



MONASH University

*Experiences of Australian Adult Mental Health Clinicians Who Work with
Parents with a Mental Illness*

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Abstract

Parental mental illness is common and may impact negatively on children. Adult mental health clinicians are well positioned to address these impacts. There is an emerging evidence base for the use of family-focused practices when a parent has a mental illness. Family-focused practices are those where clinicians extend their focus beyond the consumer's immediate mental health needs to consider the functioning and needs of all family members (including parenting needs and the wellbeing of children). Despite the promise of family-focused practices, they are not regularly utilised by clinicians when working with parents. Barriers relate to a range of factors including insufficient organisational support, gaps in clinicians' skill and knowledge, engagement issues with parents and factors that prevent children and families from being involved with the parent's treatment. Although clinicians are central to the implementation of family-focused practices, their experiences and views have not been widely researched.

The aim of this thesis was examine the experiences of clinicians who work with parents in the Australian adult mental health sector. The thesis includes four published studies examining clinicians' experience of different aspects of work with parents:

- (i) What challenges have clinicians experienced when working with parental mental illness and what strategies have they found beneficial for managing those challenges;
- (ii) What personal reactions and perspectives have clinicians had towards parents with a mental illness and their children;
- (iii) How did clinicians view and experience the introduction of a legislation mandating that the children of parents receiving mental health services should have their needs recognised and protected;

- (iv) What were clinicians views and experiences of an e-learning resource for developing family-focused practice

The first three studies employed semi-structured telephone interviews with clinicians from the Australian adult mental health sector which were analysed with Interpretative Phenomenological Analysis (IPA). The final study employed a sequential mixed methods design with quantitative and qualitative components. The quantitative component was a comparison of participants' family-focused practice before and after completion of an e-learning resource. This was supplemented with interviews about participants' experiences with the resource, which were analysed with Thematic Analysis.

The overall findings across these studies highlighted the emotional complexity of working with parents, the specialised nature of the work and the impact of organisational factors on clinicians' experiences and practices. Five key areas were identified that influenced clinicians' practices with parents. These related to organisational structures, managers' attitudes and communication, organisational support, clinicians' attitude and stance and specific skill and knowledge related to working with parental mental illness. The thesis concludes with a discussion of the thesis limitations, implications for practice and possible future research directions.

General Declaration

The following declarations are made in accordance with Monash University Doctorate Regulation 17:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes four original papers published in peer reviewed journals. The core theme of the thesis was to examine the experiences and views of clinicians in the adult mental health sector towards working with parents who have a mental illness. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the Faculty of Education under the supervision of Professor Andrea Reupert and Professor Daryl Maybery from the Monash School of Rural Health.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research. In the case of chapters 4, 5, 6 and 7, my contribution to the work is outlined in Table 0.1.

Table 0.1

Outline of the candidate's contribution to publications in the thesis

Thesis Chapter	Publication Title	Status	Nature and % of candidate contribution	Co-author(s) names, nature and % contribution	Co-author(s) is a Monash Student?
4	How do Australian Adult Mental Health Clinicians Manage the Challenges of Working with Parental Mental Illness? A phenomenological Study	Published	85%. Candidate contributed to concept, design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, submission of manuscript.	Prof. Andrea Reupert 10%: Input into concept, participant recruitment, preparation of research materials, analysis, manuscript preparation. Prof. Darryl Maybery 5%: Input into concept, interpretation of findings, manuscript preparation.	No No

6	Legislative policy to support children of parents with a mental illness: Revolution or Evolution?	Published	80%. Candidate contributed to concept, design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, submission of manuscript.	Professor Darryl Maybery 10%: Input into concept, development of research materials, analysis, manuscript preparation. Prof. Andrea Reupert 10%: Input into concept, development of research materials, analysis, manuscript preparation	No
8	“Let’s Talk about Children”: A pilot evaluation of an e-learning resource for mental health clinicians	Published	75%. Candidate contributed to development of research materials, participant recruitment, data collection,	Professor Andrea Reupert 15%: Input into concept, design, development of	No

			transcription of interviews, qualitative and quantitative analysis, writing and editing of manuscript, submission of manuscript.	research materials, participant recruitment, qualitative analysis, manuscript preparation. Professor Darryl Maybery 10%: Input into concept, quantitative analysis, manuscript preparation.	No
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Student signature:



The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student’s and co-authors’ contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature:

List of Publications

Maybery, D. J., Goodyear, M. J., Reupert, A. E., Sheen, J. A., Cann, W., Dalziel, K. M.,

Tchernegovski, P., O'Hanlon, B., & Von Doussa, H. G. (2017). Developing and Australian-first recovery model for parents in Victorian mental health and family services: A study protocol for a randomised control trial. *BMC Psychiatry*, 17(1), 198-204. doi:

10.1186/s12888-017-1357-4

*Tchernegovski, P., Reupert, A. E., & Maybery, D. J. (2018). Adult mental health clinicians' perspectives of parents with a mental illness and their children: single and dual focus perspectives. *BMC Health Services Research*, 18(1), 611-621. doi: 10.1186/s12913-018-3428-8

*Tchernegovski, P., Reupert, A. E., & Maybery, D. J. (2018). How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study. *Child & Family Social Work*, 23(3), 381-389. doi: 10.1111/cfs.12426

*Tchernegovski, P., Maybery, D., & Reupert, A. (2017). Legislative policy to support children of parents with a mental illness: revolution or evolution? *International Journal of Mental Health Promotion*, 19(1), 1-13. doi: 10.1080/14623730.2016.1270847

*Tchernegovski, P., Reupert, A., & Maybery, D. (2015). "Let's Talk about Children": A pilot evaluation of an e-learning resource for mental health clinicians. *Clinical Psychologist*, 19(1), 49-58. doi: 10.1111/cp.12050

*Publications included in this thesis

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responses were not always the friendliest when asked, “So, how is the PhD going?” Thanks for standing by me anyway. Thanks for understanding when I disappeared into a writing cave and for the offers of food at those times. I’m looking forward to spending post-PhD time with you all.

Author's Note

This thesis includes published works, known as a thesis with publication. A thesis with publication is not a different qualification to a traditional thesis. Instead, it is one in which the core chapters of the thesis include studies or articles that have been prepared, submitted or accepted for publication in peer-reviewed journals during the candidate's enrolment.

A thesis with publication must include framing and linking text to introduce the research and show how the publications fit within the overall premise of the thesis. Overall, the thesis must provide a cohesive and sustained discussion of the central themes. Accordingly, the publications in this thesis are not in order of publication, but have been presented in the order which provides the most cohesive flow of information and clarity.

While every effort has been made to minimise repetition within the thesis, some overlap of information in various places was unavoidable so that the studies were able to stand alone as publications. This is especially true when describing existing literature and research that underlies the aims of the studies and when describing the research designs and methods used in the published studies. Where such duplication of information was necessary, detail has been provided in the publication chapters and broader discussion is provided in other areas of the thesis. Publication across different peer-reviewed journals has also required some minor divergence from the main themes of the thesis. For example, one paper was published within a journal with a specific focus on social work and required implications for social workers to be discussed more extensively than for other types of mental health clinicians.

In accordance with the Monash University Graduate Research guidelines, the published articles have been presented in their publication format within the main body of the thesis. The different styles and requirements of the journals have resulted in variation in formatting for each

published paper. Monash University Graduate Research guidelines for a thesis with publication recommend that pagination is inclusive and consistent throughout the thesis. For this reason, published pages which have their own pagination have had a second pagination added which pertains to the thesis.

Reflexivity Statement

The range of factors that might influence my understanding of data is seemingly endless. I might begin with my age, gender, sexuality, ethnicity... however, I will focus on factors that feel more connected to the nature of the research.

I relate immediately to the challenge of the work in the adult mental health sector. I am reminded of my experiences in teaching and in child protection. The demands of institutional workplaces with so many policies and procedures mean that may feel impossible for many staff to keep up. So much happening that it can become frightening. I identify with clinicians who may feel lost within it. I admire clinicians who find success and confidence in this context. I bring the assumption that the workplace is overwhelming. This puts me at risk of hearing things as more overwhelming than what the clinician/participant is saying. It creates a halo effect when the clinician/participant seems to be doing well – who am I to interrogate what they have said and find anything less than perfect?

I am a defender of the underdog. I came from a poor family. I was a bullied teenager. I've felt oppressed. I've seen mental illness from the outside. I've seen it from the inside. I may not be a parent, but I sympathise with the mental illness part of the parent with a mental illness. Consequently, I have a tendency to align with the clinician/participant who speaks empathically of parents and families. I find it grating when clinician/participant speaks about their frustrations and impatience. It is tempting to judge the clinician/participant.

Interestingly, I really care about the clinician/participant who wants to be patient and understand but is becoming so frustrated because they are just so overwhelmed (add the above two together). My job is to understand them – that is hard to do when I feel compelled to help them.

There are many ways I am positioned to the research undertaken in this thesis. Pulling me strongest are three ways that I am positioned to the participants and what they are saying:

- I want to side with the participants who show empathy for parents and families
- I want to identify with the participants who are feeling overwhelmed
- I want to idolise the participants who are confident

Diligent reflection is required to limit the bias created by factors such as these. This may be promoted through formal and semi-formal methods such as note-taking, structured meetings, interrogating the findings at various stages of analyses to check their alignment with the data.

List of Abbreviations used in the Thesis

CoPMI	Children of parents with a mental illness
FaPMI	Families where a parent has a mental illness
FFMHPQ	Family-Focused Mental Health Practice Questionnaire
FFWQ	Family-Focused Workforce Questionnaire
MHA	Victorian Mental Health Act (2014)
IPA	Interpretative phenomenological analysis
LT	Let's Talk about Children

Chapter 1

Introduction to the Thesis

Parental mental illness is common (Maybery, Nicholson & Reupert, 2015) and can have substantial impacts on family members (Awram, Hancock & Honey, 2017; Gladstone, Boydell, Seeman & McKeever, 2011). Therefore, it is crucial that these parents and their families are provided with adequate support. The adult mental health system is uniquely positioned as a point of contact for some of the most vulnerable families. A growing body of literature has investigated the effectiveness and implementation of practices for working with parental mental illness (Maybery & Reupert, 2009; Siegenthaler, Munder & Egger, 2012; Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009; Swartz et al., 2008). Largely absent from this literature is the viewpoint of clinicians. Thus, the current thesis sought to examine the experiences and views of clinicians towards working with parental mental illness within the Australian mental health sector.

Chapter 1 provides an overview of the prevalence and impacts of parental mental illness on parents and their children. Chapter 2 reviews literature related to workforce issues of treating parental mental illness within the adult mental health sector. In particular, chapter 2 outlines the limitations of standard treatment for parents with a mental illness and the benefits of family-focused practices. Consideration is then given to factors that hinder family-focused practices and initiatives to promote their use. A rationale is then provided for the examination of clinician's perspectives and experiences of working with parental mental illness. The aim of the research is then outlined.

Chapter 3 provides a rationale of the chosen methodology for the first three studies in this thesis and an outline of the procedure employed. The following three chapters present published studies relating to clinicians experiences of the challenges of working with parents (Chapter 4), emotional responses to consumers who are parents and their children (Chapter 5) and the introduction of the Victorian Mental Health Act (Chapter 6). The methodology for the final study is provided in Chapter 7. This study, an evaluation of a family-focused e-learning resource, is then presented in Chapter 8.

Chapter 9 is a general discussion of the findings from the thesis. This includes a summary of the rationale and the main findings from each study. General themes from across studies are then discussed before considering the limitations and strengths of the thesis and making recommendations. Concluding statements are then made.

1.1 Definition and prevalence of parental mental illness

Definitions of parental mental illness vary considerably. Some research has considered mental illness generally (Gladstone et al., 2011; Jones et al., 2016), while other sections of the literature have focused specifically on severe mental illness, including schizophrenia, bipolar and personality disorders (Diaz-Caneja & Johnson, 2004; Dolman, Jones & Howard, 2013; Howard & Hunt, 2008), or on specific disorders such as depression (Solantaus, Paavonen, Toikka, & Punamäki, 2010). Some studies have considered substance use disorders as relevant to the study of parental mental illness (Edwards, Eiden & Leonard, 2006; van der Ende, van Busschbach, Nicholson, Korevaar & van Weelghel, 2016), though others have not included participants with these diagnoses (Drost, van der Krieke, Sytema & Schippers, 2016; Goodman et al., 2011). This thesis focuses on the support of parents with mental illness within the adult mental health sector. Although this sector specifically provides services during periods of crisis when individuals have

heightened distress or impairment (Department of Human Services, State Government of Victoria, 2006) there is no exclusion criteria around the types of diagnosis that may be treated. Within this thesis, mental illness is considered as any mental illness, including drug and alcohol abuse, which may result in engagement with adult mental health services. While this definition is highly inclusive, it is recognised that adult mental health services are more likely to be involved when the mental illness is most severe or at times of crisis.

The concept of *parent* has also varied across the literature relating to parental mental illness. Although some literature has focused on parents who have full-time custody of dependent children (Afzelius, Plantin & Östman, 2018; Stallard, Norman, Huline-Dickens, Salter & Cribb, 2004), other authors have been more inclusive and recognised parents do not live with their children (Diaz-Caneja & Johnson, 2004; van der Ende et al., 2016) or have adult children (Awram et al., 2017). Further complicating the matter, much of the research into parental mental illness has focused specifically on mothers (Dolman et al., 2013; Halsa, 2018; Perera, Short & Fernbacher, 2014). Except where otherwise stated, it is recognised within this thesis that a parent may be any person who identifies with this role, regardless of gender, custodial status, biological relationships or the age of the child.

Determining the prevalence of parental mental illness is not a straight forward process. In addition to the issues of defining parenthood and mental illness, there are also difficulties associated with sampling and data collection. Maybery, Nicholson and Reupert (2015) described two broad approaches to estimating the prevalence of parental mental illness and the limitations associated with each. The *top-down* approach involves the analysis of pre-existing data from general populations, such as national surveys (Luciano, Nicholson & Meara, 2014) or census information (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). A limitation of such

methods is that measures are not sensitive or accurate at determining the presence of parental mental illness because they were not developed specifically for this purpose. Alternatively, the *bottom-up* approach utilises data that has been collected from within specific services such as audits of case files (Fernbacher, Goodyear & Farhall, 2009; Gatsu et al., 2016) or surveys completed by consumers of particular services (Handley, Farrell, Josephs, Hanke & Hazelton, 2011). Importantly, samples from bottom-up studies are not representative of larger populations, limiting the generalisability of findings.

Maybery, Nicholson and Reupert (2015) reported estimates of parental mental illness in Australia from a combination of top-down and bottom-up approaches. Top-down findings were based on broad population data from the Australian Bureau of Statistics (1998; 2003) and indicated that approximately 23.3% of Australian families have at least one parent with a mental illness. Another estimate was calculated from a large community survey which suggested 14.4% of families have a parent with a mental illness. Differences between these estimates were attributed to methodological differences, specifically that the first estimate was based on a diagnostic questionnaire while the second relied on participants to self-identify their mental illness or the mental illness of a partner.

A bottom-up estimate utilised data from adult mental health service records across the state of Victoria. These data were extrapolated to the wider population, which indicated that approximately 1.3% of Australian families have a parent who is receiving support from adult mental health services. This estimate is understandably lower as it refers to a specific subset of parents with a mental illness who are receiving clinical services.

Despite the variation between these prevalence estimates, it is clear that parental mental illness is common in Australia. The higher estimate suggests that one in five families have a

parent with a mental illness. Despite the second estimate being considerably lower, it still equates to over 300 000 Australian families where a parent has a mental illness (Maybery, Nicholson & Reupert, 2015). Moreover, 20 000 of these cases involved parents who were receiving services from clinical adult mental health services. Therefore, given the prevalence of families where a parent has a mental illness, it is essential that parental mental illness is well-understood and adequate services are available for these parents and their families.

1.2 Experiences of parents

A growing body of literature has investigated the experiences of parents who have a mental illness. While many people with a mental illness may manage parenting responsibilities very well (Awram et al., 2017), multiple studies have highlighted difficulties that can be experienced when attempting to balance the demands of parenting and address mental health needs (Awram et al., 2017; Montgomery, Mossey, Bailey & Forchuk, 2011). Specifically, parents have reported that having a mental illness may make it more difficult to discipline children, enforce boundaries, arrange activities and maintain routines (Ackerson, 2003; Stallard et al., 2004; van der Ende et al., 2016). Additionally, the presence of a mental illness may make it difficult for parents to respond empathetically and form a nurturing bond with their children (Abrams & Curran, 2011; Hine, Maybery & Goodyear, 2017). Moreover, interactions with children may be experienced as stressful and subsequently aggravate the parents' mental illness (Evenson, Rhodes, Feigenbaum & Solly, 2008).

Parents with a mental illness may have unreasonable ideals of what it means to be a good parent (Jones et al., 2016; Montgomery, Tompkins, Forchuk & French 2006). This may include not only performing parenting tasks to an exceptional standard, but also expecting themselves to enjoy completing these tasks (Halsa, 2018). When these expectations are not met, it can lead to

feelings of inadequacy and failure (Abrams & Curran, 2011; van der Ende et al., 2016) as well as shame and guilt (Dolman et al., 2013). These feelings can exacerbate the parent's mental illness (Davies & Allen, 2007). Thus, parents may experience tensions between multiple self-concepts – being a person with a mental illness, the desire to be a good parent and the perception of actually being a bad parent and a failure (Abrams & Curran, 2011; Davies & Allen, 2007; Jones et al., 2016;).

Parents' perceptions of themselves as bad parents may be reinforced by stigmatising attitudes from the community and mental health services (Dolman et al., 2013). A survey of over 2000 parents who had accessed mental health services indicated that nearly 30% of participants had experienced stigma and/or discrimination in relation to their parenting (Jeffery et al., 2013). Stigma may include assumptions that a person with a mental illness cannot be a good parent (Benders-Hati, Barber & Alexander, 2013; Diaz-Caneja & Johnson, 2004) or will maltreat their children (Halsa, 2018). Parents have also reported having their views and concerns about their children dismissed by health professionals after disclosing their mental illness (Davies & Allen, 2007; van der Ende et al., 2016; Jeffery et al., 2013). Consequently, parents described efforts to conceal their mental illness (Davies & Allen, 2007; Montgomery et al., 2006) and remain cautious about the information that they shared publicly and with health services (Jones et al., 2016; Halsu, 2018).

Some studies have reported on parents' concerns about the consequences of their mental illness on their parenting and the wellbeing of their children (Dolman et al., 2013; Jones et al., 2016). Parents may have concerns that their mental illness prevents them from responding appropriately and providing adequate care and structure for their children (Diaz-Caneja & Johnson, 2004; Dolman et al., 2013). They may also worry about passing their mental illness to

their children (van der Ende et al., 2016; Evenson et al., 2008; Jones et al., 2016). Additionally, parents may be concerned about the stigma and bullying that children may experience through their association with the parent's mental illness (Jones et al., 2016; Halsa, 2018). Furthermore, several studies have described parents' fears of losing custody of their children (Dolman et al., 2013; Jones et al., 2016; Montgomery et al., 2011), with some parents reporting that their mental illness had been used against them during custody or access disputes (Jeffery et al., 2013; Reupert & Maybery, 2009).

Notwithstanding the challenges reported by parents, positive experiences of parenting with a mental illness have also been reported. Even when managing a mental illness, parenting was described as a central role in people's lives which brought joy (Abrams & Curran, 2011; Diaz-Caneja & Johnson, 2004) and meaning (Dolman et al., 2013; Evenson et al., 2008). Working through difficult times may provide an opportunity for families to develop strong relationships (Ackerson, 2003; Jones et al., 2016). The acceptance of family may be reassuring for some parents in managing their mental illness (Evenson et al., 2008). Caring for children may provide daily structure and opportunities to engage socially with other parents (van der Ende et al., 2016), which are all factors that may promote recovery from mental illness (Maybery & Reupert, 2018a, 2018b). Overall, the wellbeing of children can be a motivating factor for some parents to commit to their mental health recovery (Evenson, et al., 2008; Reupert & Maybery, 2009) and an incentive to engage with services (Diaz-Caneja & Johnson, 2004).

1.3 Experiences of children of parents with a mental illness

Parental mental illness also has implications for children (Leijdesdorff, van Doesum, Popma, Klaassen & Amelsvoot, 2016; Tabak et al., 2016). Gladstone, Boydell and McKeever (2006) pointed out that the children of parents with a mental illness were traditionally viewed as

passive victims who are at risk of being harmed. In contrast to this view, they argued that these children actively participate in families and respond to the challenges that may occur when a parent has a mental illness. Thus, it is essential to consider the viewpoint and experiences of these children.

Research with these children indicates that their experiences may fluctuate, with ‘good’ periods of stability being punctuated by ‘bad’ periods of disruption (Dam, Joensen & Hall, 2018; Riebschleger, 2004). This disruption may be unpredictable (Mordoch et al, 2008; Tabak et al., 2016) and can arise suddenly (Tronsden, 2012). Children may use specific parenting behaviours to distinguish between periods of stability and disruption (Fjone, Ytterhus & Almvik, 2009). For example, trips to the beach might signify good periods (Riebschleger, 2004) while periods of disruption might be signified by parental moodiness, yelling, violence (Pölkki, Ervast & Hupponen, 2004) or withdrawal and disengagement (Tabak et al., 2016). The specific behaviours that children use to signify good and bad times are influenced by factors such as the nature of the mental illness and the age of the child (Backer, Murphy, Fox, Ulph & Calam, 2017).

Children have reported numerous difficulties associated with their parent’s mental illness. Routines may be disturbed and parents may not be able to arrange activities or events (Tronsden, 2012; Maunu & Stein, 2010). Family relationships may also be disrupted. Some parents may become over-involved (Aldridge, 2006) while others may become emotionally unavailable (Tabak et al., 2016). Some children experience a longing for their parent who is physically present but feels like a different person (Pölkki et al., 2004; Tronsden, 2012). When a parent has a mental illness, there may be more conflicts between family members (Perera et al., 2014). The parent without the mental illness may have difficulty coping with these conflicts and may become less responsive to the child (Pölkki et al., 2004).

Children have reported experiencing a variety of emotions related to their parents' mental illness. For example, they may become angry when parents are unavailable or moody (Backer et al., 2017), uncomfortable or embarrassed if the parent acts strangely (Knuttsen-Medin, Edlund & Ramklint, 2007) and/or sad when the parent appears upset (Dam et al., 2018). Parental mental illness may also lead children to experience feeling such as confusion, shame, embarrassment and guilt (Gladstone et al., 2011).

Although children may be negatively impacted by parental mental illness, there is often a great deal of silence around the topic (Tronsden, 2012). Children may not receive adequate information to make sense of their experiences (Dam, et al., 2018; Fjone et al., 2009). Unusual or negative events may not be openly acknowledged or explained by family members (Knuttsen-Medin et al., 2007) and children may become acutely aware that there is something that they are not being told (Mordoch et al, 2008). When children do not have a reliable and open dialog to make sense of their family experiences, they may glean information from other sources such as overhearing parts of adult conversations (Gladstone et al., 2011; Mordoch et al, 2008). They may then misinterpret this information and their experiences. For example, they might attribute their parent's moods to their own misbehaviour. (Backer et al., 2017). Similarly, the silence experienced by these children can lead them to feel that their family is shameful, deviant and less worthy than other families (Dam et al., 2018; Fjone et al., 2009).

When children of parents with a mental illness do not have an adequate explanation for the events they are experiencing, they often begin to worry. These worries may be about the wellbeing of their parent (Tronsden, 2012). In particular, they may have concerns that the parent's behaviour will worsen and that the parent will not get the support that they need (Knuttsen-Medin et al, 2007). Children may also fear that suicide or hospital admissions will

separate them from their parent (Gladstone et al., 2011; Riebschleger, 2004). Money and living standards may be a concern for these children if they believe the parent is not able to take care of these matters (Stallard et al., 2004). These worries may lead children to monitor for signs of disruption from their parent or family (Mordoch & Hall, 2008).

Children may adjust their own behaviour to maintain a stable environment. They may attempt to prevent any disruptions by prioritising their parent's needs (Gladstone et al., 2011). This can involve deliberately remaining quiet and out of the way (Mordoch & Hall, 2008; Tronsden, 2012) or refraining from behaviours that could make the parent angry or disappointed (Knuttsen-Medin et al., 2007). When the parent displays symptoms of their mental illness, the child may try to mend or accommodate for the changes that occur. For example, they may be overly compliant to the wishes of the parent, provide company, attempt to make the parent laugh (Mordoch & Hall, 2008) or make efforts to distract people's attention from their parent's behaviour (Fjone et al., 2009). Thus, the parent's behaviours and needs may become the focus of the child, rather than addressing or considering their own needs.

Children may also accommodate for their parent's mental illness by taking control of day to day tasks (Mordoch & Hall, 2008). This can include performing household tasks and taking care of siblings (Knuttsen-Medin et al., 2007). Children may have difficulty recognising if/when these family responsibilities are getting in the way of their own needs (Gladstone et al., 2011). Due to the fluctuating nature of many mental illnesses, children may also find it hard to identify when they should take on these responsibilities and when they should step back (Tronsden, 2012).

Although children want to retain a connection with their parents and families (Reupert, Goodyear & Maybery, 2012), they also need time away from them. Withdrawal and avoidance

are coping strategies that children may use when their parent has a mental illness (Backer et al., 2017; Reupert & Maybery, 2007a). Children may find respite through school, hobbies and time with friends (Backer et al., 2017; Fjone et al., 2009; Mordoch & Hall, 2008). These outlets may also provide these children with stability and a sense of normalcy. When children are particularly overwhelmed by the impacts of their parent's mental illness, they may disengage from the relationship (Mordoch & Hall, 2008) and older children may move out of home (Tronsden, 2012).

Children of parents with a mental illness report being exposed to stigma and discrimination (Ackerson, 2003). They may be bullied or ignored by their peers because of their association to their parent (Dam et al., 2018; Pölkki et al., 2004). Children may respond to this by behaving more quietly and avoiding activities that might draw attention to themselves (Fjone et al., 2009). They may limit socialising and choose not to invite people over to their homes (Gladstone et al., 2011). The combination of public and internalising or self-stigma is also a barrier to children talking about their experiences and seeking help (Gladstone et al., 2011; Tabak et al., 2016).

1.4 Intergenerational transmission of mental illness and mental health issues

Without appropriate support, the children of parents with a mental illness are more likely to experience poor functioning and negative mental health outcomes than their peers (Goodman et al., 2011; Walsh et al., 2009). Utilising the strengths and difficulties questionnaire, Maybery, Reupert, Goodyear, Ritchie and Brann (2009) found that children of parents with a mental illness scored significantly higher than children of parents without a mental illness for behavioural problems, hyperactivity and peer problems. Furthermore, for all of these problem areas they were twice as likely to score within the borderline and clinical ranges. Having a parental with a mental

illness is also associated with social and emotional difficulties (Goodman et al., 2011), poor educational and employment outcomes (Mowbray, Bybee, Oyserman, MacFarlane & Bowersox, 2006), reduced adaptive coping (Walsh et al., 2009), substance abuse (Mowbray & Oyserman, 2003), attention problems (Ashman, Dawson, & Panagiotides, 2008), difficulties trusting others (Maunu & Stein, 2010) and increased rates of suicide (Hammerton, Zammit, Thapar & Collishaw, 2016; Webb, Pickles, Appleby, Mortensen & Abel, 2007).

Children of parents with a mental illness are at an increased risk of developing their own mental illness (Leijdesdorff et al., 2016). Some research has focused on diagnosis specific transmission of mental illness. For example, Weissman et al., 2006 reported that parental depression increases the risk of children also developing depressive disorders. However, there is also a growing body of evidence that these children are also at an increased risk of developing a broad range of other mental illnesses such as attention deficit disorder, conduct disorder (Leischied, Chiodo, Whitehead & Hurley, 2005) and anxiety (Avenevoli & Merikangas, 2006). Goodman et al. (2011) conducted a meta-analysis of research related to mental illness in the children of mothers with depression and found equivalent effect sizes for the development of internalizing (eg, depression) and externalizing (eg, conduct disorder) disorders. This suggests that parental depression is a risk factor for children developing a range of mental illnesses and not just depression. Similarly, Leijdesdorff et al., (2016) conducted a review of literature related to psychopathology in children of parents with various mental illness. Again, findings indicated that these children are at risk of various mental illnesses rather than just the same diagnosis as their parent.

Multiple pathways have been suggested for this intergenerational transmission of mental illness. Genetic and environmental factors have been implicated in the development of mental

illness (Fracic', Middeldorp, Dolan, Ligthart & Boomsma, 2010; Reupert, Maybery & Nicholson, 2015). Genetic influences have been widely acknowledged, with approximately 30% of the variability in depressive symptoms accounted for by heritability (Rice, Harold & Thapar, 2005). Genetic influences are considerably higher for severe mental illnesses such as bipolar and schizophrenia (Insel, 2009). Specific genes have been associated with mental illnesses (Hammen, Brennan, Keenan-Miller, Hazel & Najman, 2010) and some research has investigated how these genes interact with environmental factors (López-León et al., 2008). Beyond genetic influences, shared environmental factors have also been implicated in the transfer of mental illness from parents to their children, including shared negative life events, low family income and low socioeconomic status (Lewis, Rice, Harold, Collishaw & Thapar, 2011).

Parent-child relationships have been identified as a pathway for the transmission of mental health problems. Research into infant attachment indicates that children with secure attachment in early childhood tend to be more resilient than children with insecure attachment to the fluctuations and impacts of parental mental illness (Milan, Snow & Belay, 2009). The impact of this early attachment may be maintained into late childhood (Wan & Green, 2009). Similarly, negative parent-child relationships in middle childhood are associated with increased rates of suicidal ideation in late adolescence (Hammerton et al., 2016). Specific parental behaviours are also mediators of the transmission of mental illness and/or mental health problems. These include parenting which is permissive (Oyserman, Bybee, Mowbray, & Hart-Johnson, 2005), harsh or inconsistent (Goodman et al., 2011) and parental expressions of hostility (Harold et al., 2011), intrusiveness (Cresswell, Apetroaia, Murray & Cooper, 2013), over-involvement and fear (Cresswell, Willetts, Murray, Singhal, & Cooper, 2008). Conversely, behaviours such as actively

listening and talking to children may ameliorate at least some of the negative impacts of the parent's mental illness (Weissman et al., 2006). Thus, the mediating impacts of the relationships between parents with a mental illness and their children are multifaceted and complex.

Mental health literacy is another important factor in the transfer of mental health problems from parents to children. Mental health literacy refers to a person's level of understanding about mental health and mental illness, as well as attitudes towards mental health issues (Kutcher, Wei & Coniglio, 2016). Low levels of mental health literacy mean that people may not understand mental health issues being experienced by themselves or those around them (such as their parents) and may be unaware of how to access support (Furnham & Swami, 2018).

Psychoeducation is one method for addressing mental health literacy deficits. Numerous studies have demonstrated benefits of psychoeducation-based interventions for ameliorating the negative impacts of parental mental illness on children (Beardslee, Wright & Gladstone, 2007; Riebschleger, Tableman, Rudder & Onaga, 2009). After viewing a DVD (Grové, Reupert & Maybery, 2015) or booklet (Grové, Melrose, Reupert, Maybery & Morgan, 2015) about parental mental illness, children reported greater understanding and acceptance of their parent, knowledge about how they could access support and a realisation that they were not the only children experiencing parental mental illness. They also described an improved relationship with their parent. Recent efforts have focused on identifying the types of knowledge children require when a parent has a mental illness. Riebschleger, Grové, Cavanaugh and Costello (2018) conducted a thematic analysis of relevant literature and identified various knowledge needs of children when a parent has a mental illness. These included general information about mental illness, causes and prognosis, methods of seeking support and coping with fluctuations and what happens in mental health services.

The volume of literature relating to the impacts of parental mental illness and transmission to children continues to grow. Knowledge of these issues is crucial for the development of effective interventions and support services. Unlike genetics or broad environmental factors, parent-child relationships and mental health literacy may be readily addressed. Services are needed which investigate the wellbeing of children and address these pathways.

