI before issues may arise (Korhonen, Pietilä, et al., 2010). Relating to children within an adult mental health context also means an acknowledgement and validation of children's welfare (Falkov, 2012; Lauritzen et al., 2014b; Nicholson, 2010). Moreover, determining parenting status and recognising the varied roles that service users have, including parenting, is central to recovery orientated care (Benders-Hadi et al., 2013; Nicholson, in press). The hope for a better quality of life for their children and family may be of critical importance in a parent's recovery (Nicholson, in press). Hence, mental health professionals cannot meaningfully relate to parents without acknowledging children's important presence in the mental and emotional life of the parent (Benders-Hadi et al., 2013; Falkov, 2012; Nicholson, 2010).

In addition, with appropriate supports parents can be caring and effective parents (Lauritzen et al., 2014b; Liangas & Falkov, 2014; Nicholson, 2010; Royal College of Psychiatrists, 2011). Similarly, children can be facilitated to cope with their parents' mental illness and manage to thrive despite the problems they may encounter (AICAFHMA, 2001; Falkov, 2012; Lauritzen et al., 2014b; Nicholson, in press; Toikka & Solantaus, 2006). Falkov (2012) suggests that for mental health professionals to provide optimal support for parents and their families they should address the six domains within the Family Model, the

relationships between these domains, and employ a longitudinal life span approach to look beyond a family's immediate crisis (Falkov, 2012). Moreover, to use the model in practice, mental health professionals, including RPNs, need to adopt a whole family approach and collaborate across professional and service boundaries (Baker & Lees, 2014; Nicholson, in press).

Relevance and Integration of the Family Model in the Current Study

Although Falkov's Model is informed by his experience as a child and adolescent psychiatrist in Australian and English mental health services he contends that the Model has been easily translated in other contexts and countries due to its simplicity and comprehensiveness in detailing the various elements that require consideration when a parent has a mental illness (Falkov, 2012). There are several theoretical models that could have been used including Bronfenbrenner's Ecological Theory (Bronfenbrenner, 1979), Hosman and colleagues' Developmental Model of Trans generational Transmission of Psychopathology (Hosman et al., 2009) and Nicholson and Henry's Parent-child Functioning and Potential Intervention Targets Model (Nicholson & Henry, 2003). The Falkov Model is attractive to the study of RPNs' FFP as it considers the needs of both parents who have mental illness, their children and to lesser extent adult family members and highlights the link between parenthood and mental illness. The model acknowledges the needs of children and parents through identifying the reciprocal relationship between a parent's mental illness and children's well-being, an important factor because to date the literature has not sufficiently emphasized the effects of children's mental health and development on parents' well-being and parents' needs in relation to this (Falkov, 2012). Equally important and relevant to the

present research, domain five explicitly considers the role of services, including general adult mental health services, in supporting parents who have mental illness, their children and families.

The Family Model also embodies principles underpinning other related models as detailed above (Bronfenbrenner, 1979; Hosman et al., 2009; Nicholson & Henry, 2003). These three models have similar components to that of the Family Model in that they acknowledge that "parents and children's functioning, well-being and experiences are intimately intertwined" (Nicholson, 2010, p. 365) and "If parents do better, children do better and vice versa" (Nicholson, 2010, p. 367). They also address the impact of a child's immediate environment, including family environment and children's community and institutional supports, social networks and professional care. However, unlike the Family Model, the reciprocal nature of parents' mental illness and children's well-being is not explicit in these models, hence reducing their relevance for use in the current study, especially as the primary aim is to examine RPNs' practice in supporting parents who have mental illness. The Family Model is used within the current study to structure the subsequent literature review and as a framework to guide the methodology and discussion.

Summary

Falkov's Family Model, when used in conjunction with the wider literature, is a useful conceptual framework for examining RPNs' FFP, with parents who have mental illness, their children and families. Essentially, the model suggests that because of the reciprocal inter-relationships amongst several domains, an integrated family focused model of service delivery is required, within general adult mental health services. Hence, to provide

optimal support for all family members, RPNs need to acknowledge and address the individual and family needs of service users, including children.

As previously noted, in order for RPNs to engage in FFP, and address the needs of parents, children and adult family members, the necessary resources must also be in place. The following chapter will explore the response of adult mental health services in meeting the needs of families when a parent has a mental illness.

Chapter 3: Literature Review

This chapter will outline the needs of parents who have mental illness, their children and families, before proceeding to outline good practice in supporting parents and their families, as recommended by Falkov (2012) and the wider literature. After discussing the implications of the Family Model and wider literature for RPNs' FFP, the reasons why RPNs could be key players in supporting parents who have mental illness, their children and families will be explicated. The remainder of the chapter will review the response of general adult mental health services to parents who have mental illness, their children and families. This entails a comparison in developments in family focused policy and practice in the International and Irish context. Various stakeholders' perspectives of RPNs' FFP are then considered including, parents, children, adult family members and RPNs themselves. This literature suggests that various barriers exist to the adoption of a whole family approach in practice. The chapter closes by identifying gaps in the existing literature and how the current study will address these gaps. Finally, the research aims and questions underpinning this study are presented.

Needs of Parents, Children and Adult Family Members

All members of the family have needs in relation to the direct or indirect effects of PMI but children may be particularly impacted. As previously noted, domain one in Falkov's Family Model highlights the impact of PMI on children's well-being (Falkov, 2012). Children's difficulties may be evidenced in non-attendance at school, anxiety, depression, poor peer relationships, low self-esteem, delayed speech development, eating and sleeping

problems and aggressive behaviour (Fudge & Mason, 2004; Giallo, Cooklin, Wade, D'Esposito, & Nicholson, 2013; Maybery et al., 2005; Nilsson et al., 2014; Riebschleger, 2004; Somers, 2007; Stallard et al., 2004).

Whilst children of parents who have mental illness may have additional needs, as outlined above, their parents might be unable to meet their needs as they may be consumed by their own mental health needs (Gamache, Tessler, & Nicholson, 1995; Nicholson et al., 2001; Reupert & Maybery, 2007). Even if children do not have additional needs parents must juggle the demands of their day to day lives or running a household and looking after children with managing their mental illness (Nicholson, in press; Nicholson et al., 1998a; Nicholson et al., 1998b). Consequently they may neglect their children's needs (Ackerson, 2003b; Falkov, 2012; Khalifeh et al., 2009; Liangas & Falkov, 2014; Reupert & Maybery, 2007; Riebschleger, 2004). For example, obtaining services, implementing treatment regimes, and maintaining relationships with service providers require time and energy and may detract from the time parents spend with their children (Ackerson, 2003a; Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998a; Nicholson et al., 1998b) In addition, the medication prescribed to treat the parent's mental illness may further compound their difficulties in parenting by reducing their energy, concentration and capacity to think clearly (Falkov, 2012); making it extremely difficult for a parent to carry out normal daily activities (such as wake up in time to prepare breakfast or get children to school) (Falkov, 2012; Nicholson, 2010). Parents' therapy may also focus their attention on difficult and painful past memories and lead to them being distracted, irritable and depressed (Falkov, 2012).

Research with children suggests that whilst they experience a sense of distress, risk and responsibility when their parent is unwell (Aldridge, 2006; Charles et al., 2009; Handley

et al., 2001; Khalifeh et al., 2009) they may hide their distress in an effort to better manage their problems (Mordoch & Hall, 2008). Moreover, treating acutely unwell parents within the home environment may mean that their children may experience additional stress (Mordoch, 2010; Mordoch & Hall, 2008) and be exposed to significant risks associated with parents' unpredictable behaviour and disrupted parenting capacity (Brockington et al., 2011; Khalifeh et al., 2009). Children may also struggle to sustain effective relationships with their mentally ill parent as a consequence of their symptoms and behaviours (Cowling, 1999; Fudge & Mason, 2004; Handley et al., 2001; Mordoch, 2010; Mordoch & Hall, 2008). For instance, Mordoch and Hall (2008) found that children constantly monitored and adapted to their parent's behaviour in an attempt to remain connected to their parents and to enhance their family stability. Mordoch and Hall (2008) concluded that whilst children need to maintain good connections with their parents they also need to have their own lives, boundaries and identities to avoid being consumed and absorbed by their parent's mental illness. Moreover they need to feel safe and secure within their families and have stability in their daily routines (Mordoch & Hall, 2008). Research also suggests that children need education about PMI to help them understand their parent's unpredictable behaviour and to help them to manage their emotional distress in response to their parent's behaviour (Gladstone et al., 2011; Handley et al., 2001; Maybery et al., 2005; Mordoch, 2010; Mordoch & Hall, 2008). Children also need information to reduce their concern regarding their parent's hospitalisation (Fudge & Mason, 2004; Mordoch & Hall, 2008; O'Brien, Anand, et al., 2011; Riebschleger, 2004; Stallard et al., 2004) and their fears that they too may develop mental illness (Gladstone et al., 2011; Handley et al., 2001).

When parents with mental illness are acutely unwell children may also assume age inappropriate responsibilities, particularly in single parent families. It is estimated that up to

29 percent of all young carers are caring for someone with mental health problems (Dearden & Becker, 2004; Royal College of Psychiatrists, 2011). Older children report having to resolve family conflicts, look after their younger siblings and undertake a range of domestic and emotional care responsibilities until their parent regains their motivation to look after themselves and resume their parenting role (Aldridge, 2006; Cleaver, Unell, & Aldgate, 2011; Dooley & Fitzgerald, 2012; Fives, Keenan, Canavan, Brady, & Cairns, 2010; Gray, Robinson, & Seddon, 2008; Nilsson et al., 2014; The Children's Society, 2013). Children's support for their ill parent can help stabilize their parent's condition, and may even help children's sense of fulfilment and self-esteem (Charles et al., 2009; Gray et al., 2008; Kennan, Fives, & Canavan, 2012). However, it may also cause children to worry about their parents (Aldridge, 2006; Handley et al., 2001) and preclude them from enjoying normal childhood entitlements due to the time required for them to undertake age inappropriate caring responsibilities for their parent and/or siblings (Aldridge & Becker, 2003; Armstrong, 2002; Charles et al., 2009; Reder et al., 2000). Children who care for a mentally ill parent may also have needs arising from restrictions in their education and leisure, and their fears about child protection and family separation (Charles et al., 2009; Gray et al., 2008; Kennan et al., 2012; Maybery et al., 2005; Mordoch & Hall, 2008).

As previously noted, whilst PMI may negatively impact children's development, parenthood may also adversely affect parent's well-being. Domain two in Falkov's Family Model highlights the impact of parenthood on parents' mental health (Falkov, 2012). Parents suggest that they have needs in relation to general parenting that are common to all parents as well as specific needs related to understanding and managing their mental illness and its impact on their parenting capacity (Diaz-Caneja & Johnson, 2004; Montgomery et al., 2006; Nicholson, in press; Nicholson et al., 1998a). Parents worry about meeting their children's

physical needs, their capacity to emotionally connect with their children and exposing their children to distressing symptoms and behaviours (Khalifeh et al., 2009; Nicholson, in press; Nicholson et al., 1998a). They are also concerned about the effects of children having to take age inappropriate responsibilities when they are ill (Falkov, 2012; Khalifeh et al., 2009; Nicholson et al., 1998b) and may worry that any signs of misbehaviour or distress on their children's part are signs that they are developing emotional or behavioural disturbance (Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998a; Nicholson et al., 1998b).

Due to concerns about their children's well-being, parents generally want mental health professionals to support their children and to help them understand the events and circumstances surrounding their mental illness (Diaz-Caneja & Johnson, 2004; Handley et al., 2001; Maybery et al., 2005; Somers, 2007; Stallard et al., 2004). Parents also have needs related to the additional, illness-related challenges of understanding the impact of their illness on their children, and communicating with their children about their illness and recovery (Falkov, 2012; Nicholson et al., 1998a). If parents' mental health deteriorates, to the extent that they need to be hospitalised, their situations become even more difficult as they may have to relinquish the role of parent (Nicholson et al., 1998a). Being forced to relinquish the role of parent, even temporarily because of illness, can cause parents to worry about their children's welfare and make them feel like a failure (Doucet et al., 2012; Nicholson, 2010; Nicholson et al., 1998a; O'Brien, Anand, et al., 2011). The need to have their children looked after by others can make parents vulnerable to experiencing greater depression and anxiety as it may exacerbate their low self-esteem and negative thinking (B. Davies & Allen, 2007; Nicholson, 2010).

Both parents and their children also have needs related to disruptions in family relationships and parenting (domain 3). Disruptions to parents and children's relationships may occur for a variety of reasons (Nicholson, in press; Royal College of Psychiatrists, 2011; Singleton, 2007). For instance, as previously noted, a parent's mental illness may lead them to abuse or neglect their child(ren) (Bass & Jones, 2011; Nicholson, 2010; Reder et al., 2000; Royal College of Psychiatrists, 2011). Hence to protect children's mental health and development needs, parents with mental illness may lose custody of their children on a temporary or permanent basis (Hollingsworth, 2004; Mason, Subedi, & Davis, 2007; Nicholson, in press; Nicholson et al., 2006; Seeman, 2013). While custody loss may adversely affect the parent's mental health (Mowbray et al., 2001; Nicholson et al., 1998b; Oyserman, Mowbray, Meares, & Firminger, 2000; Zemencuk et al., 1995) it may also have long term detrimental effect on the parent-child relationship (Nicholson, 2010, in press; Nicholson et al., 1998a). Even if children are only temporarily placed in foster care it can be difficult for parents to maintain relationships with their children (Nicholson, 2010; Nicholson et al., 1998a; Nicholson et al., 1998b). Visits may be stressful to both parent and child, particularly if not well planned or managed, as they may find it difficult to communicate with one another and be reminded of their losses each time a visit ends (Nicholson et al., 1998a; Nicholson et al., 1998b). In addition, parents' awareness that their behaviour will be constantly monitored and that the incidence of custody loss is high creates additional stress (Nicholson et al., 1998a; Nicholson et al., 1998b). Fear of losing custody contributes to parents' distress and further deters them from acknowledging and disclosing their problems and requesting services (Miller, 1990), which may exacerbate their illness and problems in parenting (Hearle, Plant, Jenner, Barkla, & McGrath, 1999; Nicholson, in press; Nicholson et al., 1998a; Nicholson et al., 1998b). If parents' fears are realised and their parental rights are

terminated, they may lose their motivation to recover, and may experience further deterioration in their mental state (Nicholson, in press; Nicholson et al., 1998a; Nicholson et al., 1998b). The termination of parental rights may have lifelong effects for parents who experience chronic sadness and grieve the loss of their child/ren (Mowbray et al., 1995; Nicholson, 2010; Nicholson et al., 1998a; Nicholson et al., 1998b). This ongoing grief may also perpetuate the parents' mental illness (Dipple, Smith, Andrews, & Evans, 2002; Joseph, Joshi, Lewin, & Abrams, 1999; Nicholson et al., 1998a). Similarly, children worry about being separated from their parent and this fear may reduce their capacity to seek support in coping with PMI and further compound their problems (Aldridge, 2011; Aldridge & Becker, 2003; Fudge & Mason, 2004; Handley et al., 2001).

Parents, their children and families may also have needs related to risk factors and stressors (domain 4) and cultural influences and broader social and community networks (domain 6). As previously noted, as a consequence of direct and indirect effects of PMI, parents and their families may have limited social supports (Falkov, 2012; Nicholson, 2010; Nicholson et al., 1998a). For instance, relationships may be strained as parents with mental illness' partners and extended family may find it difficult to cope with changes in their behaviour, energy levels, mood and contribution to household chores and activities (Ackerson, 2003b; Fudge & Mason, 2004; Miller, 1997; Nicholson et al., 1998b). As a consequence, parents with mental illness are likely to have less support in the parenting role while struggling with debilitating illnesses that affect their cognitive and emotional abilities (Aldridge & Becker, 2003; Falkov, 2012; Nicholson, 2010; Nicholson et al., 1998b). Even if parents with mental illness are not isolated from their relatives, or partners, assistance with childcare may not always be constructive or helpful for the parent if family members do not understand the parent's mental illness, blame them for problems that arise or take over and

assume parenting responsibilities for the parent (Falkov, 2012; Nicholson & Blanch, 1994; Nicholson et al., 1998a; Nicholson et al., 1998b). Socioeconomic circumstances may be an additional stressor for parents and their families and can compound their social isolation (Falkov, 2012; Nicholson, in press; Nicholson et al., 2001). Hence, parents have indicated that to address their socioeconomic needs they want mental health professionals to link them in with additional supports and services (Alakus, Conwell, Gilbert, Buist, & Castle, 2007; Gladstone et al., 2011; Khalifeh et al., 2009; McNeil, 2013; Nicholson, in press).

Mothers' experiences of managing stigma and their dual identities as mothers and women who are mentally ill is also a prevalent theme in the literature (Beresford et al., 2008; Diaz-Caneja & Johnson, 2004; Montgomery et al., 2006; Nicholson, 2010; Nicholson et al., 1998a). Mentally ill women may experience stigma even before they become pregnant (Nicholson, in press; Nicholson et al., 1998a), and their normal desire to bear and raise children is undermined by negative societal attitudes (B. Davies & Allen, 2007; Nicholson et al., 1998a; Nicholson et al., 1998b). As having a mental illness is not part of the idealisation of motherhood, for many mentally ill mothers accepting the diagnosis of a mental illness can mean accepting a failure to achieve the ideal of motherhood (B. Davies & Allen, 2007). Having to prove themselves as parents, sometimes to unrealistic standards (Nicholson et al., 1998a; Nicholson et al., 1998b) exacerbates mothers' difficulties in parenting and in managing their mental illness (Bassett et al., 1999; Benders-Hadi et al., 2013; Diaz-Caneja & Johnson, 2004; Joseph et al., 1999; Nicholson et al., 1998b). Parents have suggested that in order for them to disclose their problems they need mental health professionals to be non-judgmental and to recognise the central role that their parenting role and children have in their lives (Nicholson, in press). They also need mental health professionals to help them advocate for themselves and their children and to assert their rights as parents (Fudge &

Mason, 2004; Nicholson, in press). Children can also experience social isolation, bullying and secondary stigma as a result of their parent's mental illness (Mordoch & Hall, 2008; Nicholson et al., 2001; Reupert & Maybery, 2007; Reupert, Maybery, et al., 2012; Thomas & Kalucy, 2003) and need help to integrate and fit in within their communities and at school (K. Foster, 2010; Mordoch & Hall, 2008; Nicholson et al., 2001) and to open up to people they trust (Handley et al., 2001; Mordoch, 2010; Mordoch & Hall, 2008; Thomas & Kalucy, 2003).

Finally, and most importantly in terms of this thesis, research suggests that parents, children and adult family members want health care professionals (i.e. Family Model Domain 5), including mental health professionals in adult mental health services, to address their needs; particularly in relation to understanding PMI, and how to cope with their illness in regard to parenting, children and their daily lives (Baker & Lees, 2014; B. Davies & Allen, 2007; Doucet et al., 2012; Khalifeh et al., 2009; Maybery et al., 2005; Mordoch, 2010; Mordoch & Hall, 2008; Nicholson, 2010; O'Brien, Anand, et al., 2011). Parents report that within mental health services they need a consistent key worker who is aware that they are a parent and conveys to them that they perceive them as capable of parenting despite having a mental illness (B. Davies & Allen, 2007; Diaz-Caneja & Johnson, 2004; Hauck et al., 2008; Montgomery et al., 2006). Parents have also suggested that they need mental health professionals to engage in effective interagency collaboration so that they could be linked in with additional supports and services (Alakus et al., 2007; Gladstone et al., 2011; Khalifeh et al., 2009; McNeil, 2013). Mothers have also reported that they need realistic plans, achievable goals with well specified action steps and people they trust to help with their plan in order to recover from an acute phase of their mental illness (Nicholson, in press, p. 21).

Children have also reported that they want mental health professionals to recognise that they are important to their parent's well-being and want support, information and reassurance from mental health professionals who are caring for their parents (Aldridge & Becker, 2003; Gladstone et al., 2011; Mordoch, 2010; Mordoch & Hall, 2008; O'Brien, Anand, et al., 2011; Stallard et al., 2004). Older children also want mental health professionals to recognise that sometimes they may be undertaking caring roles and responsibilities that they may, or may not want to take, or that may be difficult (Aldridge & Becker, 2003; Charles et al., 2009; Falkov, 2012; Khalifeh et al., 2009). Moreover, children want mental health professionals to involve them in decision making when possible and ascertain whether they wish to continue, reduce or to stop caring for their mentally ill parent (Aldridge & Becker, 2003; Grant et al., 2008). For further information about parents and children's needs please see appendix A.

Implications of the Family Model and Wider Literature for Mental Health Professionals' FFP

This section outlines the implications of Falkov's Family Model and wider literature for RPNs' practice with parents who have mental illness, their children and families. In doing so recommendations regarding good practice in supporting parents, children and adult family members to meet their needs are made.

Falkov (2012) recommended that mental health professionals, including RPNs, should consider all domains of the Family Model if they are to effectively assess and support parents who have mental illness, their children and families. He also articulated a vision for family focused mental health services to include:

> The development of a competent, confident, positive workforce, that is able to identify families (parents and children), assess, screen, intervene according to level and type of need, and that is able to refer appropriately, work collaboratively and evaluate practice routinely (Falkov, 2012, p. 243).

As domain one and two highlight the reciprocal relationship between parents and children's well-being, RPNs need to identify if service users are parents of dependent children, upon admission to mental health services, and if they are to factor this into their ongoing care (Benders-Hadi et al., 2013; K. Foster et al., 2012; Krumm et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Mordoch & Hall, 2008; National Institute for Health and Care Excellence [NICE], 2009; Nicholson, 2010; Reedtz et al., 2012; Seeman, 2013; Vidair et al., 2011). The Royal College of Psychiatrists (2011) recommend that:

> Any assessment should measure the potential or actual impact of mental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on the adults' mental health. Appropriate support and ways of accessing it should also be considered in the assessment (p.8).

Effectively this requires RPNs to address service users' needs related to their parenting role and mental illness within the same clinical encounter (Cowling, Luk, Mileshkin, & Birleson, 2004; B. Davies & Allen, 2007; Montgomery et al., 2006; Nicholson, 2010).

Addressing domains one, two and three, RPNs could help parents to understand their mental health problems, their treatment plan and the potential impact of mental health problems on their parenting, the parent-child relationship and the child (Ackerson, 2003b; Falkov, 2012; Fudge & Mason, 2004; Nicholson, 2010; Royal College of Psychiatrists, 2011; Seeman, 2013). By educating parents about their mental illness they may be able to minimise the effect of PMI on themselves and their children (Moore et al., 2012; Nicholson, 2010; Reedtz et al., 2012; Toikka & Solantaus, 2006; Trivette, Dunst, & Hamby, 2010). Educating parents may also help parents to sustain relationships with their children (Montgomery et al., 2006; Nicholson, 2010; Seeman, 2013) and reduce the likelihood of their children

experiencing long term problems (Nicholson, in press; Seeman, 2013). In turn this may also promote parents' mental health (Baker & Lees, 2014; Diaz-Caneja & Johnson, 2004; Falkov, 2012; Nicholson, in press).

RPNs should also work with children (with the parent's consent) to enable children to understand what is happening to their parent (Gladstone et al., 2011; Krumm et al., 2013; Maybery et al., 2005; Mordoch, 2010; Mordoch & Hall, 2008; Nicholson, in press; Solantaus & Toikka, 2006) and if children are assuming caring roles and responsibilities within the home to help them to discuss their experiences and concerns regarding this (Aldridge & Becker, 2003; Falkov, 2012; Khalifeh et al., 2009; Mordoch & Hall, 2008). If children have additional needs that cannot be met by RPNs alone, they should endeavour to refer children to various agencies including family support services (Baker & Lees, 2014; Brockington et al., 2011; Cowling & McGorry, 2012; Reedtz et al., 2012; Sheehan, Paed-Erbrederis, & McLoughlin, 2000). In these circumstances, RPNs, in conjunction with their colleagues in other services, should devise strategies for the management of joint cases, and particularly when the situation is complex or there is a high risk of poor outcomes for children and parents (Cleaver et al., 2011; Department of Children and Youth Affairs [DYCA], 2012; Gillam et al., 2003; Hauck et al., 2008; Mordoch, 2010; SCIE, 2012; Verrocchio, Ambrosini, & Fulcheri, 2013). RPNs should also collaborate with other services, including the educational system, to promote children's capacity to manage their emotions and behaviours in response to PMI (Mordoch, 2010).

As domain three highlights that disruptions to family relationships and parenting can have long term effects for children's well-being parents should also be enabled and supported to plan ahead, in the event of the need for hospitalisation for treatment of the acute phase of

their mental illness (Krumm et al., 2013; Nicholson, in press; Nicholson et al., 1998a; Reupert et al., 2010; H. Sivec & Masterson, 2009) and to remain in contact with their children when hospitalised (Doucet et al., 2012; Mordoch & Hall, 2008; O'Brien, Brady, et al., 2011; Royal College of Psychiatrists, 2011; H. J. Sivec & Montesano, 2012). Parents should also be facilitated to remain in contact with their children, when possible, if they lose custody of their children (Diaz-Caneja & Johnson, 2004; Dipple et al., 2002; Nicholson, 2010; Nicholson et al., 1998a; Royal College of Psychiatrists, 2011).

As domain four suggests; risk factors, stressors and protective factors can all influence family outcomes of PMI (Falkov, 2012). Assessment and subsequent interventions need to focus on both parental symptoms and behaviours as well as socioeconomic factors that affect parents and their families; including poverty, isolation, domestic violence, insecure housing and substance misuse (K. Foster et al., 2012; Krumm et al., 2013; Mordoch & Hall, 2008; Nicholson, 2010; Seeman, 2013). Assessment also needs to take into account the strengths of parents and their families (Baker & Lees, 2014; Brockington et al., 2011; Nicholson, in press; Seeman, 2013), with decisions about interventions reflecting how things are while the parent is acutely ill and when they are more well (Falkov, 2012; Nicholson, 2010; Nicholson et al., 1998a; Seeman, 2013). RPNs might also consider what can be done to increase parents, children and families' resilience (Falkov, 2012; Nicholson, 2010; Reupert et al., 2010) and empower parents to use their strengths and resources (Nicholson, 2010), including other trusted adults, to help them to overcome or reduce their difficulties (Aldridge & Becker, 2003; Falkov, 2012; Hansson et al., 2013; Nicholson, 2010).

If RPNs are to detect and respond to parenting difficulties before a crisis occurs, parents also need to be encouraged to disclose their problems in parenting (Doucet et al.,

2012; Falkov, 2012; Nicholson, 2010; Nicholson et al., 1998a). Whilst stigma and fear of custody loss is likely to impede this (Brockington et al., 2011; Nicholson, in press; Nicholson et al., 1998b; Seeman, 2013) parents' trust may be more readily established if RPNs convey to parents that they are aware of the significance of children in their lives and that they would like to work in partnership with them to support them in their role as parents (Diaz-Caneja & Johnson, 2004; K. Foster et al., 2012; Hauck et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Nicholson, 2010; Seeman, 2013). RPNs should also help partners and other adult family members to tap into their informal networks for support (Baker & Lees, 2014; Monahan et al., 2008; Nicholson, in press) as well as facilitating their access to peer support groups to help them cope with disruptions to family relationships and additional care giving responsibilities when parents are unwell (Baker & Lees, 2014; Doucet et al., 2012; Monahan et al., 2008; Nicholson, in press). To assist adult family members to support parents and children, RPNs should give them information about the parents' mental illness and treatment (Doucet et al., 2012; Falkov, 2012; Nicholson, 2010) and how they may best support parents during their ongoing treatment, convalescence and recovery (Doucet et al., 2012; Falkov, 2012; Nicholson, 2010; Royal College of Psychiatrists, 2011). RPNs also need to intervene to promote effective family dynamics when adult family members are unsupportive (Khalifeh et al., 2009; Nicholson, 2010; Nicholson et al., 1998b). Related to domain six, RPNs also need to display sensitivity and understanding of the cultural environment of parents and their family to facilitate opportunities for positive parenting (Bornstein, 2012; Hauck et al., 2008; Nicholson, 2010).

The above recommendations regarding a whole family approach may help to promote the quality of contact/engagement that RPNs have with parents and their families and thereby the overall outcome for all family members (domain 5). However, as previously noted,

RPNs' capacity to adopt a whole family approach is also contingent upon developments in policy, practice guidelines, education and managerial support (K. Foster et al., 2012; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Reupert & Maybery, 2008; Sheehan et al., 2000) and these should be embedded, within multiple levels of organisations, using long term implementation strategies (Lauritzen et al., 2014b; Owen, 2010; Sheehan et al., 2000). It is recommended that national policies, in line with those in Norway, Netherlands, Finland and Sweden be developed to obligate RPNs to identify service users' parenting status on admission to mental health services and factor this in to ongoing care (M. J. Foster et al., 2013; Korhonen, Pietilä, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Nicholson, in press; Reedtz et al., 2012). Furthermore, Maybery and Reupert (2009) contended that mental health workforce competency standards should include principles in relation to knowledge and skills, regarding working with families affected by PMI; this content should also be included in both undergraduate and post graduate programmes and in-service education (Korhonen et al., 2008; Krumm et al., 2013; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Royal College of Psychiatrists, 2011).

As previously noted, other organisational resources, including implementation frameworks (Lauritzen et al., 2014b) family focused frameworks and time to engage in FFP (Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, Pietilä, & Kattainen, 2009; Lauritzen et al., 2014b; Maybery & Reupert, 2009), are also necessary to enable RPNs to engage in FFP, as is supervision opportunities to discuss the emotional challenges of caring for families (Gomby, Culross, & Behrman, 1999; Schmied et al., 2008). Hence, senior level commitment is also required if RPNs are to practice in a family focused manner (Falkov, 2012; Lauritzen et al., 2014b; Maybery & Reupert, 2009; SCIE, 2012; Toikka & Solantaus, 2006). Changes in structures and processes at the organisational level are also required to

enable interagency co-operation (Doucet et al., 2012; Falkov, 2012; Gillam et al., 2003). Finally, research is also necessary to enhance understanding of the core components of RPNs' FFP and to provide the necessary information to enable development of FFP within general adult mental health services in line with recommendations outlined (Lauritzen et al., 2014b).

The following section outlines why RPNs may play a key role in supporting parents, children and adult family members and implications for RPNs in their daily practice.

Implications for RPNs in their Day to Day Practice

It is contended that RPNs and registered nurses with psychiatric experience should play a key role in FFP in future (Devlin & O'Brien, 1999; K. Foster, 2010; K. Foster et al., 2012; Korhonen, Pietilä, et al., 2010; Korhonen, Vehviläinen-Julkunen, et al., 2010; Mordoch & Hall, 2008). RPNs are primarily concerned with promoting the healthy development of the service user (patient) within the context of their family and community (P. Barker, 2008; McCardle, 2008; Morrissey et al., 2008; Nursing and Midwifery Board of Ireland [NMBI], 2014) and "are in a unique position to evaluate the situation of …children before problems arise" (Korhonen, Vehviläinen-Julkunen, et al., 2010, p. 65). They are also in a unique position because they are the largest staff group involved in the provision of mental health care in Ireland (Cusack & Killoury, 2012; Morrissey et al., 2008), and are responsible for a wide range of services in community and hospital environments (McCardle, Parahoo, & McKenna, 2007; Morrissey et al., 2008). They are also often the first point of contact for parents with mental illness who are receiving treatment in adult mental health services (K. Foster et al., 2012; Houlihan et al., 2013; Korhonen et al., 2008). Finally, according to K.

Foster et al. (2012, p. 6), "they are also among the few groups of health professionals who have direct, frequent, and sustained contact with consumers and families".

In the in-patient setting RPNs should discuss parenting issues on admitting the person to hospital (K. Foster et al., 2012; Lauritzen et al., 2014b) and conduct family and parenting assessments if necessary (Ackerson & Venkataraman, 2003; Mordoch, 2010), including determining if there are chronic problems associated with mental illness, which may have a long-term negative effect on parenting and children. They should factor this information into ongoing care (K. Foster et al., 2012). Moreover, RPNs in acute settings

> …can be involved in changing forms, the nature of treatment plans, and the organisation of psychiatric services to include children of parents with mental illness (Mordoch, 2010, p. 1142).

In the community setting RPNs can also play a major role in providing FFP. For instance, community RPNs can use their sustained relationships with parents (Houlihan et al., 2013; Liangas & Falkov, 2014; Slack & Webber, 2008) to identify signs of relapse of PMI and to implement early treatment for the benefit of parents and their children (Ackerson, 2003b). They can also use a case management approach (McCardle, 2003) and employ a broad social and holistic perspective (McCardle, 2008; Slack & Webber, 2008) to address parents' wider needs (including socioeconomic needs), that impact on their well-being and parenting capacity (Devlin & O'Brien, 1999; Korhonen, Vehviläinen-Julkunen, et al., 2010). As community RPNs may also spend a significant proportion of their time with parents within their home environment they also have a unique opportunity to observe parents' capacity to cope with their daily lives and parenting roles (A. Davies, 2004; K. Foster et al., 2005; Houlihan et al., 2013; Jackson & Darbyshire, 2004; Slack & Webber, 2008). They can use this information to inform their interventions with parents and to assist parents to reduce the impact of their illness on themselves, their children and adult family members (Devlin &

O'Brien, 1999; Liangas & Falkov, 2014). Furthermore, given their opportunity to develop close and ongoing relationships with parents, their families and the wider community, RPNs can empower parents to access additional community services for the benefit of the whole family (Devlin & O'Brien, 1999; Hauck et al., 2008; Lagan, Knights, Barton, & Boyce, 2009).

The remainder of this chapter will explore the response of general adult mental health services in supporting parents, children and adult family members.

Family Focused Policy and Practice in Ireland and Internationally

The International policy and practice context. Until recent times the medical model has dominated the mental health paradigm. It shaped and governed mental health professionals' practice within acute admission units and to a lesser extent within adult community mental health services (Cusack & Killoury, 2012; Falkov, 2012; Farrelly, 2008). Hence, the primary focus of mental health professionals' practice was determined by the service users' psychiatric diagnosis and care was restricted to resolving or reducing the symptoms associated with the particular psychiatric disorder that the service user was diagnosed with (Falkov, 2012; Farrelly, 2008; Lauritzen et al., 2014b; Verrocchio et al., 2013). This restricted focus precluded mental health professionals, including RPNs, from considering service users' needs arising from the effects of their mental illness on their daily lives and wider family context. As the focus was on the service users' psychiatric symptoms, service users' parenting roles were overlooked (Baker & Lees, 2014; Falkov, 2012; Maybery & Reupert, 2009). However, in an attempt to provide holistic care and to enhance service users' recovery, (Kilmer et al., 2010; Nicholson, in press) mental health policy in many

countries is increasingly advocating that mental health professionals consider all aspects of service users' lives, that may impact on their mental health and general well-being, including parenting (Benders-Hadi et al., 2013; Brockington et al., 2011; Cusack & Killoury, 2012; Nicholson, in press; SCIE, 2011). Moreover, mental health and family policy, in many countries, is also beginning to acknowledge the unique vulnerability of parents who have mental illness, their children and families and recommend that general adult mental health services adopt a whole family approach (Benders-Hadi et al., 2013; DoHC, 2006; Hansson et al., 2013; Hinden, Biebel, Nicholson, Henry, & Katz-Leavy, 2006; Krumm et al., 2013; Lauritzen et al., 2014b).

Such an approach can meet the needs of children and family members whilst providing preventative health care and guidance for parents (Krumm et al., 2013; Lauritzen et al., 2014b; Nicholson, in press; Royal College of Psychiatrists, 2011; SCIE, 2009). Researchers from multiple countries have also highlighted that family focused policy is essential to support this practice change within general adult mental health services (Cowling, 1999; Falkov, 2012; K. Foster et al., 2012; Hansson et al., 2013; Houlihan et al., 2013; Korhonen et al., 2008; Krumm et al., 2013; Lauritzen et al., 2014b; Reedtz et al., 2012; Reupert et al., 2010). The following information summarises key policy and practice developments from Australia, UK, Canada, USA, Finland, the Netherlands, Norway and Sweden where significant work is being undertaken to develop effective and timely supports for parents who have mental illness, their children and families (Falkov, 2012; Lee, 2004; Nicholson, in press).

Australia was one of the first countries to identify and address the needs of children of parents who have mental illness (Cowling, 1999). Key policy documents in Australia that

promote FFP, for families where a parent has a mental illness, include: *Pathways to Resilience: Children of Parents with a Mental Illness Project Report* (W. Smith & Nicholls, 2002), *Principles and Actions for Services and People Working with Children of Parents with a Mental Illness* (AICAFHMA, 2004) and *the Victorian Government's Families Where a Parent has a Mental Illness* (Victorian Government, 2007). There are also state based approaches such as FaPMI in Victoria and a COPMI framework for mental health services in New South Wales (NSW) (Falkov, 2012). These aim to foster the development of a whole family approach within general adult mental health services, by among other things "supporting the ability of the workforce to provide appropriate family-focused interventions and care to parents with mental illness, their children and families (New South Wales Department of Health, 2010 as cited in Falkov, 2012, p.242).

Additionally, the AICAFMHA, (2001) undertook a major initiative to undertake a scoping project that identified current evidence based initiatives for parents who have mental illness, their children and families. The project also identified gaps in services for parents and children and outlined activities and recommendations regarding future work in developing effective supports for parents and their families (Beardslee et al., 2012). As a consequence, the Australian Government now recognises children who have a mentally ill parent as a key target group for mental health promotion, prevention and early intervention (Falkov, 2012; Reupert et al., 2009; Reupert & Maybery, 2011; Reupert, Maybery, et al., 2012; Thompson & Fudge, 2005). Further developments occurred in Australia in 2001 when AICAFMHA was successful in tendering for a Government funded national initiative, known as 'The Children of Parents with a Mental illness Project' (COMPI), which aims to improve outcomes for children whose parent has a mental illness through the development of guidelines and principles for workers/services and resource materials for workers, parents and young people

(AICAFHMA, 2004; Falkov, 2012). For instance, COPMI developed a DVD based on the *Family Talk* Intervention devised by Beardslee et al. (2007), for families and an associated online professional development resource for mental health professionals (Beardslee et al., 2012). Furthermore, in some Australian states, designated mental health professionals have become COPMI co coordinators or champions in a formal and informal basis. The role of these champions "have been redefined to enable them to incorporate a family focus into their work in a more formal way" (Falkov, 2012, p. 250). Accordingly, they spend a proportion of their time engaged in COPMI activities and act as a resource or support for other mental health professionals (Falkov, 2012).

A recognition of the need to identify service users who are parents, on entry to mental health services, has also led to systematic efforts to document parenting status in NSW (Falkov, 2012; K. Foster et al., 2012). Furthermore, a scoping study of all available programs from Australian Government and non-Government agencies identified 60 programs specifically targeting these families; 26 targeted child and adolescents and six targeted parents with mental illness. There are also 24 workforce training initiatives (Reupert et al., 2009), including a bi monthly online resource, sponsored by the AICAFMHA which aims to make research in the area of PMI accessible to mental health professionals and consumers.

Like Australia, over the last fifteen years, the UK has made concerted efforts to enhance mental health services' response to PMI through policy and practice developments (Singleton, 2007). Various reports (i.e. *Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare; Family Minded: Supporting Children in Families Affected by Mental Illness; Supporting Children who Have a Parent with a Mental Illness; Patients as Parents; Parents as Patients; Preventing Harm to Children from Parents with*

Mental Health Needs) have drawn attention to the needs of children whose parent has a mental illness, the need for collaboration between children and adult services, and the need for mental health professionals to assess parenting capacity (Royal College of Psychiatrists, 2011; SCIE, 2009 , 2011, 2012). Additionally, in June 2004, the Social Exclusion Unit published a report which addressed the impact of PMI on family well-being and child development (Fowler, Robinson, & Scott, 2009) and in 2005 the National Institute for Clinical Excellence (NICE) launched the National Social Inclusion Programme to deliver the Government's action plan on mental health and social exclusion. Action 16 of this plan has the family at the centre of thinking and policy development in the UK so that there is a recognition that mental health service users are often parents whose illness may have an impact on the whole family, including children (Fowler et al., 2009). The objectives, which were developed from this plan, are helping to develop a focus and services for families where a parent has mental illness (Fowler et al., 2009) by:

- Improving understanding and capacity of general adult mental health services to support parents and their children, manage risk and reduce negative impact,
- Influencing improvements in hospital family visiting facilities and ensuring that service users' experiences are paramount and that their children and families are thought about in the provision of general adult mental health services,
- Securing a higher profile for parental mental health and children's needs at appropriate levels within regional and Government organisations (Office of the Deputy Prime Minister, 2004, as cited in Fowler, 2009, p.7).

Also In 2009, NICE recommended that FFP become a more dominant feature of treatment and care planning in mental health services and made several recommendations in relation to screening, assessment, planning care, providing care and evaluation. For instance, in order for mental health professionals, including RPNs, to address service users' parenting

roles, screening systems must routinely and reliably identify and record information about adults with mental health problems who are also parents (NICE, 2009). They also suggest that identification of parental status during initial assessment will enable the development of treatment and care plans that take into account parenting needs, alleviate possible stressors and consider the needs of dependent children and others in the family (NICE, 2009).

Other developments in the UK with a practice focus include the Meridian programme.

> The Meriden programme is a training and organisational development programme that has been promoting the development of family-sensitive, evidenced based mental health services since 1998, with a particular emphasis on the implementation of family work in mental health services (Falkov, 2012, p. 276).

Profession specific position statements have also been made for psychiatrists, including *Patients as Parents* (Royal College of Psychiatrists, 2002) and *Parents as Patients* (Royal College of Psychiatrists, 2011) which have emphasised the need for mental health professionals to involve the whole family; offering help to the parents on parenting as well as support for their children. However, currently, the SCIE are leading the development of national practice guidance on parental mental health and child welfare in the UK (Falkov, 2012; Fowler et al., 2009; SCIE, 2005, 2009, 2011, 2012). For example, they established the Parental Mental and Child Welfare Network following the publication of the Mental Health and Social Exclusion report in 2004 (Fowler et al., 2009). It was established by the SCIE as a vehicle to promote collaborations between children and adult services and to share information and practice examples in guidelines and to promote family focused approaches and policies. The SCIE also directly influences *Think Family* policies and practice. The organisation provides various resources for professionals to *Think Family*. Through sharing good practice, knowledge, resources and research, the SCIE provides a link to the mental

health workforce that will be vital in affecting meaningful change in policy and practice (Fowler et al., 2009).

SCIE has also undertaken several projects examining how services can better support parents with mental health problems and their families. For instance, in 2005 the SCIE compiled a systematic map of the research in the area (SCIE, 2005) and between 2006 – 2008 conducted a practice inquiry in five sites across the UK to examine practice in relation to parents with mental health problems. Subsequently, the SCIE published a number of guides to improve services which recommended a *Think Family* approach across adult mental health services and children's services (SCIE, 2009, 2011, 2012). SCIE's guides features key recommendations to promote a whole family approach throughout the care pathway and strategic work to support this approach (Falkov, 2012; SCIE, 2009). The SCIE guidelines make specific recommendations relating to screening, assessment, planning, providing and reviewing care of service users, actions at the strategic level and workforce development and stipulate what practitioners, managers and organisations should do. Between 2009 and 2011, SCIE worked with five sites in England and five sites in Northern Ireland to implement the recommendations in the guide (SCIE, 2012).

In Canada there have been several initiatives to make visible the needs of parents who have a mental illness, their children and families. For instance, in British Columbia, the ten year Mental Health Plan, *Healthy Minds, Healthy People*, has deliverables that direct health authorities to respond to some of the issues that arise as a consequence of PMI (Ministry of Health Services, 2010). In this document, a recommendation is that " by 2013, health authorities and key partners will use a cross-sector framework for planning and children and families with parents who experience mental health…problems will receive more coordinated

services and supports" (Ministry of Health Services, 2010, p. 22). In response to these recommendations, the British Columbia Family Mental Health and Substance Use Task Force created a cross sector action planning resource called *Families at the Centre*. This resource aims to focus on risk and protective factors for families affected by a mental health or substance misuse problem, and encourage FFP (S. Smith & Saari, 2014). However, to date, whilst there have been concerted efforts to implement the recommendations from *Healthy Minds, Healthy People* into practice, the success of this has been limited (R. Lee, personal communication, February 2014).

Other initiatives in British Columbia have stemmed from the Report *Safe Relationships, Safe Children* which "underscores the importance of approaches that are family-oriented and family-sensitive, while promoting the safety and well-being of children" (Ministry of Children and Family Development, 2013, p. 1). For example, a series of initiatives have occurred around interpersonal family violence, PMI and substance misuse. The aim of these initiatives are to support front-line staff in various health and community settings to effectively and consistently manage situations of mental illness, substance use problems and domestic violence that may impact on children's well-being (Kido & Miller, 2012). In 2012 two pilot sites developed procedures, staff training and collaborative efforts to promote children's well-being in these contexts. The second phase of this initiative will entail expansion of the number of pilot sites from two to twenty one. Moreover, a community Implementation Toolkit, Practice guidelines and a Care Pathway has been developed; these aim to support staff in implementing this initiative in preparation for province wide implementation. Going forward,

> It is recommended that the Ministry of Health will work in partnership with the Ministry of Children and Family Development to introduce protocols,

> policies and tools within health and child serving systems to ensure that all staff and professionals understand, identify and reduce risk factors for children and families affected by serious untreated parental mental illness, problematic substance use and/or domestic violence" (Ministry of Children and Family Development, 2013, p. 1)

Another initiative in the public health sector which has an indirect impact on mental health services is the *Towards Flourishing strategy*. This initiate aims to embed mental health promotion into the public health system and is directed to professionals working with families in the postpartum period. All public health nurses and paraprofessional home visitors in the offices are involved in the project (about 3/4 of the province of Manitoba) have been trained and encouraged to utilise the everyday strategies and health promotion interventions for all parents in the post-partum period. Within this initiative health promotion trainers are registered psychiatric nurses and/or registered nurses with psychiatric expereince or social workers. The aim of the initiative is to help public health nurses to promote families' awareness of their mental health, their children's socio-emotional development and how to prevent short and long term mental health problems (M. Chartier, personal communication, February 2014). While this strategy focuses on public health nurses as opposed to mental health professionals practicing in adult mental health services, there has been close collaboration and cross learning between mental health services and public health nursing services in devising and implementing the strategy. Moreover, it has the potential to indirectly impact on practice within adult mental health services by increasing interagency collaborations.

A number of reports have also been written to promote FFP philosophy and practice in Canadian mental health services (Centre for Addiction and Mental Health, 2004; Family Mental Health Alliance, 2006; Kirby & Keon, 2006; Mental Health Commission of Canada, 2009; Minister's Advisory Group, 2010). Collectively, "these reports recommended fostering

collaborative partnerships with families, providing quality mental health information, education and support" (McNeil, 2013, p. 58). Nonetheless, whilst there is some evidence that FFP is being implemented through individual providers and support groups, these developments tend to focus on adult carers as opposed to children and have not been provided in a systematic, coordinated manner (R. Lee, personal communication, February 2014).

The USA has also been instrumental in leading developments in FFP. For instance, the concept of FFP first originated from consumer and family service agencies in the United States in the 1950's (McNeil, 2013). Over the last couple of decades there has been increasing efforts made by State Mental Health Authorities, throughout the USA, to meet the needs of families where a parent has a mental illness (Biebel, Nicholson, Williams, & Hinden, 2004). For example, Biebel et al. (2004) identified that over half of the Authorities (n = 27, 53 percent) respond to some extent to service users' parenting roles. Actions include identifying parenting responsibilities, assessing parenting capacity and/or providing specific services, policies and guidelines. There are also family intervention programs that support both parents and their children (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee, Swatling, et al., 1998; Beardslee et al., 2007). Nonetheless, Biebel et al. (2006) identified wide variation in the Authorities response to PMI and highlighted that just under half overlooked service users' parenting roles. Moreover, whilst Hinden et al. (2006) identified that there were 23 programs across the USA, specifically for parents with mental illness, and their children, Biebel et al. (2006) suggested that State Authorities were less likely to address service users' parenting needs in 1999 than in 1990. However, in more recent times there is some evidence that there is increasing efforts to develop community based interventions (Hinden et al., 2006; Hinden, Biebel, Nicholson, & Mehnert, 2005; Hinden, Wolf, Biebel, &

Nicholson, 2009; Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007). One such example is the *Family Options* Intervention (Biebel, Nicholson, & Woolsey, 2014; Nicholson et al., 2009). This community based rehabilitation intervention, for parents with serious mental illness and their children, aims to promote families' recovery and resilience (Hinden et al., 2009). Whilst this is not an innovation within general adult mental health services it provides a resource for mental health professionals in adult mental health services to refer parents and their families to (Biebel et al., 2014). Within this intervention, a team of family coaches establish partnerships with parents, their children and families for on average 12 months. Part of this process entails developing a tailored family care plan in conjunction with families to help them develop necessary skills to maintain their well-being and functioning in their community, including capacity to access supports and resources (Biebel et al., 2014).

Relative to developments currently undertaken in Australia, UK, Canada and the USA, there has been greater development of legally mandated, national, formalised and binding child and family focused policy and service investment in the Netherlands, Finland, Sweden and Norway (Beardslee et al., 2012; Falkov, 2012; Lauritzen et al., 2014b; Reedtz et al., 2012; Solantaus & Toikka, 2006). For instance, in the Netherlands, there is a comprehensive, multi-component, national prevention programme, derived from national health policy that focuses on children of parents who are mentally ill. Consequently, a network of prevention and health promotion teams are an integral part of the mental health system (Falkov, 2012). As part of this national prevention programme, mothers and infants in 70 percent of adult mental health centres, receive between eight to ten home visits from a prevention specialist to enhance the quality of the parent's relationship with their child(ren) (Kowalenko et al., 2012). Furthermore, the intervention *Child Talks* was developed in the Netherlands and has been incorporated into some adult mental health services as part of

regular practice (Van Doesum & Hosman, 2009). The intervention *Child Talks* is a health-promoting and preventive intervention which involves mental health professionals conducting two to three sessions with parents and family members (including children) and aims to support parents in their parenting role and thereby support their children (Van Doesum & Hosman, 2009). The intervention allows parents to think about and to describe their children's resources and vulnerabilities and to develop capacity to explain their mental illness to their children. Children are involved by assessing their understanding and experiences of the family situation and by obtaining their perspective as to what may improve their situation (Reedtz et al., 2012).

In Finland, national legislation and policy also compels general adult mental health services to address the needs of service users' children (Beardslee et al., 2012). Over the past 12 years a national programme, the *Effective Child and Family Programme*, supported by the Ministry of Social Affairs and Health, has been established which aims to implement system – wide changes in health care; focusing on the needs of parents with mental illness and their children (Beardslee et al., 2012; Solantaus et al., 2010). The more specific aim of the programme is to implement a preventative family focused approach, within general adult mental health services, by incorporating care of service users' children into routine practice (Falkov, 2012; Toikka & Solantaus, 2006). As part of this approach, mental health professionals are facilitated to use network meetings to bring together professionals involved in caring for service users' children to devise a coordinated plan for the family (Falkov, 2012; Toikka & Solantaus, 2006). Beardslee's *Preventative Family Intervention* (Beardslee et al., 2003) and the parent-focused intervention *Let's Talk about Children* (Solantaus & Toikka, 2006) are also key elements of the programme. The evidence to date suggests that it is now

mainstream practice in most Finnish mental health services for mental health professionals to address service users' parenting roles (Beardslee et al., 2012).

In Sweden, there have been similar legislative changes to identify the needs of service users' children within adult mental health services (Pihkala et al., 2012a). In addition Beardslee's *Preventative Family Intervention*, which as previously noted, is a family-based preventive method for children of parents with mental illness, has been implemented on a national level (Pihkala et al., 2012a). Some psychiatric services have also established Children's Representatives in in-patient units (Östman & Afzelius, 2011). Children's Representatives are responsible for identifying whether service users have dependent children, and then subsequently addressing parents and children's needs; they also support colleagues to address service users' parenting roles. This development in Swedish mental health services has helped to make service users' children more visible to mental health professionals (Östman & Afzelius, 2011).

Similarly, in Norway, various changes in laws now mandate adult mental health services to identify and support service users' children (Lauritzen & Reedtz, 2013; Lauritzen et al., 2014b; Reedtz et al., 2012). Policy in this country stipulates that mental health professionals in each hospital and community mental health service are responsible for identifying service users' children (using the *Family Assessment Form*) and ensuring they obtain required support (Lauritzen & Reedtz, 2013; Lauritzen et al., 2014b). In conjunction with these changes in law, mental health professionals, in some mental health services, are receiving training in the Netherlands developed *Child Talks* intervention (Lauritzen et al., 2014b); with a view that this intervention becomes incorporated into routine service provision nationally (Lauritzen et al., 2014b; Reedtz et al., 2012). It is anticipated that the obligation to

complete the *Family Assessment Form* and implement the *Child Talks* intervention will lead to changes among mental health professionals in terms of knowledge, attitudes, collaborative routines and clinical practice (Lauritzen et al., 2014b; Reedtz et al., 2012). Moreover it is anticipated that these changes will promote parents' competence in parenting and reduce parenting concerns (Lauritzen et al., 2014b; Reedtz et al., 2012).

Despite these policy and practice developments, there is much that is still required to achieve the vision of comprehensive family focused care within general adult mental health services (Fowler et al., 2009; Lauritzen et al., 2014b; Maybery & Reupert, 2006; O'Brien, Brady, et al., 2011). Lauritzen et al. (2014b) found that three years after the implementation of policy, although the frequency of mental health professionals identifying service users' children had significantly increased, there was limited change in the extent to which needs were subsequently addressed.

The Irish policy and practice context. During the last decade, attempts to modernize Irish mental health policy and practice has resulted in on-going changes to the organisation and delivery of services (Cusack & Killoury, 2012; Hansson et al., 2013). Similar to the International experience these changes have included a move towards FFP and making services child friendly (DCYA, 2012; Hansson et al., 2013). To achieve a shift from a child protection to child welfare focused service, substantial family policy development (i.e. *The National Children's Strategy, 2000, The Best Health for Children Initiative 2002, Agenda for Children's Services, 2007 & Children First: National Guidance for the Protection and Welfare of Children, 2011*) and investment of resources in the childcare system has been on-going since the 1990's. These policies reflect the Irish Government's commitment to improving the lives of children and young people in Ireland and the lives of their parents

(Hansson et al., 2013).

These policies place a renewed emphasis on prevention and early intervention and collaboration between agencies that provide services for parenting and children (DCYA, 2012; DoHC, 2007; Hansson et al., 2013). They also support the notion that wherever possible, children should be brought up by their own families and parents should be supported in their parenting role. Moreover, society as a whole also has a part to play in the well-being of children (DCYA, 2012). For example *Children First: National Guidance for the Protection and Welfare of children* (DCYA, 2011) explicitly outlines the roles, responsibilities and procedures of mental health and addiction services in safeguarding the interests and well-being of service users' children. It indicates that many parents, particularly parents with mental illness, from time to time, require support and help from the Government in carrying out their parental role. The report also suggests that these families need intensive assessment, support and direct interventions to ensure the safety and well-being of their children and that early action by service providers is very often the best way to protect children and to enable families to stay together (Hansson et al., 2013). The report recommends that professionals who are treating a person with a mental health or addiction problem must "always consider the impact of their adult client/patient's behaviour on a child and act in the child's best interests" (DCYA, 2011, p. 4).

Importantly, although these family policies, reported above, encapsulate many ways to support parents, children and families, none of them, with exception of *Children First* (DCYA, 2011), explicitly mention PMI or the particular difficulties that families with a mentally ill parent may experience. In the various policies discussed above, children are identified as in need, due to having family backgrounds characterised by instability, marital

conflict, lone parenting and poverty. Therefore, though these reports and legislation have furthered child welfare in Ireland they have done little to raise the profile of PMI.

Within general adult mental health services, *A Vision for Change* (DoHC, 2006) is the primary policy influencing mental health professionals' practice and hence is of particular relevance to the current study. In January 2006, the Government adopted the Report of the Expert Group on Mental Health Policy, *A Vision for Change*, as the basis for the future development of mental health services in Ireland (Barrington et al., 2009). This policy is central to the current research because it confirms that the DoHC (2006) acknowledges the needs of parents who have mental illness, their children and families and the important role that mental health professionals should play in supporting them. This policy reflects the mounting awareness, both nationally and internationally, that "children whose parents have complex recurrent mental health problems are at risk of developing mental health problems themselves and require sensitive consideration" (DoHC, 2006, p. 89). The DoHC concede that:

> The experience of having a service user in the family can negatively impact on the development, health and education of children in the household. Children may be undertaking an array of caring responsibilities, including household and financial management; care of other siblings and family members and administering medication (DoHC, 2006, p. 29).

In relation to addressing the needs of service user's children recommendation 3.7 states that:

> The experiences and needs of children of service users should be addressed through integrated action at national, regional and local level in order that such children can benefit from the same life chances as other children (DoHC, 2006, p. 30).

In relation to specific input from mental health services the DoHC also state that:

> The experiences and needs of children of service users must be addressed by the mental health services … Support for families … must become an integral

> component of a comprehensive, family-centered approach to mental health provision and adult mental health services should be child friendly (DoHC, 2006, p. 29).

and that:

> A skillful needs and risk assessment of children in high-risk situations should be adopted by mental health services as a minimum standard. This should involve cooperation and consultation between child and adolescent CMHTs and adult CMHTs. The emphasis at all times should be on supporting the child and the family and ensuring the needs of the child are met (DoHC, 2006, p. 89).

The DoHC (2006) go on to recommend that supports for children should include: provision of practical support and education about the parent's mental illness and treatment, communication and liaison with community support services, if necessary, with an emphasis on supporting the child and the family and access to age – appropriate educational and social activities that support a positive experience of childhood. Finally, with regard to supporting parents, who have mental illness, the DoHC state that, "family members who experience mental health difficulties should be supported in realising their full potential as parents" (DoHC, 2006, p. 30).

The importance of this paradigm shift, towards seeing unwell parents in relation to their immediate and their wider family contexts, is of fundamental importance. Hence, the recommendations within *A Vision for Change* (DoHC, 2006), regarding parents who have mental illness, their children and families, are both timely and pertinent, especially considering the increasing numbers of service users who are parents and the International developments in this area. Despite the lack of policy and practice development underpinning services for parent who have mental illness, their children and families, in Ireland, and a lack of evaluation of existing services, the recommendations of *A Vision for Change* (DoHC, 2006) have implications for mental health professionals' practice. The acceptance by the Irish

Government that services must be developed for parents who have mental illness, their children and families, places the onus on mental health professionals, in Irish mental health services, to work closely across service boundaries, to develop protocols, policies and programmes in consultation with service users, their children and families. A family context perspective necessarily means that many aspects of the conventional treatment approach may have to be revised or completely rethought (Barrington et al., 2011; Falkov, 2012). A family context perspective also means less certainty for mental health professionals who will now need to take into account simultaneously many points of view, including the need to balance the interests of the child and the parent (K. Foster et al., 2012; Maybery & Reupert, 2009; Royal College of Psychiatrists, 2011). Addressing service users' parenting roles and switching from a focus on diagnosis or pathology, to instead concentrate on individual strengths and interventions, that are strongly associated with promoting mental health and recovery, and sustaining families, also require many RPNs to change their existing attitudes and practice (Barrington et al., 2011; Cusack & Killoury, 2012; Falkov, 2012; NICE, 2009; Nicholson, 2010).

In order to implement the recommendations within *A Vision for Change* (2006), the DoHC (2006) and Barrington et al. (2011) indicated that substantial changes in the organisation, culture and structure of mental health services is required. Essentially, there needs to be a cultural shift in how mental health services are delivered, moving from a professional dominance towards a person-centered, partnership approach (Barrington et al., 2011). The DoHC (2006) also suggest that a change in thinking is required by those responsible for planning and funding mental health services. In particular, reference is made to the importance of health promotion and early intervention to prevent mental health difficulties and personal crises arising in the first instance. Additionally, the DoHC (2006)

suggest that the recommendations in *A Vision for Change* have direct implications for education and training of mental health professionals stating that:

> Changes in thinking are achieved through education and training. The vision and physical structures in any mental health policy are not, in themselves, sufficient to bring about substantial change in mental health service delivery; those providing the services need to be enabled to change their practice (DoHC, 2006, p. 58).

However, although developments in the Irish policy context are necessary in raising mental health professionals' awareness of PMI, a general lack of attention to policy and practice development in this regard, is likely to impact on mental health professionals' FFP in Irish mental health services. Furthermore, whilst there is an independent monitoring group (IMG) that provides an annual report of progress of recommendations in *A Vision for Change*, there has also been no substantial evaluation or research that examines and/or explores mental health professionals' capacity to meet the recommendations within *A Vision for Change* (DoHC, 2006) regarding parents who have mental illness, their children and families. Available data suggest that mental health professionals are not particularly family focused. For instance, in 2009, the IMG reported that there was some evidence that "…mental health professionals, who have concerns regarding the welfare of children of service users, link with local community services and/or child and adolescent mental health teams" (Barrington et al., 2009, p. 23). However by 2011 they indicated that only limited effort had been made to involve family members in the provision of mental health services and that "more often than not the specific needs of members are not identified and acknowledged in the care planning process" (Barrington et al., 2011, p. 43). By 2012 the DoHC concluded that:

> Although psychiatric nurses…incorporate a large number of areas when assessing and planning care with service users, further emphasis needs to be

> placed on a holistic assessment which incorporates…the needs… of children of service users (Cusack & Killoury, 2012, p. 21).

Aside from a lack of policy development in Ireland, there are key distinctions between the recommendations made in *A Vision For Change* (DoHC, 2006) and those in Finland and Norway. Unlike *A Vision for Change*, which recommends that mental health professionals should engage in FFP, policy documents in these other countries require changes in family focused mental health services and practice (Falkov, 2012) and have a clear national corporate policy implementation framework. Conversely, in Ireland there is no legal obligation to translate recommendations in relation to parents who have mental illness, their children and families into practice nor is there a systematic, nationwide approach, to doing so. Reflecting the limited scope of *A Vision for Change* (DoHC, 2006), to mandate change in Irish mental health services, there has been no national investment, including training and guidelines to enable mental health professionals to meet recommendations in relation to parents who have mental illness, their children and families. The implementation of the Health Service Executive's recruitment embargo and the public service moratorium from 2009 to date serves to compound these problems (Barrington et al., 2011).

To summarise, anomalies in the implementation and evaluation of recommendations within *A Vision for Change*, pertaining to parents who have mental illness, their children and families, provided some of the impetus for this current study. An examination of RPNs' practice with parents who have mental illness, their children and families will generate insight into the extent to which RPNs are implementing the recommendations of *A Vision for Change* (DoHC, 2006) and in doing so provide information to further develop RPNs' practice in this context.

The following sections will review the empirical literature exploring parents, children families and RPNs' perspectives of RPNs' FFP. The chapter will come to a close by and identify gaps in the existing literature which detract from a comprehensive understanding of RPNs' FFP.

Parents, Children, Families and Mental Health Professionals' Perspectives of FFP

This section commences by exploring parents, children and families' perspectives of FFP before proceeding to review mental health professionals' perspectives of FFP.

Parents, children and families' perspectives. Multiple researchers have explored mentally ill mothers' perspectives (Ackerson, 2003a; Aldridge & Becker, 2003; Bassett et al., 1999; Campbell et al., 2012; B. Davies & Allen, 2007; Diaz-Caneja & Johnson, 2004; Dipple et al., 2002; Doucet et al., 2012; Howard & Hunt, 2008; Khalifeh et al., 2009; Maybery et al., 2005; Montgomery et al., 2006; Nicholson et al., 1998a; Nicholson et al., 1998b; O'Brien, Anand, et al., 2011; Stallard et al., 2004; Stanley et al., 2003; Zemencuk et al., 1995) and mentally ill fathers' perspectives (LeFrançois, 2012; Nicholson, Nason, Calabresi, & Yando, 1999; Reupert & Maybery, 2009; Spector, 2006) as to whether mental health professionals, including RPNs, support them in their parenting (for more information see Appendix A).

B. Davies and Allen (2007) found that some mothers in their study perceived that key workers/case managers considered and addressed their needs related to their mental health and their parenting. Similarly, mothers in a study by Montgomery et al. (2006) perceived that compassionate key workers/case managers, who allowed them to fully convey their situation, without judging them, enabled them to disclose their problems in parenting and to cope with their parenting role. Parents have also suggested that a family focused approach is also an

important source of support (Doucet et al., 2012; Maybery et al., 2005). For instance, Pihkala et al. (2012a) conducted 39 interviews with 18 Swedish family members to explore their experiences of psychiatric services implementing a family focused approach (e.g. Beardslee's *Family Talk).* The findings suggested that confidence and security in the mental health professional's family focused approach were prerequisites for enabling parents to discuss their mental illness with their children. The relationship and trust between mental health professionals and family members enabled collaboration to set and achieve goals. Pihkala et al. (2012b) concluded that the family focused approach provided a solid base for an alliance with the parents and might be a practical method when parenthood and children are discussed with service users.

Parents also identify barriers to effective support and perceive that these are generated by themselves and by mental health professionals (Aldridge & Becker, 2003; Diaz-Caneja & Johnson, 2004; Doucet et al., 2012; Falkov, 2012; Khalifeh et al., 2009; Maybery & Reupert, 2006, 2009; Mowbray et al., 1995). For example, parents may be reluctant to disclose their parenting role and parenting issues to mental health professionals, for fear of losing access to their children (Ackerson & Venkataraman, 2003; Diaz-Caneja & Johnson, 2004; Khalifeh et al., 2009; Montgomery et al., 2006; Mowbray et al., 2000; Nicholson et al., 1998a; Nicholson et al., 1998b). They may also find it difficult to ask mental health professionals for support as they may feel embarrassed about having parenting problems and perceive that mental health professionals will not understand their issues (Handley et al., 2001). When parents are hospitalised they may also be reluctant to let their children visit them due to a fear that their illness will frighten their children (Nicholson et al., 2001).

Parents also indicate that mental health professionals create barriers as they seldom ask them about their parenting status and/or role (Aldridge & Becker, 2003; Bassett et al., 1999; Diaz-Caneja & Johnson, 2004; Doucet et al., 2012; Nicholson et al., 1998a). They also perceive that there is a lack of consideration by mental health professionals of the challenges they experience in assuming their parenting role in conjunction with managing their mental illness (Doucet et al., 2012; Falkov, 2012; Nicholson et al., 2001). Moreover, Diaz-Caneja and Johnson (2004) found that a focus on crisis intervention, with little preventative work, and a lack of a consistent key worker/case manager also deterred mothers from disclosing their parenting concerns to mental health professionals. Furthermore, Alakus et al. (2007) found that parents considered insufficient collaboration between services and referral systems impeded their recovery and capacity to function as parents.

Mothers have also suggested that they found it difficult to access help for their children and adult family members from mental health professionals. For instance, parents perceived that mental health professionals provided limited or no information to their children, partners or other adult family members to help them understand their mental illness (Alakus et al., 2007; Khalifeh et al., 2009). Furthermore, according to mothers, if mental health professionals had provided partners with more information regarding their illness, the stress endured by their families could have been alleviated and their recovery could have been improved (Dennis & Chung-Lee, 2006; Doucet et al., 2012; Robertson & Lyons, 2003). Parents also perceived that the organisation impeded them from seeing their children whilst hospitalised and that there was a lack of policy and guidelines around children visiting. For instance, O'Brien, Brady, et al. (2011) found that whilst parents wanted advice as to how to prepare children for a visit and when to visit, they perceived that children's visits were not well managed, and that they received little support from mental health professionals about

decisions around this issue. Parents also perceived that at times, supervision for children was problematic when the parent and adult family member needed to meet with the medical staff and there was no one to care for the child. O'Brien, Brady, et al. (2011) concluded that the issue of children visiting parents is commonly not addressed in models of in-patient mental health care and others have also underscored this in highlighting the lack of adequate facilities for children, such as family rooms separated from the main ward (Diaz-Caneja & Johnson, 2004; Fowler et al., 2009; Östman & Afzelius, 2011). Fowler et al. (2009) also found that parents perceived that stigma attached to PMI exacerbated their difficulties in maintaining positive family contact when they were in hospital (Fowler et al., 2009).

A number of researchers have also explored children's perspectives (Aldridge & Becker, 2003; Cowling, 1999; Fudge & Mason, 2004; Handley et al., 2001; Khalifeh et al., 2009; Maybery et al., 2005; Mordoch, 2010; Mordoch & Hall, 2008; O'Brien, Anand, et al., 2011; Riebschleger, 2004; Somers, 2007; Stallard et al., 2004) and adult family members' perspectives (Doucet et al., 2012) as to whether mental health professionals, including RPNs, could support them (Appendix A). Similar to parents, research with children suggests that they perceive that they receive inadequate support from mental health professionals to understand, manage and cope with their parent's mental illness, especially at times when their parents were hospitalised (Cowling, 1999; Falkov, 2012; Fudge & Mason, 2004; Gladstone et al., 2011; Mordoch, 2010; Mordoch & Hall, 2008; O'Brien, Anand, et al., 2011; Somers, 2007; Stallard et al., 2004). For example, Stallard et al. (2004) found that around 40 percent of children reported that no one explained their parent's mental illness to them and concluded that lack of information about PMI and why their parent was hospitalised was the primary reason for children's stress. Mordoch and Hall (2008) also suggested that children experienced hardship and stress due to their limited understanding of PMI and received

limited explanations of what was happening to their parent by a mental health professional. Similarly, others have found that although children wanted help from their parents' worker/case manager, to understand their parent's mental illness, and to assist them to support their sick parent, they perceived that key workers/case managers ignored their needs and their contribution to their parent's care (Aldridge & Becker, 2003; Cowling, 1999; Fudge & Mason, 2004; Handley et al., 2001; Maybery et al., 2005; Riebschleger, 2004; Somers, 2007; Stallard et al., 2004).

In relation to adult family members, Doucet et al. (2012) found that the majority of partners of mothers with postpartum psychosis did not have access to any form of professional support, even though some partners wanted mental health professionals to be more proactive in directly enquiring about their needs. Partners also perceived that mental health professionals were inflexible and detached and did not allow them adequate access to their relative whilst they were hospitalised to provide them with support (Doucet et al., 2012). Furthermore, partners also reported that they were not allowed to bring their children with them when visiting their mentally ill partner. Other researchers have also found that adult family members want collaboration, information and support from mental health professionals (Bryan, 2009; Doornbos, 2002; Gerson et al., 2009; McNeil, 2013; Perreault et al., 2005). Nevertheless male partners also conceded that they are too proud and private to seek support and acknowledge that this is a barrier to FFP that they create themselves (Doucet et al., 2012). Nonetheless, Maybery and Reupert (2006) contended that while parents and adult family members may be reluctant to discuss PMI, mental health professionals still needed to develop the skills, knowledge and attitudes to work sensitively with parents and families around this issue and to support children.

The following section explores mental health professionals' perspectives of FFP and in particular factors that impede their FFP.

Mental health professionals' perspectives. Although there is a body of research suggesting that mental health professionals perceive they are beginning to address service users' parenting roles (A. Davies, 2004; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen, 2014; Liangas & Falkov, 2014; Thompson & Fudge, 2005; Toikka & Solantaus, 2006), there is increasing evidence that mental health professionals perceive they also experience varying degrees of difficulty in engaging in FFP (Bellin, Osteen, Heffernan, Levy, & Snyder-Vogel, 2011; Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen & Reedtz, 2013; Lauritzen et al., 2014a; Maybery et al., 2009). Hence, the research exploring mental health professionals' perspectives of their FFP, has predominately generated knowledge regarding barriers to FFP (Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014a; Maddocks, Johnson, Wright, & Stickley, 2010; Maybery & Reupert, 2006; O'Brien, Brady, et al., 2011; Östman & Afzelius, 2011) (please see Appendix B for additional information). The research corroborates parents and children's perspectives that barriers are generated by the mental health care system and by mental health professionals, parents, children and families (Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014a; Maybery & Reupert, 2006). While one quantitative study in Ireland (Houlihan et al., 2013) has previously examined RPNs' FFP, with parents who have mental illness and their children, the majority of studies have been conducted in the UK, Finland, Norway, Sweden and Australia.

In Ireland, Houlihan et al. (2013) surveyed 113 RPNs, in one mental health service, to obtain information regarding their education, knowledge, confidence and practice in relation

to supporting service users' children. RPNs reported relatively low levels of education, knowledge, confidence and supportive practice in caring for service users' children. Just over half of the RPNs enquired about service users' parenting status and only 35 percent documented if service users were parents. Even when children were identified during the nursing assessment, this information was not often acted on. The majority of RPNs reported never or seldom exploring if children had support needs, if parents required assistance in talking to children about PMI, or if children had questions they would like to have asked. RPNs' gender, age and work setting (i.e. hospital or community) did not result in significant differences in their confidence, knowledge and skill. However those who had 10 or less years experience as an RPN, were statistically more likely to support service users' children than other RPNs. RPNs also suggested that there was limited educational emphasis on family and children in undergraduate and in-service training. If, and when, RPNs did receive education, it appeared to be risk focused with an emphasis on providing information on reporting procedures, and the *Children First* guidelines (DCYA, 2011). RPNs perceived that the focus on child protection, within *Children First* training, did not enable them to assess child-parent relationships, communicate effectively with children of all ages or provide early interventions to the child and parent.

Houlihan et al. (2013) suggested that the lack of education on child-and family-focused practices may in part explain RPNs' low levels of self-reported education, knowledge, skills and confidence in supporting service users' children. Lack of time, clinical supervision, managerial support and a tendency to focus on the parent, as opposed to both the parent and their family, also impeded FFP, as did a lack of family focused policy to guide RPNs' interventions. Others have also identified a lack of child and family focused education, managerial support and policy as a major barrier to implementing a whole family

approach within adult mental health services (Gillam et al., 2003; Korhonen et al., 2008; Lauritzen et al., 2014a; Maybery & Reupert, 2006, 2009; Royal College of Psychiatrists, 2011). Similarly, Östman and Afzelius (2011) found that children's representatives in Swedish mental health services were deterred from fulfilling their role in supporting parents and children by poorly defined job descriptions and limited managerial support.

Similar barriers to FFP have been identified within mental health services in the UK. For example, and as previously noted, between 2009 and 2011, the SCIE evaluated the capacity of five local authority areas in England and five health and social care trust areas in Northern Ireland to implement recommendations made in 2009 to help services improve their response to parents who have mental illness, their children and families (SCIE, 2011). The findings suggested that the various services had undertaken a range of activities to implement SCIE recommendations, and had developed promising ways to *Think Family, e.g.* by raising awareness, developing strategic goals, training staff and tackling stigma. However, there were a number of barriers to FFP. Barriers were mental health professionals' overflowing schedules, conflicting demands and the time it took to establish relationships with other professionals and agencies. These difficulties were compounded by a lack of support from senior management to change work practices, and a lack of family perspective in policy and performance indicators. Limited managerial support and reference to the family perspective in policy and performance indicators impeded FFP as it meant mental health professionals did not have sufficient guidance and resources, including time, to practice in a family focused way. Additionally, the broader financial climate had a negative impact on sites' capacities to implement a *Think Family* approach. Nevertheless, mental health professionals' willingness to view their remit flexibly enabled them to some extent to engage in FFP despite the above constraints.

Also in the UK, Maddocks et al. (2010) explored RPNs' lived experience of caring for parents with PMI within two long term residential wards. Similar to other researchers (Gillam et al., 2003; Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014a; Maybery & Reupert, 2006; Sheehan et al., 2000) they found that RPNs lacked knowledge and skills to engage in FFP and had inadequate contact with child-welfare services. RPNs experienced a role conflict in caring for parents who had PMI as they indicated that the need to develop and sustain a therapeutic relationship with parents meant they had to remain impartial towards children. They also suggested that the lack of guidance within Government policy documents, regarding nursing practice, with parents with mental illness, meant that they were uncertain about which aspects of care they were responsible for and whether they should address children's needs when caring for parents. Fleck-Henderson (2000) used the term *seeing double* to describe how mental health professionals are being asked to simultaneously recognise and work with the needs of adult clients and of their children and the difficulties in juggling these dual and sometimes competing demands. Other researchers have concluded that there is an inevitable tendency for adult mental health services to be focused on the therapeutic objectives of the mentally ill adult client and moreover, that the perceived need to maintain a therapeutic relationship with the adult client may be an impediment to the full consideration of children in these families (Cousins, 2004; Macdonald et al., 2011; Maybery & Reupert, 2006; Östman & Afzelius, 2011; Sheehan et al., 2000).

However, Slack and Webber (2008) found that not all mental health professionals experienced the same degree of role conflict in simultaneously caring for parents and their children. Slack and Webber (2008) surveyed various types of mental health professionals (n = 94), working in in-patient or community settings, in one outer London Borough and found that although all participants were overwhelmingly in favour of supporting children, those

mental health professionals practicing within in-patient facilities did not necessarily perceive that it was within their remit to support service users' children. Attitudes and practices were significantly associated with profession, setting and whether the respondent was a care co-coordinator or key worker. Mental health professionals, working within the CMHT, and particularly key workers/case managers, were more likely than in-patient staff to say that they would always assess for the involvement of another agency, and would sometimes directly support service users' children themselves (Slack & Webber, 2008). Similarly, Lauritzen et al. (2014a) found that those mental health professionals with a medium level of discipline specific education, such as RPNs, were more positive about identifying service users' children and addressing their needs than those with a higher level of education, including psychiatrists and psychologists. They suggested that because many psychiatrists are responsible for budgets they may be reluctant to invest time and money in addressing the needs of service users' children.

Compounding these structural divisions in services is the perception by mental health professionals that parenting difficulties are more of a child welfare concern than a mental health issue (Sheehan et al., 2000). The Royal College of Psychiatrists (2011) states that:

> Mental health professionals may agree that offering support to the children of their parents is important but often feel that this is not their role, whereas their natural sympathy and alliance with their parent may lead to blindness about seeing the needs of the child (p.32).

As this division of care deters mental health professionals from considering the needs of both parents, their children and family together, it may be difficult to assess problems in family functioning or to respond to them when they are identified (Byrne et al., 2000; Gillam et al., 2003; Grünbaum & Gammeltoft, 1993; Lauritzen, 2014; Maybery & Reupert, 2006; Reedtz et al., 2012; Stallard et al., 2004; Stanley et al., 2003). Furthermore, obtaining access to

service users' children is problematic (Hauck et al., 2008; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Letourneau et al., 2007; Maybery & Reupert, 2006, 2009). For example, limited opportunities for children to visit their parents in hospital reduces mental health professionals' exposure to service users' children (Korhonen et al., 2008), which in turn further reduces their capacity to develop skills in communicating and supporting children (O'Brien, Anand, et al., 2011). O'Brien, Anand, et al. (2011) found that staff were unsure of their role with children, felt ill-equipped to talk to children about mental illness and lacked knowledge of age-appropriate resources. They concluded that models of in-patient care need to be developed with a family focus that acknowledges the parental roles of clients and supports children visiting.

A lack of emphasis on PMI in undergraduate and postgraduate curricula is another barrier for mental health professionals for working with the family (Diaz-Caneja & Johnson, 2004; Korhonen et al., 2008; Lauritzen, 2014; Maybery & Reupert, 2006; Reupert & Maybery, 2008; Thompson & Fudge, 2005). Increasingly, research has found that while mental health professionals might want to work with children and other family members, and see the importance of doing so, they simultaneously report clear knowledge and skill limitations in relation to (1) working with children, (2) working with a service user on parenting issues, and (3) working with the whole family (Byrne et al., 2000; A. Davies, 2004; Gillam et al., 2003; Korhonen et al., 2008; Maybery & Reupert, 2006; Slack & Webber, 2008). Consequently, they are often unsure how to connect with families and what outcomes to aim for (Gillam et al., 2003; Maybery & Reupert, 2006; Thompson & Fudge, 2005).

However, even those mental health professionals who are trained to work with service users' children and families may also experience difficulties. For example in countries such

as Australia, Norway, Sweden and the UK where concerted efforts have been made, over the last number of years, to enable mental health professionals to provide effective supports for parents who have mental illness, their children and families, it has been noted that worker attitude, skill and knowledge is still often deficit based and negative (K. Foster et al., 2012; Lauritzen et al., 2014a, 2014b; Liangas & Falkov, 2014; Östman & Afzelius, 2011; Reupert et al., 2010). For instance, an Australian consultation found that mental health professionals perceived that they required further skill development and organisational support to identify and meet the needs of parents who have mental illness, their children and families (AICAFHMA, 2004). Despite education and training, Maybery and Reupert (2009) found that some mental health professionals still believed that 'the adult is our consumer not the family', or 'children are not our responsibility', whereas Reupert et al. (2010) found that not all workers believed that a family focused approach was either possible or beneficial.

Similarly, in Sweden Östman and Afzelius (2011) found that many of the staff trained to act as children's representatives in in-patient psychiatric units did not feel confident in working with service users' children. In Norway, Lauritzen et al. (2014b) also found that despite the introduction of legislation and training, around identification and support of service users' children, 56 percent of health care professionals did not identify service users' children and only modest changes in practice had occurred in terms of addressing children's needs. They concluded that the existence of worker related and organisational barriers precluded FFP despite legislation and that implementation frameworks within the organisation are critical to enabling translation of policy in practice (Lauritzen et al., 2014a).

In the Interfaces Project in the UK, Gillam et al. (2003) found that (33%, n = 9) of health care professionals from adult mental health services did not feel confident in working

with service users' children/families despite having received training in behavioural family therapy. They also found that adult mental health services and child and adolescent mental health services did not provide truly family orientated services, and there were no strategic plans or structures in place for health care providers to address the specific needs of parents who have mental illness, their children and families. Whilst some mental health professionals, from adult mental health services, were aware of their service users' parenting responsibilities, there was no specific documentation requirements to record parental status. Furthermore, neither children nor parents were routinely assessed or offered any planned, purposeful therapeutic intervention to promote family functioning. Interagency co-operation was also limited, especially in adult mental health services. Gillam et al. (2003) also found that the majority of mental health professionals, practicing within adult mental health services, did not have good links with colleagues working in child and adolescent psychiatry and therefore did not work across service boundaries. Adult mental health professionals suggested that strict entry criteria and service boundaries did not allow them to collaborate or undertake joint working arrangements across service settings.

Whilst there have been repeated calls for interagency collaboration (Darlington et al., 2005; Korhonen, Pietilä, et al., 2010; Mordoch & Hall, 2008; Verrocchio et al., 2013), Byrne et al. (2000) found that 82 percent of the 77 mental health workers they surveyed, reported that a major barrier to effective service delivery was a lack of liaison between service agencies. Disparate roles, practices, philosophies and education, mutual distrust, unrealistic expectations, confidentiality issues and professional domains and boundaries between mental health and other services are primarily responsible for the lack of interagency collaboration (Cowling et al., 2004; Darlington et al., 2005; Grünbaum & Gammeltoft, 1993; McNeil, 2013; Stallard et al., 2004). Lack of time and resources, including protocols, have also been

identified as impeding interagency collaboration (Darlington et al., 2005; Korhonen et al., 2008; Maybery & Reupert, 2009; McNeil, 2013; Royal College of Psychiatrists, 2011; SANE, 2012).

In the UK, A. Davies (2004) found that RPNs did not perceive that caring for parents' family related issues should be a priority for adult mental health services and instead considered that children's services had an explicit responsibility towards the welfare of children of service users. Nonetheless, they identified themselves as providing an advocate role to parents, and were clear about their responsibilities towards child protection and felt adequately trained in the procedures. Additionally, a lack of resources and time deterred RPNs from addressing service users' parenting issues themselves. Hence, A. Davies (2004) concluded that whilst the needs of families, where a parent has mental health difficulties, are becoming more visible in adult mental health services, there is much work to be done in order for services to be more family/child focused.

In addition to research on barriers, two research teams have developed measurement tools to audit existing practice, identify factors that enabled FFP and measure the effects of various barriers on FFP. For instance, In Finland, Korhonen et al. (2009) devised an instrument to measure various components of RPNs' FFP; including their interactions with parents around parenting, their interactions with children around the impact of PMI and factors that hindered and enabled these interactions. Korhonen et al. (2008) found that many of the factors that contribute to the adoption of FFP were already available at an organisational, RPN and family level, but that there were still many factors that hindered implementation. RPNs perceived that the primary barrier to FFP was parents' limited insight regarding effects of PMI on children's well-being and parents' reluctance to disclose

parenting issues. Lack of resources (including time and education) and resistance within teams to address service users' parenting issues was another major factor that hindered FFP (Korhonen et al., 2008). However, those RPNs who had received additional family focused education and worked in out-patient units reported less barriers in FFP. RPNs' personal characteristics also significantly enabled FFP. For example, older female RPNs who were parents themselves were most likely to engage in FFP (Korhonen et al., 2008).

In Australia, Maybery and Reupert (2006) identified and rated the barriers that impeded mental health professionals and welfare workers from addressing service users' parenting roles. Similar to Korhonen et al. (2008) both groups experienced four barriers which related to parent-related issues, child-related issues, worker-related issues and the fear of a negative impact on the relationship between the worker and parent. Again similar to Korhonen et al. (2008) both groups suggested that the greatest barrier to FFP stemmed from the parents' lack of insight into the impact of PMI on children's well-being and their reluctance to discuss parenting issues. Worker-related barriers included a lack of resources, knowledge, skills and time and a perception that it was not within the workers' remit to address family issues. A lack of appropriate knowledge and skill regarding working with service users' children was also identified. In comparison to other workers, mental health professionals, within general adult mental health services, reported more barriers in relation to time and resource limitations and skill and knowledge deficits to work with parents, children and adult family members. After psychometric work to refine their questionnaire, (Maybery, Goodyear, O' Hanlon, Cuff & Reupert, in press) distributed the survey to a relatively large sample (n = 307) of mental health professionals in Victoria and obtained a 62 percent response rate. Most participants were psychiatric nurses (n = 155, 51%), social

workers (n = 52, 17%), or psychologists (n = 43, 14%), with similar barriers identified in their previous study.

These studies reviewed above are useful in illuminating the barriers that RPNs experienced in supporting parents who have mental illness, their children and families. Going forward, if mental health professionals, including RPNs, are to provide optimal supports for parents, children and adult family members it is important to recognise and address these previously mentioned barriers (Korhonen et al., 2008). This is all the more important considering that Falkov's fifth domain highlights that "the quality of contact /engagement between individuals, families, practitioners and services is of central importance to the overall outcome for all family members" (Falkov, 2012, p. 16).

In comparison to most previous research, several studies have identified workers who engage in FFP, though these were conducted in either Australia or Finland. For example, in Australia, Thompson and Fudge (2005) found that the majority of RPNs in their study, (n = 233, 76%), clearly believed that part of their role involved discussing family and parenting concerns with service users, and if deemed necessary, by the parent or other health care professionals, talking with their clients' children about mental illness. In tandem with this, (n = 279, 91%) perceived that their workplace supported their role in discussing parenting/family issues with clients. The majority of RPNs also referred their adult clients to community agencies for support with parenting or family issues (n = 261, 85%). Only 11% (n = 34) of RPNs lacked confidence in working with other agencies with these families. However, the most commonly listed agency recommended to families was child and adolescent mental health services. Thompson and Fudge (2005) attributed RPNs over reliance on child and adolescent mental health services because of their belief that family issues was

within a mental health framework. This reliance on child and adolescent services implies that RPNs were either not aware of, or did not consider it beneficial, to refer service users, their children and families to the various other services that provided family support in conjunction with mental health services, including child and family health and welfare agencies. Also in Australia, Liangas and Falkov (2014) conducted an audit in community mental health services and found that mental health professionals, including RPNs, recorded parenting status in approximately two third of parents' case notes. Interventions employed included direct action by mental health professionals themselves to support parents in their parenting role and referral to child protection and child welfare services.

In Finland, Toikka and Solantaus (2006) employed a questionnaire to examine 30 mental health professionals' (including RPNs) perspectives of the impact of *Preventative Family Intervention* training on their professional skills and work satisfaction. Their capacity to train their colleagues to use this intervention was also measured. As previously noted, this training was provided as part of the *Effective Family Programme*. The main aim of training was to enhance mental health professionals' capacity to support service users' children and to reduce the potential impact of PMI on them and to equip mental health professionals to train their colleagues in Beardslee's *Preventative Family Intervention* (Beardslee et al., 2003; Beardslee, Swatling, et al., 1998) and *Lets Talk about Children* (Solantaus & Toikka, 2006). The sample was comprised of RPNs (n = 18), social workers (n = 9), doctors (n = 6) and psychologists (n = 6). The results suggested that training in these interventions had the potential to positively impact mental health professionals' job satisfaction, clinician skill and referral practices. Moreover their collaboration with child protection and child mental health services had also increased considerably. Most of them also reported that they had trained others to use Beardslee's *Preventative Family Intervention* and *Lets Talk about Children* in

their practice and that the majority of their colleagues were using these interventions on a routine basis. Just under half reported that there were standardised practices and guidelines in their clinical settings on how to care for the children of parents with mental illness. A majority (73%) also felt that they had enough resources to use the new working methods in their practice and that their managers were mostly positive and constructive in helping them to practice in a family focused way. On the basis of their findings, Toikka and Solantaus (2006) concluded that managers were supportive partly because these mental health professionals generated an impetus for the implementation of FFP within their organisations. Moreover, FFP was sustained within the organisation by participants using the interventions themselves and by training their colleagues to use them and by systematic support for FFP including sustained managerial support, including provision of resources and time to engage in FFP.

Also in Finland, Korhonen, Vehviläinen-Julkunen, et al. (2010) found that whilst RPNs did not have regular contact with service users' children the majority (95%) reported that they gathered information about children's needs by discussing these with parents. For instance, over eighty percent asked parents if their children had behavioural problems. The majority also ensured that mechanisms were in place to ensure children were cared for whilst their parent was hospitalised. The majority, when they met children, also provided them with explanations regarding PMI, encouraged children to discuss their concerns and how they coped with PMI and provided reassurance and information about who to contact if they needed help.

There are several limitations to previous studies. For instance, many studies include an array of professional disciplines and workers, from different settings, within the one

sample, as opposed to focusing specifically on RPNs. For example, over half of the existing studies captured mental health professionals' perspectives as a heterogeneous group (Bibou-Nakou, 2003; Byrne et al., 2000; B. Davies & Allen, 2007; Gillam et al., 2003; Lauritzen & Reedtz, 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2006; Montgomery et al., 2006; Slack & Webber, 2008; Stanley et al., 2003; Toikka & Solantaus, 2006). Fewer studies focused specifically on RPNs' FFP as a discrete group (A. Davies, 2004; Houlihan et al., 2013; Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maddocks et al., 2010; O'Brien, Brady, et al., 2011; Thompson & Fudge, 2005). Some participant groups comprised of professionals from both statutory and non-statutory services (Bibou-Nakou, 2003; Byrne et al., 2000) and from both adult and adolescent mental health (Gillam et al., 2003). Some studies included teachers and members of the police force, (Bibou-Nakou, 2003; Byrne et al., 2000; Maybery & Reupert, 2006; Stanley et al., 2003). Eliciting data from all of these service providers, from varied backgrounds, within a single study is problematic, as the roles and responsibilities of these different professionals vary widely (Falkov, 2012). It has also resulted in superficial understanding of RPNs' FFP.

Finally, the majority of previous research did not employ an explicit theory or conceptual framework to guide and inform their study design and data analysis. This makes it difficult to consider how assumptions about the impact of PMI and FFP on parents, children and adult family members influenced research findings. Furthermore, a theoretical framework can assist in identifying the various pathways of risk for such families, and the knowledge and skills professionals need to have to provide optimal supports for these families. Inconsistencies in findings, within and between studies, regarding the extent of RPNs' FFP, also highlights the need for further study in this area, to increase understanding as to why

differences in RPNs' FFP occurs and what these differences mean. Given that most research has focused on FFP barriers (Lauritzen et al., 2014b; Maddocks et al., 2010; Maybery & Reupert, 2006; Östman & Afzelius, 2011; Rutherford & Keeley, 2009; Slack & Webber, 2008), it is important to examine how and why barriers impede FFP in different settings (including in community and in-patient settings). Furthermore, considering that a proportion of mental health professionals are able to engage in FFP, to varying extents, despite experiencing barriers (Korhonen, Vehviläinen-Julkunen, et al., 2010; Liangas & Falkov, 2014; Maybery & Reupert, 2006; Slack & Webber, 2008; Thompson & Fudge, 2005; Toikka & Solantaus, 2006) it is important to explore how FFP is conceptualised by those engaging in FFP and those enablers that allow mental health professionals to become family focused. This thesis is positioned within these existing gaps and tensions in the current research base.

Research Aims and Questions

Little is known about RPNs' FFP with parents who have mental illness, their children and families, especially in the Irish context. Building upon the previous International research (particularly from Australia) this study will explore the Irish situation further. This study will extend the International work by employing a theoretical Model and by examining differences in RPNs' FFP in acute and community settings. The study will also identify factors that predict and enable FFP and how high scoring RPNs' conceptualise FFP.

The overarching aim of the thesis is to determine the FFPs of RPNs in Ireland. The specific aims are to:

1. Benchmark RPNs' FFP, with parents who have mental illness, their children and families, from the perspective of RPNs practicing within either acute admission units or in community mental health services in Ireland.

2. Compare and contrast the survey findings, obtained in Ireland, with Australian data on RPNs collected by Maybery and Reupert (2006) and Maybery, Goodyear, O'Hanlon, Cuff, and Reupert (in press).

3. Identify the significant predictors of RPNs' FFP.

4. Establish if there are significant differences between RPNs' FFP in acute admission units and RPNs' FFP in community mental health services.

5. Establish the nature and scope of high scoring RPNs' FFP and determine what factors affect their capacity to engage in FFP.

6. Explore how high scoring RPNs' capacity to engage in FFP may be further developed.

7. Develop recommendations addressing the future development of RPNs' FFP, with parents who have mental illness, their children and families, within the context of education, policy, practice and research.

The research questions are:

1. What is the extent of RPNs' exposure to parents who have mental illness and their children in Irish adult mental health services?

2. How does RPNs' FFP in Ireland compare with Australian RPNs?

3. What are the significant predictors of RPNs' FFP?

4. What are the significant differences, if any, between RPNs' FFP in acute admission units and RPNs' FFP in community mental health services?

5. What is the nature and scope of high scoring RPNs' FFP?

6. What factors, if any, facilitate and/or hinder high scoring RPNs' FFP?

7. How, if at all, may RPNs' capacity to engage in FFP, with parents who have mental illness, their children and families, be further developed?

Chapter 4: Methodology for Study One and Study Two

This chapter describes the research design and methodology employed to answer the research questions. It was thought that both quantitative and qualitative approaches were required to answer these questions. This chapter initially gives an overview and rationale for the overall thesis design and then outlines in detail the quantitative methodology and analysis that was employed in the first study of RPNs' FFP in Ireland. This is then followed by the second study methodology that outlines the qualitative approach and analysis that was undertaken as follow-up to Study One.

Overview of Research Design

As there is limited International research, and only one small scale Irish study, exploring RPNs' FFP with parents who have mental illness, their children and families, a descriptive, exploratory approach, in conjunction with a sequential mixed methods design (explanatory, complementary, follow-up design), was employed to address the research aims and questions. Study One employed a large representative sample of Irish RPNs (n = 346) and Study Two involved follow-up interviews with a subsample (n = 14) of RPNs from Study One. The nature of the research questions and the strengths of the mixed methods approach guided the selection of a mixed methods approach (J. Brewer & Hunter, 2006; Creswell & Clark, 2007; Fox et al., 2013; Giddings & Grant, 2006; Onwuegbuzie & Leech, 2004). It was considered that as there is an absence of knowledge in Ireland in this area, an approach that enabled an in-depth exploration as well as a generalisation of the findings to the wider

population of RPNs working within general adult mental health services best addressed this gap.

In the sequential mixed methods design, quantitative data is collected and analysed in Study One, before qualitative data is collected and analysed in Study Two. The qualitative data helps explain, and elaborate upon, the quantitative results (Creswell & Clark, 2007). In this way, both methodologies complement and extend each other, by addressing the research question(s) from different perspectives. The quantitative component addressed the first four research questions and aims and was designed to: describe the profile of Irish RPNs' FFP and to compare the extent of their FFP with that of Australian RPNs; to examine the factors that predict RPNs' FFP; and to determine whether there were significant differences between RPNs' FFP in acute admission units and within community mental health services. The qualitative component, addressed the final three research questions and aims; it explored the nature and scope of RPNs' FFP and capacity to engage in FFP. Hence, although the focus of the interviews were shaped by the quantitative data analysis, there was additional scope for the author to explore and capture RPNs' experiences of the day-to-day reality of caring for parents who have mental illness, children and families, as they perceived it.

Use of both quantitative and qualitative approaches, within a multi-phase study, can "uncover some unique variance which otherwise may have been neglected by a single method" (Jick 1979, as cited in Hanson, Creswell, Clark, Petska, & Creswell, 2005, p.255). Integration of the quantitative and qualitative findings is critical in mixed methods research (Creswell & Clark, 2007; Wilkins & Woodgate, 2008) and can be defined as "the process of research procedures at which the investigator mixes or integrates the quantitative and qualitative data collection and analysis" (Creswell, Fetters, & Ivankova, 2004, p. 10). By

using both approaches, the researcher provides a better understanding of the problem than if either dataset had been reported alone. Although the quantitative and qualitative elements were conducted sequentially the quantitative and qualitative data were connected and integration occurred at two stages. Data connection occurs when the analysis of one type of data leads to (and thereby connects to) another data set (Creswell & Clark, 2007). In this case, the author connected the quantitative and qualitative data by selecting the participants for the qualitative interviews from those who responded to the FFMHPQ (Appendix C) in Study One, based on participants' numeric scores on the FFMHPQ (i.e. high scorers comprised the sample in Study Two). Furthermore, as the findings from the FFMHPQ were used to develop a framework for the topic guide (Appendix D) for the subsequent interviews, integration flowed from quantitative data analysis into qualitative data collection. The author also mixed the quantitative and qualitative approach by integrating the results from the quantitative and qualitative phases while discussing the outcomes of the whole study and drawing implications. Data from the FFMHPQs and interviews were initially discussed independently in separate sections but integrated where there was overlap of findings from the two methods of data collection. This mixing of the quantitative and qualitative methodologies has the potential to produce a high quality of inferences (Teddlie & Tashakkori, 2009). The discussion chapter also highlighted points of intersection and differences between the data sets. However, despite the many advantages of employing a mixed methods approach, its use poses various challenges for researchers (Creswell & Clark, 2007).

Completing mixed methods research demands flexibility in the operationalisation of methods, an understanding about the different methods and an appreciation of how to merge two distinct paradigms (Creswell & Clark, 2007). Some of the difficulties in utilizing a mixed

methods design are tempered by the author using an explanatory design, often considered the most straightforward of the mixed methods designs (Creswell & Clark, 2007). In this study, the author conducted the two methods in separate phases and collected one data type at a time. The approach is also pragmatic, in that the diverse approaches employed are considered to be the best in meeting the research aims and answering the research questions, and one that values both objective and subjective knowledge (Creswell & Clark, 2007; Denscombe, 2008).

Preparatory Fieldwork to Promote the Study

As adult mental health services are widely distributed throughout Ireland the author needed to promote the study in a variety of ways and mediums to inform as many RPNs and their managers as possible. Prior to data collection, the author advertised the forthcoming study by presenting her research in verbal, written and poster format at various conferences, including the Community Mental Health Nursing Association's Annual Nursing Conference and the Irish Institute of Mental Health Nurses annual symposium conference (Appendix E).

Study One - Methodology

Basic tenants of the quantitative approach and rational for its use. Quantitative research emphasizes quantification in the collection and analysis of data (Bryman, 2007; Creswell & Clark, 2007). Surveys are a convenient way of collecting useful comparable data from a large number of individuals (Dillman, Smyth, & Christian, 2009) and in particular, certain types of factual, descriptive information, the hard evidence (De Vaus, 2002). For instance, a survey approach may be appropriate for identifying broad trends in a population and to compare two or more groups in relation to the phenomena under consideration.

Surveys can also be used to collect information on attitudes and behaviour and factors that predict behaviour (Creswell & Clark, 2007). Mindful of this description, the rationale for choosing a quantitative approach in Study One was to address the first four aims of the study, albeit partially, as these aims also have a qualitative dimension which necessitated further exploration in a subsequent qualitative phase. The value of the information obtained in Study One depended upon the type and number of participants; therefore the total sample size, rationale and process for selecting RPNs, practicing within acute admission units and four areas within community mental health services is now discussed.

Sample size, selection and access.

Sample size estimation. The sample size estimation was determined by various factors, including: the size of the population to which results are generalisable to, the results of previous research, and particularly findings from previous use of the FFMHPQ in different populations and the overall purpose of the current study which was to compare two groups of RPNs with regard to their FFP. Hence, a two sample comparison of means was used to estimate the overall sample size.

Based on previous research (Maybery & Reupert, 2006) and to mitigate the risk of having an insufficient sample size, in the current study, the sample size was estimated on a projected medium to small effect size between the two groups of RPNs. Based on the overall mean standard deviation (1.188) obtained by Maybery and Reupert (2006) and the estimated difference (0.45) between the two groups in the current study, there was an effect size of 0.379 in the current study. Based on an assumed standard deviation of scores on the subscales of the survey being 1.188 units of the Likert Scale, the following sample size calculation provided 90 percent power to detect a difference in groups with a level of significance of 0.05

for a two sample test on mean scores. This means that if there was an anticipated difference in mean scores between community and acute unit RPNs of 0.45 points on the Likert Scale, then a group sample size of 120 would provide at least 90 percent power with a level of significance of 0.05. This would be considered a small to medium effect size. To achieve a sample size (n = 120) in each group, and assuming a minimum response rate of 40 percent, the author estimated that she needed to send the FFMHPQ to approximately 300 RPN practicing in acute admission units and 300 RPNs practicing in community mental health services.

Sampling and selection of mental health services and access to RPNs in acute and community services. In Ireland, within the public mental health system, there are 31 general adult mental health services, organised within 13 super catchment areas, within four Health Service Executive (HSE) areas. Within these mental health services there are a number of different types of services, including acute admission units and community mental health teams (CMHTs). The population for this study was RPNs practicing within the 31 general adult mental health services in Ireland within acute admission units and CMHTs (in four main areas including the day hospital, day centre, community mental health nursing services and homecare). Information regarding the sample and population was obtained from the 2010 and 2011 Inspector of Mental Health Services Report (Mental Health Commission, 2010, 2011). As there is no register of RPNs practicing in either of these areas, a clustered, random sampling approach was used to select 20 of the 31 mental health services that had acute admission units and CMHTs within the regions. Twelve of these 20 mental health services had CMHTs with three or more community mental health nurses (CMHN). Ten of these 12 mental health services were randomly selected for inclusion in the current study. While this was undertaken for practical purposes (i.e. getting enough numbers) it was also thought

important to include the services with less overall numbers of CMHNs. As a consequence two of the smaller mental health services were then randomly selected from the total eight remaining smaller services. This made a total 12 mental health services with approximately 305 RPNs, practicing within 17 CMHTs (in four distinct areas as described above) who were then invited to participate. In addition, approximately 305 RPNs practicing in thirteen acute admission units, linked to these 17 CMHTs, within the 12 mental health services, across all four Health Service (HSE) regions were also invited to complete the FFMHPQ.

A clustered, random sampling approach allowed the statistical inference of results and conclusions that were applicable across the entire population (Brown & Lloyd, 2001). It was anticipated that RPNs would be of different ages, sexes, have various years of experience and educational qualifications and be practicing within different services and in different circumstances in terms of roles, resources and geographical locations. In addition, participants were recruited from both rural and urban locations, enabling access to services for parents in both lower and higher socioeconomic circumstances. This allowed for maximum variation in the sample of RPNs in both groups.

All RPNs who met inclusion criteria, within these 12 mental health services, in the various areas were invited to participate. Inclusion criteria included all RPNs practicing within acute admission units (at Clinical Nurse Manager [level one and two] and Staff Nurse grade) and within day hospitals, day centres, community mental health nursing services and homecare (at Clinical Nurse Specialist, Community Mental Health Nurse/Community Psychiatric Nurse, Clinical Nurse Manager [level one and two] and Staff Nurse grade), who were employed on a permanent or temporary basis, in a full time or part-time capacity. In acute admission units where RPNs provided a 24 hours service, all periods of nursing duty

were included in the data collection. RPNs in the grade of CNM three or above were not invited to participate as they are generally more involved in the management of staff/services as opposed to actual delivery of care. RPNs working outside of the four areas, in community mental health services, such as rehabilitation and within hostels were also not invited to participate as the caseload in these areas are constituted by older service users who would not tend to have children under the age of 18 years. RPNs that were on the locum staff, maternity leave or long term sick leave were also excluded.

To obtain the most detailed information, from the largest number of RPNs, it made most sense to predominantly select more developed (larger) mental health services as the sampling pool. In addition to obtaining access to the largest number of RPNs, without over extending the author's resources, it was anticipated that the RPNs in more developed CMHTs, for a variety of factors, would be better placed to discuss their FFP than RPNs within less developed CMHTs. For example, RPNs practicing within larger CMHTs may have increased opportunity for teamwork and broader scope of services. Another factor considered in selecting mental health services, with more developed CMHTs, was that fact that it may have been difficult to generate a sufficient response rate because of the method used to elicit data in Study One. Ordinarily, when researchers employ postal surveys to collect data, they encounter a variety of challenges and have to expend time and energy in obtaining a sufficient response rate (Dillman, 2000). Compounding the problem of poor response rate, inherent in surveys, is the fact that data was collected at a time of great economic uncertainty in Ireland. On-going recruitment embargos and structural changes in the management and provision of Irish mental health services have resulted in cuts and reductions to services and low workforce morale (O'Brien, 2012; Psychiatric Nursing Association, 2010). Bearing in mind the context in which data was to be collected and the

method of data collection to be employed the author perceived that, to obtain an adequate response rate, that it was imperative to conduct extensive fieldwork to promote the study in advance of data collection.

Due to the economic climate and because DoMHN occupy a position of gate keepers to RPNs, the author perceived that the fieldwork necessitated both written and face-to-face contact with DoMHN in the 12 mental health services from which the sample was drawn. Therefore it was concluded that, with exception of targeting two mental health services, with less developed CMHTs, the best use of time and resources would be spent in obtaining DoMHN cooperation in more developed mental health services. It was thought that there was nothing to be gained by including all 31 mental health services in the sampling frame and possibly having to distribute FFMHPQs in more than 12 mental health services. The additional fieldwork necessitated to promote the study and to gain access would have entailed the author spreading her resources too thinly; with an increased likelihood of an insufficient response rate. It should be noted that the potential of non-participants being different from participants on important survey items (i.e., nonresponse error) may be greater when the response rate is lower (Dillman, 2000). In summary, while the sampling approach employed here was rigorous and every effort was made to obtain a representative sample, it must be considered within the confines of the author's resources, the degree of support and enthusiasm from individual DoMHN and CNM and the Irish economic and political environment at the timing of the survey package being distributed.

Direct contact with the DoMHN, to obtain the contact details of all the RPNs who met the study inclusion criteria, was required as neither the NMBI nor Nursing Associations provide a complete and up to date list of RPNs practicing within acute admission units or

CMHTs. Therefore the author was unable to establish the identity of these RPNs without the support of a link person in the local area. It was also anticipated that the link person may be able to provide useful support to encourage the response rate. However, as previously noted, accessing RPNs, through DoMHN, constituted a major piece of work as there are such varied organisational structures from one area to another (McCardle et al., 2007). However, the author perceived that this was the best way to obtain an accurate and representative sampling frame; DoMHN, with their knowledge of local organisational structures, were best placed to identify those RPNs who practiced within acute admission units and within the four areas within community mental health services. As the DoMHN are the only people who compile, maintain and manage an accurate and up to date list of the RPNs in the various areas, accessing RPNs through DoMHN ensured that the sample surveyed represented all the members of the organisation. Providing DoMHN with details regarding inclusion and exclusion criteria also helped to ensure, in the majority of cases, that the FFMHPQ was not distributed indiscriminately to RPNs, who fell outside of the study population. Collaborating with DoMHN thereby assisted the author to minimise or omit coverage problems and support the contention that the FFMHPQ results represented all members of the population (please see Appendix F for selection of DoMHN consent to access RPNs).

The author sought the co-operation of DoMHN to distribute pre notice letters (Appendix G) one week prior to visiting each of the 12 mental health services in person to distribute FFMHPQs. Fifty FFMHPQs were distributed in each mental health service, irrespective of the size of mental health service, or numbers of RPNs practicing within. An equal number of FFMHPQs were distributed to each mental health service as the author was not able to estimate the exact number of eligible RPNs in each service because this information was not always provided by the DoMHN and sometimes when the information

was provided the figures within the CMHTs differed from those supplied by the MHC (2010, 2011).

Immediately prior to distribution of the FFMHPQ, the author made brief presentations in all of the mental health services to RPNs, their managers and practice development managers, to increase awareness of the purpose of the research and to enhance RPNs' motivation to complete FFMHPQs. In the week following initial FFMHPQ distribution CNMs and Practice Development Managers were asked to distribute FFMHPQs to RPNs that the author did not meet during her visit and to advertise and encourage completion of the FFMHPQs. Reminder FFMHPQs were not sent as DoMHN and CNM preferred to remind RPNs in person. The author advised DoMHN and CNM how to obtain extra copies of the FFMHPQ, if required, and one mental health service requested 10 additional FFMHPQs.

FFMHPQ packages were made available to RPNs in hard copy formats. Electronic format was not used as not all RPNs have access to a computer and in a recent national study by Cusack and Killoury (2012), of Irish RPNs, there was a poor response to electronic surveys. Prior research elsewhere has also suggested that mail-based surveys have higher response rates than their online counterparts (Schonlau, Ronald Jr, & Elliott, 2002). The FFMHPQ (Appendix C) was designed and distributed using a variation of the Total Design Method (TDM) (Dillman, 2000). Substantial and sustained preparatory fieldwork then enabled the author to secure DoMHN and CNM co-operation to allow RPNs to complete the FFMHPQ at their place of work. Once RPNs had completed the FFMHPQ they could return it in a sealed envelope, via internal mail, to their DoMHN (for onward return to the author) or to the author directly using the external mail system.

Participants' demographics and mental health service context. A total of 356

RPNs participated in the quantitative study; however, following data entry and screening, the sample was reduced to 346 participants. Five case deletions were made due to participants violating the inclusion criteria set for the study in relation to type of service setting they were practicing in. As previously noted, RPNs were required to practice within acute admission units or within four areas of community mental health services, including community mental health nursing services, day hospitals, day centres and homecare. Four of the cases in question were practicing within rehabilitation and one in a hostel setting. Five cases were also excluded who were working within assertive outreach on the basis that none of them had experience of caring for service users who were parents of children under the age of eighteen. On this basis they were different to the rest of the sample and consequently their responses not included in the analysis. The age and gender of the 346 participants, included in the analyses, are shown in Table 4.1 below.

Table 4.1

Gender and age demographic details of RPNs in Ireland

Variables	**Gender and Age**	**N**	**%**
Gender	Total	346	100.00
	Female	247	71.39
	Male	99	28.61
Age	Total	343	100.00
	21 – 30	83	24.20
	31 – 40	113	32.94
	41 – 50	97	28.28
	51 – 60	48	13.99
	61 – 70	2	0.58
	Missing	3	0.87

The majority of participants were female (n = 247, 71.4%) and there was a wide spread of age groups with the majority aged between 21- 64, with an average age of 39.02 (*SD* = 9.64). The demographic profile of the RPNs in the current study (in relation to gender and age) is similar to other Irish research with RPNs, including studies conducted by Houlihan et al. (2013), James and Cowman (2007) and Yadav and Fealy (2012). For instance, Houlihan et al. (2013) reported that the majority of their sample was female (n = 90, 78.9) and that there was a wide spread of age ranges represented, with the age of participants ranging from 20 – 55 plus years; with the majority falling within the 20 – 31 age group (n = 43, 37.7%). This may indicate that the sample in the current study is perhaps representative of the general population of RPNs in Ireland. Table 4.2 below outlines the number of participants sought in each of the 12 mental health services and the respective response rates.

Table 4.2
RPN respondents who met criteria and type of service from 12 mental health services

Mental health Service	Acute unit	CMHT	Total RPNs	Total RPNs responded	Total RPNs % responded	Total no of surveys distributed
Waterford	35	15	50	23	46%	50
Laois/Offaly	33	17	50	36	72%	50
Mayo	37	19	56	16	29%	50
Longford/Westmeath	31	23	54	27	50%	50
Carlow/Kilkenny	28	9	37	23	62%	50
Dublin North Central	60	36	96	55	57%	60
Donegal	40	24	64	23	36%	50
West Cork	15	11	26	10	38%	50
Dublin Mid Leinster	30	61	91	41	45%	50
South Wicklow	32	18	50	32	64%	50
West Wicklow	35	42	77	25	32%	50
Dublin South East	40	15	55	35	64%	50
Total	416	290	706	346	49%	610

Note: 57% of RPNs responded to the distributed survey

Although everyone eligible had the opportunity to participate, the response rates from each mental health service were variable. The majority of participants were employed within Dublin North Central mental health services (n = 55, 15.9%), Dublin Mid Leinster (n=41, 11.8%) and Laois/Offaly mental health services (n = 36, 10.4%). As service area is also potentially an important variable in type and extent of FFP (A. Davies, 2004; Devlin & O'Brien, 1999; Korhonen et al., 2008; Slack & Webber, 2008), items within the FFMHPQ sought information regarding the type of mental health service area that RPNs were practicing in. The majority of RPNs were practicing within acute admission units (n = 194, 56.1%) whilst (n = 152, 44%) were practicing within community mental health services. The

largest number of RPNs practicing within community mental health services were practicing within community mental health nursing services (n = 86, 24.9%). The remaining RPNs practiced within the day hospital setting (n = 46, 13.3%), day centre (n = 12, 3.5%) or homecare (n = 8, 2.3%). The majority of the sample were practicing in an urban location (n = 229, 66.2%).

Process of obtaining ethical approval. At the outset of Study One, ethical approval was sought from both DoMHN in the 12 mental health services surveyed (Appendix F) and from University College Dublin (UCD) Human Research Ethics Committee (HREC) (Appendix H). Although this research was considered low risk, and as such fulfilled the criteria for exemption from full review within UCD, HREC, the author applied for full ethical review and approval, which was subsequently granted (LS-11-54-Grant-Maybery).

Full ethical review from UCD, HREC, indicated to potential research participants and their DoMHN that the project was approved by an Irish authority and offered the stamp of approval of the author's employer, UCD. Considering that this research was being completed to fulfill the requirements for a PhD in Monash University in Australia, it was anticipated that full approval, from UCD, HREC, would provide DoMHN with additional reassurance that the author had the necessary plans and resources in place to meet the ethical requirements; in turn this helped to facilitate the author to access RPNs through DoMHN. In addition, it was perceived as important to obtain ethical approval through UCD, HREC, because the research was being undertaken in Ireland and ethics of the study should be given due consideration in that jurisdiction as there may have been local nuances or ethical circumstances not known by the similar committee at Monash University. In addition, the Monash PhD and ethics procedures also required that the UCD ethics approval be considered by the Monash

University. The project was approved accordingly by Monash University Human Research Ethics Committee (Certificate of Approval number CF12/3957 – 2012001695 [Appendix I]).

Following receipt of ethical approval from UCD, the author contacted each of the DoMHN, in the 12 mental health services, by telephone to provide them with information about the study and to make the necessary arrangements to visit them in person (individually and in groups) to discuss possible access to RPNs and distribution of the FFMHPQ. The author also sent each DoMHN an information pack to review in the interim. This pack included a cover letter (Appendix J) outlining the purpose of the study, an information sheet for participants (Appendix K), a copy of the criteria for inclusion of RPNs, and a copy of the FFMHPQ (Appendix C). Upon data collection the majority of DoMHN confirmed their support in writing (Appendix F).

Ethical principles addressed in Study One. Integral to the principle of beneficence is the avoidance of harm to the participants (Orb, Eisenhauer, & Wynaden, 2001; D. Silverman, 2010). This requires that researchers examine in advance the likely consequences of the research for participants and guard against physical and or psychological harm (Bryman, 2004; Denscombe, 2003; D. Silverman, 2010). The study was voluntary, with no coercion from managers or the author to complete the anonymous FFMHPQ and participate in semi-structure interviews. In terms of Study One, anonymity was maintained as participants were instructed not to include any identifying information on the survey – ensuring their anonymity. Talking about, describing and providing written information, about work practices is a responsibility of publicly funded adult mental health services and accordingly, the mental health professionals who work within them (Mental Health Commission, 2007). However, as DoMHN identified RPNs who met the inclusion criteria it was important that

the author took the necessary precautions to safeguard RPN participants from feeling coerced into responding. Hence the author highlighted the voluntary nature of FFMHPQ completion in the cover letter. Furthermore, rather than RPNs having to return FFMHPQs to their DoMHN, they were given a choice to send it back to either their DoMHN by internal mail or to the author by external mail.

In addition, participants should not be harmed due to disclosure of sensitive information, arising from the research; therefore confidentiality should be adhered to at all times (Denscombe, 2003; D. Silverman, 2010). The information sheet informed RPNs of the measures that would be taken to ensure their anonymity, should they volunteer to respond. As no identifying information was collected from RPNs they could not be identified and therefore their privacy was not violated. The storage of information during and after the study was informed by the principles of the Data Display Model (Miles & Huberman, 1994). The de-identified data from the FFMHPQs was password protected and stored securely on the author's computer in UCD and will be held for five years after the study has been completed.

The second ethical principle expressed in the Belmont Report is respect for human dignity (Orb et al., 2001). The right to self-determination and the right to full disclosure are central to this principle and form the basis for informed consent (Orb et al., 2001; D. Silverman, 2010). Informed consent is defined as "the voluntary and revocable agreement of a competent individual to participate in a therapeutic or research procedure, based on an adequate understanding of its nature, purpose, and implications" (Sim, 1986, p. 584). As previously noted, participant involvement in Study One and Study Two was entirely voluntary. Participants were provided with information about the study in the form of written

information sheets and reinforced verbally as needed. In Study One, consent was implied through return of the completed FFMHPQ by RPNs.

The principle of justice is the third broad principle outlined in the Belmont report and is concerned with participants' right to fair treatment (Orb et al., 2001). Participants were advised in writing that there were no foreseeable risks to their participation in either Study One or Study Two and they did not have to respond to any question they considered to be distressing. The right to privacy also forms part of the principle of justice which was maintained by ensuring that confidentiality and/or anonymity were preserved at all stages of the research study as previously described.

Selection and purpose of the FFMHPQ and its modification for use in the Irish context.

Selection of the FFMHPQ. In order to elicit the quantitative data in Study One the author utilised an existing instrument known as the FFMHPQ devised by Maybery and Reupert (2006) and further refined by Maybery et al. (2012a). As measurement tools can be crucial to determining the merit of a study, Dillman (2000) suggests that novice researchers should generally not construct their own questionnaires or scales unless the literature reveals that there is no tool to measure the phenomenon they are studying and they have access to an expert in constructing the tool. The author decided to use a previously established questionnaire, as opposed to developing her own questionnaire, because she perceived that the FFMHPQ had the capacity to partly address her research question(s). Additionally she was aware that developing an instrument with sound psychometric properties is a complex and time consuming activity (Creswell & Clark, 2007). Furthermore, in recent research the authors of the FFMHPQ (Maybery et al., 2012a) have further enhanced the validity and

reliability of the FFMHPQ. As it has been employed in Australia, Norway and Canada (the latter unpublished) there is normative data available as a baseline for the author to compare her results with; thereby creating the foundations for ongoing comparative research between the three countries.

Although a small number of questionnaires exist which are designed to measure mental health professionals' FFP with parents who have mental illness, their children and families (Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Thompson & Fudge, 2005) the FFMHPQ devised by Maybery and Reupert (2006) and further refined by Maybery et al. (2012a) was deemed to be the most suitable for use in this current study. This was because its Likert Scale structure permitted a higher level of measurement than the scoping questionnaire devised by Thompson and Fudge (2005) and the subscales are more comprehensive than that of Korhonen et al. (2008). In addition, the subscales are thought to measure the key factors associated with mental health professionals' FFP (Maybery et al., 2012a). Additionally although Australian mental health services would appear to be more advanced than Irish mental health services, particularly in regard to FFP, the structure and philosophy of Australian mental health services is somewhat similar to that in Ireland. Furthermore, as the FFMHPQ has been constructed in English, the author did not have to translate its items, as would have been the case if she were to have used the Finnish questionnaire devised by Korhonen et al. (2009).

The FFMHPQ. The original multidimensional measure employed a seven point Likert Scale (ranging from strongly disagree to strongly agree) and used 49 items within 16 subscales which focused upon variables that represent FFP behaviours. The subscales include family and parenting support, support to carers and children, assessing the impact on

children, connectedness and referrals and include variables that represent potential predictors of mental health professionals' FFP (workforce support, location issues, time and workload, policy and procedures, professional development, co-worker support, worker confidence, engagement issues, training, skill and knowledge, inter-professional practice and service availability). In this respect the measure is capable of identifying which variables best predict mental health professionals' FFP (Maybery et al., 2012a). For example, is skill and knowledge (or other variables) the key variables driving family-focused behaviours, such as providing support to carers and children or making referrals?

A low, medium or high score on any particular sub scale is interpreted according to the particular dimension of FFP that that particular sub scale is designed to measure. However a low score suggests a reduced family focus and a high score increased family focus. Each of the individual subscales are conceptually distinct from one another but together they measure various dimensions of FFP. In addition to the subscales there are a number of demographic items measuring participants' role and work related characteristics, i.e. education and experience that may impact on their FFP.

Modification of the FFMHPQ. Although the FFMHPQ had the capacity to partially address the research aims and questions, in the current study, it required minor modification to enhance its appropriateness for use in the Irish context and to enable the author to develop and expand upon the findings in the Australian context. That said, in order not to compromise the integrity of the FFMHPQ and to enable comparison of findings, modifications were kept to a minimum (Dillman, 2000). Table 4.3 illustrates the structure and items from the measure.

The questionnaire design and layout is crucial when designing self-administered questionnaires as participants usually provide the relevant information without assistance

from the researcher (Burton, 2000; Creswell & Clark, 2007). In keeping with Dillman's TDM, the FFMHPQ was designed in a booklet style comprising 15 pages (see Appendix C). A cover page provided instructions to the participants regarding the layout and completion of the FFMHPQ. RPNs were also advised to refer to their experience in their current position. As the author wanted to compare RPNs' FFP, within acute and community settings, she needed RPNs to refer only to their current area because although they may have been working in acute units immediately prior to FFMHPQ completion, they may have been working in community settings at time of completion or vice versa.

Considering that the original version of the FFMHPQ was devised for use in the Australian context, with a variety of professional disciplines (e.g. psychologists, social workers), and not specifically RPNs, the author also needed to adapt the language in the FFMHPQ to reflect its exclusive use with RPNs practicing within general adult mental health services in Ireland. For example the term 'consumer parent' was changed to 'service user' and the term 'worker' was changed to 'RPN'. It was also conceivable that some RPNs may not have understood certain terms such as 'family sensitive practice', 'family focused care' or 'family work'. For this reason, the term FFP was used throughout and a short and simple explanation was placed in the cover sheet of the FFMHPQ, to explain what this term meant in the context of the study. A more comprehensive definition of FFP, in line with Falkov's Family Model (2012), was provided to reflect the reciprocal impact of parenting on the parent's mental health and the parent's mental illness on their parenting role and children's well-being. For instance FFP was defined as the process of working with service users around issues related to parenting with a mental illness, which may affect their parenting capacity and/or their mental health. It also entailed working with service users' children (those younger than 18 years of age) and their families.

Additional questions were also included in the biographic section to ascertain: which HSE area RPNs were located within, whether they practiced in a rural or urban location and within acute admission units or community mental health services, which of the four areas within adult community mental health services (i.e. day hospital, CMHNS, day centre and homecare) and if they were directly involved in delivering care to service users. This enabled separate analyses to determine: differences between the amount and type of RPNs' FFP, between community mental health services and acute admission units and between one particular area of community mental health services (RPNs practicing within community mental health nursing services) and acute admission units. Participants were also asked whether they worked within the home environment as this variable has been identified as having the potential to be important in facilitating FFP (Devlin & O'Brien, 1999; Slack & Webber, 2008). Information regarding family training and child training was also collected as these have been identified in the literature as potentially important variables (Korhonen et al., 2008; Korhonen et al., 2009; Krumm et al., 2013; Maybery & Reupert, 2006, 2009) in predicting and enabling FFP.

Additional variables were also included in the biographic section to measure the amount of FFP RPNs undertake in the normal course of their work. These variables included the number of parents on RPNs' case load and the number of RPNs' face-to-face contact with parents and with children within a specific time frame. These items also helped to quantify the extent to which RPNs engaged in FFP within a particular time frame and how this was undertaken. This aspect was not sufficiently addressed by Maybery and colleagues in their previous work, yet it is an important factor in interpreting RPNs' responses (Korhonen et al., 2008; Maybery & Reupert, 2006) and the information will also be invaluable for managers and policy makers.

The degree of RPNs' contact with service users and their children may also have had ramifications for how they responded to items in the FFMHPQ; those who had little or no previous experience of caring for service users who were parents would be likely to score low, particularly on those items and subscales that measured FFP. Hence RPNs' lack of exposure to service users who were parents may have been the reason for their low scores as opposed to them choosing not to engage in FFP. Alternatively, RPNs may also have scored low despite having current, or previous contact with service users who were parents; by having measured RPNs' exposure to parents who have mental illness, their children and families, the author was able to factor this in when interpreting the findings.

Three additional items were also added into the final part of the biographic section to ascertain whether the RPN was a parent themselves and whether they felt confident around their own and or their friends/families' children. Korhonen et al. (2008) found that those RPNs who were parents themselves felt more confident about engaging in FFP. These items in the biographic section were situated towards the end of the FFMHPQ as RPNs may have found them difficult to answer. Also, for this reason, as per Dillman's (2000) instructions, the author included a brief explanation as to why these particular items were included. This explanation was located immediately prior to the items and may have served to reduce RPNs' reluctance in answering them.

In addition to the changes described above, minor changes were made within some of the 16 subscales, (Appendix L) to substitute the term 'consumer parent' with 'service user'. Furthermore, item number three 'there is no time to work with service users' children/families' was also split into two items as follows: 'there is no time to work with service users' children' and 'there is no time to work with service users families', to reflect

the fact that service users' family and service users' children are generally seen as two distinct entities within Irish Mental Health Services. In addition, as three of the 16 existing subscales had low reliabilities (location .41, engagement issues .42 and support to carers and children .58) five additional items were added to these subscales in an attempt to increase their reliability, as recommended by Maybery et al. (2012a).

Three additional subscales were also developed to measure key aspects of FFP that were not considered by Maybery et al. (2012a) and to more comprehensively address the author's research aims. The first of these subscales measured RPNs' interventions to promote parents' mental health. Three items within this subscale measured RPNs' perceptions of the extent to which they were able to identify how parenthood can precipitate and influence service users' mental health, assess the impact of the service users' parenting role on their mental health and suggest practical strategies to facilitate service users to manage the dual effects of their parenting role and their mental illness. As previously noted, only a few researchers have noted the impact of parenting on parents' mental health (Ackerson & Venkataraman, 2003; Baulderstone et al., 2012; Beardslee et al., 2012; Cowling & McGorry, 2012; Diaz-Caneja & Johnson, 2004; Falkov, 1998, 2012; Montgomery et al., 2006). Moreover, the author contends that children's needs and well-being appear to be the primary concern in the existing literature and there is a dearth of information about interventions to support parents.