Chapter 2

Literature Review

2.1 Parental mental illness and the adult mental health sector

Given the high prevalence (Maybery, Nicholson & Reupert, 2015) and the potential negative impacts of parental mental illness for all family members (Reupert & Maybery, 2007a), it is vital that these families receive appropriate support. There are various opportunities for intervention with families where a parent has a mental illness. Initial points of contact include, but are not limited to, prenatal and paediatric services (Earls, 2010), medical clinics (Rishel, 2012), early childhood services (Leletas, Goodyear & Reupert, 2018), schools (Bibou-Nakou, 2004; Reupert & Maybery, 2007b) and mental health settings (Reupert, Maybery & Kowalenko, 2012; Reupert, Maybery & Morgan, 2015b). Each of these service types play a crucial role in the support of families to alleviate the impacts of parental mental illness.

This thesis focuses on the role of adult mental health services when a parent has a mental illness (Dolman et al., 2013; Foster, O'Brien, & Korhonen, 2012; Maybery & Reupert, 2009). Although the specific nature of adult mental health services may vary across countries and jurisdictions, they share some common characteristics. In Australia, adult mental health services provide treatment to adults who experience severe mental illness, significant disturbance and/or crisis situations (Department of Human Services, State Government of Victoria, 2006). Treatments may range from triage and crisis assessment, through to continuing care and rehabilitation and may include admission as an inpatient, outpatient or treatment within a community setting (Department of Health and Human Services, State Government of Victoria, 2011). Thus, engagement with adult mental health services may be limited to a single encounter or may include multiple encounters over several years.

A recent systematic literature review (Maybery & Reupert, 2018b) identified nine studies used to estimate the proportion of people who are parents and who are receiving adult mental health services. Although there was considerable variation in the findings of these studies, the majority reported between 20 and 38 percent of people receiving clinical adult mental health services were parents with children below the age of 18 years. Estimates from the lower end of this range equate to nearly 60 000 children in Australia who have a parent receiving adult mental health care (Maybery, Nicholson & Reupert, 2015). Thus, the adult mental health sector is a major point of contact for some of the most vulnerable families impacted by parental mental illness. Accordingly, it is crucial that these services adequately support these parents, as well as their children and families. In order to achieve this, effective forms of intervention for parental mental illness must be identified and then implemented across the sector.

2.2 How effective is ‘treatment as usual’ when a parent has a mental illness?

Some mental health clinicians assume that the generic treatment of a parent’s mental illness symptoms will be adequate to address the needs of the parent and reduce risks to children (Reupert, Maybery & Morgan, 2015b). However, research relating to ‘treatment as usual’ for parental mental illness indicates otherwise. Forman et al., (2007) investigated the impact of 12 weeks of treatment on the parenting of mothers who experienced postpartum depression. They reported that the treatment did not have a significant impact on the parents’ responsiveness to their children or parents’ self-reports of the quality of the parent-child relationship after the treatment of at an 18-month follow-up. Although some reduction in parenting stress was found after treatment for depression, it remained higher than for a control group of mothers who did not have depression. Mothers who received the treatment also continued to rate their children lower in attachment, higher in problematic behaviour and more negative in temperament at an 18

month follow-up. They concluded that treatment as usual was not sufficient to adequately address parenting issues associated with depression or disruptions to the mother-infant relationship.

Coiro, Riley, Broitman and Miranda (2012) reported that child outcomes were not significantly impacted by parent treatments for depression. However, remission of depression did result in some positive changes for children. They allocated mothers experiencing depression to one of three interventions for depression – waitlist, cognitive-behavioural therapy or medication. No significant differences in children's behavioural or adaptive functioning between these groups at six or twelve months after treatment. The data were re-analysed, with comparisons made between children of mothers who had remained depressed and mothers whose depression had remitted, regardless of treatment condition. The children of mothers whose depression had remitted showed significantly fewer behaviour problems but adaptive functioning was not significantly different to children of mothers with depression. Thus, benefits to children were only seen in some areas of functioning and were related to remission of parental depression rather than treatment.

Weissman et al., (2014) also found that children benefited when parental depression remitted, but that these benefits were lost if the mothers experienced a relapse in depression. They assessed mothers and their children over a nine-month period. Their results showed that decreases in parent symptomology were associated with decreases in symptoms of child depression. However, subsequent relapses in maternal depression were associated with increases in child symptoms. These associations between maternal and child symptoms were found to be mediated by communication and bonding between the mother and child.

Collectively, these studies have important implications for the treatment of parental mental illness. When offered treatment as usual, the benefits for children are contingent on a reduction of parents' symptoms which may not be timely and cannot be guaranteed. Child difficulties may reoccur if the parent's mental illness is episodic or fluctuating. Further, parenting stress and disruptions to the parent-child bond may not be ameliorated by standard treatments and may continue to cause problems after parental symptoms have improved. The above research findings suggest that treatment as usual may not adequately support parents who have a mental illness or their children. Instead, adult mental health services should utilise family-focused practices when a parent has a mental illness (Foster et al., 2012). These are practices that extend the focus of care beyond the parent's mental health symptoms to also consider the needs wellbeing of all family members (Foster et al., 2016).

2.3 Family-focused practice

Family-focused practice originated in the field of paediatrics in response to parents' demands to participate in the treatment of their children (Jolley & Shields, 2009). Although family-focused practice has no clear definition and may be referred to with inconsistent terms such as family-centred, family-sensitive or family-oriented practice (Foster et al., 2016), key principles are consistently referred to. In a seminal paper, Briar-Lawson and Lawson (2001) described family-focused practice as a partnership between staff and families who are recognised as experts on what will help or harm the child and the family. Extending on this, MacKean, Thurston and Scott (2005) asserted that family-focused practice required clinicians to recognise the uniqueness of families, their strengths and their capacity for skill-building and involved offering families the opportunity to connect with community-based supports. In a different approach, Mikkelsen and Frederiksen (2011) reviewed relevant literature to conduct a concept

analysis of family-focused practice with children in hospital. They identified key attributes of family-focused care. These included the promotion of parent autonomy and control, shared responsibility and negotiation between staff and families of clinical care, shared goals and support for families. Although the presence of these attributes was consistent across the literature, the authors argued that more clarity is needed about the definition and operationalisation of each of these areas.

Family-focused practice has since expanded into other care settings, including palliative care (Del Gaudio, Zaider, Breir & Kissane, 2012) child and adolescent mental health (MacKean et al., 2012) and adult mental health (Eassom, Giacco, Dirik & Priebe, 2014). The intention of utilising family-focused practices within the adult mental health sector is to reduce potential negative impacts of the mental illness on family members in addition to enhancing the support that these families can provide for the person with the mental illness (Lakeman, 2008; Reupert et al., 2018). This is particularly pertinent to the treatment of parental mental illness when children are at increased risk to adverse outcomes (Ashman et al., 2008; Tabak et al., 2016) and may be caring for the parent (Aldridge, 2006).

As with the paediatric setting, there is a lack of consistent definition and operationalisation of family-focused practice within adult mental health settings (Reupert et al., 2018). Foster et al. (2016) aimed to address these issues with a systematic review of literature relating to family-focused care across child and adult mental health settings. They found that conceptualisations of family-focused care varied according to the nature of the family being discussed and the type of service involved. For example, in a family of origin (where the person with a mental illness is a child within the family) emphasis was placed on supporting the family to meet the needs of the person with the mental illness. Alternatively, family-focused care in

regard to family of procreation (where the person with a mental illness may be a parent) place an emphasis on addressing the impact of the mental illness on other family members and ensuring their wellbeing. Foster et al. (2016) identified six core aspects family-focused practices within this literature. These were (i) family care planning and goal setting, (ii) liaison between services and families, (iii) instrumental, emotion and social support for family members, (iv) assessment of the wellbeing of family members and family functioning (v) family psychoeducation and (vi) coordinated system of care between services and families. This synthesis of the literature was an important step to progress towards a more consistent delivery of family-focused care across mental health settings.

Particularly relevant to this thesis are family focused practices that may be employed with parents in the adult mental health sector. Emphasis has been placed on practices that recognise and support parenting roles and child wellbeing. Although family-focus practices extend beyond the parent and child and encompass the wellbeing of all family members (Foster et al., 2012), the parenting domain has been recognised as a key area of need and intervention (Goodyear et al., 2015). Consequently, the focus on family-focused practices related to parenting and child wellbeing are warranted in the context of this thesis.

Despite the conceptual issues associated with family-focused practice, there is an emerging evidence base for the use of family-focused practices when a parent had a mental illness. Siegenthaler et al. (2012) conducted a meta-analysis of the effectiveness of family-focused interventions for reducing the psychological difficulties in the children of parents with a mental illness. They identified 18 articles from four countries that reported on randomised control trials of 13 interventions with follow-up times ranging from 0-15 years. The interventions were for delivery to parents or couples (n=7), adolescent children (n=2) or families (n=4). The

meta-analysis showed that these interventions reduced the risk of children developing their own mental illness by up to 40%. Furthermore, interventions that were completed by only the parent with the mental illness were as beneficial as those delivered to the child or involving the whole family.

Although less research has investigated the benefits of family-focused practices for parents, the findings are promising. An early study by Beardslee et al. (1997) found that a psychoeducational intervention for parents with a mental illness led to improvements in self-understanding, coping strategies, daily functioning and the amount of attention paid to children. These benefits were maintained at a 4.5 year follow-up (Beardslee et al., 2007). Other evaluations of family-focused interventions showed improvements to parents' efficacy and confidence as well as reductions in guilt (Solantaus et al., 2010; Solantaus et al., 2009). Swartz et al., (2008) found that family-focused adaptations of existing treatments may also benefit parents. They compared a family-focused adaptation of interpersonal psychotherapy with standard interpersonal psychotherapy to treat mothers with depression. At 3 and 9 months after the interventions, the mothers in the family-focused adaptation reported significantly lower levels of depression and higher levels of global functioning than the mothers who received the standard treatment.

Additionally, family-focused interventions have also resulted in whole-family improvements. These benefits have been reported in the areas of general family functioning and communication (Solantaus et al., 2009). In particular, families reported improved family communication about the parent's mental illness (Beardslee et al., 2007). This growing evidence base proves a sound argument for the use of family-focused interventions with parents in adult mental health services to negate the potential negative impacts on their children.

2.4 How family-focused are adult mental health services?

Although there is a strong rationale for adopting a family-focus in adult mental health services when a parent has a mental illness, this may not be common practice. A survey conducted in Norwegian psychiatric units showed that 56% of staff did not regularly identify the children of consumers (Lauritzen, Reedtz, van Doesum & Martinussen, 2014). Benders-Hadi, et al. (2013) audited the case notes of mothers who had been admitted to an inpatient psychiatric unit in New York. Although motherhood was mentioned in 80% of the files, only about 40% of files indicated that it had been substantially considered in case planning. In a similar study, case files from adult mental health services in central England were reviewed (Gatsu et al., 2016). From 100 files, only 62 had information recorded about parenting status and only 28 indicated that the parent-child relationship had been assessed. A third study involved an audit of case files from mental health crisis response units in Wellington, New Zealand, which was supplemented with data from staff focus groups (Pfeiffenberger, D'Sousa, Huthwaite & Romans, 2016). Findings showed that records of parenting status were inconsistent. Where this information was included in files, it was noted as a risk or protective factor without specific details of the children or their wellbeing. During focus groups, clinicians further acknowledged that the welfare of children was often not considered during assessment and planning (Pfeiffenberger et al., 2016). These studies suggest that the uptake of family-focused practices in adult mental health services is inadequate across many parts of the world.

2.5 Factors that hinder the use of family-focused practices

A body of research has examined why family-focused practices have not been taken up in adult mental health settings when working with parents with a mental illness. Maybery and Reupert (2009) reviewed this literature and developed a hierarchical model of the issues and

barriers that hinder use of family-focused practice (Figure 2.1). The model comprises four levels of barriers pertaining to organisational support, clinician attitude, skill and knowledge, client engagement and factors relating to families and children. The authors argued that these are key points of intervention to promote workforce change.

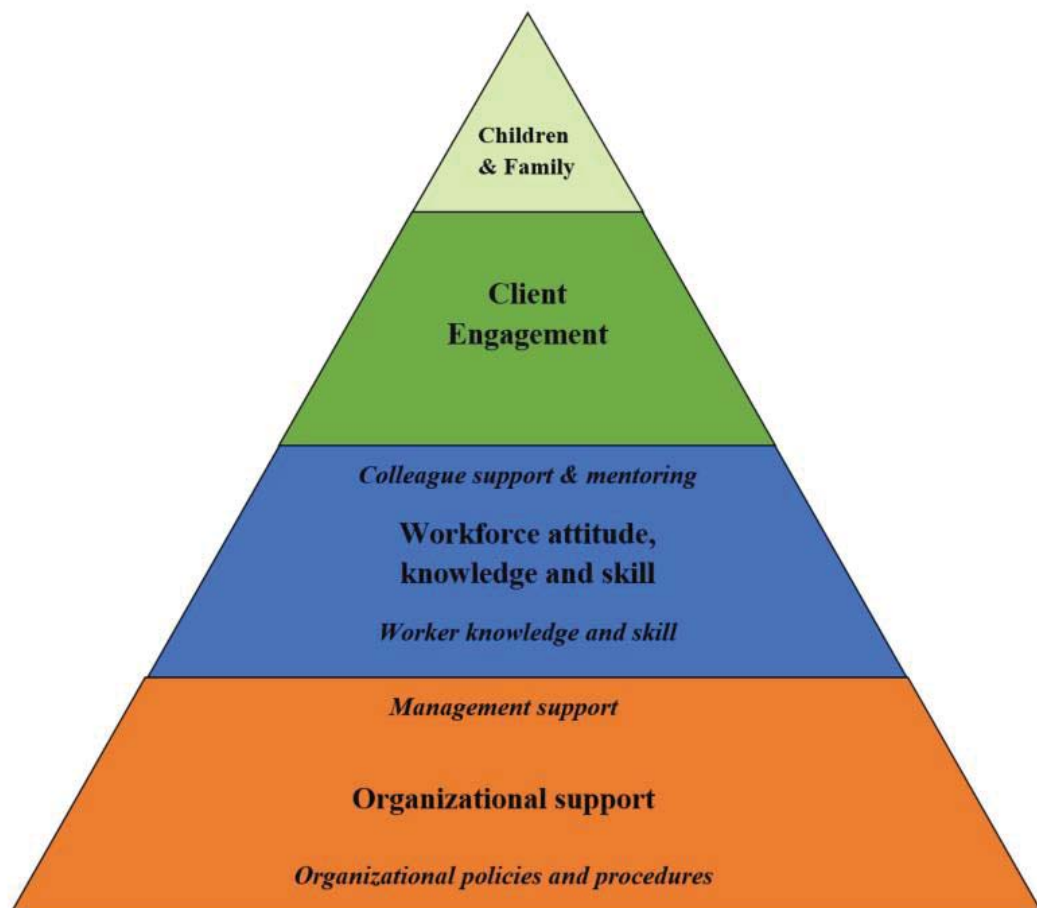


Figure 2.1. Model of issues and barriers that hinder the use of family-focused practices and points of entry for workforce change (Maybery & Reupert, 2009)

Maybery and Reupert (2009) identified multiple issues within the level of organizational support. A key concern at this level was a lack of policy relating to the role of mental health clinicians and guidelines for undertaking family-focused work. High workloads and a lack of resourcing were other restraints. Finally, the attitudes of management were reported as a common difficulty, with family-focused practices not being communicated as a priority within organisations.

The next level in the model consisted of factors pertaining to clinicians, with a particular focus on clinicians' skill and knowledge deficits. Key skill and knowledge for working with parents extends beyond the identification and reporting of significant child protection issues. (Houlihan, Sharek, & Higgins, 2013). It also involves an assessment of the impact of parental mental illness on children and the provision of support to a client for their parenting and the provision of support to the clients' children (Maybery, Goodyear & Reupert, 2012). The ability to engage with clients around parenting and children's wellbeing are other critical skills (Korhonen, Vehviläinen-julkunen, & Pietilä, 2008). Another barrier at the clinician level are attitudes that family-focused practice is not core work in mental health settings (Maybery & Reupert, 2009).

The final two levels of the model are related to engagement difficulties with parents and family members. Examples of issues from the parent level included parental fears that their parenting would be judged or that child protection would be called. Difficulties associated with families and children included transportation and availability factors and reluctance to become involved. Maybery and Reupert (2009) proposed that the organisational level was the main entry point and a necessary point of change before the other levels could be addressed. Although this framework is an important step towards understanding the factors hindering family-focused

practices, little of the underlying research has examined the perspectives of clinicians who undertake this work with parents.

2.6 Efforts to promote family-focused practice

A range of initiatives have been developed to promote the use of family-focused practices when working with parental mental illness (Maybery, Foster et al., 2015). These initiatives have been implemented in mental health workforces across various countries and include legislation, manualised interventions, practice resources and the development of specialist support roles. The following discussion acknowledges developments across various countries with an emphasis on those implemented in Victoria, Australia.

2.6.1 Legislation and policy

Legislation has been introduced in a limited number of countries in relation to the support of children by adult mental health services when a parent has a mental illness. Legislation in Finland mandates that dependent children should have their need for care and support taken care of whenever a parent receives support for mental health or substance abuse problems (Solantaus & Toikka, 2006). Similarly, Norwegian legislation requires the children of parents receiving mental health services to have their needs for information and follow up addressed (Lauritzen & Reedtz, 2013). In the Norwegian legislation, it is specified that the needs of children should be monitored and addressed through conversations with the parents at adult mental health services (*Public Health Act 2011* (No) sch 10a). Lauritzen et al. (2014) investigated the effectiveness of this legislation and found that clinicians identified the presence of dependent children more frequently after the introduction of the legislation, but it did not prompt them to engage in more conversations about parenting and child welfare. This suggests that the legislation in Norway has

been limited in its promotion of practices that address the needs of children when a parent is receiving mental health services.

More recently, legislation was also introduced in Australia that recognises the need to support the children of parents who receive mental health services. In the state of Victoria, the Mental Health Act (2014) states that the children of people receiving mental health services “have their needs, wellbeing and safety recognised and protected” (Principle J). This Act also allows for children to be formally recognised as the parent’s carer. While this key mandate to address the needs of children is encouraging, the Act does not provide clear directives for how this should be achieved. This may allow organisations flexibility in their service delivery, but also means that the expectations of the Act may be unclear to clinicians and services.

Although Australian states and territories provide policy regarding parental mental illness, these tend to focus on departmental strategic planning and risk management rather than providing practical guidance for undertaking practices with parents and/or families (NSW Department for Health, 2010). The Australian Principles and Actions for Services and People Working with Children of Parents with a Mental Illness is one piece of policy that provides clear and practical guidelines for undertaking family-focused practices (Australian Infant Child Adolescent Family Mental Health Association, 2004). This policy was developed through consultation with specialists in the area of parental mental illness (Fudge, Falkov, Kowalenko, & Robinson, 2004) and outlines tasks that can be adopted by adult mental health services and clinicians to effectively respond to parents and their families. For example, it stipulates that clinicians or work teams can promote early identification of risk factors by enquiring about the mental health of family members and children. It also outlines systems-based responses that can be implemented by organisations, such as providing parenting support and skills groups.

Models of family-focused care have also been proposed within the academic literature to support implementation in practice settings. Mottaghypour and Bickerton, (2005) proposed a pyramid of family care that outlines five levels of service provision to incorporate a family-focus. At the base of the pyramid are tasks that make up a minimum standard of family-focused care and should be undertaken with all parents who receive mental health services. This level includes the identification of all family members and assessment of their safety. Higher up the pyramid are more specialised practices identified for families with greater needs. The second and third levels relate to education for families about general factors (such as information about the service being accessed) and specific psychoeducation about the individual's symptoms and treatment. The fourth level is formal family consultation and family therapy is at the apex of the pyramid. While referral to specialist clinicians or other services may be necessary at the higher levels it is expected that all clinicians should undertake tasks at the base of the pyramid with all families when a parent has a mental illness.

Goodyear et al. (2015) developed a set of practice standards for family-focused care in the adult mental health sector. These standards provided a map of family-focused practices across six stages of care, from screening and referral to discharge/transfer of care. Aspects of family-focused practice were identified for each stage and specific tasks were listed. For example, assessment of family is a core aspect of family-focused care during entry into the service. Specific tasks involved the completion of a genogram, determination of the legal status of dependents, identification of any child protection involvement and assessment of family vulnerabilities. Tasks were categorised as essential or recommended.

2.6.2 Manualised interventions

Manualised interventions have also been developed to provide clinicians with structured family-focused methods for working with parental mental illness. Family Talk was the first of these family-focused interventions (Beardslee et al., 1997; Beardslee et al., 2007). It consists of 6-10 sessions and involves participation by parents, children and other family members. Thus, it requires considerable investment from families, clinicians and mental health organisations.

Let's Talk about Children (LT) is a less intensive intervention that can be delivered to the parent over 2-3 sessions and does not require the participation of other family members (Solantaus & Toikka 2006; Solantaus et al., 2010). Comparison studies suggest that LT achieves similar outcomes, and possibly greater benefits in the long term, than the more intensive Family Talk intervention (Punamäki, Paavonen, Toikka, & Solantaus, 2013; Solantaus et al., 2009). Furthermore, adult mental health clinicians in Finland reported increased skill, joy and motivation for working with parental mental illness after completing training in these interventions (Toikka & Solantaus, 2006). Previously these interventions have only been evaluated in relation to the treatment of parental depression in Finland. However, a large scale study is currently underway to investigate the implementation and effectiveness of LT in response to multiple diagnoses across the state of Victoria in Australia (Maybery et al., 2017).

2.6.3 Training, professional support and resources.

Much work has been undertaken in Australia to provide clinicians with training, support and resources for undertaking family-focused practices when a parent has a mental illness. Multiple states, including Victoria, have established a network of workforce coordinators who specialize in the area of Families affected by Parental Mental Illness (FaPMI). The role of these FaPMI coordinators is to increase the awareness and capacity of adult mental health services in

providing support to these families with the overall aim of reducing the impact of mental illness on parents and families (State of Victoria, 2007). They utilise a range of methods, including the provision of information and training, consultation, co-work and direct intervention with parents and families. Increased funding from the state government allowed this program to be extended in Victoria in 2017 which allows FaPMI coordinators to be allocated to all regions across the state (The Bouverie Centre, 2018).

In 2001, the Australian government funded the creation of the National Initiative, Children of Parents with a Mental Illness (COPMI). This initiative was established to provide information and resources relating to parental mental illness to clinicians, parents and families (Fudge & Robinson, 2009). The National Initiative provided this service primarily through an online platform (www.copmi.net.au). The information and resources are free to download from this website and include web-based training resources. An e-learning resource to train in an Australian adaptation of the LT intervention is one of the resources available for clinicians on the site. Also available are practice resources such as booklets that clinicians can share with parents and children (Cooper & Reupert, 2017).

The efforts outlined above to promote family-focused practices align with the points of entry identified by Maybery and Reupert (2009). Legislation and practice guidelines provide relevant policy for organisations. At the clinician level, family-focused practice is supported by manualised interventions, accessible training, practice resources and specialist FaPMI coordinators. Parent and family engagement have been promoted through available information and resources about parental mental illness and family recovery. The influence of these initiatives on the use of family-focused practices has not been well studied and requires further investigation.

2.7 What about clinicians' perspectives?

Clinicians have a vital role in the delivery of family-focused practices. Maybery and Reupert (2009) initially postulated that organisational factors were the key entry point for evoking the uptake of family-focused practices. However, it has since been demonstrated that clinician-related factors are the strongest predictors of family-focused practice (Maybery, Goodyear, Reupert & Grant, 2016). Clinicians are in the unique position of directly navigating the myriad of factors that hinder and promote the use of family-focused practices. It is clinicians who ultimately make the decision, at any particular moment, whether to deliver family-focused practices or not.

Essences refers to essential characteristics of a phenomena that are perceived when it is experienced and influence how it is responded to, (Dahlberg, 2006). In this case, essence refers to those elements of work with parents that are meaningful to clinicians. It is crucial to also build a comprehensive understanding of these essences (through clinicians' experiences and views of their work with parents) and not just the list of externally identified barriers.

Few studies have directly examined clinicians' views and experiences relating to work with parental mental illness. Dolman et al. (2013) conducted a systematic literature review of the experiences of clinicians when treating mothers with a severe mental illness. They found only eight papers and, on that basis of these papers, reported on four common themes. These themes related to worker discomfort, impact of stigma on the clinician-mother relationship, the need for additional training and difficulties relating to inter agency collaboration. It should be noted that the reviewed papers were biased towards specific service types. Six of the eight papers were related only to inpatient settings and half of the papers focused specifically on the support of mothers with postpartum psychosis. Additionally, the overall focus of the review was the

experiences of treating mothers with severe mental illness (mainly psychotic and bipolar diagnoses). Thus, the findings of the review may not be reflective of the experiences of the overall workforce who engage with parental mental illness.

A broad review of the literature relating to clinicians' perspectives of working with parents with a mental illness was conducted for this thesis. Issues identified in this review included clinicians' attitudes towards their work with parents, skill and knowledge deficits, clinicians' emotional experiences and problems with inter-agency collaboration. These issues corroborate and extend on the themes within the review by Dolman et al., (2013). They are further detailed below.

2.7.1 Clinicians' attitudes and perspectives towards their work with parents

Several studies have reported a range of attitudes held by clinicians towards their work with parents. Slack and Webber (2008) surveyed mental health clinicians at a London hospital about their work with parents. They found that the majority of clinicians recognised the importance of supporting parenting and children, but many did not consider it to be within their remit. Similarly, findings from focus groups indicated that some mental health nurses in the UK considered parenting support to be the role of rehabilitation services rather than a component of their own work (Maddocks, Johnson, Wright, & Stickley, 2010). Contrastingly, when Australian mental health clinicians were asked if it was irrelevant to their role to consider the wellbeing of consumers' children, the mean response was in the disagree-strongly disagree range (Maybery & Reupert, 2006). The different findings of these studies may be attributable to a range of factors, including the various locations, other contextual factors and the different sampling and methods employed.

2.7.2 Clinicians' emotional experiences

Clinicians may experience a variety of emotions when working with parental mental illness. Dolman et al, (2013) described the discomfort that clinicians may experience when working mothers with severe mental illness. This discomfort was in the form of anxiety and stress of caring for infants who may be admitted to inpatient wards along with their mothers. Clinicians also reported feeling uncomfortable about other aspects of their work with parents. They may feel a responsibility to support spouses and keep families together (Engqvist, Ahlin, Ferszt, & Nilsson, 2011). Additionally, clinicians may have very strong emotional reactions if a parent harms themselves or a child after being released from care (Engqvist, Ferszt, Ahlin & Nilsson, 2009). These emotions include guilt or anger towards the parent.

Clinicians may experience anxiety when initiating conversations with parents about parenting and child wellbeing. They may have concerns that consumers will view these conversations as an interference in their family life (Lauritzen & Reedtz, 2013) or that such discussions may disrupt the therapeutic relationship (Maybery & Reupert, 2006). Contrastingly, Hackett and Cook (2016) reported that some clinicians who are not parents themselves may feel anxious about discussing parenting topics because it is not an area that they are familiar with. Further research is required to identify how clinicians manage the various emotions associated with working with parental mental illness and the supports that may benefit them.

2.7.3 Skill and knowledge deficits

Clinicians have reported feeling unskilled and/or unqualified for working with parents who have a mental illness (Maybery & Reupert, 2009; McConachie & Whitford, 2009). Maddocks et al. (2010) reported on mental health nurses' concerns of not knowing how to assess for the impact of parental mental illness on children. Houlihan et al., (2013) conducted surveys

and interviews with mental health nurses in Ireland. Participants from this study also commented on skill deficits in relation to assessing the impact of parental mental illness on children. These mental health nurses highlighted a need to develop skills for assessing parent-child bonding as well as skills for working directly with children. They wanted more knowledge about resources for working with parents. Other clinicians have reported the need to develop skills specific to engaging with parents and family members around the topics of parenting and child wellbeing (Korhonen et al., 2008) due to hesitancies that parents and families may have about discussing these stigmatised topics (Dolman et al., 2013; Maybery & Reupert, 2006).

Training and education are generally assumed to be the solution to these skill and knowledge deficits (Dolman et al., 2013; Slack & Webber, 2008). A range of training methods have been developed, including workplace training and e-learning resources (Reupert, Maybery & Morgan, 2015a). A survey conducted in Ireland found that clinicians perceived day-to-day interactions to be more influential on their skill and knowledge acquisition than such formal training (Yadav & Fealey, 2012). The influence of supervision has received little attention, other than finding that clinicians receive very little supervisory support for family-focused practices or matters relating specifically to parental mental illness (Korhonen et al., 2008). Overall, more research is needed to investigate clinicians' views on training programs and other factors that promote family-focused skill and knowledge acquisition and use.

2.7.4 Collaboration between services

When a parent has a mental illness, multiple services may become involved in supporting the various needs of the parent and/or children. Due to the different roles and mandates of these services, they may function as siloed entities (Reimers, 2012) and tensions can arise between them (Scott, 2005). In particular concern are tensions between adult mental health and child

focused services, such as child protection (from both service types) who work with parental mental illness (Darlington, Feeney & Rixon, 2005). This tension has been recognised as a long-standing problem (Hetherington & Baistow, 2001; Tye & Precey, 1999).

Darlington et al. (2005) investigated clinicians' experiences and perceptions of the partnerships (or lack thereof) between adult mental health and child protection services. They identified four potential problematic areas. These were communication, knowledge of the other service, clarity of the roles of each service and the availability of resources. Initiatives have been effective for addressing some of these problems. These include joint protocols (Webber, McCree & Angeli, 2013) and specialist champion roles to educate clinicians about the other service (Pietrantonio et al., 2013). Despite the benefits of such initiatives, clinicians have expressed views that ongoing effective collaboration will require considerable large-scale changes within and between both organisation types.

2.7.5 Balancing the needs of parents and children

In addition to the tensions between services, Scott (2005) suggested that individual clinicians may experience internal conflicts when considering the needs of parents and their children. She added that this may become most evident when children are particularly vulnerable, such as in situations of neglect or abuse. Darlington et al. (2005) found that the potential removal of children when a parent had a mental illness lead to internal conflict for some clinicians. These clinicians recognised the need to ensure the safety of children but also acknowledged the negative impact that child removal could have on the parent. Thus, the needs of parents and children may sometimes seem at odds and be difficult for clinicians to balance.

In the context of family violence, Fleck-Henderson (2000) asserted that clinicians should be trained to maintain parallel perspectives of the needs of mothers and their children. She

referred to this as ‘seeing double.’ Cousins (2004) questioned the feasibility of seeing double in the adult mental health sector. She suggested that clinicians may become torn between the need to give parents time to address mental health and parenting issues and the child’s need for things to change quickly. She further argued that association with an adult mental health service requires clinicians to prioritise advocacy of the needs of the parent. These internal tensions may influence how mental health clinicians work with parents and their families. However, it is yet to be empirically investigated if seeing double is something that clinicians do (or attempt to do) and their experiences of doing this.

2.8 Summary and aims of the thesis

Parental mental illness is common (Maybery, Nicholson et al., 2015) and may negatively impact children (Awram et al., 2017; Gladstone et al., 2011; Leijdesdorff et al., 2016; van der Ende et al., 2016). Adult mental health services are in a unique position to assist some of the most vulnerable families where a parent has a mental illness. Standard treatment is inadequate for addressing the specific needs of these families (Forman et al., 2007; Weissman et al., 2014). Instead, it has been argued that family-focused practices are appropriate for addressing parental mental illness and the needs of families, especially children (Foster et al., 2012). Despite the lack of conceptual clarity around family-focused practices (Foster et al., 2016), an emerging evidence base has demonstrated benefits for parents and children (Siegenthaler et al., 2012; Solantaus et al., 2010).