The second subscale measured RPNs' confidence around parenting and children in general. Although Korhonen et al. (2008) suggested that RPNs' parenting status may affect their FFP, it was unclear as to how and why parenting status impacted FFP and whether being

a parent was essential and/or sufficient, or whether experience around family and friends' children was also beneficial.

Whilst the third additional subscale was designed to measure whether RPNs perceived that FFP was within their remit, it, along with five original subscales, was excluded from the final analysis due to low reliabilities. Initial reliabilities of the FFMHPQ subscales, when used in the current study, are reported in Appendix L. The table that follows is modified from table one in the manual devised by Maybery, Goodyear, and Reupert (2012b) and outlines the version of the modified FFMHPQ highlighted earlier. It also delineates the subscales of the FFMHPQ, used in the final analysis, along with definitions of those concepts.

Table 4.3

The FFMHPQ including subscales, subscale definitions, Cronbach reliabilities and items.

Subscale (alpha reliability)	**Subscale Definition**	**Item**	**Item**
Support to carers and children (.54) (DV)	The level of information, advocacy and referral provided to carers and children.	I don't provide information to the carer and/or family about the service user's medication and/or treatment	9
		Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the service user's mental illnesses	26
		Rarely do I consider if referral to peer support program (or similar) is required by my service user's children	37
Engagement issues (.51)	The opportunity for engagement with family members	Many service users do not consider their illness to be a problem for their children	10
		Discussing issues for the service user with others (including family) would breach their confidentiality	27
		The children often do not want to engage with me about the service user's mental illness	38
Assessing the impact on the child (.57) (DV)	How well the worker assesses the impact of the parent illness on the child/ren	I am able to determine the developmental progress of service user's children	11
		I am able to assess the level of children's involvement in their parent's symptoms or substance abuse	28
		I should learn more about how to assist service users about their parenting and parenting skills	29
		I would like to undertake future training to increase my skills and knowledge for working with the children of service users	39
		I would like to undertake training in future to increase my skills and knowledge about helping service users with their parenting	44
Skill and knowledge (.76)	Worker skill and knowledge regarding impact of parental mental illness on children.	I am knowledgeable about how parental mental illness impacts on children	13
		I do not have the skills to work with service users about how parental mental illness impacts on children	30
		I am not experienced in working with child issues associated with parental mental illness	40
		I am skilled in working with service users in relation to maintaining the well-being and resilience of their children	45
		I am knowledgeable about the key things that service users could do to maintain the well-being (and resilience) of their children	49
Service availability (.51)	There are programs to refer families to.	There are no parent-related programs (e.g. parenting skills) to refer service users to	14
		There are no family therapy or family counseling services to refer service users and their families to	31
Connected-ness (.68) (DV)	Workers assessment of parent awareness of child connectedness	I am able to determine the level of importance that service users place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)	15
		I am able to determine the level of importance that service users place on their children maintaining strong relationships with other family members (e.g. other parent, siblings)	32
		I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)	41
Referrals (.54) (DV)	Referring family members to other programs	I do not refer children of service users to child focused (e.g. peer support) programs (other than child and adolescent mental health)	16
		I refer service users to parent-related programs (e.g. parenting skills)	33

Subscale (alpha reliability)	Subscale Definition	Item	Item
Time and workload (.51)	Time or workload issues regarding family focused practice	There is no time to work with families or children	3
		The workload is too high to do family focused work	20
Family and parenting support (.56) (DV)	Providing resources and referral information to consumers and their families	I regularly have family meetings (not therapy) with service users and their family	7
		I provide written material (e.g. education, information) about parenting to service users	24
		I regularly provide information (including written materials) about mental health issues to the service user's children	36
		I often consider if referral to parent support program (or similar) is required by service users	43
		I provide education sessions for adult family members (e.g. about the illness, treatment)	47
Worker confidence (.61)	The level of confidence the worker has in working with families, parents and children	I am not confident working with service users about their parenting skills	8
		I am not confident working with families of service users	25
		I am not confident working with children of service users	48
Inter-professional practice (.59)	Team work and inter-professional practice	Children and families ultimately benefit if health professionals work together to solve the family's problems	34
		Team-working skills are essential for all health professionals providing family focused care	42
		I want to have a greater understanding of my profession in a healthcare team approach to working with children and families	46
Training (.79)	Worker willing to undertake further training	I should learn more about how to assist service users about their parenting and parenting skills	29
		I would like to undertake future training to increase my skills and knowledge for working with the children of service users	39
		I would like to undertake training in future to increase my skills and knowledge about helping service users with their parenting	44
Confidence around parenting and children generally (.91)	Confidence around own or others (family and friend's) children	In general I am very happy with my parenting	63
		I have confidence in my parenting skills	64
Interventions to promote parents' mental health (.74) (DV)	RPNs' interventions to reduce the impact of the service user's parenting role on their mental health	I am able to identify how parenthood can precipitate and influence the service user's mental health	50
		I assess the impact of the service user's parenting role on their mental health	51
		I suggest practical strategies to facilitate service users to manage the dual demands of their parenting role and their mental illness	52

In order to integrate Falkov's (2012) Family Model, within the study methodology, parallels were drawn between the subscales within the FFMHPQ and the six domains within the Family Model, as illustrated in Table 4.4 below. Hence in measuring and reporting the

findings of these subscales cognisance was also taken of the corresponding domains within the Family Model. The subscales within the FFMHPQ were mapped to the domains of the Family Model that they most coincided/resonated with in terms of definition and scope (please see subscale definition and items in Table 4.3 above).

Table 4.4

Link between the subscales in the FFMHPQ and the domains of the Family Model

Domains of Family Model	**Subscales in FFMHPQ**
1 Adult/parental mental illness can adversely affect the development, mental health and in some cases, the safety of children (an adult/parent - to-child influence).	Assessing the impact on the child Skill and knowledge
2 Children, particularly with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill-health in their parents/carers (a child-to-parent influence).	Interventions to promote parents' mental health
3 Growing up with a mentally ill parent can have a negative influence on the quality of that person's adjustment in childhood and in adulthood, including their transition to parenthood (a childhood-to-parenthood family lifespan influence).	Connectedness
4 Adverse circumstances (such as poverty, lone parenthood, social isolation or stigma) can negatively influence both adult/parent and child mental health and generate resilience (an environment-to-family influence).	Connectedness
5 The quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members (a service-to-family influence).	Support to carers and children Engagement issues Training Service availability Referrals Time and workload Family and parenting support Worker confidence Inter-professional practice Confidence around parenting and children generally
6 The above five principles and their interactive relationships all occur within a broader social network encompassing cultural and community influences (a broader, more distal, environment-to-family influence).	Connectedness

Reliability and validity of the FFMHPQ. In using an established instrument the researcher must consider the validity and reliability of past scores, whether the items fit their research question(s) and whether adequate scales are used to report the information (Creswell & Clark, 2007). The FFMHPQ has been developed over ten years, is designed for use in adult mental health settings and its subscales have good content and face validity (Maybery et al., 2012a). Initially Maybery and Reupert developed the items for the FFMHPQ in parallel with a systematic review of the literature (Maybery & Reupert, 2009) and with detailed input from the Victorian Families where a Parent has a Mental Illness (FaPMI) Co coordinators and Vichamps project (Maybery & Reupert, 2006). The review highlighted workplace policy and supports, worker skill and knowledge and service user factors as focal to FFP. These focal domains guided the initial generation of 100 items. These items were then subjected to rigorous review, rewrite and re- review, in Delphi focus groups with FaPMI coordinators.

The FFMHPQ was then further refined and validated in a research study that outlined the psychometric properties of the FFMHPQ when used in adult mental health services. The measure was developed from data collected from 307 adult mental health workers, predominantly RPNs, in mental health services across ten regions in Victoria (Australia) between 2008 – 2010 (Maybery et al., in press). A principle component analysis was undertaken to determine the subscale structure of items. The principal component analysis highlighted 16 subscales that summarised 49 items (Maybery et al., 2012a). Due to the rigorous development of the scale with expert family focused workers (e.g. FaPMI coordinators) the scale is considered to have face and content validity. With regard to reliability, Cronbach's alpha coefficients were reported between 0.70-0.90 for all of the subscales excluding the three previously noted.

Although the FFMHPQ appears to have worked well with a variety of mental health professionals practicing within the Australian adult mental health services, where it was originally developed, and in Norway (Lauritzen et al., 2014b), a number of issues needed to be addressed when using it in the Irish context. First, the validity of the FFMHPQ outside the Australian adult mental health service context had to be established. Additionally, no evaluation of the instrument has been published that examines its psychometric properties when used with RPNs within any service in Ireland. Although there are similarities between the Australian and Irish adult mental health systems, the validity of the questionnaire in one country may not necessarily transfer to another (Drennan, 2008). Furthermore, the FFMHPQ was designed for use by all mental health professionals and not specifically for use by RPNs.

Reliability and validity of the additional items included in the FFMHPQ, including the three additional subscales, was established by both a panel of experts, pilot study, principle FFMHPQ administration, and internal consistency reliability indexes. Initially an advisory panel assessed the additional items in the FFMHPQ for their content validity. The members of this panel were selected for their expertise in FFP and PMI or were in a position to represent their professional grouping's opinion on the measure. In order to evaluate the FFMHPQ all those involved were asked to rate each item using a five point Likert Scale (not relevant – extremely relevant). If an item had been evaluated as not relevant by 20 percent of these experts it would have been deleted (Lynn, 1986). All the items were deemed relevant and therefore retained. Subsequently, the FFMHPQ was piloted with 10 RPNs from a mental health service (five from each of the two services) which had not been selected for inclusion in the study to evaluate the clarity of the questions and overall design; these RPNs were similar to those participating in the actual study. Data collected during this exercise was excluded from the final analysis. The primary changes made to the FFMHPQ after the pilot

study included an explanation of the term 'dependent children' as some RPNs were unsure as to what this term meant in the pilot study. The author also included an additional item which she situated immediately before the final item (additional information text box). This item asked RPNs if they would like to take part in an interview. The inclusion of this item was necessary as during the pilot all RPNs overlooked the information included with, but separate to the FFMHPQ, which asked them to indicate if they wished to take part in a follow-up interview. The additional items acted as a prompt for RPNs to include their contact details should they wish to participate in an interview.

Issues of reliability in the administration of the FFMHPQ during the actual study were also addressed. The potential problems of random and systematic error were also addressed. When RPNs returned their FFMHPQs data was checked upon input into the Statistical Package for the Social Sciences (SPSS version 20) and again upon the completion of inputting all data. The assistance of a statistician and supervisor was sought when devising a coding system in SPSS 20 and in deciding what tests would best demonstrate what was found in the data. Finally, reliability analysis was run on the subscales when used in the Irish context and this resulted in six subscales being excluded in the analysis due to poor reliability. Furthermore, some of the subscales that were retained were modified (by reducing items within them) to increase their reliability.

Quantitative data analysis. The statistical package for the social sciences (SPSS version 20) was used to analyse the quantitative data utilising descriptive and inferential statistics (hierarchical multiple regression, ANOVA, MANOVA, ANCOVA and MANCOVA). These methods were used to describe the sample characteristics and to determine the factors that predicted RPNs' FFP and to then compare two subgroups of

participants (e.g. RPNs practicing in acute units and in community mental health nursing services) on subscales and items within the FFMHPQ. Further detail regarding the purpose and results of the above tests is discussed in chapter five which reports the quantitative results.

Study Two - Qualitative Component

A description of the qualitative component of the study and selection of participants follows and includes ethical considerations, issues in devising and conducting semi-structured interviews, and the steps taken to enhance the methodological rigour of Study Two. This section concludes with a section on how the qualitative data were analysed.

Overview of the qualitative approach. Qualitative research methods have become increasingly important ways of developing nursing knowledge for evidence based practice (Parahoo, 2006). In general, qualitative research explores peoples' subjective understandings of their everyday lives (Pope & Mays, 2006). As it attempts to interpret social phenomena (interactions, behaviours etc.), in terms of the meanings people bring to them, it is often referred to as interpretive research (Pope & Mays, 2006). A qualitative component was considered necessary in the current study as little is known about RPNs' FFP, and is useful in following quantitative work to interpret, qualify or illuminate findings (Brown & Lloyd, 2001). In contrast to the use of closed ended questions, as employed in the FFMHPQ in Study One, the use of semi-structured interviews to collect open-ended information in Study Two allowed the author to explore RPNs' in-depth experiences of caring for parents who have mental illness, their children and families.

As previously noted, the aim of the qualitative component was to explore the nature and scope of high scoring RPNs' FFP and to identify factors that affected their capacity to engage in FFP. A purposeful sampling approach was undertaken, whereby the author identified and contacted high scorers on the FFMHPQ from Study One, (n= 109, 32%), practicing in both acute admission units and within community mental health nursing services, who had current or recent (within last 12 months) experience of caring for parents who have mental illness and who agreed to do interviews. High scorers on the FFMHPQ were identified as those who scored between five and seven on at least three of the six FFP behavioural subscales (DVs) (seven being the maximum). Fifty seven participants agreed to take part in interviews and 30 of these were high scorers. Twenty one of the high scorers were eligible to participate as they were practicing within acute units (n= 4) or community mental health nursing services (n=17). From these, 14 participated in semi-structured interviews. The highest scorers were selected as it was considered that these RPNs would be more likely to be engaging in FFP than those with lower scores and thereby able to provide the necessary information to address the final three aims and questions.

Ethical considerations. Ethical approval was sought from both UCD HREC (Appendix H) and Monash University Human Research Ethic Committee (MUHREC) (Appendix I) for Study Two.

Participants consented to participate in interviews by completing and returning a form with their contact details (Appendix M) which was included with (but separate) to their FFMHPQ. Prior to commencing the interview, the participants were invited to complete an informed consent form (Appendix N). The name and address of the volunteer remained confidential and was only used for contact purposes.

Whilst it is acknowledged that face-to-face interviews may be considered more intrusive than surveys, the nature of the questions was not considered to be personally sensitive or intrusive, but instead related to participants' professional experiences. Maintaining participants' confidentiality is often a major ethical concern of interpretive research because of the intimate nature of the research but was maintained through the use of pseudonyms and changing specific contextual details that could possibly reveal the identity of the participant. As well, two weeks after their interview, participants were invited to review their individual interview transcript, in a process known as member checking (Lincoln & Guba, 1985) and were able to delete any information they believed to be potentially identifiable, add anything they considered to be relevant and/or change anything they considered to be inaccurate.

Participants were informed about the time required to participate in the interview and told that their participation was contingent upon them returning the completed FFMHPQ. The process of digital audio recording interviews was clearly outlined in the information letter and participants' permission to record their interview was obtained in written form on the consent form and verbally at the start of the interview. Participants were given the option to not have their interview recorded and assured that they could terminate their interview at any given time without giving a reason.

The author endeavoured to minimise the possibility of psychological harm, especially pertinent given that PMI is a subject that is fraught with controversy (Falkov, 2012). RPNs may have been reluctant to discuss the extent to which they addressed (or did not address) the needs of parents who have mental illness, their children and families because they believed they should have been more proactive in meeting their needs. Therefore, the author

appreciated that there may have been some reluctance and apprehension on behalf of RPNs in relation to discussing the difficulties experienced by parents who have mental illness, their children and families and their practice in this context.

Accordingly, interview questions were carefully phrased, and participants were provided with an opportunity to ask questions, air any objections or not respond to any particular question (King & Horrocks, 2010; Orb et al., 2001; D. Silverman, 2010). Having practiced as an RPN for ten years, the author was wholly cognisant of the challenges and difficulties in engaging in FFP. Acknowledging this, the primary goal was to avoid at all costs increasing RPNs' anxiety. In an effort to further reduce RPNs' anxiety, language was kept as simple as possible, explanations were provided where needed and reassurance was provided regarding confidentiality.

Although face-to-face interviews are not anonymous the confidentiality of the information provided was assured by not disclosing the individual or agency names and through appropriate storage of data. Where participants reported service gaps, not one organisation was highlighted but was instead reported as a general issue. In reporting the findings specific comments were reported if they accentuated a particular theme, but neither participants nor their institution were identifiable from what was written. By recruiting RPNs from several mental health services and locations across Ireland (n = 8), RPNs' confidentiality was further protected as this helped mask the location, as well as the identity of the individual who generated the data (Pope & Mays, 2006). Participants in Study Two were also advised in an information sheet that interview transcripts would be assigned a code so that they could not be linked to participants' names. Assurance was provided that

participants' names would be held in strict confidence by the author and participants' names would not be connected with any statement.

RPNs were also informed of the benefits of participating in this research, including opportunities for reflection and discussion about professional practice. With regard to storage of qualitative data, no identifying information was entered onto computer held files and the author held one separate sheet that contains codes and corresponding informants' identity in a locked filing cabinet. Following all interviews, transcriptions were only identifiable by code and access to the raw data was restricted to the author.

The nature and purpose of semi-structured interviews and issues in their conduct.

Rationale for using semi-structured interviews. Interviews facilitate the collection of rich data by providing participants with the opportunity to fully describe their experience (Holloway, 1997; King & Horrocks, 2010; Sandelowski & Barroso, 2002). Semi-structured interviews were employed on the basis of a flexible structure, consisting of open-ended questions, focusing on a specific area to be explored. Flexibility within the study design enabled the author to vary the sequence of the questions and ask new questions in response to significant issues raised (Bryman, 2004; Denscombe, 2003; King & Horrocks, 2010). Hence, although the interview questions focused on specific issues raised by Study One, their open-ended nature provided participants with the opportunity to expand further (B. Davies & Allen, 2007). Individual interviews (as opposed to focus groups) were considered appropriate given that participants came from a wide geographical area and the potentially sensitive nature of the questions on professional practice.

Nature of topic guide and conduct of interviews. The interview topic guide was informed by several sources; existing literature surrounding mental health professionals' FFP, the Family Model (Falkov, 2012), research questions and the quantitative results obtained in Study One. The guide focused on the nature and scope of RPNs' FFP and factors that affected their capacity to engage in FFP. Participants' demographic data were also collected in terms of gender, age, parenting status, service type, years of experience, time in current position, highest educational qualification and family and/or child focused training.

An initial guide was established by the author in consultation with her supervisors, after which pilot interviews were conducted, with one RPN who worked in an acute admission unit and with another who worked in community mental health nursing services. Neither of these RPNs were involved in the actual study. At the conclusion of this interview, feedback was elicited from the participant on the interview guide. Both participants indicated that they were caring for mothers with a range of diagnosis and not just EMI and that they were also caring for increasing numbers of fathers who were acting as primary carers for their children. Moreover they also suggested that they would like to have discussed these aspects of their practice. Therefore the interview scheduled was modified slightly to reflect participants' requests and changing the focus on RPNs' practice with mothers with EMI to RPNs' practice with parents who have mental illness. After items were revised, additional discussions were held with the author's supervisors to complete the final interview topic guide (see Appendix D). The topic guide was divided into several sections dealing with different key issues including (a) family focused practices (e.g., tell me about your practice with service users who are parents); (b) capacity of RPNs to engage in FFP (e.g., can you tell me about what factors, if any, facilitate and/or hinder you to engage in FFP?) and (c) how to enhance RPNs' capacity to engage in FFP (e.g., what might help you in working with parents

who have mental illness? their child(ren)? other family members?). The domains of Falkov's Family Model were also aligned with the topic guide and hence informed the focus of enquiry within the interviews (see Table 4.5).

Table 4.5

Link between domains of Family Model and focus of inquiry in Study Two

Domains of Family Model	**Areas of focus**
1 Adult/parental mental illness can adversely affect the development, mental health and in some cases, the safety of children (an adult/parent - to-child influence).	How, if at all, do you decide to become involved with service users' children? Can you tell me more about that and what your involvement entails?
2 Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill-health in their parents/carers (a child-to-parent influence).	Tell me about your practice with service users who are parents
3 Growing up with a mentally ill parent can have a negative influence on the quality of that person's adjustment in childhood and in adulthood, including their transition to parenthood (a childhood-to-parenthood family lifespan influence).	Tell me about your practice with service users who are parents, with their children and adult family members
4 Adverse circumstances (such as poverty, lone parenthood, social isolation or stigma) can negatively influence both adult/parent and child mental health and generate resilience (an environment-to-family influence).	How, if at all, do you decide to become involved with adult family members of parents who have mental illness? Can you tell me more about that and what your involvement entails?
5 The quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members (a service-to-family influence).	Tell me about your capacity to engage in FFP, with parents, who have mental illness, their children and adult family members How may RPNs' capacity to support parents who have mental illness, their children and families be further developed?
6 The above five principles and their interactive relationships all occur within a broader social network encompassing cultural and community influences (a broader, more distal, environment-to-family influence).	Tell me about your practice with service users who are parents, with children and adult family members

The interviews commenced with some general questions that encouraged the participants to talk freely about their experiences as RPNs, in caring for parents who have mental illness, their children and families (e.g., tell me about your experience of caring for parents, who have mental illness, their children and their families. What has this experience been like for you?), followed by questions that explored factors that facilitated and/or hindered RPNs' capacity to engage in FFP (e.g., why do you think you work with families more than your colleagues? Why is it important to you?). Interviews concluded by exploring how RPNs' FFP could be strengthened (e.g., how do we get other RPNs to do what you are doing?). As each transcript was analysed before undertaking the next interview the topic guide was slightly changed to incorporate important areas as they arose. For example, the first three participants suggested that their relationship with parents was key to providing optimal supports for parents and that by supporting parents in their parenting role they could also support children. Hence, the belief that RPNs could support children via their parents was further explored in subsequent interviews.

The author also took brief field notes during the interviews and expanded on these notes following the completion of each of the interviews, to incorporate author insights and reflections regarding the methodology and the content discussed. The context of the interview was described in the field notes as well as any factors that might have influenced the data collection process. For example, the environment in which the interview took place, observations regarding the demeanour of the participant, and the dynamics of the interview were described.

All interviews occurred in participants' workplaces, except for one which was conducted on a university campus. At the commencement of each interview, an informed

consent form was signed, and the participant was given an opportunity to ask any questions about the study. As previously noted, while the basic interview guide was followed, the interviewer approached the guide flexibly to allow for issues to be discussed fully, and for additional topics to be explored. The duration of the interviews ranged from forty five minutes to one and half hours. With participant permission, all interviews were recorded with a digital audio recorder and subsequently transcribed.

Methodological rigour - reducing bias in Study Two. A common criticism of qualitative approaches is that they have the potential to be subjective, and lack validity and reliability (I. Parker, 2004). To address these issues, procedures were incorporated within the research process to address the author's potential biases, experiences, selective perception and theoretical predispositions. The strategies employed to maintain the methodological rigour of the research process included:

1. Examination of the author's assumptions
2. The use of a reflective journal/log
3. Examination of negative cases
4. Discussing cases with a supervisor in regard to emerging themes.

Issues of bias were addressed at the commencement of the research process and during the course of the study during supervision and through peer support from a peer reviewer and fellow doctoral students (Lincoln & Guba, 1985). The peer reviewer was a colleague known to the author who she talked to regularly about the study. Reflecting on the progress through the study allowed the author to identify areas where her attitudes and opinions may have affected the research process (Koch, 2006). Reflexive research recognises

that the author is part of the setting, circumstances and culture being investigated (Liamputtong & Ezzy, 2005). As the author acknowledged how her "identity, values and beliefs played a role in the production and analysis of qualitative data" (Denscombe, 2003, p. 269) she explicated how the research agenda had been shaped by her own insights and biases, developed from her own experience as an RPN and her reading of the literature. The author perceived that her background as an RPN and her experience of working in both Irish and Australian mental health services enhanced her credibility with participants. This enabled a connection with participants based on a sense of shared understanding of the role of RPNs and the possible challenges they may encounter in engaging in FFP. This shared understanding culminated in RPNs providing free flowing accounts of their FFP and their colleagues' FFP.

At the same time, it must be acknowledged that a background in psychiatric nursing may also be a double-edged sword in that the author' s familiarity may have caused her to ascribe or assume certain meanings to participants' words or jargon, behaviours, and decisions, (King & Horrocks, 2010; Minichiello, Aroni, Timewell, & Alexander, 1995). Being aware of this disadvantage, the author attempted to step back to reflect on the meanings of situations rather than accept possible pre-conceptions and interpretations at face value. This type of self-awareness was important and actions were taken such as listening to earlier recorded interviews in order to identify problems. Close attention to the recording during transcription sensitised the author to ways in which she could have posed questions differently or to cues which were missed (King & Horrocks, 2010; Liamputtong & Ezzy, 2005). In addition, the author maintained a reflective log/diary as part of the process to maintain rigour (Koch & Harrington, 1998; Mordoch, 2010) and used this in discussions with her peer reviewer. At all stages of the data analysis process, the author made journal entries

reflecting her interaction with the text, occasions when she was uncertain of her interpretations, possible interpretive options, insight into how her presuppositions may have influenced interpretation and how such biases were minimised. Another strategy employed to minimise author subjectivity entailed the explicit examination of negative cases as recommended by Lincoln and Guba (1985) and D. Silverman (2000). Negative cases are accounts by participants that do not fit within the dominant sentiments expressed by other participants (Pope, Ziebland, & Mays, 2000; Willig, 2001). As negative cases highlight potential areas of difference they raise questions regarding the interpretation of themes (King & Horrocks, 2010; Willig, 2001).

In a final attempt to enhance methodological rigour the author discussed cases with a research supervisor. Specifically, the first two cases were analysed independently by both the author and supervisor (A Reupert), followed by a shared examination of theme similarity and a discussion of interpretive concerns. This process revealed a high degree of similarity between the author and her supervisor in terms of the emergence of themes. In addition to discussing commonalities, the meetings also involved the discussion of points of difference in analyses when they arose, specifically examining whether such differences reflected research biases. Such a process should not be viewed as an effort to establish inter-rater reliability for the analysis, but rather as another credibility check (Elliott, Fischer, & Rennie, 1999; King & Horrocks, 2010; Willig, 2001), designed to gauge the suitability of analysis and the influence of the researcher 's biases (from both a personal and theoretical perspective). According to Ballinger (2006), such strategies can be taken as evidence of "systematic and careful research conduct" (p. 241), which is viewed as an essential part of ensuring the quality of qualitative research. The strategies provided an avenue through which the author's thoughts and assumptions were made clear and tangible, whilst also providing mechanisms to check the

impact of such beliefs and biases. At the same time it is acknowledged that it is perhaps never possible to truly separate or remove researcher subjectivity (D. Silverman, 2010).

Qualitative analysis.

Principles underpinning thematic network analysis. Data collected through qualitative methods can be unstructured and unwieldy (Ritchie & Spencer, 1994). A high proportion of qualitative data is text based, and in the case of the author's study, data consisted of verbatim transcriptions of interviews detailing participants' experiences. Consequently, the author had to provide some coherence and structure to this cumbersome data set while retaining a hold of the original accounts from which it was derived (Holloway, 1997). As a tool to facilitate analysis, thematic analysis was employed, to create core constructs from the textual data through a systematic method of reduction and analysis (Miles & Huberman, 1994). This process entails the reading and rereading of transcripts to develop themes that were inductively derived from the data (Liamputtong & Ezzy, 2005). In undertaking the thematic analysis the author employed an essentialist, realist perspective (V. Braun & Clarke, 2006) and considered meanings first in individual transcripts and then across the whole data set. Themes were identified primarily using an inductive approach, although the topic guide and research questions also guided theme development. This approach is particularly suitable when investigating an under researched area or when participants' views on the topic are not known and when wishing to inform policy development (V. Braun & Clarke, 2006), as is the case in the current study. The thematic analysis was supported by and presented as thematic networks which:

> …are web-like illustrations that summarise the main themes constituting a piece of text. The thematic networks technique is a robust and highly sensitive tool for the methodological sytemisation and presentation of qualitative analyses (Attride-Stirling, 2001, p. 385).

Thematic networks are based on some of the principles of argumentation theory - the study of how humans reach conclusions through logical reasoning (Toulmin, 1958). Argumentation theory suggests that any data can be understood by looking for both supportive data and any variant opinions expressed. It employs similar techniques and steps to those in other qualitative approaches, including grounded theory (Strauss & Juliet, 1998), and interpretive phenomenological analysis (IPA) (J. A. Smith, 2004). Thematic networks analysis is classified as an inductive bottom up approach, as opposed to a deductive, top down approach and is strongly informed by a priori reasoning (Appendix O).

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

In the current study the global themes encapsulated a position about RPNs' FFP with parents who have mental illness, their children and families, from the perspectives of RPNs, within general adult mental health services.

As there is limited research on RPNs' FFP with parents who have mental illness, their children and families this study was designed to discover new aspects of this phenomenon. Therefore the author selected a bottom up analytical method that facilitated her to explore emerging themes in conjunction with a priori themes. The bottom up approach involves a complex and detailed analysis and entails the author being much less prescriptive at the outset than if he/she were to employ a top down approach. Data analysis in the bottom up approach tends to be more emergent and less predefined. Hence, at the outset, although the topic guide directed the analysis, to some extent, the author kept an open mind and was alert to emergent themes. In this respect, thematic networks is positioned somewhere between a top down and

bottom up approach and is characterised by its sytemisation and the richness of the exploration that this process allows (Attride-Stirling, 2001).

Although this type of analysis can generate theories that can be tested, the primary concern is the description and interpretation of what is happening in a specific setting (Lacey & Luff, 2001), as in RPNs' FFP in specific settings. Through its theoretical freedom, thematic analysis and specifically thematic networks provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of the data (V. Braun & Clarke, 2006).

Thematic network analysis has been refined and developed over the years but the principles of the approach have proved to be versatile across a wide range of mixed methods studies in a variety of areas including nursing (Brenner, 2013; Brenner, Treacy, Drennan, & Fealy, in press; Fox, 2011; Fox et al., 2013; Fox, Coughlan, Butler, & Kelleher, 2010) and mental health services research (Attride-Stirling, Davis, Farrell, Groark, & Day, 2004). Its use is particularly appropriate in health services research because of the applied nature and complexity of much of health services research (Fox et al., 2013). Health services research tends to be geared towards specific practical problems or issues and this, rather than theoretical leanings, may determine the methods and analysis employed (Pope & Mays, 2006).

Process of thematic networks - analytical steps. Prior to analysing qualitative data, member checks were employed by asking participants to reflect on their individual transcripts. This process is the strongest available check on the credibility of a research project (Lincoln & Guba, 1985). Once feedback from participants had been incorporated, and transcripts approved, analysis commenced. Data analysis was initiated during the data

collection stage to inform subsequent interviews and give the opportunity to explore new areas that might otherwise be missed. Hence data generation and analysis were undertaken concurrently with the provisional analysis of transcripts informing subsequent interviews. By undertaking data analysis, in tandem with data collection, the author was able to refine her questions and develop new avenues of inquiry (Pope et al., 2000). Most important, this process enabled the author to look for deviant or negative cases.

Both thematic networks were established by initially developing basic themes and working inwards toward a global theme (Appendix O). Once the basic themes were created, they were then categorised according to the underlying story they were telling; these become the organising themes. The organising themes were then reinterpreted in light of their basic themes and "were brought together to illustrate a single conclusion or super-ordinate theme that became the global theme"(Attride-Stirling, 2001, p. 385). The full process of analysis in thematic networks constitutes six distinct though highly interconnected steps (Attride-Stirling, 2001).

The first step entailed reducing the data, devising a coding framework and dissecting text into segments using the coding framework. The coding framework was derived from the research questions, and the important issues arising from the transcripts. The second stage entailed identifying themes in the transcripts. Examination of coded text segments enabled the recognition of underlying patterns or structures (Attride-Stirling, 2001). These themes were then further refined to ensure that they were not repetitive and extensive enough to incorporate a set of ideas contained in a number of text segments. In the third stage these themes were constructed into two thematic networks. Essentially, in this stage the two thematic networks were generated "by working from the periphery basic themes inwards to

the global theme" (Attride-Stirling, 2001, p. 393). This involved arranging the themes into meaningful groups, identifying the basic themes, reorganising the basic themes into organising themes and deciphering the global themes from the organising themes. The themes were then exhibited as non-hierarchical web-like illustrations; "giving fluidity to the themes and emphasizing the interconnectivity throughout the network" (Attride-Stirling, 2001, p. 389). At this juncture, the text segments concerning each basic theme were reviewed. This strategy served to ensure that each of the themes reflected the data and that the data supported the themes (Attride-Stirling, 2001). Once the networks had been constructed, the author returned to the original text and interpreted it with the aid of the networks.

The fourth step entailed illustrating, describing and exploring each network and its underlying pattern using text segments and quotes to support the description. This represented the first part of the analysis stage B, where a further level of abstraction was reached in the analytic process. Step five entailed summarising the main themes and patterns characterising each network. Step six brought together the deductions in the summaries of both networks. These were then used in conjunction with the theoretical perspectives guiding the research questions to explore significant themes, concepts, patterns and structures that arose in the text (Attride-Stirling, 2001). In this step, the aim was to return to the original research questions and theoretical perspectives informing the study and address these by referring to the key conceptual findings in the summaries of each thematic network. The data was analysed manually and around all demographics although only salient participant demographics are reported in the findings. In reporting the findings, each of the 14 participants are identified by a number, e.g. participant one is identified as P1. This number is

used when citing quotes to illustrate that quotes were used from various participants and from the two groups of RPNs.

Conclusion

In summary, this chapter has outlined the research design and methodology employed in Study One and Two. At the outset, the author delineated the rationale for utilising a mixed methods study with two distinct but interconnected phases which drew on the principles of pragmatism in the process. The use of a mixed methods approach facilitated the collection of quantitative data, via the FFMHPQ, from a national sample (n = 346, 57%) of RPNs as well as enabling the collection of more in-depth qualitative data, via semi-structured interviews from RPNs (n = 14) who had obtained high scores on the FFMHPQ. Whilst each method stood alone, both complemented each other in their attempt to address the research question(s) in their entirety. This chapter also attempted to highlight the considerations that must be brought to bear when utilising a mixed methods approach. Other issues addressed included sampling and characteristics of the sample, ethical conduct, strategies used to gather and derive meaning from the data and the criteria and strategies used to promote reliability and validity of both the quantitative and qualitative components of the study.

Chapter 5: Study One - Quantitative Findings

Introduction

This chapter presents the findings of a series of analyses designed to describe (a) RPNs' FFP, whilst also (b) examining variables that may be useful in the prediction of RPNs' FFP and exploring the (c) difference between two specific groups of RPNs in relation to their FFP. The findings are reported in these three sections. Prior to reporting these findings the steps taken in cleaning the data, creating the subscales and checking assumptions are described.

Steps Taken in Cleaning the Data and in Creating Subscales

Descriptive statistics were run on all items within the FFMHPQ to check for minimum and maximum values to detect errors in inputting data. Spot checks were also done on 50 FFMHPQs with SPSS input compared with the hard copy output. Ten cases were then removed due to not meeting inclusion criteria reducing participant numbers to 346.

Scores for the not applicable option (N/A) in the Likert Scale were treated as missing values. The little missing completely at random (MCAR) test was done to check whether missing values, within the Likert Scale, denoted by 99, were random in nature. The results of the Little's MCAR test were not significant (Chi-Square = 88.554, DF = 10858) $p = 1.000$ indicating that missing values were random in nature; hence they were replaced by the Expected Maximization Algorithm. This algorithm was used as opposed to other methods to deal with missing values because it is the simplest and most reasonable approach to

imputation of missing data and has the capacity to cause least distortion to the overall results and produce realistic estimates of variance (Tabachnick & Fidell, 2007).

As part of creating the 20 subscales the 27 negatively worded items were reversed. The reliability of the subscales were then tested (see Appendix L). Due to weak reliabilities, denoted by Cronbach alpha values under .7 (Nunnally, 1978), six subscales were deleted and one item removed within seven other subscales to enhance reliability. As only four of the 14 remaining subscales had a reliability of .7 or above, caution needs to be exercised in interpreting the remaining ten subscales (with Cronbach alphas between .5 and .7). The final 14 subscales (Table 4.3) were employed in later analyses.

Checking Assumptions of Multiple Regression, ANOVA, MANOVA, ANCOVA and MANCOVA

The required sample was calculated based on the formula outlined by Tabachnick and Fidell (2007) of N > 50+8 cases per independent variable (IV), suggesting a minimum sample size of n=170. The sample size was sufficiently large for the series of multiple regressions to be performed within acute and community mental health services (n=329) and acute versus community mental health nursing services (n=268).

As much of the analysis involved regression, correlations between the six dependent variable (DV) subscales and between the eight IV subscales and other key independent variables (n = 7) were performed to; illustrate simple relationships between all variables, and to check for multicollinearity and singularity The correlations are presented in Table 5.1.

Table 5.1

Pearson product – moment correlations between family focused and associated demographic variables including six dependent and 15 independent variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. Family and parenting support(DV)																				
2. Support to carers and children(DV)	.53**																			
3. Assessing the impact on the child(DV)	.43**	.23**																		
4. Connectedness(DV)	.36**	.35**	.44**																	
5. Referrals(DV)	.47**	.34**	.30**	.11																
6. Interventions to promote parent's mental health(DV)	.42**	.39**	.34**	.46**	.27**															
7. age(IV)	.14*	.03	.02	.06	.24**	.07														
8. gender(IV)	-.05	-.06	-.01	-.16**	-.06	-.10	.06													
9. family training(IV)	-.12*	.04	-.12*	-.02	-.17**	-.12*	-.21**	.04												
10. Child training(IV)	-.08	-.05	-.06	-.13*	-.03	-.18**	-.15**	-.04	.25**											
11. Length of time in current position(IV)	.06	.06	.09	-.01	.11*	.13*	.41**	.12*	-.11	-.11*										
12. Length of experience(IV)	.19**	.08	.06	.07	.28**	.13*	.76**	.05	-.25**	-.20**	.50**									
13. RPN parent(IV)	-.10	-.02	-.05	-.05	-.15**	-.13*	-.51**	-.02	.12*	.09	-.26**	-.40**								
14. Time and workload(IV)	.24**	.12*	.16**	.21**	.18**	.05	.02	-.03	-.04	-.09	.06	.06	-.01							
15. Worker confidence(IV)	.22**	.22**	.17**	.22**	.29**	.26**	.13*	.07	-.04	-.12*	.09	.13*	-.23**	.19**						
16. Engagement issues(IV)	.11*	.10	.08	.24**	-.01	.15**	-.05	.03	-.04	-.12*	.08	.05	-.04	.14*	.04					
17. Training(IV)	.07	.04	.02	.02	-.12*	.10	-.13*	-.16**	.00	.06	-.14**	-.18**	.09	-.10	-.24**	-.06				
18. Skill and knowledge(IV)	.46**	.38**	.39**	.48**	.33**	.52**	.19**	-.04	-.16**	-.20**	.08	.26**	-.21**	.19**	.45**	.18**	-.16**			
19. Service availability(IV)	.18**	.23**	.12*	.18**	.26**	.07	.13*	-.06	-.07	-.19*	.00	.12*	-.05	.27**	.10	.05	-.16**	.23**		
20. Inter-professional practice(IV)	.11*	.12*	.08	.18**	-.07	.25**	.06	-.18**	-.10	-.05	.03	.01	-.02	-.08	-.13*	.03	.55**	.01	-.08	
21. Confidence around parenting and children generally(IV)	-.05	.09	.10	.10	.02	.04	.01	-.02	.08	.00	.06	.02	-.04	-.02	-.05	-.11*	.02	-.03	-.03	.08

Note. **Correlation is significant at the 0.01 level (2 – tailed). *Correlation is significant at the 0.05 level (2 – tailed).

As can be seen from Table 5.1, the correlations between the IV's were substantially less than .70 therefore the multicollinearity assumption for multiple regression has not been violated (Field, 2009; Tabachnick & Fidell, 2007) and the singularity assumption was met. Similarly the table also shows that these assumptions were also not violated between the six dependent variables. Collinearity diagnostics indicated that tolerance values were all well above 0.2 and much greater than 10 and variance inflation factor values (VIF) were substantially lower than the cut of point (less than 10), further demonstrating the absence of multicollinearity within the data. Overall the multiple regression model appears to be accurate for the sample and generalisable to the population. However there were sufficiently higher (greater than .3) correlations between variables to justify the multiple regression analyses.

Preliminary analyses were conducted on both the DV's and IV's to test for violations of the assumptions involved in multiple regression. Specifically standardised residual plots, stem and leaf plots, box plots, histograms and normal Q-Q plots helped to identify univariate outliers in the DV's and IV's which were altered to scores +/- three standard deviations from the mean (Pallant, 2010). Means and standard deviations were also checked for these variables. Two of the DV's (support to carers and children and interventions to promote parents' mental health) and four of the IV's (inter - professional practice, engagement issues, training and confidence around parenting and children generally) had a number of cases that were regarded as outliers as the standardised residual values were greater than three. One score for inter-professional practice was adjusted accordingly. Scores on the other variables were not changed as the scores in the data profile were considered an accurate reflection of a possible participants' response. In addition, the values are marginally different from the

remaining distribution – demonstrated by similar trimmed means and mean values (Pallant, 2010).

Additional procedures were used to examine for normality, linearity, homoscedasticity, and independence of residuals of the subscales using normal probability plots (P-P) of the regression standardised residual and the scatterplot. Histograms, p-plot and scatter plot were normal for all six DV's subscales indicating that there was no deviation from normal. As a consequence no dependent variable transformations were undertaken to correct normality issues.

There were some issues with normality for some of the IV's (i.e. significant results returned for Shapiro-Wilks and Kolmogorov-Smirnov tests), however Tabachnick and Fidell (2007) note that both tests can be overly sensitive. Nonetheless, when examining the nature of the variables it is argued that they represent constructs that would not be expected to be normally distributed in the general population. For example, the variable showing the greatest level of skewness is request for training (skewness = 1.342) suggesting considerable negative skew, or a higher proportion of higher scores. However, when considering the construct being measured, high scores are actually indicative of higher levels of interest in more training as would be expected in this sample as the literature suggests that mental health professionals, including RPNs would like more training to equip them to engage in FFP.

Multivariate outliers were also checked using Mahalanobis distances. Mahalanobis distance for the critical $\chi 2$ for $df = 16$ (at $\alpha = .001$) of 39.25 and for $df = 17$ (at $\alpha = .001$) of 40.79 was violated by three cases, suggesting the presence of multivariate outliers (Field, 2009). Due to the large sample size it was initially considered that the three cases with a

problematic distance score would not affect the analysis (Pallant, 2010). To confirm if this was the case, analysis was repeated for the Multiple Regression and for ANOVA, MANOVA, ANCOVA and MANCOVA without the three cases with the problematic distance scores. This demonstrated that the second set of results differed from the initial set of results (some variables were now significant). Hence the second set of analyses (with the three cases excluded) was reported.

Prior to conducting the various analyses of variances preliminary assumption tests were also conducted**.** In regard to ANOVA, Levene's Test of Equality of Error Variances indicates that the assumption of equality of variance, $p>.05$, for half of the dependent variables, was not violated. The following variables had violations: length of service $p = .032$, length of time in current position $p = .033$, number of patients delivered care to $p = .000$ and number of parents on caseload $p = .006$. Consequently, an independent t test was run on these four variables (in SPSS this allows for comparison of equal and non-equal error variance) and when equality of variance was adjusted there was no difference to the outcome. Hence ANOVA statistics employing unequal error variance are reported here.

In regard to MANOVA, Box's test of Equality of Covariance was $p = .001$, which indicates that the assumption of equality of homogeneity of variance-covariance matrices was not violated. The Wilks' Λ of .708 is significant, $F(14,265) = 7.788$, $p < .001$, indicating that the hypothesis can be rejected as the population means on the DV's are the same for the two RPN groups. The multivariate $\eta 2 = .292$ is reported following the significance test. Levene's Test of Equality of Error Variances indicates that the assumption of equality of variance, $p>.05$, for all dependent variables apart from interventions to promote parent's mental health $p = .044$ was not violated**.** An independent t test was undertaken on each of the IV's for this

DV (interventions to promote parent's mental health). There was little difference when equality of variance was not assumed.

The Demographic Profile of RPNs in Ireland and how their FFP Compares with that of RPNs in Australia

The following section outlines the first group of findings; relating to the participants' demographic profile including their employment and practice context and education and training. The section concludes by situating the Irish nursing sample in the International context by comparing RPNs' FFP in Ireland with that of RPNs in Australia. Together these sections answer the following research questions:

1. What is the demographic profile of Irish RPNs?
2. How does Irish RPNs' FFP compare with that of Australian RPNs?

RPNs' employment and practice context. As service location represents a potential confounding variable in the sample, participants were asked whether they were practicing within a rural or urban setting. The majority of participants practiced within an urban area (n = 229, 66.2%) whilst (n = 117, 33.8%) practiced within a rural area. The majority of participants practiced within the acute setting (n = 194, 56.1%) whilst the remainder practice in four areas within the community setting (n = 152, 44%). The majority of participants also practiced on a full time basis (n = 306, 88.4%) with the remaining participants practicing on a part-time basis (n = 40, 11.6%). The mean length of experience as an RPN was 14.4 years (M = 10, SD = 10.81) with participants having a minimum of one month and a maximum of 40 year's experience. The mean length of time in their current position was 5.6 years (M = 4, SD

= 5.58) with participants having spent a minimum of one month and a maximum of 32 years in their current position. The majority of participants were practicing in Staff Nurse grade (n = 204, 59%). The next most common grade was Clinical Nurse Manager 2 (n = 54, 15.6%) and Community Mental Health Nurse (n = 50, 14.5%). The majority of participants were working on day duty (n = 296, 85.5%) with the rest doing night duty (n = 42, 12.1%) or alternating between the two schedules (n = 7, 2.0%). All of the participants (excluding one missing case) reported that they directly delivered care to service users (n = 345, 99.7%). A sizeable minority of participants reported that they spent a proportion of their time working within the service users' home environment (n = 105, 30.3%) whilst the majority did not (n = 239, 69.1%).

RPNs' education and training. A range of professional qualifications were reported by participants. However the most common qualification, aside from RPN, was RPN and Community Mental Health Nurse (n = 29, 8.4%). Other common professional qualifications reported in the sample include: RPN and Registered General Nurse (RGN) (n = 27, 7.8%) and RPN and Clinical Nurse Specialist (n = 12, 3.5%). A range of academic qualifications were also reported with the most common academic qualification Bachelor of Nursing Science/Bachelor of Science (n = 76, 22%). Other common academic qualifications were Higher Diploma (n = 21, 6.1%) and Undergraduate Diploma (n = 19, 5.5%). A small number of participants had higher level academic qualifications including Master of Science (n = 8, 2.3%) and Doctor of Philosophy (n = 2, 6.1%). Fifty four participants (15.6%) had family training and (n = 51, 14.7%) had child training. The most common type of family training was Family Therapy (n = 19, 5.5%) and most common type of child training was Children First (n = 29, 8.4%). Children First training is designed to familiarise RPNs with the *Children*

First guidelines/policy document first published by the DCYA, 2011) which outlines what organisations, including general adult mental health services, need to do to maintain the safety of children. The majority of participants were parents (n = 209, 60.4%), and regardless of their parenting status participants agreed (n = 305, 88.2%) that they were confident around friends and families children.

Extent of RPNs' exposure to parents who have mental illness and their children. A number of demographic items were employed to determine the extent and nature of participants' contact with service users who were parents and extent of their contact with service users' children as shown in Table 5.2

Table 5.2

Extent of RPNs' exposure to parents who have mental illness and their children

Variables	**N**	**%**
Currently deliver nursing care to one or more parents		
Yes	293	84.68
No	35	10.12
Unsure	16	4.62
Missing	2	0.58
Previous experience of caring for parents in current position		
Yes	335	96.82
No	7	2.02
Unsure	3	0.87
Missing	1	0.29
Frequency of delivering nursing care to parent		
Daily	196	56.65
Weekly	89	25.72
Monthly	28	8.09
Few times a year	27	7.80
Never	5	1.45
Missing	1	0.29
When last cared for a parent		
Previous week	275	79.48
Less than a month	31	8.96
1 – 3 months	22	6.36
Greater than 3 months	14	4.05
Missing	3	0.87
Face-to-face contact with children in last week		
Yes	277	80.06
No	66	19.08
Missing	3	0.87
Frequency of face-to-face contact with children		
Daily	41	11.85
Weekly	111	32.08
Monthly	52	15.03
Few times a year	85	24.57
Never	50	14.45
Missing	7	2.02

The majority of participants reported that they were currently caring for one or more service users who were parents, and that they also had previous experience of caring for service users who were parents in their current positions. A small number of participants (n = 16, 5%) were unsure as to whether they were currently caring for service users who were parents and if they had cared for service users in their current position on a previous occasion (n=3, 0.87%).

Participants were also asked a number of items to measure the extent of their exposure to parents, who have mental illness and their children in the past week. Although the number of parents on participants' caseloads ranged from 0 – 21 the greatest number of participants (n = 29, 8.4%) reported that they were currently delivering nursing care to one service user who was a parent. The majority of these participants delivered care to service users who were parents on a daily basis and had cared for service users who were parents in the previous week. Participants were also asked if they had talked to service users who were parents about parenting issues in the last week. Just under half of the participants (n = 163, 47.1%) had talked to a service user about parenting issues. For those participants who did discuss parenting issues with the service user the majority (n = 66, 19.1%) did so with one parent. The mean number of service users that participants discussed parenting with was (M = 2.45, *SD* = 2.31) with a range of 0 – 18 with the greatest number of participants talking to one service user about parenting issues in the last week.

Participants were also asked if they had face-to-face contact with service users' children in the last week. The majority of participants reported that they had face-to-face contact with service users' child(ren) in the last week. The majority of participants (n = 30, 87%) reported that they had face-to-face contact on one occasion. The mean number of face-

to-face contacts with service users' children was 2.45 with a range of 1 – 15 face-to-face contacts. The majority of participants who had face-to-face contact with service users' child(ren) also reported that in their current position they have contact with service users' children on a weekly basis.

Comparison between RPNs' FFP in Ireland and Australia. To gain insight into how RPNs' FFP in Ireland can be considered in an International context the current Irish data was compared to RPNs in Australia. Australian data was taken from the paper professional differences in family sensitive practice in the adult mental health system (Maybery et al. in press). Both groups of participants had rated FFP items on a seven point Likert Scale ranging from strongly disagree to strongly agree to rate their perspectives about statements, within a number of subscales, regarding their FFP, eleven of which are reported in Table 5.3.

As illustrated by Table 5.3 the highest means in the Irish context were found in training (M = 5.87, *SD* = .1.098). Table 5.3 highlights that participants in Australia scored higher in all of the FFP subscales than participants in Ireland. The exception was training, where participants in Ireland had a slightly higher mean score (M = 5.87, SD = 1.10) than participants in Australia (M = 5.54, SD = 1.05), suggesting that both groups, and in particular participants in Ireland perceived that they would like more family focused training. Generally participants in Australia neither agreed or disagreed or slightly agreed with the items within the 11 subscales compared and participants in Ireland slightly disagreed or neither agreed or disagreed. The biggest difference between the two groups was related to time and workload, assessing the impact on the child, service availability and referrals.

Table 5.3

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

	Irish		**Australian**	
Subscales	**M**	**SD**	**M**	**SD**
Time & workload	3.24	1.54	4.52	1.21
Family and parenting support	3.59	1.11	4.46	1.06
Worker confidence	4.09	1.35	4.35	1.26
Support to carers and children	4.57	1.01	5.39	0.83
Engagement Issues	4.33	1.02	4.39	0.90
Assessing the impact on the child	3.10	1.42	4.05	1.04
Training	5.87	1.10	5.54	1.05
Skill and knowledge	3.89	1.23	4.34	0.99
Service availability	4.27	1.61	5.09	1.15
Connectedness	4.51	1.30	4.85	1.07
Referrals	3.21	1.55	4.74	1.11

Note. Irish RPN n = 346, Australian RPN n = 155

The lowest means, in the Irish context, were found in assessing the impact on the child (M = 3.10, *SD* = 1.425), family and parenting support (M = 3.59, *SD* = 1.107) and time and workload (M = 3.24, *SD* = 1.53). Assessing the impact on the child and family and parenting support are identified in the literature as key family focused activities, whereas time and workload is a factor that determines to what extent participants can engage in these activities. Overall the Irish sample scored lower on almost all FFP variables.

High scoring RPNs in the Irish context. Despite the overall tendency towards comparatively low mean scores in the FFP subscales, participants in the Irish context generally had higher mean scores on the subscales inter professional practice (M = 6.09, SD = .86), confidence around parenting and children generally (M = 6.21, SD = .63) and

interventions to promote parents mental health (M = 5.05, SD = 6.21); not measured by Maybery et al. (2012a) study.

A third of participants (n =109, 32%) also scored high (between 5 – 7 on the Likert Scale) on at least three of the six FFP behavioural subscales. An examination of the FFP responses from these higher scoring participants was undertaken to show the difference to the remaining RPNs. This was undertaken as the qualitative sample of RPNs for inclusion in Study Two was chosen based upon their high scores. Whilst (n = 36, 33%) of these high scorers were practicing within the acute in-patient setting, the majority practiced in the community setting (n=73, 67%) and in particular within community mental health nursing services (n = 48, 44%). As illustrated by Table 5.4 below the group of high scorers had higher mean scores on all 14 FFP subscales when compared with the rest of the sample. The majority of this group scored highest in interventions to promote parents' mental health (n = 107, 98.2%) and connectedness (n = 93, 85.3%). The fewest number of high scores related to assessing the impact on the child (n = 34, 31.2%) and family and parenting support (n = 38, 34.9%).

The biggest difference, in the six behavioural subscales (these are used as Dependent Variables in later analyses), between the high scorers and the rest of the sample related to referral (high scorers M = 4.22, SD = 3.21 compared to the remainder of the sample M =3.21, SD = 1.55). The biggest difference between the high scorers and the rest of the sample on the non-behavioural subscales related to FFP skill and knowledge (M = 4.77, SD = 1.08 compared to M =3.89, SD = 1.23). Only a minority of the high scorers had received child training (n = 22, 20.2%) or family training (n = 20, 18.3%).

Table 5.4

Mean (SD) scores for the high scoring Irish RPNs' on 14 FFP subscales.

	High Scoring Nurses (n=109)	
Subscales	**M**	**SD**
Time & workload	3.50	1.52
Family and parenting support	4.37	1.09
Worker confidence	4.59	1.33
Support to carers and children	5.37	0.79
Engagement Issues	4.45	1.03
Assessing the impact on the child	4.04	1.35
Training	6.06	0.94
Skill and knowledge	4.77	1.08
Service availability	4.82	1.71
Connectedness	5.46	0.95
Referrals	4.22	1.64
Inter-professional practice	6.33	0.68
Confidence around parenting and children in general	6.29	0.56
Interventions to promote mental health	5.87	0.62

Predicting RPNs' FFP

While the FFMHPQ contains 14 subscales some can be considered behavioural items (e.g. providing support to carers and children) while others can be considered attributes of the RPN (e.g. knowledge and skill about family focused practice). It was thought that being able to identify the attributes of the RPN that predicted their practice would provide insight into the key variables that might be modified through such things as training.

Outlined below are the key attributes that best predict, participants' FFP behaviours, in general adult mental health services in Ireland. Hierarchical multiple regression was used to assess how well eight IV subscales, within the FFMHPQ, predicted six DV behavioural subscales measuring family focused activities after controlling for the influence of seven confounding variables. The main aim of using hierarchical multiple regression was to identify:

> What are the key things (predictors) that predict six key family focused behaviours in a representative sample of psychiatric nurses in Ireland?

Prior to conducting multiple regression, the 14 FFP subscales were judged to be either independent variables/predictors of FFP or dependent variables/behavioural outcomes of FFP. Decisions were made in distinguishing between these two groups of variables according to the literature and individual subscale description. In addition seven IV's were identified from within demographic items in part A and C (see FFMHPQ in Appendix C) of the FFMHPQ and some of these were recoded into dummy variables to allow them to be utilised within the multiple regression model.

The effects of all 17 IV's (comprised of eight IV subscales, seven confounding variables and two IV's that were beginning to emerge in the literature as possible predictors of FFP) on six DV's was measured. The analyses were repeated for each of the six DV's subscales and aimed to determine the significant predictors of the dependent variables. The 17 IV's were entered into regression equations for each of the six dependent variables. The variables were entered in three blocks, the order based on previous literature, is outlined in the following page. The significant variables in each block are shown in the regression tables below. The regressions were initially run with the total sample and then rerun with a dummy

variable reflecting type of RPN practice at a final step. The dummy variable was a dichotomous variable that included RPNs in acute and community mental health nursing services. The analysis was run as a final step to determine if the type of RPNs' practice impacts upon FFP. The analyses provided a rationale for later ANOVA that compared the two groups.

Hierarchical Multiple Regression findings for entire sample. The FFMHPQ subscales, support to carers and children, family and parenting support, interventions to promote parents' mental health, assessing the impact on the child, connectedness and referrals were employed in the regressions as dependent variables and the respective analyses for each are shown in Tables 5.5 to 5.10 below. In performing the hierarchical multiple regression, for each dependent subscale, all demographic variables such as age, gender, length of experience, length of time in current experience, service location (rural/urban), family training and child training were entered into block (step) one to control for the effect of these variables. The block of predictors entered at step two included the known predictors (derived in part from a review of the literature) which included seven IV subscales, including time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability and inter profession practice. Block three included two new predictors that have recently emerged in the literature as potentially important variables. These were parenting status (RPN parent) and confidence around parenting and children in general.

The order of variable entry was determined in order to allow analyses to demonstrate what the key variables identified in the literature, pilot study and reflected in the FFMHPQ contributed to the prediction of FFP over and above control variables and existing measures (Tabachnick & Fidell, 2007). The significant predictors for each step within the six DV's are

reported in Tables 5.5 to 5.10. Each table reports the significance level, Unstandardised (B) and standardised (B) regression coefficients, squared semi-partial correlations (sr) for each predictor on each step and R square change (Δ R2).

Providing support to carers and children. Table 5.5 below shows the significant predictor variables in relation to this dependent variable. The table shows that on the first step of the hierarchical multiple regression analysis, for the DV 'support to carers and children', the seven confounding variables accounted for 3.6 percent of the variance in support to carers and children, ΔF (7,318) = 1.70.

Table 5.5

Hierarchical multiple regression for the dependent variable – support to carers and children

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1	.036				.108
Step 2***	.192				.000
Skill and knowledge***		.28	.34	.087	.000
Service availability**		.10	.15	.023	.007
Step 3*	.015				.044
Worker confidence*		.09	.12	.013	.042
Skill and knowledge***		.28	.34	.090	.000
Service availability**		.10	.15	.023	.008
Confidence around parenting and children generally*		.19	.11	.015	.031

Note. *** p < .001, ** p < .01, * p < .05

Consequently no significant predictors were found. On step two the seven known predictors accounted for an additional 19.2 percent of the variance on support to carers and children, *ΔF* (7,311) = 11.05. The significant predictors were skill and knowledge and service availability. On step three, the two new predictors accounted for an additional 1.5 percent of

the variance in support to carers and children, ΔF (2,309) = 3.16. The significant predictors were skill and knowledge, service availability, worker confidence and confidence around parenting and children generally. In combination, the variables explained 24.4 percent variance in predicting support to carers and children, R^2 = .244, adjusted R^2 = .204, F = (16,309) = 6.22, p = .000.

Assessing parents' awareness of child connectedness. Table 5.6 indicates that on the first step of the hierarchical multiple regression analysis, for the DV subscale 'connectedness', the seven confounding variables accounted for 4.2 percent of the variance in connectedness, ΔF (7,318) = 1.97, with gender and child training being significant predictors.

Table 5.6

Hierarchical multiple regression for the dependent variable – connectedness

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1	.042				.059
Gender**		-.47	-.16	.026	.004
Child training*		-.44	-.12	.013	.042
Step 2***	.307				.000
gender*		-.30	-.10	.015	.029
Time and workload*		.10	.12	.018	.017
Engagement issues**		.19	.15	.030	.002
Skill and knowledge***		.47	.45	.168	.000
Inter-professional practice**		.23	.15	.019	.015
Step 3*	.017				.019
gender*		-.30	-.11	.016	.026
Time and workload*		.10	.11	.017	.021
Engagement issues***		.21	.17	.039	.000
Skill and knowledge***		.48	.45	.173	.000
Inter-professional practice*		.21	.13	.016	.026
Confidence around parenting and children generally*		.26	.12	.022	.010

Note. *** $p < .001$ ** $p < .01$ * $p < .05$

On step two the seven known predictors accounted for an additional 30.7 percent of the variance on connectedness, ΔF (7,311) = 20.894. The significant predictors of connectedness were skill and knowledge, inter-professional practice, engagement issues, gender and time and workload. Child training was no longer a significant predictor of connectedness in step two. On step three, the two new predictors accounted for an additional 1.7 percent of the variance in connectedness, ΔF (2,309) = 4.020. The significant predictors were skill and knowledge, engagement issues, inter-professional practice, confidence around

parenting, and children generally, gender and time and workload. In combination, the 16 predictor variables explained 36.5 percent variance in connectedness, R^2 = .365, adjusted R^2 = .332, F = (16,309) = 11.083, p = .000.

Referral of family members to other programs. Table 5.7 below shows the significant variables in relation to referrals. The table shows that on the first step of the hierarchical multiple regression analysis, for the DV subscale 'referrals', the seven confounding variables accounted for 10.9 percent of the variance ΔF (7,318) = 5.54. Within this model, the significant predictors of referrals were length of experience and family training.

Table 5.7

Hierarchical multiple regression for the dependent variable - referrals

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1***	.109				.000
length of experience**		.00	.25	.024	.005
Family training*		-.49	-.11	.012	.047
Step 2***	.140				.000
length of experience*		.00	.17	.013	.044
Family training*		-.47	-.11	.013	.043
Worker confidence**		.17	.15	.022	.009
Skill and knowledge**		.25	.20	.034	.001
Service availability*		.12	.13	.017	.022
Step 3	.002				.715
length of experience*		.00	.16	.012	.050
Family training*		-.49	-.11	.014	.037
Worker confidence**		.18	.16	.024	.007
Skill and knowledge**		.26	.20	.035	.001
Service availability*		.12	.12	.016	.024

Note. *** $p < .001$ ** $p < .01$ * $p < .05$

On step two the seven known predictors accounted for an additional 14 percent of the variance on referrals, ΔF (7,311) = 8.303. The significant predictors of referrals were skill and knowledge, worker confidence, length of experience, service availability and family training. On step three, the two new predictors accounted for an additional 0.2 percent of the variance in referrals, ΔF (2,309) = 0.336. The significant predictors were skill and knowledge, worker confidence, service availability and family training. Length of experience was no longer a significant predictor of referrals. In combination, the 16 predictor variables

explained 25.1 percent variance in referrals, R^2 = .251, adjusted R^2 = .212, F = (16,309) = 6.459, p = .000.

Interventions to promote parents' mental health. Table 5.8 below indicates that on the first step of the hierarchical multiple regression analysis, for the DV subscale 'interventions to promote parents' mental health', the seven confounding variables accounted for 8.9 percent of the variance in interventions to promote parents' mental health, ΔF (7,318) = 4.42, with service location, child training and gender being the significant predictors.