Unfortunately, family-focused practices may be rarely employed across adult mental health services (Lauritzen et al., 2014; Pfeifferberger et al., 2016). A range of barriers to the use of family-focused practice have been identified which relate to organisations and policy, clinicians, parents and families. (Maybery & Reupert, 2009). Subsequently, a range of initiatives

have been developed and implemented to address these barriers and promote family-focused practices. These include legislation and policy specific to service provision for parents with a mental illness (Fudge et al., 2004; Lauritzen & Reedtz, 2013), manualised interventions (Beardslee et al., 2007; Solantaus et al., 2010), training opportunities and practice resources. Little research has investigated the impact of such initiatives on service provision or outcomes for families (Cooper & Reupert, 2017; Fudge & Robinson, 2009).

Clinicians are central to the implementation and maintenance of family-focused practices. Their experiences and views towards their work with parental mental illness are likely to influence if, and how, they utilise family-focused practices. However, there is a paucity of research related to clinicians' experiences of working with parents or their views of the initiatives to promote family-focused practice.

The objective of this thesis was to address these gaps and examine the experiences and views of adult mental health clinicians in relation to their work with parental with a mental illness. The four papers within the thesis address specific aspects of clinicians' experiences and views. The first two papers relate to practices with parents. The aim of the first paper (Chapter 4) was to examine clinicians' experiences of the challenges associated with working with parental mental illness and the strategies they utilised to manage these challenges. The aim of the second paper (Chapter 5) was to investigate if/how clinicians maintained simultaneous perspectives of the parents they work with and their children.

The final studies, related to two of the initiatives that sought to promote family-focused practice. The third paper (Chapter 6) focused on the Victorian Mental Health Act (2014) which contains a mandate to consider and address the needs of children when a parent received mental health services. The aim of this paper was to examine the experiences and views of the

implementation of this legislation. The final paper (Chapter 7) was concerned with an e-learning resource for clinicians to train in the LT family-focused intervention. The aim of this final paper was to investigate the effectiveness of the e-learning resource for developing clinician skill, knowledge and attitude for family-focused practice. A second aim of this paper was to examine clinicians' views towards the e-learning resource.

Chapter 3

Methodology of Phenomenological Studies

3.1 Introduction to methodology for phenomenological studies

This chapter will outline the methodological framework and procedures employed for the phenomenological studies which are presented in chapters 4, 5 and 6. Firstly the position of qualitative research in mental health research will be discussed and then the specific methodology used in the first three studies, Interpretative Phenomenological Analysis (IPA), will be described. An overview and justification of research procedures and analysis will then be given before discussing issues related to research rigour and ethics.

3.2 Qualitative methods in mental health research

The use of qualitative methods in health research has increased considerably in recent years (Gough & Lyons, 2016). Unlike most quantitative methods, qualitative research provides a thick description of phenomena, is sensitive to context and allows for unexpected concepts to emerge through the research process (Salle & Flood, 2012). Consequently, they are well suited for investigating complex phenomena (Gough & Lyons, 2016) such as the lived experiences of people receiving therapeutic interventions (Silverstein et al, 2006) and the views of clinicians and service users towards aspects of mental illness or treatment (Salle & Flood, 2012). Thus, qualitative methods are well suited to the aim of this thesis to examine the views and experiences of clinicians when working with parental mental illness.

There are a variety of types of qualitative research which emphasise different aspects of the data or phenomena being researched to achieve different aims. When discussing types of qualitative research, it is important to make a distinction between methods and methodologies.

Methodologies are theoretical orientations that guide decision making during research, while methods are the actions or activities undertaken to complete the research (Carter & Little, 2007). Many types of qualitative research share methods but have very distinct methodologies.

Several qualitative methodologies are common within mental health literature. Thematic analysis aims for theoretical neutrality with the goal of simply categorising and presenting data into a manageable form for the reader (Braun & Clarke, 2006). Ethnographic studies investigate particular cultures or social worlds through the researcher(s) immersing themselves within that particular environment (Harrison, 2018). Narrative methodologies investigate how people use stories, or narratives, to make sense of particular aspects of the world (Freeman, 2015). Grounded theory utilizes qualitative data to develop an explanatory theory about social or psychological events (Charmaz, 2014). Phenomenological methodologies explore how people experience particular phenomenon and the meaning that they draw from these experiences (Davedson, 2013; Smith, Flowers & Larkin, 2009).

The aims of the first three studies all related to the experiences and perspectives of clinicians to various aspects of their work with parents. Thus, a phenomenological approach was well suited to these studies. Specifically, the methodology utilised in these studies was IPA due to its well-developed theoretical framework, established use within psychology research and clear guidelines for implementation (Smith, 2011).

3.3 Interpretative Phenomenological Analysis (IPA)

IPA is a form of qualitative inquiry developed by Smith (1996) to examine participants' experiences, and their views of phenomena that occur in their world. Therefore, it is an ideal methodology for the first three studies in this thesis which examined clinicians' views and experiences of three different aspects of working with parental mental illness:

- (i) Challenges of working with parents
- (ii) Internal reactions towards parents with a mental illness and their children
- (iii) The introduction of the Mental Health Act which mandates the recognition and protection of the needs of children when their parents receive mental health services

Although there was an initial lag in the uptake of IPA by researchers after it was introduced, its use has steadily increased within psychology and health sciences (Smith, 2011). The majority of IPA research in mental health has focused on consumers' experiences of symptoms and treatment modalities, but some studies have also examined the experiences of carers, and clinicians (Smith, 2011). One of the studies in this thesis examines clinicians' experiences of legislation being introduced. This is not typically within the scope of IPA studies to date. However, Smith (2011) has encouraged the expansion of this methodology to examine people's experiences of a wider range of phenomena.

Although there are commonly employed steps involved in IPA, it is primarily defined by an extensive underlying theoretical framework (Smith, 1996; Smith, Flowers & Larkin, 2009). This framework rests on three interweaving concepts – phenomenology, hermeneutics and ideography. Each of these concepts has its own long history and may have multiple definitions. Below is a discussion of how each is understood from within the IPA framework.

3.3.1 Phenomenology

When developing IPA, Smith drew from the works of phenomenologists such as Heidegger and Husserl. Heidegger (1962) considered how people came to understand their own existence. He emphasised that the position of people in the world colours how they understand their experiences and the world around them. Husserl's (1983) contributions to phenomenology were based on the epistemological claim that it is not possible to separate knowledge about

objects or events from the subject experiencing them. Thus, he sought to understand how aspects of the world were understood through human experience. The work of such phenomenologists highlighted the necessity of examining lived experiences of phenomena and the context in which these experiences occur. Systematic frameworks and methodologies for phenomenological enquiry within psychology have since been developed (Moustakas, 1994; van Manen, 2002).

Smith defines phenomenology, as it applies to IPA, to be the study of peoples' personal experience and understanding of particular phenomena within the context of their worldview (Smith, 1996). The phenomena considered in the first three studies of this thesis are various aspects of working with parental mental illness. The general context is the adult mental health sector, but the personal context of each participant is also appreciated. The objective is therefore to examine how participants experience and understand these aspects of working with parental mental illness from within their context and world view.

3.3.2 Hermeneutics

Hermeneutics is a theory of interpretation that is integral to the IPA methodology (Smith, Flowers & Larkin, 2009). Hermeneutics is central to many areas of psychological research because people's experiences and views cannot be directly observed and must be understood through a process of interpretation. Davidsen (2013) argued that IPA is founded on a *hermeneutics of understanding*, meaning that the aim is to interpret how participants understand phenomena. This is in contrast to other forms of hermeneutics which may seek to interpret phenomena from a specific theoretical perspective such as feminism or psychodynamic theory. Through this hermeneutic of understanding, IPA remains grounded in data.

Smith (2007) argued that there are various levels of interpretation that may occur when a source of information (such as a piece of art, a novel or interview data) is encountered. The

person encountering the information may consider what it means to them within their own context and vantage point. Alternatively, they may consider the view-point of the person who created the source of information and what it may have meant to that person. This second form of interpretation is advocated for in IPA, whereby “...the researcher is trying to make sense of the participant trying to make sense of what is happening to them” (p. 10, Smith, 2011).

Additionally, IPA involves researchers making sense of various pieces of information within the overall context of its collection (Smith, Flowers & Larkin, 2009). For example, analysis of data within this thesis involved assigning meaningful codes to small sections of interview transcripts. However, these sections exist within the wider transcript and the interview process. Hence, it was necessary to move back and forward between codes, full transcripts, interview recordings, reflective notes and demographic information of the participant. This is referred to as a hermeneutic cycle (Smith, Flowers & Larkin, 2009) and assists the researcher to maintain connected to the context of data while interpreting it.

3.3.3 Ideography

IPA is strongly ideographic, meaning that it emphasises an in-depth investigation of individuals rather than seeking to identify norms across populations. Ideography is emphasised within the IPA framework to the extent that it is considered applicable for analysis of single case investigations (Smith, Jarman & Osborn, 1999) and is recommended for up to approximately ten participants (Smith, 2004; Smith, Flowers & Larkin, 2009). IPA is somewhat unique among qualitative research in that it involves a thorough exploration and analysis of each participant before making any attempt to identify commonalities across the sample (Smith, 2004). When comparisons of participants are made in later phases of the research, IPA researchers are

encouraged to highlight areas of convergence and divergence between participants so that individual accounts are not obscured by overall sample themes (Smith 2004; 2011).

3.4 Participants

The same participant sample provided the data for Chapters 4 and 5. This included 11 clinicians from across Australia. A different sample of 11 participants was recruited for the study in Chapter 6. Since the study in Chapter 6 is related to legislation from the state of Victoria, the participants were clinicians from adult mental health services in Victoria. More detail about participants is provided in the following chapters.

3.5 Procedure

The section below provides an overview and justification of procedures. Limited information is provided about the specific procedures employed as these details are provided in the following chapters. Procedures were approved by the Monash University Human Research Ethics Committee prior to beginning the research (See Appendix A for ethics approvals).

3.5.1 Recruitment and sampling

A convenience sample was recruited for the studies in this thesis. Practical limitations did not permit recruitment through adult mental health services directly. Thus, participants were recruited indirectly through an email which was sent through existing professional networks of the research team. This included professionals working as clinicians, managers and professional support within adult mental health services. This email contained details of the study, an explanatory statement (see appendix B) and consent and demographics forms (See appendix C). Recipients were asked to continue forwarding this email through their professional networks.

Participants expressed interest by returning the consent and demographics forms to the candidate. Chapters 4-6 provide more detail about recruitment procedures.

3.5.2 Semi-structured telephone interviews

Data was collected through semi-structured interviews. Semi-structured interviews involve a limited number of core questions or areas of content that are spoken about flexibly. Though an interview schedule is utilized (See appendix D for the interview schedules developed for this thesis), it is not followed prescriptively (Olsen, 2016). This provides the participant with opportunities to elaborate on areas that are important to them and allows the interviewer to probe for further details where relevant (Englander, 2012). Thus, it is a useful method for flexibly obtaining information about key issues and has been suggested as an ideal method for collecting data in IPA studies (Smith, Jarman & Osborn, 1999; Smith, 2004). The interview protocol was shown to two experts in the field who provided feedback which was used to adjust the final schedule. This involved minor word changes to questions.

During the interviews for Chapter 4, participants provided rich information about their personal and emotional reactions towards parents and children. Although it was not a core aim of this study, it was evident that this was meaningful to participants and was probed further. Subsequently, the data from these interviews was analysed twice – once in relation to the original research question (Chapter 4) and once with a focus on the additional area of interest that spontaneously arose during interviews (Chapter 5).

Interviews were conducted via telephone. Some researchers have compared semi-structured interviews conducted face-to-face and by telephone. Although some studies indicated that telephone interviews tended to be shorter and that participants gave less detail (Irvine, 2011, 2013) another study did not find such differences (Sturges & Hanrahan, 2004). Furthermore, the

study by Sturges and Hanrahan found that participants were more likely to participate in telephone interviews because they were flexible. This may make it particularly appropriate for busy participants who may find it difficult to schedule a time for the interview. Thus, the use of telephone interviews was considered well-suited to the participants in this study who were busy professionals and spread across a large geographical area.

Interviews were audio-recorded with participant consent and then transcribed. The candidate transcribed 70% of the interviews. The rest of the transcriptions were completed by a professional secretarial service. Participants were emailed a copy of their transcript and given the opportunity to remove anything that they believed may identify themselves or their workplace. They were also able to make amendments to their interview response, although only it was uncommon for participants to make such amendments (see the methods sections of the following chapters for specific numbers of participants who made amendments for each study).

3.6 Analysis

Analysis involved a number of phases that are commonly used across multiple forms of qualitative analysis (Braun & Clarke, 2006) and IPA (Smith, Jarman & Osborn, 1999). These phases were undertaken in such a way that they were not completely distinguishable from each other or other stages of the research. Initially, familiarization with the data was promoted. Thus, conducting and transcribing interviews could be considered an early part of the analysis stage as well as the data collection stage. Intimacy with the data was further enhanced through repeatedly listening to interview recordings and reading transcripts.

Elements of meaning from interviews were then identified by coding small sections of transcripts (A section of a coded interview transcript is provided in Appendix F) by moving between full readings of transcripts and detailed coding, with the overall context of the data was

held in mind. For each participant, these codes were collated into broader categories of meaning related to the research questions. These categories were then compared across participants to identify overarching themes.

The final phase was writing a narrative for each theme. The creation of these narratives frequently involved going back to earlier phases of analysis. For example, transcripts were often reexamined to identify key quotes or to gain clarity about specific issues. Thus, there was movement back and forward between the stages of analysis. More detail about the use of these stages of analysis for each study is provided in the following chapters.

3.7 Research rigour

Despite fundamental differences in qualitative and quantitative research paradigms, early attempts to ensure rigour of qualitative research (Guba & Lincoln, 1982; Krefting, 1991; Lincoln & Guba, 1986) took key benchmarks of quantitative rigour (such as reliability and internal validity) and adapted them into qualitative equivalents (dependability and credibility). It has been argued that such standards for assessing rigour are merely tokenistic gestures to make qualitative research more acceptable within a field that has been dominated by quantitative concepts, and do little to advance the standards of qualitative studies (Carter & Little, 2007; Gough & Lyons, 2016). Indeed, Brinkmann (2015) suggested that such frameworks may lead to qualitative research becoming *McDonaldised*, whereby they become over-standardised and the rich diversity of studies is lost.

More recent arguments have been made for a broad evaluation of qualitative methods that considers the philosophical approach and context of the research (Carter & Little, 2007; Finlay, 2014). From this perspective, it has generally become accepted that researchers cannot be completely objective or neutral and that bias must be managed rather than removed (Silverstein

et al., 2006). This stance has led to the concept of reflexivity which can be described as the process whereby a researcher examines and holds themselves accountable for any assumptions, attitudes or reactions that may influence their conduct, including interpretations of the data (Clancy, 2013; Shaw, 2016).

A common reflexive strategy is called bracketing. This is a deliberate process whereby the researcher adopts an attitude of open curiosity in order to temporarily put aside their own attitudes and consider alternative ways of perceiving the phenomena being studied (Finlay, 2014). During this thesis, bracketing was promoted through reflective discussions between the candidate and the supervisors throughout various stages of data collection, analysis and write-up. For example, the candidate asked other authors to analyse some of the transcripts and then they discussed similarities and discrepancies in their interpretations of the main ideas contained within them. The candidate also had discussions with the supervisors/other author about possible biases in his individual coding of additional transcripts. Feedback on drafts of the results sections for each paper also prompted the candidate to question assumptions about the findings being proposed and ensure that they were grounded in data.

For the studies reported in chapters 4 and 5, preliminary outlines of themes were sent to participants for their comments. While their comments were not sought to check the *correctness* of the group themes, the feedback (received by only two participants) was used as an additional tool to prompt consideration of additional perspectives.

Immersion is another consideration when evaluating the rigour of qualitative research. Immersion is the practice of developing an intimate familiarity with the phenomena being studied (Finlay, 2014). This may be through direct exposure to the phenomena or through increased familiarity with the data. Some methodologies encourage deep immersion, such as

extended experience within a social setting that is being studied (Harrison, 2018). While such extensive immersion would have been beneficial it was not practically possible during the current studies due to time and resourcing constraints. However, familiarisation with interview data was promoted through the candidate conducting all interviews and transcribing the majority of them from audio-recording a small proportion were professionally transcribed), as well as listening to audio-recordings and reading transcripts multiple times at various stages of the analysis process.

Smith (2011) proposed some guidelines for conducting, and presenting, good IPA research. In line with these guidelines, careful efforts were made to:

- (i) Define a clearly focused aim and set of research questions for each study,
- (ii) Conduct thorough interviews to produce high-quality-rich data,
- (iii) Produce themes that were interpretative, not simple descriptive,
- (iv) Provide a thorough and elaborate narrative of each theme which illustrated convergence and divergence of aspects of the theme across participants, and
- (v) Provide illustrative quotes from multiple participants for each theme as well as an indication of the prevalence of that theme within the sample.

3.8 Ethical considerations

The research procedures for the studies in this thesis were designed to ensure that they met high ethical standards. Ethics approval was obtained from the Monash University Human Ethics Research Committee for all studies.

Participation was voluntary. Expressions of interest were made in response to a recruitment email. Thus, all participants voluntarily and actively voiced their willingness to

participate. All participants were told, through an explanatory statement and verbally, that they were free to withdraw from the study at any time.

Informed consent was obtained from all participants prior to their involvement. Each participant was provided with an explanatory statement with detailed information about the study and completed a consent form along with their demographics form. Additional consent was requested verbally at the start of the interview to ensure that participants were still willing to participate and have their interview recorded. Participants were advised to seek permission from their workplace supervisor/manager prior to undertaking the interview, to ensure that there was no workplace conflicts of interest.

Interviews were not expected to cause distress to participants due to their focus on professional issues. However, participants were informed that they were welcome to skip questions or cease the interview at any time if they became uncomfortable. The candidate also monitored participants' verbal responses and tone during interviews for signs of distress. It is noteworthy that the candidate was undertaking a psychology internship during the first study and was a registered psychologist for all subsequent studies. He also had over six years of experience in casework and support positions. A short debrief was conducted by the candidate at the end of each interview, whereby the participant was asked how they were feeling and if any aspects of the interview had been challenging. Although no participants reported, or were observed to be experiencing distress, the explanatory statement advised them that discomfort raised in relation to workplace issues should be discussed with their workplace supervisor and/or they should seek psychological support for any emotional distress. The number for lifeline (a telephone crisis line) was also provided on the explanatory statement.

Multiple procedures were put in place to protect participant confidentiality. Identifying information was removed from interview transcripts prior to coding and further analysis. Participants were provided a copy of these transcripts to remove any further information that they believed to be identifying. Care was taken to report only broad demographic information that did not identify any participants. Findings were reported as general themes. Although individual quotes have been included in the results, care was taken to ensure that none of these were identifying.

All paper documentation was scanned to electronic format and then shredded. Electronic files have been stored in a password-protected account on the Monash University server and are only accessible by the candidate. In accordance with University guidelines, these will be deleted five years after the completion date of each study.

Chapter 4

How do Australian Adult Mental Health Clinicians Manage the Challenges of Working with Parental Mental Illness? A phenomenological Study

4.1 Background

This chapter presents the first of the four published studies included in this thesis. It addresses important gaps in the literature about the experiences of mental health clinicians when working with parents who have a mental illness. Previous literature has identified a range of barriers and issues that may hinder clinicians from utilising family-focus practices (Maybery & Reupert, 2009). However, this literature does not present a thorough examination of clinicians' experiences and perspectives of this work, despite their crucial role in supporting parents who have a mental illness. Also lacking from the literature is information about how clinicians might address the challenges of utilising family-focused work.

4.2 Aim of the study

The aim of this study was to examine the professional experiences of clinicians in the Australian adult mental health sector when working with parents who have a mental illness. Specifically, it examined their experiences of the challenges relating to this work and the strategies that they used to manage these challenges.

4.3 Relevance of the study

Workplace developments should take into consideration the perspectives of clinicians. An understanding of their experiences of working with parents, including aspects that they find challenging and how they manage these challenges, can be used to enhance future initiatives (such as training and supervision efforts) to support the use of family focused practices.

4.4 Declaration of contribution

The following tables outline the contributions of the candidate (Table 4.1) and the other authors (Table 4.2) to the published study presented in Chapter 4.

Table 4.1

The candidate's contribution to the published study in chapter 4

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	80%
Participant recruitment	90%
Data collection, recording and transcription	95%
Analysis and interpretation of results	90%
Preparation of manuscript	90%

Table 4.2

The contribution of the other authors to the published study in Chapter 4

Name	Nature of Contribution	Extent of Contribution (%) for student co-authors only
Prof. Andrea Reupert	Contributed to study conceptualisation, participant recruitment, development of research materials (including	n/a

	interview schedule, explanatory statement, demographics form), data analysis, interpretation of findings and manuscript preparation.	
	Contributed to study	n/a
Prof. Daryl Maybery	conceptualisation, interpretation of findings and preparation of manuscript.	

4.5 Declarations of ethical compliance

Ethics approval. All procedures undertaken as part of this study were approved by the Monash University Human Research Ethics Committee, project number CF14/3321 – 2014001764. Procedures were in accordance with the 1964 Helsinki declaration and its later amendments and comparable standards.

Informed consent. All participants provided informed consent prior to participating in the study, including consent for publication.

Conflict of interest. The authors declare that they have no conflict of interest relating to this publication.


Candidate's signature:



Primary Supervisor's Signature:

ORIGINAL ARTICLE

How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study

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Abstract

Adult mental health clinicians face a range of challenges that hinder their use of family-focused practices when working with consumers who are parents. The purpose of this study was (a) to examine clinicians' experiences when working with parents and (b) identify strategies they found to be effective when working with parents. Eleven Australian mental health clinicians were recruited who regularly worked with consumers who are parents. Semistructured interviews were conducted within a qualitative paradigm and analysed using interpretative phenomenological analysis. Themes were identified which related to (a) managing sensitive parenting conversations, (b) making decisions about child safety in unclear or unpredictable situations, and (c) working with child protection services. Participants had developed strategies for managing the challenges of the first two practice issues and suggested organizational changes that could facilitate collaboration with child protection services. The findings highlight that the challenges of working with parents with mental health issues cannot be addressed with a one-size-fits-all approach. Initiatives to facilitate the effective support of parents and their children need to be informed by contextual factors, including clinical practice.

1 | INTRODUCTION

Population estimates indicate that parental mental illness is common, with up to one third of mental health consumers having a dependent child (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). These parents may find parenting responsibilities particularly challenging when also managing a mental illness (Carpenter-Song, Holcombe, Torrey, Hipolito, & Peterson, 2014) and may experience feelings of shame and guilt about their parenting (Ackerson, 2003; Dolman, Jones, & Howard, 2013). Consumers' children may worry about their parent's mental health and take on additional responsibilities including caring roles (Mechling, 2011). These children are also more likely than other children to develop their own mental illness or psychological problems (Leschied, Chiodo, Whitehead, & Hurley, 2005; Leverton, 2003). To effectively support consumers who are parents and their children, it is important for clinicians to recognize and respond to specific issues associated with parental mental illness (Goodyear et al., 2015).

Family-focused practice extends the focus of care beyond the consumer and his or her symptoms to also consider the well-being of

their family members, including their children (Foster, O'Brien, & Korhonen, 2012). Key characteristics of family-focused practice include the consideration of family members during care planning and goal setting, assessment of family functioning and well-being of family members, psychoeducation about the impacts of mental illness on family members, and the provision of supports to family members (Foster et al., 2016). Family-focused interventions reduce the risks of parental mental illness to children by up to 40% (Siegenthaler, Munder, & Egger, 2012). Acknowledging and addressing a consumer's parenting role also has benefits for consumers, including increased parenting efficacy and confidence and reductions in shame (Solantaus, Paavonen, Toikka, & Punamäki, 2010; Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009). Family-focused interventions also result in improvements in family communication (Solantaus et al., 2009). Despite the documented benefits of working in a family-focused manner, family-focused practices are not routine (Goodyear et al., 2015). Clinicians do not routinely identify the parenting status of consumers or may not use this information in their case planning and practice (Benders-Hadi,

Barber, & Alexander, 2013; Pfeifferberger, D'Sousa, Huthwaite, & Romans, 2014).

Maybery and Reupert (2009) reviewed the literature relating to the use of family-focused practices when working with parental mental illness and developed a hierarchical model of barriers that hinder the use of these practices. The hierarchical levels related to organizational policy, management, and resourcing; interagency collaboration; clinician skill, knowledge, and attitude; consumers' hesitations when discussing parenting matters; and the reluctance of family members to be involved in the mental health treatment of the parent. According to this model, the organizational level is the foundational entry point to promote change, which then filters through the remaining levels. However, empirical investigation of this model suggested that factors relating to clinicians, such as their attitude, confidence, and skill, were better predictors of family-focused practice than the other levels (Maybery, Goodyear, Reupert, & Grant, 2016). Although it is important to identify the barriers of family-focused practice, it is arguably more important to consider how these barriers might be addressed. Given the influence of factors relating directly to clinicians, it is particularly important to examine the experiences of clinicians who regularly encounter these barriers and how they overcome these.

Currently, there is limited research on clinicians' experiences of their work with parents. In a systematic literature review of this area, Dolman et al. (2013) identified only eight papers describing clinicians' experiences of working with families affected by parental mental illness. The review found that many clinicians lacked the necessary skills for assessing and supporting the well-being of consumers' children and were uncomfortable about the additional responsibility associated with managing risks to these children. Clinicians also found it challenging to assess what was occurring within families because some consumers minimized the extent of their symptoms or parenting difficulties. Finally, interagency collaboration was difficult due to differing agency priorities, undefined role boundaries, and uncertainties about information sharing.

The current workforce literature has several limitations. Most of this research has focused on the experiences of mental health nurses (Maddocks, Johnson, Wright, & Stickley, 2010), practices related to specific diagnoses (Engqvist, Ferszt, Ahlin, & Nilsson, 2009), and/or particular work settings such as mother–baby units (Dolman et al., 2013). Further research is needed to examine the experiences of clinicians from other professional roles across the adult mental health workforce. It is also important to direct attention beyond the challenges of this work and investigate how clinicians may already be effectively supporting parenting roles and the well-being of consumers' children.

The current study examined the professional experiences of Australian adult mental health clinicians who work with consumers who are parents. The focus of this study extends previous studies, which focused on the difficulties and barriers encountered by clinicians, and examines the strategies employed by experienced clinicians to achieve, what they believed to be, successful outcomes with parents. This study was guided by the following research questions:

- What areas of practice are considered important to adult mental health clinicians when working with consumers who are parents? 56

- What are their experiences of undertaking these practices?
- What strategies do they use when engaging in these practices to achieve positive outcomes with parents and their families?

In contrast to previous studies that focused on specific professions or workplaces, participants in this study were recruited from a range of professional settings and roles, including social workers. They also worked with consumers with a variety of diagnosed mental illnesses. It is hoped that this understanding of clinicians' experiences, including practices that they find effective, will benefit future workforce initiatives, policies, and training programmes to promote practices with parents.

2 | METHOD

2.1 | Participants

Participants were 11 mental health clinicians who were currently employed within the Australian clinical adult mental health sector and worked with parents who have a mental illness. Participants had a mean of 8.4 ($SD = 6.2$, range = 2.5–20) years of professional experience in the adult mental health sector. All participants had also worked previously in other mental health and/or welfare settings, some of which included work with children. Overall, participants had a mean of 3.9 ($SD = 2.8$, range = 0–9) years of experience of working with children. Two participants had previously worked in specialist mental health units for parents with mental health and/or drug and alcohol issues. The mean age of participants was 39.3 years ($SD = 10.1$). Table 1 presents select demographic information for each participant. Pseudonyms are used to protect the privacy of participants.

2.2 | The Australian adult mental health sector

The Australian adult mental health sector provides support for adults (16–64 years) who are experiencing severe mental illness, significant disturbance, or crisis situations (Department of Human Services, State

TABLE 1 Self-reported participant demographics

Pseudonym	Gender	Profession	Work setting	Geography of workplace
Anne	Female	Psychologist	Inpatient	Regional
Doug	Male	Psychologist	Inpatient	Rural
Dianne	Female	Mental health nurse	Community	Regional
Toni	Female	Social worker	Outpatient	Suburban
Betty	Female	Social worker	Inpatient	Rural
Kim	Female	Psychiatrist	Outpatient	Suburban
Amanda	Female	Psychologist	Community	Regional
Dan	Male	Social worker	Outpatient	Suburban
Mark	Male	Mental health nurse	Community	Suburban
Demi	Female	Psychologist	Outpatient	Rural
Fiona	Female	Occupational therapist	Community	Regional

Government of Victoria, 2006). Services provided within this sector range from triage and crisis assessment, through to continuing care and rehabilitation (Department of Health and Human Services, State Government of Victoria, 2011). Although Australian clinical mental health services are legislated at the state level, they are also directed by national guidelines and share similar workplace structures (Department of Human Services, State Government of Victoria, 2006). Clinical services across Australia utilize multidisciplinary teams, whereby team members share general tasks but also provide specialist knowledge and skill according to their professional background (Bennett et al., 2012; Maybery, Goodyear, O'Hanlon, & Reupert, 2014). Shared tasks include the development of a positive therapeutic relationship, general counselling, and ongoing assessment. Table 2 outlines the specialist roles and training associated with participants in this study. Although some adult mental health organizations in Australia are privately managed, all participants in this study were from public settings.

2.3 | Procedure

Participants were recruited via an email that was disseminated through the researchers' professional networks, including mental health managers, clinicians, and practice development professionals. The email outlined the research and sought expressions of interest from adult mental health clinicians who worked regularly with consumers who are parents. A limitation of this method is that the recruitment email was unable to be tracked. Therefore, it is unknown how many potential participants were contacted, and a response rate cannot be determined. Expressions of interest were received from 14 clinicians. Three were excluded from the study because they were not employed within the adult mental health sector. The analysis method adopted in this study, interpretative phenomenological analysis (IPA), aims to examine a research topic in depth rather than breadth, which aligns with a small sample size (Smith, 1996). The developers of this method recommend approximately 3 to 10 participants for this in-depth analysis, arguing that larger samples may result in unworkable amounts of data (Smith, Flowers, & Larkin, 2009).

Participants provided consent and demographic information prior to being interviewed. Semistructured telephone interviews were conducted with all participants, ranging from 18 to 43 min (mean of 27 min). This is consistent with previous research demonstrating large variation in interview duration (Irvine, 2011). All interviews were audio recorded with participant permission for subsequent transcription. Transcripts had personal details removed

and were sent to participants to modify any sections that they believed were identifying and/or add any additional information that they thought was important. Two participants made minor additions. Ethics approval for this procedure was obtained by the university human research ethics committee.

2.4 | Interview

The semistructured interview schedule was informed by relevant literature and the research questions. Broad questions focused on participants' experiences of working with consumers who were parents, such as

- What is it like to work with consumers who are parents?
- How, if at all, is your work different when a consumer is a parent compared to when a consumer is not a parent?

Probing questions were then used to obtain more detail about specific topics or situations that participants raised, for example,

- What do you do to manage that type of situation?
- What have you found helpful when that happens?

Draft schedules were reviewed by two international research and practice experts in the field. Slight modifications were made in response to their feedback.

2.5 | Analysis

IPA was used to analyse interview data. IPA is a methodology for examining participants' experiences and meanings of a phenomena (Smith, 1996). Initially, this process involved listening to interview recordings and reading transcripts several times while making notes about the main messages being heard. Codes were then assigned to short portions of transcripts to label key phrases, ideas, and contextual information. The codes were revised multiple times and used to identify categories and themes relating to participants' experiences and meaning making. Movement occurred back and forth between reviewing transcripts, codes, categories, and themes to increase the researchers' familiarity with the data and authenticity of the findings. Analysis was conducted by the first author. An independent researcher with qualitative experience recoded five interview transcripts and identified preliminary themes. Minor differences were observed between these two sets of analysis but were resolved by

TABLE 2 Professional training and roles of multidisciplinary mental health team members in Australia

Discipline	Professional training	Role in multidisciplinary team
Social worker	A specialist undergraduate or master degree	Advocacy and assistance with psychosocial and community issues
Psychologist	Specialist undergraduate and master degrees	Administer interventions to promote positive changes in thinking and behaviour
Psychiatrist	Tertiary degrees in medicine and psychology	Prescribe and monitor medication
Mental health nurse	Tertiary degree in nursing and specialized mental health training	Provide general care and administer medications
Occupational therapist	A specialist undergraduate or master degree	Promote the development of skills relating to daily living, coping, and independence

further reviewing the transcripts. The authors also discussed possible alternative interpretations of interview data at multiple stages of analysis.

3 | RESULTS

Three overlapping themes were identified related to participants' experiences of managing difficult conversations with parents, making decisions when family circumstances are unclear or unpredictable and working with child protection services. These themes are presented below with representative interview excerpts. Quotes are tagged with participant pseudonyms from Table 1.

3.1 | Managing difficult conversations with parents

The first theme related to initiating and managing difficult discussions with parents about their parenting or concerns about risks to their children. Although challenging, participants had developed several strategies for managing such discussions.

3.1.1 | Talking about parenting

All participants recognized that parenting can be a "really sensitive" (Fiona) and "emotionally laden topic" (Demi) because parents with a mental illness often experience shame and guilt about their parenting and fear being judged as "bad parents" (Dianne). Consequently, parenting conversations were considered very delicate. Participants believed that "you don't want to deflate" (Doug) the parent's confidence and "... if you choose the wrong words they're going to get offended very easily and ... might terminate the therapy" (Fiona).

Several strategies were used by participants to ease the discomfort of parents and clinicians when having parenting conversations. Primarily, a non-judgmental and supportive approach was advocated for, with the aim of "building engagement and trust" (Amanda). Five participants regularly disclosed their own parenting experiences to normalize the difficulty of parenting and to develop rapport. A strength-based approach was also adopted. For example, Fiona deliberately built "positive self-esteem" by acknowledging parenting strengths before discussing "the areas [of parenting] that they might not be doing so well." Similarly, Betty recognized the benefits of focusing on positive changes for children, rather than past events that may have negatively impacted on them: "... if they themselves maybe aren't sure if they are able to recover—but they soon become quite motivated when they know it is for the benefit of their children."

Five participants identified structured parenting programmes that were delivered to parents at their services including Circle of Security, Triple P, and Let's Talk about Children. Dan talked extensively about Let's Talk about Children. For him, this intervention legitimized the time spent discussing parenting: "if it wasn't for 'Let's Talk [about Children]', I probably wouldn't have had some of those conversations. I would have been stuck in the crisis all the time."

Despite the sensitive nature of parenting conversations, all participants indicated that rapport with consumers was strengthened

by talking about the consumers' parenting experiences and their children:

They value that we recognise that it's a really important part of their lives ... it helps my relationship with my clients ... sometimes in the mental health system it's very much about your diagnosis and medication. That sort of holistic picture of a person can get missed out It definitely improves my relationship with them, talking about parenting. (Toni)

3.1.2 | Raising concerns about risks to children

Participants found it difficult to talk to parents about the potential impacts and risks of their mental illness for their children. They recognized that parents were often anxious or fearful about discussing parenting problems. Toni believed that many parents "have this fear in the back of their mind about losing access to their child or being controlled in another way." Similarly, Dianne suggested that "a lot of the time they think you're trying to catch them out rather than actually help them." Consequently, participants perceived parents as being "quite guarded" (Dan) and avoidant when discussing parenting problems and the impacts of their mental illness on their children.

Five participants indicated that transparency was a crucial for maintaining trust with parents when raising parenting concerns. Demi expressed her view that

... being as transparent and honest with parents as possible I think was really helpful once people have an experience of you raising an issue with them, I think they then learn to trust that you will do that rather than going and talk behind their back. So, if you're not raising an issue then you don't have one and if you are raising an issue then they're willing to trust that you'll speak with them about it first.

Five participants reminded themselves of the consequences of not raising parenting concerns with consumers. This motivated them to initiate these conversations despite the anticipated discomfort involved. For example, Amanda reminded herself that "it can be quite protective if I raise [a parenting concern] with someone and manage that effectively" and a likely consequence of not discussing the concern is that it may become "something more like a punishment or a judgment later by another service who is a little bit more penalising than me So, for me there is a really strong motivator for me to raise it, even when it's uncomfortable."

Conversations about concerns for child well-being were not always received well by parents and sometimes jeopardized rapport. However, this damage could be repaired. Kim described how she approached such situations:

... if it appears to have caused a disruption in the relationship, then having a conversation about that—their anger towards you, their feelings that you might have over reacted or it wasn't necessary—and then just come back honestly and non-defensively and just say "I

was actually doing what I thought was best and necessary at the time"

3.2 | Making decisions when family circumstances are unclear or unpredictable

Decision making around parenting matters (such as when to raise concerns, which concerns to raise and when to make referrals or reports) was difficult for participants when they were unable to fully assess the family situation or predict future events. Eight clinicians indicated that they would benefit from additional skills in assessing child safety. Assessment of child well-being was especially difficult when participants did not get opportunities to meet the consumer's family and "you've got to rely on what [the parent is] saying" (Fiona). The course of mental illness and responsiveness of child services were considered unpredictable that made it "very difficult to be clear about predicting issues of safety" (Kim).

When decisions needed to be made under uncertain situations, the support of supervisors and colleagues was crucial. Nine participants said that supervision and team support provided validation and reassurance that they had responded appropriately to the situation: "I'll just be kind of talking it through and probably feeling a bit more secure that I've done everything that I can" (Anne). Several participants were also relieved that they could share the responsibility of decision making with their work teams. Dan emphasized the benefits of a "multidisciplinary team" for considering other perspectives and strategies. The team support meant "you don't actually have to make a lot of decisions by yourself" (Dan). Demi, who had recently moved to a new service, described the importance of support from the management level:

... in my last job, I felt like they had my back ... if something went wrong I'd be supported to figure out how to do it better next time ... now I'm bit more on my own and that I'd be thrown under the bus rather than supported ... it kind of feels a bit like oh "God what if I do make the wrong decision." I've kind of got a little bit less confidence.

3.3 | Working with child protection services

Although Doug and Betty indicated that their interactions with child protection services had been limited, the other nine participants had worked with consumers who had ongoing involvement with child protection services. They described various difficulties in their work with child protection services. Mark and Amanda had been disappointed by a lack of support from child protection when making reports or requests for assistance. Specifically, Mark had become frustrated at the low level of response and the amount of time taken: "... how much intervention they'll do—don't expect much. And ... the time delay. Unless there's an imminent risk, it's gonna take a long time." In contrast, another six clinicians described urges to shelter parents from child protection services. Dan stated "... you get a call from child protection and all of a sudden you just want to put a 'shut-up shop.' Just to not put your consumer in the proverbial" Several participants recognized that their work with child protection services was challenging because of fundamental differences between mental health and child

protection organizations. Kim's view was that they were "different systems [that] are working at cross purposes."

Although interactions with child protection were generally experienced as negative, four participants had experienced instances of open communication, which had produced positive family outcomes. Kim explained how tensions between the two services had eased when "you are being informed by another department about their priorities and processes and you're informing them about your priorities and processes and you come to a mutual agreement about solutions." Several clinicians believed that open communication with child protection services required willingness and resourcing from both organizations.

Amanda and Demi had worked in specialized units that aimed to integrate mental health and child protection services. Through this experience, they benefited from an increased understanding of child protection priorities and procedures and familiarity with individual child protection clinicians. Several elements contributed to these benefits, including shared case reviews and regular opportunities to communicate with child protection clinicians, formally and informally.

4 | DISCUSSION

This study was a phenomenological examination of practices undertaken by adult mental health clinicians in their work with consumers who are parents. Three areas of practice were identified as meaningful for participants: conversations about parenting and risk; making decisions in uncertain circumstances; and working with child protection services. Although these have previously been identified as challenging areas of family-focused practice (Dolman et al. 2012; Maybery & Reupert, 2009), the current study identified how participants drew meaning from their professional experiences and developed practical strategies to navigate challenges. When parents were reluctant to discuss issues related to parenting, participants empathized with consumers' concerns and engaged in these conversations sensitively. They recognized the limitations of their skill and knowledge and sought advice and support from their professional network to make decisions about situations that seemed uncertain. Participants believed that they were unable to overcome barriers to effectively work with child protection services but drew from their experiences to identify organizational changes that would promote collaboration. Thus, recognition of contextual factors prompted participants to adapt their practices to better meet the needs of consumers and their children where possible. The processes and strategies used by the clinicians in this study could inform future initiatives to promote effective practices across the mental health workforce.

4.1 | Enabling clinicians to have delicate conversations about parenting

Participants indicated that parenting and child well-being were difficult conversation topics due to consumers' concerns of being judged, having services place restrictions on them, and/or having their children removed. By empathizing with these concerns, clinicians in this study had developed supportive strategies for having these conversations.

Their strategies included the normalization of parenting difficulties, acknowledging parenting strengths, and clinician transparency. Even though clinicians recognized that rapport with parents might be jeopardized, participants did not view these conversations as obstacles to be avoided. Participants believed that the long-term benefits for children and parents were more important than possible damage to rapport. Furthermore, delicate management of these conversations was recognized as an opportunity to build trust and deepen rapport with parents.

These findings can be used to inform strategies to develop the practices of clinicians who are inexperienced and/or ineffective at managing discussions about parenting and child well-being. Participants' strategies for managing parenting conversations grew from their understanding and empathy of consumers' concerns that they may be judged, restricted, or have their children removed, a concern that is common among parents with a mental illness (Dolman et al., 2013). This finding suggests that clinicians should be educated about common experiences of parenting with a mental illness and the possible anxieties that consumers may have about discussing parenting matters with service providers. With this important foundation, clinicians may be better placed to develop and apply strategies, such as those described by participants in this study, to manage parenting conversations effectively and sensitively.

To develop an adequate understanding of parental mental illness and skills for engaging in supportive conversations about parenting issues, clinicians need access to knowledgeable and experienced practice support staff, clear strategies to utilize, and relevant resources. It is unlikely that all supervisors will have expert skill and knowledge across all practice areas, including parental mental illness. Consequently, specialist consultants or portfolio holders are necessary. Multiple states of Australia have introduced families where a parent has a mental illness coordinators (State of Victoria, 2007) for specialist guidance. Practice guidelines have also been published to assist clinicians to embed parenting conversations into their ongoing practice (Australian Infant Child Adolescent Family Mental Health Association, 2004; Goodyear et al., 2015). Structured interventions, such as "Let's Talk about Children" (Solantaus et al., 2010), have been developed to provide a structure for having conversations about parental mental illness (an intervention that was noted by participants in this study). Such formal interventions may increase clinicians' confidence about having these discussions (Tchernegovski, Reupert, & Maybery, 2015). The findings of this study suggest that structured interventions may also legitimize time allocated to parenting matters for some clinicians.

4.2 | Increasing the capacity of clinicians to respond to unclear or unpredictable circumstances

Deciding how to respond to parenting needs and child welfare was often difficult for the clinicians in this study when they were uncertain about the family context. Many factors were considered unpredictable, including the course of the mental illness, its impacts on children, and the actions of child protection services. Consequently, participants were not confident in their decisions about how to manage these situations and sought practical advice and reassurance from supervisors and colleagues. Rouf, Larkin, and Lowe (2011) also found that

professional networks were beneficial to clinicians when making decisions about parental mental illness but pointed out some challenges. Groups were not always experienced as supportive and/or "group-think" sometimes led to a consensus being reached before issues were adequately discussed. These problems reinforce the need for clinicians to have access to multiple and diverse types of professional support, including experts in the area of parental mental illness.

Some participants recognized that they need additional skills to effectively assess and respond to unclear situations. This is consistent with prior research that highlights the need for skills in assessing the impact of parental mental illness on parenting and child well-being and providing appropriate support and resources (Maybery, Goodyear, & Reupert, 2012). Therefore, these should be targeted areas for professional development to increasing the capacity of individual clinicians and teams to respond to parental mental illness and provide clinicians with a sense of confidence when working with parents. Various e-learning resources have been developed across multiple countries for working with parental mental illness because they are considered highly accessible, flexible to use, and effective for developing clinicians' knowledge and skill (Reupert, Foster, Maybery, Eddy, & Fudge, 2011; Reupert, Maybery, & Morgan, 2015). However, translation of this learning into practice needs to be backed by policy, workplace authorization, and adequate resourcing, including time (Reupert et al., 2015; Tchernegovski et al., 2015).

4.3 | Promoting collaboration with child protection services

Not all participants worked regularly with child protection services as part of their role, but those who did, found it challenging. Challenges were perceived to be caused by the differing, and often conflictual, priorities and approaches of mental health and child protection organizations. Participants communicated a lack of confidence in child protection services, with concerns that their involvement may be detrimental to the parent and that interventions would not be timely or effective. Previous research findings show that these views of child protection are not uncommon and may result in mental health clinicians failing to make mandatory reports to child protection agencies (Alvarez, Kenny, Donohue, & Carpin, 2004; Pietrantonio et al., 2013). Furthermore, if child protection services do become involved, communication between them and adult mental health services tends to be crisis-driven, reducing the likelihood of collaborative responses that meet the needs of all family members (Darlington, Feeney, & Rixon, 2005).

Participants felt unable to overcome these challenges and urged for interorganizational changes that would allow collaborative communication and goal setting. Clinicians from mental health and child protection services have previously suggested multiple strategies for enhancing collaboration (Darlington & Feeney, 2008). These included practice guidelines, joint case planning, and joint training. Research trials demonstrated benefits of implementing joint-protocols (Webber, McCree, & Angeli, 2013) and champions within each mental health and child protection team to liaise and promote collaboration with other services (Davidson et al., 2012). Two participants from this study, Amanda and Demi, had both worked in specialized units to promote

collaboration with child protection services. They benefited from everyday opportunities to interact with the child protection clinicians and to learn about each other's experiences and operational procedures. Thus, efforts to improve interorganizational collaboration should be directed towards organizational and interorganizational changes rather than at the clinician level. Due to considerable investments that are required by both organizations, these changes are likely to be slow (Tchernegovski et al. 2017). However, until organizations invest in these large-scale changes, clinicians are limited in the amount of collaborative work that they can undertake.

4.4 | Limitations

Limitations of this study should be considered before conclusions are made. Participation was voluntary, and no material incentives were offered, which may have introduced a sampling bias such as an active interest in the research area. Although the recruitment email requested expressions of interest from clinicians who were experienced at working with parents, participants were not asked about the proportion of clients on their caseloads who were parents. Participants were mainly social workers and psychologists. Although this limits the generalizability across professions, it compliments previous literature that has specifically targeted mental health nurses (Maddocks et al., 2010).

The sample size of 11 participants was appropriate for this in-depth examination of participants' contextualized experiences with IPA. This analysis utilized a limited data set (Smith et al., 2009) that does not allow for generalization of the findings. To investigate the relevance of these findings to the wider mental health workforce, future studies may utilize quantitative and survey-based methodologies with larger samples.

The IPA methodology required the researchers to interpret clinicians' personal accounts of their work with parents. Interpretation is intrinsically influenced by the researchers' personal characteristics and viewpoints (Smith et al., 2009). In the current study, influences included the high value that the researchers placed on the use of family-focused practices for support parenting and child well-being. The impact of such personal influences was identified and moderated through reflective discussions that occurred between the authors and the independent researcher throughout data collection and analysis.

4.5 | Implications

The finding of this study highlights three challenging areas of family-focused practice that may be subsumed within the hierarchical model of practice barriers proposed by Maybery and Reupert (2009). The findings extend this model by demonstrating that these challenges are not a homogenous collection and may not constitute as specific barriers that need to be overcome. Specifically, participants did not refer to the first two areas of practice (having conversations about parenting and assessing/responding to the impacts of parental mental illness in uncertain situations) as being barriers to working in a family-focused manner. Instead, the findings suggest that both of these practice areas may be best enhanced by an organizational environment that actively fosters clinician skill and autonomy. In contrast, it does

appear appropriate to describe the challenges to collaboration between adult mental health and child protection services as a barrier. This interagency barrier would be most effectively addressed by changes at organizational and interorganizational levels so that multiple tension between the two organizations may be overcome, rather than having clinicians having to deal with, and address at an individual level.

This study has several implications for social workers. Previous research indicates that social workers tend to be relatively more family-focused than clinicians from other professional backgrounds, perhaps due to their initial training (Maybery et al., 2014). Notwithstanding these relative strengths, advanced competencies around initiating and holding sensitive conversations about parenting and assessing and responding to the impacts of parental mental illness on children (the first two themes from this study) need to be incorporated into social work professional development programmes and encouraged through supervision. Although some participants claimed that they were not expected to collaborate with child protection services, all social workers in this study saw this as within their role and role specialization. Thus, initiatives to promote this collaboration are beneficial for the effective practice of social workers. Social workers may also support consumers and families through other family-focused practices, such as providing psychoeducation and emotional support to family members (including children), organizing referrals for family members, and involving family members in a consumer's treatment plan (Foster et al., 2016; Goodyear et al., 2015). Thus, these skills also need to be developed and promoted within organizations by the provision of clear guidelines and role descriptions in regard to family-focused tasks, as well as ongoing supervision and professional development for social workers as well as other professionals.

5 | CONCLUSIONS

Increasing the capacity for clinicians to engage effectively in family-focused practices is ethically necessary. Participants from this study acknowledged that some conversations about parenting with a mental illness were difficult but that a duty of care towards consumers and their children motivated them to push forward. Unfortunately, previous research suggests that many clinicians may not recognize this ethical responsibility and may not actively engage in these conversations (Benders-Hadi et al., 2013; Maddocks et al., 2010; Pfeifferberger et al., 2014). Similarly, when clinicians are unable to adequately assess the impacts of parental mental illness or feel unable to effectively collaborate with child protection services, the needs and safety of consumers and their children may go unrecognized and unmet. The difficulties of undertaking family-focused practices are not just an inconvenience for mental health clinicians, they are an ethical dilemma for the mental health system.

Findings from this study suggest that a one-size-fits-all approach will not be helpful for facilitating clinicians in their work with consumers who are parents. Practice development initiatives need to be informed by the specific requirements and challenges of the tasks that clinicians are required to undertake. Particular consideration should be given to the views and experiences of clinicians who are performing

these tasks. This approach will ensure that practice development strategies are relevant, workable, and meet the practice needs of clinicians.

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Chapter 5

Adult Mental Health Clinicians' Perspectives of Parents with a Mental Illness and their Children: Single and Dual Focus Approaches

5.1 Background

Chapter 4 reported on clinicians' experiences of the challenges they faced when working with parents and their strategies for managing these challenges. A small amount of literature has considered how clinicians may react personally and emotionally to parents and their children and how these reactions may influence their work (Cousins, 2004; Killen, 1996; Scott, 2005). However, there is a lack of empirical research in this area. The study presented in this chapter addresses this gap.

5.2 Aim of the study

The aim of this study was to examine adult mental health clinicians' personal reactions of the parents they worked with and their children. Additionally, it sought to examine if/how clinicians balanced their perspectives and reactions to parents and children.

5.3 Relevance of the study

An examination of the personal perspectives and reactions of clinicians towards parents and children is central to supporting them in their work with parental mental illness. Identification of these reactions and clinicians' personal needs when working with parents can inform future training, supervision, practice resources and workplace decision making.

5.4 Declaration of contribution

The following tables outline the contributions of the candidate (Table 5.1) and the other authors (Table 5.2) to the published study presented in Chapter 5.

Table 5.1

The candidate's contribution to the published study in chapter 5

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	80%
Participant recruitment	90%
Data collection, recording and transcription	95%
Analysis and interpretation of results	85%
Preparation of manuscript	80%

Table 5.2

The contribution of the other authors to the published study in Chapter 5

Name	Nature of Contribution	Extent of Contribution (%) for student co-authors only
Rochelle Hine	Contributed to participant recruitment, analysis, interpretation of findings and preparation of manuscript.	10%
Prof. Andrea Reupert	Contributed to study conceptualisation, participant recruitment, development of research materials, data analysis	n/a

	interpretation of findings, and manuscript preparation.	
	Contributed to study	n/a
Prof. Darryl Maybery	conceptualisation, interpretation of findings and preparation of manuscript.	

5.5 Declarations of ethical compliance

Ethics approval. All procedures undertaken as part of this study were approved by the Monash University Human Research Ethics Committee, project number CF14/3321 – 2014001764. Procedures were in accordance with the 1964 Helsinki declaration and its later amendments and comparable standards.

Informed consent. All participants provided informed consent prior to participating in the study, including consent for publication.

Conflict of interest. The authors declare that they have no conflict of interest relating to this publication.

Candidate's signature:



Primary Supervisor's Signature:

RESEARCH ARTICLE

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Adult mental health clinicians' perspectives of parents with a mental illness and their children: single and dual focus approaches

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Abstract

Background: When clinicians in the adult mental health sector work with clients who are parents with dependent children, it is critical they are able to acknowledge and respond to the needs of the parents and their children. However, little is known about clinicians' personal perspectives and reactions towards these parents and children or if/how they balance the needs of both.

Methods: Semi structured interviews were conducted with eleven clinicians from adult mental health services in Australia. Interviews focused on clinicians' experiences when working with parents who have mental illness. Transcripts were analysed within an Interpretative Phenomenological Analysis framework to examine participants' perspectives and personal reactions to parents and children.

Results: There was considerable divergence in participants' reactions towards parents and children and the focus of their perspectives when working with parental mental illness. Feelings of sympathy and responsibility made it difficult for some participants to maintain a dual focus on parents and children and contributed to some adopting practices that focused on the needs of parents ($n = 3$) or children ($n = 1$) exclusively. Other participants ($n = 7$) described strategies and supports that allowed them to manage these feelings and sustain a dual focus that incorporated the experiences and needs of both parents and children.

Conclusions: It is difficult for some mental health clinicians to maintain a dual focus that incorporates the needs and experiences of parents and their children. However, findings suggest that the challenges of a dual focus may be mitigated through adequate workplace support and a strengths based practice framework that emphasises parental empowerment.

Keywords: Parental mental illness, Workforce issues, Family focused practice, Interpretative phenomenological analysis

Background

Up to one third of adults who access mental health services are parents caring for dependent children [1]. Managing a mental illness may make it difficult for them to meet the demands of parenting [2, 3] and may disrupt parenting behaviours and the parent-child relationship in a variety of ways. For example, some parents may become inattentive [4], hostile and aggressive [5] or controlling [6]. In response to the diminished capacity of some parents, children may

assume responsibilities, such as caring for siblings or the parent [4, 7]. These dynamics, as well as genetic and other environmental factors, may lead children to develop substance abuse problems [8], behavioural disorders [9] or their own mental illness [10, 11]. Parents may experience shame and guilt about their parenting difficulties and the impacts of their illness on children, which can in turn, exacerbate their mental illness [12]. To effectively support these parents and their children, mental health clinicians must understand and respond to issues pertaining to parenting with a mental illness [13]. Hence, a whole-family perspective is required.

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Internationally, several initiatives have emerged related to mental illness, parenting and child wellbeing. Policy and legislation has been introduced in some countries that require adult mental health services to identify the children of people who are receiving services and provide them with appropriate information and/or support [14, 15]. Victoria is the first Australian state to legislate on this issue. Section J of the Mental Health Act (2014) [15] mandates that ‘children, young persons and dependents of persons receiving mental health services should have their needs, wellbeing and safety recognized and protected.’ However, the remainder of the Act lacks clear directives about how this is to be achieved. Practice guidelines for addressing parental mental illness have also been developed in Australia [16]. While these practice guidelines are not compulsory, they outline specific areas of best practice such as the recognition and support of family needs, provision of information to family members and actions to ensure the care and protection of children.

Various programs have been developed for supporting families when a parent has a mental illness. These include programs for children [17] and whole family interventions [18]. Structured, manualised interventions have also been developed that may be delivered to the parent with the mental illness by clinicians working in adult mental health [19, 20]. One such intervention is Let’s Talk about Children [21] which involves the clinician and the parent discussing ways that the parent might strengthen family relationships and promote the healthy development of their child. Overall, family-focused interventions are effective for promoting positive outcomes for the parent experiencing a mental illness, their children and the family unit [22, 23]. Accordingly, the adult mental health sector is ideally positioned to support families where parents have a mental illness.

While initiatives such as policy and development of interventions are vital, it is also important to understand the experiences and perspectives of clinicians who work with parents. Most research in this area has focused on organisational culture, which generally does not promote family-focused work [24] and the lack of time and resourcing available to clinicians to undertake family-focused practices [25]. Research has also highlighted that clinicians believe that they lack skill and knowledge for working with parental mental illness [24] and may experience anxiety related to undertaking specific tasks such as raising concerns about child safety with parents [26, 27]. Meanwhile, little is known about clinicians’ beliefs, attitudes and emotional reactions towards parents or their children. Clinicians’ personal reactions may be incongruent to their external behaviours [28]. For example, clinicians may behave empathetically to support an individual’s

mental health, despite viewing the person negatively or experiencing feelings of frustration. Scott [29] suggested that clinicians’ personal reactions towards parenting and child wellbeing may be particularly intense. Given the potential complexity and intensity of clinicians’ personal reactions towards parents and children further research in this area is needed to inform initiatives to support clinicians when working with parental mental illness.

Literature relating to clinicians’ personal reactions towards parents and their children is sparse. Early research focused on countertransference processes of child welfare clinicians, who reportedly characterised family members as victims and/or perpetrators [30]. Clinicians’ feelings of fear, guilt, shame, anger and sympathy were also considered to be common aspects of this countertransference towards parents and children [31]. Killen [32] suggested that clinicians employed a range of defensive strategies to protect themselves from the emotional burdens of witnessing child abuse and neglect. These strategies included over-identification with parents (which allowed clinicians to avoid witnessing the hardships of the child) and over-simplified treatment approaches (which avoided a full consideration of potentially distressing family situations).

Relatively more recent literature has considered the tensions between the child-centric perspectives of child protection services and the parent-centric perspectives of adult mental health services [33]. Fleck-Henderson [34] argued that it is beneficial for clinicians from both service sectors to “see double” (p. 333) by simultaneously maintaining perspectives of parents *and* children. Nonetheless, Cousins [35] argued that the needs of parents and children are often in conflict, which makes it difficult for clinicians to balance both perspectives, especially when affiliated with a workplace that prioritises parents’ mental health. Although the arguments made by Fleck-Henderson and Cousins are supported by their own practice, there is an absence of empirical research relating to how mental health clinicians direct their attention towards parents and/or their children.

This current paper aims to address important gaps in the literature by examining mental health clinicians’ perspectives and personal reactions to the parents they work with and their children. The research was driven by the following research questions:

- What are clinicians’ personal reactions towards parents and their children?
- How, if at all, do clinicians attempt to maintain a concurrent focus on the needs of parents and their children? If they do, what are their experiences of this?

An understanding of these intra-personal experiences can inform the development of future training, workplace policy and practice and resources to support for clinicians when working with parents.

Method

Participants

Participants were recruited from Australian clinical adult mental health services. Although mental health legislation is managed at a state level, services are guided by national standards and have common workplace structures [36]. Thus, clinicians from all states and territories of Australia were eligible for inclusion. A sample of 11 participants was interviewed from Victoria, Western Australia and New South Wales.

The Australian clinical adult mental health sector provides a range of services from triage, assessment and inpatient treatment, through to community-based rehabilitation [37]. The target population for clinician adult mental health services are adults between 16 and 64 years who are experiencing significant mental health disturbance, crisis situations or severe mental illness [38]. Multidisciplinary team structures are utilised in the clinical adult mental health sector. All team members share common tasks and responsibilities while also contributing particular knowledge and expertise that is specific to their professional background and training [39, 40].

The mean age of participants was 39.3 (SD = 10.1). Participants had a mean of 8.4 (SD = 6.2, Range = 2.5–20) years of experience working in the adult mental health sector and 3.9 (SD = 2.8, Range = 0–9) years of experience of working with children. Additional demographics for each participant are presented in Table 1. Pseudonyms are used to protect the privacy of participants.

Procedure

A recruitment email was disseminated through the researchers' professional networks, including mental health managers, clinicians and practice development professionals. The email contained an explanatory statement about the research and sought expressions of interest from

potential participants. A request was also made for recipients to forward the email through their professional networks. Expressions of interest were received from 11 participants from the mental health sector. Given it is unknown how many professionals were forwarded the recruitment information, it is not possible to calculate a response rate.

Participant consent and demographic information were obtained before semi-structured telephone interviews were completed. Interview length ranged from 18 to 43 min (averaging 27 min). Interviews were audio recorded and transcribed, with participant permission. After personal details were removed from transcripts, they were emailed to participants who were then given the opportunity to add information or remove anything that they believed was identifying. Two participants made minor additions. Ethics approval for this study was provided by the university human research ethics committee.

Interview

The semi-structured interview schedule was developed by the authors specifically for this study. It consisted of open-ended questions designed to broadly examine clinicians' experiences when working with parents. These were then followed up with probing questions to obtain more detail. Key questions from the interview schedule and some of the probing questions used in interviews were:

1. What is it like for you to work with parents who have mental illness?
 - Example probes: How is that different to working with people who are not parents? Is that typical of your work with most parents? What is your main objective when working with parents?

Table 1 Self-reported participant demographics

Pseudonym	Gender	Profession	Work Setting	Geography of workplace
Claudia	Female	Psychologist	Community ^c	Regional
Craig	Male	Psychologist	Inpatient ^a	Rural
Angela	Female	Psychologist	Inpatient ^a	Regional
Emily	Female	Psychologist	Outpatient ^b	Rural
Michael	Male	Social Worker	Outpatient ^b	Suburban
Katherine	Female	Social Worker	Inpatient ^a	Rural
Kelly	Female	Social Worker	Outpatient ^b	Suburban
Kurt	Male	Mental Health Nurse	Community ^c	Suburban
Frances	Female	Mental Health Nurse	Community ^c	Regional
Vicki	Female	Psychiatrist	Outpatient ^b	Suburban
Julie	Female	Occupational Therapist	Community ^c	Regional

^aInpatient = parent resides at mental health service while receiving treatment

^bOutpatient = parent attends mental health service for scheduled appointments

^cCommunity = parent is visited at home or in a community setting by the mental health clinician(s)

2. Do you consider the needs of the parent *and* the child? If so, what is that experience like?
 - Example probes: Who is your main focus? Do you find the two perspectives compatible? How do you manage that?
3. What emotions, if any, do you experience when working with parents?
 - Example probes: When do you feel that way? Does that feeling impact on your work with the parent? How do you manage those feelings?

Analysis

Interview data was analysed using Interpretative Phenomenological Analysis (IPA) because it is a methodology for examining participants' experiences and perspectives of phenomena [41]. Thus, IPA is well suited to the objectives of investigating clinicians' perspectives and personal reactions when working with parents. The first of several analytic steps involved reviewing the interview transcripts multiple times to identify the main points communicated by each participant. Transcripts were then coded, whereby short sections of the transcripts were labelled with key phrases, ideas and contextual information. The codes were revised multiple times and used to identify categories and themes relating to participants' perceptions of parents with a mental illness and their children. The analysis was primarily conducted by the first author, with a separate analysis of five transcripts undertaken by the second author. Interpretation differences were managed by further reviewing the transcripts. All authors also engaged in reflective conversations about possible interpretations of the interview data and themes throughout the study.

Results

There was considerable variability in participants' perspectives of parents and children. Participants could broadly be categorised into one of three groups who focused on the parent, the child or both. Three themes, each with two subthemes, were identified. They are listed in Table 2 and described further below. Representative quotes are tagged with participant pseudonyms from Table 1.

Table 2 Themes and subthemes

Themes	Subthemes
Clinicians' perspectives of parents and their children	Seeing difficulties Seeing strengths
Single focus: Seeing the parent <i>or</i> the child	Focusing on parents Focusing on children
Dual focus: Seeing the parent <i>and</i> the child simultaneously	Experiences of dual focus Maintaining the dual focus

Clinicians' perspectives of parents who experience mental illness and their children

Participants' perspectives varied from sympathetic and hopeless views of parents and their children to more hopeful and optimistic views. Some participants focused on difficulties, including the disempowerment of parents and the vulnerabilities of their children. Meanwhile, others emphasised the strengths and motivations of parents and hope about achieving positive outcomes for children.