Table 5.8

Hierarchical multiple regression for the dependent variable - interventions to promote parents' mental health

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1***	.089				.000
Gender*		-.31	-.11	.014	.036
Child training**		-.54	-.15	.024	.005
Service location**		-.40	-.15	.024	.005
Step 2***	.295				.000
length of time in current position*		.00	.11	.015	.032
Service location*		-.30	-.11	.020	.013
Skill and knowledge***		.46	.47	.186	.000
Inter-professional practice***		.30	.21	.039	.000
Step 3	.001				.728
length of time in current position*		.00	.11	.014	.037
Service location*		-.30	-.12	.020	.013
Skill and knowledge***		.46	.46	.185	.000
Inter-professional practice**		.30	.20	.038	.001

Note. *** p < .001 ** p < .01 * p < .05

On step two the seven known predictors accounted for an additional 29.5 percent of the variance on interventions to promote parents' mental health, ΔF (7,311) = 21.259. The significant predictors of interventions to promote parents' mental health were skill and knowledge, inter-professional practice, service location and length of time in current position. Gender was no longer a significant predictor. On step three, two new predictors accounted for an additional 0.1 percent of the variance in interventions to promote parents' mental health, ΔF (2,309) = .318. The significant predictors were skill and knowledge, inter-professional practice, service location and length of time in current position. In combination, the 16 predictor variables explained 38.5 percent variance in interventions to promote parents' mental health, R^2 = .385, adjusted R^2 = .355, F = (16,309) = 12.086, p = .000.

Providing family and parenting support. Table 5 .9 below shows the significant predictor variables in relation to the hierarchical multiple regression analysis, for the DV subscale 'family and parenting support'. On the first step the seven confounding variables accounted for 5.1 percent of the variance in support to carers and children, ΔF (7,318) = 2.82, with length of experience being the significant predictor.

Table 5.9

Hierarchical multiple regression for the dependent variable - family and parenting support

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1	.058				.007
Length of experience*		.00	.22	.019	.014
Step 2***	.249				.000
Time and workload**		.12	.16	.031	.002
Training**		.18	.17	.024	.006
Skill and knowledge***		.39	.43	.150	.000
Step 3	.003				.516
Time and workload**		.12	.16	.031	.002
Training**		.18	.17	.024	.006
Skill and knowledge***		.40	.44	.152	.000

Notes: *** p < .001 ** p < .01 * p < .05

On step two the seven known predictors accounted for an additional 24.3 percent of the variance on family and parenting support, ΔF (7,311) = 15.96. The significant predictors were skill and knowledge, training and time and workload. On step three, the two new predictors accounted for an additional 0.3 percent of the variance in family and parenting support, ΔF (2,309) = .66. The significant predictors of family and parenting support were skill and knowledge, training and time and workload. In combination, the 16 predictor variables explained 29.7 percent variance in family and parenting support, R^2 = .310, adjusted R^2 = .275, F = (16,309) = 8.686, p = .000.

Assessing the impact of PMI on the child. Table 5.10 below indicates that on the first step of the hierarchical multiple regression analysis, for the DV subscale 'assessing the impact on the child', the seven confounding variables accounted for 2.6 percent of the

variance in assessing the impact on the child, ΔF (7,318) = 1.20. Hence there were no significant predictors.

Table 5.10

Hierarchical multiple regression for the dependent variable - assessing the impact on the child

Significant Predictors	**R^2**	**B**	**Beta**	**sr^2**	**p**
Step 1	.026				.303
Step 2***	.195				.000
length of time in current position*		.00	.14	.019	.015
Skill and knowledge***		.49	.43	.136	.000
Step 3	.010				.138
length of time in current position*		.00	.14	.018	.019
Skill and knowledge***		.49	.43	.136	.000
Confidence around parenting and children generally*		.24	.10	.013	.047

Note. *** p < .001 ** p < .01 * p < .05

On step two the seven known predictors accounted for an additional 19.5 percent of the variance on assessing the impact on the child, *ΔF* (7,311) = 11.13. The significant predictors were skill and knowledge and length of time in current position. On step three, the two new predictors accounted for an additional 1 percent of the variance in assessing the impact on the child, *ΔF* (2,309) = 1.995. The significant predictors were skill and knowledge, length of time in current position and confidence around parenting and children generally. In combination, the 16 predictor variables explained 23.1 percent variance in assessing the impact on the child, R^2 = .231, adjusted R^2 = .191, *F* = (16,309) = 5.80, *p* = .000.

Summary of regression findings. Fourteen of the 16 IV's were identified as significant predictors, in step three, in one or more of the six multiple regression models and

in combination predicted between 23.1 percent and 38.5 percent of variance. Skill and knowledge was the single most important predictor as it was significant in all six DVs tested. Confidence around parenting and children generally is also important and is a significant predictor of three of the DVs. Worker confidence, service availability, inter professional practice, time and workload, length of time in current position, child training, gender and length of experience are also important in that each of them predict two of the DVs. Training, engagement issues, family training, service location (rural/urban) are less important predictors as each predicted one DV. Two of the IV's, age and parenting status were not significant predictors within any of the six DVs.

Differences between RPNs' FFP in Acute Admission Units and Community Mental Health Nursing Services

This section outlines the third group of findings related to differences between RPNs FFP in acute admission units and community mental health nursing services and more specifically:

> What are the significant differences, if any, between RPNs' FFP in acute admission units and in community mental health nursing services?

To examine for any differences in the current sample, the above multiple regression was re run with an additional variable of RPN group dummy variable that included RPNs practicing within community mental health nursing services and acute in-patient units.

The process of setting up building blocks for the hierarchical multiple regression for the two specific groups of participants, practicing within acute admission units (n =194) and community mental health services (n =86), followed the same process as the previous

multiple regression, however this time with the inclusion of a fourth block. If this inclusion resulted in a significant improvement in the regression equation it would suggest that there were differences between the two groups of participants' practices. The results from the final step of the six regression analyses are shown in Table 5.11 below. The findings indicated that 'RPN group' or where RPNs' practice is generally a significant predictor of FFP. The data in Table 5.11 below is taken from Appendix P in order to summarise the influence of the newly created variable.

Table 5.11

Hierarchical multiple regression for the Influence of the newly created variable – 'RPN group' in identical multiple regression analyses as above (i.e. Tables 5.5 – 5.10)

Dependent variable	**Significant predictors**	**B**	**Beta**	**sr^2**	**p**
Support to carers and children	RPN group	0.67	.30	.079	.000
Connectedness	RPN group	0.28	.10	.010	.110
Referrals	RPN group	1.05	.31	.090	.000
Interventions to promote parent's mental health	RPN group	0.30	.11	.014	.066
family and parenting support	RPN group	0.48	.20	.041	.001
Assessing the impact on the child	RPN group	0.49	.16	.023	.016

Note. RPN group denotes 2 specific groups of RPNs – RPNs practising within acute admission units and community mental health nursing services.

Table 5.11 illustrates that the distinction between the two groups is important in terms of participants' family focused behaviours. Consequently a further series of analyses (of variance) were undertaken to examine the differences between the two groups.

Initially ANOVA were conducted with the newly created IV (RPN group) on eight RPN background variables: age, length of experience, length of time in current position, number of patients delivered care to, number of parents delivered care to, number of face-to-face contact with parents, number of face-to-face contacts with children and number of service users discussed parenting with. This was undertaken in order to determine if there were differences in group members on demographic/background variables.

Table 5.12 below illustrates that there was a significant difference between the two groups on age, length of experience and number of service users delivered care to. Community participants were on average six years older than participants practicing in acute in-patient units and had seven years of additional clinical experience. They also cared for four times as many service users.

Table 5.12

ANOVA comparison of the two RPN groups for eight continuous dependent variables in part A & C of FFMHPQ

	Total		**Community(n=86)**		**Acute(n=194)**				
Subscales	**M**	**SD**	**M**	**SD**	**M**	**SD**	**p**	**F (1,274)**	η_p^2
Age*	38.74	9.41	42.95	8.88	36.92	9.05	.000	26.037	.087
Length of experience*	170.56	129.00	230.17	130.81	144.79	119.65	.000	27.877	.093
Length of time in current position	69.35	66.90	77.21	75.58	66.00	62.77	.210	1.580	.006
Number of patients delivered care to*	29.06	49.78	61.23	81.34	15.21	10.85	.000	22.405	.182
Number of parents on caseload	7.43	7.89	8.48	10.49	6.93	6.28	.274	1.204	.009
Number of face-to-face contact with parent	6.02	5.20	5.19	5.31	6.36	5.15	.295	1.107	.011
Number of face-to-face contact with children	2.48	2.42	2.96	3.16	2.13	1.65	.217	1.565	.029
Number of service users discussed parenting with	2.39	2.35	2.58	2.91	2.29	1.99	.511	0.434	.004

Note. *p<.006. In order to keep the experiment wise error rate to α= .05 the significance level was set at <.006.

These findings are not surprising and are reflective of the literature. Generally participants practicing within community mental health services are older and more experienced than participants practicing within acute in-patient services and they also tend to have greater caseloads (McCardle, 2003). There was no significant differences between both groups in relation to the other five continuous dependent variables identified above and all had a small effect size.

Results of MANOVA on fourteen FFP subscales. A MANOVA was then conducted to investigate if there were differences between the groups on the 14 FFP subscales. There was a statistically significant difference in between RPN groups on the independent variables, $F(16, 260) = 8.08$, $p < .0001$; Wilk's $\Lambda = 0.668$, partial $\eta 2 = .33$. A series of one way analyses of variance were then undertaken between the two groups on each of the FFP subscales as shown in Table 5.13.

Table 5.13

ANOVA statistics on 14 FFP subscales – comparison between two RPN groups

	Total (SD)		**Community (SD)**		**Acute (SD)**				
Subscales	**M**	**SD**	**M**	**SD**	**M**	**SD**	**p**	**F (1,278)**	η_p^2
time and workload	3.18	1.53	3.35	1.40	3.10	1.59	.214	1.552	0.006
family and parenting support*	3.55	1.09	4.12	1.04	3.30	1.02	.000	37.035	0.119
worker confidence	4.05	1.35	4.22	1.37	3.98	1.33	.171	1.883	0.007
support to carers and children*	4.53	1.01	5.07	0.78	4.30	1.01	.000	38.892	0.124
engagement issues	4.30	1.03	4.37	0.95	4.28	1.07	.504	0.449	0.002
assessing the impact on the child*	3.08	1.42	3.51	1.45	2.90	1.36	.001	11.298	0.039
training	5.89	1.05	5.89	0.92	5.89	1.10	.998	0.000	0.000
skill and knowledge*	3.86	1.19	4.35	1.13	3.65	1.16	.000	21.766	0.073
service availability*	4.10	1.60	4.92	1.42	3.74	1.54	.000	36.342	0.117
connectedness*	4.44	1.32	4.86	1.18	4.26	1.34	.001	12.315	0.043
referrals*	3.08	1.55	4.08	1.44	2.64	1.38	.000	61.359	0.182
inter-professional practice	6.06	0.87	6.09	0.80	6.04	0.90	.637	0.223	0.001
interventions to promote parent's mental health*	4.99	1.23	5.45	1.03	4.79	1.26	.000	17.842	0.061
confidence around parenting and children in general	6.21	0.63	6.13	0.57	6.25	0.66	.156	2.026	0.007

Note. *p<.05

Table 5.13 highlights that there was a significant difference across eight of the fourteen variables between the two groups of participants, with participants practicing within community mental health nursing services, having higher scores on these subscales. However before outlining these differences further it should be noted that a MANCOVA (Appendix Q) and a series of ANCOVA's (Appendix R) were undertaken to examine for differences between the groups when age, experience and number of patients were controlled for (i.e. included in the MANOVA as covariates).

This was undertaken because it was thought that any difference in practices may merely stem from the intrinsic differences between the group (i.e. community participants being older, more experienced and/or caring for more service users, as shown in Table 5.13 above). With the exception of connectedness and assessing the impact on the child six of the eight FFP subscales remained significantly different between the groups in the MANCOVA and as a result the ANOVA findings are shown here. Notably these two latter subscales, while not significant in the MANCOVA, also had similar mean differences in both analyses. Consequently, it was decided to report the MANOVA and resultant ANOVA data in the body of this thesis.

Importantly and as anticipated, participants practicing within community mental health nursing services had higher mean scores across all six FFP behavioural subscales. There was a moderate effect size on four of the 14 subscales including: referrals, family and parenting support, support to carers and children and service availability, providing a degree of certainty that the differences in the two groups on these subscales are attributed to the independent variable 'RPN group'. Assessing the impact on the child, skill and knowledge, interventions to promote parents' mental health and connectedness all had a small effect size.

There was no significant difference, between the two groups on time and workload, worker confidence, confidence around parenting and children in general, engagement issues and inter-professional practice and training, all of which had a small effect size.

Summary. To conclude, overall participants were not particularly family focused, especially when compared with Australian RPNs. However, RPNs practicing in community mental health nursing settings had higher mean scores than those in acute settings. A third of RPNs in the Irish sample also scored at a high level (between 5 – 7 on the Likert Scale) on at least three of the six FFP behavioural subscales; suggesting that while on average FFP is low, there are a large group of RPNs who understand and undertake FFP. Multiple hierarchical regression revealed that 17 IVs predicted RPNs' FFP. Aside from RPN group (work setting) the most significant predictors were knowledge and skill followed by confidence around parenting and children generally.

Chapter 6: Study Two - Qualitative Findings

The focus of Study Two was threefold: (1) to identify the nature and scope of high scoring RPNs' FFP, (2) to elucidate the factors that affect RPNs' capacity to engage in FFP and (3) to explore how RPNs' FFP may be further developed. This chapter presents the qualitative findings beginning with an overview of the sample.

Study Sample

Thirty RPNs who scored high on the FFMHPQ agreed to be interviewed; from these, 20 were eligible to participate as they were practicing within acute units or community mental health nursing services. Fourteen of those eligible to participate were contactable and interviews were subsequently conducted. Participants practiced within eight of the twelve mental health services sampled in Study One. Most were female (n = 9) and were parents themselves (n = 9). The majority of the participants (n=10) were practicing as CMHNs whilst four were practicing within acute admission units. There was a range of participant demographics in terms of length of experience as an RPN, time in current position, grade, educational and professional qualifications. Over half of the participants had family focused training (n = 8) and/or child focused training (n = 9).

The number of parents on participants' caseloads varied between five and forty and according to participants interviewed, each parent had an average of three children. Children's ages and stages of development varied, from babies through to 18 years. The parents experienced a broad range of mental illnesses varying from the severe and enduring

disorders, such as schizophrenia and bipolar affective disorder through to relatively less severe mental illnesses including post natal depression and anxiety. Some parents also had a diagnosis of personality disorder and/or substance misuse. Whilst most parents were mothers, a substantial minority were fathers.

Overview of Findings

In recounting their experiences, the majority of participants were, on the whole, reflective and appeared to find the questions easy to respond to. This was particularly so for CMHNs who described many examples, contexts and scenarios to describe and illuminate their FFP, suggesting they had more scope than participants in acute units to engage in FFP. With regard to three themes, there were differing perspectives between the two groups of participants, as highlighted in the respective themes reported below.

Analyses were considered along a range of participant demographics including work setting (acute versus community), own parenting experience, age, work experience and gender. Major differences were noted with respect to work setting and own parenting experience. For example, community based participants, who were parents themselves, tended to provide more examples of FFP and to talk more freely within the interview. Less salient differences were also noted in relation to age, work experience and gender. When reporting on subsequent themes, work setting is reported for all of the results whilst the less salient demographics are noted when relevant.

Two global themes emerged from the interviews and were conceptualised as (1) the nature and scope of RPNs' FFP and (2) RPNs' capacity to engage in FFP (Figure 6.1). In the

first instance, participants described FFP as complex and multifaceted, comprising various family focused activities and underpinned by a number of principles and processes. Family focused activities capture what RPNs *do* in relation to FFP, process captures *how* they do it and principles focus on *why* they do it. Furthermore, participants suggested that all three components, particularly principles, interact and impact upon each other and that family focused activities and processes stem from and are underpinned by FFP principles.

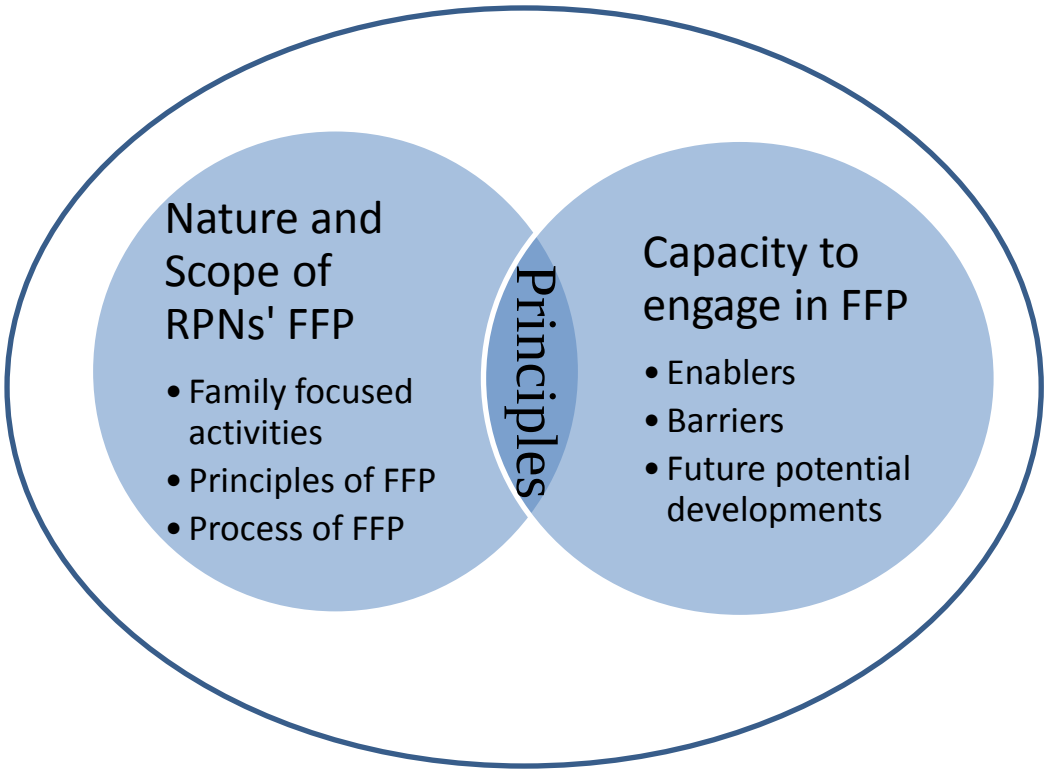


Figure 6.1: Overview of two thematic networks

At the same time, RPNs' capacity to engage in FFP (again see Figure 6.1), was found along three main elements associated with capacity including (1) enablers, (2) barriers and (3) future potential developments. The two global themes are interconnected through the principles of FFP, e.g. whilst principles are an integral component of the nature and scope of

RPNs' FFP they also affect RPNs' capacity to engage in FFP (see Figure 6.1) Each of these global themes and their constituent themes are examined in the following sections.

The Nature and Scope of RPNs' FFP as Perceived by High Scoring RPNs

Participants recounted a variety of family focused activities whilst illuminating the essential principles and processes underpinning their FFP (Figure 6.2) as detailed below.

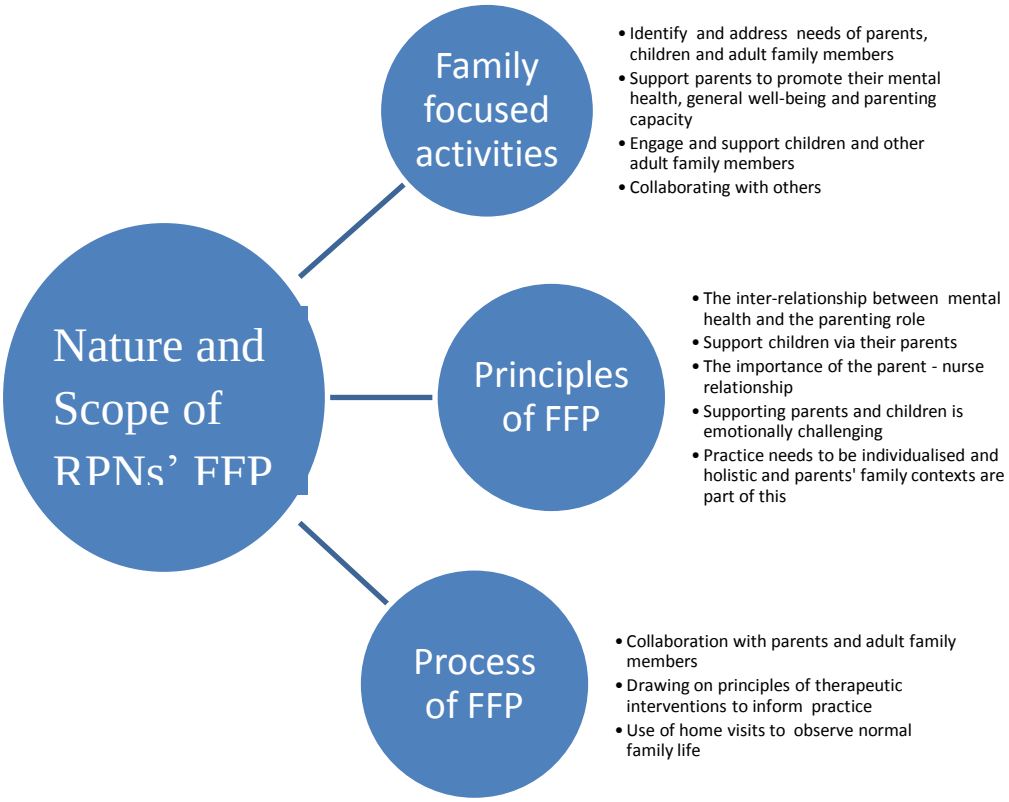


Figure 6.2: The nature and scope of RPNs' FFP

Family focused activities. Participants identified four core family focused activities including: (1) identifying the needs of parents, children and adult family members, (2) supporting parents to promote their mental health, general well-being and parenting capacity, (3) engaging and supporting children and other adult family members and finally, (4) collaborating with others.

Identify and address needs of parents, children and adult family members. All participants acknowledged and identified the needs of parents, children and other adult family members. Participants reported that they first identified whether the service user was a parent and the number and ages of their children during their initial assessment, for example, P 10 (acute) signified that as part of his assessment he would "ask them [the parents]…have they children in their care", while P 11 (cmhn) suggested

> …I would ask them…about the composition of the family, who they're living with…have they children in their care…what the arrangements are…as you need context for what it is your dealing with…our nursing assessment…gives you an opportunity to explore…the number of children and their ages and…relationships…and enables you to tease out all the issues that are going on.

Similarly, others reported:

> …at the very first assessment...we would ask about…children…age…how many…gender…how they are getting on…we would take that in straight away from the beginning (P 7:acute).
>
> We…tease out all the issues that are going on…it's important that you understand exactly…the full background…it's not just the individual who's affected, it's the whole family…when you get a really clear picture of what's going on for the individual [parent]…you can then start formulating…a care pathway…what it is that we should…be doing…(P 9:cmhn).

Upon establishing the service user's parenting status P 12 (cmhn) contended:

> … any mention of children…you're immediately checking…welfare …and bonding issues…all those kind of things…the thrust of our original training

> wouldn't have been inclusive of this but it's such a huge part of what we do now.

Whereas, P 3 (cmhn) reported "I will be looking at…how the parenting skills are affecting the person's mental health".

The majority of participants (n = 10) also described how they teased out information about parenting when the parent was reluctant to discuss this, for instance, P 13 (acute) suggested "this lady more spoke about symptoms…I found myself…bringing in about the children", while P 8 (cmhn) reported:

> …you're going to probe…and…if they don't bring it up directly then you say…what's happening in your life…then more directly…how's your son…how's school going…I remember you talking about him…four weeks ago and you felt okay with him then…has anything changed?…at that point it's a more direct question…

Participants gathered information from multiple sources; "you're gathering information at multiple levels…home visits…clinic visits…living in parent's neighbourhood", (P 11: cmhn), while others obtained information regarding parents' needs by obtaining collateral information from adult family members; "…I spoke to her husband…and…got a collateral history…and objective point of view of what is going on within the family home" (P 14:acute). Other participants and particularly community participants reported that they gathered information through observation of parents and children interacting for example, P 12 (cmhn) suggested that she was "observing the whole time…the interactions between the mom or the dad and then children or between the children themselves". Others reported that they gathered information about children's well-being and family functioning from engaging with children;

> …I'd get to know the names of the children, I'd speak directly to them, look at what they're doing…how they are finding school and just general chit

> chat…you're getting information about… what's going on in the bigger system…(P 11:cmhn).

Some participants indicated that when they identified parents' needs they stood back and observed: "…we wouldn't… rush in. The first thing is to… wait and see…what's happening and to get a gut sense", (P 1: cmhn) and "sometimes we …wait and watch…for a little while" (P 4: cmhn). Some participants also indicated that as soon as a parenting need was identified they took immediate action;

> If parenting is mentioned…I get straight into it…it's easier to get straight into it than be with somebody…for four or five years and then saying…by the way I don't think you're doing that very well or do you need…help with that…It's…better if we…see it as part of our role [addressing parenting] and embrace it from the beginning then….it's not as critical, it's much more constructive (P 5:cmhn).

Six participants reported that they prioritised parents with the most pressing parenting needs, for example "the caseload would be split up into…high…medium…and low need" (P 12:cmhn). Similarly, another suggested:

> … if there was a problem in it [parenting] I would …do a lot more visits…when I find a mum is doing well I would…see her weekly, two weeks, three weekly and monthly…with a dad it's a little bit longer, you're doing a lot more weekly visits (P 3:cmhn).

Support parents to promote their mental health and general well-being and parenting capacity. All participants provided various examples of activities that were directly or indirectly related to supporting parents in their mental health, general well-being and parenting capacity. It was repeatedly noted that parents' mental health and well-being were intertwined with their parenting capacity and their relationship with their children. With regard to parents' mental health and general well-being, all participants stressed the need for parents to take time out to focus on themselves to remain well and/or to recover from the acute phase of their illness, For example, P 7 (acute) reported that she told parents:

> … it's natural to be worried about your family but when you're unwell…it's a flag for you to realise that you need a bit of time for yourself as well and if that's what it takes for you to get back out there and to be able to cope and …enjoy your family… you do need to give yourself that time…

Whilst another reported

> …I said it's a little window in his [child's] life…where you need to just concentrate on yourself for a week or two (P 6:cmhn).

In acknowledging that parents' mental health, well-being and parenting capacity were intertwined, some participants, particularly those from the community, described how they addressed parenting needs while simultaneously addressing parents' mental health needs. Participant 9 (cmhn) suggested

> …whenever you are…asking…how do you spend your day or how do you feel…you…also ask the questions…how do you find your interactions with others…and how are you getting on with the kids…

Both groups focused on promoting the parent's recovery from the acute phase of their mental illness, so as to restore their normal daily functioning, e.g., "Our focus is…treating their mental illness…getting them…back to how they normally function…if they can't get well…they are not going to be able to look after their children… (P 13:acute). However, in comparison to those working in the acute setting, community participants adopted a more comprehensive and holistic approach in supporting parenting by addressing wider issues impacting on parents' daily lives. Resonating with a holistic view, several community participants noted the impact of economic problems on the parents' living circumstances and parenting capacity, e.g. "I go to squalor every day… so you can see the end result of a severe enduring mental illness…they [parents and their children] don't need to go to that level [of poverty], there are interventions that can be put in place to prevent that slide" (P 1:cmhn). Similarly another contended:

> If we can keep her bills straight, if we can lessen the stress, she's less irritable, less paranoid…in reassuring her…and trying to …lessen the stress…you hope that it won't affect the children (P 3:cmhn).

With regard to meeting parents' social needs, community participants indicated:

> …It wasn't only treating the depression…it was about trying to encourage her to get out into the community, parent and toddler groups etc… (P 6:cmhn).
>
> I encourage parents to… have a life outside of their children. A life with their friends, a social life, an exercise life, and then a life with their partner… and that to be a good parent and to be a well person they have to look after themselves (P 4:cmhn).

All community participants (n = 10) and three of the acute participants also intervened to promote parents' parenting capacity. Many noted that parents primarily needed reassurance from the nurse, "they need permission to parent…to be sick and to recover slowly and gently" (P 4:cmhn). Participants, and particularly those in the community, also reported that an important part of their role was to promote the parent's confidence and capacity in their parenting role, and to promote their relationship with their children and provided many examples of this in different contexts. For example, in relation to promoting parents' confidence, P 14 (acute) reported "parents need an awful lot of one to one assertiveness work in relation to their parenting…because the illness has knocked the stuffing out of them in terms of their confidence and …self-esteem". Others suggested

> … the biggest thing that we as nurses provide for our patients is …pure basic support…just being there and hearing what they have to say, …acknowledging their experience and what it has been like for them…not dismissing it…we need to offer…as much support as it takes…and as things improve the more supportive you are…they start to feel good about themselves…more confident…about their parenting capacity (P 7:acute).

In relation to promoting parenting capacity P 3 (cmhn) suggested " …you're trying to help the mother to build her own supports and…mothering skills…I'm there to support

her…to discuss whatever she feels is her deficits and sometimes to point out things that I feel aren't deficits…", whilst P 11 (cmhn) suggested:

> … watching how parents interact with children and being able to … do some guidance work around that can be helpful…Teaching them basic interaction skills can alleviate a lot of potential stressors before it becomes a bigger problem for the child.

Some participants provided examples of how they helped parents deal with practical aspects of parenting e.g. P 3 (cmhn) reported "The child had head lice…the mother wasn't doing anything about it…I went down to the house and I brought a bottle of the stuff [treatment for head lice] with me and said [to the mother] come on, we'll do this together".

Most participants (nine community, two acute) also supported parents in their relationships with their children. Some community participants described times when they advised parents how to manage their children's unruly behaviour for example, "a lot of people that I see one to one, mothers especially, a lot of it's to do with parenting in a super nanny 911 approach" (P 4:cmhn), while others reported " I would talk to them about parenting strategies…how to manage inappropriate behaviours" (P 6:cmhn) and

> … if I've made them feel that someone has… heard what's important for them… and give them a little bit of guidance on how to deal with it…they're able to put it into perspective and then change the way they would have done things (P 1:cmhn).

Others advised parents how to establish and maintain a good relationship with their children.

> I have conversations with guys about…what kind of father they want to be and about…taking responsibility for their children…how would they like their children to view them… and about having fun with your kids…and being active with them (P 8:cmhn).

Two participants working in acute settings advised parents about relationships with their children for example, Participant 13 (acute) reported that he said to one particular father:

> They [children] are entitled to be angry, you've done a lot of things to piss them of …some of this you have to take on board and you just have to suck up…there comes a point when you have to be a parent and say…I have a responsibility…to make sure that you are not going to go down the same road I went down.

And P 7 (acute) reported:

> …our gentleman at the moment…feels that his relationship is deteriorating with his two children. He is getting text messages that are…hurtful…they're blaming him and he…doesn't know how to respond to that. So you listen to him and…try to get him to see where they're coming from and that they might be…confused…so try to reassure him and …get him to see the reality of the situation and bring him back a little bit from it to gain some perspective.

Eight participants described the benefit of disclosing their own parenting experience for example:

> …I would have no issue disclosing…it…because I think that it is important to have a good working relationship where people understand who you are as well…that you're not some gobshite…who's read loads of textbooks…or watched super nanny and thinks that they know it all…that you are actually bringing to bear a bit of common sense…particularly if you're dealing with…young mums or…fathers…you can…espouse your wisdom…it's an appropriate thing to do giving people…reasonable advice (P 9:cmhn:parent).

Some participants employed hypothetical scenarios to support parenting.

> We plan…events…scenarios that if this happens, if that happens, what are you going to do…and put a crisis plan in place…I would be trying to think if…problems…arise when the children have to be taken out of the house for appointments…we would be trying to put something in place for that… (P 5:cmhn:parent).

In an additional effort to promote parents' relationship with their children, all participants in the acute setting indicated that they encouraged parents and adult family members to allow children to visit parents in hospital; P 10 (acute) reported "I always insisted…bring the kids up, let them see where she [the mother] is and let them see the other people on the ward", and P 14 (acute) indicated "It must be awful for children to have the parent in hospital…and not able to see them…I would…instill into them [the parent] that it is

really important to keep in contact…and encourage...the…relatives…to bring the children". Participant 7 (acute) reported "…we facilitated her to have a single room so that she could…bond with the baby".

Both groups also described assisting parents to explain their illness to their children because "some of them are so afraid of shattering a child's illusions or…disappointing them that they're afraid to tackle it" (P 11:cmhn). Participant 13 (acute) told parents "you need to talk to them in a manner that's equivalent to their age…don't scare the crap out of them", whereas P 7 (acute) suggested to parents "maybe you could… explain to them that you're sad at the moment" and that "…you can word it... so that your child does understand, you don't have to tell them your depressed".

Another way in which participants promoted the relationship between parents and their children was to advocate for parents who had lost custody of their children. Participant 13 (acute) informed the Multi-Disciplinary Team (MDT) that "she [the mother] has to have input here… has to have visitation…has to be involved in some shape or form, not just for her sake, but for the kid's sake". Another described how maintaining a regular report of a mother's progress for child protection enabled the mother to increase access to her child "we are in regular contact with child protection services…to provide…a consistent report…that this lady is taking her medication…" (P 1:cmhn). When parents had permanently lost custody of their children a number of participants described how they comforted parents by being there for them and listening to them "most people like to be listened to…when things are…getting on top of her…it is just really a matter of sitting and listening to her…" (P 3:cmhn).

Engage and support children and other adult family members. The majority of participants (n = 10), and predominantly community participants, described engaging with and supporting children. Three conveyed how, with the parent's consent, they engaged with younger children to establish rapport with them to enable the child to feel comfortable in their presence for example,

> ...on visits where you'd be playing with the child…it's about…the kids being comfortable with you there and you give them their little bit of attention… (P 6:cmhn).

One community participant, at a parent's request, held a series of meetings with younger and older children to establish what they knew about their parent's mental illness and to help them understand it. For example,

> The children... ranged from …fifteen down to four…the older ones we took separately…had a chat with them…tested the water…what did the younger ones know… what they knew, what they saw…let them label it and name it…with the younger ones…the older ones were there and the mother was in the other room…so she could hear what was going on…we had… a number of sessions (P 1:cmhn).

Others (n = 7) primarily engaged with older children, as opposed to younger children, to advise them to how to deal with a crisis, for example, P 8 (cmhn) suggested "…older kids…have asked about how they can manage a situation so as parents don't go into hospital…what do I do in relation to…a crisis..". Participant 13 (acute) talked at length about the need to inform and reassure adolescents about their parent's mental illness when they visited their parent in hospital.

> We…encourage the parent to bring their child…to meet…the nursing staff…it helps to allay the fears of a child…the 13 to 15 year olds are trying to be more mature than they need to be about it… We'd often sit down with them and say look…here's what we're going to do...it takes away the mystery of it all…it takes away the stigma for a kid to realise…mental illness is no different than cancer…

Another indicated that she would give older children "information on what facilities were available to them…and…talk to them about…their own space and … mental health…" (P 3:cmhn).

In addition, all participants discussed how they engaged and empowered adult family members to support the mentally ill parent and the children in the family for example, "…illness doesn't operate in isolation from families…increasing awareness and education…can make a huge …difference…to encourage them to help out…" (P 14:acute). Another reported, "part of our brief is that we support families and significant others and…we'd be using that relationship to support children as well as best we can" (P 12:cmhn).

Participants also used their communication skills to involve other adult family members in caring for a parent, for instance, P 11 (cmhn) suggested, "If someone doesn't want their family to know we have to work with them to say…do you not think your family need to know that?". Others described how they managed to involve adult family members and outside services without jeopardising parents' confidentiality, for instance,

> Even if we can't talk…to adult members of the family…we can still…listen to what has to be said…so we can still work with families without this [parent's permission to engage with adult family members]…(P 7:acute).

Another suggested, "I can always listen…it's amazing how much you can hear without saying anything…and how much you can say without saying anything" (P 3:cmhn). However, one participant indicated that the involvement of other family members was not always useful for parents and their subsequent role in managing these relationships:

> …some grandparents … could be very negatively involved, very critical… talk about a triangle. I…would be between the two of them in managing that situation…mediating that all the time…it's about having those three-way conversations (P 11:cmhn).

Some participants also acknowledged the needs of other adult family members and their role in supporting them for example,

> …we weren't necessarily just looking at the mother. Also looking at the family unit and…offering supports to them, to the partner of the child…because they were probably taking on a lot of the caring role of the child where they needed a support and outlet (P 1:cmhn).

Collaborating with others. The final component of FFP involved participants, most community based, collaborating with colleagues and outside agencies to support parents and their children. Participant 6 (cmhn) suggested "on the…team it's about sharing the information so that everybody knows this person is a parent and...there is somebody who might be relying heavily on this person". Similarly, P 4 (cmhn) suggested "we all pitch in on people's caseloads…" and P 5 (cmhn) reported "…if I have a problem…we have a buddy system…we would trash it out a little bit and see where to go from there". Others reported:

> My…first point of call…in situations like that would be the Public Health Nurse…they wouldn't hesitate in …ringing me about something and I don't hesitate in ringing them (P1:cmhn).

> If there was a welfare issue …you might bring it back to a team meeting to discuss it with a social worker (P 8:cmhn).

Only two acute nurses described collaborating with others; P 13 (acute) who reported "I'd link in with the community nurse to see do they know…if they have kids?…how are the kids?...what's the story in the home situation" and P 10 (acute) who reported "…ultimately the decision as to whether we can refer to psychology or…to community services is made by the consultant but if the decision is made…I can send the referral straight away…".

Some community participants also described how they engaged in joint working/visits for example,

> We tend to go in pairs…whenever possible on home visits…you may have an impression about something…it's good to bounce something off…someone else… (P 6:cmhn).

> We would joint work at times…when you're dealing with particularly disruptive families…it's always useful to have that kind of…link (P 2:cmhn).

Another used what he referred to as a "gender bias" when working with others:

> … we were going out and…doing joint visits with the public health nurse…the gender bias was actually quite effective. It would be easier for me to talk to the mother's partner [father]…about difficulties in the home…with the children… it was easier for her [the public health nurse] to talk to…the mother about…parenting issues…(P1:cmhn:male).

Four community participants suggested that while they were equipped to deal with the more common every day parenting problems experienced by parents in general they needed to refer parents who required further intervention;

> … the first thing that you do…is try and de-escalate things yourself so that you can contain it and manage it and find out what are the factors that are causing a difficulty…and try and put solutions and strategies in place to support the parent or get them additional help and assistance…If it is something that needs further intervention and you can't manage it yourself …we have …to recognise when it's going into a remit that we can't manage… move it along (P 11:cmhn).

With regard to referral to outside agencies, P 9, (cmhn) indicated that she would refer parents who she "…identified are potentially going to have difficulties…to other agencies like…early intervention programmes". Similarly, P 2 (cmhn) suggested that " there's lots of community groups that you would look to use…I might get …other ancillary services involved…the likes of domestic violence …or refer parents to mother toddler groups". Another indicated that she would both refer and collaborate with family support workers.

> Usually if i see a parent is struggling…I would encourage them to avail of a family support worker…if a family support worker …is finding it …difficult to get the parent involved…I'd be trying to get them all to work

> together...suggest things like cooking, going for a walk…making decisions (P 5:cmhn).

Other participants described collaborating with outside agencies to "educate…the social worker…about mental health…" (P 3:cmhn) and to keep "the communication open on a positive way" (P 8:cmhn) between parents and the services supporting them.

Principles of FFP. The principles described by participants fell into five broad categories: (1) the inter-relationship between mental health and the parenting role (2) supporting children via their parents (3) the importance of the parent-nurse relationship, (4) supporting parents and children is emotionally challenging and (5) practice needs to be individualised and holistic and parents' family contexts are part of this.

The inter-relationship between mental health and the parenting role. A critical principle of FFP was the recognition of the inter-relationship between parenting and mental health, and specifically that parenting impacts on mental health and conversely, that mental health impacts on parenting. In the first instance, participants recognised the stress of parenting on parents' mental health.

> It's very stressful parenting and especially when their [parent's] skills are demeaned quite often….they have social workers…me…all of these people going in telling them to do things differently than they feel like doing them…it's very, very hard for them (P 3:cmhn).

> There's a whole extra dimension to somebody presenting with children as opposed to not doing….it's…easier when you don't have children and you're ill…it's an easier thing to manage, it's tough to manage a depression or…a psychotic episode, but with kids its even tougher…there's a huge amount…of emotional stuff…guilt that goes along with having an illness in the first place…(P13:acute).

Similarly, P 6 (cmhn) contended "…if someone is vulnerable sometimes being a parent can kind of push it over the edge…the responsibility…can be overwhelming" and P 2 (cmhn) reported "…she was under significant stress looking after her children…their behaviour was becoming more and more difficult to manage…I think the…stress …was bringing her…psychotic illness…to the fore…". Some participants perceived that the impact of the recession in Ireland further exacerbated parent's stress, "pre the recession they [children] wanted everything and you had to get it for them, now…they want it but the money's …not there and that's creating a whole set of stress by itself" (P 7: acute). Participant 14 (acute) indicated:

> She was the least motivated I had ever seen, and the reason for it was that all of her children had emigrated because of the recession…she was absolutely devastated …and it was the primary reason that she became depressed again.

All participants acknowledged that a parent's mental illness may impact on parenting capacity and their children's well-being:

> Parents may find it extremely difficult to get up in the morning…to cope with the children if they're in bad form…struggle with the day to day things of making lunches, breakfasts …and disciplining their children…(P 5:cmhn).

> …they…find it extremely difficult to rear children…not in a loving…way, but in the day to day running of children…it's chaos…when things don't work out…they give up very easily (P 4:cmhn).

Participant 11 (cmhn) indicated:

> I remember one little boy… he was …about eight or nine…and he was…the parentified adult…he actually saw it that he might have a role in looking after food preparation…he was talking about bread rolls….I'll never forget it…

Because of the link between mental health and parenting some participants reported a need to address parenting issues as part of overall care, for example, P 8 (cmhn) suggested

that care would be inadequate "if we only address the person's mental health problem and don't link it [parenting needs] in".

Supporting children via their parents. Another important FFP principle was the belief that participants could support children via or through the parent for example,

> My primary focus is on the mother's mental health…knowing that that will improve the …child's lot…if we can work out the stressors we can improve the quality of life for the family, not just for this woman, but for the kids as well (P 3:cmhn).

Similarly, others reported "…we need to get the parent right so they are effective parents to the children…this is the way that we operate" (P 1:cmhn), and "the aim is to restore functioning at a normal level which would be minding kids or taking care of family, so it [parenting needs] will be incorporated in that way" (P 13 acute). Likewise, P 4 (cmhn) suggested

> If the mother recovers well and maintains recovery…she's going to be better able…to do her parenting…if…were guiding the parents…towards their own personal wellness and their parenting skills then the kids will automatically innately benefit from that.

Participant 7 (acute) suggested "these kids will …develop their own issues if we don't teach her to be a better parent…if we don't teach her how to handle her stuff for the benefit of her children". Supporting children via their parents was further described in relation to participant's obligation to protect children's safety and well-being:

> The primary outcome is…the welfare of the child and the mother…is secondary in one way…because if the mother can't look after herself we have to protect the child…the emphasis then shifts to the child and the mothers concerns…have to become secondary (P 1:cmhn).

The importance of the parent-nurse relationship. All participants described the nurse-parent relationship as central to FFP for example, P 11 (cmhn) reported "…you can't

…work with people [the parent] unless you've an emotional connection with them…" whilst others contended "…if they're comfortable with you and…trust you, if they are experiencing difficulties they're more likely to…admit that they're experiencing…difficulties" (P 10: acute), and "I would be very dependent on my relationship with the parent. If I didn't know somebody well, I wouldn't be able to be as forthright. My relationship is…pivotal" (P 12:cmhn).

Some characterised this partnership in terms of supporting parents to help themselves. Participant 9 (cmhn) contended "my job is to try and help this individual determine what it is that's going on for him and if there is anything that we should be doing for him". Similarly, "these parents are the experts in their own lives" (Participant 14: acute). Participant 11 (cmhn) stated "It doesn't go well for relationships with parents…if you've come in and made decisions and taken control away from theme as parents. I think everything has to be done with them…the whole thing is…get them on board". Another suggested

> …it works better when they [the parent] come up with the suggestions themselves and …they just need a little bit of empowerment …to follow through on it. It works much better than me going in with suggestions and saying this isn't right and this is the way to do it" (P 5:cmhn).

Supporting parents and children is emotionally challenging. Three female, community participants, who were parents themselves, described the challenging nature of FFP, especially when they were concerned about children's welfare or there were child protection issues,

> It's a horrendous thing, it was two of my clients with a learning disability…plus a mental health problem…and couldn't tell the time so they couldn't know when to feed the baby…it was horrendous because on one level you were meeting with the social workers to try and organise the transfer of the baby from them and then on another level trying to support them…it…was

> probably one of the toughest days of my life at work…where the baby was removed (P 12:cmhn).

> …for yourself it's desperate…I've sat…while social workers are putting kids into cars and taking them away. It's horrendous, absolutely horrendous because you're normally bringing the parent to hospital…after that. Emotionally…that's all very difficult (P 11:cmhn).

> I had a lady…with post natal depression…she was upset and overwhelmed…and wasn't coping… there was a risk to the child…I had to advise her to go into hospital…that was very hard…I'm a mother myself…I was separating this very tiny baby from its mother…so that was…difficult (P 6:cmhn).

FFP needs to be individualised and holistic and parents' family contexts are part of this. Three participants described the individualised nature of FFP, for example, P 14 (acute) contended "everybody's journey might be similar but they're all unique…we have to look at everybody uniquely and it's not a one size fits all type of thing…", and participant 1 (cmhn) reported "It's very individualised, case by case".

The majority of participants (n = 11) also suggested that as practice needs to be holistic it is important to consider and address service users' parenting role and wider family context. For example,

> …it helps us to get a broader picture of what the person's life is like outside of the hospital, to try and figure out…what it is that increases their stress levels…that contributes to what's going on for them…is there problems at home…with the kids?...with the marriage?...it helps to formulate where the treatment's going to go (P 13:acute).

> …you need to have a good understanding of all the things that are influencing the mental health problem and having children is going to be a factor…it may be that it's minimal or it may be significant… it's just that holistic, recovery orientated approach…you… have a duty of care to people to do your best for

> them…and your job is easier if you have all the information…having bits of a picture…isn't much use (P14:cmhn).

There was a sense that focusing solely on the parent's mental illness was insufficient; "If they're worried about their bills and their children's well-being and it's causing them to be paranoid, rather than give them another tablet it would be much more effective to deal with …their bills and their concerns regarding their children" (P 3:cmhn). Being holistic also meant recognising the importance of children for parents for example, P 12 (cmhn) indicated "they're in the conversation, the children, even if they're not in the room" and P 4 (cmhn) suggested that for some people parenting is "…so much part of their identity, that…recovering and being able to do that better again is important". Similarly, other participants recognised the centrality of children in parent's lives "…it would be something that you would hear quite regularly…it was in the top of his priorities, my kids, my kids…I just want to get home to my kids" (P 7:acute).

Endorsing this, P 1 (cmhn) described how it was easier for him to work with a mother to promote her recovery because she had lost access to her child on a temporary basis and was motivated to get well to gain increased access to her child.

> Some of the goals…would have been mutual like…finding a flat…getting a job…showing that she's stable…as a result she …went from… not seeing her daughter…to fortnightly access visits to weekly and now we are looking at weekend visits…

Likewise, P 14 (acute) contended that

> … parenting is a huge, positive aspect to somebody's identity…we are …really scuppering people's ability to rehabilitate and reconnect with that sense of themselves if we diminish that role and …identity…and how can you…be the best parent you can be.

Being holistic also meant acknowledging, involving and supporting other adult family members including parent's partners:

> Adult family members have a wealth of knowledge of what's going on and…there an important link because they are principally part of the support for that person getting better…so we need to…keep those links nice and solid…and help the patient (parent) realise the value of them as well (P 12:cmhn).

With regard to the need to involve adult family members in an attempt to both maintain child safety and to support parents,

> Families need to be aware of how much the person is struggling…once they become a parent families tend to take a step back…only when the person asks for help...we empower the family to…drop in and see how things are going… if things aren't working out great we empower the mum or dad to ask for help (P 5:cmhn).

It was also acknowledged that parental mental illness affected the whole family, including parent's partners, and that in this respect partners also required support. Participant 1 (cmhn) indicated "he didn't realise his wife had been referred to the CMHT, he …was getting very worried about her so in that way if offered him a lot of reassurance".

Being holistic also involved being flexible, for example,

> …you do whatever you have to do to try and keep them all…going…as a family…my role is fixed if I want it be fixed but my experience tells me that, especially with those with enduring mental health problems, that you have to be fluid. (P 9:cmhn).

Similarly another participant contended

> It's not something that you go in thinking you're going to do either, it's something….you're faced with and it's just to get rid of the chaos…just step in and do what you have to do…if you're waiting for a service to go in you could be waiting for months for it…so you have to…weigh it all up…and sometimes it's outside your role (Participant 3:cmhn).

Finally, being holistic included having a broad long term view:

> … it would be very important to get them [children] when they are young to try and educate them on …why their mother or father reacts to certain things in this way…to prevent us seeing them coming into the service (P 13:acute).

> need to be approaching things with a…preventative hat on your head…thinking to yourself…hopefully this won't be the next generation that come through your door because of the stuff that they've endured…so its…breaking the circle type conversations…that need to be held (P 10:acute).

This broader view was further reiterated by P 10 (acute) when he argued "I appreciate that there's costs involved…but if we don't start to develop it we're looking at a generation that's going to keep having these issues…when we could have prevented it".

Process of FFP. Another central feature of the nature and scope of RPNs' FFP is its underlying processes – or in other words, the methods employed by participants to engage in the various family focused activities and to translate the various principles in practice as previously described. These processes included (1) collaboration with parents and adult family members (2) drawing on principles of therapeutic interventions to inform practice and (3) use of home visits to observe normal family life.

The collaborative relationship between parent and nurse is included despite having discussed the importance of the parent-nurse relationship in principles. In principles the focus is on why the need for the parent-nurse relationship whereas in process it's about how the relationship is forged and used to engage in FFP.

Collaboration with parents and adult family members. FFP principles and activities were processed through an authentic, warm and responsive relationship between nurse and parent. This relationship was formed in order to establish goals and problem solve, as

reflected by P 4 (cmhn) who suggested her approach to care entailed "goal setting …it's not what I want…it's what she [mother] can agree…collaborate…and participate with". Similarly, P 7 (acute) reported "…You're spending a lot of…time and …energy getting them [parents] to co-operate and collaborate with them to see this as being part of a solution as opposed to making a bigger rod for their back…". Another reported, " I…see myself as…an advocate and a support…rather than as somebody in there telling her how to do things" (P 3:cmhn). Likewise others suggested:

> I would be asking the mother or…father what their agenda would be with me coming in and we'd sort of find a common place if we could…I would like to see…them having their own suggestions and maybe…picking up on what's wrong in the house…what ideas have they…in helping out and making it…right for the children… (P 5:cmhn).

> …it is about a negotiation. You don't want to isolate or have the parent feel threatened. This is not something they've done wrong. It's an illness…it's a nimble kind of balance…you're trying to …say to them look…we can't let this go on, will you come with me on this and you work… at it like that…you just don't go in there and…lay down the law…you'll get nowhere doing that (P 12:cmhn).

Participants also described collaborating with other adult family members to support parents for example, "…trying to encourage them to help out…to drop in and…sit down…do homework" (P 6:cmhn), while another reported "…we suggest…they do…babysitting…a plan would be formed…as regards helping out as much as possible and I would follow through on that" (P 5:cmhn).

The skills employed to build these relationships varied. Participant 12 (cmhn) described how he allowed parents to:

> … develop the problem…with…open-ended questions and hearing what they have to say and putting it back to them…and it develops so that often times

> without me having to say you need to do this, they…say…maybe I need to look at it in a different way. So it is much more of a partnership approach…

Sustaining long term relationships with parents was important, especially for community nurses, which meant participants had a comprehensive knowledge of parents' lives when they were well and unwell. In contrast, although many participants in acute settings had long term relationships with parents they only cared for parents when they were unwell and so had limited insight as to how they functioned when well. Participant 8 (cmhn) suggested that "when the person is very well you can make the comparison, you can say…when you're well this isn't happening so therefore we need to do something about it now because this child is developing problems". Likewise P 9 (cmhn) contended:

> … you use your relationship…your past experience of this person…this is not you…this is a sign that you're not doing so good…we'll have to sit down …and talk about this…and we'll…see what has to be done…and what do you think the kids need…

Participant 11 (cmhn) concurred, highlighting the emotional connection between nurse and parent built over time:

> it's about knowing people on multiple levels…I've seen them through the thick and I don't just always see them as a client…when they come and talk about issues in relation to their children they're not talking about issues from the point of view of a problem, they're talking about it just as an everyday issue… they're having difficulty getting somebody [children] going to school, they want to talk about…that…you can't do that piece of work with people unless you've an emotional connection with them.

Participants also noted that they endeavoured to be as transparent in their communication with parents as was possible as reflected by P 7 (acute) "it was said to her that there was a concern and…it was within our duty to…report that on the social worker", whilst at the same time negotiating with the parent to keep them on board.

In order to forge and sustain a partnership with the parent it was also essential that participants avoid being judgmental as reflected by P 14 (acute) who contended "I've always believed that the primary requirement for psychiatric nursing is that you need to be able to communicate…to interact and…do that in a non-judgmental way". Participant 4 (cmhn) also suggested:

> …it's not what you say, it's the way that you say it…we would choose our words and phrases and our way of relating that gently…we never put it across in a critical way, even if you thought to yourself mother of heaven what have you been doing with this child? We wouldn't go it that way because it would damage it [the relationship] otherwise.

Others suggested " you would see things that are wrong in the house…and you would broach that very gently…like if the children weren't washed, or starving and looking for food" (P 5:cmhn) and "I'm not lecturing in any way because…no one's going to come to see you if they feel they're being lectured to" (P 8:cmhn), and "…it they feel there's going to be a judgment coming with your experience…that's where the difficulty is going to be and that's where they're holding back" (P 11:cmhn). Participant 14 (acute) also indicated that she would find it difficult to engage in FFP if she had "a preconceived idea of how things should be".

Participants' own experiences of parenting were also important in building this relationship with parents. Participant 6 (cmhn) indicated that she would say to parents "God I remember when they were that small and it's not easy", to convey to parents that "everybody experiences difficulties as a parent and to get across to them…don't be afraid to ask for support". Likewise P 7 (acute) indicated "I think it's very helpful to share a little bit of yourself as well…to go in and say…I know it's hard I…have kids, I know that the stage is really difficult, they have you up half the night…and I think people know if you're getting them…". In building these relationships there were some boundaries however.

> I would use limited…self-disclosure discreetly and frequently…but I would have to be really careful to get the that balance right, to not be putting myself across as…some sort of catalogue parent because I'm not…I make mistakes as well (P 4:cmhn).

Drawing on principles of therapeutic interventions to inform practice. Another central element underpinning the process of RPNs' FFP was the use of specific interactional approaches/therapeutic interventions to support parents and their children including cognitive behavioural therapy (CBT), solution focused therapy (SFT) and/or family therapy. The type of interventions depended on the specific needs of parents and their families as reflected by participant 3 (cmhn) who contended "if you have a specific family in front of you, you plan for that family…it depends on what's going on in the family home…the families' needs". Furthermore, most participants (n = 8) indicated that they utilised principles of two or more specific therapeutic approaches to inform their practice.

> I …use both systemic family therapy and cognitive behavioural therapy (CBT). Sometimes you'd have to sit in on a family meeting and it could be very difficult and I'd be able to use it there. The CBT…would be excellent for getting them [parents] to challenge their negative thinking and dealing with panic and anxiety (P 14:acute).

Participant 11 (cmhn) indicated that she employed the principles of systemic family therapy "…the basis for my…assessment would be…a genogram and I'd plot relationships within that". Participant 1 (cmhn) employed CBT because "…if you don't educate parents… don't offer them solutions or different ways of thinking about it, how are they going to change?".

Use of home visits to observe normal family life. Additionally, all community based participants indicated that a vital part of their practice involved regular home visits over a period of time. These visits were used primarily to forge a relationship with the parent and to observe normal family life so as to gather additional information about the parent's daily

functioning, to assess their parenting capacity, to facilitate relationships between parents and their children and to monitor and protect children's well-being. In terms of observation:

> You're observing the whole time…the interaction between the mom or dad and the child or between the children themselves (P 4:cmhn).

> …you…make sure you've the time blocked off so that you can spend time with them to watch the interaction…there's so much you see…that probably you're not meant to see…particularly if you go in unannounced (P 11:cmhn).

> I don't go into everybody's house…It's not essential, but sometimes we might sit back thinking…I've seen that person six times…I need to see what that house looks like…feels like and I'll find a way of making that happen…the happy kids are obvious the minute you look at them…and you can see they're close to their parent. …you can't do it in a minute …over a period of time. You can feel the tension in a house sometimes (P 3:cmhn).

Participants also described using home visits to enhance the parent-nurse relationship as a medium to support parents and their children. Participant 12 (cmhn) suggested "…you're intervening…you're not just befriending the mom, you're doing something therapeutic but it looks like that to the kids". A number of participants also indicated that they would use home visits specifically to get access to children so as to observe and monitor their well-being, for example, "…one of the main reasons that we would do a home visit is if people have young children and the kids were at home and we would go out and visit people whilst their children are present…" (P 6:cmhn).

Summary. The purpose of this section was to outline the nature and scope of RPNs' FFP as reported by high scoring family practice RPNs. Notwithstanding the complex nature of RPNs' FFP, and drawing on the various themes emerging from the data, in the main, participants are engaging in FFP by endeavouring to support parents, their children and other adult family members, especially those practicing within the community setting. Having

elicited participants' views on the nature and scope of their FFP, their capacity to engage in FFP is now discussed.

RPNs' Capacity to Engage in FFP

Three main components associated with RPNs' capacity for FFP included (1) enablers (2) barriers and (3) future potential developments in FFP (Figure 6.3). Once again analyses demonstrated differences between community and acute participants. The community participants identified more enablers and fewer barriers than those practicing in acute settings. There were several suggestions across both groups regarding FFP promotion such as FFP training, systematic structures to support FFP, strategies to address the needs of parents, children and adult family members as well as theory development in FFP.

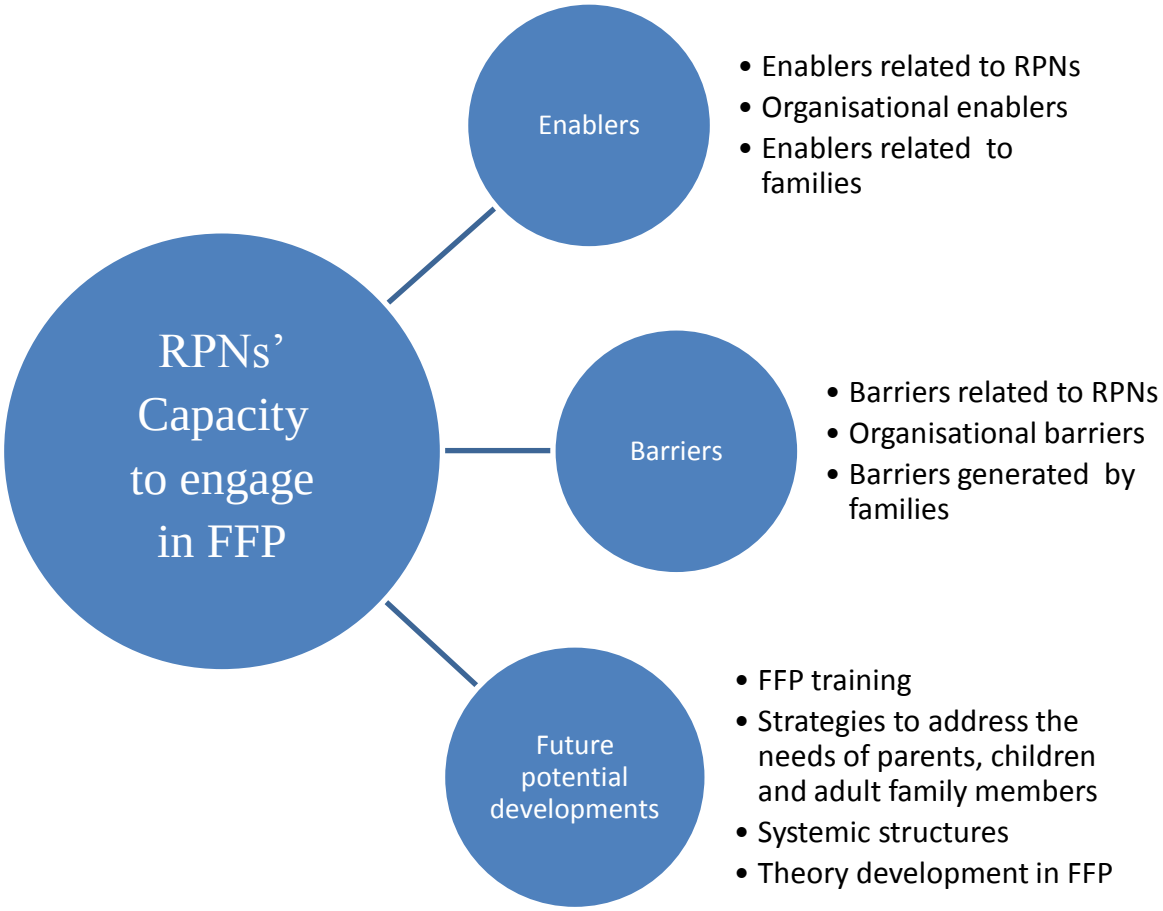


Figure 6.3: RPNs' capacity to engage in FFP

Enablers. Participants, and particularly those within the community setting, identified a wide array of FFP enablers, within three areas related to nurses, the organisation as a whole and as emulating from parents, children and adult family members.

Enablers related to RPNs. All participants identified a variety of factors related to themselves and/or their nursing colleagues that enabled FFP. Of central importance was participants' acknowledgement of the importance of effective parenting and their knowledge and skills in parenting acquired from caring for their own or family and friend's children.

Some participants described an awareness of the importance of effective parenting, for example,

> I'm…into parenting…I would seek it out because I feel passionate about it…probably my biggest soapbox issue…I view parenting as singularly the most important job in the world and I see how easy it can go wrong…I don't think it's something that we generally take seriously enough…people learn how to parent by accident…(P 4:cmhn).

Another suggested "I take the role of being a father very serious…and I think blokes should take the role of being fathers serious" (P 9:cmhn).

For many (n = 9) the skills, knowledge and attitudes to engage in FFP was developed through caring for their own children and to a lesser extent, caring for others' children, for instance, P 8 (cmhn) suggested "a lot of RPNs are in the process of becoming first time parents and this motivates them to think about the challenges experienced by service users who are parents" while P 3 (cmhn) contended "…my own experience as a mother is one of the most important factors in it to be honest…most of us are aware of our own children's needs and then when you see a child and you think their needs aren't being met you become aware…". Others suggested "I think you have to be a parent yourself, I…think that's more valuable to me at the moment than my course" (P 6 cmhn). Some suggested that being a parent enabled them to relate to parents, "…I can relate to the anger and the frustration and the annoyance and the Jesus, just eat your dinner" (P 4:cmhn). Likewise, P 11 (cmhn) reported "…because you have a sense of these are the trigger times…you can ask…empathise, understand and…your also able to say to clients...I know what that's like…I have kids…it gives you a route to be able to say what's that like for you". Being a parent also helped participants to engage with parents as they were able to "use limited personal self – disclosure discreetly and frequently" (P 4:cmhn). Others suggested:

> …you do bring your own experiences…My oldest is twenty and my youngest is nine…and there's five all together so there is plenty of scope for practice…you use your own experience, your own common sense a lot of the time...(P 14:acute).

> [I would say to parents] I had three small children the same and you would know when they are sick they all tend to get sick at the one time, you're going to be…tired…not…sleeping yourself because you'd be constantly on edge to watch out for them (P 5:cmhn).