Seeing difficulties

All participants recognised that parents felt disempowered in many ways. Six participants stated that parents were disempowered by child-focused services who "scrutinised" (Claudia) or restricted their parenting. Some also saw other family members as contributing this disempowerment, through a lack of support and criticism. For example, when describing parents who have a mental illness Frances reported that "they never get to make a choice about anything. Everybody thinks they know better... so they really never learn these parenting skills because they've always been told themselves what to do... because they're sort of at this stunted level in development in everybody else's eyes." This disempowerment of parents by services and families was seen to sometimes create a "very hopeless place for [these parents] which is very sad and distressing for them." (Frances).

In relation to children, seven participants viewed them as vulnerable to the impacts of their parents' behaviours and to the intergenerational cycle of mental illness. Consequently, five participants reported strong feelings of sympathy, fear and/or responsibility towards the children. For example, Kelly said; "Sometimes I do feel quite sorry for those children because you can see them getting caught up in those patterns of behaviour because they are learning some of that." Claudia recognised that her emotional responses towards these children had intensified since she became a mother herself; "when I see children that are babies or children the same ages to my child - that, for me, is quite confronting."

Vicki recognized that such emotions occurred when she identified with the powerlessness of the child's situation; "I think there is so much fear around mental illness and so much fear that children will be harmed or neglected... I think it relates to the vulnerability of the child... to identify with the vulnerability of the child... can add to those very powerful feelings for the worker."

Seeing strengths

Eight participants acknowledged that being a parent was a meaningful experience; "Peel it all back and there's a child there at the heart of it" (Michael). These participants believed that most parents were dedicated and hopeful about their parenting, as demonstrated by Emily's comment that

“parents really, really, really want to do a good job for the most part.” Consequently, being a parent was seen as a strong motivating factor to work harder towards mental health recovery; “The main motivation is their children... they do want to give well more than 100%” (Julie).

Six participants were also hopeful for the outcomes of these children. For example, Katherine said that these children held “potential and possibility”. These participants viewed their own work with the parent as “early intervention” (Claudia) and an opportunity to “break that cycle” (Emily) of intergenerational mental illness.

Single focus: Seeing the parent or the child

Three participants with particularly strong sympathetic perspectives of parents had developed a singular focus of those parents, with minimal attention paid to their children. Similarly, five participants became heavily focused on children when triggered by sympathetic feelings towards them. While this child-focus was transient for four of these participants, one participant remained constantly focused on children.

Focusing on parents

While all participants acknowledged that the wellbeing of children was paramount, three participants (Angela, Craig and Julie) reportedly attended to child wellbeing only if there were signs of abuse or neglect. They did this by reporting the issue to child protection services. These participants remained focused on the presenting issues of the parent; “I’m much more client focused about ‘What are you here for?’” (Angela). When they discussed parenting issues, it was from the parent’s perspective such as to “talk about the stress of parenting” or “let off steam” (Craig).

These three participants felt especially sympathetically towards parents due to their disempowerment by services and families. This was especially meaningful for Angela and Julie who had supported multiple parents during or after the removal of their children by child protection services: “It effects the parent in a huge way... and that doesn’t seem to be looked into as much as it should be” (Julie).

These participants assumed that other clinicians or services would address the wellbeing of these children. For example, Angela, a psychologist, said; “The social workers do a lot of the family work and the doctors might talk to the family for collateral history and things like discharge planning. I’m a bit more one-on-one therapy with the client themselves.”

Focusing on children

Five participants reported becoming overwhelmed by sympathy for children and became disproportionately focused on these needs of children. Further, three of these

participants had experienced negative feelings and judgments towards the parents. This was evident when Kurt commented; “If you’ve got one job in life, try and do it correctly - being a parent. You know, you feel like saying ‘Put more effort in!’”

The following comment suggests that Kurt also felt helpless when attempting to support children who he believed “have a high expectation of you.” He commented; “It’s difficult to leave a kid in a crappy situation. You don’t want to and you want things to improve the next day but you’re leaving that kid in a less than ideal - by a long shot - environment.”

While most participants commented that their emotionally charged focus on children was temporary, Kurt prioritised “the child in front of the parent” most of the time.

In order to advocate for these children, Kurt believed that it was necessary to “take on an authoritarian role instead of a clinician role... you’ve moved across the line from someone who’s trying to help them to someone who’s against their will.” He recognised that a limitation of this approach was that parents sometimes thought that he was “judging them” and so became “very defensive.”

Dual focus: Seeing the parent *and* the child simultaneously

Seven participants attempted to maintain a focus on parents and children simultaneously. However, they found this challenging and sometimes became temporarily focused on party or the other. They had developed strategies for managing the difficulties of maintaining this dual focus.

Experiences of dual focus

The concurrent view of parents and children was described by Vicki as “a dual focus... there needs to be a focus on the child outcomes and wellbeing and there needs to be a focus on the parent outcomes and wellbeing.” Within this dual focus, five participants said that their goal was to support the parent with their mental health and parenting so that the parent was able to meet the needs of their children; “If we can make a difference for these parents so that they can do what they need to do to meet their kids ... then that’s kind of best for everybody” (Emily).

When utilising a dual focus, participants had experienced conflict between attending to the needs of the parent and the needs of the children. They described this as “a real balancing act” (Vicki), “walking a line” (Katherine), a “tight rope” (Frances), a “push and pull” (Michael) and “balancing back and forth” (Claudia). These tensions were especially intense for participants when faced with formal decisions, such as making child protection reports. This was illustrated in a comment made by Frances; “It gives you a few sleepless nights because you wonder what the impact will be on the

parents if the welfare turn up.” Five of these participants also experienced the tensions of a dual focus when adequate support was not available from services, families and the community for the family; “in an ideal world, there would be sufficient support ... to support the parent to do what they can do and to make up for the parts that they can’t do ... There seems to be never enough” (Vicki).

Maintaining the dual focus

Participants had developed several strategies for balancing their perspectives of parents and children, and associated emotions. Four participants remained mindful of their focus and purposefully alternated between perspectives of the parent and the child, as necessary to help manage emotional reactions. For example, Kelly described her deliberate efforts to empathise with a father after becoming frustrated at what she perceived to be his unprotective parenting behaviours; “I had to sort of push through that and keep engaging with him... understanding the consumer’s story a lot better... he did want to act protectively but that his illness made it difficult for him.”

Five participants managed sympathetic feelings towards parents and children by utilising a strengths-based approach to empower parents and families. Kelly highlighted the benefits of this approach “... using the strengths based words and reminding them of the hope that there is ... self-care in itself because we’re working towards something better together. And I think working towards those goals step-by-step also helps clinicians to remind themselves that there is hope and that it’s not just an endless cycle.”

Similarly, Frances discussed the benefits of a strengths-based approach to counteract her feelings of sympathy and parents’ feelings of helplessness. She commented, “there’s a lot that’s positive ... [even] when you see a family who have been really struggling and thinking that they’re not going anywhere.” By focusing on these positive factors and strengths, she encouraged families, and herself, to realise that “... we might not be perfect but then nobody is ... It’s not all bad and we are not all bad as parents. We can still be a family. We can still love our children, nurture them and give them the best that we can which is the same as any other parent would do.”

Participants also promoted parental empowerment by encouraging parents to make their own decisions about their mental health and parenting. Katherine commented; “if I decide to do anything, then immediately I’m creating a sort of semi-resistance to this woman’s capacity to do it for herself.” Likewise, Michael clarified that his role with parents “... is not telling them what to do, but to allow them to be well informed and give them a range of options.”

Those participants who attempted to maintain a dual focus benefited from support within their workplace. This support came in multiple formats, including “supervision”

(Kelly), debriefing (Frances), “team consultation, team supervision, team discussion” (Emily), formal and informal “multidisciplinary team” discussions (Michael), clinical review (Claudia), and consultations with specialists such as “FaPMI” (Kurt) co-ordinators who specialise in families where a parent has a mental illness.

Four participants appreciated that their colleagues were less emotionally involved in their cases than themselves, so could offer objectivity and a redirection towards a balanced perspective of parents and children when necessary. Support from these co-workers helped clinicians decide “... which direction we go in and the timing of it. And I find that clinical support is very helpful in knowing where to go next” (Vicki).

In addition to support for decision making when working with parents, clinicians also valued the emotional support that they received from within their organisations. Emily said this support allowed her to “accept that you’re a human and you’re going to have emotional reactions to things as well and that’s okay. Let’s just have a quick de-brief and then you’ll be okay.”

Discussion

This study examined the self-reported perceptions and personal reactions of mental health clinicians within the Australian adult mental health sector towards parents who have a mental illness and their children. Overall, participants’ perspectives of parents and children were emotionally laden which influenced the particular focus on their work in terms of who they supported. Clinicians in this study tended to approach their work with parents in one of three ways – focusing on the parent, the child or both.

Three participants focused solely on the needs of parents. Although they acknowledged mandates to report suspected incidents of abuse or neglect, they did not actively enquire about child wellbeing. Early research by Killens [32] suggested that clinicians may choose to focus solely on parents so that they do not have to witness the hardships of children. In contrast, the parent-only focus of some participants in this study may have been driven by a sense of loyalty towards the parents. These participants perceived parents as being distressed and disempowered by child-focused services and family members. Thus, they viewed the advocacy of children as conflicting with the support of the parents. This is consistent with Cousins’ [35] assertion that clinicians within adult mental health services may feel compelled to side with parents. By maintaining a focus on the parent, and not the child, participants may have affirmed their alliance with the parent, thereby reducing their own internal tensions and tensions in their interactions with parents.

Organisational factors may also contribute to clinicians adopting a singular parent-focus. A lack of an organisational policy to promote and guide the support of children has been well documented [13, 24]. Although recent legislation in the state of Victoria mandated the support of children whose parents receive mental health services, one study found that the support of children was not consistently implemented as a priority nor enforced within organisations as had been achieved with sections of the Act that had been supported with clearer directives and resourcing [42]. Thus, it is perhaps understandable that participants from this study and previous research [30, 31, 43, 44] claimed that issues related to parenting and child wellbeing were the responsibilities of other professionals rather than within their own remit. In the absence of strongly endorsed policy within organisations, the perception that the wellbeing of the children of parents with mental illness is beyond the clinician's role is easily promulgated.

It may be common for clinicians in the adult mental health sector to focus exclusively on parents, with many clinicians failing to identify the presence of dependent children or consider them in case planning [45, 46]. Clinicians may assume that issues related to parenting and child wellbeing will be adequately addressed by supporting the parent's mental health [47]. However, reductions in parents' mental health do not always lead to beneficial outcomes for children [48, 49]. For example, even with a reduction in a parent's mental health symptoms, disruptions to the parent-child relationship may persist and negatively impact on child wellbeing [50]. Thus, the needs of children are unlikely to be reliably identified and supported by clinicians who have a singular focus on parents.

In contrast, other participants reported times that they became focused on risks posed to children by the parents' mental illness and associated parenting behaviours. This child-focus occurred when they experienced feelings of sympathy, responsibility and a sense of hopelessness for these children. While this focus on children was constant and pervasive for one participant, others reported it as being a temporary stance. Gladstone, Boydell and McKeever [51] suggested that the risks to children are often over-emphasised which may result in them being characterised as passive victims. They argue that this perspective of children does not acknowledge their capabilities nor allow them to actively contribute to the planning of their parents' recovery or the promotion of their own wellbeing. Thus, clinicians who focus solely on risks and vulnerabilities of these children may fail to recognise the complexity of their experiences and may not respond appropriately to meet their needs.

Participants with a focus on the needs of children described becoming angry and judgmental towards parents

for not adequately protecting and caring for their children. Similarly, Munroe [52] suggested that child protection clinicians may readily assign blame to parents. She argued that this perspective offers a straightforward explanation of the situation and a clear path of action to correct the behaviour of the parent. Likewise, one of the participants in this study, Kurt, believed it was necessary to adopt a non-supportive, authoritarian approach with parents to advocate for their children. He reported that this approach led to parents feeling judged and was detrimental to his rapport with them. This is understandable, given that parents who experience mental illness may already be worried about services judging or placing restrictions on their parenting or removing their children [26, 53]. Furthermore, such an approach negates the significant social and economic disadvantage many parents with a mental illness experience and adds further to their disempowerment [53].

Several participants attempted to maintain a dual focus on parents and their children concurrently, despite some becoming preoccupied by the needs of children at times. Previous literature argues that a dual perspective is necessary to effectively work with parental mental illness, but also asserts that tensions exist between these two perspectives [34, 35]. Findings from this study affirm that such tensions were experienced by participants who adopted a dual focus. In contrast to participants with a singular focus on parents or children participants, those with a dual focus felt the pressure of meeting the needs of parents *and* the children. They worried that actions to support one party may negatively impact on the other. Therefore, the process of maintaining a dual focus involved actively and consciously juggling and balancing of the perspectives of parents and their children.

The tensions of maintaining a dual focus were eased when participants directed their efforts toward empowering parents to care for their children. In contrast to the assumption that the needs of children are unavoidably in conflict with the needs of parents [34, 35], a practice framework of parental empowerment allowed participants to unify the goals of supporting parents as well as meeting the needs of their children. An emphasis on parental empowerment also encouraged clinicians to recognise the strengths of parents and their children and eased feelings of sympathy and responsibility towards them. Thus, a model of parental empowerment is likely to assist clinicians to maintain a dual focus as well as relieve anxieties that are associated with working with parents [26].

Parental empowerment is a central goal of Let's Talk about Children, a short intervention for working with parental mental illness [21]. During the Let's Talk about Children intervention, clinicians encourage and support parents to identify and create positive changes within their family to strengthen relationships and build the

resiliency of their children. Completion of online training in the intervention influenced clinicians' attitudes relating to their work with parents, along with increased skill and knowledge [54]. Specifically, some clinicians realised, for the first time that positive family change could be achieved through parental empowerment. The promotion of this intervention, and the underlying principle of parent empowerment which promotes the view that parents may be the conduit of change back in their families, would support clinicians to manage a dual perspective of parents and children.

A recent study identified characteristics of clinicians associated with family-focused practices [55]. The strongest predictor of family-focused practices was prior training. Experienced, female clinicians practicing in rural locations were also more likely to engage in family-focused practices. The findings corroborate the importance of training which may be especially useful for clinicians who are inexperienced, male and/or working in populated locations. Moreover, the findings of the present study suggest that clinicians who are parents themselves may experience particularly strong emotional reactions towards parents and children. Further research is needed to determine the specific support that clinicians who are parents may need to manage feelings toward parents and children.

On the basis of this study and previous research, a number of recommendations can be made. Services need to support clinicians to employ a dual perspective when working with parents through strengths-based frameworks that emphasise parental empowerment. While policy is important, organisations and managers must also support clinicians by providing them with adequate time, resourcing and a workplace culture that affirms this complex and challenging work. Ongoing dialogue and support for working with issues related to parenting and child wellbeing may be provided by including this as a regular agenda item at regular meetings such as supervision and case reviews. It may also be beneficial to provide clinicians with a forum to discuss issues relating to parents and their children. Opportunities for consultation with specialists in the area of parental mental illness may also be of use. Additionally, clinicians should be trained in practice frameworks, such as the Let's Talk about Children intervention, that promote concurrent support of parents and children through parental empowerment.

The voluntary sampling method utilised in this study is a limitation which may have attracted participants with a strong interest working with consumers who are parents. Although a range of professions were represented, the sample is skewed heavily towards psychologists and social workers. The sample size of 11 participants was appropriate for the contextualised,

in-depth examination of their perspectives and experiences [56], but findings may not be generalisable. It is likely that clinicians may perceive and react to parents and children in additional ways to those identified in this study and that other factors may influence the focus of their work. Therefore, qualitative or survey-based methods with larger sample sizes are required to generalise and extend on these findings across the adult mental health workforce. The results of IPA are unavoidably influenced by the researchers' preconceptions and biases [56]. All researchers of this study were advocates for the support of children and parents when parental mental illness is present. The influence of such biases were identified and moderated through the separate analysis of a subset of transcripts by the second author and conversations between all authors during all stages of the study.

Further research could investigate a range of areas related to clinicians' perspectives of parents with a mental illness and their children. It would be beneficial to examine if/how clinicians' perspectives are influenced by contextual factors such as the severity of the parental mental illness, the presence and supportiveness of the other parent or the age of children. Research could also examine the relationship between clinicians' self-reported perceptions and actual practice. It is also crucial to develop and evaluate resources to support clinicians to maintain balanced perspectives of parents and children.

Conclusions

The findings of this study indicate that a dual focus on parents and children may be difficult for mental health clinicians to maintain due to sympathetic feelings towards parents, children or both. Such feelings may lead clinicians to believe that the needs of parents conflict with the needs of children. Consequently, clinicians may feel torn between the two parties or compelled to take sides. Maintaining a balanced perspective of parents and children was supported by adopting a strengths-based framework of parental empowerment. It is vital that clinicians are supported by adult mental health services to employ such a framework and maintain a balanced perspective of parents and their children.

Abbreviations

IPA: Interpretative Phenomenological Analysis

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Availability of data and materials

The dataset supporting the conclusions of this article is not publicly available to protect the privacy of participants. Reasonable requests for information about the data should be directed to the corresponding author at: philliptchernegovski@monash.edu.

Authors' contributions

PT designed the study, managed participant recruitment, developed the interview schedule, conducted interviews, managed the analysis and led the writing of the manuscript. RH assisted with recruitment of participants, conducted a secondary analysis of five interview transcripts, participated in reflexive discussions to interpret interview data and identify themes and contributed to writing the manuscript. AR contributed to the design of the study, development of the interview schedule, reflexive discussions during analysis and writing the manuscript. DM contributed to the design of the study, development of the interview schedule and writing the manuscript. All authors read and approved the final manuscript.

Ethics approval and consent to participate

Ethics approval was granted by Monash University Human Research Ethics Committee. Informed consent was obtained from all participants prior to interviews being conducted.

Consent for publication

Participant consent included agreement for publication of the current study. All authors read and approved the manuscript for publication.

Competing interests

The authors declare that they have no competing interests.

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Chapter 6

Legislative Policy to Support Children of Parents with a Mental Illness: Revolution or Evolution

6.1 Background

The previous two chapters examined different aspects of their work with parents. Various initiatives have been developed to promote and support family-focused practices with parents who have a mental illness. The Victorian Mental Health Act (2014) mandates adult mental health services to recognise and support the children of parents receiving mental health treatment. While this legislation is a positive step forward, it is important to examine how this legislation, and its introduction to the mental health sector, have been received by clinicians.

6.2 Aim of the study

The aim of this study was to examine adult mental health clinicians' experiences of the introduction of the Victoria Mental Health Act, with reference to if/how the Act influenced how they approached their work with parents.

6.3 Relevance of the study

Findings from this study can guide workplace resourcing and decisions to enhance the impacts of the Mental Health Act. They can also inform future policy relating to family-focused practice so that it can be effectively developed and implemented to maximise impact on clinicians' practices.

6.4 Declaration of contribution

The following tables outline the contributions of the candidate (Table 6.1) and the other authors (Table 6.2) to the published study presented in Chapter 6.

Table 6.1

The candidate's contribution to the published study in chapter 6

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	80%
Participant recruitment	80%
Data collection, recording and transcription	95%
Analysis and interpretation of results	80%
Preparation of manuscript	85%

Table 6.2

The contribution of the other authors to the published study in Chapter 6

Name	Nature of Contribution	Extent of Contribution (%) for student co-authors only
Prof. Darryl Maybery	Contributed to conceptualisation, development of research materials, interpretation of findings and manuscript preparation.	n/a
Prof. Andrea Reupert	Contributed to study conceptualisation, participant recruitment, development of research materials, data analysis,	n/a

interpretation of findings and
manuscript preparation.

6.5 Declarations of ethical compliance

Ethics approval. All procedures undertaken as part of this study were approved by the Monash University Human Research Ethics Committee, project number CF14/3179 – 2014001730. Procedures were in accordance with the 1964 Helsinki declaration and its later amendments and comparable standards.

Informed consent. All participants provided informed consent prior to participating in the study, including consent for publication.

Conflict of interest. The authors declare that they have no conflict of interest relating to this publication.

Candidate's signature:

A solid black rectangular box used to redact the candidate's signature.

Primary Supervisor's Signature:



Legislative policy to support children of parents with a mental illness: revolution or evolution?

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Legislative policy to support children of parents with a mental illness: revolution or evolution?

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ABSTRACT

In 2014, a Mental Health Act was introduced in Victoria, Australia which mandated clinicians to recognize and support consumers' children. Interviews were conducted with 11 clinical adult mental health professionals about their views and experiences of the introduction of the Act and its impact on their practices. Interviews revealed that sections of the Act relating to consumers' children were not promoted within organizations and did not result in revolutionary practice change. Instead, practice development staff within organizations were viewed as the main drivers of practices to support consumers' children. Suggestions are made for enhancing the impact of legislation to promote practice change.

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Mental health legislation; legislative policy; children of parents with a mental illness; workforce; practice change; interpretative phenomenological analysis

Introduction

Mental health systems are continuously undergoing change and development. There has been a major trend in most anglicized countries over the past 30 years to move away from a medical model of intervention and towards recovery-focused practices that promote consumer choice in their treatment and support them in important life roles such as parenting (Jacobson & Greenley, 2001; Watson, 2012). Simultaneously, an emerging body of research about children of parents with a mental illness has highlighted their need for support (van Santvoort, van Doesum, & Reupert, 2015).

The experiences of these children vary due to multiple factors, including parental symptomatology, chronicity and severity (Levertson, 2003). Some children described their parent being unavailable (Stallard, Norman, Salter, Cribb, & Huline-Dickens, 2004) while others experience their parent as over-involved and/or controlling (Aldridge, 2006). Although there is considerable variability in children's experiences, several longitudinal studies across a broad spectrum of parental psychiatric disorders have found that mental health concerns among these children ranges from 41 to 77% (for a review see Hosman, van Doesum, & van Santvoort, 2009).

When mental health organizations support the parenting roles of consumers and promote the well-being of their children the risks to children may be considerably reduced

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(Siegenthaler, Munder, & Egger, 2012). Unfortunately, service change to incorporate family and parent focused practice has been gradual and is yet to become fully embedded into mental health systems in many parts of the world (Lauritzen, Reedtz, van Doesum, & Martinussen, 2014; Rummel-Kluge, Pitschel-Walz, Bäuml, & Kissling, 2006).

In a seminal paper describing systems change, Gersick (1991) presented a model of punctuated equilibrium, whereby systems experience small and gradual changes referred to as evolution. These changes do not disturb the overall functioning of the system, which is said to remain at equilibrium. Evolution in mental health systems includes changes such as the modification of treatment programs that services offer or additional resources to facilitate practice. Occasionally, major events occur which punctuate the equilibrium of the system. Such changes are referred to as 'revolutionary' and result in the system being unable to function as it previously had been. In mental health systems, revolutionary change often occurs from top-down modifications (originating from upper levels of the system) including the restructuring of roles within organizations. When revolution occurs, significant and timely changes must be made to operational processes so that the system can re-establish equilibrium and function effectively.

Initiatives across multiple countries have promoted the evolutionary uptake of mental health practices that recognize and support consumers' children. This has included social and educational programmes for children of mental health consumers (Orel, Groves, & Shannon, 2003; Reupert & Maybery, 2009), manualized interventions for clinicians to deliver to parents and families (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2013; Swartz et al., 2008) and the development of resources for families (Grove, Reupert, & Maybery, 2015; Marston, Maybery, & Reupert, 2015). In Australia, the national Children of Parents with a Mental Illness (CoPMI) initiative was established to provide information and resources to clinicians, parents and children (Fudge & Robinson, 2009). The state of Victoria established a network of workforce coordinators in the area of families where a parent has a mental illness. The central role of these FaPMI (Families where a Parent has a Mental Illness) coordinators is to 'increase the capacity of specialist mental health services ... to provide a family-focused response to the parenting needs of their clients and the needs of their client's children' (Department of Health & Human Services, 2007, p. 4). Despite these initiatives, the uptake of practices to support consumers' children are hindered by numerous factors including a lack of specific policy that recognizes the needs of children living in these families (Maybery & Reupert, 2009).

Recent legislation in Norway and Finland include sections that relate specifically to the rights of consumers' children. For example, legislation in Norway requires all health clinicians to determine if consumers have children and to consider their need for information and follow-up (Lauritzen & Reedtz, 2013). Similarly, mental health clinicians in Finland are required to identify and provide support for consumers' dependent children (Solantaus & Toikka, 2006). Following the introduction of this legislation in Norway there was an increase in the identification of consumers' children by clinicians, but no significant change to the frequency of conversations that clinicians were having with consumers about parenting and child well-being (Lauritzen et al., 2014). It appears that, to date, legislative changes to promote the support of consumers' children have had limited impact on the way that services meet their needs.

In 2014, the Victorian state government in Australia introduced the Mental Health Act (MHA, 2014). The MHA was driven by several objectives, including the establishment of a

recovery oriented framework and reducing the use of compulsory treatment (State of Victoria, Department of Health, 2014). Several provisions were included to facilitate these objectives. First, a Mental Health Tribunal was created to arbitrate on matters of compulsory treatment, a power which was previously held by psychiatric staff. Secondly, the provision of Advanced Statements was introduced – a written document that consumers may complete (prior to compulsory treatment) which outlines their treatment preferences. Thirdly, the legislation entitles consumers to appoint a Nominated Person to advocate for them and make treatment decisions on their behalf.

Of particular relevance to the current study, the Victorian MHA also makes specific reference to the children of mental health consumers. Principle (j) states that ‘children, young persons and dependents of persons receiving mental health services should have their needs, wellbeing and safety recognized and protected’. The MHA also stipulates that children may be formally appointed as a nominated person and/or as their parent’s carer. Other sections relate to the type of information sharing that should occur between carers and organizations, but does not specifically refer to children. Thus, while acknowledging the needs of consumers’ children, it could be said that the MHA does not provide clear directives or procedures for doing so.

The Department of Health produced an online mental health handbook (State of Victoria, 2015) which outlined important features of the MHA. The handbook emphasized the importance of reducing the frequency of treatment orders and increasing consumer and carer participation when making treatment decisions. The principle about consumers’ children is also listed. Additionally, a section of the handbook states that Advanced Statements may include a plan for the care of consumers’ children if they are unable to care for them. The handbook is available to mental health staff and the general public. Organizations were given flexibility over the specific training strategies used to apply the MHA within their services, including how the online handbook was utilized. The Department of Health began providing information to organizations and requesting them to prepare clinicians approximately 12 months prior to the commencement of the MHA. They also funded specialist senior clinicians to assist with the coordination of tribunal hearings, conduct training sessions and provide consultation to clinicians about matters pertaining to the MHA. The mental health tribunal began operating in accordance with the MHA on 1 July 2014, the same date by which mental health organizations were to comply with all aspects of the MHA that related to the tribunal.

Whether the new MHA will prompt a revolution in practice and service delivery for the support of consumers’ children remains to be seen. This study examined adult mental health clinicians’ views and experiences of the Victorian MHA with reference to how the legislation has (or has not) influenced their work with consumers who are parents. Since clinicians’ responses to the legislation are likely to be influenced by their personal views and experiences of the MHA and its introduction, a phenomenological methodology was used. This study was guided by three main research questions:

- What are clinicians’ understandings of the Act as it relates to work with consumers who are parents?
- What are clinicians’ experiences of the introduction of the MHA?
- What practice changes have clinicians experienced in their workplaces since the introduction of the MHA, especially in regard to practices when working with consumers who are parents?

An understanding of clinicians' perspectives towards the current legislation and its impact on practices will assist in determining how resources might be directed to maximize the impact of legislation and to ensure that future policies are effectively promoted and translated into change at practice and service levels.

Method

Sampling and participants

A recruitment email was disseminated to professionals in the Victorian adult mental health sector, known to the researcher. This included the state-wide FaPMI coordinator (who then disseminated it to all twelve Victorian FaPMI coordinators) six adult mental health managers and two clinicians. These professionals were asked to forward the email to clinicians in various workplaces with the aim of obtaining a sample of clinicians across professional backgrounds, settings and geographical regions. The email contained an explanatory statement outlining the research and sought expressions of interest from potential participants. A request was also contained within the email for recipients to forward the research information to others in their professional network. Inclusion criteria specified that participants were to be employed as a clinician within the Victorian adult mental health sector.

As well as clinicians, expressions of interest were received from senior clinicians in specialist roles that were created to assist with the implementation of the MHA. The purpose of these specialist roles was to promote clinician knowledge and compliance in regard to MHA directives through group training and individual consultation. Another component of these roles was to act as an intermediary between the tribunal and mental health services. Given their experiences in working with a wide range of clinicians in relation to the MHA, they were also included in the study.

Interviews were conducted with 11 participants. Six were clinicians, two were in the specialist roles and the remaining three were in combined clinician/specialist roles. The mean age of all participants was 39.2 (SD = 9.4), and 44.6 years (SD = 10.3) for participants in specialist roles. The average length of experience in adult mental health for the entire sample was 10.2 (SD = 2.5), and 14.6 years (SD = 4.8) for participants in specialist roles. The mean length of experience working with children was 6.4 (SD = 3.0). For specialist participants, it was 2.8 years (SD = 3.9). See Table 1 for select demographic information for each participant.

Interview procedure

A semi-structured interview schedule was developed specifically for the current study and informed by relevant literature. Broad questions were followed-up with more specific questions to explore participant responses in greater depth. A modified schedule for specialist participants included questions about their own experiences of the MHA and their observations of how clinicians in their organizations had responded to the MHA. Draft interview schedules were reviewed by two international experts in the area of practice change and policy relating to families where a parent has a mental illness. Slight modifications were made in response to their feedback (Appendix 1).

Interviews were conducted between 10 and 16 months after the introduction of the MHA. Prior to completing interviews, participants provided written consent and completed

Table 1. Self-reported participant demographics.

Participant code	Role	Gender	Profession	Work setting	Geography of workplace
P1	Clinician	Female	Psychologist	Outpatient	Suburban
P2	Clinician	Female	Social worker	Community	Suburban
P3	Clinician	Female	Social worker	Community	Suburban
P4	Clinician	Female	Social worker	Rehabilitation	Regional
P5	Clinician	Male	Psychologist	Community	Regional
P6	Clinician	Male	Psychologist	Crisis	Regional
P7	Clinician/specialist [§]	Female	Mental health nurse	Intake	Regional
P8	Clinician/specialist [§]	Female	Mental health nurse	Across units	Suburban
P9	Clinician/specialist [§]	Male	Social worker	Across units	Suburban
P10	Specialist [§]	Female	Social worker	Across units	Suburban
P11	Specialist [§]	Female	Mental health nurse	Community	Rural

[§]'Specialist' refers to participants who were in specialist senior clinician roles to assist with the implementation of the Mental Health Act.

demographic questions. Interviews were 20–35 min (average 28 min) in duration and were audio recorded with participant permission for subsequent transcription. Member checks were conducted (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008), whereby participants were sent their interview transcripts to review. Two participants made written additions to clarify the meaning of statements in their transcripts. Ethics approval for this procedure was obtained by the university human research ethics committee.

Analysis

Interview data were analysed with Interpretative Phenomenological Analysis (IPA) (Smith, 1996). IPA shares some procedural similarities with other forms of qualitative analysis (Braun & Clarke, 2006) but has a distinctive epistemological approach. IPA is phenomenological and concerned with participants' views and experiences of phenomena rather than the phenomena themselves (Smith, 2004). Consequently, IPA involves two levels of interpretation; the participant's interpretation of the phenomena and then the researcher's interpretation of the participant's interpretation (Smith, 2004). IPA is also ideographic (Smith, 2004), with the aim of examining individual's experiences, including the similarities and differences between individuals.

The analysis conducted for this study involved multiple steps. Interview transcripts were read and re-read several times, while making notes about initial impressions and interpretations. Units of meaning were identified throughout transcripts (phrases or sentences) and assigned codes which summarized their content and/or interpreted meaning (as considered within the context of the whole interview). Codes were reviewed to identify key messages within each transcript. Only after key messages were identified for each participant were they compared across transcripts to identify themes relevant to the research aims. Particular attention was given to similarities and differences between participants for each of these themes. These steps were not conducted in a linear process. Instead, there was movement back and forward between the transcripts and the results, to increase the researchers' closeness to the data which promoted deeper interpretation and the authenticity of resulting themes.

Interviews were initially analysed separately for the clinician and specialist groups. Although the specialist group were more knowledgeable about the MHA than the clinician

group, the overall resulting themes were very similar. Subsequently, the groups were combined to produce an overall set of themes for the entire sample. Narratives were produced for each theme with quotes being tagged according to key demographics. Member checks were conducted again at this stage (Burnard et al., 2008), with participants being sent this brief narrative and invited to respond with feedback. Five participants responded, all with positive feedback that the results reflected their views.

Results

Three themes related to participants understanding of sections of the MHA that referred to consumers' children, their perspectives of practice change and their experiences of the implementation of the MHA. These themes are described below with key interview quotes. Quotes are tagged with participant codes (P1, P2, P3 ...) (See Table 1).

Children: what does the Act say about them?

Five of the clinicians in this study reported receiving group-based training from within their organization, along with regular updates about the MHA via email. The sixth clinician was introduced to the MHA more recently as part of his workplace induction. For these participants, the training had impressed on them the importance of the MHA for compulsory treatment, but not for practices with consumers who are parents.

Five of the interviewed clinicians were unfamiliar with the MHA principle which calls for the recognition and protection of consumers' children. One clinician stated: 'I have not read – I do not know that part of the Act' (P4). Four of the five MHA specialists were aware of this principle. One of these specialists was 'particularly excited' (P10) about its inclusion in the MHA but the other four indicated that it had not been a widely promoted part of the MHA within their organizations: 'That principle specifically, I don't think we've done all that much in terms of focusing specifically on that ...' (P8).

Half of the clinicians were unaware that the MHA allowed children to be formally recognized as carers and nominated persons. One MHA specialist described how conversations at his organization challenged clinicians' perspectives of the roles that consumers' children may be undertaking in families: 'We've certainly been given the direction that it's certainly ok [for children to be carers] ... Some staff members question that. It gets them thinking' (P9). Although this aspect of the MHA had prompted conversations in some workplaces no participants were aware of any children who had been declared a carer or nominated person. One participant suggested that this part of the MHA has not been translated into practice because many clinicians struggle with the idea that children are 'actually doing a caring responsibility role. And because staff don't want to see children being in that position, they don't see them doing that, and don't acknowledge that' (P10).

Practice change: changing what I do or how I go about doing it?

Although participants had diverse views regarding the MHA's potential to create practice change, they shared a common theme – that compliance with new workplace procedures was not sufficient for genuine and sustainable practice change. It was believed that genuine practice change required a shift in the clinician's underlying stance or approach to practice,

which would, in turn, alter their interactions with consumers. The MHA was perceived as a tool to support such change, but according to participants, organizations and clinicians are responsible for effectively utilizing it in practice. One participant highlighted this view: 'It depends on how well [organizations] embrace it and whether they do the absolute minimum to get compliance or whether they get into the spirit' (P10).

No participants had noticed specific changes, since the introduction of the MHA, in the way consumers' children were identified and supported. Three participants were hopeful that the Advanced Statements provision might be utilized by clinicians to help parents plan for the care of their children, although this was not yet occurring at the time of the interviews. These participants also pointed out that the attitude and approach of the clinician was as important as the tasks undertaken for empowering families. More specifically, one participant asserted that the Advanced Statements would need to be 'done in a transparent manner and it's actually the consumer that's driving the bus' (P7) and would not be effective if conducted by 'an overzealous clinician that thinks that I can help this person by telling them how to, what they should want' (P7).

In comparison, some participants noted meaningful changes in how teams approached practices related to other sections of the MHA (decreasing the use of treatment orders and increasing the voice of consumers) which had been widely embraced and promoted by their organizations: '[the way clinicians] document things and discuss them as a team has really moved away from the medical model and really focused on the recovery side of things ... advanced statements has been a huge part of that' (P11). Other participants had only noticed superficial changes in their workplaces: 'I can't see any difference. We know that the Mental Health Act has changed ... the terminology is different' (P4).

From Act to action: experiences of the MHA's introduction to the workplace

The state government was recognized as the driving force behind the MHA. Most participants felt that the government's introduction of the MHA was underprepared. Dissemination of relevant information was considered too vague by some: '... we knew it would be more consumer focused but that is all we knew. We didn't know where it was heading' (P7). Several participants had been frustrated by delays with the associated training package and resources. Other participants were confused by changes to terminology and forms that were used for compulsory treatment. Consequently, several participants described clinicians in their workplace who continued with old procedures because they felt unsupported in the transition period. However, once the mental health tribunal began arbitrating compulsory treatment matters, clinicians felt forced to comply with the new procedures, including the application for treatment orders.

Participants noticed that the government pressured organizations to comply with some, but not all, sections of the MHA. No encouragement or pressure was seen to be targeted towards practices to support consumers' children. Instead participants described ways that the government compelled organizations to reduce the use of treatment orders. This included the collection of operational data on the frequency of treatment orders and the 'type of funding' (P1) and resources that were allocated to practice alternatives. One participant commented that the managers of her organization were pressured 'to be abiding by the Act and providing statistics ... accountability is something that can change practice. It's not going to change everything, but it's certainly provides enough momentum from the

senior management' (P10). This highlights the effectiveness of coercive strategies in changing organizational procedures, but not attitudinal change.

According to participants, adult mental health services changed operational systems and procedures for the areas prioritized by the government, including changes to reporting systems, training, supervision, meeting structures and organizational communication. Forms and reporting systems were particularly influential to clinicians' practices. One clinician described how the 'computer system auto-populates some of the Mental Health Act forms [for applying for treatment orders]' (P6) to make this task easier. In comparison, he continued by pointing out how recording systems made it difficult to record information about consumers' parenting status and children. '... so when they get handed over from the intake team ... a lot of the [parenting] information is not recorded' (P6). Another participant reasoned that the lack of documentation on consumers' children had stemmed from the government's failure to communicate this as a priority: '... there's nothing in the [computer] system or our paperwork ... the essential details [about parenting and children] aren't being asked for by the state government, so [organizations] don't put them in' (P10). Additionally, she indicated that '... we did have a space to help identify children on our assessment form but that's been removed, and we're fighting to have that put back' (P10).

All participants reported that these ground-level operation systems were more influential to their practice than overarching policy and legislation, for example:

I think there's policies about everything ... How often they refer to them is another thing ... in such a busy workplace, it's more the stuff that's on the ground and in the workspace that people really grab onto (P9).

While the MHA was not seen as effective for developing practices to support consumers' parents, participants suggested that other forces promoted the identification and support of consumer's children from within organizations. In particular, staff such as FaPMI coordinators, portfolio holders, supervisors or clinicians with a particular interest in families, were seen as ongoing advocates for whole-family perspectives and mentors for clinicians to develop relevant skills.

Discussion

The support of parenting roles and the well-being of consumers' children is crucial for ameliorating increased risks of mental health problems (Siegenthaler et al., 2012). The new Victorian MHA requires mental health services to recognize and respond to the needs of these children. The purpose of this study was to examine adult mental health clinicians' experiences of the legislative policy and how it impacted (or not) on their practices with consumers who are parents. The sections of the MHA relating to consumers' children were seen as having limited or no impact on practices, with more than half of the interviewed clinicians being unaware of these specific sections. In comparison, participants described other sections of the MHA (mainly relating to compulsory treatment) as having impacted on workplace procedures and clinician behaviours.

Participants noticed key differences in the introduction of sections of the MHA relating to consumers' children and other sections that resulted in observable changes in clinicians' behaviours (such as those relating to treatment orders). Overall, changes in clinician behaviour were reported when the government and/or organizations followed-up sections of the MHA with active strategies. This included the introduction of the Mental Health Tribunal and

collection of operational data to increase accountability of clinicians and organizations to adhere to new procedures. Overall, it could be said that such strategies punctuated the workplace equilibrium (Gersick, 1991), meaning that clinicians could no longer continue with previous practices to achieve revolutionary change. According to Corrigan, Steiner, McCracken, Blaser, and Barr (2001) such active strategies are crucial for successful uptake of practices as they address potential barriers to new procedures, motivate clinicians to develop necessary skills and promote the coordination of organizations and teams that may not occur otherwise. Sections of the MHA relating to consumers' children were not accompanied by such strategies. Hence, it may be argued that these sections were passively disseminated to clinicians rather than actively implemented (Proctor et al., 2009). While this passive dissemination may contribute to evolutionary change in the longer term, it does not directly address potential barriers or provide incentives for rapid change. Thus, the introduction method was not seen to be effective for creating a revolution in the way that consumers' children are supported by the mental health system.

Participants argued that compliance with some sections of the MHA was a positive start, but that it was not sufficient for widespread improvement of mental health service delivery. Many areas of practice were seen as unchanged, including the support of consumer' children. Additionally, participants questioned the benefit of complying with new procedures if they are undertaken reluctantly. Similarly, consumers' and carers' views of a new Scottish MHA indicated that some changes had occurred (in the use of new provisions such as Advanced Statements) but there had been little impact on clinicians' attitudes or underlying approaches and therefore no improvement in the overall nature of the support that was provided to consumers and their families (Ridley & Hunter, 2010, 2013). Participants in the current study indicated that authentic and genuine change occurred through more gradual processes, akin to the evolutionary changes described by Gersick (1991). The experiences of the participants reported here suggests that revolution may initiate and expedite the adoption of new procedures, but that evolution is required for new procedures to be gradually accepted and embedded into clinical practice. Participants from this study commented that a gradual embedding of practices was reliant on intra-organizational factors such as reporting systems, meeting structures and ongoing discussions with co-workers, supervisors and practice development staff. In relation to the support of consumers' children, FaPMI coordinators, were considered crucial for providing encouragement and guidance, about consumers' children, and sharing resources.

Some sampling and methodological issues limit the conclusions that may be drawn from this study. Firstly, it is not possible to know how many potential participants received the recruitment email nor is it possible to ascertain the response rate for the study. While the aim of the study was to recruit widely, participants ultimately self-selected into the study. This may have resulted in some sample bias, although it is notable that participants' views towards the MHA ranged from favourable through to critical. Additionally, the high proportion of participants who were unaware of sections of the MHA relating to consumers children suggests that the sample was not biased towards particular knowledge and expertise about those sections of the legislation.

Findings reflected participants' reported perceptions and experiences. While these are essential for understanding how such legislations can be utilized more effectively, it does not provide a measurable account of the process or performance outcomes (such as the number of children who have been formally recognized as carers, or how often advanced

statements refer to consumers' children). Further studies are necessary to obtain this type of information, as might be provided by the auditing of consumer records. As with many qualitative studies with small samples, the findings cannot be confidently generalized across workforce populations. The experiences of these 11 participants may not be representative of the state-wide population of adult mental health clinicians. However, the purpose of this study was to examine clinicians' experiences in depth and within context, rather than to produce generalizable findings. Further studies may investigate how experiences might vary in different contexts such as specialized clinical units or in reference to other legislative policy in other states and countries.

IPA is a hermeneutic methodology (Smith, Flowers, & Larkin, 2009), thus it is inevitable that researcher bias will influence the results. However, any potential bias was minimized by the input of specialists when developing the interview schedule, member checks and ongoing review and discussion between the authors throughout the interview and analysis processes. Previously IPA has been most effectively used with homogenous participant samples (Smith et al., 2009). The present sample was not homogenous as it included participants who were senior clinician implementation specialists alongside clinicians. This was addressed by conducting a separate analysis for each group. Although the clinician group had less detailed knowledge of the MHA the identified themes for both groups were very similar and were reported as a single participant group.

Although the MHA was not perceived as influential to practices for supporting consumers' children, participants indicated that it has impacted their practices in other areas. Based on the results of this study and other research in this area, some strategies are outlined below for broadening the revolutionary impact of legislation to include increased support for consumers' children, facilitating its translation into practice and promoting ongoing evolutionary development.

The findings of this study suggest that clinicians experienced a revolution when the MHA prevented them from continuing with previous practices and compelled them to comply with new workplace procedures. The influence of this revolution may have been widened by linking these sections of the MHA to other areas of practice. For example, a directive may have been established for clinicians to notify the mental health tribunal of consumers' parental details when treatment orders are sought. Such a requirement would encourage organizations and clinicians to routinely collect and record parenting information. Such links between sections of the MHA relating to consumers' children and compulsory treatment may also reduce the likelihood that the sections relating to consumers' children go unnoticed as they had with many clinicians in this study.

Revolutionary change may also have been enhanced by ensuring that all aspects of the MHA were clear and ready to be operationalized. Delays with training and practice tools frustrated participants from this study and hindered their adoption of new practices. Similarly, the MHA did not include clear directives for how to implement the principle to recognize and provide for the needs, well-being and safety of consumers' children. Goodyear et al. (2015) recently developed a set of practice standards for incorporating the care of consumers' children throughout the service continuum of adult mental health care. These guidelines range from the documentation of all family members at the first point of contact, through to the identification of ongoing support for consumers' children during the parents' discharge or transfer from the adult mental health service. By endorsing these guidelines, with reference to the corresponding sections contained within the MHA, the government could greatly

enhance the capacity of mental health organizations to support consumers' children as required in the MHA.

The findings also indicate that evolutionary processes within organizations make an important contribution to how (and if) clinicians support consumers' children. Participants reported that organizations promoted gradual changes in clinicians' practices in various ways. These include the provision of appropriate tools and resources such as forms and meeting agendas that contain prompts for clinicians to consider consumers' children and ongoing dialogue from management and supervisory staff. Participants also appreciated opportunities to observe senior staff modelling practices. Video demonstrations have been well received by clinicians as an alternative method of learning new skills for talking to consumers about parenting (Tchernegovski, Reupert, & Maybery, 2015) when specialist staff are not available to mentor clinicians.

Despite the inclusion of directives relating to consumers' children, the MHA was not seen as influential in how clinicians might identify and support consumers' children. The legislation was considered to be more successful in changing practices associated with compulsory treatment. These new practices were promoted by structural changes within the adult mental health system and top-down pressure within the system to comply with new procedures. Contrastingly, the uptake of practices to support consumers' children was seen to be encouraged within organizations – particularly by staff in key service development and mentoring roles such as FaPMI coordinators.

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Appendix 1. Interview schedule

- How did you find out about the changes in the Act?
- What were your impressions of the Act?
- What do you think the Act says, if anything, about how to work with consumers who are parents?
- Are you aware of the principle relating to dependents of consumers? What do you think about this principle?
- If not aware of it, read principle 'children, young persons and dependents of parents receiving mental health services should have their needs, wellbeing and safety recognised and protected'.
- What was your experience of the MHA being introduced into your organization?
- How, if at all, has the MHA influenced your practice? How, if at all, has the MHA influenced practice within your service?
- How, if at all, has the MHA influenced your practice with consumers who are parents?
- What other influences are there, if any, on how you work with parents?
- Would you like to add anything else?

Chapter 7

Methodology of the Mixed Methods Study

7.1 Introduction to methodology for the mixed methods study

The final study in this thesis utilized a mixed methods methodology. This chapter provides a context to the study before discussing some of the principles of mixed methods research. The procedures employed in this study are then outlined with a focus on the key ideas and rationale for study design. Detail about these procedures are provided in the next chapter.

7.2 Context of the study

The design of this study was influenced by the context in which it was undertaken. The study was funded by the National Initiative, Children of Parents with a Mental Illness (COPMI) to evaluate an e-learning resource for clinicians who work with parental mental illness. This provided an opportunity to collect data prior to the public release of the e-learning resource to further inform its development. The resource was intended for use by a wide range of clinicians. Thus, it was necessary to recruit participants from a range of sectors and not just adult mental health settings.

7.3 Mixed methods research

Mixed methods research designs involve the combination of quantitative and qualitative data into a single study (Palinkas, 2014). Cresswell (2014) argued that mixed methods research allows researchers to select the best suited methods for their research aims from a wide range of methods, thus making it a rigorous, yet flexible research paradigm. Interest in mixed methods research has increased considerably in last two decades, but publication rates have not expanded as rapidly as qualitative research (Palinkas, 2014).

Povee and Roberts (2015) suggested a number of reasons for this slow uptake of mixed methods research. They investigated attitudes of students and academics towards mixed methods research and found participants believed that they lacked the breadth of knowledge about quantitative and qualitative methods, as well as how to integrate them. Some participants were also suspicious of researchers' reasons for combining two methods, believing that qualitative methods were often simply added-on without due cause. The authors suggested that these concerns were a result of the lack of formal training offered in mixed methods research in most university courses. Despite these negative views, they found that participants viewed mixed methods as offering a broader range of perspectives, more flexibility to respond to research questions and increased validity of results (Moon, 2019).

Inherent in mixed method studies is the concept of triangulation. Triangulation is the examination of a phenomenon from multiple perspectives which can be achieved by researching a phenomenon with multiple participant groups, multiple researchers, multiple theoretical approaches and/or multiple methods (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014). Through the use of multiple methods within a single study, mixed method research necessarily involves methodological triangulation. It is suggested that this triangulation increases the validity of findings by demonstrating how they compare across the methods employed (Moon, 2019).

7.3.1 Design of the mixed methods study

The study in chapter 8 utilized a sequential mixed methods design. Participants completed questionnaires before and after completing an e-learning resource. Differences in scores at these two time points were statistically analysed. This quantitative component was then

expanded on with a quantitative investigation through individual, semi-interviews which were analysed with thematic analysis.

7.4 Participants

The e-learning resource was developed for use by clinicians from across a variety of settings. Therefore, participation was not restricted to adult mental health clinicians as it was for the previous studies. A sample of 72 clinicians was recruited from several mental health sectors (primary, adult, child and adolescent, community and private practice) and education settings. There was a high drop-out rate with only 21 participants completing the post-questionnaire. Eight participants participated in an interview. Adult mental health clinicians made up 28% of the sample at the pre-questionnaire and 24% at the post questionnaire. None of the participants who completed an interview were from the adult mental health sector. More detail about participants is reported in Chapter 8.

7.5 Procedure

To limit repetition, this section will provide an overview and justification of the procedures. Specific detail about procedures is provided in chapter 8.

7.5.1 Recruitment and sampling

The e-learning resource being investigated was developed by the Australian National Initiative, Children of Parents with a Mental Illness (COPMI). Consequently, recruitment occurred primarily through advertisements on their website. This was supplemented with recruitment emails that were forwarded through professional networks of the candidate and supervisors. Access to the e-learning resource was restricted to individuals who had signed up to the study and completed a pre-questionnaire, thus providing an incentive for participation. All participants who had completed a pre- and post-questionnaire were invited to participate in an

interview and were offered a gift voucher as an incentive and acknowledgment of their time. See chapter 8 for more detail about the recruitment procedure.

7.5.2 Data collection

Demographics and quantitative data were collected electronically via an online questionnaire. After completion of the pre-questionnaire, participants were provided with a link to the e-learning resource. Four weeks later, they were emailed a link to the post-questionnaire. At the end of the post-questionnaire, participants indicated if they were interested in completing an interview. Procedures for conducting interviews and transcription were the same as outlined in chapter 3 for the previous studies.

7.6 Family-focused workforce questionnaire (FFWQ)

Participants' family-focused practice was measured with one section of the Family-Focused Mental Health Practice Questionnaire (FFMHPQ) that relates specifically to worker factors (Maybery et al., 2012). Other sections of the FFMHPQ focus on organisational issues. The section of the questionnaire completed by participants in this study is referred to as the Family-Focused Workforce Questionnaire (FFWQ) and consists of seven subscales that measure different aspects of family-focused practice. A table with a description of these subscales and reliability values is presented in the following chapter. This has not been reproduced here to limit repetition.

The FFWQ consists of 32 items about family focused practices with parents who have a mental illness. Participants rate their agreement with these items on a seven-point scale to indicate how strongly it applies to their practice. The FFWQ items are presented in Appendix F. The mean response is calculated for each subscale, providing a score out of seven.

Psychometric evaluation of the overall FFMHPQ demonstrates good reliability on most subscales (Maybery et al., 2012). However, the reliability coefficient for one subscale in the FFWQ (engagement issues) section was not within the adequate range. Additionally, two of the subscales have recently been added and do not have published psychometric data. Development of the scale through expert consultation supports its validity (Maybery et al., 2012). However, a lack of alternative scales to measure family-focused practice means that it has not been possible to assess convergent and divergent validity. The FFMHPQ has been used to examine family-focused practice across a variety of professions (Maybery, Goodyear, O'Hanlon, Cuff & Reupert, 2014) and countries (Grant, Goodyear, Maybery & Reupert, 2015), and evaluate family-focused resources (Laletas, Reupert, Goodyear, & Morgan, 2015).

7.6 Analysis

7.6.1 Statistical analysis of questionnaire data

Analysis of the questionnaire data was conducted with SPSS software (IBM, n.d.). T-test and ANOVA statistics were both appropriate for the comparison of pre- and post- data. A decision was made to analyse the data with ANOVAs because SPSS offers an option to include effect size statistics in the ANOVA output.

Data were cleaned and missing values were replaced via imputation. Prior to analysis, the assumptions for the ANOVA were tested. There was a minor violation to the assumption of normality for three of the subscales. Since this violation was only slight, it was not considered a threat to the robustness of the ANOVA analysis (Blanca, Alarcon, Arnau, Bono & Bendayan, 2017; Lix, Keselman, & Keselman, 1996). More detail about the data cleaning and quantitative analysis are provided in Chapter 8.

7.6.2 Thematic analysis of interview data

Thematic analysis was selected to analyse the interview data. Thematic analysis is a method of categorising and presenting data with reduced theoretical consideration (Braun & Clarke, 2006). This is a simpler analysis than IPA. It was considered appropriate for this study because the aim was to compliment the quantitative data, rather than develop thorough, independent qualitative findings.

Many of the steps involved in the thematic analysis were similar to IPA, but were conducted with less thorough interrogation and interpretation of the data. Familiarisation with the data was promoted through listening to audio-recordings and reading transcripts several times throughout the analysis. Codes were assigned to small sections of the data and then categorised. Finally, overarching themes were identified and written into narratives with representative participant quotes. Categories and themes were developed from the dataset as a whole. This is in contrast to the IPA analysis in previous chapters where a full analysis was completed for each participant before considering the sample together. More detail about this analysis is provided in the following chapter.

7.7 Research rigour

Robustness of the quantitative components was ensured through the use of the FFWQ which has pre-existing credibility regarding reliability and validity. The ANOVA and partial eta squared statistics are also considered to be highly robust and are commonly used (Coolican, 2014).

The qualitative analysis utilised many of the same methods as in the previous studies to ensure rigour. This included ongoing reflexive discussions between the candidate and supervisors to consider interpretation bias and promote bracketing of the candidate's potential

biases. Transcripts were also emailed to participants for their review and comment. Immersion in the interview data was promoted through repeated exposure to audio-recordings and transcripts.

Finally, the combination of quantitative and qualitative methods allowed for triangulation. The findings from both analyses were able to be compared and contrasted, which enhances the validity of the overall study (Moon, 2019). It also provided a thorough understanding of the phenomena being examined. In addition to identifying the areas of practice that were impacted by completion of the e-learning resource, the findings also elaborated on how participants' views towards family-focused practice had changed and the aspects of the resource that they found beneficial.

7.8 Ethical considerations

The ethical considerations are similar to the previous studies. Approval was received from the Monash University Human Ethics Research Committee prior to commencing. Participation was voluntary and informed consent was obtained from all participants via an explanatory statement and a consent form. Confidentiality was promoted through de-identification of interview transcripts prior to analysis. Participants also provided a code, rather than their names, to match pre- and post-questionnaire responses. Standard University procedures were followed for storing data.

Chapter 8

“Let’s Talk about Children”: A Pilot Evaluation of an E-learning Resource for Mental Health Clinicians

8.1 Background

Let’s Talk about Children (LT) is a short, manualised intervention that clinicians can undertake with parents who have a mental illness. An e-learning resource was developed for clinicians to be trained in delivering this intervention. Such training should be evaluated to ensure that it is acceptable to clinicians and effective for developing necessary skill and knowledge.

8.2 Aim of the study

The aim of this study was to evaluate the effectiveness of the LT e-learning resource for enhancing the family-focused practices of Australian mental health clinicians when working with parents who have a mental illness. Clinicians’ views of the resource were also examined.

8.3 Relevance of the study

The findings from this study can be used to modify and enhance the current e-learning resource as well as future training initiatives and resources. They can identify what further supports may be beneficial for clinicians to implement the LT intervention and engage in family focused practices more generally after completion of the e-learning resource.

8.4 Declaration of contribution

The following tables outline the contributions of the candidate (Table 8.1) and the other authors (Table 8.2) to the published study presented in Chapter 8.

Table 8.1

The candidate's contribution to the published study in chapter 8

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	65%
Participant recruitment	80%
Data collection, recording and transcription	95%
Qualitative analysis	85%
Data cleaning and statistical analysis	90%
Preparation of manuscript	75%

Table 8.2

The contribution of the other authors to the published study in Chapter 8

Name	Nature of Contribution	Extent of Contribution (%) for student co-authors only
Prof. Andrea Reupert	Contributed to conceptualisation and design, development of research materials, participant recruitment, qualitative analysis, interpretation of findings and manuscript preparation.	n/a
Prof. Darryl Maybery	Contributed to study conceptualisation, participant recruitment, development of	n/a

research materials, statistical
analysis, interpretation of findings
and manuscript preparation.

8.5 Declarations of ethical compliance

Ethics approval. All procedures undertaken as part of this study were approved by the Monash University Human Research Ethics Committee, project number CF 11/2820 - 2011001658. Procedures were in accordance with the 1964 Helsinki declaration and its later amendments and comparable standards.

Informed consent. All participants provided informed consent prior to participating in the study, including consent for publication.

Conflict of interest. The authors declare that they have no conflict of interest relating to this publication.

Candidate's signature:

A solid black rectangular box used to redact the candidate's signature.

Primary Supervisor's Signature:

“Let’s Talk about Children”: A pilot evaluation of an e-learning resource for mental health clinicians

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Key words

e-learning resource, parental mental illness, professional development.

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Abstract

Background: Given the prevalence of parental mental illness, accessible opportunities are needed to enhance clinicians’ capacity for working with parents, in an early intervention framework. The Let’s Talk about Children e-learning resource aims to provide clinicians with skills to empower parents to support their family. This pilot study examines clinicians’ views regarding the acceptability of the resource and assesses its effectiveness in developing clinicians’ attitude, skill, and knowledge when working with parents with a mental illness.

Methods: A sequential mixed-method design was employed. There were 21 mental health clinicians (primarily nurses, social workers, and psychologists) who completed the Family-Focused Workforce Questionnaire, pre- and post-training with the e-learning resource. All 21 participants were offered a post-training interview to discuss their experience of the resource, and 8 participants accepted.

Results: The e-learning resource was effective at enhancing participants’ practices, such as assessing the impact of mental illness on parenting and child development, and providing information and resources to families. Participants recognised the importance of empowering parents, although noted that further organisational support was required to implement the intervention.

Conclusions: Preliminary results tentatively indicate that the e-learning resource may be an effective professional development tool for clinicians. Future research is required to ascertain its long-term impact.

Key Points

- 1 In the field of parental mental illness, there is a paucity of professional development resources.
- 2 The Let’s Talk about Children e-learning resource aims to provide clinicians with the skills to empower parents to support their family within the context of parental mental illness.
- 3 Although results indicate that the e-learning resource is useful, other factors including follow-up support, the provision of time and organisational readiness are required to affect workforce change.

Funding: The evaluation study was funded by the COPMI national initiative.

Conflict of interest: None.

Introduction

There are many Australian families affected by parental mental illness, with 23.3% of Australian children having one or both parents with a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). Without intervention, these children are at two to three times greater risk than their peers of developing their own mental health issue (Edwards, Eiden, & Leonard, 2006; Leschied, Chiodo, Whitehead, & Hurley, 2005) or associated problems such as poor academic achievement and school failure (Farahati, Marcotte, & Wilcox-Gök, 2003), being taken into care (Leschied et al., 2005), or acquiring a substance abuse disorder (Mowbray & Oyserman, 2003). These problems may continue into adulthood (Weissman et al., 2006). Given the prevalence and associated risk for these children, it is imperative that services

have appropriate identification strategies and clinicians are able to offer early intervention programmes.

Although genetics play a role in the generational transmission of mental illnesses from parents to children, environmental factors are also critical. There is strong evidence that parental mental illness disrupts parenting (Compas et al., 2010) and that the generational transmission of psychiatric risk is significantly mediated by parenting and parent–child interactions (Harold et al., 2011; Leinonen, Solantaus, & Runamäki, 2003). For example, parents with anxiety disorders may catastrophise during interactions with children or grant them less autonomy (Pape & Collins, 2011). Another causal pathway is social learning, such as depressed parents who may model rumination as a coping strategy (Berg-Nielsen, Vikan, & Dahl, 2002). Thus, the parent–child relationship is a key component of this generational transmission, which can be modified and is a crucial focus for early intervention.

A recent meta-analysis found that interventions for these families significantly decreased the risk of children developing their own mental health issues by 40% (Siegenthaler, Munder, & Egger, 2012). Approaches were cognitive, behavioural, and/or psycho-educational. Targets for these interventions included the parent, the family or youth; those which focused on the parent were delivered exclusively to mothers, parents of newborns, or groups of parents. Programmes were offered discretely and not linked to ongoing treatment. One exception is Let's Talk about Children (LT), which is offered to parents as a two- to three-session supplement to their usual treatment. Thus, LT can be implemented as a part of everyday clinical practice.

Despite the promise of prevention and early intervention programmes, Maybery and Reupert (2006, 2009) found that many professionals, including psychologists, psychiatrists, and psychiatric nurses, lack necessary knowledge and skills to work in a family-focused manner with families where a parent has a mental illness. Specific deficits include engaging and interacting with children (especially for adult mental health workers), working with the client on parenting issues, and having insufficient knowledge about referral pathways (Maybery & Reupert, 2009). Moreover, training in this area is often inaccessible, especially for those in rural locations (Reupert, Foster, Maybery, Eddy, & Fudge, 2010). When training is available, it focuses on raising the awareness of professionals about the needs and general issues for these families, rather than promoting skills (Reupert et al., 2010). More generally, a gap exists in mental health between what is known about effective treatment (research) and what clinicians actually deliver (practice); for example, Proctor et al. (2009) suggest that some interventions “languish”

for 15–20 years before being incorporated into clinical practice. Hence, it is important to determine how acceptable any given intervention is (social validity), and its training, for different stakeholders.

LT is an evidence-based intervention that has been implemented across Finnish adult and child mental health services and selected early childhood settings. LT is a manualised intervention for professionals to deliver to parents. The primary aim of LT is to empower parents to strengthen their relationships with their children. In this way, the parent is a catalyst of change within the whole family. It provides parents with the skills to discuss mental illness with their children and support their family within the context of their illness. Two randomised controlled trials in Finland reported increased parental understanding and reduced guilt, whereas children reported significantly reduced emotional symptoms and improved prosocial behaviour (Solantaus, Paavonen, Toikka, & Punamäki, 2010; Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009).

The Australian Children of Parents with a Mental Illness (COPMI) national initiative collaborated with a reference group of clinicians, researchers, consumers, family members, and Professor Tytti Solantaus (the founder of LT) to develop an e-learning resource for mental health clinicians to train in LT. This resource is available for self-directed access by individual clinicians, or organisations may request staff to complete it as part of larger training programmes. The e-learning resource consists of four, self-paced modules (see Table 1) and employs various mediums, including interactive activities, written information, links to websites, and interview videos of consumers, family members, and clinicians from a range of disciplines, including psychology.

The LT e-learning resource is publicly available to mental health clinicians across Australia via the COPMI initiative website (<http://www.copmi.net.au/>). This pilot study aimed to evaluate the effectiveness of the LT e-learning resource in enhancing clinicians' skills and knowledge when working with parents with a mental illness, in particular their ability to assess the impacts of parental psychopathology on parenting and child development, engaging with parents around parenting issues, providing appropriate resources and referrals, and increasing confidence for using family-focused practices. Another aim was to ascertain how acceptable clinicians consider the resource to be.