Some participants, who were not parents, suggested that experience in caring for siblings or other people's children helped them to relate to parents:

> … my sister came along when I was 10…so changing nappies I have been doing that since I was a child so I can relate to some of the issues new mothers are encountering" (P 1:cmhn).

Life experience, associated with age, was another FFP enabler, for example, P 12 (cmhn) suggested that [life experience] "has taught us…to be responsive and responsible", while others reported:

> I think my own life experience and…own crises have helped me to stand up and say what I blooming well think…If the consultant didn't want me to do it [FFP] it could get quite difficult…but I'd just have to put the gloves on for that fight (P 4:cmhn).

> …It's just life experience…my morals are not the same as your morals…parenting is the same, the way I parent is different to how you parent and who am I to say my way's right and yours is wrong and I think that younger staff don't get that. That you come to that much later…you come to looking at things more broadly later… (P 3:cmhn).

Similarly, P 10 (acute) indicated that his own life experiences helped him to support others reporting that:

> … my own mother was widowed quite early in life with four small kids…we got sent to live with a bunch of people we didn't even know…so I understand how difficult life can be for people…there's no better school of learning than life experience and for us to do what we do and for nurses to be good nurses you can't do that if you don't draw on your own experiences.

Some participants also described the benefit of other team members being parents for example, "within our own team… we're all family focused…and we all have kids" (P 3:cmhn). P 14 (acute) suggested "…[I] tend to talk to other staff about it…and I think I would always…veer toward staff who, like me, had grown up children that were that age".

Participants' attitudes to FFP and the need for holistic care was another major enabler: "…I knew from the very first time I went out into the community…my focus would have been on families…and the wider network…I would have seen myself in community before I ever came into nursing, so it's a bigger piece of all of that…"(P 11:cmhn). Others suggested:

> …on a human level you…use your own experience, your own humanity…a lot of what we do is instinctive…we may be the only person going into the house so we have to think about the family…you have a moral obligation (P 12: cmhn).

> I think it's …human nature really…being humane…caring about people and…their extended family, you don't just care for them, you care about the extended family when you…look after them (P 3:cmhn).

> I think you should be treating the whole person and the extended family is…part of that…(P 2:cmhn).

> …services should be extremely family focused…I would be very proactive…in family orientated practice… (P 8:cmhn).

> Family work is invaluable…RPNs need to expand their remit and focus upon and view the children and family members as an integral part of care planning (P 7:acute).

The awareness of the inter-relationship between parenting and mental health were other enablers; "…I think…there is…an obligation on you to be family

focused…if you're treating a parent, because…children can affect the parent's mental health…so you have to be involved with the family…as well…" (P 2:cmhn).

Finally, three of the male participants implied that their gender facilitated them to engage in FFP, i.e., P 9 (cmhn) indicated he was "able to have man up type of conversations [with fathers]" while P 1 (cmhn) suggested "I suppose being a man it would be easier for me to talk to the father and the public health nurses…to talk to…the lady".

Organisational enablers. There were six organisational enablers that were common to both groups though these primarily came from those who were community based. With regard to common organisational enablers participants suggested that developments in policy enabled their FFP, i.e., "…the legislation…from Children First has made us…broaden what we're taking on…It's measures like that that make things more concrete" (P 13:acute). Similarly P 8 (cmhn) reported:

> With …changes in…legislation…changes in Children's First training….it's [FFP] become more prominent now…when a referral comes in…it'll be the person [parent] but also …a number of dependents…you're not just looking at the person, you're looking at…whose in the house… we've…as a team…become more…family orientated…it's more…a rounded view of what's going on….with the children…is there any risk…things like that…

Others suggested "…if we suspect the child is being neglected…under the Child Welfare Act we have a responsibility …to report it" (P 14:acute) and "there is a mechanism in the service to report suspected child abuse" (P 10:acute). Another reported, "We've all done…Children's First…I think that there is huge awareness of the children…and the impact that this [PMI] could have on them" (P 6:cmhn).

Training was a significant enabler for five participants for instance, "I did family therapy later in my nursing career and I think it changed my whole outlook on nursing…it's

the extra training, it's the CBT and family therapy that pull the whole thing together for me" (P 14 acute). Another suggested:

> …the course I did in…psycho social…interventions….one of the main stems of that is family work and…from that…you gain a greater understanding of the…effects …of mental health problems in the family…(P 8:cmhn).

> Other training foci was also helpful, "I started doing…motivational interviewing…it's much easier to allow them (the parents) to develop the problem" (P 10:acute).

Work experience also enabled participants to engage in FFP for instance,

> I worked in the child and adolescent services for a long time…so there was an awful lot of family work involved and you…bring that experience to the adult field (P 9:cmhn).

Similarly, P 3 (cmhn) suggested "…we're on the community and we're picking up the skills as we go…", and another reported "…you're always learning…each new experience with different parents" (P 7:acute). Others reported that their interpersonal skills were enablers for working in a family sensitive manner e.g., "a lot of it is your own…interpersonal skills…you develop a sense of what works and what doesn't work and how far to push it and when to back off" (P 11:cmhn). Others suggested that establishing parents' trust enabled them to sustain their relationships with parents in difficult circumstances including referral to child protection. Participant 4 (cmhn) suggested

> As long as parents' trust you and realise that you have the best interests of both them and their child or children at heart then it is possible to continue to support them even when you have been involved in referring them to social services and when child protection are involved.

Working with patients over an extended period of time was another FFP enabler, for example, P 7 (acute) suggested "a lot of the patients [parents] I would know from having met

them previously and so you…get a picture of people over time…you have a rapport with them…they're more secure in telling you how they feel", and P 10 (acute) reported "…we're the people on the ground floor, we're the people that are offering support 24/7". Another suggested "she felt comfortable…talking to us but I suppose it was quieter on the ward at night…so maybe she felt a little bit more comfortable because of that" (P 7:acute). Others suggested:

> …a lot of women that I'd have coming to me…are in their 40s. I've been with them all along when their children have been very small…and some of these children are now having children…there's a whole cycle that goes into what we do with families, that gives us a different relationship with people and allows us to make interventions in a different way than…other professionals that are coming in…for the purpose of making a specific intervention (P 11:cmhn).

The experience of witnessing intergenerational transmission of mental illness also motivated some participants to engage in FFP, i.e., "…over the years its [FFP] evolved as a way of thinking, through seeing…that trans generational cycle…" (P12:cmhn) and "it is very upsetting for RPNs to see service users' children and no that some of them will become service users themselves due to the family dysfunction and due to copying their parent's behaviour" (P 13:acute).

There were also physical FFP enablers that allowed nurses to see multiple family members, e.g., "…having my own office space, that is a huge, huge plus for me…seven years ago we were literally in cloakrooms, kitchens, absolutely horrible facilities to bring people into" (P 11 cmhn). Another participant suggested that the physical setting of the hospital enabled FFP,

> …it's a great opportunity when you have seven or eight people around the bed…you stroll in…and after five minutes you might find yourself in the middle of conversation about what's going on (P 14 :acute).

There were also a number of enablers that were specific to the community setting. The importance of a positive organisational culture was repeatedly emphasized as a FFP enabler. A positive organisational culture stemmed from the adoption of a holistic and family-centered philosophy, for instance:

> …out here it's the family…you build on…whereas in the hospital it's the person you build on" (P 5:cmhn)

> …within the community nursing service…it's…one of those unwritten values [FFP] that we…strive towards or…know it's part of your job so just get on and deal with it and you don't necessarily question it… (P 1:cmhn).

> I think a lot of us are…putting our oar in [addressing parenting needs] maybe where it wasn't intended in the first place but by the nature of the job we've always subscribed to holistic models of care. I came into nursing with that belief system and i…have been lucky enough and fortunate to get a community job that allows me to follow through (P 11:cmhn).

> …we all…sing of…the same sheet...our team philosophy…is just orientated to families and to ensuring that we don't see little Johnny in ten years time" (P 6: cmhn).

Working alongside colleagues who were family focused also enabled participants to engage in FFP, for instance, P 3 (cmhn) reported "within our own team…we're all very family focused…and that facilitates FFP", while P 8 (cmhn) reported ""my colleague…has a similar training to me and…similar interests…it does help…if colleagues are supportive..". Predecessors, who had set standards regarding FFP, for others to follow, also enabled FFP.

> …a colleague…was very involved with a family…when the wife was dying the husband who had schizophrenia was useless, he had lots of negative symptoms so he wasn't able to look after the children…this colleague and the social worker…took turns staying overnight…looking after the children…they dressed the children for Christmas and things like that because that was the mothers dying wish to see her children looked after and that community nurse

> became…a surrogate grandmother…when the children became older and started having their children she was invited to the christenings and the communion and to the different life events…it wasn't questioned it was just done…it was seen as a need a role you filled that need, that role…I don't know if I'd be able to do the sleeping over bit but…because I have seen what other colleagues have done…I would hope…that I would be able to live up to…my predecessors their goals, their expectations and I think that there has been a history of that in this service where people do get involved with the families… (P 1:cmhn).

The majority of community participants (n = 7) also reported that collegial and managerial support was an important enabler for example, P 11 (cmhn) reported "…you can tease things out…it's down to the relationships…we have with each other…it's…the human things, being a support to your colleagues if they're struggling", and P 9 (cmhn) suggested "most of the community mental health nurses that I'm working with in this area have been at it for a good few years…so there's a wealth of knowledge there…and I can always tap into that myself". Similarly, others suggested:

> …one of the most powerful things over the years has been…the…exchange of experience…throughout the years and…we've always advised one another so the cases are picked apart…that's all very supporting (P 12:cmhn).

> Having the support of my Assistant Director of Nursing is very helpful…I would have clinical supervision…and we would…go through…what we are doing…is there any concerns…if there happens to be children…what are the issues with the children…giving you an objectivity to how you work and how to…proceed (P 1:cmhn).

Other participants perceived that the interdisciplinary nature of the teams enabled FFP as they were able to draw on other areas of expertise in supporting parents and children for example, "…the social worker…she's really good…to link in and ask if you're in a situation…to bounce things off...it's invaluable to have that as part of your team…" (P 6:cmhn) while P 9 (cmhn) reported:

> She [the social worker] was very useful in child protection type issues and when social services were involved she was great at liaison because she was well linked in...so we would joint work at times…that was very helpful….

Some participants noted ongoing and clear good communication with outside services also enabled FFP, for example, "…there's good communication between the services…good working relationships and that's really important…" (P 3 :cmhn). Sustained working relationships were facilitated by having a common base, which meant that "now we've got the primary care teams up and running…I can stick my head in the door and slag them off and have a laugh but at the same time…you can have good detailed conversations" (P 9: cmhn). Similarly, P 11 (cmhn) suggested:

> …we've [got] very informal relationships…the relationship is kind of an informal route into something that's quite formal…we meet each other regularly, bump into each other down in the coffee shop…and then if there's an issue with the children you can just flag it up with them or find out what's their experience going in…so there would be a lot of informal exchanges of information…

All community participants described how conducting home visits enabled them to access children and other adult family members and observe parents.

> …the home is the centre point of the family…being able to go into the home is pivotal in being family focused…because you're not only working with the service user [parent] but you're also able to gauge the feelings and interpretations of the family members…(P5:cmhn).

Others described the importance of home visits in obtaining accurate assessments, for example, P 6 (cmhn) contended "… if we're not sure whether someone is being honest with us…or whether…we have a handle on someone…a home visit can…speak volumes". Another suggested:

> …you could be there when the children were coming in from school and you'd see how it's working or you could drop in in the evening. You can see a mum on her own when the children have gone out of the house and everything

> is rosy and she's making it out to be rosy and you could go back the next…evening when the children are in and there's chaos…it's a good learning curve for me as well as for the mum to see how she is managing (P 4:cmhn).

Impromptu home visits were identified as particularly important e.g., "…there's so much you see that you're not probably meant to see and particularly if you go in unannounced" (P 11:cmhn), while P 2 (cmhn) indicated "usually if I have a problem with the family I would say I would be calling…but I can't give them a time…". Similarly, P 1 (cmhn) contended " …it's not that you want to catch people out but there's nothing better or no better way to do an assessment that just to land on the door". Some participants also implied that their colleagues in the acute setting were disadvantaged by not being able to do home visits, for example, "…the community perspective is so different to working in an in-patient setting because we see it as it is…"(P12.cmhn). However P 5 (cmhn) identified a down side to home visits; "at the moment I'm working out of the boot of the car…we don't have space, we don't have a room that we can call our own, where we can hold groups".

Two participants suggested that flexibility in service delivery enabled FFP, with P 6 (cmhn) reporting:

> … we try and…work with the person and the restrictions that they have on their time…and what they have to do with their children and that has to be a priority…we slot in around that…even though it's very important that they look after their mental health it doesn't really matter whether we see them at twelve in the day or seven in the evening. We can see people regularly and they can continue on with the normal life of the child.

Participants also suggested that caring for parents in the community, when they were managing their mental illness in conjunction with their normal daily activities, including parenting, enabled FFP, for instance:

> … we're trying to treat people who are sometimes unwell in the community…we're a bit more clued in to what's going on with the kids and are they getting to school, who's getting them to school, who's making their lunches, and how's all that happening (P 4:cmhn).

This contrasted with the hospital setting "If you're in the hospital ward your focus is much narrower. You're just dealing with the issues with the patient on the ward…you don't have all those things that affect the client when they are in the community…and you have to deal with them to de stress for the client" (P 3:cmhn).

Accessing additional community supports for referral was also important;

> … it works well with the child and family centre…they have a group of mothers that are struggling mostly from our service…they let them sit…and talk…and they learn and cope with what's happening…so it's great (P 5:cmhn).

Enablers related to families. Parents' receptivity to discussing family issues enabled FFP; P 13 (acute) reported "when they come in…they start talking about their kids straight away and how they're stressed…", and P 5 (cmhn) contended "she was quite open…she was saying that she wasn't able to manage...and cope". Relatedly, parents' insight into the effect of their mental illness on their children was an enabler; "…some people hear what you say very quickly and…sit back and go God, i can't believe I've done that to my children…" (P 10:acute). Similarly, "she wanted to do it right and she wanted to look after the baby so she was doing her best so she…asked for help" (P 7:acute). Parents' receptivity to FFP was influenced by their perception of usefulness;

> … so long as the parent can see…the benefit for the child…they know from your…interactions with the child that you've a sense of the child and what's going on with the child so they seem to just take it on board (P 11:cmhn).

> …most parents…can have…honest conversations about their behaviour…and…the negative impact that it's having…it's about focusing on the welfare of the children and the nature of her illness and she can rationalise why what was done…was done. She's not pleased about it…but she can see that there was a rationale for it (P 9:cmhn).

Building sustaining relationships with patients' children was another enabler; P 3 (cmhn) reported "…the little one would…come over and…climb up on my knee and she'll sit down and…have a chat with me before the mother has a chat with me…", and P 12 (cmhn) indicated "…kids know me from going in and out…they…nearly…see me…as …mom's friend…the person that will support things, that'll…put the fires out…if there's something wrong".

Barriers. Notwithstanding that participants in this study were identified as high on the FFMHPQ, a number of FFP barriers were identified, related to their own, as well as their colleagues practice. All participants identified barriers to FFP, particularly participants in the acute setting. Similar to enablers, barriers fell within three areas, including barriers related to RPNs, the organisation as a whole and as emulating from parents, children and/or adult family members.

Barriers related to RPNs. When discussing the impediments to FFP, some participants noted knowledge and skill limitations experienced by themselves and their nursing colleagues "…If I did a course in family focused care I'm sure I would realise I'm quite ignorant" (P 2:cmhn) and "…I probably would need further training in it [FFP] to be honest" P 6 (cmhn). In particular, participants reported a lack of confidence and skill when working with service users' children, for instance, "It's about my area of specialty and me being confident to sit down with the children…I…would need further training in it…" (P

5:cmhn), and "…it's…specialised…I don't know if I'm the best person to do it" (P 13 :acute) and "…it's different communicating with children…I've always worked with adults…I would feel out of my comfort zone" (P 7:acute). Similarly, P 14 (acute) suggested "… children's needs are different and we…wouldn't be as equipped to deal with what their needs are".

Three participants in the acute setting also indicated that if they didn't suspect children's safety was jeopardised they would only discuss parenting when parents identified parenting issues themselves for example, P 10 (acute) reported "…normally it would be the service user who would bring it up…". Likewise;

> …it would be brought to your attention…when they're worrying about it, they will tell you…it's parents asking you directly more so than me going and seeking it out and suggesting it of my own …accord (P 7 acute).

> … they're [parent]…worried about…their son…they mightn't bring it up…at that point you're unaware of things…[worries re son] but then a couple of months down the road…it might run into a major problem…(P 14:acute).

Also reflecting limited skills, four participants suggested that whilst they were happy to address common everyday parenting problems they did not have the knowledge and skills to deal with complex parenting problems, for example P 1 (cmhn) suggested "if it's something…a little bit more deeper…primarily it's the responsibility of the social worker" and P 9 (cmhn) reported " [I can have] conversations with people [parents] about common sense issues [but] there are experts in the field and if there's big issues that's where they [parents] should go…". Another suggested

> I will address the normal challenges of parenting but if there are more ingrained problematic issues for either parents or children I will refer to

> specialist support services such as child and family support services or to psychology (P 5:cmhn).

Not being a parent also impacted on participants' skills to engage in FFP for instance, P 1 (cmhn) reported "I don't have children myself so…it can be difficult". Similarly,

> I haven't got kids…I don't know what it's like…so it's harder to identify with people…I think if she thought that I had kids she would have spoken to me more openly about it…it…probably should have occurred to me that she'd be more comfortable with… staff who have children…themselves (P 7:acute).

Others suggested:

> In the hospital we need to try to create an awareness among staff [of needs of parents and children]…you probably won't have any difficulty in staff that are parents, because it will be easy for them to put it into context but it will be more difficult to inform…RPN's who are not parents themselves (P 14:acute:parent).

> …that's one of the questions that they [parents] will ask you…do you have kids yourself? …maybe they're [parents] questioning whether this person [nurse] may or may not understand… (P 8:cmhn:parent).

Finally, six community participants contended that most of the RPNs in acute units they came into contact with in the course of their work had little contact with children and family members due to attitudinal limitations, for instance P 4 (cmhn) suggested:

> …in the acute units they're not at all family focused…they nearly hate to see family coming through the door in any capacity…they're…not tuned into it…some of them feel…God spare me from families…

> …bar hitting some people across the head with a hammer…I don't know how… [we can get] more staff equally interested…We need to completely and utterly change the way we communicate with families at all levels because we're not doing it sufficiently at all…some people innately see if as part of their job and others don't…my team are family focused, but within the hospital service they're not, I don't believe they are anyway… (P 11:cmhn).

Organisational barriers. There were common organisational barriers across all participants, such as role definition (n=9) for example, P 3 (cmhn) contended "I don't know whether directly we're doing enough for the child in the situation… there needs to be more support for the children of service users" and "it's an area that is so neglected…we do a lot of follow on work with our parents but I don't think we do enough follow on with the kids…to see how they're doing…their let slip through the cracks" (P 10:acute). Some participants also suggested that they had limited contact with children because "The service itself would say refer to the social work team and let them refer to somebody outside that we're not really equipped to deal with it (P 14:acute).

Policy, as outlined above was a facilitator for FFP (see the *Children's First* guidelines) but the lack of anything specific or formal about parental mental illness in the policy was a barrier. Participant 12 (cmhn) contended "…there isn't anything…formal…" while others indicated:

> It's not something that is…there in black and white that you have to ask them but the assessment documentation does ask you to find out what their home situation is…so it's up to each individual nurse whether you ask them or not (P 7:acute).

Another suggested,

> RPNs are aware that things are changing and that there is a need to involve children and adult family members and there is impetus to change but structures to allow this are not in place, either in terms of culture or concrete resources such as policy and guidelines (P 2:cmhn).

Another barrier was a lack of time and resources, for instance, P 4 (cmhn) suggested "…there is a reluctance and reticence amongst most people to take on more jobs and they will see this…as taking on…more skills, more work with…less money…less time…" and " nurses may feel that this is another area of responsibility and one that they are ill equipped to

consider due to a lack of resources and training…they are therefore hesitant to take it on" (P 8:cmhn). Another suggested "…sometimes a work day doesn't allow it [FFP]…with staff pressures [deadlines and responsibilities]… "P 10 (acute).

Many noted a lack of family and/or child focused training as P 7 (acute) reported "…you don't really get any training about how to handle these things…". Others described the problems associated with obtaining necessary training:

> Within the organisation…management…would encourage us to…do Children's First training …they say its mandatory but…they can't release the staff to go and do it…our staff numbers have gone down…It's the whole recession and the cut backs within the organisation…(P 13:acute).

Additionally one participant indicated that she and her colleagues were not facilitated to use additional training, such as formal family therapy training, within their practice, for example,

> The HSE trained me for family therapy…they spent nearly 30 grand…and in the four and half years since I completed it…I have never seen one family [as a family therapist]. I've gone to consultants…directors of nursing…but it never became part of it…I don't think there was the will to develop it…for the last…5 years it's just been…so busy...but it still doesn't make sense…nurses in different areas…say…if only we had somebody who can deal with families (P 14:acute).

Some noted the limited formation and functioning of teams and that this impeded FFP for example, **"**…since the recession…[there is] different staff every day…there's very little consistency…", P 13 (acute). Others reported:

> …the speed at which the teams are being set up is absolutely appalling (P 14:acute).

> …we had half a social worker for a period of time…we…have a social worker now but she's only just in the team…" (P 9:cmhn).

> …we don't have a social worker in our services at the moment and that's a huge disadvantage…we have a psychologist, she started a few weeks ago and

> we are getting a social worker but they never last very long [laughing] (P 3:cmhn).

A lack of social workers was particularly problematic as participants saw their contribution as valuable to FFP; P 6 (cmhn) suggested:

> We've only a social worker linked in with this team for the last two months. Before that we were it [performing role of social worker]. Although it's not our area of speciality we would be trying to help parents complete medical card application forms etc. but we could only advise people [parents] to go off and sort out their allowances themselves because we don't know what allowances they are entitled to…it's more complicated…

Another barrier to FFP, common to both groups, (n = 10) was the need to maintain parents' confidentiality, for example, P 7 (acute) indicated:

> Confidentiality is a huge thing in our service…if they [parents] don't give their consent, I don't do it [discuss parenting with anyone outside of the team]. It's very black and white with me.

Similarly, others reported "…a lot of people don't want their information shared with certain members of the family and…that's their choice…and right…we…do nothing outside of our immediate team without written consent from the person" (P 14:acute). In comparison, P 4 (cmhn) contended:

> I think people [mental health professionals] very conveniently hide behind confidentiality; it's very handy, it means they don't have something to do and I think that's a big problem.

Participants (n = 4) in both settings also noted that their obligation to report suspected child abuse can negatively impact upon their relationship with the parent, for instance, P 12 (cmhn) suggested "…when you have to report on [inform child protection] it does for a while devastate the relationship because it's all sorts of friction within the family and the people that support it" and P 13 (acute) suggested "there is always that kind of stereotype about "…if I disclose you'll take my kids off me".

There were also a number of barriers that were specific to either setting, though mostly were reported by those working in the acute setting. With regard to the acute setting, how the "patient" was defined was a significant barrier; P 13 (acute) suggested "within the profession a lot of the time…we think of the client" and P 7 (acute) indicated "the family is not your client; the individual is your client". Similarly, the focus in this setting was predominately on mental illness, P 10 (acute) suggested "…in the acute unit the focus is very much on illness…unfortunately…", whilst P 3 contended:

> If you're in a hospital ward your focus is much narrower, you're just dealing with the issues with the patient on the ward…when they're in hospital the issue is mainly about their acute illness and getting that under control (Participant 7:acute).

An exclusive focus on the parent's mental illness within the acute setting also meant that the family context was seldom considered as reflected by P 5 (cmhn), "out here it's the family you build on…whereas in the hospital it's the person you build on". P 13 (acute) contended:

> Most parents will have photos in but…unless they have them up…you're still…looking at them in terms of what their care plan is and why they're here…it's not evident they're not in their home setting, the kids aren't here…you're viewing people as patients…and while you are… trying to be…person-centered in the business of the ward setting, you're not…viewing everybody as parents…

The problem focused approach within the acute setting was also a barrier to FFP, i.e., "unless there was a risk…it probably wouldn't be…integrated with the person's care plan…it is more firefighting than working from the very start with the parent in case something happens" (P 14:acute). In contrast to this approach, a community based participant reported:

> If we can do anything to…avert it happening [difficulties in parenting] I think that's where we have a role…we're doing a lot of health promotion…it's not sufficient…that the only time we think about them [parents] in terms of their mothering role is when it's going wrong and its bring in social workers around a child protection issue (P 11:cmhn).

A number of participants (n = 6) suggested that the acuity of the acute setting also deterred nurses from engaging in FFP. In comparing the acute and community setting P 9 (cmhn) contended:

> Acute is very different…very hectic…you're dealing with all sorts coming through the door…all sorts of stuff kicking off…there's an awful lot of drug and alcohol related issues...people who are desperate. So there just isn't the same scope…the type of practice is different…acute illness and the kind of things that we're dealing with are very very different….

Similarly, P 14 (acute) suggested "…in the community, it's completely different…it's a little more relaxed because the parent is generally that bit better…".

Two participants suggested that the short duration of parent's stay, in acute settings, also reduced their capacity to engage in FFP as there was insufficient time to establish an effective relationship with parents. P 7 (acute) suggested:

> Some parents are…literally in and out the door…It wasn't…until the week…that she was being discharged that she…felt comfortable enough to talk to us…and disclose her parenting problems…sometimes we don't have enough time to get to know parents…to any great extent…

Two participants also noted that not having a fixed caseload further compounded their difficulty in getting to know parents, for example, P 13 (acute) suggested:

> …in the community you have your group of service users and you're always working with them, so you'd know them well…it's not like that here…you may not be caring for the same service users every day…

All of the acute participants (n = 4) and some of the community participants also suggested that limited contact with children and adult family members within the acute setting may also impede FFP.

> In the community, you get to meet all the family, you get to meet the kids…and you can have a little chat with them, whereas here, the kids are rarely in…They might be in the evening but you're just trying to keep

> them…contained… if they do come in…here you're not afforded the opportunity to know the family as well as you do in the community…(P 7:acute).

A lack of adequate visiting facilities for children, in acute units, also impacted on FFP, with P 11 (cmhn) reporting, "our admitting hospital doesn't have facilities…for having children there…children's visits have to be supervised by a nurse of the ward, they don't always have the staff". P 5 (cmhn) contended:

> The acute setting doesn't enable a family to come in…if the family comes in they're sitting beside the side of a bed…the children are…on top of the bed…the mum is trying to keep them quiet…there probably is someone sick beside them and it doesn't work.

Similarly, P 14 (acute) suggested "sometimes if you have very…disturbed people it's horrendous to have children coming into that and there's urgent need for a room to facilitate family visits". Others reported:

> I don't think the ward is a great setting…we don't really get to see the kids…I might be talking to parents about their children but I might never see them…parents can be in here for months…you might still not see the children ever (P 7 acute).

The structure of the acute ward also impeded FFP as it reduced RPNs' autonomy and limited the time they had to talk to service users about their parenting needs.

> In the community you were far more autonomous…[however] in an acute unit…the day is structured…there's boxes to be ticked…whereas in the community…it's up to you to organise your day…how you structure it and all of that (P 14:acute).

> …it's very much …task orientated…you get them out of bed…make sure they're showered…and then there's…medication…breakfast…groups…there is a rigidity…to in-patient care that makes it difficult for nurses to do more than just the basic safety issues and maybe deal with the acute anxiety, stress and depression (P 13:acute).

> …thinking about what I had to do next…who was my next priority…and fit that in around…supervising the dining room…the medications…doing the vital signs…the observation checks…so that prevents you from getting the time to…sit down and talk to them and get to know their whole story… (P 7:acute).

Three of the acute participants also suggested that communication difficulties impeded multi-disciplinary teamwork (MDT), for example,

> …there are people who pay lip service to it [teamwork] and they turn up to MDT's and…protect their corner of the pie…if you suggest things to them…or you interfere in what they consider their domain they get very territorial about it…basically the buck stops with the consultant…(P7:acute).

Relatedly, two participants, in the acute setting, also suggested that FFP was impeded by the requirement for consultants to initiate referrals and contact with other services. P 10 (acute) suggested " It is up to the consultant to initiate contact and engage with other services…contact is consultant led".

Finally, not caring for parents within the home environment was also identified as an important barrier to FFP for those in acute settings, for instance,

> When you're…in their house…you can see evidence of…kids…and you could tell what age they could be….even if they are not there by toys or pictures…whereas those little bits of knowledge you don't gain from working in here (P 13:acute).

> …Dysfunction is less obvious whilst they [parents] are on the ward as the family are not playing a big role in what goes on at that time. By caring for the parent in their own home the community mental health nurse is able to get a good sense of family dynamics and functioning and it is hard to ignore issues. Family dysfunction is very apparent and cannot be ignored (P7:acute).

As was only caring for parents when they were unwell e.g.,

> … when I know them here I only know them when they are very unwell…I wouldn't see how their interactions are with their family…when they are at home…when they are well and what their normal base line is…whereas here

> their interactions wouldn't be as good as it would be when they're at home so though you know them well, you know them in their unwell state (P 13:acute).

There were also a few barriers specific for those in a community setting. Some participants indicated that there was a lack of communication between services, i.e., "…one of the biggest problems is our services are not integrated" (P 3:cmhn). Lack of integration hampered participants FFP as it caused problems in referring parents to other services, including a delayed response to referrals.

> We'd see their clients as soon as we can and then when we refer we're waiting months…on an assessment or interaction…and that's a problem…I should be able to say there is a problem with this family, can you visit them…they need support now…and they should be able to get the support now…that isn't there (P 1:cmhn).

Others reported that when they referred parents to other services there was reluctance for those services to keep them updated as to how parents were progressing. This was a FFP barrier as it reduced participants' knowledge about the family, for example., P 3 (cmhn) indicated "…we would very rarely get a phone call from a public health nurse…we are doing the liaising…they don't return phone calls…don't seem to put as much focus on it…as we do…". Similarly, P 6 (cmhn) suggested "…sometimes that's all it is…referral and…nothing in between…when they come here the communication stops and they don't want to know until you're referring them back to them…".

Some participants also noted the reluctance of some parenting services to address mental health issues.

> …I think mental health is misunderstood by a lot of other services…we discharged her from our service to their service…and she showed some mild signs of paranoia so she was sent back to…casualty…instead of trying to work with us, it's kind of nearly dump her back (P 3:CMHN).

Or conversely, as participant 5 (cmhn) iterated:

> …we have people [parents] who the Child Protection Agency haven't been able to…deal with the issues involved…because there is alcohol…drugs…involved…they [the Child Protection Agency] try to give the mother a chance by sending her to psychiatry but alcohol is not a problem of psychiatry…drug abuse is not a problem of psychiatry…so sending them our way and then we're sending them back saying no and it looks like…we're all being bolshy…

Two participants suggested that to enhance communication between agencies "we need to step back from the medical model" (P10:acute) and instead:

> …try and move towards the Bio psychosocial…model of mental health care that…leans towards and respects all professionals…if there was unity…we could have… better organisation around…family orientated practices (P 7:acute).

Nine participants noted that there was a lack of resources and services to refer parents to, particularly in rural areas, resulting in a lack of FFP follow through, P 4 (cmhn) indicated "…the only resource we feel we have is mother and toddler groups…there isn't an awful lot more", whilst another suggested "we used to have a rehab service but that's got swept away under the cuts that we're experiencing" (P 9:cmhn). Similarly, P 5 (cmhn) indicated "if a mum is struggling…we've huge waiting lists with psychology at times...it comes down to resources, we don't have them…because there is no money…" while P 14 (acute) reported "…not one family therapist in the whole service…". Participant 9 (cmhn) suggested that rural areas were particularly affected by limited resources.

> …if you're in the big town…you'll be able to access …things a lot easier…if you live out here in the sticks…that's a different matter…because the population is so scattered…so rural, that has implications for service provision.

Finally one participant identified that a lack of funding to undertake home visits deterred his FFP, for instance "…a lot of the times I'll bring people to me…I will go to the

home occasionally, but you're not allowed to claim miles anymore so you try and get folk to come to you as much as possible" (P 9:cmhn).

Barriers generated by families. The majority of participants from both settings identified barriers emanating from parents, children and adult family members, though barriers from this source were notably less than those existing in the organisation. In relation to parents, some participants (n = 6) suggested:

> Parents are afraid that we're going to see them as deficient…because of their pathology and their mind set…people are very wary of anybody who's Health Service Executive [Government body] connected making any enquiries about their children…it's a constant fear that we are going to report them… (P 11:cmhn).

Similarly, P 7 (acute) suggested "…she was very uncomfortable discussing her ability to be a parent or even discussing the baby…she wouldn't get into it with nursing staff for a …long time". Three participants also indicated that fathers may be more difficult to support than mothers because they are more reluctant to accept support and to admit that they have parenting problems, for example,

> I have one young guy…he has a little girl…he struggles quite a lot with it…he is not as open as a mum would be…he's more resistive to help…requires a lot more visits…to empower…to change if things aren't going right (P 5:cmhn).

Another barrier (n = 3) to FFP emulated from parents not wanting their children to know about their mental illness, for example,

> …parents' don't always tell their children that they're in here. They'll tell them that they're away for work or that…they're in hospital but the children think that they're in with a broken leg…they don't want to get into what's really going on (P 7:acute).

Similarly others suggested

> …there is not this openness to talk about [PMI]. It's still very much stigmatised…they are afraid of their children finding out about their mental illness and talking to others about it…" (P 14:acute).

Three participants argued that some parents do not consider family work to be part of a nurse's role:

> …a lot of patients will hear it coming from the social worker, rather than coming from a nurse…they'll look at it that that's their (social worker's) expertise…they'll look at nurses and go it's just the medical stuff they're involved in…that's where their background…knowledge is (P 10:acute).

> The clients themselves would say you know the children have nothing to do with you…you are there to treat the individual so…you have to be careful at times if your over stepping the mark… or threading on other peoples roles that are more specific to children (P 2:cmhn).

Two participants indicated that some parents were not concerned about the impact of their illness on children, for example, "…people… pay you lip service, they're not really too concerned about how this is affecting their kids" (P 10:acute).

Two participants also indicated that parents want to be cared for by nurses who are parents themselves, i.e., P 7 (acute: not a parent) suggested "…she would ask…staff…have you got kids…and if you didn't she tended to go to the other nurses who did…".

Three community participants also suggested that parents may not always want them to undertake home visits for example; P 6 (cmhn) suggested "sometimes the parent's reluctant to let you do a home visit…" Another indicated "…she wouldn't allow me to see the children…I'm not allowed to visit and if I do visit I'm…kept to one room…I find it very strange that she wouldn't let me see the children…and I'm wondering is she struggling…we need to see normal family life"(P 1:cmhn).

Some participants (n = 4) indicated that working with adult family members could be challenging, for instance, "when people are in the acute unit they're acutely unwell and sometimes families are very frustrated…very angry…very nasty and…can be very difficult to deal with" (P 4 cmhn). Children's behaviour can also be problematic.

> …one kid was about 12 and…the child greeted me with a barrage of bad language, that I was to stop F'ing telling her mother how to F'ing…run the house because I was making her life a bloody nightmare and all the rest of it… she practically attacked me (P 4:cmhn).

Some participants (n = 3) also noted that children themselves may not wish to discuss their parent's mental illness, because "…this isn't something new to them…this is something that's evolved…as it's evolved so have they, so has the relationship" (P 11:cmhn). Similarly another contended:

> …usually the kids that I'm dealing with, they're not at a stage where they can make that comparison, this is normal…it's when they get much older that they'll realise oh my God this was very difficult… (P 12:cmhn).

Future potential developments. Four ways to develop FFP further were identified, including FFP training, strategies to address the needs of parents, children and adult family members, systematic structures to support FFP and theory development in FFP.

FFP training. All of the acute participants (n = 4) and half of the community participants (n = 5) reported that in order to develop nurses' capacity they required FFP training. In relation to undergraduate education, P 14 (acute) reported

> In…undergraduate nursing programmes there should be modules on…family therapy…it's hugely important. It makes people aware that there are other people within this family… and how the behaviour of one family member affects the other and how they react to it…every nurse should be educated in it [family therapy]…every nurse needs to have the tools to deal with individuals

> and their families…nobody…with a mental illness comes to us as an individual. There's always the bigger picture…

Another suggested:

> You're taught how to interact with the …person…you're going to be looking after, you're not taught how to look at…if that persons experiencing difficulty with family or…children…It would be important for undergraduates to have that in their education (P 7:acute).

With regard to the need for in-service education, in FFP, participants suggested:

> I feel that training for nurses in regard to meeting the needs of parents and their children is something that would greatly aid families in returning to their optimal level of functioning. I also feel that it would assist the RPN in gaining a parents' respect and trust, both of which are paramount in developing a therapeutic relationship with the parent (P 2:cmhn).

> …most people haven't had any training…even if was just a workshop for one day…just to build up some idea…get a bit more comfortable with it…you're trying to come up with a plan in your own head while you're in that situation [dealing with parenting issues]…if you've done some kind of workshop…you'd feel more prepared for it…you'd have a little bit more of an idea about how to go around dealing with that… (P 7:acute).

> …at this point it is about information…getting…the message across and informing people on the front line like myself… (P 12:cmhn).

There were several suggestions as to what in-service education should, for example, P 13 (acute) suggested "I'd like to see training as to what services are available…how to deal with children…developmental levels in children…". Others indicated that they would like information about other services to which they could refer parents to for example, P 8 (cmhn) suggested that he would like "information sessions…from voluntary organisations…once a month…to tell us…who they are…what they're about and how to access services…and refer to them". Another suggested "we need information about building capacity and competency to manage complex family and parenting issues, how to put the family at the centre of care

and recovery, how to refer and pathways to family services, how to utilise voluntary sector supports" (P 2:cmhn).

There were also suggestions as to how information could be shared to develop FFP, for instance, P 1 (cmhn) suggested "…there should be…shared forums like…internet forums…journal clubs…conferences…to obtain information regarding PMI…we can learn from other services…there are…practices that we are doing that other people could learn from and things that they are doing that we could learn from…". Participant 1 (cmhn) further iterated:

> … if you had people who were part-time clinical and part-time academic…as a support structure…to lead…who was able to keep up to date with the research and encourage others…role model…what was…expected (P 1:cmhn).

However, P 4 (cmhn) pointed out that information and education alone was not sufficient to change practice:

> I don't want to be the only person in my team or my service that does it [training] because I don't think that's the point. I think we need to change the way the whole service looks at family, the way they look at the adult members in a family, a patient's family life and the children…We need to completely and utterly change the way we communicate with families at all levels…we need a change of philosophy…so it needs to be coming from everybody in the team…and therefore loads of us would have to do this…training.

Strategies to address the needs of parents, children and adult family members. Five participants suggested that there is a need to adopt a whole of family focused approach, within adult mental health services, to meet the needs of parents, children and adult family members. Such a shift alluded to a fundamental philosophical shift in services:

> I think at a very basic level there needs to be…a bigger approach…to people as family units and all that that entails…that it's not just the person coming through the door, that it is the whole unit, the whole system (P11:cmhn).

The need to provide early intervention to service users' children was repeatedly made:

> I'd love…to…bring a group of mums…and…children in…and someone to facilitate…that…where the children are doing something constructive and parents are…sitting around and having a chat or getting involved as well (P 5:cmhn).

> …there needs to be more support for the children of service users…that you could refer the family…in a purely supportive role…someone who was trained to speak to young kids up to teenagers about mental illness and…help them understand…why their mam is flying around the place sometimes and lying in bed crying other days…(P 6:cmhn).

> …I think there's great benefit for a younger teenager to here from somebody who's in their 20s…here's how I did it …that's what missing in our service…there are lessons for people to teach each other, children who have dealt with this all their lives to give to other kids, it's a support system for them…(P 10:acute).

Participant 10 (acute) further iterated:

> [It's important] from the ages of…seven onwards to acknowledge these kids and to acknowledge what they've witnessed and how they've dealt with it and how hard it is for them…and to get them into the concept of…accepting help and…dealing with their stuff instead of bottling it up all the time…if we did something in those terms we could cut back on so much stuff further down the line.

Some participants also suggested that RPNs should talk to children about PMI and their own mental health for example,

> We need to…let…kids know that it's okay…to be unwell…that it's ok to link in with services and get the help you need…if they are ever seeking help they'll know how to do it…they won't be afraid to admit I need some help (P 7:acute).

> Tuesday evening…dedicated to kids groups…loads of staff on the ward and it wouldn't be an issue releasing the staff to do it (P 13:acute).

> It needs to be…more formalised…that if there is children that at some point…you have to tick a box to say you sat down and had a chat with the children…with the parent's consent (P 6:cmhn).

In order to further support service users in their parenting role, some participants suggested:

> I would love to see a lot more…available to parents…I would love to see…a parent support group…it should be mental health led…where we get a group of parents with similar problems together…empowering them… (P 5:cmhn).

> …parents don't always know how to explain…mental illness to their children and if there was a support group available…where they could talk about things like that or they could see other people [parents] in similar situation and how they've dealt with their children or how it [PMI] can be explained or simplifies [to children] it would be helpful (P 7:acute).

Some participants also highlighted the need for increased provision of family meetings for instance, P 7 (acute) suggested, "all parents should be able to have a family meeting…so that their issues around their kids can be addressed and so that they are able to share their stress with somebody else that they are close to such as their spouse". Others suggested the need for family support groups, i.e.

> …I would love to see…family support groups. We don't have that yet, hopefully it will come…with [our move] to primary care…we're hoping to move into a new state of the art primary care centre and it would be good to provide family support groups as part of our service at that point…(P 5:cmhn).

Finally, three participants also highlighted the need for family friendly hospital facilities, for example, P 14 (acute) suggested "there's urgent need for a room to facilitate family visits…away from…the acuteness" and another indicated "…have rooms that would accommodate…small kids…that is…more private… with… a…play area" (P 13:acute).

Systemic structures. Systemic or organisational changes were required to support FFP, as reflected by P 12 (cmhn) "…there isn't anything…formal…that needs to be included

in…some…way in how we reach out to family". Supportive management and colleagues were a critical part of this organisation by providing appropriate resources:

> It does help…if colleagues are…supportive…if the levels of management are supportive as well…that they're aware of…what you do [with regard to FFP] and giving you… the resources that you need…to drive out family focused services and consider how you would be best placed to manage…to keep the focus of your work…family orientated (P 8:cmhn).

> I would love if more of my colleagues felt the same and felt that they had the energy, time and enthusiasm to …address it because I think it's what we should be doing. [It] would need to be led from the top nurse down, all the nurses in sideways, within the team from the consultant (P 4:cmhn).

Having more time was another way in which FFP could be prompted, " …if I didn't have to spend as much time on administration…it would free me up…to give…parents more quality time" (P 10:acute) and P 8 (cmhn) suggested "…it helps…if…management are supportive…giving you the time to do things [FFP]".

The majority of community participants (n = 6) and one acute participant suggested that going forward there is a need to work in teams and to collaborate with other specialists to jointly address the needs of parents and their children in the recognition that FFP is "intense and complex work" and as such requires input from various disciplines, including nursing. Participant 6 (cmhn) indicated "I would love…if the family liaison officer was part of the team or a family support worker". Similarly, P 5 (cmhn) suggested "I'd love to have social care workers…about five of them…they would be able to follow through what I would do in a much more…family orientated way". P 7 (acute) suggested "…each multidisciplinary team should have…designated family workers…family therapy…". Participants also suggested parents and children should receive specialised support when they need it rather than face long waiting periods; P 5 (cmhn) reported "…I would like to see a lot more involvement

with…psychologists…within our services…[for parents] who have very negative thinking…when problems arise they need to be dealt with at that time…if they're not dealt with…they're [parents] always struggling with it…".

Finally, two participants also suggested that it would be helpful if the wider service acknowledged that caring for parents can be emotionally challenging for example,

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

Theory development in FFP. Some participants (n = 5) suggested that there was a need for theory development around FFP, with regard to what it is and RPNs' role in relation to FFP, for instance, "we need to identify first what it is we do…and debate…what nurses should be doing" (P 14:acute), and "research in the area may facilitate FFP to be organised in a more systematic way than is currently the case as it's to adhoc" (P 8:cmhn). Others perceived that RPNs' need to communicate what they are doing in relation to FFP, for example, (P 1:cmhn) suggested that there should be "sharing and articulation of information regarding FFP within and between mental health services" Another suggested "we need to make what we do tangible" (P 3:cmhn) and "...nurses need to stand up a little bit more and be a little bit more forceful about their input [within the team and to outside services re their FFP]" (P 10:acute).

Summary

In this chapter, the findings of the qualitative aspect of this study have been presented and two global themes were identified in the process. These included (1) The nature and scope of RPNs' FFP and (2) RPNs' capacity to engage in FFP. The first global theme suggests that participants view their FFP as being comprised of three central elements including (1) family focused activities, (2) principles and (3) processes. Although all three elements are connected they are distinct and illuminate what RPNs *do* in relation to FFP, *why* they do it and *how* they do it.

The second global theme was concerned with RPNs' capacity to engage in FFP which was described in terms of enablers and barriers to FFP and future potential developments. Generally there were more enablers than barriers to FFP and many of the enablers derived from participants' personal attributes such as own parenting experience, life experience, and to some extent gender. The community setting was also identified as a key organisational enabler primarily due to opportunities for home visits and a family focused philosophy that framed service provision. In addition there were suggestions for future potential developments within four areas including FFP training, strategies to address the needs of parents, children and adult family members, systemic structures and theory development in FFP. Again these suggestions emerged as a consequence and response to identified barriers to FFP.

Chapter 7: Discussion

The chapter initially presents a brief overview of the key quantitative and qualitative findings. Consistent with the order of the research studies the chapter initially discusses the quantitative findings, focusing on the first four research questions posed. The remainder of the discussion addresses the last three questions discussing qualitative findings emanating from the group of high scoring RPNs who completed interviews in Study Two. However, an integration discussion of findings from the two studies will be undertaken where it is considered necessary.

Overview of Quantitative Findings in Study One

The focus of Study One was to (a) describe the extent of RPNs' FFP and compare it with Australian RPNs' FFP, whilst also (b) identifying variables that may be useful in the predictions of RPNs' FFP and exploring the (c) differences between two specific groups of RPNs (acute versus community mental health nurses) in relation to their FFP.

Overall the Irish sample was not particularly family focused. For the most part, the average RPN in the study 'slightly disagreed' or 'neither agreed or disagreed' with the majority of items within the 14 subscales in the FFMHPQ. However a series of ANOVAs indicated that RPNs, practicing within community mental health nursing services, had higher mean scores, across all six FFP behavioural subscales, than RPNs in acute settings. Nevertheless, on the whole, the Irish sample scored lower than the Australian sample on almost all the subscales that were compared.

Despite this overall tendency towards low mean scores, in the FFP subscales, a third of RPNs in the Irish sample (n =109 , 32%) scored at a high level (between 5 – 7 on the Likert Scale) on at least three of the six FFP behavioural subscales. This suggests, that while FFP is low, there are a large group of RPNs who do understand and undertake FFP. The majority of these high scorers were practicing within the four community settings (n = 73, 67%) and most prominently within community mental health nursing services (n = 48, 44%). In general the findings highlighted that the RPNs in the community undertook many more family focused practices than did those working in the acute in-patient psychiatric setting.

Finally, multiple hierarchical regression revealed that of the 17 IVs the most significant predictor of RPNs' FFP was knowledge and skill as this was significant in all six DV's. Confidence around parenting and children generally was also considerably important, being significant in three of the six DV's.

Overview of Qualitative Findings in Study Two

The focus of Study Two was to explore the nature and scope of RPNs' FFP, when working with parents who have mental illness, their children and families, as reported by RPNs who obtained high scores in the FFMHPQ (Study One). In addition, Study Two sought to establish what factors affected RPNs' capacity to engage in FFP.

RPNs viewed FFP in terms of three distinct but interconnected elements including (1) family focused activities, (2) principles and (3) processes. As previously noted, family focused activities capture what RPNs *do* in relation to FFP, processes capture *how* they do it and principles focus on *why* they do it. RPNs' capacity to engage in FFP included (1)

enablers (2) barriers and (3) potential future developments in FFP. On the whole, RPNs experienced more enablers than barriers, with key enablers involving RPNs' personal attributes, including their own parenting, life and work experience. Community setting experiences further enabled FFP. Suggestions for potential developments in FFP included strategies to address the needs of parents, children and adult family members, theory development in FFP, FFP training and systematic structures to support FFP.

The Profile of RPNs' FFP in Ireland and how their FFP Compares with that of RPNs in Australia

Whilst RPNs had frequent contact with parents and children they engaged in FFP to a limited extent, as denoted by low mean scores on the FFMHPQ subscales, especially when compared with Australian RPNs. Nevertheless, despite the tendency towards low mean scores, a third of the Irish sample appeared to engage in FFP.

Whilst, the majority of RPNs practiced within the acute setting, a sizeable number practiced within the community setting and of these a third spent a proportion of their time working within the service users' home environment. The majority of RPNs were also parents themselves. Only a minority had family or child focused training and the predominant focus of child focused training entailed instruction in using the *Children's First* guidelines (Barrington et al., 2011). As previously noted, these guidelines are designed to equip RPNs to identify and to report suspected child abuse as opposed to working in a preventative way with parents and children to prevent intergenerational transmission of mental illness.

Whilst it is was anticipated that RPNs would have limited child and family focused training it was important to benchmark training and other demographic variables, including parenting status, in the Irish context for two reasons. Firstly, as these variables had the potential to influence RPNs' FFP, they were factored into the multiple regression models as confounding variables, the findings of which will be discussed later. Moreover, as there are no national studies in Ireland that examined RPNs' FFP, it was important to obtain demographic information to check that the sample was representative of the wider population of RPNs, practicing within the various areas of general adult mental health services, from which the sample was drawn. As previously noted, the demographic profile of RPNs coincides with that of other small scale studies, which used non-random samples in Ireland (Houlihan et al., 2013) and larger studies with random samples of RPNs (James & Cowman, 2007; Yadav & Fealy, 2012) suggesting that the sample in the current study is representative.

Regarding exposure to parents who were mentally ill, at time of completing the FFMHPQ, the vast majority of RPNs had previous and current experience of caring for one or more parents and primarily cared for parents on a daily or weekly basis. The majority also reported that they last cared for one or more parents in the week before completing the FFMHPQ and just under half reported that they had talked to one or more service users about parenting issues in this timeframe. This finding is not surprising, considering that other researchers (Fernbacher, Goodyear, & Farhall, 2009; Howe et al., 2009; Liangas & Falkov, 2014; Maybery et al., 2009; Verrocchio et al., 2013) and professional bodies (AICAFHMA, 2001; SCIE, 2009) have highlighted that increasing numbers of service users, of general adult mental health services, are parents of one or more children under the age of 18. However, the findings regarding RPNs' exposure to parents with mental illness, within general adult mental

health services, are important as they contribute to an understanding of the prevalence of PMI in Ireland and the percentage of general adult mental health service users who are parents. The findings also help to quantify the extent of contact RPNs have with service users who are parents and whether they discussed parenting issues. The findings that a proportion of general adult mental health service users are parents can be used as an impetus for further research to accurately estimate prevalence of PMI in Ireland and the number of parents using general adult mental health services at any one point in time. Also important is the finding that just under half of the RPNs indicated that they had talked to parents about parenting issues in the week prior to completing the FFMHPQ. While no information is provided about the nature or quality of these interactions with parents, the findings do provide some evidence that generally RPNs were cognisant of service users' parenting status and endeavoured, to some degree, to discuss parenting issues with them. These findings contrast to most of the literature exploring parents' perspectives of FFP which suggests that mental health professionals, including RPNs, frequently fail to identify service users' parenting status, let alone factor this in to parents' overall care (Diaz-Caneja & Johnson, 2004; Houlihan et al., 2013; Lauritzen et al., 2014a; O'Brien, Anand, et al., 2011)**.** For example, Handley et al. (2001) found that mothers had unmet needs for support from key workers. There appears to be a mismatch between what RPNs report they do and what parents perceive RPNs do, that might be further explored in research.

The majority of RPNs also reported that they had face-to-face contact with service users' children in the week prior to completing the FFMHPQ and a sizeable minority suggested that this contact occurred on a weekly basis. Nonetheless, the majority of RPNs did not directly engage with children when they were in contact with them. Whilst other

researchers (Korhonen, Pietilä, et al., 2010; Maybery & Reupert, 2006) suggest that RPNs may have infrequent contact with service users' children and that this impedes FFP (A. Davies, 2004; Hauck et al., 2008; O'Brien, Brady, et al., 2011) the findings here suggest that while RPNs have regular contact with children they also did not undertake behaviours that were beneficial to parenting or in the prevention of mental illness in children (i.e. family focused practices). Rather, other barriers may affect RPNs' capacity to capitalise on opportunities to support children, when they come into contact with them, including limited knowledge and skills to work with children. This is discussed later in the chapter.

In addition to measuring RPNs' exposure to parents who have mental illness and their children, the FFMHPQ also measured the extent to which RPNs engaged in FFP (captured by six behavioural family focused subscales) and the factors that affected their capacity to be family focused (captured by eight family focused outcome variables). As previously noted, overall RPNs in the current study were not particularly family focused and neither agreed or disagreed with many family focused items in the FFMHPQ, perhaps indicating indecisiveness. For the most part, RPNs slightly disagreed or neither agreed or disagreed with the majority of items, within the 14 subscales in the FFMHPQ. The lowest means, in the current study, were found in assessing the impact on the child, referrals, family and parenting support, time and workload and skill and knowledge. Assessing the impact on the child, referrals and family and parenting support are identified in the literature as key family focused activities; whereas time and workload and skill and knowledge are variables that may determine to what extent RPNs can engage in these family focused activities. The higher mean score for training (between agree and strongly agree), signifies that RPNs felt a need for further child and family focused training and is perhaps reflective of their low scores in

skill and knowledge and in the majority of the family focused behavioural subscales. Moreover the Irish sample also scored lower than the Australian sample on all the subscales, excluding training. This suggests that in future attention should be paid to training Irish RPN's in family focused skill and knowledge to build worker confidence. Moreover, managing time and workload and service availability may also enable RPNs to better engage in FFP.

Others have also suggested that mental health professionals, including RPNs, are not particularly family focused and that they experience a number of barriers that impede their capacity to engage in FFP, including limited or no training (Hansson et al., 2013; Houlihan et al., 2013; Lauritzen et al., 2014a; Maybery & Reupert, 2006; Rutherford & Keeley, 2009; Slack & Webber, 2008). For example, Korhonen et al. (2008) suggested that those nurses with least education and training experienced more barriers to FFP than nurses who had more training. Whilst findings of the current study highlight similar issues, in the level of skill and resources that RPNs have in Ireland to engage in FFP, drawing comparisons with RPNs in the Australian context enabled an International comparison to benchmark Irish RPNs' FFP. Other researchers and professional organisations have also proposed that these outcome variables are necessary pre requisites if organisations are to develop and sustain FFP. For instance, Toikka and Solantaus (2006) suggested that the *Effective Family* (EF) Programme in Finnish mental health services have enabled mental health professionals to support both parents and their children by providing training, resources and managerial support for FFP.

The differences found in the International comparison of Irish and Australian RPNs' FFP also highlights the importance of preparatory and supportive work to promote FFP. As previously noted in chapter three, in comparison to Ireland, there has been substantial

investment in Australia, in developing mental health professionals' FFP, within general adult mental health services, in terms of policy and education (AICAFHMA, 2004; Falkov, 2012; Reupert et al., 2009; Thompson & Fudge, 2005). This has not been the case in Ireland, with participants suggesting that there was limited or no Government and organisational policy to guide FFP. As the Australian RPNs' scores are somewhat better than those of the Irish sample, with exception of training, it could be assumed that greater organisational support through policy initiatives for Australian RPNs enabled their FFP. This may be particularly so in relation to enabling Australian RPNs' capacity to assess the impact of PMI on the child. One of the biggest differences between the Irish and Australian samples related to this aspect of practice, with Irish RPNs scoring considerably lower than Australian RPNs in this subscale. The Irish RPNs' low scores in this behavioural subscale, like the others, could be explained by their reported lack of knowledge and skills, training and other organisational enablers including, policy and procedures, supervision and mentoring and collegial support. All of these variables were scored low by RPNs in the Irish context.

Other differences between the two samples' FFP could also be due to the marked and ongoing economic recession in Ireland which, as previously noted, has adversely affected the development and delivery of general adult mental health services (Barrington et al., 2011; O'Brien, 2012; Psychiatric Nursing Association, 2010). This could partly explain RPNs' low scores in time and workload, service availability and referrals. An embargo on staff recruitment, coupled with reduction in the number of staff overall, and reduction of services may affect RPNs' capacity to be family focused and this requires consideration by the Irish Government and mental health service managers alike. As previously noted, organisational readiness for FFP is a necessary pre requisite for RPNs' FFP (K. Foster et al., 2012; Halle et

al., 2013; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Owen, 2010; Reedtz et al., 2012; Trowse et al., 2013) and the process employed by organisations to implement FFP are crucial (Aarons et al., 2011; Curran et al., 2008; Lauritzen et al., 2014b; Moore et al., 2012). Whilst it is acknowledged that this study may not be comparing like with like (i.e. Irish RPNs have different undergraduate preparation and practice within different organisational structures to RPNs in Australia) these comparisons are important; they have implications for training, practice and policy within the Irish context. This is particularly so when seen in light of RPNs having regular contact with parents and children along with the potential benefits for families that can come from Irish nurses undertaking more family focused practices.

Despite the overall tendency towards low mean scores and tentative responses in the FFP subscales, the RPNs had high mean scores on three additional subscales that were not previously measured in the Australian context including: inter-professional practice, confidence around parenting and children generally and interventions to promote parents' mental health. These subscales were added here to further develop the FFP literature. High scores in inter-professional practice suggest that RPNs understand the importance of team work in enabling FFP. High scores in interventions to promote parents' mental health indicate that they are also cognisant of the reciprocal relationship between parents' mental health and parenting role and endeavoured to address this.

Other researchers (Baulderstone et al., 2012; Beardslee et al., 2012; Cowling & McGorry, 2012; Liangas & Falkov, 2014) and professional bodies, including the Royal College of Psychiatrists (2011), increasingly recognise the link between mental health and parenting. However, there is limited information as to what this means for RPNs and in what way they factor this in to parents' care. The research here suggests that RPNs intervened in

several ways to help parents cope with their parenting role, so as to reduce the stress of parenting on their mental health, including suggesting practical strategies to facilitate service users to manage the dual demands of their parenting role and their mental illness.

Also of note, Irish RPNs' highest score related to confidence around parenting and children generally, (subscale measuring confidence around own and family and friends' children) signifying that they are happy and confident in their own parenting skills. This finding is important because it could be deduced that RPNs' own parenting experience may enable them, to some extent, to engage in FFP. This finding also fits with research in Finland conducted by Korhonen et al. (2008) and Korhonen, Vehviläinen-Julkunen, et al. (2010) who first suggested that being a parent enabled FFP, though other researchers have not yet investigated this link. Additionally, whilst this study suggests that confidence around their own or family and friend's children could enable RPNs to engage in FFP, their low scores on five of the six FFP subscales suggest that it is not sufficient and that other enablers are also necessary. Moreover, developments in training and policy may be necessary to help RPNs capitalise on their FFP skills, acquired through their own parenting experience. As previously noted in chapter three, in Finland national legislation and policy mandates general adult mental health services to address the needs of service users' children (Falkov, 2012; Korhonen, Pietilä, et al., 2010; Lauritzen & Reedtz, 2013; Lauritzen et al., 2014b; Pihkala et al., 2012a; Solantaus & Toikka, 2006). It may have been a combination of policy, training and own parenting experience that enabled Finnish mental health nurses to engage in FFP. The interplay between RPNs' personal attributes and organisational contexts in promoting FFP requires further investigation.

Also of note, despite the overall tendency towards low mean scores, a third of RPNs scored high on three or more of the six family focused behavioural subscales. The biggest differences between high scorers and the rest of the sample related to referrals, and then to connectedness, assessing the impact on the child and skill and knowledge, in that order. Other researchers (Bracken & Thomas, 2001; Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2009) have suggested that skill and knowledge is key to enabling FFP. For example, Houlihan et al. (2013) suggested that a lack of FFP skill and knowledge reduced RPNs' confidence in addressing parenting issues as part of routine care. Additionally, the descriptive and inferential statistics in this study here provided evidence that RPNs' knowledge and skill was the most significant predictor of FFP.

Similar to the rest of the Irish sample as a whole, the majority of this group scored highest in interventions to promote parents' mental health. The second highest number of high scores related to connectedness. Connectedness measures RPNs' capacity to assess parents' awareness of the importance of children having strong relationships with others inside and outside of the family unit. It also measures RPNs' capacity to work with parents to promote children's connectedness. The majority of high scoring participants agreed that they were able to assess parents' awareness of the importance of their children having good relationships with other members of their family and wider community context. Other researchers (Gladstone et al., 2006; Hansson et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maybery et al., 2005; Reupert et al., 2010) have emphasized the important role that children's wider family and community context may play in supporting them to cope with PMI. The literature also suggests that connectedness is a higher level skill that necessitates the worker having good engagement with the parent, knowledge of the impact of PMI and the

skill to assess parents' insight of the importance of their children having good relationships (Falkov, 2012; Korhonen, Pietilä, et al., 2010; Toikka & Solantaus, 2006). However the existing research suggests that mental health professionals have limited awareness and capacity to consider children's wider contexts or to assess parents' acknowledgement of the importance of this factor in children's overall well-being (Gillam et al., 2003; Stanley et al., 2003; Thompson & Fudge, 2005).

Considering that this is a higher level skill, it is not surprising that the high scorers agreed that they were cognisant of the importance of children's connectedness whilst the rest of the sample were more tentative in their response to this subscale. Moreover, the study also found that the high scorers also had a greater desire for training than the rest of the sample. This finding endorses Korhonen, Vehviläinen-Julkunen, et al. (2010) and Lauritzen (2014) contention that as workers engage in FFP they may become more aware of the need to acquire more knowledge and skill and understanding of issues experienced by parents, who have mental illness, their children and families. Additionally, this study illuminates high scoring RPNs' activities in relation to connectedness and this will be discussed later in the chapter.

Similar to the overall sample, the fewest number of high scores, within the high scoring group, related to assessing the impact on the child and family and parenting support. The low numbers of RPNs who scored high on these two family focused activities, in comparison to other activities, may explain why high scorers desired more child and family focused training despite being considered to be high scorers overall. As previously noted, the literature suggests that whilst RPNs may be somewhat able to support service users in their parenting capacity they experience greater difficulty in directly support service users'

children (Korhonen et al., 2008; Lauritzen et al., 2014b; Reupert et al., 2010; Slack & Webber, 2008; Stanley et al., 2003). The findings from this study provide evidence that this is also the case in Ireland and that even those RPNs who are most family focused also experience difficulty in these two family focused activities.

The majority of high scorers were community based. This finding contrasts with that of Houlihan et al. (2013) who did not find that RPNs in community settings in Ireland were any more family focused than RPNs in in-patient units. Additionally, this study suggests, that as a third of the high scorers were from the acute setting that it is possible for RPNs to engage in FFP, despite work setting, albeit to various degrees. Hence, whilst work setting (and particularly community setting) may be an important predictor of FFP it is not only work setting that predicts FFP, generating the impetus for Study Two to further explore the array of enablers that affect RPNs' capacity to engage in FFP. Additionally the findings in Study One suggest that not all community settings are equally able to promote FFP, as evident by the variability in scores of community participants, with just over half not being high scorers. This further suggests that other enablers aside from organisational enablers may be key in promoting FFP. Again, this will be further discussed at a later point in this chapter when discussing the findings of Study Two.