Method

A sequential mixed-method design was employed with pre- and post-training questionnaires, supplemented

Table 1 The four modules of the Let's Talk about Children (LT) e-learning resource

Module	Description
Module 1	LT overview, philosophy, and evidence base. Video interviews of clinicians and parents who have experienced LT are included. Scripts are provided for clinicians to introduce the LT method to parents, including prompts for addressing potential parental hesitancy.
Module 2	Introduces the first discussion that clinicians have with parents, which involves the completion of a developmental log for each child in the family in a strengths and vulnerability framework. Videos demonstrate the application of this discussion to case studies.
Module 3	Presents the second discussion, which is a follow-up of any concerns raised from the developmental log to set goals and identify potential actions to support the consumer and his/her family. How clinicians might discuss the impact of a parent's mental illness on children and how parents can support their children is presented. Videos demonstrate the application of this discussion to case studies.
Module 4	An implementation strategy is presented, along with strategies for promoting clinician and organisational readiness.

by post-training interviews. Ethics approval was provided by the Monash University Human Research Ethics Committee.

Participants

Participants were recruited through the COPMI website, where clinicians can access information and resources for working with families where a parent has a mental illness. Additionally, an email invitation was distributed in a snowball method via the researchers' professional contacts across Australia.

A total of 72 participants completed the pre-training questionnaire and 23 responded post-training. Responses were unusable for two participants and were removed, resulting in matched pre- and post-data for 21 participants (retention rate of 29.2%). All participants who completed the post-questionnaire were offered an interview, and eight of them accepted. Table 2 presents the self-reported demographic information of participants during each phase of the study. Most participants were female and/or from urban areas. Many had prior training in this area, although some participants reported no prior experience working with children or parents. The lowest retention rates post-training were for participants from adult mental health and

educational organisations, social workers, those without previous training, and males.

Procedure

Participants completed an online version of the Family-Focused Workforce Questionnaire (FFWQ) before being given access to the LT e-learning resource. They were emailed a link to the online post-training questionnaire after 2 weeks and an additional reminder after 4 weeks. The post-training questionnaire was accompanied by an invitation to complete a telephone interview. Participants logged onto both questionnaires with a self-generated, unique code to match pre- and post-questionnaires. Interviews were arranged and conducted within 2 months of participants completing the training. Interviews went for 30–60 minutes (averaging 38 minutes).

Interviews were audio recorded, with participant consent, and professionally transcribed. Member checks were employed whereby participants were invited to change or delete any aspect of their transcript they believed to be incorrect or identifiable, or to add anything they considered important (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008). Three participants made minor alterations.

Materials

The Family-Focused Workforce Questionnaire (FFWQ) is a shortened version of the Family-Focused Mental Health Practice Questionnaire (Maybery, Goodyear, & Reupert, 2012), which measures clinicians' skills, knowledge, and attitudes for family-focused practice. Participants indicate their level of agreement with 32 statements on a 7-point scale. The FFWQ retains seven subscales from the larger questionnaire. The measure has very good content and construct validity and generally good internal subscale reliability (see Maybery et al., 2012). Subscale descriptions and reliability values are presented in Table 3. Demographic items were included with the pre-questionnaire to identify participant age, geographic classification, organisation type, profession, duration of previous experience, and previous training in this area.

Telephone interviews were semi-structured and focused on participants' experiences of the training and implementation issues, for example,

- What are your thoughts about the training resource?
- What did you learn, if anything, as a result of doing the training?
- What other factors, if any, would impact on using the "Let's Talk about Children" intervention?

Table 2 Self-reported demographic information for participants completing pre-questionnaires, post-questionnaires, and interviews

Demographic information		Pre (<i>n</i> = 72)	Post (<i>n</i> = 21)	Interview (<i>n</i> = 8)
Age	Mean	45.9	45.3	47.2
	Range	26–67	27–60	31–60
	Standard deviation	10.2	9.0	8.9
Sex	Female (%)	62 (86)	16 (76)	7 (88)
	Male (%)	10 (14)	5 (24)	1 (12)
Geographic classification	Urban/suburban (%)	37 (51)	13 (62)	5 (63)
	Regional (%)	22 (31)	4 (19)	2 (25)
	Rural (%)	13 (18)	4 (19)	1 (12)
Organisation type	Medicare/primary mental health (%)	5 (7)	2 (9)	1 (13)
	Adult mental health (%)	20 (28)	5 (24)	0 (0)
	Child and adolescent mental health (%)	19 (25)	7 (33)	5 (62)
	Community/NGO (%)	20 (28)	6 (30)	2 (25)
	Private practice (%)	4 (6)	1 (4)	0 (0)
Profession	Education (%)	4 (6)	0 (0)	0 (0)
	Nursing (%)	22 (31)	7 (34)	2 (25)
	Social worker (%)	14 (19)	3 (14)	2 (25)
	Psychiatrist (%)	3 (4)	1 (5)	0 (0)
	Psychologist (%)	10 (14)	3 (14)	1 (13)
	Occupational therapist (%)	2 (3)	1 (5)	0 (0)
	Youth/family worker (%)	12 (17)	3 (14)	3 (36)
	Consultant (%)	3 (4)	1 (5)	0 (0)
	Coordinator/manager (%)	6 (8)	2 (9)	0 (0)
	Mean years	11.2	12.9	13.88
Experience in mental health	Range	0–33	0–37	2–38
	Standard deviation	10.0	10.1	13.1
Experience working with parents	Mean years	12.9	13.3	19.19
	Range	0–39	0–33	7–34
	Standard deviation	10.2	9.5	9.3
Experience working with children	Mean years	12.5	11.5	15.0
	Range (<i>SD</i>)	0–39	0–32	4–30
	Standard deviation	10.1	8.8	9.0
Other relevant training	Keeping families and children in mind (%)	22 (31)	9 (43)	6 (75)
	Family-focus (%)	7 (10)	4 (19)	4 (50)
	Child aware supervision (%)	4 (6)	2 (10)	0 (0)
	Other (%)	11 (15)	2 (10)	1 (13)
	None (%)	43 (60)	11 (52)	2 (25)

Note: NGO, non-government organisation; *SD*, standard deviation.

Results

Quantitative Analysis

Questionnaire data were checked for anomalies and outlying responses were noted for two participants on negatively worded items from the Worker Confidence and Connectedness subscales. Pre- and post-training differences for these responses were unusually large (6–7 points) and inconsistent with their responses on similar items. It was considered that participants missed the negative wording of these items. Removal of these items and participant selection of “N/A” for some items resulted in missing data for 1.1% of the overall data set (0–9.5% for individual items). A consistent pattern of missing

items was not evident, and missing data were estimated and replaced with regression imputation (Rässler, Rubin, & Zell, 2013).

Subscale scores were calculated from the imputed data set. Differences between pre- and post-training scores were all in the expected direction, indicating practice development, except for a small negative difference for the Inter-professional Practice subscale. Bonferroni adjustments were made for the nine analyses to account for the multiple comparisons. This reduced the significance level to .005. Effect sizes were also estimated for each subscale with partial eta squared (η_p^2). Table 4 shows analysis of variance statistics and effect sizes for participants before and after completing the LT training resource. Differences were significant for subscales

Table 3 Family-focused worker questionnaire subscale descriptions and reliability values

Subscale	Area of skill, knowledge, or attitude	Reliability (α)	
		Maybery et al. (2012)	Current sample
Family and Parenting Support	Providing resources and referrals to parents and families	.78	.58
Worker Confidence	Confidence when working with parents, families and children	.76	.90
Support to Carers and Children	Providing information, advocacy, and referrals to carers and children	.75	.65
Engagement Issues	Opportunities for engagement with parents, children and families	.55	.36
Assessing the Impact on the Child	Assessment of impacts of parental mental illness on the child	.77	.87
Skill and Knowledge	General skill and knowledge when working with families and mental illness	.85	.89
Connectedness	Assessment of parent's awareness of child's connectedness with others and its importance	.92	.65
Inter-Profession Practice	Collaboration with other professionals	N/A	.55
Parenting and Mental Illness	Addressing parenting issues within the context of mental illness	N/A	.88

measuring Family and Parenting Support, Assessing Impact on the Child, Connectedness and Parenting and Mental Illness, and approaching significance for the Worker Confidence and Worker Knowledge and Skill subscales. Effect sizes for these six subscales were all moderate to large.

Qualitative Analysis

Thematic content analysis was conducted on interview transcripts. The first stage involved coding individual transcripts by labelling phrases, sentences, and paragraphs (Liamputtong, 2013). Labels were summaries or key words that were taken directly from the text. An open coding system was initially employed, followed by a cyclic process of refining codes, which grouped sections of text according to concrete similarities, and then built descriptions of more abstract themes across multiple transcripts (Bazeley, 2013). Interview excerpts are tagged according to participant number (e.g. P1 = participant one).

Three main themes emerged from participant interviews: (1) general feedback of the LT resource; (2)

clinicians' self-reported training outcomes; and (3) implementation issues when using LT and other family-focused approaches.

General feedback on the LT resource

Overall, the resource was well received. Participants appreciated the focus on developing skills and the provision of scripts and structure, especially for clinicians "who aren't trained systematically perhaps, or who are new [to family sensitive methods]" (P1). Another participant stated that "[previous training] explained all what anorexia was or what depression was but then it didn't give you any useful steps to do. So, I like [LT], in that it gave some strategies and steps to move forward" (P4).

All participants valued the combination of delivery methods and provision of downloadable resources as per the following:

... it actually gave you documents to use with clients, which I thought was terrific ... what I thought was very good about it is that you can actually download the manual ... (P1).

Table 4 FFWQ subscale scores, ANOVA statistics, and effect sizes for participants before and after completion of the LT training resource

Subscale	Pre Mean (SD)	Post Mean (SD)	Diff Mean	df	F	P	Effect size (η_p^2)
Family and Parenting Support	5.11 (1.05)	5.63 (.87)	.51	20	15.53	.001*	.44
Worker Confidence	5.31 (1.65)	5.81 (1.31)	.50	20	6.42	.020	.24
Support to Carers and Children	5.27 (1.28)	5.62 (1.01)	.35	20	2.74	.113	.12
Engagement Issues	3.86 (1.19)	4.10 (1.28)	.24	20	1.22	.283	.06
Assessing Impact on the Child	5.06 (1.73)	5.97 (1.03)	.92	20	14.74	.001*	.42
Worker Skill and Knowledge	5.56 (1.29)	6.18 (.74)	.62	20	9.63	.006	.33
Connectedness	5.57 (1.12)	6.29 (.73)	.72	20	13.58	.001*	.40
Inter-Professional Practice	5.24 (.50)	5.20 (.43)	-.04	20	.18	.736	.01
Parenting and Mental Illness	4.21 (1.07)	4.78 (.73)	.57	20	10.64	.004*	.35

Note: ANOVA, analysis of variance; FFWQ, Family-Focused Workforce Questionnaire; LT, Let's Talk about Children; SD, standard deviation. * $P < .005$.

Participants appreciated the video sequences of the case studies that followed two clinicians and families, as it provided a demonstration of how the intervention can be used with different consumers and therapeutic styles.

... if there was just [a video of] the first interviewer ... I don't think that's really the way I would approach it. But the other- the second interviewer ... I was really pleasantly surprised to think, "oh that's probably more the way I would approach it." So, I think that was more useful for me (P5).

The amount of material was considered "very comprehensive [and] all the content was important" (P7). Many participants reported that the duration of training (4 hr) was "pretty much spot on" (P6), although some indicated that the training took longer because of "the time it took to download videos" (P5) and wanting to fully engage and reflect on the material. Suggested additions were a wider coverage of "family relationships and resources" (P3), providing more dialogue from children, and the inclusion of more Australian research. Those in supervisory work roles benefited from the implementation processes presented in Module 4, but three other participants said that it "was the least valuable section of the training. This was because it "wasn't applicable" (P4) to their role or because it "covers things that, in reality, on the ground, you don't have time to do" (P1).

The online delivery method was accepted well because it was "free" (P8), "relatively easy to use" (P5), and "flexible" (P2), although some highlighted the lack of opportunity to discuss with others what they had learnt. Nonetheless, the case-study videos of clinicians reflecting on their LT experiences provided participants with some sense of what others were thinking:

I found that that with the role plays that were online and the films of the practitioner's and the consumer's experiences of it, maybe gave me that interaction that I was looking for (P5).

Participant reflection was prompted when the resource requested them to "think about what you would do next—where you would take this conversation" (P5) but may have been extended by providing "a little box that you could type something into" (P5).

Clinicians' self-reported training outcomes

Overall, participants described becoming more family responsive as a result of the training, as per this representative quote:

I think having a deeper insight into how a parent's illness can actually impact on the children. And how ill health of a parent can actually impact them on their feelings of how they're parenting (P2).

Some participants were previously unaware that positive outcomes can be achieved for children by working with the parents:

It surprised me how the mental health worker never meets with the child. It's all done with the parent, that kind of surprised me ... but having read the research, it suggests that doesn't need to happen for it to be effective (P3).

Similarly, one participant recognised how:

... useful it can be to allow the ... parents to be the ones to share that information, and how it can help shift some of the dynamic in the family and the parents to reclaim some power around their parenting (P5).

Another commented on the need to fully engage with parents:

... they're the ones that you really have to listen to and you can't be prescribing things to them when you don't fully understand where they are and where they're coming from ... [so I need to] listen to what they're saying to me and try to work from that point of view (P6).

Participants responded well to the strengths-based approach, which allowed for a "conversation without starting to sound like an interview" (P5). In particular, it was noted that the case-study videos modelled "a lovely way to have that conversation as opposed to always looking at the concerns and risks" (P5). For one participant "talking about strengths and vulnerabilities, rather than weaknesses" (P6) was particularly poignant in reducing negative connotations and engaging positively with parents. Similarly, another reported:

[Previously] I've probably come across as blaming the parents for not doing the best for their children even when they're ill. I was a bit judgmental as far as parenting issues and now I'm more understanding and more supportive ... I can tell from the response from the mother that it's been more positive (P2).

One participant reported that in her view, consumers at a private practice setting would not see the relevance of LT: "when people are paying out of their own pocket, they wouldn't allow [clinicians] to do this. They would be saying 'what's this for? ... I want [my symptoms] fixed in three sessions'" (P1).

Implementation issues when using LT and other family-focused approaches

Given the time frame of the interviews, participants reported having limited opportunity to put the training into practice, but on the whole, they were keen to “try it out” (P3). Although some indicated that they would practice the intervention as presented in the resource, others indicated that they would “adapt the [method] slightly to fit the people [they] are working with” (P8). Consumer factors that influenced adaption included: “the diagnosis of the client” (P1), “severity of the [parent’s] symptoms at the time” (P2), “socio-economic group” (P8), “cultural considerations” (P7), and “level of literacy” (P7). Suggested adaptations were to “look at the whole family before going specifically on the child” (P3), “including other family members” (P7) in conversations, or using the developmental log as homework instead of a tool for facilitating discussion. Most participants also recognised that the conversations around children could be revisited at a later stage if the parent was initially unresponsive, “you can always go back to it at a later date . . . it isn’t necessarily a closed conversation” (P2).

The main concern for practicing LT was ensuring that their organisation “will give you the time to do it” (P4), especially when “the nature of the work sometimes is responding to crises” (P5). Many stressed the need to make family-focused practice a priority, with one suggestion that “It’s about having a mandate to do stuff” (P6).

Participants were clear that, after training, they needed to have “follow up or more ability to talk about how you’re putting [LT] into practice” (P8). Such opportunities would enable them to “sit down and talk about how it worked, how it didn’t work, how [you] might adapt it to your particular organisation . . . doing things like this in isolation is not a good thing” (P1). Peer discussions, supervision, or specialist consultation were suggestions that might address this. Three participants also highlighted the need for specialist leadership to facilitate “at least some consistency” (P7) of family-focused approaches across workplaces around Australia.

Discussion

These pilot results indicate that the LT e-learning resource enhanced clinicians’ attitude, knowledge, and skill for working with parents with a mental illness. Additionally, participants, on the whole, accepted the training resource and appreciated its applied nature. They reported that the downloadable practice resources and training videos were particularly effective for promoting skill development.

After completing the LT resource, participants reported advances in important elements of family-

focused practice. FFWQ scores indicated significant increases in skill and knowledge across a range of areas—providing resources and referrals to parents and families, assessing the impact of parental psychopathology on children, assessing parent understanding of the child’s other relationships, and working with parents to address the impact of their mental illness on their children. Increases also approached significance for worker confidence and general knowledge and skill for family-focused practice. The failure to reach significance in these two areas may be due to the small sample size and the very conservative Bonferroni-adjusted significance level. The effect sizes for the above six areas were moderate to large, suggesting that these were meaningful gains. Interview findings also indicate increased awareness of the relationships among parent psychopathology, parenting, and the impacts on children along with clinicians’ reports of feeling more confident to use family-focused practices in the future.

It is not surprising that there were no significant changes on the Support to Carers and Children or Inter-professional Practice subscales. The LT resource does not specifically target these areas. Interestingly, the Engagement Issues subscale results were also not significant despite this being a major focus of training. This contrasts with interview responses that the training prompted listening and engagement with parents. Items from the Engagement Issues subscale emphasise consumer characteristics, rather than clinician skills (e.g., many consumer-parents do not consider their illness to be a problem for their children) and are unlikely to change in the timeframe of this study. Additionally, the reliability of this subscale was considerably lower than the other subscales. The lack of significant results for engagement issues may be a limitation of the subscale, and not the training resource.

During interviews, participants described insights about working with families. For some, it was surprising that positive outcomes for children could be achieved by working with parents, rather than directly with children. Solantaus et al. (2010) compared LT (which aims to empower parents to work with their children), with a more intensive intervention (Family Talk) that involved a clinician working with both parents and children. Although the impact of LT on family members was slower, after 1.5 years the same level in family improvement was reported across the two interventions. The authors suggested that this delay may be due to the time taken for parents to process their LT experiences before initiating change with their family. As several participants noted, an advantage of the LT approach is that it empowers parents to work with their family themselves, rather than relying on clinicians.

Although some participants reported that they would use LT as outlined in the training resource, many highlighted possible adaptations that may better suit their practice or meet the needs of particular consumers. Some of the suggested modifications align with LT principles, such as the inclusion of a family member or partner during discussions, although other adaptations may compromise its fidelity. In particular, it was suggested that the developmental log may be used as a homework exercise rather than a tool for structured, collaborative discussion. Future studies might investigate clinicians' practice of LT with respect to fidelity and how they integrate LT into existing services. This is particularly pertinent in child mental health services, where the presenting client is the child, in contrast to adult mental health services where the parent is the client. Similarly, further research is warranted to investigate how professionals in different agencies might implement LT differently.

One participant argued that parents treated in private settings would not be receptive to LT because the intervention does not address mental illness symptomology and is not relevant to parents as privately paying consumers. Although the original trials did not directly measure changes in parents' mental health, LT was effective in improving parenting efficacy, confidence and reduced guilt, and children reported significant reductions in emotional symptoms and improved prosocial behaviour (Solantaus *et al.*, 2009, 2010). Given the reciprocal relationships between parental psychopathology, and child well-being and behaviour, (Reupert & Maybery, 2007) it might be hypothesised that enhanced parenting confidence and competence would positively impact on illness symptomology, although further research is required to substantiate this claim. A related misconception is that the adverse impact of parental mental illness on children will dissipate, when symptoms are relieved (Reupert, Morgan, & Maybery, *in press*); such a perception may impede the willingness of parents and clinicians to engage in LT. Forman *et al.* (2007) found that infants experienced difficulties 18 months after their mothers' depression was reduced or resolved. Additionally, mental illness and recovery processes are often experienced by the whole family and can continue for many years (Muhlbauer, 2002). The need to embed parenting and early intervention work as standard practice when treating a consumer's mental illness, rather than as an additional service, is therefore critical.

Lyon, Stirman, Kerns, and Bruns (2011) argue that single exposure training models (in what they describe as the "train and hope" strategy) are insufficient for promoting workforce change. They continue by suggesting that ongoing contact through supervision and coaching is important to build proficiency in a new skill, in much the

same way that clinicians here described the need to have ongoing support after completing the LT resource. Many participants alluded to the importance of organisational policy, time, and management support in order to transfer training benefits into practice, which resonates with the views of others in the field (Maybery & Reupert, 2009). Some participants also highlighted the need for a consistent, national approach to family-focused practice, across treatment settings. The national COPMI national initiative is well placed to provide strategic support and direction in this area. Thus, although professional development resources, such as the LT e-learning resource, are important, other factors including follow-up support, organisational climate, and a data system that identifies parenting status at intake are also critical in promoting workforce change.

Limitations of this study include the self-reported nature of the data, which were collected shortly after completion of the resource, allowing little time for clinicians to implement acquired skills. There was no control group and the convenience sample came from clinicians who accessed the COPMI website and/or had existing interests in family-focused practices. Most participants were women, from urban areas and/or had previous training in this area. Those who were favourable towards family-focused practices may have been more likely to provide feedback. The retention rate was also poor, particularly from the adult mental health sector. Contributing factors for the low retention and sampling bias may have included participant time and resources, perceived relevance of the LT resource or lack of incentive to complete the post-training questionnaire. Future studies into the efficacy of the resource might incorporate longitudinal designs, observational data, and larger samples of participants covering a variety of professions and experience levels. Drawing on a larger sample group is important given the demographic profile of those who were not retained at the post-training phase.

Moreover, completing the online training does not necessarily mean that clinicians are delivering the intervention. Although there is sufficient evidence to indicate that LT is effective for families (Solantaus *et al.*, 2009, 2010), implementation trials are needed to investigate how LT is adopted, by which professional groups, who the intervention reaches (and who it does not reach), and the settings in which it is delivered (in terms of agencies and geographic location). Fidelity and adherence, as well as organisational supports to facilitate its delivery may also be examined in such trials.

In terms of training models in this field, there is a paucity of research regarding the optimal duration of training required and the necessary combination of online and face-to-face delivery. Further exploration

might investigate whether training of this nature should be delivered as an individual activity and/or as part of group training. Given that there were lower retention rates in this study for those without prior training in this area, it is important to ascertain what baseline level of knowledge/skill is required for commencing such applied, skill-focused training. Similarly, different LT modules might be more appropriate for some professionals/agencies than others and this could be further explored. Different professional groups will also require different skills, depending on their discipline (for example, psychology, social work, psychiatry, occupational therapy, mental health nursing), their role (for example, supervisor, or front line clinician) and the agency or context in which they work (for example, adult mental health, or child mental health). Moreover, different undergraduate training backgrounds and treatment paradigms will have implications for training resources (see for example, Maybery, O'Hanlon, Goodyear, Cuff, & Reupert, in press), which need to be considered in future development.

In conclusion, preliminary evaluation results of the LT e-learning resource were positive and tentatively demonstrate positive knowledge and skill change. These results suggest that the e-learning resource may be an effective professional development tool for enhancing the capacity of the mental health workforce to intervene with parents with a mental illness. The flexibility afforded by the online delivery method of the LT resource may be especially useful for clinicians who live in rural or remote areas. Further evaluation is required to assess its long-term impact on a broader range of clinicians, when working with parents with a mental illness.

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Chapter 9

General Discussion

9.1 Introduction to General Discussion

In this chapter, the rationale and aims of the thesis are restated and the main findings of the four studies reviewed. The findings are synthesised to discuss common themes across the studies. Strengths and limitations of the thesis are outlined. Finally, recommendations are made in relation to clinical adult mental health practice and future research. Concluding statements are provided.

9.2 Rationale and Summary of Aims

Up to one third of adults who receive mental health services have a dependent child (Maybery, Reupert, Patrick et al., 2009). A growing body of literature has highlighted the challenges and implications of parental mental illness for the parent with the mental illness (Jones et al., 2016; van der Ende et al., 2016), their children (Gladstone et al., 2011) and their families (Reupert & Maybery, 2007). ‘Treatment as usual’ does not address the specific issues of parental mental illness and does not directly reduce risks to children (Gunlicks & Weismann, 2008). Instead, there is a growing evidence base for the use of family-focused practices to treat parental mental illness and address the needs of different family members (Siegenthaler et al., 2012; Solantaus, et al., 2009).

Initiatives have been developed in multiple countries to promote the use of family-focused practices when a parent has a mental illness. These include legislation and policy (Lauritzen & Reedtz, 2013; Solantaus & Toikka, 2006), resources for families (Grové et al., 2015), manualised interventions (Solantaus et al., 2010) and the creation of specialised practice

support positions (State of Victoria, 2007). While there is little research about the impact of these initiatives on the uptake of family-focused practices, there is some evidence to suggest that the impact has been limited (Lauritzen, Reedtz, van Doesum & Martinussen, 2014).

Hence, the use of family-focused practice is not common practice within adult mental health services (Benders-Hadi et al., 2013; Goodyear et al., 2015; Pfeifferberger et al., 2016). In a seminal paper, Maybery and Reupert (2009) developed a framework of barriers for family-focused practice when working with parents who have a mental illness and their families. Four levels of barriers were identified that relate to (i) organisation policies and procedures, (ii) clinician skill, knowledge and attitude, (iii) client engagement and (iv) factors associated with families and children. Moreover, the framework provided some clarity to the challenges of family-focused practices and how they might be better promoted. This framework suggested that changes at the organisation and policy level would have the greatest impact and filter through to the other levels. However, empirical investigation of this model indicated that factors relating to the clinicians were the strongest predictors of family-focused practice being utilized (Maybery et al., 2016). Thus, it is important to consider the viewpoint of clinicians when considering how to best promote the use of family-focused practices.

Few studies have examined the experiences and perspectives of clinicians when working with parental mental illness. Previous research suggested that clinicians may have difficulty working with parents with a mental illness due factors such as a lack of specialist knowledge (Houlihan et al., 2013), feelings of discomfort and anxiety (Dolman et al., 2013), uncertainty about the scope of their roles (Maddocks, et al., 2010; Slack & Webber, 2008), and challenges associated with inter-professional collaboration (Darlington et al., 2005). Though these studies provide some insight into the difficulties experienced by clinicians, it is important to develop a

thorough understanding of clinicians' experiences of the challenges to family focused practice, the strategies that they use to manage these challenges and their views of initiatives that aim to promote family-focused practice.

The aim of the thesis was to build on existing research and investigate the experiences of adult mental health clinicians when working with parental mental illness. The first two studies examined practice-related experiences and strategies used by clinicians to implement family-focused practices. One focused on clinicians' experiences of undertaking particular tasks in their work with parents, and the other focused on the clinicians' perspectives of parents and their children. The final two studies focused on clinicians' experiences of initiatives that promote family-focused practice. These were the Victorian Mental Health Act (2014) and an e-learning resource for clinicians to train in Let's Talk about Children (LT), an intervention for parents with a mental illness (Solantaus et al., 2010).

9.3 Summary of Research Findings

The studies in this thesis examined participants' experiences and views of their work with parents and initiatives to promote family-focused practices. The following sections summarise the main findings in these two areas.

9.3.1 Clinicians' experiences of working with parental mental illness

The study in chapter 4 built on existing literature relating to the barriers to family-focused practice (Maybery & Reupert, 2009) to examine the aspects of practice that clinicians found challenging when working with parents, as well as the strategies that they used to manage these challenges. Three areas of practice were identified as challenging for clinicians: (1) managing difficult conversations about parenting with a mental illness and risks to the wellbeing of

children; (2) decision making when family circumstances are unclear or uncertain; and (3) working alongside child protection services.

The findings indicated there was no single generic solution to overcoming the challenges of family-focused practice. Instead, clinicians considered the unique context of each challenge to develop strategies that enabled family-focused practice within their work setting. Clinicians did not view all challenges as *barriers*. For example, conversations about parenting were recognised as sensitive and sometime difficult, but also as an opportunity to develop rapport with parents if managed supportively. Conversely, clinicians believed that organisational (and inter-organisational) were, in fact, barriers that hindered collaboration with child protection services. Clinicians believed that they were largely unable to improve their interactions with child protection services until significant changes were made at organisational and inter-organisational levels. These findings highlight the importance of considering contextual factors, including the experiences of the clinicians, in order to thoroughly understand the challenges of family focused practice, and possible solutions.

The paper presented in chapter 5 built on an assertion made by Cousins (2004) that it might not be possible for adult mental health clinicians to maintain balanced perspectives of parents and their children when working with parental mental illness. Although the argument put forward by Cousins was persuasive, it was based on personal experience rather than empirical investigation. Thus, Chapter 5 strengthens previous literature by directly examining clinicians' perspectives of parents and children. Additionally, it examined how they managed these perspectives.

Findings showed considerable divergence in the ways that clinicians viewed parents and children. Feelings of sympathy and responsibility towards parents and/or children influenced the

focus of clinicians who fell within three broad categories: those who focused on the needs of parents; those who focused on the needs of children; and those who adopted a ‘dual focus’ on the needs of parents and children. Some clinicians felt torn between addressing the needs of parents and the needs of children, which made it difficult to maintain a balanced perspective. These findings are consistent with Cousins’ (2004) arguments about the difficulties of maintaining a dual focus.

A framework of parental empowerment enabled clinicians to maintain a balanced perspective. This framework allowed clinicians to see the needs of parents and children as being aligned rather than in conflict. The focus on empowerment also encouraged clinicians to recognise the strengths of parents and children, which relieved their feelings of sympathy and responsibility.

The findings from these chapters add to the limited literature related to clinicians’ experiences of working with parents who have a mental illness (Dolman et al., 2013) and highlight the challenging and emotional nature of this work. These chapters also highlight the importance of the clinician’s voice for understanding the challenges of working with parental mental illness, the solutions that they have devised and the support that they need.

9.3.2 Clinicians’ experiences of initiatives for promoting family-focused practices

A framework of revolutionary and evolutionary change was utilised in chapter 6 to examine clinicians’ experiences of the implementation of the Victorian Mental Health Act (MHA) (2014). Three themes were identified using IPA. These related to (1) participants (lack of) understanding of the sections of the MHA that related to consumers’ children; (2) their experiences of the implementation of the MHA into their workplaces and; (3) their views about the types of practice change that had (and had not) occurred since the introduction of the MHA.

Results showed that clinicians were not familiar with aspects of the MHA that related to the children of consumers, largely because these aspects were not promoted or enforced by the government or within mental health organisations. Conversely, sections of the MHA that had been promoted and regulated, such as processes relating to compulsory treatment, had resulted in widespread change in practices. This finding highlighted the need for a regulated top-down approach for creating revolutionary change.

Despite the widespread adoption of new procedures in some areas of practice, participants in Chapter 5 indicated concerns that clinicians may do the bare minimum to meet requirements rather than undertaking tasks with an appropriate attitude. For example, one participant expressed concerns about the way that some clinicians in her workplace completed advanced statements with consumers to record their treatment preferences if hospitalisation became necessary. Her concern was that some clinicians adopted an authoritarian attitude to complete the task quickly, rather than creating a supportive environment where consumers could openly communicate their desires. This authoritarian attitude may also mean that preferences for the care of children during hospitalisation were not discussed. The experience of participants was that changes to such attitudes were essential to best practice, but were slow and evolutionary. They spoke about such attitude and cultural change occurring in their workplaces through the influence of peers and practice development specialists, such as FaPMI coordinators, who maintained an open dialogue relating to the needs of parents and children and the benefits of family-focused practices.

Overall, the findings of this study indicated that a combination of revolutionary and evolutionary change mechanisms are required to ensure appropriate and widespread uptake of family-focused practices. The MHA was unsuccessful in creating a top-down revolutionary

change, at this point of time at least. However, bottom-up evolutionary change had been promoted in many workplaces through consistent promotion of family-focused practices by co-workers with a specialisation and/or interest in family-focused practices.

The study presented in chapter 8 was a pilot evaluation of an e-learning resource for clinicians to train in LT, a family-focused intervention for parents with a mental illness (Solantaus et al., 2010). Pre- and post- measures indicated that the e-learning resource enhanced clinicians' skill, knowledge and attitudes across multiple aspects of family-focused practice. Thematic analysis of interviews with clinicians identified three themes: (1) general feedback about the resource, (2) self-reported training outcomes, and (3) issues for implementing the intervention after training.

Clinicians appreciated several aspects of the training, including practical resources and videos demonstrating how the intervention might be delivered. They stated that these features of the training encouraged skill building rather than just providing information about the topic. The e-learning resource had also prompted clinicians to re-consider their attitudes towards their work with parents. Attitude changes included an increase in empathy towards parents with a mental illness and acknowledging that the parent may be a conduit for change within the family.