This study also identified that whilst there was a group of high scoring RPNs in Ireland, this groups' scores were not high considering that they were generally not any higher than the average scores in the Australian sample. Of further note, the Australian sample was comprised mainly of RPNs practicing in acute settings and the majority of high scorers in the Irish sample were from community settings. Hence, in effect, Irish high scoring RPNs were generally no more family focused than RPNs in Australian acute in-patient settings, which

are typically identified as less family focused than community settings in general (A. Davies, 2004; Fagin, 2001; Montgomery et al., 2006; Slack & Webber, 2008; Toikka & Solantaus, 2006). This finding is important as it suggests that developments in policy and training in Australian mental health services enables FFP irrespective of setting. Also whilst factors within community settings may enable FFP in Ireland, FFP is impeded in these settings by limited developments in policy and training.

Differences between RPNs' FFP in Acute Admission Units and Community Mental Health Nursing Services

As indicated above, the RPNs in community settings engaged in FFP to a greater extent than RPNs in acute settings. RPNs in acute admission settings had lower mean scores on all six family focused behavioural subscales and seven of the eight FFP outcome subscales, than those practicing within community mental health nursing services. Others have also suggested that RPNs in community settings are more likely to engage in FFP (A. Davies, 2004; Devlin & O'Brien, 1999; Fagin, 2001; Gillam et al., 2003; Montgomery et al., 2006; Slack & Webber, 2008; Toikka & Solantaus, 2006). This study supports this previous research but also suggests multiple ways that this might occur. This will be discussed further later in the chapter.

There was a moderate effect size on four of the 14 subscales including: referrals, family and parenting support, support to carers and children and service availability, suggesting a moderate difference between the two groups with the community RPNs scoring more highly. Whilst the literature suggests that service availability is important for referral to occur in the first instance (Falkov, 2012; Gillam et al., 2003), RPNs in the community are

also identified as more likely to engage in referrals than RPNs in acute settings (Falkov, 2012; Korhonen et al., 2008; Slack & Webber, 2008). It has been surmised by others that this is because RPNs in the community have greater autonomy to make referrals to outside agencies due to using a case management approach (Slack & Webber, 2008). Additionally, the findings from the study here suggest that there may be many factors that enable community RPNs to engage in referral, aside from the case management approach, and this will be discussed further at a later point in this chapter.

Other researchers (A. Davies, 2004; Gillam et al., 2003; Houlihan et al., 2013; Jackson & Darbyshire, 2004; Slack & Webber, 2008) have also suggested that community RPNs may be more likely to address parenting and to support parents, children and adult family members because opportunities to work within the home environment may enable them to observe family dynamics and to intervene to promote family functioning. Additionally, the findings from Study One suggest that whilst this may be true to some degree there are other factors, aside from caring for parents within the home environment that may enable FFP within community settings including, among other things, service availability, and capacity to engage in referral. Again, this will be further discussed when exploring enablers of FFP.

Whilst there was significant differences between the two groups in relation to assessing the impact on the child, connectedness, skill and knowledge and interventions to promote parents' mental health, all these had a small effect size. It is not surprising that there was less difference between the two groups, with regard to assessing the impact on the child and connectedness, as both groups were unanimous in their need for further training to increase their skills and knowledge for working with service users' children. As previously

noted, other researchers, (Houlihan et al., 2013; Korhonen et al., 2008; Maybery & Reupert, 2006, 2009) have also identified that supporting service users' children causes RPNs the greatest perceived difficulty; representing an important barrier to FFP. This study suggests that while both groups do find these aspects of practice difficult, RPNs in community mental health services have greater capacity, than RPNs in acute settings, to assess the impact of PMI on the child and to assess parents' awareness of the importance of children having strong relationships with others. This has clear implications for RPN practice and training.

It is also not surprising that RPNs in both groups had similar scores in relation to promoting parents' mental health considering that the primary role of RPNs is to facilitate service users to address factors that impact upon their mental health (NMBI, 2014). However, this finding is important as it signifies that in promoting parents' mental health, both groups, and particularly community RPNs, endeavoured to address the inter-relationship between parenting and mental health. This is important as cognisance of this inter-relationship may act as an impetus for RPNs to engage in FFP; albeit limited to addressing the effects of parenting on mental health. As previously noted, whilst others have identified the inter-relationship between parenting and mental health (Falkov, 2012; Hansson et al., 2013; Liangas & Falkov, 2014; Nicholson, in press; Nicholson et al., 1998a; Royal College of Psychiatrists, 2011), little is known about how RPNs factor this in to their practice; the current study provides beginning information on this aspect of practice.

Surprisingly whilst there were differences between the two groups, on knowledge and skills, these differences were minimal. Other researchers have identified that RPNs' limited knowledge and skill represents an important barrier to FFP (Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maddocks et al., 2010; Maybery & Reupert, 2009). The

findings from this study suggest that there are other factors, aside from knowledge and skill that may also enable FFP. Hence identification and consideration of all the factors that affect RPNs' capacity to engage in FFP is paramount.

There were no significant differences noted between the two groups on worker confidence, confidence around parenting and children in general, engagement issues, time and workload and inter-professional practice. These findings regarding worker confidence are not surprising considering that, on the whole, RPNs in both settings had only minimal differences (small effect size) in knowledge and skill. Other researchers have identified that knowledge and skill are necessary to promote mental health professionals, including RPNs,' confidence to engage in FFP (Falkov, 2012; Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2009). Moreover, RPNs practicing within community mental health services, may engage in FFP to a greater extent because of a greater degree of worker confidence (Devlin & O'Brien, 1999). Additionally, this study suggests that whilst knowledge and skill and worker confidence are important, other factors also exist that contribute to the differences in extent of RPNs' FFP in the two settings. For instance, community RPNs may be more family focused, than those in acute settings, because of other enablers that in part mitigate the effect of low worker confidence. Again, this will be discussed further later in the chapter.

In relation to confidence around parenting and children generally (this includes personal experience of parenting) it is unsurprising that there is no difference between the two groups. Despite the equal level of confidence, RPNs in acute settings were less family focused than those in community settings, endorsing other evidence from Study Two that factors within RPNs' organisations are also required to promote FFP (Falkov, 2012; Houlihan

et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2009). As previously noted, Study Two unpacked how and why factors enabled FFP.

Furthermore, whilst there were significant differences between the two groups on three demographic data, including, age, length of experience and number of patients delivered care to, these confounding variables were not found to be causing the disparities between the FFP scores; nor was age a significant predictor of RPNs' FFP. This contrasts with the findings of other researchers (Coyne et al., 2013; Houlihan et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014a) who suggest that demographic variables, particularly age and length of experience, may influence RPNs' FFP. For example, Houlihan et al. (2013) found that those RPNs who were qualified for 10 years or less were statistically more likely to support service users' children. Similarly, Lauritzen et al. (2014a) found that younger mental health professionals had more positive attitudes towards engaging in FFP than those who were older. These inconsistencies further prompted the need for Study Two to further explore and unpack the impact of these variables on RPNs' FFP.

Finally, and most importantly, other researchers, in suggesting differences in mental health professionals' capacity to engage in FFP, within different settings, have initiated debate surrounding which mental health professionals are best placed to engage in FFP and who should do what (Falkov, 2012; Lauritzen et al., 2014b; Mottaghipour & Bickerton, 2005; Slack & Webber, 2008; Stanbridge & Burbach, 2007). As previously noted, whilst recognising that some groups may be more able to engage in FFP than others, it is suggested that all mental health professionals should be able to practice in line with minimum standards for FFP (Falkov, 2012; K. Foster et al., 2012; Hansson et al., 2013; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Nilsson et al., 2014). For example, all mental health professionals

are expected to safeguard children's safety through identifying parenting status, assessing parents and children's needs and by supporting parents to meet children's needs (Falkov, 2012; K. Foster et al., 2012; Lauritzen et al., 2014b). However, mental health professionals core responsibilities and roles in FFP will differ according to the level and scope of their particular position and work setting; with particular groups having more responsibility to engage in FFP and in particular to support parents' children (Falkov, 2012; Lauritzen et al., 2014b). However, while it is recognised that all mental health professionals have a responsibility to engage in FFP it is less clear which mental health professionals are best placed to support parents with mental illness and their children and in what ways. Whilst debate regarding roles and responsibilities of different groups, differs according to particular countries and contexts (i.e. in Australia, debate centers around mental health professionals' and COPMI co coordinators' roles in FFP and in Finland distinctions are made between children's representatives and other mental health professionals' FFP) it could be argued that similar principles could be applied to Irish mental health services; with a distinction made between roles and responsibilities of community and acute setting mental health professionals in promoting FFP, in line with capacity.

The findings of this study further inform this emerging debate by benchmarking and comparing acute and community RPNs' FFP. Whilst the findings provide evidence that RPNs' FFP differs according to setting, with community RPNs more able to engage in FFP than RPNs practicing within acute settings, they also suggest that there is scope for RPNs, in both areas, to engage in FFP providing they are enabled to do so. The findings of Study One also suggest that it is predictors within either setting that will dictate and shape the roles and responsibilities of RPNs in either area with regard to FFP. Moreover, this difference in FFP,

in the two RPN groups, was factored into a multiple regression model and found to be the second most significant predictor of RPNs' FFP; adding weight to the argument that work setting (RPN group) needs further consideration and scrutiny by researchers and professional bodies alike in debating how best to develop and sustain a whole family approach within general adult mental health services.

Predicting RPNs' FFP

Study One also sought to establish factors that predicted RPNs' FFP. As previously noted, whilst a limited number of researchers have described various aspects of RPNs' FFP (A. Davies, 2004; Houlihan et al., 2013; Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2006; O'Brien, Brady, et al., 2011; Thompson & Fudge, 2005) this study and that of Lauritzen (2014) represents a first attempt to identify factors that predict RPNs' FFP. Whilst description of RPNs' FFP is important, developing information about what predicts FFP increases understanding of RPNs' FFP and provides information that can be used to inform policy, training and practice. Figure 7.1 highlights that 14 of the 17 IV's were significant predictors, in the final step, in one or more of the six multiple regression models conducted.

Figure 7.1: Significant predictors of RPNs' FFP[1].

Before discussing these predictors it is also important to highlight that in total the predictors explained between 23.1 and 38.5 percent of variance across the six dependent variables. This suggests that a considerable amount remains unexplained, offering fertile

[1] The size of the predictor circles represents the amount of variance explained by each variable in relation to the six dependent variables corresponding with FFP behaviours. Also note that some 'license' was taken with the circles as they represent how strongly each variable performed, on average, across the 6 equations.

ground for future research. Skill and knowledge was the single most important predictor and is significant in all six DV's. Next most important was confidence around parenting and children generally which was a significant predictor of three of the DV's. Worker confidence, service availability, inter-professional practice, time and workload, length of time in current position, child training, gender and length of experience were somewhat important in that each predicted two of the DV's. Training, engagement issues, family training, service location (rural versus urban) were least important as each predicted one DV. Hence the overall variance in the six DV's was only minimally explained by these four predictors. Two of the IV's, age and parenting status were not significant predictors within any of the six DV's. One additional significant IV was identified (RPN Group [acute versus community]) when the multiple regression was repeated with two specific sub groups within the sample, including RPNs practicing in acute units and community mental health nursing services.

As previously noted, the most important predictor was skill and knowledge. Skill and knowledge relates to RPNs' knowledge of the effects of PMI on children and their skill in working with parents to reduce the potential for negative outcomes for children. Therefore RPNs' awareness of the impact of PMI on children and capacity to help parents to reduce this negative interaction are very important in enabling RPNs' FFP. Other researchers have also suggested that skill and knowledge may be a key predictor of FFP and recommend that mental health professionals should receive child and family focused training to develop their skill and knowledge to support parents, children and adult family members (Falkov, 2012; Houlihan et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). Additionally, the findings from this study suggest that whilst child and family focused training may increase RPNs' awareness of potentially

negative interactions between parents and children and develop their capacity to work with parents around this, other factors, aside from training may enable RPNs to develop skill and knowledge in this area. The ANOVA results endorse this contention. For example, whilst high scoring RPNs had higher levels of skill and knowledge than the rest of the sample, only a minority had received either child or family focused training. Moreover, whilst the ANOVAs also detected significant differences in extent of FFP, between RPNs practicing within acute and community settings, they also found a minimal difference in level of skill and knowledge between the two groups. This suggests that the differences in extent of FFP between the two groups occurred for other reasons aside from levels of skill and knowledge. For example, differences may have occurred due to RPN group (work setting).

The third most important predictor of FFP was confidence around parenting and children generally, which was a significant predictor of three of the DV's including; support to carers and children, connectedness and assessing the impact on the child. This key variable pertains to RPNs' confidence around their own or others (family and friends) children. This finding is surprising considering that parenting status was not significant in enabling FFP. Moreover the finding, regarding parenting status, differs from Korhonen et al. (2008) contention that parenting status (being a parent) enables RPNs' FFP. The findings from the current study suggest that confidence around parenting and children may be less to do with parenting status than experience around children in general and that it is not parenting status that predicts FFP per se but it is confidence and skills in enacting the parenting role that enables RPNs who are parents to engage in FFP.

Having had child training was somewhat important in predicting FFP (identified as significant in two of the regression models). As previously noted, other researchers (Falkov,

2012; Houlihan et al., 2013; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2006, 2009; Toikka & Solantaus, 2006) and professional bodies (AICAFHA, 2001; DoHC, 2006; Royal College of Psychiatrists, 2011; SCIE, 2009) have suggested that training is important in enabling FFP. Additionally, this study suggests that to some extent, whilst this may be the case, there may be other more important predictors of FFP that also required consideration.

Worker confidence was also identified as somewhat important being a significant predictor in two elements of FFP, namely support to carers and children and referrals. These two activities are similar in that both include referring children and other adult family members to other services. In addition support to carers and children also entails providing information and acting as an advocate for carers and children. Others have suggested that mental health professionals, including RPNs, require confidence to engage in referral and to advocate for children and other adult family members (Gillam et al., 2003; Houlihan et al., 2013; Korhonen et al., 2008; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). However (low) worker confidence is frequently identified as a substantial barrier to FFP (Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2006, 2009) and developing worker confidence is a central aim of training (Falkov, 2012; Maybery & Reupert, 2009; Royal College of Psychiatrists, 2011). Korhonen et al. (2008) also suggested that workers may perceive that they have less need for training when they are confident to engage in FFP. However, as previously noted, this study found that whilst high scoring RPNs were slightly more confident than the rest of the sample they also desired more training.

Service availability was also identified as somewhat important in relation to support to carers and children and referrals. This is plausible considering that, as previously noted, service availability is likely to impact on the extent to which RPNs can engage in referral (Falkov, 2012; Gillam et al., 2003; Maybery & Reupert, 2006, 2009; McLean, Hearle, & McGrath, 2004). In addition participants were unsure as to whether or not there are sufficient services to refer parents, children and adult family members to as reflected by their tentative scores within this subscale. Others have also noted that whilst service availability, including parenting programmes and/or family therapy, is essential to meet the needs of parents and children an important barrier to FFP is a lack of service availability (Gillam et al., 2003; Korhonen et al., 2008; Maybery & Reupert, 2006, 2009). Whilst the findings of this study suggest that services are limited it also suggests that RPNs may not be aware of existing services due to limited experience of referral or capacity to engage in referral in the first instance. Either way, this has implications for RPNs in providing comprehensive supports for parents, children and adult family members.

Inter-professional practice was also identified as somewhat important being significant in connectedness and interventions to promote parents' mental health. Inter-professional practice measures RPNs' understanding of the importance of health professionals working together to solve the family's problems. Teamwork has been identified by other researchers as central to enabling FFP (Falkov, 2012; Lauritzen et al., 2014b; Reupert & Maybery, 2009; Toikka & Solantaus, 2006). Additionally, this study suggests that while RPNs understood the importance of teamwork, in enabling FFP, and were unanimous in their desire for effective teamwork, that teamwork was only necessary for two primary elements of FFP. This is interesting considering that the literature suggests a central element

of effective referral is teamwork or inter-professional practice (Falkov, 2012; Gillam et al., 2003; Maybery & Reupert, 2009). This inconsistency between the findings and the current study and existing literature provided further impetus for Study Two.

Whilst length of experience was also identified as somewhat important, in predicting FFP, this variable was not identified within the ANCOVAs as causing a difference in the extent of FFP within acute and community mental health nursing services. Again this inconsistency required further exploration within Study Two. Gender, time and workload and length of time in current position were also identified as somewhat important. Others have also suggested that these variables may serve to enable or hinder FFP (Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2006, 2009). Additionally, the hierarchical regression serves to provide evidence that this may be the case.

Three of the least important predictors were training, having had family training and engagement. Training relates to RPNs' perceptions of their capacity to support service users' parenting capacity and their willingness to undertake further training to develop their capacity to support parents and their children. It is not surprising that a desire for training is of least importance in predicting FFP as wanting training does not necessarily equate to ability to be family focused. Rather a desire for training is often related to mental health professionals' perceptions that they have limited knowledge and skills to engage in FFP (Houlihan et al., 2013; Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2006, 2009; Slack & Webber, 2008). This finding regarding the limited importance of training in predicting FFP is also not surprising considering that only a minority of RPNs, who were high scorers, had child or family focused training suggesting other variables are important in enabling FFP aside from training.

The findings also suggest that family training is of less importance in predicting FFP than child training. This is not surprising considering that RPNs suggested that they had greater difficulty in supporting children than adult family members. Others have also contended that mental health professionals, including RPNs, find supporting children particularly difficult and as such require child focused training (Houlihan et al., 2013; Lauritzen et al., 2014b; Reupert & Maybery, 2007; Toikka & Solantaus, 2006). Moreover, the literature also suggests that family focused training is not specifically designed to equip mental health professionals to support children. Rather the focus is on how to involve and support adult family members in parents' care (Coyne et al., 2013; Falkov, 2012; Houlihan et al., 2013). Additionally, this study suggests that whilst both types of training are important, child focused training is particularly important as RPNs are less well equipped to support children than adult family members. As such it is important to consider the distinction between the two types of training when considering how best to develop RPNs' capacity to engage in FFP.

Engagement issues were only significant in connectedness. Engagement issues measures the extent to which RPNs perceive parents have insight about the impact of their mental illness on their children and to which RPNs can discuss parenting issues with others without breaching parents' confidentiality. It also measures RPNs' perception of the likelihood that children will be willing to discuss their parents' mental illness with them. It is logical that RPNs need to be positive regarding the above if they are to be able to assess parents' understanding of how their mental illness affects their children and to help parents reduce the impact of PMI on children. Lack of engagement has been identified by other researchers as a significant barrier to FFP (Korhonen, Pietilä, et al., 2010; Korhonen et al.,

2008; Liangas & Falkov, 2014; Maybery & Reupert, 2006). Interestingly, whilst the high scorers agreed that they could assess parents' awareness of the importance of child connectedness; they were more tentative in their responses regarding engagement suggesting that other factors may enable connectedness aside from engagement. Nevertheless, improving the capacity of RPNs to engage parents and family members may enable them to undertake FFP (Lauritzen et al., 2014b; Toikka & Solantaus, 2006).

To conclude, Study One provided insights about a relatively large group of RPNs' FFP in Ireland. Whilst gaining insights into both low and high scoring RPNs' FFP, it placed Irish RPNs' FFP in the wider context by comparing their FFP with that of Australian RPNs. This highlighted, that on the whole, the Irish sample had relatively low levels of FFP, especially when compared with Australian RPNs. Aside from low scores, RPNs' FFP, in Ireland, was characterised by distinct differences in extent of FFP in acute and community settings; community RPNs were more family focused than RPNs in acute settings. Furthermore, 17 IV's were found to predict RPNs' FFP, and most important was knowledge and skill, followed by RPN group (acute versus community setting) and confidence around parenting and children in general. Despite the overall low scores in the Irish sample a select group of RPNs, from both acute and community settings, scored high in at least three of the six FFP behavioural subscales and this group were the focus of Study Two. Identification of this high scoring group, within Study One, generated further queries that needed to be addressed including: what made this group of RPNs different to the majority of the sample? Why and how did they engage in FFP? And, what enabled them to engage in FFP when the majority of the sample was not family focused?

The Nature and Scope of RPNs' FFP as Perceived by High Scoring RPNs

Activities underpinning RPNs' FFP. In Study Two, RPNs, particularly community RPNs, described a variety of family focused activities which included: (1) identifying and addressing the needs of parents, children and adult family members, (2) supporting parents to promote their mental health, general well-being and parenting capacity, (3) engaging and supporting children and other adult family members and finally, (4) collaborating with others.

In their practice each of the RPNs indicated that they consistently assessed the potential or actual impact of mental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on parents' mental health. They then utilised this information while caring for parents and their children. For example, RPNs promoted parents' mental health by helping them to develop their parenting skills and relationships with their children. RPNs, particularly those in community settings, also engaged with older children and collaborated with colleagues, other services and adult family members to support parents and their children. These are practices that are often recommended by researchers and by policy makers (Aldridge & Becker, 2003; Baker & Lees, 2014; Beardslee, Swatling, et al., 1998; Falkov, 2012; Gladstone et al., 2011; Houlihan et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery et al., 2005; Moore et al., 2012; Mordoch, 2010; Mordoch & Hall, 2008; Nilsson et al., 2014; Seeman, 2013) and professional affiliations (AICAFHMA, 2001; NICE, 2009; Royal College of Psychiatrists, 2011; SCIE, 2012).

At the same time, previous research has suggested that mental health professionals, including RPNs, rarely acknowledge and/or support service users' parenting responsibilities (A. Davies, 2004; Houlihan et al., 2013; Maybery & Reupert, 2009; Montgomery et al., 2006;

Nicholson & Biebel, 2002; Oyserman et al., 2000). Although the various family focused activities are not new, the findings are significant as they suggest that this group of RPNs practice in accordance with recommendations made by various researchers and professional groups as identified above. The findings are perhaps not unexpected considering that these RPNs obtained high scores on the FFMHPQ, which indicates that they work in a family oriented manner. Nevertheless, this finding is important, given it is the first Irish wide study to examine and explore RPNs' family focused activities, with parents who have mental illness and their children and families. Moreover, information regarding activities of RPNs' FFP enhanced understanding of the core components of RPNs' FFP and this has relevance for effective implementation of FFP within adult mental health services (Aarons et al., 2011; Moore et al., 2012).

The principles underpinning RPNs' FFP. In Study Two, RPNs outlined five central principles that underpinned FFP and these principles influenced the activities they undertook, the processes they employed and their capacity to engage in FFP. The principles included the need to acknowledge: (1) the relationship between parenting and mental health, (2) that it is possible to support children via their parents, (3) the centrality of the nurse – parent relationship, (4) that supporting parents and their children can at times be emotionally difficult and, (5) that practice needs to be individualised and holistic and parents' family contexts are part of this. These principles demonstrate what RPNs considered to be at the core of FFP and help to address the gap in knowledge regarding the principles of RPNs' FFP in adult mental health services. This is important information for advancing the understanding of RPN family focused practice.

The nurse-parent relationship was central to this model of FFP, in which RPNs understood the inter-relationship between parenting and mental health, where parenting impacted on mental health and where mental health impacted on parenting. They acknowledged the need to work with parents in a holistic manner and that this compelled them to address parenting issues, though some also simultaneously argued that by working with parents in terms of their parenting capacity and wellness, they could then support children. Underpinning all of this was a view that supporting parents and their children, could at times, be emotionally challenging. Some of these principles are similar to those previously identified. For example, an individualised and holistic approach, in conjunction with a partnership process, is identified in the literature as constituting the foundations of FFP in a variety of health care settings (Espe-Sherwindt, 2008; Falkov, 2012; Kuo et al., 2012; Moore et al., 2012; Mordoch, 2010; Nicholson, in press). However, the findings of the current research add to the understanding of how principles inform FFP by identifying why RPNs perceive that 'it is possible to support children via their parents' and by qualifying what RPNs perceive as a holistic approach and why they feel compelled to address parenting as part of this. RPNs' descriptions of their practice also highlighted how the principles shaped their practice, how they translated the principles in practice, and what this meant for their practice overall including their family focused activities and processes and capacity to engage in FFP.

RPNs suggested that a key reason why they strived to be family focused was their acknowledgement and understanding of the inter-relationship between parenting and mental health. Their understanding that parenthood could both promote parent's recovery and jeopardise their mental health compelled RPNs to identify and address parenting issues;

especially given that their remit was to promote parents' mental health. As part of this, RPNs also acknowledged the impact of the parents' mental health on children's well-being; in turn this fuelled a desire to keep children in mind whilst caring for their parents. It is only in recent times that the literature has acknowledged the inter-relationship between mental health and parenting (Baker & Lees, 2014; Baulderstone et al., 2012; Beardslee et al., 2012; Benders-Hadi et al., 2013; Cowling & McGorry, 2012; Falkov, 2012; Hansson et al., 2013; Liangas & Falkov, 2014; Nicholson, 2010). Furthermore, although Falkov (1998, 2012) and the Royal College of Psychiatrists (2011) urge mental health professionals to address this inter-relationship, as previously noted, there is a paucity of research that has considered what this means for RPNs and how they use parenthood to support service users' recovery.

In response to acknowledging the inter-relationship between parenting and mental health, RPNs developed partnerships with parents to support parents, their children and to a lesser extent other adult family members. Essentially RPNs used a process of partnership with parents to empower parents to support themselves and their children. To forge a genuine partnership with parents, RPNs needed to have the motivation and ability to work collaboratively with the parent. This partnership also required RPNs' empathetic responding to, and involvement with, the parent and agreement between the RPN and parent regarding goals and tasks of care. RPNs also described a range of personal attributes which enabled their partnership with parents such as being flexible, honest, respectful, trustworthy, confident, warm, interested, transparent and non-judgmental.

This finding that RPNs form a partnership with parents, to accommodate and capitalise on parents' expertise, contrasts with findings of other research including that in Ireland, by Patton (2009), who found that RPNs, practicing within acute units, did not engage

in partnerships with service users nor consider service users own knowledge of their problems important. Warne and McAndrew (2007) also suggested that RPNs may find it difficult to acknowledge the expertise that service users possess as it challenges the traditional power base that RPNs supposedly have.

The partnership between RPNs and parents is of interest for various reasons. In the first instance, the finding that RPNs do engage in partnership with parents is contrary to the notion that service users (including parents) are passive recipients of care, particularly whilst an in-patient. Furthermore, establishing a partnership with parents, to empower them to manage their problems, suggests that RPNs' FFP incorporates a strengths and recovery orientated approach as recommended by researchers and by policy makers (Baker & Lees, 2014; Barrington et al., 2011; Cusack & Killoury, 2012; Falkov, 2012; Kuo et al., 2012; Nicholson, in press) and professional affiliations (DoHC, 2006; Royal College of Psychiatrists, 2011). Also of note is the similarity between RPNs' descriptions of the partnership process in the current study and the concept of therapeutic alliance, as used in the field of psychotherapy (Ardito & Rabellino, 2011; Elvins & Green, 2008). The therapeutic alliance has been identified as the single most important factor in all psychotherapy, having a strong correlation to treatment outcome (Ardito & Rabellino, 2011; Elvins & Green, 2008; Shirk, Karver, & Brown, 2011; Stern, 2008; Wampold, 2001). The therapeutic alliance is characterised by a helpful and trusting relationship between clinician and service user (Ardito & Rabellino, 2011) and includes agreement about the treatment goals (related to family dynamics within the context of PMI) and the means with which to reach the goals. In this model, it is the parents, in collaboration with the professionals, who define their specific

goals and parents, are provided with a structured procedure for reaching particular goals (Pihkala et al., 2012a).

The therapeutic alliance is also central to most parent and family focused interventions that are specifically designed for families where a parent has a mood disorder (Pihkala et al., 2012a; Toikka & Solantaus, 2006). These interventions provide a solid base for the establishment of an alliance with the parent (Pihkala et al., 2012a; Toikka & Solantaus, 2006). This importance of the alliance between parents and professionals in such models resonates with RPNs' accounts of their partnership with parents. It is interesting that RPNs were able to forge a partnership that so closely mirrored the concept of alliance as discussed in the wider literature; and without, for the most part, having had extensive child or family focused training. This capacity of RPNs to form partnerships with parents and to work on parenting issues, without specific family focused training, to some extent explains the findings from Study One, regarding the limited significance of child focused training as a predictor of FFP. Moreover, it further strengthens the contention that there are many ways to enable mental health professionals to be family focused aside from formal child and family focused training. It further illustrates the need for greater understanding of factors, aside from formal child focused training that enable FFP.

The need for RPNs to forge an effective partnership/alliance with parents was all the more important considering their belief that they could support children via their parents. This principle is of interest as it implies that mental health professionals do not need to always work directly with children, and that using the partnership process to promote parents' mental health and parenting capacity (Nicholson, in press; Reedtz et al., 2012) may be sufficient to address the needs of their children. Others have also suggested that mental health

professionals, including RPNs may use partnerships with parents to support children. For instance, Kalmanson and Seligman (1992) indicated " a good relationship with a professional can enhance the sense of being understood and supported. This, in turn, can lead to changes in the parent – child relationship (Kalmanson & Seligman, 1992 , as cited in ; Moore et al., 2012, p. 13). Similarly, (Nicholson, in press, p. 5) suggested " supporting mothers in achieving their goals as parents for themselves and their children, promotes recovery in women and undoubtedly contributes to positive outcomes for their children". RPNs suggested that to support children they treated parents' mental illness in the conventional way (attention to resolving symptoms of mental illness) and simultaneously supported parenting capacity by working with parents to develop effective parenting strategies and relationships with their children. They also helped parents to understand the potential impact of their illness on their children's well-being. This importance of attending to both the parent's mental illness and parenting needs has been previously affirmed by Forman et al. (2007) and Hebbeler and Gerlach-Downie (2002) who found that treating a mother's mental illness, without regard to parenting or family context, is insufficient to improve maternal responsiveness and child outcomes.

However at the same time, RPNs suggested that in addition to supporting children via their parents there was also a need for more direct face-to-face contact and support of children (particularly older children) at critical times such as during the acute phase of the parent's mental illness and when parents were hospitalised. The question of how to effectively support children (e.g. directly or via their parents or both) is important and strikes at the core of what constitutes FFP. Of note, Falkov (2012) argues that just as a parent's mental illness impacts on children, there is also a "child to parent" influence, where the

child's behaviour and emotional state impacts on the mental health of parents. This means that even if a parent's mental illness is treated and their parenting capacity supported and enhanced, his or her children's own mental health issues might continue to adversely impact on family life and on the mental health of the parent. These discussions highlight the importance of including the family in treatment protocols and the need to focus on both children and parents.

How parents with mental illness and their children might be best supported is far from clear. As previously noted, there are a number of child focused interventions available, including peer support programs (Fraser & Pakenham, 2008; Goodyear et al., 2009; Grant et al., 2008; Hayman, 2009; Morson et al., 2009; Nilsson et al., 2014; Richter, 2006; Riebschleger et al., 2009) online discussion support groups (Drost et al., 2011; Woolderink et al., 2010) and educational materials (sometimes referred to as biblio-therapy) (Tussing & Valentine, 2001). In addition there are other forms of interventions designed for these families with a family focus (Beardslee et al., 2003; Beardslee et al., 2007; Bühler et al., 2011; Compas et al., 2011; Ginsburg, 2009; Nicholson et al., 2009; Reedtz et al., 2012; Solantaus et al., 2010; Valdez et al., 2011). Recent research from Finland compared two interventions; the first called *Family Talk*, which was directed to parents, children and the family and the second, *Let's Talk about Children* directed only to parents (Punamaki et al., 2013). The aim of *Let's Talk about Children* was to empower parents to support their children within the context of mental illness. It is important to note that participation in the parent only intervention (*Let's Talk about Children*) was associated with greater positive changes to children's cognitive attributions than the family focused intervention. The researchers suggested that this (unexpected) result may relate to the processes in which

psycho-education was presented to children. In *Family Talk*, children are provided with psycho-education in clinician led sessions (perhaps leading parents to believe that their job was done), while in *Let's Talk about Children*, parents needed to make their own decisions about how and when this is done, as an active agent for change in the family.

Another component of FFP was the need to be individualised and holistic. This entailed RPNs considering and addressing all the factors in parents' daily lives that affected their mental health, including their parenting role, wider family context and socioeconomic circumstances, as opposed to just focusing on treating their mental illness. In order to adopt a holistic approach RPNs felt compelled to consider service users' family context and parenting responsibilities. Being holistic also required RPNs to be flexible in their role when caring for parents and their children. Taking preventative action was another element in this theme, considered important to reduce the likelihood of parents and children experiencing problems in relation to PMI. Others have also highlighted that a holistic approach entails the need to consider service users' family contexts and parenting roles (Benders-Hadi et al., 2013; Espe-Sherwindt, 2008; Falkov, 2012; Kuo et al., 2012; McGavin, 2013; Nicholson, in press; Royal College of Psychiatrists, 2011). For instance, Benders-Hadi et al. (2013) suggested " the refocusing of mental health care goals to provision of individualised, recovery-orientated treatment makes consideration of the parenting role more important than ever" (p.66). This study expands upon this by highlighting that a holistic approach does serve as an impetus for RPNs to address service users' family context and parenting role and by unpacking the elements of individualised and holistic practice, with parents who have mental illness, their children and families, as perceived by a group of RPNs in Irish general adult mental health services.

Some RPNs, who were parents themselves, reported that supporting parents and their children can be emotionally challenging. Difficulties arose when RPNs had to fulfill their obligations around child safety, whilst at the same time having an emotional connection with parents. Others have also identified the emotional challenges in caring for parents and their children simultaneously (Cousins, 2004; Gomby et al., 1999; Nicholson et al., 1998a; Östman & Afzelius, 2011; Reupert & Maybery, 2007; Schmied et al., 2008) suggesting that it may not be possible for all workers, for professional and personal reasons, to consider the needs of both parents and children, or as Fleck-Henderson (2000) suggested *seeing double*. Additionally, findings from this study suggests that it is not a conflict of loyalties, between meeting needs of parents and children, that is challenging; rather RPNs' capacity to empathise with parents and a sense of what it must be like as a parent to lose custody of child(ren), on a temporary or permanent basis, caused RPNs' emotional distress. RPNs suggested that they could cope better with the emotional challenges of working with parents and children if their managers and colleagues acknowledged and understood their difficulties. As previously noted, Toikka and Solantaus (2006) found that mental health professionals who were trained in three preventative interventions, to support parents and their children, including, *Let's Talk about Children,* experienced increased joy and work satisfaction when using these interventions with parents and children in practice. This suggests that the emotional challenges of working with parents and children can be reduced when workers perceive they have the necessary resources, skills and knowledge and managerial support to do so.

RPNs' reports that FFP is individualistic and holistic, that children could be supported via their parents, the importance of the parent-worker alliance, the inter-relationship between

mental health and parenting and that caring for parents and children can be emotionally challenging, collectively represent an attempt to develop a theoretical construct of FFP, grounded in practice. This has implications for future research and theory development in FFP which will be discussed in the subsequent chapter.

Process of FFP. During the interviews, RPNs suggested that they employed various processes (methods and ways) to engage in FFP. In addition to partnership with parents, most RPNs used a specific interactional/therapeutic approach and community RPNs also used home visiting as a means of engaging in FFP.

As previously noted, the parent-nurse relationship/partnership was a core component of how RPNs worked with parents. This partnership enabled them to collaborate, negotiate and set goals with parents and their adult family members to manage parents' problems. It also allowed RPNs to assess children's needs, indirectly, through discussion with parents. The partnership process also enabled RPNs to secure parents' permission to refer children to outside services when they could not meet children's needs by supporting their parents. These partnerships with parents were nurtured through RPNs' capacity to use limited self-disclosure of their own parenting experiences and, being non-judgemental and transparent in their communication, over a sustained period of time. Others also highlight the importance of mental health professionals being non-judgemental and transparent in order to establish partnerships with parents (D. Braun, Davis, & Mansfield, 2006; Moore et al., 2012; Nicholson, in press). The findings from this study extend our understanding by suggesting that high scoring RPNs also used disclosure of their own parenting experience as a strategy to further forge partnerships with parents. Working collaboratively fostered a sense of shared understanding between RPNs and parents of the issues to be addressed, goals to be met and a

commitment from both to work together to resolve family difficulties. According to RPNs, these collaborative partnerships helped promote parents' insight and awareness of their situation and enabled RPNs to secure parents' agreement to communicate with others, including other adult family members and outside services. These partnerships were promoted by sustained contact with parents over a protracted period of time. While barriers emulating from families were nonetheless found, the strong collaborative partnership was considered essential in the implementation of FFP.

Just over half of the RPNs (n = 8) also used one or more interactional/therapeutic approaches to structure part of their work with parents, such as solution focused therapy (SFT), cognitive behavioural therapy (CBT) and motivational interviewing. Using the alliance as a basis, these therapeutic approaches were subsequently employed to engage parents around issues related to managing their mental illness and their parenting role. For example, theoretical approaches were used by RPNs to challenge parents to question their negative thinking around being a parent with a mental illness and to build strengths and resilience. Thus it was considered that a family approach could be embedded within therapeutic approaches such as CBT. Considering that the majority of the high scoring RPNs had not received training in child focused interventions, it is not surprising that they did not describe using a therapeutic approach specifically designed to intervene with parents and children in a preventative way, including Beardslee's *Preventative Family Intervention* or the *Let's Talk about Children* intervention designed by Solantaus in Finland, or *Childs Talk* in Norway. Whilst others have identified that RPNs (and particularly community RPNs) in Irish mental health services use therapeutic approaches such as CBT as a method to engage and work with service users (Cusack & Killoury, 2012; McCardle et al., 2007; Morrissey et al.,

2008) the findings from this study extend our understanding by suggesting that RPNs were able to infuse a family focus within a well-established therapeutic intervention such as CBT. This information would be useful when mental health service managers are making decisions around developing and implementing a whole family approach, within general adult mental health services, in Ireland. Infusing FFP into an established therapy warrants further investigation around family outcomes and a consideration of what FFP means theoretically.

Finally, community RPNs undertook home visits to further forge relationships with parents, their children and adult family members, to observe normal family life and to address parenting and children's needs. Kuo et al. (2012) identified care in the context of family and community as an important principle underpinning FFP and others have suggested that community mental health nurses can use home visits to engage in FFP (A. Davies, 2004; Devlin & O'Brien, 1999; Jackson & Darbyshire, 2004; Slack & Webber, 2008). Others have also described the benefits of home visiting programmes in supporting parents and their families including: (a) home visiting based parenting interventions for depressed mothers (Van Doesum & Hosman, 2009; Van Doesum et al., 2008), (b) the prenatal and infancy home visiting programme (Olds, 2002) and (c) the nurse-family partnership (Isaacs, 2007; Karoly, Kilburn, & Cannon, 2006; Olds et al., 1997). Whilst there is some evidence that community RPNs do use home visiting to engage in FFP (A. Davies, 2004; Liangas & Falkov, 2014; Slack & Webber, 2008) as previously noted, there is a lack of information about how home visits might be employed to promote FFP or how home visiting fits theoretically within a FFP framework. Visiting homes was not sufficient for the RPNs interviewed here; instead it was how RPNs worked with parents around family and child related issues when undertaking a home visit, which ensured the visit was a component of FFP. Conducting home visits gave

community RPNs the opportunity to be family focused and to obtain objective information about the parents' capacity to cope with their parenting role and to assess children's needs (directly and indirectly). Working with the parent in the home enabled RPNs to detect PMI symptoms early, as well as detecting emerging difficulties in parenting, the parent-child relationship and children's mental health and development. This information was then used by RPNs to work with parents in a collaborative and holistic manner. According to RPNs, the partnership between RPNs and parents, and the transparency, mutual regard (acceptance) and equality within this partnerships enabled parents and their children (for the most part) to see home visiting as a supportive measure as opposed to an exploitive and intrusive intervention. Thus, it appears that home visiting might be an important vehicle for general adult mental health services to employ when developing a whole family approach, when used within collaborative parent-clinician relationships.

RPNs' Capacity to Engage in FFP

Barriers to FFP. Even though interview participants were selected on the basis of their high scores and were able to provide various examples of their FFP, a number of barriers were identified, especially from those located in acute settings. Barriers primarily originated from the organisation as a whole and to a lesser extent from RPNs and parents, children and adult family members. RPNs reported that factors specific to acute settings limited FFP including a predominant focus on treating the parent's mental illness as opposed to also considering their wider family context. RPNs, working in acute settings, also indicated that a person-centered approach was a barrier to working with families. In a person-centered approach, as described by RPNs here, the parent is the primary client and the focus is their

mental illness as opposed to also considering their parenting role and family, including children. According to RPNs the person-centered model does not explicitly acknowledge or address the complex relationship between parents and their children or enable direct interventions with children and adult family members when caring for parents. Instead these same participants supported children's well-being by supporting the parent in a person-centered approach. These findings for the most part fit with research that has explored barriers experienced by a range of mental health professionals, including RPNs, social workers, psychiatrists and psychologists, across multiple settings and countries (Bellin et al., 2011; Lauritzen et al., 2014b; Manderson & McCune, 2004; Reupert et al., 2010; Rutherford & Keeley, 2009; Slack & Webber, 2008; Stallard et al., 2004) as well as research that focused specifically on RPNs (A. Davies, 2004; Houlihan et al., 2013; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maddocks et al., 2010; O'Brien, Brady, et al., 2011; Thompson & Fudge, 2005). This confirms the role that organisations and systems have in promoting or impeding FFP, in Ireland and elsewhere, and that community mental health services tend to be more family focused than acute in patient services.

However, the findings from the study here extend understanding by identifying different environments can enhance or restrict FFP, why barriers exist, how they impede FFP and how RPNs managed to minimise their impact on FFP. The notion that FFP might be implemented differently in various practice settings also implies that there might be different ways of conceptualizing FFP and that it may be helpful to consider FFP in terms of a continuum (K. Foster et al., 2012). The optimal level of FFP is however at present unclear. Also of relevance, and somewhat interestingly the findings suggests that many of the barriers to FFP originate from the principles underpinning FFP. For example, a belief that children

can be supported via their parents may lead to a lack of contact with children and interventions for children and a subsequent lack of confidence, skills and knowledge in working with young people directly. Again, this warrants further investigation around what FFP really is and the role of principles in influencing the activities and processes underpinning mental health professionals' FFP.

Some RPNs also discussed examples of RPN related barriers. For instance, RPNs indicated that a lack of personal experience in caring for their own or family and friend's children meant that they did not have the necessary knowledge and skills to support service users in their parenting; particularly when they had received little or no child and/or family focused training from their employers. This finding is consistent with findings in Study One which suggested that high scoring RPNs had relatively low levels of knowledge and skill. Korhonen, Vehviläinen-Julkunen, et al. (2010) also found in a study of Finnish nurses that those RPNs who were not parents themselves reported more difficulties supporting parents, than those RPNs who were parents. Additionally, this study here provides explanations as to why limited or no personal experience of caring for children negatively impacted RPNs' capacity to support parents and their children. For example, not being a parent meant for some that they were not able to tap into their own personal knowledge, skills and experiences around parenting. Additionally, RPNs, in this study reported that not being a parent meant parents were less likely to disclose their parenting problems to them.

As previously noted, the RPNs in interviews also identified barriers related to families though notably less so that other researchers who found family related factors as most hindering (Korhonen et al., 2008; Maybery & Reupert, 2006). RPNs described some parents' reluctance to disclose parenting issues in case it resulted in referrals to child protection

services; others also thought that some parents did not consider FFP as part of their role. Some RPNs suggested that it was difficult to support children when parents were reluctant to disclose to their children that they had a mental illness and children themselves may not acknowledge that their parent was mentally unwell. For some RPNs hostility from children and adult family members also hindered FFP. Other researchers have also identified that barriers to FFP may arise from children and adult family members (Doucet et al., 2012; Korhonen et al., 2008; Maybery & Reupert, 2009; Reupert & Maybery, 2007). For example, Doucet et al. (2012) found that male partners of mentally ill mothers were reluctant to access and accept support from mental health professionals, due to concerns around privacy and pride.

This current study expands our understanding by suggesting that mentally ill fathers may be more difficult to support than mentally ill mothers. RPNs suggested that fathers in particular may be difficult to support because they are less likely to acknowledge that they need support and were more difficult to engage in discussions around parenting, than mothers. Given the reluctance of fathers to ask for, or to accept support, this finding highlights the importance of developing RPNs' capacity to be proactive in probing fathers about their needs.

Additionally, whilst acknowledging that relationships with some parents and their families may be more easily formed than others, this study suggests that RPNs can use their relationships/partnerships with parents to reduce family related barriers. The findings that RPNs could sustain relationships with parents, in difficult circumstances, (i.e. where child safety is an issue) is important as it contrasts with much of the existing literature which suggests that RPNs' role in maintaining child safety conflicts with their role and

responsibilities in supporting parents (Aldridge & Becker, 2003; Diaz-Caneja & Johnson, 2004; Maddocks et al., 2010; Maitra & Jolley, 2000; Maybery & Reupert, 2009; Mowbray et al., 1995; Royal College of Psychiatrists, 2011). The findings in this study suggest that this does not have to be the case. RPNs were able to sustain their relationships with parents, in difficult circumstances, through their capacity to empathise with parents and by being non-judgmental and transparent. This stance enabled them to work with parents in partnership to maintain children's well-being and allowed RPNs to help parents understand that by addressing children's needs, parents themselves were being supported; in line with Falkov's (2012) mantra that *supporting children, supports parents, supports children*.

Another barrier to FFP related to the need to respect parents' confidentiality especially when working with others services, similar to concerns other clinicians have voiced in other studies (Gillam et al., 2003; Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Maybery & Reupert, 2006; Slack & Webber, 2008). At the same time, RPNs indicated that working with parents in a collaborative manner overcome many of these confidentiality concerns, in that when parents felt they were trusted and respected they did not have a problem with the RPN working with other services. Considering these findings, further investigation is warranted to examine the influence of partnership in reducing family related barriers.

Enablers for FFP. In Study Two, all RPNs, and particularly those within the community setting, described an array of enablers of FFP. These enablers primarily stemmed from their own personal attributes, community setting experiences and to a lesser extent the parents, children and adult family members they cared for. In this study, all RPNs reported more enablers than barriers and the overall findings imply that they were able to utilise a

family-centered approach to a varying extent despite practicing to a greater or lesser degree within organisations that primarily used a professional-centric and person-centered approach to care. As many of the enablers originated from what might be considered to be personal or professional centered factors located with the RPN, this may explain why this group of RPNs also achieved high scores on the FFMHPQ despite also experiencing organisational related barriers.

Enablers related to RPNs. RPNs' gender, life experience (linked to age) and personal experience around their own and/or family and friend's children, were identified as key enablers to family focused practice. Others have also identified that age, gender (Houlihan et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Maybery & Reupert, 2006, 2009; Reupert & Maybery, 2011) and RPNs' own parenting experience (Korhonen, Pietilä, et al., 2010; Korhonen et al., 2008) may enable FFP. This study here extends our understanding by explicating how and why theses enablers allowed RPNs to engage in FFP and by suggesting that a range of experiences, including experiences around children generally, is also important in promoting family focused capacity.

In contrast to Study One, (where age was not found to be a significant predictor of FFP), life experience (linked to age) helped RPNs to empathise and relate to parents and was also suggested, by those interviewed, to contribute to their desire to be family focused. In addition, RPNs suggested that these personal experiences increased their confidence to communicate the need to be family focused with colleagues, parents and services/agencies. This suggests that personal experiences equipped RPNs with the necessary emotional intelligence to relate effectively with parents and their particular circumstances. The findings regarding the importance of increased age (and life experience) in enabling FFP corresponds

with that of Korhonen, Vehviläinen-Julkunen, et al. (2010) but contrasts with those of Lauritzen (2014) and Houlihan et al. (2013) who found that RPNs with less work/clinical experience (i.e. ten years or less) were statistically more likely to support service users' children than other RPNs. This means that the association or relationship between age, personal experience and FFP is not clear and warrants further investigation.

Consistent with Study One, confidence around their own or family and friends' children enabled FFP as it helped RPNs to comprehend the needs of children and the challenges faced by their parents in caring for them. Korhonen, Vehviläinen-Julkunen, et al. (2010) also suggested that RPNs who had experience of parenting and were raising children may be more family focused as they may be more aware of the needs of service users' children. Additionally, this study suggests that these experiences also provided the necessary credibility to work with parents and to disclose relevant parenting experiences. Hence, RPNs recognised that their own parenting experience enabled them to support parents through their shared understanding of parenting. The findings also suggested that whilst parenting experience was an important enabler so too was RPNs' perception that they were confident and comfortable around children in general. If RPNs were not parents themselves they suggested that they could obtain this confidence from caring for family and friend's children. Similarly, male RPNs reported being particularly able to engage with fathers as they could relate to fathers' problems in parenting and were able to have 'man up' conversations with them. In sum, if RPNs were able to draw upon their own personal experience, including experience around their own or family and friend's children, they were better able to engage in FFP than RPNs who did not have such experience.

Organisational enablers. Although it is important that RPNs themselves possess the necessary personal attributes to enable their FFP, the findings from the two studies also suggest that organisational enablers are essential to promote RPNs' FFP. Korhonen et al. (2008) argues that FFP is not solely reliant upon individual RPNs' personal attributes; hence it is important to understand why and how various organisational enablers facilitate FFP (Lauritzen et al., 2014b).

Overall, thirteen organisational enablers were identified by RPNs who participated in interviews, six of which were common to both community and acute groups. Three of these common enablers included policy developments, child focused training and sustained contact with parents over time. With regard to policy, RPNs suggested that recent legislation from *Children's First* (DCYA, 2011) enabled FFP, to some extent, as it made their responsibilities surrounding child safety more concrete. This policy motivated RPNs to learn about the impact of PMI on children and helped to focus their attention on children and parents' wider family context. The accompanying guidelines also facilitated mechanisms within general adult mental health services to report suspected child abuse. The importance of relevant policy and its integration to child protection policy as a FFP enabler resonates with previous research (Korhonen et al., 2008; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Toikka & Solantaus, 2006). Additionally, the current study highlights the need for family focused policy that focuses RPNs' attention on the prevention of mental health problems in service users' children, in the first instance, as opposed to only reacting to difficulties when or if they arise.

Similar to Study One, the findings in Study Two also challenge the importance of specific child and family focused training as outlined by Toikka and Solantaus (2006). Whilst

Study One identified that child and particularly family focused training was only somewhat important in predicting FFP, Study Two provided explanations as to why these were not critically important. For example some RPNs suggested that there were many types of experiences that promoted FFP, including personal experiences of caring for children and undertaking courses not specifically related to FFP but including motivational interviewing, SFT and CBT. Additionally, the need to encourage RPNs to draw upon a range of unique experiences, skills and knowledge when caring for parents who have mental illness, their children and families is underscored by these findings. While important, specific child focused FFP training may not be a pre requisite to enable family practices and particularly if children can be supported, to a large extent, via their parents. Nonetheless, whilst we know that some interventions can be used to support parents, their children and families (Siegenthaler et al., 2012) we are still not clear why specific interventions/approaches work or what the specific mechanisms that enable change are.

Similar to Study One, which found length of experience and length of time in current position to be significant predictors of FFP, RPNs who were interviewed suggested that sustained professional experience facilitated their FFP. Whilst Korhonen, Pietilä, et al. (2010) had similar findings the current study suggests that it does so by enabling RPNs to acquire effective interpersonal skills and knowledge which they used to form partnerships with parents. Critically, RPNs suggested that this relationship enabled them to simultaneously balance the needs of parents and children and support parents in difficult circumstances such as when there were child safety issues.

Another organisational enabler was working with parents over a sustained period of time as it allowed RPNs to obtain comprehensive information about parents and their wider

family context and sometimes provided the opportunity to work with families across generations. Sustained contact allowed RPNs to get to know parents' circumstances over time, to accurately assess the family context and provide appropriate interventions and referrals. More importantly, sustained contact enabled RPNs to develop deep and authentic relationships with parents. In addition, community RPNs suggested that sustained contact with parents, when they were both well and unwell, enabled them to obtain a complete picture of parents' capacities, including strengths.

The findings that RPNs, in acute settings, can develop information about service users' family contexts and establish rapport with service users through sustained contact, contrasts with much of the literature which suggests that short periods of hospitalisation preclude RPNs from developing relationships with parents (Korhonen et al., 2008; Maybery & Reupert, 2006, 2009). Whilst this is true to a large extent, the current research highlights that, despite short durations of parents' hospitalisation (i.e. two weeks), RPNs are able to have sustained relationships with parents if they require more than one admission which is possible given the recurring nature of many types of mental illness (Falkov, 2012; O'Brien, Anand, et al., 2011). As the average length of time that RPNs had spent in their current position, at time of completing the FFMHPQ was 5.6 years, it is likely that some would have had an opportunity to care for the same parents on their subsequent admissions. On this basis RPNs perceived that it was possible to build up information about parents over time and to develop effective relationships with them from one admission to the next. Moreover, the findings also suggest that even when RPNs have limited time with parents due to short admissions (i.e. two weeks) some were still able to build good relationships with parents as these admissions were usually an intense time for parents and they required sustained contact

from RPNs for the duration of their admission. However, capacity to utilise short admissions to establish relationships with parents was contingent upon RPNs being allocated to the same parents on a consistent basis and to being family focused in the first instance. Additionally, whilst other researchers (Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Montgomery et al., 2006; Nicholson, in press) and professional groups (AICAFHMA, 2004; Royal College of Psychiatrists, 2011; SCIE, 2009) have identified the importance of the nurse-parent relationship, the current findings endorse the centrality of the relationship between parents and RPNs and provide some depth as to what this relationship might look like (sustained over time, strength and recovery based, in times of wellness and sickness and based on a partnership process).

The organisational culture was also paramount in enabling FFP and included the widespread use of a holistic, family focused philosophy framed by prevention and early intervention, support from colleagues and managers and scope for service delivery flexibility. Others have also noted the importance of a family focused organisational culture, emulating from managers, colleagues and policy (Falkov, 2012; Houlihan et al., 2013; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). For example, Korhonen et al. (2008) suggested that RPNs' ability to discuss the impact of PMI with parents and their children was increased by the use of a family-centered care framework within their organisation.

Additionally this study here suggests that the family focused philosophy within RPNs' organisations made it easier for them to address parenting on a routine basis; it conveyed to them and their colleagues that families were important and that parenting and family related issues needed to be factored into service users' care. This organisational

support meant that the time required to engage in FFP was sanctioned, planned and accommodated by RPNs and their colleagues. Moreover, this conducive philosophy enabled RPNs and their colleagues to accumulate FFP experience, and so resulted in the development of a wealth of knowledge, within respective teams. FFP knowledge and skills across the organisation was then drawn upon and 'tapped into' by RPNs to further develop capacity. The interdisciplinary nature of the teams and encouragement and support from managers reinforced this positive organisational culture and sharing of information and skills. Moreover, the findings, regarding the importance of teamwork in Study Two, resonate with and explain those in Study One in relation to inter-professional practice and its significance in predicting FFP. It also suggests that the sharing of knowledge and skills within teams is an important enabler of FFP particularly in the absence of formal training resources. Sharing of information, collegial and managerial support is also a central principle espoused within implementation science for enabling organisations to adopt, implement and sustain change (Aarons et al., 2009; Fixsen et al., 2005; Halle et al., 2013; Lauritzen et al., 2014b; Rogers, 2003; Van Achterberg, Schoonhoven, & Grol, 2008); RPNs' capacity to engage in FFP may be explained in part by the presence of effective inter-professional practice.

Effective communication and collaboration with other services was another organisational enabler as it allowed RPNs to access additional supports for parents, their children and families and to engage in joint work as required. Interagency collaboration meant that services provided to parents and their families were more comprehensive, than they would have been otherwise. Other researchers and policy makers (Coyne et al., 2013; Falkov, 2012; Gillam et al., 2003; Toikka & Solantaus, 2006) and professional organisations (Royal College of Psychiatrists, 2011; SCIE, 2009) have identified effective communication

and collaboration, with other services, as an important element of FFP and some have also suggested mechanisms to promote this (Beck et al., 2009; Coyne et al., 2013; Falkov, 2012; Gillam et al., 2003; Maybery & Reupert, 2009). For example, in the UK Cleaver et al. (2011) suggested that mental health professionals and staff in child protection services should undertake joint assessments when child abuse is suspected. In Canada the report *Healthy Minds, Healthy People*, recommend that health authorities and key partners use a cross-sector framework for planning so that parents and their children will receive more coordinated services and supports (Ministry of Health Services, 2010). Moreover the *Towards Flourishing* strategy has resulted in close collaboration and cross learning between mental health services and public health nursing services (M. Chartier, personal communication, February 2014). Additionally, this research here identifies that close physical proximity (being located in the same building) to other services enables collaboration. Situating community mental health nursing services headquarters within primary care centres was one way to promote collaboration, in that close physical proximity and easy access to other services within the same building enabled RPNs to get to know staff, working within these services, on an informal basis; in turn this familiarity enabled ready access and collaboration with these services in a more formalised way. The relocation of community mental health services headquarters into primary care centres in Ireland presents an ideal opportunity to ensure that the structural design of centre buildings support the delivery of FFP.

Enablers related to Families. RPNs also identified some enablers related to parents, children and adult family members that fell within two broad areas including parents' receptivity to discussing parenting issues, and allowing RPNs access to their children so that they could establish rapport and interact with them.

Parents' receptivity to discussing parenting problems, stemmed from their insight into the potential or actual effect of their mental illness on their child(ren) and their desire to effectively care for their children. These insights developed partly as a consequence of the partnership between RPNs and parents as the partnership process allowed parents to feel accepted and secure in disclosing parenting issues. This information was then used by RPNs to inform the partnership between parent and RPNs with the two working together to manage parents' problems or issues. RPNs also suggested that the partnership process enabled them to convey to parents that they had a good understanding of their children's needs and to obtain parents' consent to access and support their children. In comparison, others suggest that some parents can be most resistant to the concept of family approaches, because of the fear of child protection (Falkov, 2012; Korhonen et al., 2008; Maybery & Reupert, 2006; Nicholson, in press; O'Brien, Anand, et al., 2011) or because of a lack of insight into how their mental illness might be impacting on children (Falkov, 2012; Maybery & Reupert, 2006, 2009). Whilst acknowledging that these factors and others (including type of parent's mental disorder) may increase parent's resistance to FFP the findings nonetheless suggest that a parent's lack of insight may not represent an intractable barrier; further underscoring the importance of genuine collaborative relationships with parents.

Potential developments in FFP. In Study Two RPNs provided a number of suggestions, including theory development in FFP, FFP training, strategies to address the needs of parents, children and adult family members and systematic structures to support FFP. In many ways, RPNs' suggestions were related to the FFP predictor variables in Study One and the principles and barriers participants described in Study Two. RPNs suggested that in order to promote a whole family approach, specific services were required to address the

needs of parents, children and adult family members collectively as well as individually, a suggestion also mooted by others (Falkov, 2012; Gladstone et al., 2011; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Nilsson et al., 2014). For example, RPNs suggested that there should be separate peer and professional led support groups and interventions available for parents, for their children and for adult family members as well as groups for the families. Furthermore, RPNs suggested that these groups should be initiated and led within general adult mental health services, as happens in mental health services in Finland, Norway and Netherlands (Reedtz et al., 2012; Toikka & Solantaus, 2006; Van Doesum & Hosman, 2009). Simultaneously, RPNs indicated that opportunities for individual work with parents and children were required. Regardless of the focus of such work, RPNs considered that a priority was on facilitating children's understanding of PMI and coping capacity as well as enhancing service users' parenting capacity and ability to discuss their mental illness with their children. While in practice many described supporting children via their parents, here they visualise a whole of family approach in which individual and specific needs are simultaneously met. This comprehensive family focused approach has been advocated by others (Falkov, 2012; K. Foster et al., 2012; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Nilsson et al., 2014; Reedtz et al., 2012), though is rarely enacted in practice (Falkov, 2012; Maybery & Reupert, 2006, 2009); perhaps due to the demands this type of approach might make to service and workers (Falkov, 2012; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Nicholson, in press).

A need for theory development in FFP was raised by RPNs, so that a shared understanding could be developed around what RPNs currently do and should do when working with families. According to participants, such a theory would render FFP tangible

and enable the nursing profession to be consistent in their FFP approach. The need for more theory development within the psychiatric nursing profession in general has been highlighted (Cusack & Killoury, 2012), and while there is substantial literature on FFP and its working principles in other disciplines, especially paediatrics, (Coyne et al., 2013; Espe-Sherwindt, 2008; Kuo et al., 2012; Wright, 2007), there is a paucity of literature that has defined and conceptualised FFP within mental health settings (Korhonen et al., 2008; Korhonen, Vehviläinen-Julkunen, et al., 2010; Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maddocks et al., 2010) and for RPNs (K. Foster et al., 2012; Korhonen, Vehviläinen-Julkunen, et al., 2010; Thompson & Fudge, 2005). It needs to be pointed out however that by highlighting FFP activities, principles and processes, RPNs have contributed to the development of FFP theory for RPNs within general adult mental health services. At the same time, a consolidation of this theory development is still required particularly around models of intervention and an efficacy base for interventions targeting children and parents. Such a theory would need to delineate child focused services, which the RPNs in the present study were not able to clearly articulate. Developing a comprehensive construct of FFP has implications for education, adoption of FFP and service evaluation.

RPNs suggested that all mental health professionals required child and family focused education at the undergraduate level and post registration. Education was thought to increase mental health professionals' understanding of the importance of FFP and provide the necessary knowledge, skills and attitudes to care for parents, children, and family members. These findings, regarding a need for greater opportunities for family focused training, reflect the conclusions made by others (Falkov, 2012; Lauritzen et al., 2014b; Liangas & Falkov,

2014; Maybery et al., 2009; Royal College of Psychiatrists, 2011), suggesting once again that the lack of family focused training opportunities is a problem not unique to Ireland.

RPNs also highlighted the importance of systemic structures in which managerial and collegial support was paramount, a finding that resonates with previous research (Korhonen et al., 2008; Lauritzen et al., 2014b; Maybery & Reupert, 2006, 2009; Reedtz et al., 2012; Toikka & Solantaus, 2006). As argued by several researchers (Falkov, 2012; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Toikka & Solantaus, 2006), training alone is insufficient to implement and sustain FFP; rather training needs to be built from an organisational culture that promotes FFP (Lauritzen et al., 2014b; Liangas & Falkov, 2014; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). Similarly, family focused policies and protocols are a critical component of organisational culture (Falkov, 2012; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Toikka & Solantaus, 2006). Some RPNs suggested that policy should formalise a requirement for mental health professionals to identify and support service users' children as happens elsewhere (namely, Finland and Norway). In line with research with RPNs conducted by Houlihan et al. (2013) RPNs here suggested that there was a need to develop a comprehensive family focused policy, aside from *Children's First* guidelines (DoHC , 2011); which primarily defines their responsibilities around child protection. These findings suggest that RPNs wanted to assume a different and more preventative role when working with parents and their families. Finally some RPNs suggested joint appointments between universities and clinical services could be used to ensure that evidence based FFP is successfully integrated into practice.

Theoretical Approach: Suitability of Falkov's Family Model as an Interpretive Lens

Although the Family Model has been developed from practice it has not been critiqued to any great degree. Falkov (2012) contended that the Family Model identifies important aspects for mental health professionals to consider when parents have a mental illness and provides a framework for supporting FFP, within general adult mental health services (Falkov, 2012). In this study the Family Model was used as a lens to interpret and structure the wider literature in the initial chapters of the thesis and to provide a partial framework for the methodology and interpretation of the results. The links between the theoretical aspects of the Family Model and methodology are important. However, whilst reference was made to Falkov's Family Model throughout the discussion, this was done in an implicit way, so as to allow greater attention to new information emerging from the study in response to the research questions posed.

The Model was particularly useful in interpreting high scoring RPNs' FFP. This is not surprising considering that the Model highlights important components of a family focused approach. Accordingly, parallels can be drawn between Falkov's domains and high scoring RPNs' accounts of their practice. For instance, RPNs' activities in supporting parents and children were prompted by their awareness of the reciprocal relationship between a parent's and their children's well-being similar to the iterative nature underlined in the Family Model. Similar to the Model, the RPNs here reported that children could be supported via their parents; RPNs' perceived that supporting parents in their mental health and parenting capacity enabled parents to act as a catalyst of change for the whole family. Moreover, by enhancing parenting capacity parents' mental health could also be improved. Parallels could also be drawn between domain three and RPNs' family focused activities in relation to

promoting parent's relationships with their children. Similar to Falkov, RPNs here spoke about the need to help parents forge good relationships with their children with a view to preventing problems for both parents and their children. Relatedly, some RPNs also indicated that the experience of witnessing intergenerational transmission of mental illness acted as an impetus to engage in FFP in an effort to reduce the likelihood of long term problems for parents and their children. Falkov also highlighted the importance of mental health professionals incorporating a developmental and life span approach in supporting parents and children. Associated with this some community RPNs suggested that the opportunity to care for families over an extended period of time that is, through various stages of the family life cycle, enabled FFP as it helped them have a better understanding of families' circumstances, needs and challenges. Reflecting domain four and six RPNs also recognised the significance of risks, stressors and protective factors in family's lives and addressed these. For instance, RPNs, and particularly community RPNs, worked in partnership with parents to address their socioeconomic needs for the benefit of parents, children and adult family members. Moreover they assisted parents to recognise and to utilise their strengths. They also helped parents to promote their broader community networks. However, for the most part, cultural considerations were not a central feature of RPNs' accounts of their practice, whereas culture and culturally competent care is a feature of the Family Model. This is surprising considering ethnic groups make up approximately 15 percent of the population of Ireland (Central Statistics Office, 2012) and cultural diversity is increasingly identified as an important issue in the Irish healthcare sector (NCCRI & Irish Health Services Management Institute, 2002). It may be partly explained by the fact that all of the high scoring RPNs were born in Ireland and were of Anglo Saxon descent. Considering the importance of culturally competent care

(Cusack & Killoury, 2012; DoHC, 2006; Falkov, 2012) further research could explore this further.

Also differing with the Family Model, RPNs explicitly discussed their activities in involving and supporting adult family members. For instance, they described how they encouraged and facilitated adult family members (including parent's partners) to support parents and their children and how they supported them to cope with the effects of the parent's mental illness in their own lives. Whilst Falkov does make reference to the needs of adult family members and their role in supporting parents and their children this is not explicitly highlighted in the Model. As previously noted, adult family members have their own needs in relation to PMI (Bland & Foster, 2012; Doucet et al., 2012; Khalifeh et al., 2009; McNeil, 2013; Monahan et al., 2008; Nicholson, 2010; Reader, 2002), play a key role in supporting parents who have mental illness and their children (Bland & Foster, 2012; Nicholson, 2010) and as such are an integral dimension to consider in a whole family approach (Bland & Foster, 2012; Coyne et al., 2013). This lack of explicit reference to adult family members in the Family Model may impede mental health professionals and researchers from giving this dimension due consideration in implementing and /or researching FFP and is an important variable to consider in future research. Finally, the finding that RPNs' perceived that their relationships with parents was crucial in enabling them to provide optimal support for parents and their families fits with Falkov's suggestion in domain five that the quality of contact/engagement between individuals and practitioners is of central importance to the overall outcome for all family members. However the findings from the study extend understanding of what constitutes effective engagement, and what enables it.

Going forward this information can be used in conjunction with Falkov's Family Model to provide a comprehensive framework for researchers to examine RPNs' FFP.

Summary

The current study, conducted in two stages, generated information regarding RPNs' FFP, within general adult mental health services, in Ireland. Falkov's Family Model and the wider literature was used to inform the examination and exploration of RPNs' FFP.

Study One identified that RPNs had generally low levels of FFP, especially in comparison to RPNs in Australia. However RPNs, in the Irish community setting were more able to engage in FFP than those in the Irish acute setting. The most significant predictors of FFP included skill and knowledge, RPN group (acute versus community) and confidence around parenting and children generally. While most RPNs were not family focused there was however a significant majority (mostly from the community setting) who were regularly FFP focused in their approach. Fourteen of these high scoring RPNs were asked to participate in qualitative interviews as part of Study Two.

Overall the findings in Study Two resonate with and expand upon those of Study One. From the perspective of the high scoring RPNs, FFP is comprised of three distinct and inter related elements; activities, principles and processes. These elements are connected to enablers, barriers and future potential developments in FFP chiefly through the principles of FFP. In turn, enablers, barriers and future developments in FFP impact upon activities, principles and processes. Findings indicate that FFP is context dependent, with differences noted in acute and community settings. Overall RPNs, particularly those in acute settings,

were employing a family focused approach (albeit supporting children and family members via parents) within organisations that predominantly employed a professional centered model of service delivery. RPNs here were able to employ a family focused approach and to form partnerships with parents, to meet the needs of children and adult family members, alongside that of parents due to a variety of enablers deriving, for the most part, from RPNs themselves. Hence, there is an uneasy conflict that RPNs in both settings experience, and particularly those in acute settings, around negotiating FFPs. Although a conducive organisational culture was an important enabler of FFP, RPNs suggested that they could overcome organisational barriers, in varying degrees, by various personal enablers. For example, RPNs' attitudes and beliefs that children and family were a central part of parents' lives motivated RPNs to address parenting issues, regardless of limited organisational enablers. Moreover, a belief that parents had the strength to resolve their own problems deterred RPNs from assuming the role of expert. Furthermore, a lack of FFP training did not necessarily impede RPNs' FFP if they had adequate personal and professional experience to work in a family focused way and were able to use existing skills and resources in a family orientated way, including various therapies such as CBT. RPN enablers also reduced the likelihood of barriers arising from parents, children and adult family members (such as parents' reluctance to discuss children). RPNs that were most family focused described having an array of enablers at their disposal fostered by themselves and their organisations.

Overall, the findings from Study One highlight that RPNs engage in FFP, in varying levels, depending upon an array of factors including level of skill and knowledge, RPN group and confidence around children generally. To reduce the disparities within and between

settings, in terms of extent of FFP, it is important to attend to factors that predict RPNs' FFP as outlined in Figure 7.1

Overall the findings from Study Two highlight the need to develop the necessary principles and organisational enablers as identified in Figure 6.2 and 6.3; these could then be used to maximize and build upon enablers emulating from RPNs themselves. Finally, and most importantly, the findings represent a beginning attempt to conceptualise FFP, within general adult mental health services, and raise questions that require further debate; including whether it is sufficient to support children via their parents or whether mental health professionals should endeavour to also support children directly and whether particular settings should dictate the range of family focused activities that occur.

Chapter 8: Conclusion

New Knowledge Emerging from this Thesis

While a number of studies have examined and/or explored various elements of RPNs' FFP (with a dominant focus on barriers to FFP), this thesis provided new insights into the extent and type of RPNs' FFP according to setting, differences between low and high scoring RPNs' FFP and how Irish RPNs' FFP compares with the FFP of Australian RPNs. Importantly, this thesis also identified factors that predicted RPNs' FFP and provided insights into the nature, scope and enablers of high scoring RPNs' FFP.

Despite an overall tendency towards low mean scores, a third of RPNs obtained high scores on at least three of the six FFP subscales, within the FFMHPQ, suggesting that whilst on average FFP is low, that there is a larger group of RPNs who understand and undertake FFP. The majority of these high scorers practiced within community settings. Aside from work setting, other significant predictors of FFP included knowledge and skill, and confidence around parenting and children generally. High scoring RPNs' FFP was comprised of three distinct but interconnected elements including, activities, processes and principles. Their capacity to engage in FFP was influenced by enablers, barriers and future potential developments in FFP. On the whole, high scoring RPNs experienced more enablers than barriers, with key enablers involving RPNs' personal attributes, including their own parenting and life experience. Community setting experiences further enabled FFP. The principles underpinning RPNs' FFP were key as they affected RPNs' family focused activities and processes and capacity to engage in FFP.

Implications and Recommendations

The findings allow for the development of recommendations in regard to RPNs' FFP, in Irish adult mental health services, in terms of education, practice, policy and research. These recommendations are grounded in the findings of this thesis and whilst they relate to the Irish context, there is some potential International applicability. Many of these recommendations overlap with one another and fall under the remit of multiple agencies and professional groups. It is important that parents who have mental illness are involved in the implementation of these recommendations (Cowling, Edan, Cuff, Armitage, & Herszberg, 2006; Falkov, 2012; Fiorillo et al., 2013; Nicholson et al., 1998a).

Education. Whilst RPNs perceived that they required further education to support parents who have mental illness, their children and families, only a minority had received education in this area. It is recommended that undergraduate and post registration educational programmes are strengthened to equip RPNs with the appropriate knowledge, skills, attitudes and competencies to support parents who have mental illness, their children and families. Third level institutions should develop a cohesive approach to ensuring FFP knowledge and skills become a part of undergraduate and post graduate curricula and are embedded in practice. Similarly, in-service education should be provided and this information needs to be infused within existing in-service education programmes, including those designed to facilitate RPNs to adopt a recovery orientated approach. This is important considering high scoring RPNs suggested that their awareness of the link between parenting and recovery enabled FFP. As limited opportunity to engage in in-service education impeded FFP, it is recommended that employers should also be provided with the necessary finance and resources to enable the provision of systematic in-service education. Such education should

incorporate principles of best practice and provide RPNs with the skills and knowledge beyond that provided through existing *Children First* training and family focused education programmes. The Mental Health Commission (MHC) could monitor and report the extent of child focused in-service education available. Furthermore, considering that inter-professional practice and teamwork predicted and enabled FFP, evidenced based, interdisciplinary education in FFP could be developed and made accessible to all mental health professionals at the under and postgraduate level.

In the longer term, Irish mental health services might consider systematic and standardised ways for the extent and type of in-service education provided nationally. The model of training available within the Finnish *Effective Family Programme* (Beardslee et al., 2012) might be emulated in Ireland. In particular, education programmes need to enable RPNs to work with children to inform them about PMI. Programmes also need to help RPNs to form partnerships with parents, particularly fathers, so that they can support children via their parents. Such programmes also need to enable RPNs to link parents and their families with a range of health and social services within the community. As this study found that RPNs drew upon their own unique life, work and parenting experience, these personal experiences might be acknowledged and incorporated into education programmes. The importance of clinical supervision has also been highlighted in this study and while the MHC could advise how to implement clinical supervision nationally, Practice Development Managers could facilitate its operationalisation locally.

As home visiting was regarded as a potential process for the implementation of FFP, training programmes and professional organisations might conceptualise and/or standardise how home visiting may be used by RPNs to engage in FFP. Given that high scoring RPNs

infused interventions such as CBT and SFT with family practices, training might also employ a family lens when using these methods. Discussion could occur as to how to enable RPNs to use best evidence, in relation to families where a parent has a mental illness, with joint appointments between universities and clinical services a possible way forward.

Practice. The recommendations outlined here are reliant on a change in work practices, service models and attitudes. Many of these recommendations are in line with those of other Irish researchers (Cusack & Killoury, 2012; Houlihan et al., 2013) and policy makers (DoHC, 2006) and researchers elsewhere (Falkov, 2012; K. Foster et al., 2012; Lauritzen et al., 2014b; Maybery & Reupert, 2009; Nilsson et al., 2014).

Key stakeholders (such as, the DoHC, RPNs and their employers and managers, the Nursing and Midwifery Board of Ireland and the MHC) need to take cognisance of the predictors, enablers and principles of RPNs' FFP, especially in acute admission units, when working towards adopting a whole family approach within Irish mental health services. Irish mental health services should be informed and guided by a holistic, family and recovery orientated philosophy. To foster and sustain this type of service delivery, it is essential that mental health services have the necessary resources in place including, education programmes, policy, standard guidelines and financial resources. This is important, particularly in acute settings, where a biomedical and professional centered approach typically prevails (Barrington et al., 2011). Clinical leadership is also central.

As flexibility of service delivery, and willingness to work within an expanded scope of practice, enabled community RPNs' FFP, a willingness to work within teams in a flexible way is required. This means that all professionals across disciplines need to assume various roles in supporting parents, who have mental illness their children and families. Relatedly,

educational programmes might need to incorporate how RPNs could work across professional and service boundaries. RPNs should continue to negotiate their scope of professional practice with other professionals in the MDT and CMHT. Organisational structures need to be established to facilitate flexible service delivery, particularly in acute in-patient settings. Discussion could also occur within and between the different disciplines as to what flexible service delivery means in practice.

As early identification of parenting status was key to enabling high scoring RPNs to incorporate service users' parenting role, all service users attending mental health services need to be questioned about their parenting status and number and ages of children at the outset. This information should then be documented in standard written initial assessments as happens elsewhere, including Norway and Finland. Furthermore, while RPNs need to be transparent about their role in child protection they also need to emphasize their role in collaboratively supporting parents to maintain children's well-being. In recognition of the emotional toll of working with parents, systems need to be established to allow RPNs to discuss the emotional aspects of their work and to develop the skills and knowledge to deal with challenging situations.

RPNs might need to provide parents and adult family members with literature to help them understand the potential impact of PMI on children and to support any assertions made. Currently it would appear that this does not happen to any great extent. Such literature needs to be created for the Irish context, similar to the Australian COPMI initiative (http://www.copmi.net.au/). Within this context, RPNs might also support parents to explain their mental illness to children; the Finnish *Let's Talk about Children* or *Childs Talk* in

Norway are two such models that might assist in this regard (Lauritzen et al., 2014b; Reedtz et al., 2012).

Services directly targeting parents and children, such as parent support groups (Reedtz et al., 2012; Solantaus et al., 2010) or children's peer support groups (Fraser & Pakenham, 2008; Goodyear et al., 2009; Richter, 2006) might also be delivered. Referral networks and pathways within and outside of services also need to be clearly defined, within strong service partnerships, considering RPNs may not be able to meet all the needs of parents, their children and families (Reedtz et al., 2012). As close physical proximity (being located in the same building) to other services, enabled collaboration in community settings, community mental health service headquarters could be situated within primary care centers. The inequity of CMHT services could be addressed so that parents receive optimal care wherever they live. The importance of holistic assessment is also underscored in this study.

Policy. In line with mental health services in other countries such as Finland, Norway and Australia, practice guidelines and policies should be developed and implemented in relation to parents who have mental illness, their children and families. For instance, policy might be incorporated that stipulated the identification of parenting status on admission, with accompanying steps to support service users' children. Such measures will enable systematic documentation of service users' parenting status nationally and subsequently used to obtain and direct funding and resources in this area. The translation of policy to practice also needs to be supported and promoted. This would mean that existing policies and guidelines be reviewed and amended, to ensure they make explicit reference to families where a parent has a mental illness, as managed through local clinical governance structures. Policies and guidelines could also be developed to enable children to remain in regular contact with their

parent when they are hospitalised. The impact of principles underpinning RPNs' FFP could also be debated to ensure they promote their capacity to provide optimal support for parents who have mental illness, their children and families. Time could also be provided to enable RPNs to work with service users' children as required.

Practices consistent with FFP also need to be reflected in the national practice standards and key performance indicators for RPNs, when they are developed. An inclusive consultation process, involving all stakeholders, including parents and young people, might be undertaken to investigate what a whole family approach should constitute in general adult mental health services and how it could be implemented and sustained. The MHC, HSE and professional organisations, including NMBI, should also endeavour to determine and secure the necessary resources, including capital funding, that are required to translate developments in policy in practice.

Limitations and Future Research

While the FFMHPQ had documented validity and reliability in the Australian and Norwegian context (Lauritzen, 2014; Maybery et al., 2012a), there was poor reliability of the majority of subscales in the Irish context (i.e. most of the subscales had reliabilities greater than .60, with 4 subscales greater than .70). This poor reliability may be largely explained by a lack of sensitivity of RPNs to FFP and their limited understanding of concepts being measured. Future researchers need to be cognisant that the reliability of a scale in one context may not necessarily transfer to another context and factor this into their study designs. Furthermore, while the first study identified 17 predictors of FFP these only explained between 23.1 percent and 38.5 percent of variance across the six FFP behavioural subscales

measured, suggesting that a considerable amount remains unexplained, offering fertile ground for future research. Moreover, as this study did not measure the differences in extent of FFP between the various mental health services further research could examine this. If disparities in FFP between mental health services are identified, this could be further investigated using a case study approach to examine and explore the particular organisational systems, structures and processes that enable and/or hinder FFP. As the second study did not identify low scoring RPNs' perceptions of their FFP, further research might interview RPNs in the various settings to specifically compare FFP in order to provide comprehensive understanding of RPNs' FFP.

Interview data collected here represents RPNs self-reported views of their FFP and this may not be a reflection of their actual practice (Lauritzen et al., 2014b). Observational research might be conducted to provide a different set of data regarding the extent and type of RPNs' FFP. This information could be augmented by the multiple perspectives of RPNs' FFP, including those of RPNs' managers and most importantly, parents who have mental illness, their children and families (including partners and grandparents) (Gladstone et al., 2011; Korhonen, Pietilä, et al., 2010; Krumm et al., 2013; Mordoch, 2010). Similarly, further research might be conducted with parents and children to determine if they perceive RPNs' interventions as beneficial and to establish desired outcomes of interventions.

A need for theory development around models of intervention for children is highlighted in this study, including a need to delineate child focused services, which the RPNs in the present study were not able to clearly articulate. Additionally, while it is recognised that all mental health professionals have a responsibility to engage in FFP, further research is required to explore whether particular practice settings should dictate the range of

family focused activities that occur, especially as in the current study, community RPNs were found to be best placed to engage in FFP. Further research is also required to increase understanding of other Irish mental health professionals' FFP (including psychiatrists, social workers and psychologists), and how RPNs may work in tandem with the various disciplines, within the MDT/CMHT to support parents who have mental illness, their children and families. Finally, considering that the majority of RPNs cared for one or more parents who have mental illness, on a regular basis, there is a need for prevalence studies in Ireland to establish a baseline of the numbers of parents using adult mental health services at one point in time and the number of children who have a parent with a mental health problem.

To conclude, in an effort to address the potential and actual effects of PMI on parents who have mental illness, their children and families it is recommended that general adult mental health services adopt a whole family approach. Whilst barriers to adopting a whole family approach have been identified, little is known about the factors that predict and enable RPNs' FFP, the nature and scope of RPNs' FFP and differences in extent of FFP between practice settings or countries. The various education, practice, policy and research recommendations, drawn from this study and others, can be used to develop RPNs' capacity to provide optimal support for parents who have mental illness, their children and families, in general adult mental health services in Ireland and elsewhere.

Appendix A: Parents and Children's Experiences, Needs and Perspectives of FFP

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Sands (1995)	USA	Comparison of the experiences of ten single, low-income mothers with mental illness with the experiences of eight single, low income mothers without psychiatric impairment.	Ten single, low-income mothers, with EMI and eight single, low income mothers without psychiatric impairment.	Qualitative	Interview	Qualitative	Mothers who have EMI have a strong desire to develop normal lives for themselves and their children. However when their experiences were compared with mothers without psychiatric impairment mentally ill mothers had greater difficulty disciplining their children and experienced greater stress from role strain. The mothers with EMI also tended to minimise their illness and the impact that their illness had on their children due to fear of custody loss and they did not directly acknowledge the need for guidance or help with parenting.
Zemencuk & Rogosch (1995)	USA	Explored parenting sensitivity and needs, parenting style and parenting function of mothers with EMI	48 women who were hospitalised	Quantitative – mothers were assisted to complete measures by psychology graduate students trained in the administration of the measures.	Children's Reports of Parental Behaviours Inventory (Raskin et al., 1971), Social Support Questionnaire (Bogat et al., 1983) Child Behaviour Checklist (Achenbach et al., 1983). Sensitivity to Children Questionnaire (Stollak et al., 1973).	Quantitative	Mothers have multiple risk factors for parenting difficulties. Most mothers were functioning adequately as parents. Mothers need considerable support to deal with stressors that may put them and their children at risk.
Caton, Cournos, Felix & Wyatt, (1998)	USA	Report on childhood experiences, current life situation, level of adjustment, and prior mental health service use of off spring of indigenous people with schizophrenia	39 adolescents & adults	Quantitative	Questionnaire	Descriptive statistics and thematic analysis of open-ended questions	Participants reported embarrassing, frightening and aggressive parental behaviours, parents' inability to support family, take medications and lack of initiative. Participants had never talked about PMI with a professional and lacked information re PMI. A significant number undertook caring roles.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Nicholson, Sweeny & Geller (1998a)	USA	Understand the parenting experiences of women with EMI from the perspectives of mothers and their case managers	15 mothers randomly recruited who were receiving community mental health services. 55 Case managers randomly recruited who worked for the Department of Mental Health	Qualitative	Focus groups	Transcripts were coded and items grouped by themes in qualitative analysis	Many of the issues of mothers with mental illness are generic to all parents; others are specific to the situation of living with mental illness (stigma, managing mental illness and parenting, custody issues). Mothers also found it hard to distinguish between the effects of stress and the effects of illness. Some mothers reported purposely missing their medication doses in order to stay alert and focused on their child. Mothers must play a role in developing standards for clinical care and the research agenda in the area.
Basset, Lampe & Lloyd (1999)	Australia	Gain insight into the experiences of mothers who have a mental illness and explore their perceptions of mental health services	Mothers with EMI. No details of sample size not provided	Qualitative exploratory descriptive	Focus groups and interviews	Verbatim transcription of audiotapes, thematic analysis	Themes to emerge included: fear of losing custody, trauma of hospitalisation, social isolation, care of the child if the mother becomes ill, accessing community services, stigma and discrimination, dissatisfaction with mental health services and relationships with their children.
Joseph, Shashank, Lewin & Abrams (1999)	USA	Estimate prevalence of mothers who have EMI and identify number who retain contact with children. Identify perceived needs.	Purposive sample of 52 women with EMI who were hospitalised	Cross sectional survey	Questionnaire	Descriptive analysis	Almost 50 percent of the women in the sample were mothers. Hospitalised women were not able to be involved in taking care of their children. Those mothers who had lost contact with their children required help to deal with their sadness about their children.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Mowbray, Schwartz, Bybee, Spang, Rueda – Riedle & Oyserman (2000)	USA	Explore demographic characteristics, stressors and resources of mothers with EMI	Non-random sample of 379 mothers receiving services from community mental health centres.	Quantitative	Interviews – trained interviewers administered a two-part interview 10 days apart. Structured measures included: The Moms Study Questionnaire, The Diagnostic Interview Schedule, Substance abuse questionnaire	Quant analysis	High level of poverty. Concomitant with poverty, respondents experienced adverse living situations (poor standard of housing, crime, and victimization). They also had poor physical/mental health and chronic stress. Whilst respondents experienced stressful lives they did have resources available to them. Mental health services must consider mothers' socioeconomic contexts when providing care.
Handley, Farrell, Josephs, Hanke & Hazelton (2001)	Tasmania	Identify children's needs, how children can be supported to cope, current level of support & report key recommendations in supporting children	116 parents 54 children 74 service providers	Mixed methods	Semi-structured Interviews and Questionnaires	Descriptive analysis of questionnaires using SPSS Thematic analysis of qualitative data	Difficulty in understanding PMI, Assuming of age inappropriate responsibilities, Impact of parents' hospitalisation, Unmet needs for support from parents' key workers in mental health services, Feelings of shame, guilt and self-blame, Parents reported children's difficulties understanding and talking about PMI, Service providers suggest children should be educated about PMI.
Dipple, Smith, Andrews & Evans (2002)	England	Explore the experience of motherhood of older mothers who had lost custody of one or more of their children on either a temporary or permanent basis	43 mothers with EMI who had been or who were still in contact with rehabilitation services.	Quantitative	Case notes, structured interviews & enquiries with key-workers on demographic information	Quantitative data analysis using SPSS	Many women in long-term psychiatric care have experienced multiple losses. 68 percent of mothers were permanently separated from at least one child and there was a paucity of information in the case notes regarding the respondent's role as mother.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Aldridge & Becker (2003)	UK	Explore experiences and needs of children, children's caring relationships & nature of professional intervention	40 Parents 40 Children 40 Service providers	Qualitative	2 phase in-depth semi-structured individual interviews	Not discussed	Children undertook a range of domestic and caring responsibilities for parents, Caring helped children feel involved and needed, Unmet needs for support from parents key workers, Professionals must recognise caring contributions, Children need age-appropriate and reliable health information.
Ackerson (2003)	USA	Explore how mothers cope with the dual demands of parenthood and their illness	Purposive sample of 12 mothers and 1 father who had EMI	Qualitative	Semi-structured interviews	Used grounded theory techniques of constant comparison and theoretical sampling in conjunction with narrative history.	Themes that emerged included: problems with diagnosis and treatment, stigma, chaotic interpersonal relationships, strain of single parenthood, custody issues, and relationships with children, social support, and pride in being a parent. Need for early intervention and treatment. Respondents must cope with a disorder that at times challenges their ability to effectively carryout the parenting role.
Stanley, Penhale, Riordan, Barbour & Holden (2003)	UK	Identify barriers to inter professional collaboration Explore parents perceptions of their needs and evaluation of service	Non random sample of 500 health and social care professionals 11 mothers who had EMI whose children had been subject to a child protection case conference	Mixed methods	Postal survey of health and social care professionals In-depth semi Interviews with 11 mothers	Quantitative analysis using SPSS Thematic analysis	More communication problems existed between child care workers and psychiatrists and child care workers and GP's than between other groups. Mothers valued support from professionals whom they felt were 'there for them' and whom they could trust. Child care social workers perceived that they could not fulfill this role. Researchers concluded that a dyad of workers should share the key worker role.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Diaz - Caneja & Johnson (2004)	UK	Explore participants' experiences, views about services and needs for support in parenting	Purposive sample of 22 women with EMI on the case loads of community mental health teams	Qualitative	Semi-structured interviews	Qualitative thematic analysis	Participants described motherhood as rewarding and central to their lives. Demands associated with parenting and at the same time coping with mental illness is considerable. Parenting responsibilities created practical impediments to engaging with mental health services. Services were perceived as offering little continuing support in relation to parenting, intervening only in crises.
Fudge & Mason (2004)	Australia	Explore children and young people's experiences and suggestions re family friendly mental health services	33 children aged between 7 – 12 and 25 young people aged between 13 - 25	Qualitative	Focus groups with children focus groups and peer interviews with young people	Thematic analysis	Communication problems with parents' key workers and between families, Additional care giving responsibilities.
Riebschleger (2004)	USA	Children's experiences and perceptions of psychiatric rehabilitation services	22 children aged between 5 - 17	Secondary analysis of data generated in study by Riebschleger et al., (1993)	9 children were interviewed and 11 children participated in focus groups	Thematic analysis	Children expressed concerns about multiple family stressors and bias associated with psychiatric disability.
Stallard, Norman, Dickens, Salter & Cribb (2004)	UK	Ascertain prevalence of parents with mental illness, Ascertain the impact of parental mental illness on children using child and parent completed assessments	24 adults 26 children	Mixed methods	Semi-structured interview and structured questionnaire	Not discussed	Children were concerned about their parents, had little understanding of their parents mental illness and wanted more information. Parents were unaware of the negative impact of the illness upon their children. Some wanted children to know more about PMI. Parents also perceived that there were barriers to identifying children's needs.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Maybery, Ling, Szakacs, Reupert (2005)	Australia	Examine and explore experiences and needs of children, quantify the impact of various strategies which might be helpful for children when their parent is hospitalised, replicate and extend findings from previous Australian research on children of parents with mental illness.	12 parents 12 children 62 mental health professionals	Mixed methods	Focus groups and questionnaires with children and parents Questionnaires with mental health professionals	Thematic analysis of qualitative data and descriptive analysis of quantitative data	Main themes from children pertained to: parents' hospitalisation, development of coping mechanisms and importance of sibling support and friendships. Main themes from parents: Children's coping strategies, caring role, need for children's education, availability of external support. Health care professionals and parents perceived that children should receive professional help to facilitate them to cope whereas children perceived that their friendships with peers would be more helpful.
Montgomery, Tompkins, Forchuk & French (2006)	Canada	Explore the experiences of mothers with EMI and how they attempt to manage their mothering circumstances.	Purposive sample of 20 women with EMI who were receiving treatment from mental health services	Qualitative	Unstructured Interviews and field notes	Glaser's grounded theory approach and purposive and theoretical sampling	Mothers made efforts to have meaningful relationships with their children and to do this they would hide their illness for the sake of protecting their parenting roles and their children.
Davies & Allen (2007)	UK	Explore the Influence of child – care responsibilities on access to services for mentally ill women	Purposive sample of 11 women under the care of the community mental health team	Qualitative	Individual, semi-structured interviews	Used grounded theory techniques of constant comparison and theoretical sampling	Mentally ill mothers who use mental health services face particular challenges in managing the contradictory aspects of their dual identity. Health professionals can use their disciplinary power in a positive way to help women in this task.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Somers (2007)	Ireland	To explore impact of parental schizophrenia on children's daily lives, Explore parents' perceptions of services	39 Parents & 37 children who were matched with a control group of children whose parents did not have mental illness	Mixed methods	Semi-structured interviews and questionnaires	Descriptive analysis using SPSS and open-ended questions collated by hand	Children whose parent had mental illness had more psychiatric disturbance, problems associated with school, less contact with relatives, spent more time at home and had little access to services. Parents wanted an educational programme and support for their children and a more co-ordinated approach between child and adult mental health services.
Mordoch & Hall (2008)	Canada	To explore children's perceptions of living with a parent with a mental illness and how they manage their experiences of living with a parent with a mental illness	22 children aged between 6 and 22 years of age whose parent had depression, schizophrenia or bipolar disorder	Mixed methods and Symbolic Interactionism	Semi-structured interviews, participant observation and drawing	Grounded theory, concurrent data collection and constant comparative analysis	Children reported that to maintain their relationship with their parent they needed to monitor and adjust to their parent's behavior. In order to sustain their connection with their parent they also needed to maintain their own boundaries.
Khalifeh, Murgatroyd, Freeman, Johnson & Killaspy, (2009)	UK	Explore the experiences, treatment preferences & needs of mothers of dependent children who were treated at home as an alternative to hospital admission. Explore needs and experiences of their children.	18 mothers with Enduring Mental Illness & five of their children	Qualitative	Semi-structured interview	Thematic analysis	Mothers perceived that home treatment provided good care and they preferred homecare to being in hospital. Most mothers felt that they struggled to parent adequately and to meet their children's needs. Most mothers were reluctant to seek help from professionals to cope with parenting issues due to fear of custody loss. Most children preferred their parent to be treated in hospital when acutely unwell as it relieved them of distress, responsibility and risk. The needs of children should be considered in the planning of home treatment.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Mordoch (2010)	Canada	To explore how children understand PMI and mental illness (MI) and what they want other children to know about this.	22 children aged from 6 – 16 living with a parent with depression, schizophrenia or bi polar disorder	Secondary analysis	Interviews	Secondary analysis of a grounded theory study – interviews were re-read, coded and analysed along with field notes and memos from the original study	Children had limited understanding of MI and had received little explanation from mental health professionals about PMI. Limited information caused children distress and older children worried that they too would develop MI. Mordoch concluded that children need help to understand and to manage. Mental health professionals could support children in collaboration with the education system.
O'Brien, Anand, Brady & Gillies (2011)	Sydney , Australia	Explore parents and adult family members' perspectives of children visiting parents in hospital	Participants were drawn from in-patients (and their families) admitted to acute mental health facilities There were a total of 5 parents, 3 adult family members and 5 children	qualitative, interpretive framework	Semi-structured interviews	Thematic analysis	Children visiting psychiatric in-patient facilities were not well managed, and families received little support about decisions around children visiting. There was no assistance with visiting, and decisions about visiting were not discussed by clinicians with parents. Children wanted to visit their parent in hospital and to remain involved with their parent, but that there was little support from staff. The children in this study were largely invisible to clinicians, with little or no acknowledgement of their presence and no attempt made to include the children in the health-care plan of their parent.

Authors & year	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Doucet, Letourneau & Robertson Blackmore, (2012)	Canada & USA	Explore the perceived needs and preferences of women with postpartum psychosis and their partners	Purposive sample of 9 mothers and 8 fathers	Exploratory qualitative descriptive design	One to one in-depth semi-structured interviews	Inductive thematic analysis	Couples who experienced post-partum psychosis wanted mental health professionals to provide reassurance and information on the illness and its management. Quality of support and interaction with staff varied. Couples had difficulty in obtaining professional support when discharged. All participants wanted to avail of group support. Despite feeling overwhelmed women's partners were reluctant to identify their own support needs and struggled to ask mental professionals for help.

Note: studies are arranged chronologically

Appendix B: Mental Health Professionals' Perspectives of FFP

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Byrne, Hearle, Platt, Jenner & Mc Grath (2000)	Australia	Explore perceptions of needs of parents with EMI, interventions required to meet their needs & barriers to effective service delivery	Non random sample of 77 service providers from a range of Government and non-Government agencies	Quantitative	Self-report survey	Quantitative analysis using SPSS	30 percent of sample perceived that parents with EMI cannot adequately care for their children. Most service providers perceived that genetic factors can harm children more so than environmental factors. Parent based support programmes were the most favoured method of helping parents. Whilst service providers perceived they acknowledged parents' difficulties the lack of interagency cooperation impeded FFP.
Bibou - Nakou (2003)	Greece	Perceptions of collaboration issues with children and parents and Issues that practitioners would find difficult or easy to address when working with parents and children	Non random sample of 18 practitioners working with different agencies (6 social workers, 3 psychologists, 2 psychiatrists, 3 community psychiatric nurses, 2 police officers, 2 teachers)	Exploratory, descriptive	3 semi-structured focus groups	Transcripts of audiotapes and discourse analysis	Service providers expressed anxiety about parenting issues and children's understanding of PMI. Service providers rarely asked parents about their experiences of parenting.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Gillam, Crofts, Fadden & Corbett (2003)	UK	Examine extent to which mental health system in West Midlands was responding to service users as parents, and working in partnership with other agencies who ensure children's well being	Service providers working in child and adolescent mental health services and adult mental health services across the West Midlands	Mixed methods – primarily qualitative in nature	Surveys Observation for 3 months	Not discussed	A high percentage of service providers are aware that their clients are also parents. Children of service users are not routinely assesses or offered any planned purposeful therapeutic intervention. Over a third of service providers in adult mental health services do not feel confident in working with children of service users. When there are concerns about a service users child, clinicians working in adult mental health were most likely to liaise with a child and family social worker.
Davies (2004)	UK	Explore the experiences of mothers who have EMI and the community psychiatric nurses who support mothers with EMI	13 CPNs working in two CMHTs & 5 women receiving services from the CMHT	Qualitative	Focus groups with CPNs Interviews with mothers	Thematic analysis and narrative analysis	CPNs were clear about the parameters of their role, whilst acknowledging practical limitations which prevented them considering mothers' parenting roles. Mothers highlighted ways in which hospitalisation and medication can obstruct the parenting process. Continuity of care, having a crisis plan and input from specialist services was identified as helpful features of support.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Thompson & Fudge (2005)	Australia	Gather broad based information about psychiatric nurses' beliefs and practices in relation to assisting adult clients to address parenting roles and family issues, Elicit level of knowledge and practices elated to mandatory notification	307 South Australian registered psychiatric nurses working in patient and community settings	Mixed methods	Questionnaire Focus groups Telephone interviews	Thematic analysis of qualitative data and quantitative analysis of data from questionnaire	Vast majority of nurses perceived that it was part of their role to discuss parenting with their clients and to speak with children of clients if requested. Over a quarter reported barriers to doing so including no systems in place to facilitate nurses to work with other agencies. More than a third of those who suspected child abuse made no formal notification in this regard.
Maybery & Reupert (2006)	Australia	Identify the core barriers that impede clinicians from considering their adult clients' parenting role. Rate the importance of these barriers for adult mental health and other workers	Convenience sample of 92 mental health and welfare workers	Mixed methods using two phases	Interviews - 60 participants Questionnaires - 32 participants	Not discussed	All workers reported that it was part of their role to get involved with issues regarding their patients children, Most important barrier was patients not identifying their illness as a problem for their children, In comparison to other workers, adult mental health workers reported time and resource limitation as well as skill and knowledge deficits.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Toikka & Solantus (2006)	Finland	Explore mental health professionals' perspectives of the impact of training in Beardslee's PFI on their practice and their experience in training colleagues to also use PFI.	Convenience sample of mental health professionals who had completed training within the Effective Family Programme. This included nurses (n = 18), social workers (n = 9), doctors (n = 6) and psychologists (n = 6).	Quantitative	Questionnaire	Descriptive statistics	Training enabled mental health professionals to increase their skills and knowledge re FFP. This enabled them to support parents and children. They also experienced greater job satisfaction as a consequence. Most respondents also reported that they had trained others to use PFI in their practice and that the majority of their colleagues were using PFI on a routine basis. A majority (73 percent) also felt that they had enough resources to use the new working methods in their practice and that their managers were mostly positive and constructive in helping them to practice in a family focused way.
Korhonen, Julkunen & Pietila (2008)	Finland	Identify factors that hinder nurses from implementing family focused nursing into adult psychiatric services	Non random sample of 223 registered psychiatric nurses and 88 practical mental health nurses	Quantitative study	Questionnaire	Quantitative analysis using SPSS	Family related factors, such as families' fear and lack of time, were considered as 'most hindering'. Nurses who used a family-centered approach and had further family education considered most of the factors as 'less hindering' in comparison to other nurses.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Slack & Webber (2008)	UK	Explore attitudes of mental health professionals regarding support needs of service users' children, highlight potential barriers to identifying or meeting children's support needs	Non random sample of 94 health care professionals working within statutory mental health teams in in-patient and community settings within one outer London borough	Cross sectional survey	Questionnaire	Quantitative analysis using SPSS	Practitioners were overwhelmingly in favour of supporting children. However, mental health professionals do not consider it their role to provide this support. Attitudes and practices were significantly associated with profession, setting and whether the respondent was a care co-coordinator.
Maybery & Reupert (2009)	Australia	Paper review the constraining barriers and issues for the psychiatric workforce that impede their capacity to address service user's parenting roles	None	Literature Review	None	None	Psychiatric workers experienced an array of barriers to addressing service users' parenting roles related to policy and management, interagency co-operation, worker attitude, skill and knowledge, parents and their family, including children. Potential solutions were presented and recommendations made, including organisational audits to identify the most pressing barriers that impede family sensitive practice.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Korhonen , Vehviläinen-Julkunen & Pietilä (2009)	Finland	Identify the extent to which registered and practical mental health nurses address service users' parenting roles.	Non random sample of 223 registered psychiatric nurses and 88 practical mental health nurses	Quantitative study	Questionnaire	Quantitative analysis using SPSS	The majority of respondents perceived that they did endeavor to address service users' parenting roles but the extent to which they did this depended on whether they were parents themselves and the extent of their professional experience and education. Those nurses who were parents and who had more experience and education were more likely to address service users' parenting roles.
Rutherford & Keeley (2009)	UK	Discussion paper to challenge existing practice in relation to mental health nurses' role in assessing parenting capacity within adult mental health services	None	Literature Review	None	None	Mental health nurses in the UK are involved in the assessment of parenting capacity of mothers with EMI. However, there is little provision for mental health nurses to undertake this role. There are significant tensions for mental health nurses undertaking parenting assessments and there is no specific training for this role.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Korhonen, Vehviläinen-Julkunen & Pietilä (2010a) Korhonen, Vehviläinen-Julkunen & Pietilä (2010b)	Finland	Describe the interaction that psychiatric nurses have with service users' children and predictors of this interaction (2010a) Describe the interaction that psychiatric nurses have with service users and predictors of this interaction (2010b)	222 registered mental health nurses & 88 practical mental health nurses	Cross sectional quantitative	Questionnaires	Descriptive and non-parametric statistical analysis	Although nurses had irregular contact with children when they did meet them the majority explained PMI. They also asked children how they were coping, reassured them and provided information about who to contact if they needed further help (2010a). Nurses also supported parents, asking them about their own and their children's needs and advised and supported them to develop their parenting capacity (2010a). The nurse's personal characteristics such as age, gender, marital status, professional experience and being a parent were significantly related to nurses addressing the needs of service users' children. Nurses' professional experience, further family education and use of FFP increased their interaction with service users' children.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Maddocks, Wright & Stickley (2010)	UK	Explore RPNs' lived experience of caring for adults with EMI who are parents.	Six RPNs practicing within two long-term residential wards	Phenomenological study	Semi-structured interviews	Thematic analysis	This study highlighted the role conflict experienced by RPNs who care for service users with EMI who are parents. Participants identified the importance of the therapeutic relationship with parents and the need to remain impartial towards children. The lack of guidance within Government policy documents, regarding nursing practice, related to this very specific client group meant that RPNs experienced uncertainty regarding which aspects of care they were responsible for. Feelings of powerlessness also resulted from lack of knowledge and inadequate communication with child-welfare services.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
O Brien, Brady, Anand & Gillies (2011)	Australia	The aim of this study was to identify and understand the perceptions of staff regarding children visiting parents in an acute in-patient mental health facility. To better inform service planning.	Nine staff participated (3 nurses, 2 psychiatrists/ registrars, 2 social workers, and 2 occupational therapists).	Qualitative exploratory research framework	Semi-structured interviews	Qualitative thematic analysis	Findings indicated that staff experienced being in a dilemma about children visiting and there were barriers to implementing family-friendly services. While staff mostly agreed in principle that children's visiting was beneficial, there was a lack of local policy and guidelines, and ad hoc arrangements existed. In addition, staff were unsure of their role with children, felt ill-equipped to talk to children about mental illness and lacked knowledge of age-appropriate resources. Models of in-patient care need to be developed with a family focus that acknowledges the parental roles of clients and supports children visiting

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Ostman & Afzelius, (2011)	Sweden	To explore perceptions of the role and benefit of children's representatives in in-patient units in mental health services in Lund/Sweden	22 children's representatives and 19 mental health professionals	Qualitative	Semi-structured interviews	Thematic analysis /naturalistic inquiry	Children's representatives expressed difficulty in functioning as advocates for children and service users due to poorly defined role descriptions and inconsistent managerial support. Whilst mental health professionals were aware which service users were parents they seldom met with children as they focused on parents' needs and relied upon children's representatives to work with children.
Lauritzen & Reedtz (2013)	Norway	To investigate if health care professionals' failure to identify service users' children was related to their attitudes and organisational barriers	219 health care professionals in the largest regional hospital in Northern Norway	Mixed methods - pre-test, post-test, one-year follow-up design	Open-ended questions in a survey	Framework analysis	Barriers to identifying children were caused by the organisation, workers, child/family and contextual factors. These factors need to be taken into account if health care professionals are to provide parents and their families with optimal support.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Houlihan, Sherek & Higgins (2013)	Ireland	To explore RPNs' education knowledge, confidence and practice with regard to supporting children whose parent has a mental health problem.	113 registered psychiatric nurses from one integrated mental health service in Ireland	Quantitative	Questionnaire	Independent samples t-tests, ANOVAs and Kruskal–Wallis tests. Textual data analysed using thematic analysis.	The sample reported relatively low levels of education, knowledge, confidence and supportive clinical practice when it came to children whose parent had a mental health problem. Just over half of the participants enquired about service users' parenting status and only 35 percent documented if service users were parents in nursing documentation. No significant differences were found between genders (male or female), location working (hospital or community) in terms of confidence, knowledge and skill. RPNs qualified for 10 years or less were statistically more likely to engage in clinical practices supporting children whose parent has a mental health problem.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Lauritzen Reedtz, Van Doesum, Martinussen, (2014a) Lauritzen Reedtz, Van Doesum, Martinussen, (2014b)	Norway	To evaluate if use of a *Family Focused Assessment Form* and *Child Talks* lead to a change in practice in identifying and addressing the needs of service users' children. To determine factors that may facilitate or hinder FFP.	129 mental health professionals at pre test and 185 at post test practicing in a hospital	Pre-test post-test study	Web based survey	Descriptive and inferential Statistical analysis using SPSS (version19)	Frequency of identification of service users' children had increased significantly since the introduction of legislation in 2010. However the extent of support provided to service users' children has not changed significantly. An array of barriers affected the translation of policy in practice. Only 44% of mental health professionals identified service users' children despite perceiving that it was important to support children and the introduction of legislation around mandatory reporting.
Liangas & Falkov (2014)	Australia	This file audit examined case managers recording of service users children's needs and safety, on relevant components of New South Wales Mental Health Structured Clinical Documentation.	Non random selection of 8 CMHTs and 280 files of service users who were parents of dependent children were audited across these 8 CMHTs	Case note audit - comparison of clinical documentation usage and quality before and after case managers received CBNSW training.	Phase one entailed selection of files and phase two entailed review of files	Screening of selected case note files	Parenting issues form an important load of work on community mental health teams, highlighting the need for systematic identification of parental status in mental health patients.

Note: studies are arranged chronologically

Appendix C: Family Focused Mental Health Practice Questionnaire

Registered Psychiatric Nurses' practice with parents who have mental illness, their children and families in general adult mental health services in Ireland

Anne Grant, School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland

The central aim of this survey is to determine your activities/skills, knowledge, training needs and interests in relation to your practice with service users who are parents and with service user's children and families. The term family focused practice is generally used within this research to describe the process of working with service users around issues related to parenting with a mental illness, which may affect their parenting capacity and/or their mental health. It also entails working with service users' children (those who are younger than 18 years of age) and their families.

The survey can be completed even if you have no current or previous experience of caring for service users who are/were parents; it is designed to rate your perspective about statements relating to your knowledge and skill about family issues; your interest in working with children, parents and families; your perception of organisational policy and supports for family focused practice and your level and type of family focused practice undertaken in your work.

What is involved? This survey will take between 20 and 25 minutes to complete. There are no right or wrong answers; we are simply interested in obtaining feedback on the work activities of RPNs and their organisations. We would like to empathise that your involvement is VOLUNTARY and to maintain your ANONYMITY please do not put any identifying information on the survey.

PART 1: Demographics

The purpose of this part of the survey is to establish background information about you and the position /role that you have within your organisation. Please answer all of the following questions.

1.1 What gender are you?
tick one box only

Female [ ]

Male [ ]

1.2 What age are you? _____ (years)

1.3 How long have you been practicing as an RPN?

(please indicate either weeks, months or years) _____(weeks)

_____(months)

_____ (years)

1.4 What professional/academic qualifications do you hold?
please tick all that apply

RPN	[ ]	Undergraduate Certificate	[ ]
CMHN/CPN	[ ]	BNS/BSc	[ ]
CNS	[ ]	MSc	[ ]
ANP	[ ]	HDip	[ ]
Undergraduate Diploma	[ ]	PhD	[ ]

Other (please specify) _____

1.5 Have you had any family-focused training?
tick one box only

YES [ ]

NO [ ]

If **yes** please detail type
and length of training _____

_____

1.6 Have you had any solely child-focused training?
tick one box only

YES [ ]

NO [ ]

If **yes** please detail type
and length of training _____

_____

1.7 Which Mental Health Service are you currently working in?

(please specify) _____

1.8 In which mental health setting are you currently employed?
tick one box only

Acute Admission Unit	[ ]	Community Mental Health Nursing Services	[ ]
Day Hospital	[ ]	Homecare Services/Assertive Outreach	[ ]

Other (please specify) _____

1.9 How long have you been working in your current position?

(please indicate either weeks, months or years) _____ (weeks)

_____ (months)

_____ (years)

1.10 Where is your service located?
tick one box only

Rural Location [ ]

Urban Location [ ]

1.11 On what basis are you currently employed?
tick one box only

Full-time [ ]

Part-time [ ]

Other (indicate hours per week) _____ hrs/wk

1.12 What is the average length of stay of service users in your service?

Please indicate the number of days for the average user _____ (days)

1.13 Which grade are you currently employed at?
tick one box only

Staff Nurse	[ ]	CNM 2	[ ]
CMHN/CPN	[ ]	CNS	[ ]
CNM 1	[ ]		

Other (please specify) _____

1.14 What schedule are you currently working on?
tick one box only

Day duty [ ]

Night duty [ ]

Other (please specify) _____

1.15 Are you directly involved in delivering care to service users?
tick one box only

YES [ ]

NO [ ]

If **yes,** please specify number of service users you are responsible for _____(number)

1.16 Do you spend a percentage of your time each week delivering care within the service users' home environment?
tick one box only

YES [ ]

NO [ ]

If **yes**, please specify percentage of time spent in the home environment_____(per week)

PART 2: Family Focused Mental Health Practice Questionnaire

The following scale is designed to rate the extent to which you agree or disagree with statements regarding family focused practice. Please refer to your experience in your current position and provide a response for every item regardless of whether you have current, previous or no experience of caring for service users who are parents. If you have no experience of caring for service users who are/were parents, please tick the not applicable (N/A) option for those items that ask you to comment on your actual activities with parents, their children and families.

In responding to the questions below, please use the following scale which ranges from (1) strongly disagree to (7) strongly agree and includes a (N/A) not applicable category. For each question, please circle the answer (number) that best corresponds with your experience.

Not applicable	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neither agree or disagree**	**Slightly Agree**	**Agree**	**Strongly agree**
N/A	**1**	**2**	**3**	**4**	**5**	**6**	**7**

1	My workplace provides supervision and/or mentoring to support RPNs undertaking child-related work in regard to service users who are parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2	In my area we lack services (e.g. other agencies) to refer children to in relation to their parent's mental illness (i.e. programs for children)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3	There is no time to work with service users' children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4	Government policy regarding family focused practice is very clear	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5	Professional development regarding family focused practice is not encouraged at my work place	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6	I often receive support from co-workers in regard to family focused practice	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7	I regularly have family meetings (not therapy) with service users and their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8	I am not confident working with service users about their parenting skills	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9	I don't provide information to the carer and/or family about the service user's medication and/or treatment	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
10	Many service users do not consider their illness to be a problem for their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
11	I am able to determine the developmental progress of service users' children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
12	I sometimes wish that I was better able to help service users discuss the impact of their mental illness on their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	**1**	**2**	**3**	**4**	**5**	**6**	**7**

13	I am knowledgeable about how parental mental illness impacts on children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
14	There are no parent-related programs (e.g. parenting skills) to refer services users to	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
15	I am able to determine the level of importance that service users place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
16	I do not refer service users' children to child focused (e.g. peer support) programs (other than child and adolescent mental health)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17	Working with other health professionals enhances my family-focused practice	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
18	My workplace does not provide supervision and/or mentoring to support RPNs undertaking family focused practices	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
19	Due to location it is difficult to coordinate families and children with the required services	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
20	The workload is too high to do family focused work	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
21	At my workplace, policies and procedures for working with service users on family issues are very clear	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
22	My workplace provides little support for further training in family focused practices	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
23	In my workplace other workers encourage family focused practice	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
24	I provide written material (e.g. education, information) about parenting to service users who are parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
25	I am not confident working with families of service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
26	Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the service users' mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
27	Discussing issues for the service user with others (including family) would breach their confidentiality	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
28	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
29	I should learn more about how to assist service users about their parenting and parenting skills	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
30	I do not have the skills to work with service users about how parental mental illness impacts on children and families	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
31	There are no family therapy or family counselling services to refer service users and their children to	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	1	2	3	4	5	6	7

32	I am able to determine the level of importance that service users place on their children maintaining strong relationships with other family members (e.g. other parent, siblings)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
33	I refer service users to parent-related programs (e.g. parenting skills)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
34	Children and families ultimately benefit if health professionals work together to solve the family's problems	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
35	There is time to have regular contact with other agencies regarding families or children or service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
36	I regularly provide information (including written materials) about mental health issues to service users' children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
37	Rarely do I consider if referral to peer support program (or similar) is required by my service users' children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
38	The children often do not want to engage with me about the service user's mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
39	I would like to undertake future training to increase my skills and knowledge for working with the children of service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
40	I am not experienced in working with child issues associated with parental mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
41	I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
42	Team-working skills are essential for all health professionals providing family-focused care	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
43	I often consider if referral to parent support program (or similar) is required by service users who are parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
44	I would like to undertake training in future to increase my skills and knowledge about helping service users with their parenting	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
45	I am skilled in working with service users in relation to maintaining the well-being and resilience of their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
46	I want to have a greater understanding of my profession in a healthcare team approach to working with children and families	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
47	I provide education sessions for adult family members (e.g. about the illness, treatment)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
48	I am not confident working with children of service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
49	I am knowledgeable about the key things that service users could do to maintain the well-being (and resilience) of their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
50	I am able to identify how parenthood can precipitate and influence the service user's mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	1	2	3	4	5	6	7

51	I assess the impact of the service user's parenting role on their mental health	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
52	I suggest practical strategies to facilitate service users to manage the dual demands of their parenting role and their mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
53	It is within my remit to address the needs of service users' children directly and/or indirectly	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
54	I should facilitate service users to cope with stress related to their parenting role	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
55	RPNs should facilitate service users to realise their potential as parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
56	Other members of the multidisciplinary team (i.e. social worker) are better placed, than RPNs, to address issues related to service user's parenting roles	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
57	There is no time to work with service users' children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
58	I discuss the impact of family functioning, on children's well-being, with the service user's adult family members/carers	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
59	I would classify my interaction with service users' children as planned, purposeful involvement with therapeutic intervention	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
60	Service users generally do not want to engage with me about the impact of their mental illness on their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
61	Discussing issues for the children would compromise my rapport with service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
62	Insufficient numbers of allied health professionals (i.e. social worker, clinical psychologist) in my service reduces RPN's capacity to address service user's parenting roles	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

There is some evidence to suggest that RPNs who are, or have been, parents of dependent children may feel more comfortable and/or able to address service users' parenting roles. The following questions focus on how comfortable you are regarding parenting and children generally. If you do not have children please indicate N/A to questions 63 & 64

63	In general I am very happy with my parenting.	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
64	I have confidence in my parenting skills	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
65	I feel comfortable around other peoples' children (e.g. friends, family)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

PART 3: Experience with service users who are parents

The purpose of this part of the survey is to establish the extent of your exposure to service users who are parents and your experience in caring for parents who have mental illness their children and families. The term 'dependent children' is used to describe children under the age of 18. Please answer all of the following questions irrespective of whether you have experience of caring for service users who are parents.

3.1 Are you a parent?

tick one box only

Yes [ ]

No [ ]

3. 2 Currently are any of your service users parents of dependent children? (tick one box only)

YES [ ] (please specify number) ____

NO [ ]

Not Sure [ ]

3.3 Have you previous experience, within your current position, of caring for one or more service users who are/were parents?

tick one box only

YES [ ]

NO [ ]

Not Sure [ ]

3.4 Have you experience in previous positions of providing care for service users who were parents?

tick one box only

YES [ ]

NO [ ]

Not Sure [ ]

3.5 In your current position how regularly do you care for service users who are parents of dependent children?
tick one box only

Daily	[ ]	Few times a Year	[ ]
Weekly	[ ]	Never	[ ]
Monthly	[ ]		

3.6 How long is it since you last provided care to service users who are parents of dependent children?
tick one box only

In the last week	[ ]	6 – 12 months	[ ]
Less than a month	[ ]	More than 1 year	[ ]
1 – 3 months	[ ]	Never	[ ]
3 – 6 months	[ ]		

3.7 Did you have face-to-face contact with a service user who has a dependent child(ren) in the last week?
tick one box only

Yes [ ]

No [ ]

If **yes**, please indicate the number of face-to-face contacts, in the last week _____

3.8 During the last week did you talk about issues related to parenting with service users?

Yes [ ] (**Go to 3.9**)

No [ ] (**Go to 3.11**)

3.9 How many service users did you discuss parenting with during the last week?

Please indicate the number of service users _____

3.10 What was the focus of your interaction(s)?

_____

_____

_____

(**Go to 3.12).**

3.11 What factors and/or circumstances(s) deterred you from discussing parenting?

_____

_____

_____

_____

3.12 In your current position how often do you have face-to-face contact with a service user's child(ren)?
tick one box only

Daily	[ ]	Few times a Year	[ ]
Weekly	[ ]	Never	[ ]
Monthly	[ ]	Other _____	

3.13 Did you have face-to-face contact with a service users' child(ren) in the last week?
tick one box only

Yes [ ]

No [ ]

If **yes**, please indicate the number of face-to-face contacts, in the last week _____

3.14 If you have current, or recent, experience (within the last 12 months) of caring for one or more mothers, who are/were mentally ill, would you like to take part in a semi-structured interview in order to discuss your experiences further?
tick one box only

Yes [ ] (please complete the enclosed slip and forward with your questionnaire)

No [ ]

Have you any additional comments that you would like to make?

Thank you for completing this questionnaire. Your contribution in this research is greatly appreciated! Please return your completed questionnaire in the envelope provided to:

Ms. Anne Grant
School of Nursing, Midwifery, & Health Systems
Health Science Complex
University College Dublin
Belfield
Dublin 4
Ireland

Telephone: 01 716 6424 (work)
086 126 7037 (mobile)

Email: anne.grant@ucd.ie

The artwork on the front cover of this questionnaire was provided by the participants of the Vic Champs programme (support group for children whose parents have a mental illness) in Australia.

Appendix D: Interview Topic Guide

Registered psychiatric nurses' practice with parents who have mental illness their children and families, within general adult mental health services in Ireland

Preamble

Thank you for agreeing to participate in this interview.

I would like to digital audio record this interview – please let me know if this is a problem for you. (If participant/s agree with digital audio recording and consent forms have been received, then switch the digital audio recorder on).

Good morning, my name is Anne Grant and I am a psychiatric nurse and lecturer in the school of Nursing, Midwifery and Health Systems in University College Dublin.

Thank you for agreeing to participate in this study, I appreciate your time in this.

The aim of the study is to explore your views on your practice with parents who have mental illness, their children and families.

I need to let you know that your participation in this research is entirely your choice and even though you are participating you can withdraw from the project at any time without giving a reason, and it's also entirely up to you whether you want to answer all of my questions. So if there is a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

Finally, all the data that I collect from you will be treated in a confidential manner, so I'll be removing all information that identifies you from the transcript, and you can check that yourself because you'll be receiving a copy of the transcript before I do any analysis on it. So you can make any changes to it.

It is important that you know that there will be no disadvantage or penalties if you chose not to be involved in the study.

Do you have any questions or concerns about any of this?

I first need to know:

Your position? Title?

And a brief description of your duties? How long have you performed that role?

Family Focused Practices:

- Do you ascertain if your service user is a parent? Why or why not?
- What do you do, if anything, when you know a service user is a parent? Can you tell me more about that?
- How, if at all, do you decide to become involved with the children of parents who have mental illness? Can you tell me more about that and what your involvement entails?
- How, if at all, do you decide to become involved with the other family members of parents who have mental illness? Can you tell me more about that and what your involvement entails?
- How do you think a parent's MI impacts on their parenting? How do you think being a parent impacts on a parent's MI? What is your role, if any, in supporting parents in these potentially negative interactions?

Capacity of RPNs to engage in family focused practice:

- Do you think that the care you provide meets the needs of parents who have mental illness? The needs of their children? The needs of their families? Can you tell me more about this?
- Are there needs of parents that are not being met that should be? And how could these needs be met?
- What factors facilitate and/or hinder you in meeting the needs of parents who have mental illness? The needs of their children? The needs of their families? Can you tell me more about this?
    - Essential skills and knowledge required to engage in FFP?
    - Confidence in addressing service user's parenting role?
    - Impact of service setting on engaging in FFP?
    - Impact of being a women/man and engaging in FFP?

How may RPNs' capacity to support parents who have mental illness, their children and families, be further developed?

- What might help you in working with parents who have mental illness? Their child(ren)? Other family members?
- On the basis of your experience, describe what competencies and behaviours are essential to enable RPNs to effectively support parents, who have mental illness, their children and their families?

- What other information, knowledge or skills do you need to work out how to recognise and respond to the needs of parents, who have mental illness, their children and families?
- How, if at all, may mental health service provision for parents who have mental illness, their children and families be further developed? Specific examples?

Closing questions

- Are there any topics which I did not address which you would have liked, or expected, me to have asked/discussed?
- Is there anything you would like to clarify for me?

Thank you for your time, I really appreciate your effort and energy. I will be in touch to give you the interview transcript. What is the best way to get this back to you? If you think the information is incorrect or might identify you, I would encourage you to change or delete this and ensure I get it back.

Appendix E: Conference Presentation (poster)

REGISTERED PSYCHIATRIC NURSES' PRACTICE WITH SERVICE USERS WHO ARE PARENTS

Anne Grant, School of Nursing, Midwifery and Health Systems, University College Dublin
In collaboration with
Associate Professor Darryl Maybery and Dr Andrea Reupert, Monash University, Australia

Artwork provided by the Participants of the Vic Champs program in Australia

Background

20 – 50% of mental health service users may be parents (Howe *et al.*, 2009).

Discussion of the complex interactions between mentally ill parents and their children/families is entering mainstream clinical practice (Gopfert *et al.*, 2004).

In *A Vision for Change*, the Government of Ireland (2006), recommended that mental health services should support service users to realize their full potential as parents and address the needs of service users' children.

Mentally ill parents commonly describe parenthood as a rewarding experience (Gopfert *et al.*, 2004).

However, a parent's mental illness may adversely affect their parenting capacity and stress from the parenting role can jeopardise their mental health. Difficulties in parenting tend to occur at times of relapse and during the acute phase of the parent's mental illness and can adversely affect both the parent and their children/families' well being on a temporary and on an ongoing basis (Maybery and Reupert 2009a, Gopfert *et al.*, 2004)

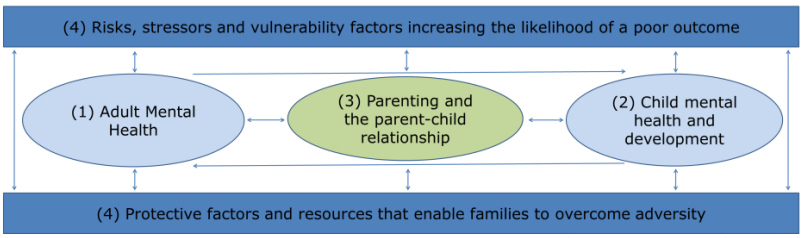
The ability of mental health professionals, including RPNs, to respond to children and family issues, when the service user is a parent, is an important point of intervention for such families (Maybery and Reupert 2008).

Research demonstrates the benefits of family focused practice to the service user, as well as his or her children and other family members (Maybery and Reupert 2009b).

However there is limited knowledge about RPN's practice with mentally ill parents and their children/families.

Within the family system it can be seen that

Parental mental illness affects children (1-2)	Parental mental illness can affect parenting and the parent-child relationship (1-3)	Parenthood can precipitate and influence parental mental illness (3-1)	Children's mental health and development needs impact on parental mental health (2-1)



The Crossing Bridges Family Model(Falkov 1998)

Aims

- This study aims to:
  - Establish RPN's capacity to engage in family focused practice.
  - Identify factors that facilitate and hinder RPN's family focused practice.
  - Establish if RPN's practice is consistent with national and international governmental policy objectives and international practice.
  - Determine how RPN's capacity to engage in family focused practice may be further developed.
  - Develop recommendations addressing the future development of RPN's practice with mentally ill parents and their children/families within the context of education, policy, practice and research.

Participants and methods

- In the first phase, approximately 300 RPNs practicing in acute admission units and 300 RPNs practicing within adult community mental health services (in day hospitals, day centres, community mental health nursing services and homecare/assertive outreach services), will be invited to complete a questionnaire on a national basis.
- In the second phase, a subsample of RPNs from the quantitative sample, (n = 20), who have experience of caring for mothers who have Enduring Mental Illness, will be invited to expand upon the findings of the questionnaire.

Outcomes

- The study will develop understanding of RPN's practice with service users who are parents; the findings may be used as a starting point for future research in both the national and international context; with an ultimate aim of developing RPN's capacity to meet the needs of mentally ill parents and their children/families. With appropriate supports to enhance their resilience, mentally ill parents can be caring and effective parents. Effectively identifying, supporting and intervening with mentally ill parents and their children/families is also a crucial way that the intergenerational transmission of mental illness can be prevented.

Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC).
If you would like further information about this study, you may contact Anne at (01) 7166424, email: anne.grant@ucd.ie
or http:\\www.parentalmentalillness.info

Appendix F: DoMHN Consent

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

4th November, 2011

To Whom It May Concern:

Re : Ms. Ann Grant R.P.N. UCD School of Nursing, Midwifery and Health Systems

I wish to confirm that I have given approval for Ms. Ann Grant to conduct interviews and distribute questionnaires to Registered Psychiatric Nurses in the Acute Admission Unit, Department of Psychiatry and the Community Mental Health Service settings within Laois / Offaly Mental Health Service in order that she can carry out her research on family focused practice.

Signed : [redacted]

P.J. Lawlor
Director of Nursing

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DONEGAL MENTAL HEALTH SERVICE
CENTRAL SECTOR CMHT
Level 1, Scally Place,
Justice Walsh Rd.
Letterkenny, Co Donegal.
Phone 0749197150 / 185
Fax 0749197192

25/10/11

To whom it concerns,

Re: **Registered Psychiatric Nurses' practice with mentally ill parents and their children/families within general adult mental health services in Ireland**

I would take this opportunity to confirm that Ms Anne Grant has sought and been granted permission to distribute the questionnaires relating to the above study to the appropriate community nursing staff within the Donegal Mental Health Service. Any follow up interviews may also be undertaken with the permission of the staff member as outlined in the study brief.

I am confident that this study will support and contribute to the continued development of the role and practice of Mental Health Nurses in Ireland. It will also afford the opportunity for international comparisons as the survey being used by Anne has been used in Canada and Australia and I offer my full support to this body of work.

Yours sincerely

John McCardle
Assistant Director of Nursing
Donegal Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE South,
A.C.C.E.P.T.,
Addiction Centre Co-ordinating
Education Prevention & Treatment,
Brook House,
Cork Road,
Waterford,
Ireland.

Telephone: 353 51 842790
Fax: 353 51 842348

JM/yl

22nd September 2011.

To Whom It May Concern:

A Chara,

I the undersigned outline that access was granted to Anne Grant to survey RPN's at Waterford Mental Health Services.

This access was granted via the Director of Services.

Yours sincerely,

[redacted]

John Murray,
C.N.S. Community Mental Health.

Feidhmeannas Seirbhíse Sláinte
Health Service Executive

Office of Director of Nursing,
St Loman's Hospital,
Mental Health Services,
Ballyowen,
Palmerstown,
Dublin 20.

Phone: 6207312
Fax no: 6207423

25th January 2012.

Ms. Anne Grant,
The School of Nursing, Midwifery & Health Sciences,
Health Science Complex,
University College Dublin,
Belfield,
Dublin 4.

RE: Site approval to undertake research regarding RPN family focused practice.

Dear Anne,

I wish to confirm that the Service Management Team in the Dublin West/South West Mental Health Services has agreed that you can access the Mental Health Services to undertake your study. This approval is based on your ethical approval granted from Ethics Committee in AMNCH, Tallaght, Dublin 24.

I would like to wish you every success with your research study and if I can be of any further assistance please do not hesitate to contact me.

Yours sincerely,

[redacted]

Colum Bracken,
Director of Nursing, Mental Health Service.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Donegal Mental Health Services
Nursing Administration
St.Conal's Hospital
Letterkenny
Co. Donegal
Tel: (074) 9123704
Fax: (074) 9123667

25/10/11

To whom it concerns,

Re: Research into Registered Psychiatric Nurses' practice with mentally ill parents and their children/families within general adult mental health services in Ireland

I would take this opportunity to confirm that Ms Anne Grant has sought and been granted permission to distribute the questionnaires relating to the above study to the appropriate community nursing staff within the Donegal Mental Health Service. Any follow up interviews may also be undertaken with the permission of the staff member as outlined in the study brief.

I am confident that this study will support and contribute to the continued development of the role and practice of Mental Health Nurses in Ireland. It will also afford the opportunity for international comparisons as the survey being used by Anne has been used in Canada and Australia and I offer my full support to this body of work.

Yours sincerely

[redacted]

Kevin Mills
Director of Nursing
Donegal Mental Health Services

Baile Átha Cliath & Lár Laighin

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Laois/Offaly Mental Health Services
Community Mental Health Centre
Bury Quay
Tullamore
Co. Offaly
Tel: 057 9351019 Fax: 057 9351498

Ms Anne Grant
School of Nursing, Midwifery and Health Systems
University College Dublin
Belfield
Dublin 4

20th October 2011,

Re; Research RPN's practice with mentally ill parents and their children/family's in Ireland.

Dear Anne,

I am writing to you in order to confirm my approval for the staff of the Tullamore Sector Mental Health Services to participate in the above study. I have made arrangements for you to visit our HQ here in Bury Quay on the 26th of October to further discuss this study with staff.

Regards

Yours sincerely

[redacted]

Mr Mick O'Hehir
Asst Director of Nursing

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LONGFORD/WESTMEATH MENTAL HEALTH SERVICES
St Loman's Hospital
Mullingar
Co Westmeath

Telephone: (044) 9340191
Fax: (044) 9343022

ATH CLIATH LAR-LAIGHEAN
DUBLIN MID-LEINSTER

13TH September 2011

Ms. Anne Grant,
School of Nursing, Midwifery & Health Systems,
Health Science Complex,
University College Dublin,
Belfield,
Dublin 4,
Ireland.

Re: Access to Staff in St. Loman's Hospital, Mullingar, Co. Westmeath.

Dear Ms. Grant,

I wish to confirm that following your request to visit and meet with nursing staff in various areas of St. Loman's Hospital & Community Services to complete research relating to Family Focused Practice, permission was granted by the undersigned.

Yours sincerely,

[redacted]

Gerardine Kelly,
Assistant Director of Nursing.

Saint John of God *Hospitaller* Services
Provincial Administration

15th December 2011

Ms Anne Grant
Lecturer
School of Nursing, Midwifery & Health Systems,
Health Science Complex
UCD
Belfield
Dublin 4

Dear Anne,

Re Proposal: ID No. 478 ***"Registered Psychiatric Nurses' Practice with Mentally Ill Parents and their Children/Families in General Adult Mental Health Services in Ireland"***

Thank you for attending the meeting of the Provincial Ethics Committee on 13th December and presenting the above proposal.

The Provincial Ethics Committee is happy to approve your proposal which is for this study only, pending receipt of the following amendments:

- Clarification of the selection and contact process
- Completion and submission of Transfer of Data form (attached)
- Letter of Information and Consent Form to include the fact that the research is in partial fulfilment of your doctoral studies.
- Name and signature of Academic Supervisor

Please forward your amendments for the attention of Jackie Hall at the address above. Please note there is no need to return the entire application again. Only the amendments, clearly highlighted are required. Following receipt of these amendments the Provincial Ethics Committee will be in a position to formally approve this study. If you have any further queries please do not hesitate to contact Jackie Hall on 01 277 1500 Ext 1694.

Kind regards

[redacted]

Jane McEvoy
Chair
Provincial Ethics Committee

Stillorgan, County. Dublin. Ireland | **Tel:** 01 2771500 | **Fax:** 01 2831257 | **www.sjog.ie**
Reg Charity No: CHY3822

Saint John of God Hospital

27 February 2012

Ms Anne Grant
Lecturer
UCD School of Nursing & Medical Sciences
Belfield
Dublin 4

Dear Anne

Re: Access to registered psychiatric employed by St John of God Hospital

Further to our conversation, I wish to confirm that you have permission to speak with registered psychiatric nurses employed in our acute units, should they agree, regarding your thesis.

Kind regards

Yours sincerely

[redacted]

Lesley Vard
Director of Nursing

Stillorgan, County Dublin, Ireland. | **Tel.:** 01 2771400 | **Fax:** 01 2881034 | **www.sjoghosp.ie**
Directors: Michael Kearns, Michael John Neild (British), William Brennan-Whitmore, Patrick McCrory, Ronald Michael Morgan (British).
Reg. Company No.: 430743. **Reg. Charity No.:** CHY18282.
Saint John of God Hospital is a Company Limited by guarantee.

Hospitality • Compassion • Respect • Justice • Excellence

THIS NOTEPAPER MUST NOT BE USED FOR PRESCRIPTIONS OR INVOICING PURPOSES

THE ADELAIDE & MEATH HOSPITAL, DUBLIN
INCORPORATING
THE NATIONAL CHILDREN'S HOSPITAL

TALLAGHT, DUBLIN 24, IRELAND
TELEPHONE +353 1 4142000

SJH/AMNCH Research Ethics Committee Secretariat
Ursula Ryan Ph: 4142342 email: Ursula.Ryan@amnch.ie
Secretariat Fax 4142371

Ms. Anne Grant
School of Nursing, Midwifery & Health Systems
University College Dublin
Belfield
Dublin 4

October 25th 2011

Please quote this reference in any follow up to this letter: 2011/10/04 Chairman's Action

Re: Registered Psychiatric Nurse's Practice with Mentally Ill Parents and Their Children / Families Within General Adult Mental Health Services in Ireland.

Dear Anne,

Thank you for your recent submission of the above proposal to the SJH/AMNCH Research Ethics Committee.

The Chairman, having reviewed the proposal has given ethical approval on behalf of the Ethics Committee.

Yours sincerely,

[redacted]

Secretary
SJH/AMNCH Research Ethics Committee

335703001

Appendix G: Pre Notice letter

5th May 2011

Dear Colleague, I am writing to ask for your help with an important study being conducted by myself - Anne Grant, Registered Psychiatric Nurse (RPN) and lecturer in Nursing, at University College Dublin (UCD), in collaboration with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. In the next few days you will receive a request to participate in this study by completing a questionnaire, designed to obtain your perspectives of your practice with service users who are parents.

Increasing numbers of adult mental health service users are parents. Whilst a parent's mental illness may adversely affect their parenting capacity, stress from the parenting role can jeopardise their mental health. Difficulties in parenting tend to occur at times of relapse and during the acute phase of the parent's mental illness and can adversely affect both the parent, their children and families' well-being on a temporary and on an on-going basis. There is increasing evidence to suggest that RPNs represent a potentially valuable source of support for parents, who have mental illness their children and families. However there is only limited understanding of RPNs' practice in this context and the challenges they experience in caring for service users who are parents. This questionnaire is important; by completing it you will help to increase understanding of RPNs' practice with parents, who have mental illness their children and families and assist the psychiatric nursing profession and allied health professionals to comprehend the issues and challenges encountered by RPNs in this respect. This understanding can then be used to develop mental health service

provision for parents who have mental illness, their children and families in the Irish context; in line with developments in countries such as Australia, Canada, Norway and the United Kingdom.

Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC). The Director of Mental Health Nursing, in your area, has also endorsed this study and has agreed to facilitate you to participate, if you so wish. You can obtain additional information about this research study at http://www.parentalmentalillness.info or directly from me at the address and/or phone number above.

We would like to do everything that we can to make it easy and enjoyable for you to participate in the study. I am writing to you in advance because I am aware of the constraints on your time and because many people like to know ahead of time that they will be asked to fill out a questionnaire. This research can only be successful with the generous help of people like you. I hope that you are able and willing to take 20 - 25 minutes of your time to help us. Most of all, I hope that you enjoy the questionnaire and the opportunity to voice your thoughts and opinions about RPNs' practice with service users who are parents.

Yours Sincerely,

Anne Grant

Appendix H: UCD Human Research Ethics Committee Approval

21st April 2011

Ms Anne Grant

UCD School of Nursing, Midwifery and Health Systems

Health Science Centre

Belfield

Dublin 4

Re: LS-11-54-Grant-Maybery: *Registered Psychiatric Nurses' practice with parents, who have mental illness their children and families within adult mental health services in Ireland*

Dear Ms Grant

Thank you for your response to the Human Research Ethics Committee – Sciences (13/04/11). **The Decision of the Committee is to grant approval for this application which is subject to the conditions set out below.**

Please note, if not already done, that a signed hard copy of the HREC Application Form is required by the Research Ethics Office. Please ensure that the signed form includes all approved revisions – your approval status will be registered upon receipt of this document.

Please also note that approval is for the work and the time period specified in the above protocol and is subject to the following:

- If applicable - all permissions to access participants, whether internal (heads of Schools/Registrar) or external are obtained before recruitment of participants is commenced;
- Any amendments or requests to extend the original approved study will need to be approved by the Committee. Therefore you will need to submit by email the *Request to Amend/Extend Form* (HREC Doc 10);
- The Committee should also be notified of any unexpected adverse events that occur during the conduct of your research by submitting an *Unexpected Adverse Events Report* (HREC Doc 11);
- You are required to provide an *End of Study Report Form* (HREC Doc 12) to the Committee upon the completion of your study;
- This approval is granted on condition that you ensure that, in compliance with the Data Protection Acts 1988 and 2003, all data will be destroyed in accordance with your application and that you will confirm this in your *End of Study Report* (HREC Doc 12), or indicate when this will occur and how this will be communicated to the Human Research Ethics Committee;

…/.

- You may require copies of submitted documentation relating to this approved application and therefore we advise that you retain copies for your own records;
- It must be understood that any ethical approval granted is premised on the assumption that the research will be carried out within the limits of the law.
- Please note that approved submissions are subject to a random audit.

The Committee wishes you well with your research and look forward to receiving your report. All forms are available on the website www.ucd.ie/researchethics please ensure that you submit the latest version of the relevant form. If you have any queries regarding the above please contact the Office of Research Ethics.

Yours sincerely

_____

Professor William Watson

Chairman, Human Research Ethics Committee - Sciences

Appendix I: Monash Ethics Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date:	**7 February 2013**
Project Number:	**CF12/3957 - 2012001695**
Project Title:	**Registered psychiatric nurse's practice with mentally ill parents and their children/families**
Chief Investigator:	**Assoc Prof Darryl Maybery**
Approved:	**From: 7 February 2013 To: 7 February 2018**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research**.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. **Complaints:** The researchers are required to inform MUHREC promptly of any complaints made about the project, whether the complaint was made directly to a member of the research team or to the primary HREC.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, MUHREC

cc: Ms Anne Grant, Dr Andrea Reupert, Ms Melinda Goodyear

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted]
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix J: Cover Letter to DoMHN

UCD School of Nursing, Midwifery and Health Systems

UCD Health Sciences Centre,
University College Dublin,
Belfield, Dublin 4, Ireland
www.ucd.ie/nmhs

[redacted]

Scoil na hAltrachta, an Chnáimhseachais agus na gCóras Sláinte UCD

Ionad Eolaíocht Sláinte UCD
An Coláiste Ollscoile, Baile Átha Cliath,
Belfield, Baile Átha Cliath 4, Eire

[redacted]

1st May 2011

Dear (Director of Mental Health Nursing)

I wish to thank you for taking my recent telephone call. I found our conversation very helpful. This letter and other information is a follow-up from that call. As I stated in our telephone conversation I am a lecturer in the School of Nursing, Midwifery and Health Systems, University College Dublin, and I am undertaking a study to examine and explore Registered Psychiatric Nurses' (RPN) practice with parents who have mental illness, their children and families within general adult mental health services in Ireland. In undertaking this study I am collaborating with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC).

As part of my data collection method I wish to recruit RPNs practicing within acute admission units and within four areas in community mental health services (day hospital, day center, homecare and community mental health nursing services) throughout Ireland. I would like to obtain your permission to distribute a questionnaire and supporting documentation to RPNs practicing within your area. Hopefully upon reading the information in this envelope you will grant me such permission.

In order to invite RPNs to participate in this study, I would be grateful if you could distribute a pre notice letter and information sheet to those colleagues who are working in the grade of Staff Nurse, CMHN, Clinical Nurse Specialist and Clinical Nurse Manager 1 & 2 within your service. I enclose for your attention; a letter confirming that I have obtained full ethical approval from UCD, a letter of support from my primary supervisor, Associate Professor Darryl Mayberry, the pre notice letter, information leaflet, participant information sheet and questionnaire.

Could you please distribute the pre notice letter and information sheet a week in advance of my visit to your mental health service to distribute the questionnaire? I will distribute the questionnaire to all those RPNs who I meet during my visit to your mental health service and would appreciate it if you could distribute questionnaires to the remaining RPNs who I do not meet in the week following my visit. Participants will not have to place their name on the questionnaire, nor will they have to divulge confidential client/service user information. Included with the questionnaire will be an interview volunteer form asking RPNs if they would like to participate in a semi-

structured interview which would be arranged at a later date. Again, persons who participate in interviews will remain confidential, as will their employers. Participants are free to refuse to take part at any given time, without giving a reason. I may wish to use data gathered in questionnaires and interviews in further publications. Neither participants nor their employer will be identified in these.

There are no known risks to participants from taking part in this research. It is anticipated that the research will provide a baseline level of skill, knowledge and activity regarding RPNs' family focused practice with parents, who have mental illness, their children and families, on a national basis. This will be used as a starting point for future research in this area. Ultimately, it is hoped that this research will benefit the psychiatric nursing profession and mental health professionals in general to develop their capacity to engage in family focused practice and to support parents who mental illness, their children and families. If you have any queries regarding the study please do not hesitate to contact me at [redacted] Otherwise I may contact you in two weeks time. May I thank you for your time and in anticipation of your help.

Yours sincerely,

Anne Grant

Appendix K: Participant Information Sheet

UCD School of Nursing, Midwifery and Health Systems

UCD Health Sciences Centre,
University College Dublin,
Belfield, Dublin 4, Ireland
www.ucd.ie/nmhs

[redacted]

Scoil na hAltrachta, an Chnáimhseachais agus na gCóras Sláinte UCD

Ionad Eolaíocht Sláinte UCD
An Coláiste Ollscoile, Baile Átha Cliath,
Belfield, Baile Átha Cliath 4, Eire

[redacted]

5th May 2011

Participant Information Sheet

Dear (name of participant),

I am writing to invite you to take part in a research project which is being conducted by Ms Anne Grant, lecturer in Nursing at University College Dublin (UCD), in collaboration with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC).

Study Title: Registered Psychiatric Nurses' practice with parents who have mental illness, their children/families within adult mental health services in Ireland

Purpose of the study

Increasing numbers of service users of adult mental health service are parents. Parents with mental illness commonly describe parenthood as a rewarding experience and generally care for their children adequately. However, the demands of parenting while managing a mental illness can be challenging. Whilst a parents' mental illness may adversely affect their parenting capacity, stress from the parenting role can jeopardise their mental health.

In *A Vision for Change* the Department of Health and Children (2006) recommend that mental health services should support service users to realize their full potential as parents and address the needs of service users' children. However, there is only limited information about Registered Psychiatric Nurses' (RPN) practice with parents with mental illness and their children/families from an International perspective and an absence of information on this topic from the Irish perspective. It is envisaged that this research will develop understanding of RPNs' practice with parents with mental illness and their children/families. This knowledge can then be used to develop adult mental health service provision for parents with mental illness and their children/families.

Selection and participation

You have been invited to take part in this study along with other Registered Psychiatric Nurses (RPNs) practicing within acute admission units and community mental health services in Ireland.

If you agree to participate in this research, you will be asked to complete an anonymous postal survey which explores your practice; this should not take longer than twenty five minutes to complete. Additionally, if you have previous, (within the last twelve months), or current experience of providing services to one or more mothers with Enduring Mental Illness you may also volunteer to take part in a follow-up, semi-structured interview. The interview will last for no longer than one hour and will be held in a location which is convenient to you. If you choose to take part in an interview, with your permission, the interview will be audio recorded. You can ask for the tape recorder to be turned off at any time.

Your participation in this research is voluntary. Return of the completed questionnaire in the stamped addressed envelope provided will imply that you have consented to participate. If you would like to take part in an interview, after you have completed the questionnaire, you may send me your contact details on an interview volunteer slip which is included with, but separate to, the questionnaire. With regard to the questionnaire and or the interview you are free to refuse to take part at any time without giving a reason. You may refuse to answer any questions and may stop taking part in the study at any time without disadvantage. Please note that as the questionnaire is anonymous, once data collection has been completed and submitted, participants will not be able to withdraw from the study.

Possible risks and benefits of participating

There are no known risks to you from taking part in this research, and no foreseeable direct benefits to you. However it is anticipated that the information that you supply will help to develop knowledge about RPN's practice with parents with mental illness, their children and their families, on a national basis. This will be used as a starting point for future research on this topic within the Irish context. Ultimately, it is hoped that this research will benefit the psychiatric nursing profession and mental health professionals in general to develop their capacity to support and work with parents with mental illness and their children/families. The main findings of this research will be communicated to Directors of Mental Health Nursing who will provide you with feedback. Alternatively you may contact the primary researcher directly.

Confidentiality

The research knowledge might lead to publications in a theses, journals, books and/or evaluation reports for the future benefit of others. It may also be used for comparison purposes with other countries such as Australia and Canada. To maintain your anonymity please do not put any identifying information on the questionnaire. Individual responses to either questionnaires or interviews will not at any time be identified or published. All information from questionnaires and interviews will be filed under a number and not your name. Your information will also be combined with information provided by other RPNs

throughout Ireland and findings will be reported in a collective way as opposed to identifying one particular service or location. Note that the anonymous information you provide in the questionnaire and or the interview will be stored for five years on a password protected computer in the principal researcher's office at UCD. After this time it will be shredded. Audiotapes will be destroyed once they have been verified for accuracy of transcription.

Contact for further information

Ms Anne Grant is a Registered Psychiatric Nurse and lecturer at University College Dublin. You may contact her at:

School of Nursing, Midwifery and Health Systems
Health Sciences Building
Belfield
Dublin 4
[redacted]

Thank you for reading this information. We are aware of the constraints on your time and appreciate the effort required to participate. Please take time to consider whether you want to take part in this research. It would be a privilege to have you participate and hopefully your involvement will help to develop mental health service provision for parents with mental illness, their children and their families.

Yours sincerely,

Ms Anne Grant

Appendix L: Initial FFMHPQ Subscale Reliability

Table L1

Initial FFMHPQ subscale reliability

Subscale	Subscale Definition	Item no in FFMHPQ	Item
Workplace Support	*The workplace provides support (e.g. supervision) for family focused practice.*	1	My workplace provides supervision and/or mentoring to support RPNs undertaking child-related work in regard to service users who are parents
A			
.469		18	My workplace does not provide supervision and/or mentoring to support RPNs undertaking family focused practices
Location issues	*Transport and services to refer family members to are not a problem in this area*	2	In my area we lack services (e.g. other agencies) to refer children to in relation to their parent's mental illness (i.e. programs for children)
B			
.357		19	Due to location it is difficult to coordinate families and children with the required services.
Time and workload	*Time or workload issues regarding family focused practice*	3	There is no time to work with service users children
C		20	The workload is too high to do family focused work
.503		35	There is time to have regular contact with other agencies regarding families or children or service users
Policy and procedures	*Family focused policy and practices are clear at the*	4	Government policy regarding family focused practice is very clear

Subscale	Subscale Definition	Item no in FFMHPQ	Item
D .258	*workplace*	21	At my workplace, policies and procedures for working with service users on family issues are very clear
Professional development E .434	*There are opportunities for professional development regarding working with families*	5	Professional development regarding family focused practice is not encouraged at my work place
		22	My workplace provides little support for further training in family focused practices
Coworker Support F .483	*The support from other workers regarding family focused work*	6	I often receive support from co-workers in regard to family focused practice
		23	In my workplace other workers encourage family focused practice
Family and parenting support G .555	*Providing resources and referral information to consumers and their families*	7	I regularly have family meetings (not therapy) with service users and their family
		24	I provide written material (e.g. education, information) about parenting to service users who are parents
		36	I regularly provide information (including written materials) about mental health issues to the service user's children
		43	I often consider if referral to parent support program (or similar) is required by service users who are parents
		47	I provide education sessions for adult family members (e.g. about the illness,

Subscale	Subscale Definition	Item no in FFMHPQ	Item
			treatment)
Worker confidence H .610	*The level of confidence the worker has in working with families, parents and children*	8 25 48	I am not confident working with service users about their parenting skills I am not confident working with families of service users I am not confident working with children of service users
Support to carers and children I .504	*The level of information, advocacy and referral provided to carers and children.*	9 26 37 57 58 59	I don't provide information to the carer and/or family about the service user's medication and/or treatment Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the service user's mental illnesses Rarely do I consider if referral to peer support program (or similar) is required by my service user's children There is no time to work with service user's children I discuss the impact of family functioning, on children's well-being, with the service user's adult family members/carers I would classify my interaction with service user's children as planned, purposeful involvement with therapeutic intervention
Engagement issues J .496	*The opportunity for engagement with family members*	10 27	Many service users do not consider their illness to be a problem for their children Discussing issues for the service user with others (including family) would breach their confidentiality

Subscale	Subscale Definition	Item no in FFMHPQ	Item
		38	The children often do not want to engage with me about the service user's mental illness
		60	Service users generally do not want to engage with me about the impact of their mental illness on their children
		61	Discussing issues for the children would compromise my rapport with service users
Assessing the impact on the child K .568	*How well the worker assess the impact of the parent illness on the children*	11	I am able to determine the developmental progress of service user's children
		28	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse
Training L .738	*Worker willing to undertake further training*	12	I sometimes wish that I was better able to help service users discuss the impact of their mental illness on their children
		29	I should learn more about how to assist service users about their parenting and parenting skills
		39	I would like to undertake future training to increase my skills and knowledge for working with the children of service users
		44	I would like to undertake training in future to increase my skills and knowledge about helping service users with their parenting
Skill and Knowledge	*Worker skill and knowledge regarding impact of parental*	13	I am knowledgeable about how parental mental illness impacts on children

Subscale	Subscale Definition	Item no in FFMHPQ	Item
M .761	*mental illness on children*	30	I do not have the skills to work with service users about how parental mental illness impacts on children
		40	I am not experienced in working with child issues associated with parental mental illness
		45	I am skilled in working with service users in relation to maintaining the well-being and resilience of their children
		49	I am knowledgeable about the key things that service users could do to maintain the well-being (and resilience) of their children
Service availability N .499	*There are programs to refer families to*	14	There are no parent-related programs (e.g. parenting skills) to refer service users to
		31	There are no family therapy or family counselling services to refer service users and their families to
		62	Insufficient numbers of allied health professionals (i.e. social worker, clinical psychologist) in my service reduces RPN's capacity to address service user's parenting roles
Connectedness O .677	*Workers assessment of parent awareness of child connectedness*	15	I am able to determine the level of importance that service users place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)
		32	I am able to determine the level of importance that service users place on their

Subscale	Subscale Definition	Item no in FFMHPQ	Item
			children maintaining strong relationships with other family members (e.g. other parent, siblings)
		41	I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)
Referrals P .542	*Referring family members to other programs*	16	I do not refer children of service users to child focused (e.g. peer support) programs (other than child and adolescent mental health)
		33	I refer service users to parent-related programs (e.g. parenting skills)
Inter-professional Practice Q .578	Team work and inter-professional practice	17	Working with other health professionals enhances my family-focused practice
		34	Children and families ultimately benefit if health professionals work together to solve the family's problems
		42	Team-working skills are essential for all health professionals providing family-focused care
		46	I want to have a greater understanding of my profession in a healthcare team approach to working with children and families
Interventions to promote parent's mental health R	*RPN's interventions to reduce the impact of the service user's parenting role on their mental health*	50	I am able to identify how parenthood can precipitate and influence the service users' mental health
		51	I assess the impact of the service user's parenting role on their mental health
		52	I suggest practical strategies to facilitate service users to manage the dual

Subscale	Subscale Definition	Item no in FFMHPQ	Item
.742			demands of their parenting role and their mental illness
Remit to address parenting S .389	*Whether it is within RPN's remit to address parenting issues*	53	It is within my remit to address the needs of service user's children directly or indirectly
		54	I should facilitate service users to cope with stress related to their parenting role
		55	RPNs should facilitate service users to realise their full potential as parents
		56	Other members of the multidisciplinary team (i.e. social worker) are better placed, than RPNs, to address issues related to service user's parenting roles
Confidence around children generally T .832	*Confidence around own or others (family &friend's) children*	63	In general i am very happy with my parenting
		64	I have confidence in my parenting skills
		65	I feel comfortable around other people's children

Appendix M: Interview Volunteer Form

Registered Psychiatric Nurses' Practice with Parents who have mental illness, their Children and families within Adult Mental Health Services in Ireland

Interview Volunteer Form

If you have current or previous (within the last 12 months) experience of providing services to one or more mothers with Enduring Mental Illness and would be willing to take part in a semi-structured interview, please complete the Interview Volunteer Form below and forward it to me along with your questionnaire in the stamped self-addressed envelope. If you complete this form and agree to participate in a follow-up interview you will not remain anonymous but your confidentiality will be maintained.

The semi-structured interview will provide an opportunity for you to talk about your practice in more detail; it will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the audio recorder to be turned off. All of the information that you provide will be confidential including your name, place of employment and responses. Your response will be combined with those of other registered psychiatric nurses practicing in various adult mental health services within Ireland.

If you decide to participate in a semi-structured interview and complete the Interview Volunteer Form below and return it to me, on receipt of the form, I will contact you by telephone or email, whichever you prefer, in order to arrange a time and place to meet. Your participation in a semi-structured interview would be greatly appreciated and will make a difference to the outcome of the study.

Yes I would like to take part in a semi-structured interview:

My name is: _____

I work in the following type of care setting (please tick one)

(a) Acute Admission Unit

(b) Community Mental Health Nursing Services

(c) Homecare services

(d) Day Hospital

(e) Day Centre

My contact telephone and /or email address are as follows:

Telephone number: _____

E-mail address: _____

Appendix N: Interview Informed Consent Form

Title: Registered Psychiatric Nurses' practice with parents who have mental illness, their children and families within general adult mental health services in Ireland

Dear (name of participant)

Thank you for agreeing to participant in a semi-structured interview. The purpose of the semi-structured interview is to follow-up on findings from the questionnaire which examined RPNs' practice with parents, who have mental illness, their children and families. The semi-structured interview will focus on your practice with parents who have mental illness and on your practice with their children and families; It will provide an opportunity for you to talk about your practice in more detail; it will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the digital audio recorder to be turned off.

The research knowledge might lead to publications in a theses, journals, books and/or evaluation reports for the future benefit of others. It may also be used for comparison purposes with other countries such as Australia. However, all of the information that you provide will be confidential including your name, place of employment and responses. Your information will also be combined with information provided by other RPNs throughout Ireland and findings will be reported in a collective way as opposed to identifying one particular mental health service or location. You will be able to withdraw from the study at any time, up until the point when I commence writing up my research.

All information from the semi-structured interviews will be filed under a number and not your name. Note that the confidential information you provide in the interview will be stored for five years on a password protected computer in my office at UCD. After this time it will be shredded. Audio recordings will be destroyed once they have been verified for accuracy of transcription.

I am aware of the constraints on your time and appreciate the effort required to participate. Please take time to consider whether you want to take part in this research. It would be a privilege to have you participate and hopefully your involvement will help to develop mental health service provision for parents, who have mental illness their children and families. If you have any questions please do call me at [redacted]

Thank you

Anne Grant

Consent Form

If you are willing to participate in the semi-structured interview outlined above please complete the following Informed Consent Form:

I (name of participant) have spoken to the researcher and have had the study explained to me and I agree to the following:

1. I have read the information provided in the Interview Consent Form and have had time to consider whether to take part.
2. I understand the purpose of the study.
3. I understand what will be personally entailed should I agree to participate in the study.
4. Details of procedures and any risks have been explained to my satisfaction.
5. I agree to take part in this research.
6. I agree that my information and participation can be audio recorded and subsequently transcribed.
7. I understand that I am free to withdraw from the interview at any time without disadvantage.
8. I am aware that I should retain a copy of the Interview Consent Form for future reference.
9. I agree that the data can be used in publications.
10. I agree that the data can be shared with other International groups, including researchers in Australia and Canada
11. I understand that:
    - I may not directly benefit from taking part in this research.
    - My participation is voluntary (it is my choice).
    - I am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified in any way and individual information will remain confidential.

Name of Participant (in block letters): _____

Participant's Signature _____ Date _____

I certify that I have explained the study to the participant and consider that he/she understands what is involved and freely consents to participation.

Researcher's Signature __ _____ Date _____

Appendix O: Steps in Thematic Network Analysis

Table 01

Steps in Thematic Network Analysis

Stage	Step
Analysis Stage A:	Step 1 Code Material
Reduction or breakdown of text	a) Devise a coding framework
	b) Dissect text into segments using the coding framework
	Step 2 Identify Themes
	a) Abstract themes from coded text segments
	b) Refine themes
	Step 3 Construct Thematic Networks
	a) Arrange themes
	b) Select basic themes
	c) Rearrange into organising theme
	d) Deduce global themes(s)
	e) Illustrate as thematic network(s)
	f) Verify and refine the network(s)
Analysis Stage B:	Step 4 Describe and Explore Thematic Networks
Exploration of text	a) Describe the network
	b) Explore the network
	Step 5 Summarise Thematic Networks
Analysis Stage C:	Step 6 Interpret Patterns
Integration of exploration	

Attride-Stirling (2001)

Appendix P: Influence of the Newly Created Variable – 'RPN group' in Multiple Regression

Table P1

Influence of the newly created variable – 'RPN group' in multiple regression

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
Support to carers and children	1	Age	-.006	-.050	.001	.039
		gender	-.213	-.097	.009	
		length of experience	.001	.162	.010	
		Famtraining	.035	.012	.000	
		child training	-.015	-.005	.000	
		length of time in current position	.000	-.001	.000	
		servlocation	-.214	-.100	.010	
	2	Age	-.006	-.059	.001	.175
		gender	-.110	-.050	.002	
		length of experience	.000	.047	.001	
		Famtraining	.067	.023	.000	
		childtraining	.194	.063	.004	
		length of time in current position	.001	.044	.001	
		servlocation	-.150	-.070	.005	
		Time and workload	-.010	-.016	.000	
		Worker confidence	.095	.126	.011	
		Engagement issues	.050	.050	.002	
		Training	.053	.058	.002	
		Skill and knowledge	.251	.296	.058	
		Service availability	.116	.180	.027	
		Inter-Profession practice	.116	.098	.006	
	3	Age	-.001	-.007	.000	.022
		gender	-.089	-.041	.001	
		length of experience	.000	.038	.001	
		Famtraining	-.011	-.004	.000	
		childtraining	.203	.066	.004	
		length of time in current position	.001	.040	.001	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		servlocation	-.163	-.076	.005	
		Time and workload	-.024	-.037	.001	
		Worker confidence	.117	.156	.016	
		Engagement issues	.072	.073	.005	
		Training	.058	.064	.002	
		Skill and knowledge	.254	.299	.059	
		Service availability	.116	.181	.028	
		Inter-Profession practice	.103	.088	.005	
		Confidence around parenting and children generally	.227	.132	.016	
		RPNparent	.221	.106	.008	
	4	Age	-.006	-.058	.001	.051
		gender	-.042	-.019	.000	
		length of experience	.000	-.015	.000	
		Famtraining	.108	.038	.001	
		childtraining	.286	.093	.007	
		length of time in current position	.001	.054	.002	
		servlocation	-.084	-.040	.001	
		Time and workload	-.025	-.038	.001	
		Worker confidence	.119	.158	.017	
		Engagement issues	.075	.076	.005	
		Training	.023	.025	.000	
		Skill and knowledge	.218	.257	.043	
		Service availability	.077	.120	.011	
		Inter-Profession practice	.122	.103	.007	
		Confidence around parenting and children generally	.249	.146	.020	
		RPNparent	.096	.046	.001	
		rpngroup	.606	.272	.051	
connectedness	1	Age	.008	.057	.001	.044
		gender	-.459	-.163	.026	
		length of experience	.001	.072	.002	
		Famtraining	.163	.045	.002	
		childtraining	-.367	-.093	.008	
		length of time in current position	-.002	-.089	.006	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		servlocation	.069	.025	.001	
	2	Age	.014	.102	.004	.315
		gender	-.226	-.080	.006	
		length of experience	-.001	-.126	.005	
		Famtraining	.242	.066	.004	
		childtraining	-.030	-.007	.000	
		length of time in current position	-.001	-.043	.001	
		servlocation	.121	.044	.002	
		Time and workload	.124	.146	.018	
		Worker confidence	-.026	-.027	.001	
		Engagement issues	.198	.155	.022	
		Training	.035	.029	.001	
		Skill and knowledge	.505	.462	.142	
		Service availability	.085	.103	.009	
		Inter-Profession practice	.289	.190	.023	
	3	Age	.020	.139	.007	.015
		gender	-.202	-.072	.005	
		length of experience	-.001	-.132	.006	
		Famtraining	.158	.043	.002	
		childtraining	-.023	-.006	.000	
		length of time in current position	-.001	-.048	.002	
		servlocation	.110	.040	.001	
		Time and workload	.109	.129	.014	
		Worker confidence	-.005	-.005	.000	
		Engagement issues	.221	.173	.027	
		Training	.040	.034	.001	
		Skill and knowledge	.507	.464	.143	
		Service availability	.086	.103	.009	
		Inter-Profession practice	.275	.181	.021	
		Confidence around parenting and children generally	.252	.114	.012	
		RPNparent	.203	.076	.004	
	4	Age	.017	.120	.005	.006
		gender	-.181	-.064	.004	
		length of experience	-.002	-.151	.008	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		Famtraining	.212	.058	.003	
		childtraining	.015	.004	.000	
		length of time in current position	-.001	-.042	.001	
		servlocation	.146	.053	.003	
		Time and workload	.109	.128	.014	
		Worker confidence	-.004	-.004	.000	
		Engagement issues	.222	.175	.027	
		Training	.024	.020	.000	
		Skill and knowledge	.491	.449	.131	
		Service availability	.068	.082	.005	
		Inter-Profession practice	.284	.187	.022	
		Confidence around parenting and children generally	.262	.119	.013	
		RPNparent	.146	.055	.002	
		rpngroup	.278	.097	.006	
Referrals	1	Age	.008	.050	.001	.138
		gender	-.315	-.095	.009	
		length of experience	.003	.263	.025	
		Famtraining	-.490	-.114	.011	
		childtraining	.274	.059	.003	
		length of time in current position	-.001	-.034	.001	
		servlocation	-.359	-.111	.012	
	2	Age	.003	.020	.000	.128
		gender	-.362	-.109	.011	
		length of experience	.002	.199	.014	
		Famtraining	-.579	-.135	.016	
		childtraining	.507	.109	.010	
		length of time in current position	.000	-.003	.000	
		servlocation	-.286	-.089	.007	
		Time and workload	.056	.056	.003	
		Worker confidence	.215	.189	.025	
		Engagement issues	-.118	-.079	.006	
		Training	.019	.014	.000	
		Skill and knowledge	.160	.125	.010	
		Service availability	.140	.144	.017	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		Inter-Profession practice	-.171	-.096	.006	
	3	Age	.010	.060	.001	.005
		gender	-.371	-.112	.011	
		length of experience	.002	.197	.013	
		Famtraining	-.573	-.133	.015	
		childtraining	.528	.114	.011	
		length of time in current position	.000	.005	.000	
		servlocation	-.302	-.094	.008	
		Time and workload	.056	.056	.003	
		Worker confidence	.232	.204	.028	
		Engagement issues	-.112	-.075	.005	
		Training	.023	.017	.000	
		Skill and knowledge	.161	.126	.011	
		Service availability	.139	.143	.017	
		Inter-Profession practice	-.171	-.096	.006	
		Confidence around parenting and children generally	-.070	-.027	.001	
		RPNparent	.253	.081	.004	
	4	Age	.000	.003	.000	.063
		gender	-.292	-.088	.007	
		length of experience	.002	.137	.006	
		Famtraining	-.372	-.087	.006	
		childtraining	.668	.144	.018	
		length of time in current position	.000	.021	.000	
		servlocation	-.171	-.053	.003	
		Time and workload	.055	.055	.003	
		Worker confidence	.234	.206	.028	
		Engagement issues	-.107	-.071	.005	
		Training	-.036	-.026	.000	
		Skill and knowledge	.101	.079	.004	
		Service availability	.073	.076	.005	
		Inter-Profession practice	-.140	-.079	.004	
		Confidence around parenting and children generally	-.031	-.012	.000	
		RPNparent	.044	.014	.000	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		rpngroup	1.018	.303	.063	
interventions to	1	Age	-.009	-.067	.002	.089
promote parents'		gender	-.314	-.118	.014	
mental health		length of experience	.001	.110	.004	
		Famtraining	-.185	-.054	.003	
		childtraining	-.493	-.132	.016	
		length of time in current position	.001	.046	.001	
		servlocation	-.445	-.172	.028	
	2	Age	-.007	-.052	.001	.290
		gender	-.071	-.027	.001	
		length of experience	.000	-.021	.000	
		Famtraining	-.052	-.015	.000	
		childtraining	-.271	-.073	.005	
		length of time in current position	.002	.095	.006	
		servlocation	-.332	-.129	.015	
		Time and workload	.003	.003	.000	
		Worker confidence	.047	.052	.002	
		Engagement issues	.072	.060	.003	
		Training	.142	.128	.010	
		Skill and knowledge	.500	.486	.157	
		Service availability	.002	.003	.000	
		Inter-Profession practice	.282	.197	.025	
	3	Age	-.005	-.038	.001	.002
		gender	-.063	-.024	.001	
		length of experience	.000	-.023	.000	
		Famtraining	-.079	-.023	.000	
		childtraining	-.269	-.072	.005	
		length of time in current position	.002	.094	.006	
		servlocation	-.336	-.130	.016	
		Time and workload	-.002	-.003	.000	
		Worker confidence	.055	.060	.002	
		Engagement issues	.079	.066	.004	
		Training	.144	.130	.010	
		Skill and knowledge	.501	.487	.158	
		Service availability	.002	.003	.000	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		Inter-Profession practice	.278	.194	.024	
		Confidence around parenting and children generally	.080	.039	.001	
		RPNparent	.070	.028	.001	
	4	Age	-.008	-.062	.001	.012
		gender	-.036	-.014	.000	
		length of experience	.000	-.049	.001	
		Famtraining	-.010	-.003	.000	
		childtraining	-.221	-.059	.003	
		length of time in current position	.002	.101	.007	
		servlocation	-.291	-.113	.011	
		Time and workload	-.002	-.003	.000	
		Worker confidence	.056	.061	.002	
		Engagement issues	.081	.068	.004	
		Training	.123	.111	.007	
		Skill and knowledge	.480	.467	.142	
		Service availability	-.020	-.026	.001	
		Inter-Profession practice	.289	.202	.026	
		Confidence around parenting and children generally	.094	.045	.002	
		RPNparent	-.002	-.001	.000	
		rpngroup	.351	.130	.012	
family and parenting support	1	Age	-.005	-.045	.001	.065
		gender	-.173	-.074	.005	
		length of experience	.002	.237	.021	
		Famtraining	-.228	-.075	.005	
		childtraining	-.056	-.017	.000	
		length of time in current position	-.001	-.052	.002	
		servlocation	-.181	-.079	.006	
	2	Age	-.003	-.024	.000	.252
		gender	-.017	-.007	.000	
		length of experience	.001	.099	.003	
		Famtraining	-.198	-.065	.004	
		childtraining	.168	.051	.002	
		length of time in current position	.000	-.001	.000	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		servlocation	-.129	-.056	.003	
		Time and workload	.142	.200	.034	
		Worker confidence	.042	.052	.002	
		Engagement issues	.008	.007	.000	
		Training	.178	.182	.020	
		Skill and knowledge	.367	.402	.107	
		Service availability	.062	.089	.007	
		Inter-Profession practice	.019	.015	.000	
	3	Age	-.001	-.006	.000	.003
		gender	-.025	-.010	.000	
		length of experience	.001	.099	.003	
		Famtraining	-.182	-.059	.003	
		childtraining	.176	.053	.002	
		length of time in current position	.000	.005	.000	
		servlocation	-.135	-.059	.003	
		Time and workload	.144	.204	.035	
		Worker confidence	.047	.057	.002	
		Engagement issues	.006	.006	.000	
		Training	.179	.183	.020	
		Skill and knowledge	.367	.402	.107	
		Service availability	.061	.089	.007	
		Inter-Profession practice	.021	.017	.000	
		Confidence around parenting and children generally	-.073	-.040	.001	
		RPNparent	.082	.037	.001	
	4	Age	-.005	-.042	.001	.025
		gender	.011	.005	.000	
		length of experience	.001	.062	.001	
		Famtraining	-.092	-.030	.001	
		childtraining	.239	.072	.005	
		length of time in current position	.000	.015	.000	
		servlocation	-.076	-.033	.001	
		Time and workload	.144	.203	.035	
		Worker confidence	.048	.059	.002	
		Engagement issues	.009	.008	.000	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		Training	.153	.156	.014	
		Skill and knowledge	.340	.372	.090	
		Service availability	.032	.046	.002	
		Inter-Profession practice	.036	.028	.001	
		Confidence around parenting and children generally	-.056	-.030	.001	
		RPNparent	-.012	-.005	.000	
		rpngroup	.458	.191	.025	
Assessing the impact on the child	1	Age	-.009	-.062	.002	.024
		gender	-.046	-.015	.000	
		length of experience	.000	.024	.000	
		Famtraining	-.341	-.088	.007	
		childtraining	-.108	-.026	.001	
		length of time in current position	.002	.107	.008	
		servlocation	.135	.046	.002	
	2	Age	-.009	-.058	.001	.215
		gender	.158	.053	.003	
		length of experience	-.001	-.122	.005	
		Famtraining	-.279	-.072	.004	
		childtraining	.122	.029	.001	
		length of time in current position	.003	.165	.019	
		servlocation	.193	.066	.004	
		Time and workload	.095	.107	.010	
		Worker confidence	-.032	-.031	.001	
		Engagement issues	-.022	-.016	.000	
		Training	.102	.082	.004	
		Skill and knowledge	.523	.453	.137	
		Service availability	.074	.084	.006	
		Inter-Profession practice	.127	.079	.004	
	3	Age	-.007	-.047	.001	.009
		gender	.181	.061	.003	
		length of experience	-.001	-.126	.005	
		Famtraining	-.349	-.090	.007	
		childtraining	.119	.028	.001	
		length of time in current position	.003	.158	.017	

Dependent variable	Step	significant predictors	B	Beta	sr^2	ΔR^2
		servlocation	.190	.066	.004	
		Time and workload	.083	.093	.007	
		Worker confidence	-.021	-.020	.000	
		Engagement issues	-.005	-.004	.000	
		Training	.104	.084	.004	
		Skill and knowledge	.525	.455	.137	
		Service availability	.074	.085	.006	
		Inter-Profession practice	.117	.073	.003	
		Confidence around parenting and children generally	.228	.098	.009	
		RPNparent	.067	.024	.000	
	4	Age	-.012	-.078	.002	.019
		gender	.220	.074	.005	
		length of experience	-.002	-.159	.008	
		Famtraining	-.249	-.064	.003	
		childtraining	.188	.045	.002	
		length of time in current position	.003	.167	.019	
		servlocation	.255	.088	.007	
		Time and workload	.083	.093	.007	
		Worker confidence	-.020	-.019	.000	
		Engagement issues	-.002	-.002	.000	
		Training	.075	.060	.002	
		Skill and knowledge	.495	.429	.119	
		Service availability	.042	.048	.002	
		Inter-Profession practice	.132	.082	.004	
		Confidence around parenting and children generally	.248	.106	.010	
		RPNparent	-.037	-.013	.000	
		rpngroup	.506	.167	.019	

Providing family and parenting support

On the first step of the hierarchical multiple regression analysis for the dependent variable 'family and parenting support', the Independent variables (age, gender, length of

experience, length of time in current experience, service location, family training and child training) accounted for 6.5% of the variance in support to carers and children, R^2 = .065, F (7,260) = 2.581, p < .05, with length of experience being the significant predictor, β = .237, p < .05, sr^2 = .021.

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally)and accounted for an additional 25.2% of the variance on family and parenting support, ΔR^2 = .252, ΔF (7,253) = 13.334, p <.001. Within this model, the significant predictors of family and parenting support were skill and knowledge, β = .402, p < .001, sr^2 = .107, time and workload, β = .200, p < .001, sr^2 =.034 and training β = .182, p < .01, sr^2 = .020.

On step 3, a new subscales called (competence around parenting and children generally) and a variable around parenting status of the respondent were added to the regression equation and accounted for an additional 0.3% of the variance in family and parenting support, ΔR^2 = .003, ΔF (2, 251) = .473, p > .05. Within this model, the significant predictors of family and parenting support were skill and knowledge, β = .402, p < .001, sr^2 = .107, time and workload, β = .204, p < .001, sr^2 =.035 and training, β = .182, p < .05, sr^2 = .020.

On step 4, a new independent variable called rpn-group were added to the regression equation and accounted for an additional 2.5% of the variance in family and parenting

support, ΔR^2 = .025, ΔF (1, 250) = 9.526, p < .01. Within this model, the significant predictors of family and parenting support were skill and knowledge, β = .372, p < .001, sr^2 = .090, time and workload, β = .203, p < .001, sr^2 =. 035, training, β = .156, p < .05, sr^2 = .014 and rpngroup β = .191, p < .01, sr^2 = .025.

In combination, the 17 predictor variables explained 34.5% variance in family and parenting support, R^2 = .345, adjusted R^2 = .300, F = (17,250) = 7.729, p < .001

Providing support to carers and children

On the first step of the hierarchical multiple regression analysis for the dependent variable 'support to carers and children', the Independent variables (age, gender dummy, length of experience, length of time in current experience, service location, family training and child training) accounted for 3.9% of the variance in support to carers and children, R^2 = .039, F (7,260) = 1.514, p > .05, with no significant predictors.

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally) and accounted for an additional 17.5% of the variance on support to carers and children, ΔR^2 = .175, ΔF (7,253) = 8.074, p <.001. Within this model, the significant predictors of support to carers and children were skill and knowledge, β = .296, p < .001, sr^2 = .058 and service availability, β = .180, p < .01, sr^2 =.027.

On step 3, a new subscales called (competence around parenting and children generally) and a variable around parenting status of the respondent were added to the regression equation and accounted for an additional 2.2% of the variance in support to carers and children, $\Delta R^2 = .022$, ΔF (2,251) = 3.631, $p < .05$. Within this model, the significant predictors of support to carers and children were skill and knowledge, $\beta = .299$, $p < .001$, $sr^2 = .059$, service availability, $\beta = .181$, $p < .01$, $sr^2 = .028$ and confidence around parenting and children generally, $\beta = .132$, $p < .05$, $sr^2 = .016$.

On step 4, a new independent variable called rpn-group dummy were added to the regression equation and accounted for an additional 5.1% of the variance in family and parenting support, $\Delta R^2 = .051$, ΔF (1, 250) = .17.720, $p < .001$. Within this model, the significant predictors of family and parenting support were rpngroup, $\beta = .272$, $p < .001$, $sr^2 = .051$, skill and knowledge, $\beta = .257$, $p < .001$, $sr^2 = .043$, confidence around parenting and children generally, $\beta = .146$, $p < .01$, $sr^2 =.020$, and service availability, $\beta = .120$, $p < .05$, $sr^2 = .011$.

In combination, the 17 predictor variables explained 28.7% variance in support to carers and children, $R^2 = .287$, adjusted $R^2 = .239$, F = (17,250) = 5.926, $p < .001$.

Assessing the impact of PMI on the child

On the first step of the hierarchical multiple regression analysis for the dependent variable 'assessing the impact on the child', the Independent variables (age, gender dummy,

length of experience, length of time in current experience, service location, family training and child training) accounted for 2.4%of the variance in assessing the impact on the child, R^2 = .024, F (7,260) = .900, p > .05, with no significant predictors.

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally and accounted for an additional 21.5% of the variance on assessing the impact on the child, ΔR^2 = .215, ΔF (7,253) =10.209, p <.001. Within this model, the significant predictors of assessing the impact on the child were skill and knowledge, β = .453, p < .001, sr^2 = .137 and length of time in current position, β = .165, p < .05, sr^2 = .019.

On step 3, a new subscale called (competence around parenting and children generally) and a variable around parenting status of the respondent were added to the regression equation and accounted for an additional 0.9% of the variance in assessing the impact on the child, ΔR^2 = .009, ΔF (2,251) = 1.502, p > .05. Within this model, the significant predictor in assessing the impact on the child was skill and knowledge, β = .455, p < .001, sr^2 = .137 and length of time in current position, β = .158, p < .05, sr^2 = .017.

On step 4, a new independent variable called rpn-group were added to the regression equation and accounted for an additional 1.9% of the variance in family and parenting support, ΔR^2 = .019, ΔF (17, 250) = 5.350, p < .001. Within this model, the significant predictors of family and parenting support were skill and knowledge β = .429, p < .001, sr^2

= .119, rpngroup, β = .167, $p < .05$, sr^2 = .019, and length of time in current position, β = .167, $p < .05$, sr^2 =. 019.

In combination, the 17 predictor variables explained 26.7% variance in assessing the impact on the child, R^2 = .267, adjusted R^2 = .217, F = (17,250) = 5.350, $p < .001$.

Assessing parents' awareness of child connectedness

On the first step of the hierarchical multiple regression analysis for the dependent variable 'support to carers and children', the Independent variables (age, gender, length of experience, length of time in current experience, service location, family training and child training) accounted for 4.4% of the variance in connectedness, R2 = .044, F (7,260) = 1.704, p > .05, with gender a significant predictor, β = -.163, p < .01, sr2 = .026

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally) and accounted for an additional 31.5% of the variance on connectedness, ΔR2 = .315, ΔF (7,253) = 17.761, p <.001. Within this model, the significant predictors of connectedness were inter-professional practice, β = .190, p < .01, sr2 = .023, engagement issues, β = .155, p < .01, sr2 =.022, and time and workload, β = .146, p < .01, sr2 = .018.

On step 3, a new subscale called (competence around parenting and children generally) and a variable around parenting status of the respondent were added to the regression equation and accounted for an additional 1.5% of the variance in connectedness, $\Delta R^2 = .015$, ΔF (2,251) = 2.983, $p > .05$. Within this model, the significant predictors of connectedness were skill and knowledge, $\beta = .464$, $p < .001$, $sr^2 = .143$, inter-professional practice, $\beta = .181$, $p < .01$, $sr^2 = .021$, time and workload, $\beta = .129$, $p < .05$, $sr^2 = .014$ and confidence around parenting and children generally, $\beta = .114$, $p < .05$, $sr^2 =.012$. Engagement issues were no longer a significant predictor in Model 3.

On step 4, a new independent variable called rpn-group were added to the regression equation and accounted for an additional 0.6 % of the variance in connectedness, $\Delta R^2 = .006$, ΔF (1, 250) = 2.584, $p > .05$. Within this model, the significant predictors of connectedness were skill and knowledge, $\beta = .449$, $p < .001$, $sr^2 = .131$, inter-professional practice, $\beta = .187$, $p < .01$, $sr^2 = .022$, engagement issues, $\beta = .175$, $p < .01$, $sr^2 = .027$, time and workload, $\beta = .128$, $p < .05$, $sr^2 = .014$ and confidence around parenting and children generally, $\beta = .119$, $p < .05$, $sr^2 =.013$.

In combination, the 17 predictor variables explained 38% variance in connectedness, $R^2 = .380$, adjusted $R^2 = .338$, $F = (17,250) = 9.021$, $p < .001$.

Referral of family members to other programs

On the first step of the hierarchical multiple regression analysis for the dependent variable 'referrals', the Independent variables (age, gender, length of experience, length of time in current experience, service location, family training and child training) accounted for 13.8% of the variance in referrals, $R^2 = .138$, F (7,260) = 5.941, $p < .001$, with length of experience a significant predictor, $\beta = .263$, $p < .01$, $sr^2 = .025$.

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally)and accounted for an additional 12.8% of the variance on referrals, $\Delta R^2 = .128$, ΔF (7,253) = 6.278, $p <.001$. Within this model, the significant predictors of referrals were length of experience, $\beta = .199$, $p < .05$, $sr^2 = .014$, worker confidence, $\beta = .189$, $p < .01$, $sr^2 = .025$, Service availability = .144, $p < .05$, $sr^2 = .017$, and famtraining, $\beta = -.135$, $p < .05$, $sr^2 =.016$.

On step 3, a new subscales called (competence around parenting and children generally) and a variable around parenting status of the respondent were added to the regression equation and accounted for an additional 0.5% of the variance in referrals, $\Delta R^2 = .005$, ΔF (2,251) = .926, $p > .05$. Within this model, the significant predictors of referrals were length of experience, $\beta = .197$, $p < .05$, $sr^2 = .013$, worker confidence, $\beta = .204$, $p < .01$, $sr^2 = .028$, service availability, $\beta = .143$, $p < .05$, $sr^2 = .017$, famtraining, $\beta = -.133$, $p < .05$, $sr^2 = .015$ and gender, $\beta = -.112$, $p < .05$, $sr^2 = .011$.

On step 4, a new independent variable called rpn-group were added to the regression equation and accounted for an additional 6.3 % of the variance in referrals, $\Delta R^2 = .063$, ΔF (1, 250) = 23.443, $p < .001$. Within this model, the significant predictors of referrals were rpngroup, $\beta = .303$, $p < .001$, $sr^2 = .063$, worker confidence, $\beta = .206$, $p < .01$, $sr^2 = .028$, and childtraining, $\beta = .144$, $p < .05$, $sr^2 = .018$.

In combination, the 17 predictor variables explained 33.3% variance in referrals, $R^2 = .333$, adjusted $R^2 = .288$, $F = (17,250) = 7.354$, $p < .001$.

Interventions to promote parents' mental health

On the first step of the hierarchical multiple regression analysis for the dependent variable 'interventions to promote parent's mental health', the Independent variables (age, gender, length of experience, length of time in current experience, service location, family training and child training) accounted for 8.9% of the variance in interventions to promote parent's mental health, $R^2 = .089$, F (7,260) = 3.634, $p < .01$, with servlocation, $\beta = -.172$, $p < .01$, $sr^2 = .028$, childtraining, $\beta = -.132$, $p < .05$, $sr^2 = .016$, and gender, $\beta = -.118$, $p < .05$, $sr^2 = .014$, significant predictors.

On step 2 independent subscales of the FFMHPQ were added to the regression equation (time and workload, worker confidence, engagement issues, training, skill and knowledge, service availability, inter profession practice and confidence around parenting and children generally) and accounted for an additional 29% of the variance on Interventions to promote parent's mental health, $\Delta R^2 = .290$, ΔF (7,253) = 16.868, $p <.001$. Within this

model, the significant predictors of interventions to promote parent's mental health were skill and knowledge, β = .486, $p < .001$, sr^2 = .157, inter-professional practice, β = .197, $p < .01$, sr^2 = .025, servlocation, β = -.129, $p < .05$, sr^2 = .015, and training, β = .128, $p < .05$, sr^2 =.010. Childtraining was no longer a significant predictor in model 2.

On step 3, a new subscales called (competence around parenting and children generally) and a dummy variable around parenting status of the respondent were added to the regression equation and accounted for an additional 0.2% of the variance in interventions to promote parent's mental health, ΔR^2 = .002, ΔF (2,251) = .360, $p > .05$. Within this model, the significant predictors of interventions to promote parent's mental health were skill and knowledge, β = .487, $p < .001$, sr^2 = .158, inter-professional practice, β = .194, $p < .01$, sr^2 = .024, training, β = .130, $p < .05$, sr^2 =.010 and servlocation β = -.130, $p < .05$, sr^2 = .016.

On step 4, a new independent variable called rpn-group were added to the regression equation and accounted for an additional 1.2% of the variance in interventions to promote parent's mental health, ΔR^2 = .012, ΔF (1, 250) = 4.741, $p < .05$. Within this model, the significant predictors of interventions to promote parent's mental health were skill and knowledge, β = .467, $p < .001$, sr^2 = .142, inter-professional practice, β = .202, $p < .01$, sr^2 = .026, rpngroup, β = .130, $p < .05$, sr^2 = .012, and servlocation, β = -.113, $p < .05$, sr^2 =.011. Training was not a significant predictor in model 4.

In combination, the 17 predictor variables explained 39.2 % variance in interventions to promote parent's mental health, R^2 = .392, adjusted R^2 = .351, F = (17,250) = 9.492, $p <$ .001.

Appendix Q: MANCOVA

Table Q1

MANCOVA on 14 FFP subscales – comparison between two RPN groups

	Total		Community		Acute		Age		Experience		Patients deliver care		RPN Group	
Subscales	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**p**	η_p^2	**p**	η_p^2	**p**	η_p^2	**p**	η_p^2
Time and workload	2.94	1.47	3.20	1.50	2.84	1.46	0.49	0.00	0.66	0.00	0.42	0.01	0.19	0.02
Family and parenting support*	3.57	1.11	4.39	0.95	3.24	0.99	0.40	0.01	0.05	0.04	0.44	0.01	0.00	0.12
Worker confidence	3.91	1.42	4.53	1.48	3.66	1.32	0.68	0.00	0.92	0.00	0.13	0.02	0.11	0.03
Support to carers and children*	4.55	1.11	5.25	0.94	4.26	1.06	0.19	0.02	0.51	0.00	0.16	0.02	0.00	0.18
Engagement issues	4.41	1.01	4.56	1.06	4.35	1.00	0.05	0.04	0.68	0.00	0.24	0.01	0.31	0.01
Assessing the impact on the child	3.15	1.42	3.55	1.62	2.98	1.31	0.22	0.02	0.05	0.04	0.47	0.01	0.48	0.01
Training	6.03	0.94	5.89	0.92	6.09	0.94	0.77	0.00	0.62	0.00	0.66	0.00	0.54	0.00
Skill and knowledge*	3.85	1.23	4.67	1.24	3.51	1.07	0.46	0.01	0.03	0.05	0.81	0.00	0.00	0.09
Service availability*	3.96	1.52	4.72	1.33	3.66	1.49	0.80	0.00	0.75	0.00	0.11	0.03	0.00	0.10
Connectedness	4.52	1.32	4.92	1.27	4.35	1.32	0.92	0.00	0.99	0.00	0.22	0.02	0.26	0.01
Referrals*	2.91	1.41	3.95	1.48	2.50	1.15	0.23	0.01	0.00	0.11	0.06	0.04	0.00	0.15
Inter-professional practice	6.16	0.79	6.16	0.70	6.16	0.83	0.84	0.00	0.70	0.00	0.34	0.01	0.50	0.00
Interventions to promote parent's mental health*	4.96	1.23	5.61	0.91	4.69	1.25	0.29	0.01	0.23	0.02	0.14	0.02	0.02	0.05
Confidence around parenting & children	6.20	0.65	6.09	0.58	6.24	0.68	0.66	0.00	0.44	0.01	0.39	0.01	0.53	0.00

Note. *p<.05

Appendix R: ANCOVA on Five Scale Continuous Variables

Table R1

ANCOVA on five scale continuous variables – comparison between two RPN groups

Subscales	**Total**		**Community**		**Acute**		**Age**		**Experience**		**Patients deliver care to**		**RPN Group**	
	M	SD	M	SD	M	SD	p	η_p^2	p	η_p^2	p	η_p^2	p	η_p^2
number of parents	8.05	8.47	10.88	11.88	6.88	6.40	.758	.002	.667	.004	.000	.418	.100	.050
number of face-to-face contact	6.19	5.23	6.40	6.38	6.12	4.94	.099	.070	.220	.039	.015	.147	.351	.023
number of face-to-face contact with children	2.17	1.62	2.57	2.07	1.91	1.30	.903	.001	.621	.019	.273	.091	.545	.029
number of service user discussed parenting	2.12	1.80	2.77	1.83	1.83	1.74	.666	.005	.618	.007	.105	.068	.533	.010

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