Clinicians reported that they required further assistance to translate their learning into consistent practice. Opportunities for professional discussion were viewed as essential for clinicians to implement the training and to embed it into their ongoing practice. Time was also a crucial factor, with clinicians being unsure how to fit the intervention into their workload and how to justify the time required to deliver it. These findings show that the e-learning resource was beneficial for developing family-focused practices, but that other workplace factors may facilitate or hinder their regular use.

The findings from chapter 6 and chapter 8 suggest that a range of factors influence the effectiveness of initiatives to implement family-focused practices within adult mental health services. Organisations need to communicate the priority of these practices, provide adequate resourcing and enforce their use. Clinicians also need training opportunities that extend beyond the dissemination of information so that their skill and attitudes are developed. Finally, the findings suggest that ongoing professional dialogue about family-focused practice is essential within organisations to encourage clinicians to reflect and develop new skills and practices.

9.4 General findings across studies

Across the four studies, several themes are evident. These relate to the emotional complexity of working with parental mental illness, the specialised skill, knowledge and attitude involved and the influence of organisational management on clinicians' practices. Overall, these findings provide crucial information about how family-focused practice may be supported from the view point of clinicians. Discussion of each specific study, and how the findings are situated within existing literature has been minimised in the following sections to avoid repetition of the discussion made in Chapters 4, 5, 6 and 8.

9.4.1 The emotional complexity of working with parental mental illness

The findings of this thesis demonstrated that working with parental mental illness can be emotionally complex. This is due to the emotionally charged nature of the issues of mental illness, parental mental illness in relation to child well-being and parenting. The findings, particularly in chapters 4 and 5, demonstrated the range of emotional responses that clinicians may experience towards the parent, the child and other parties (such as family members or other service providers). Additionally, clinicians may experience anxiety relating to specific practices

and contextual factors associated with parental mental illness. Clinicians may also have positive emotional reactions in their work with parents.

Chapters 4 and 5 described a diverse range of emotional responses that clinicians may have to the parents they work with. Previous research found that clinicians may experience anxiety about raising issues of parenting and child wellbeing due to the possibility of parents disengaging (Maybery & Reupert, 2006; Dolman et al., 2013). Participants from Chapter 4 also highlighted the sensitivity of initiating conversations with parents about parenting and child wellbeing. They had concerns about how parents would perceive these discussions and their possible responses. However, the findings also showed that clinicians used these concerns to implement strategies to make these conversations less confronting for parents and themselves. Thus, some clinicians were able to use the tensions that they feel in their work to empathise with parents and work with them more effectively.

The findings in chapter 5 showed that, for some clinicians, empathy towards parents may extend to feelings of sympathy or over-identification with the difficulties they are facing. Participants reported that they experienced these feelings when they recognised the disempowerment of parents, often by child-focused family members and services. The limited research that comments on clinicians' views of parents with a mental illness found that they were aware of stigma that these parents may experience (Dolman et al., 2013), but has not considered how if/how clinicians may perceive and respond to the disempowerment that these parents may also experience.

Conversely, chapter 5 indicated that some clinicians experienced anger when they believed that parents were not meeting their parenting responsibilities. Similarly, Engqvist et al, (2009) reported that psychiatric nurses experienced anger when working with mothers with

postpartum psychosis who harmed or failed to bond with their children. The findings in chapter 5 show how negative feelings towards the parent may not be limited to cases of severe mental illness or harm to children, and may be present more generally when working with parental mental illness.

Adult mental health workers' reactions to consumers' children have not previously been a focus on research. To date, literature has been limited to understanding clinicians' knowledge of the impacts of parental mental illness on children rather than their feelings towards these children (Maybery et al., 2012). Chapter 5 indicated that clinicians may worry about children when a parent has a mental illness. When participants were focused on the vulnerability of these children, they also experienced feelings of sympathy and responsibility for their welfare. Importantly, these emotions influenced the practices of one participant who adopted an authoritarian stance with parents, which jeopardised the therapeutic relationship.

Gladstone et al. (2006) argued that the literature related to the children of parental mental illness focuses too heavily on the vulnerability of these children without acknowledging their strengths. This emphasis on vulnerabilities positions these children as victims, rather than active participants in family events who, when provided with appropriate knowledge and support, have the capacity to manage the challenges of parental mental illness. Such views that emphasise risk and vulnerability may contribute to the sympathetic perspectives of participants in chapter 5 and the hesitations of participants in Chapter 6 to include children in their parents' recovery. Children can be buffered from negative impacts of parental mental illness through provision of appropriate information (Riebschleger et al., 2018) and resources (Cooper & Reupert, 2017; Grové et al., 2015) to assist them in making sense of parental behaviours and family events.

Educating clinicians about such strategies may help them develop more balanced perspectives of children by recognising their vulnerabilities alongside their capabilities.

The findings in chapters 4 and 5 also illustrate clinicians' frustrations towards child protection and other child-focused services. They viewed these services as having power to restrict their parenting or remove their children. In some instances, clinicians described trying to avoid or shelter parents from these services. This is consistent with other research showing that some parent-focused clinicians can avoid making mandatory child protection reports (Pietrantonio et al., 2013). Conversely, some participants reported feeling unsupported by services when they made referrals that were not followed-up. These varied negative responses towards child-focused services are consistent with previous literature that has also reported tensions experienced by clinicians at the interface of child and adult focused services (Darlington et al., 2015; Reimers, 2012).

Some participants also described frustrations at family members (eg, parents of the person with the mental illness) who underestimated or undermined the capacity of parents to take care of their children. Clinicians' feelings towards family members is not documented in previous literature. Previous research appears to have been limited to clinicians' feelings of responsibility towards families (Engqvist et al., 2009). Although some family members may well contribute to parents feeling disempowered, they may also be a key support for parents and/or their children. It is likely that clinicians' perspectives of other family members may be more varied and complex than the findings in this thesis depict. Thus, further examination is needed of the range of possible emotional responses that clinicians may experience towards these family members, and how this may impact their practices.

Chapter 5 highlighted tensions that can exist between clinicians' reactions towards the multiple parties involved when a parent has a mental illness. For example, a clinician may be concerned about the welfare of a child, but may be reluctant to report this to child protection services because of the negative impact this may have on the parent's mental health. Such tensions have been considered in previous literature (Carr, 1989; Pollack & Levey, 1989; Scott, 2005). However, much of this literature is dated and has been limited to theoretical discussion and personal commentary. It has also focused on contexts of abuse and neglect (Killen, 1996) or family violence (Fleck-Henderson, 2000). Chapter 5 adds empirical data to illustrate the difficulties some clinicians have in managing their perspectives of parents and children in the adult mental health sector. Chapter 5 also highlighted possible strategies for addressing these difficulties through adequate support within organisations and frameworks of parental empowerment.

Chapters 4 and 5 indicated that specific practices may also raise emotions for clinicians when working with parents. Participants' reported feeling anxious about decision making when working with parents. Findings from chapter 4 showed that clinicians may become particularly anxious about making decisions about intervening when they have little information about what is occurring in families or consider the situation unpredictable. Similarly, Rouf (2011) described anxiety experienced by clinicians when they are uncertain about family situations and may worry about repercussions from within their organisation, or even the media, if their intervention led to a negative (such as harm to a child). Rouf (2011) further found that clinicians in these situations relied on gut instinct or intuition. Given the range of complex emotional experiences that clinicians may have when working with parental mental illness, reliance on gut instinct is unlikely to result in consistent, well-balanced practices.

Despite the many difficult emotional reactions experienced by participants, they also described times when they felt positive about working with parents who had a mental illness. Chapter 4 revealed that, after discussing parenting issues, clinicians and parents may develop a closer and stronger therapeutic relationship than they might have if they did not discuss parenting. Another positive benefit, reported by participants in chapter 5 was the hope they felt when providing early intervention for children. Previous research has reported similar positive experiences for clinicians. For example, a study with psychiatric nurses showed that they experience happiness when mothers advance their abilities to care for and connect with their children (Engqvist et al., 2009). Similarly, clinicians were found to experience joy when working in a family-focused manner with parents who have a mental illness (Solantaus et al., 2009).

Overall, the findings in this thesis indicate that clinicians' emotional experiences when working with parental mental illness may be varied and intense. These emotions may influence practices in a range of ways. The impact of these emotions may be positive such as through the development of therapeutic rapport and hope for the recovery of parents, children and families. Clinicians' emotional reactions may also have detrimental effects, such as non-evidence-based decision-making based on gut reactions, being overly directive or failing to acknowledge and assess the impact of the parental mental illness on children. Thus, it is crucial to understand these emotional reactions and to consider how clinicians can be supported when they experience them.

9.4.2 Working with parental mental illness is specialised work

Another evident theme across the studies in this thesis was the need for specialised knowledge and skill when undertaking family-focused practice with parental mental illness. In particular, these studies highlighted the need for skills to assess the impact of parental mental illness on parenting and child wellbeing, as well as engaging with parents about this impact.

Findings also indicate that such family-focused tasks are necessary, but not sufficient. Family-focused attitudes also need to be developed.

Maybery et al. (2012) reported on a range of specific areas of skill and knowledge involved in undertaking family-focused practice with parents who have a mental illness. Guidelines have also been developed which outline various family-focused tasks that should be undertaken when working with parents (Australian Infant Child Adolescent Family Mental Health Association, 2004; Goodyear et al., 2015; Mottaghipour & Bickerton, 2005). However, chapter 6 highlighted participants' views that undertaking such tasks is not, in itself, adequate to address the complexities of parental mental illness. For example, an advanced statement with a parent needs to be completed with the intent of empowerment and it may be counter-productive if heavily directed by the clinician. Thus, the attitude, or stance, of the clinician is also crucial.

In chapter 4, clinicians' attitudes towards parents was found to be important when having conversations about parenting or raising concerns about child wellbeing. Empathy towards parents allowed clinicians to find effective ways to engage parents in these discussions by being transparent, emphasising strengths and drawing on pre-established rapport with the client. Such an approach moves away from the assumption that difficult conversations are due to characteristics of the parent, such as resistance or disengagement, which may be implied in some of the earlier literature (Dolman et al., 2013; Maybery & Reupert, 2009). Further extending the importance of clinician stance and attitude, Chapter 8 found that the LT e-learning resource influenced clinicians' attitudes towards these conversations. After completing the resource, one participant recognised that she had previously been judgmental of parents, which could have limited the rapport she had with them. This indicates that training programs may develop attitudes as well as skill and knowledge.

Participants in chapter 4 commented that work with parental mental illness involved making decisions in uncertain or unpredictable circumstances. Some of the participants in this study re-framed this as a need for further assessment skills, particularly for assessing the impact of the parents' mental illness on children and parenting competence. The importance of assessing the impacts of the parents' mental illness have been emphasised elsewhere as a key skill for working with this population (Houlihan et al., 2013; Maybery et al., 2012). Fortunately, chapter 8 showed that the LT training resource also developed these skills and led to clinicians having greater confidence in their abilities to conduct family-focused work, including the ability to assess the impacts of parental mental illness on the child. Furthermore, findings from chapter 4 showed that structured interventions such as LT may legitimise the importance of dedicating time to this assessment.

Due to the specialist knowledge and skill necessary to effectively undertake family-focused practices with parents, these practices may be viewed as a role for specialist staff rather than required everyday practices of all clinicians. Participants in chapter 5 expressed their views that matters of family and child wellbeing should be referred on to other professionals or services who specialise in these areas. Similar views have previously been reported elsewhere (Maddocks et al., 2010; Slack & Webber, 2008). Policy and priorities communicated by management may contribute to this view, as indicated in chapter 6. Even with a legislative mandate to recognise and protect the children of parents at their service, participants commented that management had not communicated this to be a core role of clinicians. Although support staff, such as FaPMI coordinators, were seen to promote family-focused practices, some staff may view them as the specialists who are responsible for this work rather than to promote it throughout the organisation.

9.4.3 The influence of organisational factors on clinicians' experiences and practices

Organisational factors have previously been identified as crucial to the successful implementation of family-focused practices (Maybery & Reupert, 2009). Likewise, participants from across the studies in this thesis emphasised the influence of management on their practices with parents. They indicated that organisations and management play a vital role in developing structures to support family-focused practices and communicating these practices as a priority. Additionally, ongoing discussion within organisations were viewed as crucial for promoting family-focused practice and supporting clinicians with the challenges of these practices.

Maybery and Reupert (2009) identified a lack of policy as a barrier to family-focused practice with parents who have a mental illness. Although various forms of policy and practice guidelines have since been introduced, there has been little evaluation of how they have influenced practice. Chapter 6 examined clinicians' experiences of the introduction of the Victorian MHA. Findings indicated that the presence of this policy might not be sufficient to produce practice change. Participants indicated that, at the time of the study, the legislation had failed to produce substantial change in how clinicians worked with parents. It was their view that management needed to promote the elements of this policy pertaining to child wellbeing and emphasise them as a priority within practice settings. Participants also suggested that management needed to identify specific practices that they expected clinicians to undertake with parents. Maybery and Reupert (2009) suggested that such communication was an aspect of *management attitude*, whereby the management of an organisation can actively prioritise an area of practice or neglect it in order to focus on other areas or cut costs. Unfortunately, the findings of this thesis suggest that clinicians do not see management as holding attitudes that prioritise family-focused care.

Findings from this thesis also highlight the need for management to address structural factors that hinder family-focused practice. Chapter 4 demonstrated the need for large-scale changes at the intersection of adult-focused and child-focused services, such as child protection services. The inter-organisational structural issues between adult services and child protection services have been widely discussed in the literature with successful trials of practical solutions (Pietrantonio et al., 2013; Webber et al., 2013). Unfortunately, these trials have not led to wider implementation of these solutions. Without such widespread structural changes, participants in chapter 4 indicated that their collaborative work with child-focused services remained limited.

Findings from chapter 6 indicated that detailed aspects of organisational structures influenced whether, and how, clinicians employed family-focused practices. Specifically, participants described administrative forms and electronic recording systems that do not include fields relating to parenting status (including pregnancy) and/or do not allow easy entry of family information. The inclusion of fields relating to parenting and family would not only make it easier to enter this information, but could prompt clinicians to incorporate family matters in their work. Changes to these structures would support practice and communicate that it is a priority within the organisation.

Across the studies in this thesis, participants discussed support that they received, or would like to receive, from within their services to undertake family-focused practices. These support needs do not appear to have been identified from previous research. Overall, participants felt supported when given opportunities to discuss issues relating to parenting and child wellbeing with a range of other staff within their organisations. These discussions provided clinicians with reassurance and additional ideas that then informed decision-making (Chapter 4), normalisation of their emotional reactions and access to less emotionally involved perspectives

(Chapter 5) and opportunities to reflect on new or additional family-focused practices (Chapter 8). Although some participants relied on informal interactions with peers to meet these support needs, others indicated that they were actively supported in discussions about these matters during supervision, team meetings, portfolio holders and access to FaPMI coordinators. These findings suggest that these channels of support need to be actively encouraged and formalised by management in order to promote family-focused practices and support clinicians who utilise these practices.

9.4.4 Overview of factors influencing clinicians' practices with parents

Maybery and Reupert (2009) developed their model of barriers and points of entry for workforce change in relation to working with parents in adult mental health services (see figure 2.1) through a review of the relevant literature. Although it was developed a decade ago, it continues to guide initiatives to promote family-focused practices. Similarly, the current findings highlight five key domains that participants reported as having influenced their family-focused practices. The overlap between these domains and the model proposed by Maybery and Reupert is illustrated in figure 9.1 and similarities and differences are described below.

Maybery and Reupert (2009) emphasised the importance of organisational factors. The findings of this thesis suggest that management have two key roles in supporting clinicians' practices with parents. These are (i) in the development of workplace structures and (ii) the communication of organisational priorities. Practice support within organisations was also described as crucial, but may not always originate from the management level. At the same time, according to clinicians, management backing of these supports is preferable.

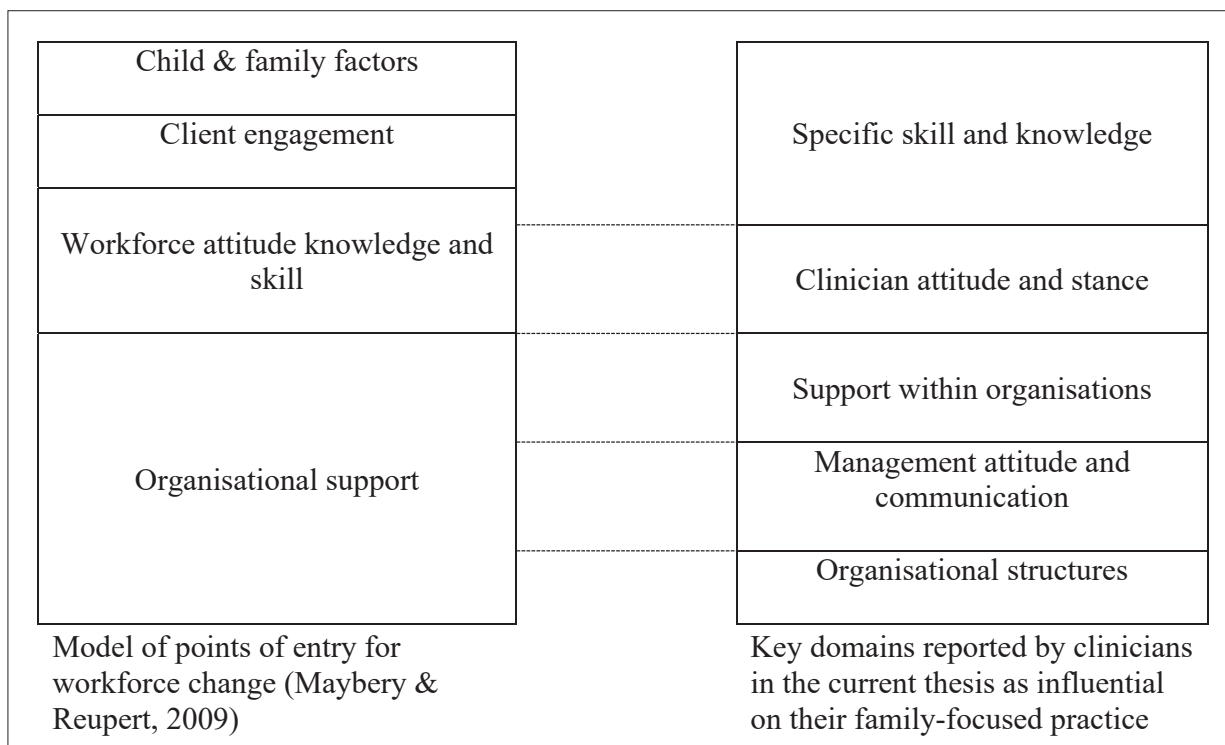


Figure 9.1. Factors influencing family-focused practice as identified by Maybery and Reupert (2009) and through the current thesis.

Clinician skill, knowledge and attitude are also central to Maybery and Reupert’s model and the findings of this thesis. The results from this thesis also recognise these factors, but give particular emphasis to the clinician’s perspectives and internal reactions when working with parents. Consequently these factors have been separated into a separate domain. This domain has been referred to as clinician attitude and stance. Here, attitude is taken to mean reactionary perspectives, such as beliefs that children are vulnerable victims which may be accompanied by feelings of pity or hopelessness to help them. It is also possible for clinicians to deliberately adopt a particular perspective of their work with parents, which can be referred to as their stance. For example, some participants in this thesis worked from a stance of parental empowerment,

whereby they aimed to support the parent to then support their children. The findings of this thesis demonstrate the complexity of clinicians' attitudes and the need for clinicians to adopt an effective stance that supports their work and their own emotional wellbeing.

Maybery and Reupert (2009) included levels in their model relating to parents and other family members, such as parents' hesitancies to discuss child wellbeing with clinicians. However, findings from this thesis suggested that engagement with parents and families was primarily guided by clinicians' contextual knowledge and skill for managing sensitive situations. Thus, these concerns have been considered within the domains of clinicians' attitude, skill and knowledge.

It is understandable that there are discrepancies between the model proposed by Maybery and Reupert and the domains identified in this thesis. They were developed with different methods and at different times. Perhaps more importantly, they have different orientations. Maybery and Reupert aimed to develop a general model, whereas the current thesis is specifically oriented towards the point of view of clinicians. Thus, the differences between the previous model and domains proposed in this thesis are not necessarily problematic. The reference point of clinicians can enhance, extend and enrich previous literature without needing to replace it.

9.5 Limitations and Strengths of the Research

Before considering implications of this research, the limitations and strengths of the thesis will be discussed. Specific limitations of each study were outlined within each of the publication chapters. Therefore, the discussion in this section will be limited to general limitations and strengths across the thesis.

Participants for all of the studies were recruited through convenience sampling. Recruitment emails and advertisements were disseminated and participants self-selected into the studies. It is not possible to determine how many eligible clinicians were reached by the recruitment methods. The final sample sizes of 11 participants is small and suggests a low response rate. The retention rate for the final study was also low. This may be due to the busy nature of the adult mental health sector, but may also be influenced by other factors. For example, clinicians may choose not to participate due to lack of interest or if they do not consider their practices with parents to be adequate. Thus, the self-selected sample may be biased towards participants who had particular knowledge or interest in the area of the study. No extrinsic rewards were offered to participants apart from the final study, which allowed participants to access the LT e-learning resource for completion of the pre-survey and a voucher for participating in the interview. Incentives for participation in all studies may have influenced the samples that were recruited and the overall findings. Any bias in the samples may be exaggerated by the use of the same dataset for chapters 4 and 5. This highlights the need to replicate and extend on these studies.

Participants in the final study were from a range of mental health services, rather than the adult mental health sector specifically. This was due to practical limitations of the research context. Some of the findings, such the challenges of allocating paid private practice sessions to the LT intervention, are not directly relevant to the scope of the thesis. Caution has been taken to keep this limitation in mind when considering how the findings from this study relate to the overall thesis.

The selected methodologies were appropriate for the research aims. IPA was selected for the first three studies, as it is a methodology for examining perspectives and experiences of

phenomena. Although it has not previously been applied to the introduction to a new piece of policy, the developer of the IPA has encouraged researchers to expand on the nature of the phenomena that it is used to investigate (Smith, 2011). One particular strength of this methodology is its adherence to ideography (Smith, Flowers & Larkin, 2009; Smith, Jarman & Osborn, 1999). IPA is used to capture the commonalities and differences in participants' experiences, rather than generalised themes. This provides a rich insight into the diversity of experiences and perspectives that clinicians may have when working with parental mental illness. The small sample sizes in these studies were also ideal for this in-depth analysis (Smith, 2004, 2011).

The combination of quantitative and qualitative methods in the final study allowed for triangulation of findings on the influence of the LT e-learning resource on participants. Meaningful comparisons were made from these findings. For example, scores relating to worker confidence and engagement issues were not found to be significantly changed by completion of the e-learning resource. These results were challenged by qualitative findings that participants were influenced in both of these areas. Thus, the qualitative component was sensitive to some areas of participant change that the quantitative component was not able to capture. Qualitative findings also elaborated on significant changes in sub-scale scores but identified specific knowledge that had been learned by participants or beliefs that had changed. Despite the benefits of this triangulation, it is important to acknowledge that this study is a pilot evaluation of the e-learning resource only and caution must be taken not to develop expectations of the resource that are beyond what the findings of this study indicate.

There are limitations of the FFWQ which was used to measure skill, knowledge and attitudes related to family-focused practice in the final study. Although good reliability has been

demonstrated for many of the subscales (Maybery et al., 2012), the subscale relating to engagement issues was not adequately reliable. Furthermore, three of the sub-scales did not have adequate reliability values for the sample of participants in this thesis. The FFWQ is considered to have good validity because it was developed rigorously by specialists in the field (Maybery et al., 2012). However, it has not been tested to predict levels of actual family-focused practice. Thus, it should be considered a measure of self-perceived levels of knowledge, skill and attitude as has been done in this thesis.

Thematic analysis was deemed to be the most appropriate form of qualitative analysis the final study. This is because the aim was to compliment and extend on the quantitative findings, rather than obtain the same depth of analysis as in the earlier studies. Thematic analysis allowed for the categorisation and presentation of data that were easily considered alongside the results of the statistical analysis. Nearly two decades ago, Sandelowski (2000) argued that thematic analysis is often underestimated for its simplicity in comparison to the complex methodologies that have also emerged, but that it is this simplicity makes it highly useful in many contexts. The relevance of this argument holds today and is particularly salient in the context of the mixed methods study in this thesis.

All of the qualitative analysis in this thesis required the candidate to make interpretations of the data. It is possible that participants, or other researchers, would not have interpreted this data in the same way. Interpretation is influenced by the researcher's experience, beliefs and attitudes, which bias their views of the data. Although it is not always possible to illuminate such bias (Silverstein et al., 2006), efforts were made to identify and moderate it through reflexive practice (Finlay, 2014). Primarily, the candidate had ongoing reflective discussions with the supervisors (and the additional researcher for the study in Chapter 5). In addition to the coding

completed by the candidate, secondary coding was also undertaken by another researcher for the studies presented in Chapters 4 and 5. This resulted in in-depth discussions about differences in coding and alternative perspectives. Where alternative interpretations were identified, transcripts were revisited to determine the most likely intention of the participant. Time and resource limitations prevented this practice from being undertaken for the other two studies.

The candidate had a limited immersion in the context of the adult mental health sector, particularly with respect to working with parental mental illness. The candidate had not previously worked in this setting but had visited such settings, when conducting interviews and focus groups for a different research project. Although this low level of prior exposure meant the candidate was not familiar with details of the adult mental health sector, it minimised bias that may occur via prior experiences in the setting. Thus, the candidate relied on participants for details about the setting and the phenomena being investigated, grounding analysis in the data. Immersion in the data was promoted by the candidate conducting all interviews and the majority of transcriptions. Audio-recordings and transcripts were also reviewed throughout the analysis process. As indicated earlier, an additional researcher was included for the study in Chapter 5. She had extensive experience in the adult mental health sector and was able to contribute additional understanding of this setting. Thus, the findings benefited from her immersion in the adult mental health context and the candidate's immersion in the data. Deeper immersion would have benefited the studies in this thesis. This may have included face-to-face interviews in work settings, longer and/or multiple interviews with each participants and participant feedback on identified themes. Unfortunately, such methods were limited by practical factors such as geographical limitations and time constraints of participants.

It is acknowledged that the findings from this study relate to a specific context. Thus, they may not be generalizable across the adult mental health workforce, nor to other countries. However, this was not the aim of this research. Instead, the aim was for findings that may be *transferable*. Research is transferable if readers are able to extrapolate the findings to other settings (Polit & Beck, 2010). By providing in-depth details about participants' experiences within their particular contexts, the reader may draw conclusions about how phenomena may be experienced by people in similar situations. This extrapolation is promoted in this thesis by the presentation of demographic information and acknowledgment of contextual influences throughout theme narratives. However, some of the onus for transferring findings to new situations remains with the reader who must compare the context of the research with the situation that is being extrapolated to.

This thesis has investigated an area that has not received much attention previously, but is of high importance. The individual studies have each touched on a different aspect of clinicians' experiences of their work with parents. These findings may largely be considered as preliminary. Additionally, the findings focus specifically on practices for supporting parenting and child wellbeing, without the additional complexity of considering additional family members. Thus, they may miss some of the complexity of employing family-focused practice more broadly. Despite these limitations, the findings have made considerable headway into understanding the complexities of working with parents and what might be done to support clinicians in this essential role. Thus, one strength of this thesis may be the door that it has opened for further research in this area.

9.6 Recommendations for practice

This thesis identified five key domains that reportedly influenced clinicians' use of family-focused practices. These domains can be considered as a framework for identifying ways to promote clinicians' use of family-focused practice in the adult mental health sector. These are discussed below and summarised in table 9.1.

9.6.1 Organisational structures

The adult mental health sector is comprised of a multitude of structures that clinicians must work with. These structures may promote or hinder family-focused practices. Two structures of particular importance to participants in this thesis related to collaboration with child protection services and the collection of information about consumers, both of which were seen to hinder effective family-focused practices with parents.

According to findings in this thesis and other research (Darlington et al., 2005; Pietrantonio et al., 2013), systematic changes are required to allow for ongoing, collaborative interactions between adult mental health and child protection services. Ideally, this would involve major structural change. A UK study found that joint protocols were beneficial for managing cases where both services were involved (Weber et al., 2013). In another project, champion roles were created in mental health and child protection services teams in Northern Ireland to specifically assist with collaboration between the two services (Davidson et al., 2012). These champions were tasked with providing education about the other service, fostering communication between services and identifying further obstructions to effective collaboration. These champion positions resulted in clinicians from adult mental health services showing more awareness of child protection issues and engaging in more discussion about child wellbeing within their own teams and with child protection services. Despite the benefits of initiatives such

Table 9.1

Domains of influence on clinicians' use of family-focused practice

Domain	Factors that promote family focused-practice
Organisational structures	<ul style="list-style-type: none"> • Collaborative processes and systems with child-focused services • Forms that include information about families, parenting status (including pregnancy) • Reporting systems with easy entry of family information • Family-focused matters as standing agenda items for meetings
Management attitude and communication	<ul style="list-style-type: none"> • Family-focused practice communicated as a priority • Clear expectation of family-focused practice by all clinicians • Collection of family-focused practice data to guide organisational decision making • Allocation of time and resources for family-focused practices
Support within organisations	<ul style="list-style-type: none"> • Reflective discussion about family-focused practices • Opportunities to collaboratively plan family-focused practice • Inclusion of family-focused discussions at team meetings and supervision sessions • Validation and normalisation of emotional reactions to work with parents • Informal discussions with peers about family-focused matters • Availability of FaPMI specialists
Clinician attitude and stance	<ul style="list-style-type: none"> • Empathic, strengths-based perspectives of parents and their children • Recognition that parents with a mental illness can be good parents • Strategies to manage emotional reactions towards parents and children • Focus on empowerment of parents and children
Specific Skill and Knowledge	<ul style="list-style-type: none"> • Access to family-focused training • Engaging with parents and families • Raising sensitive topics • Assessing impacts of parental mental illness

as these, they have not been widely adopted.

Other initiatives that could enhance collaboration are joint case-planning, joint training and resource sharing (Darlington & Feeney, 2008). Co-location of adult mental health and child protection services would assist with these initiatives and promote informal interactions between clinicians from both services. Informal interactions may further promote clinicians' understanding of the day-to-day work of the other services and buffer against the tensions that often exist between clinicians from these services.

Additionally, the findings from this thesis suggest that clinicians would find family-focused practice easier if systems for collecting information about consumers were amended to include fields about parenting (and pregnancy). Findings indicated that intake forms may not always ask about parenting. Inclusion of parenting questions about parenting status may prompt clinicians to consider this information in their work with consumers and would communicate to consumers that parenting and child wellbeing are relevant to adult mental health services. Ideally, these forms should be followed up by standardised intake procedures to thoroughly assess consumers' parenting responsibilities and relationships with children (Goodyear et al., 2015).

Participants in this thesis commented that computerised recording systems were another hindrance to effective family-focused practice, inasmuch as they make it difficult to enter and access information relating to parenting. Thus, it would be beneficial for these electronic recording systems to include specific fields for information about parenting and children. These systems should also enable genograms to be easily entered as they are an effective and commonly used method of recording information about parenting and family relationships.

According to participants, additional systematic factors for promoting family-focused practice are official roles within services for family-focused specialists and/or designated champions to encourage and support clinicians to utilise family-focused practices. It would also be beneficial to promote interest groups, where clinicians can discuss practices for supporting parenting roles and child wellbeing. Agenda templates for meetings (such as case meetings and supervision) could also include standing items relating to family-focused practices to ensure that they are regularly discussed. Such changes to organisational structures have the potential to positively impact on the use of family-focused practices, especially if implemented collectively.

9.6.2 Management attitude and communication

In this thesis, managers' attitude and communication of their expectations were identified as a domain that influenced the experiences and practices of clinicians. Thus, it is important to consider how management might convey to clinicians that family-focused practices are a priority. Communication of these practices as a necessary part of clinicians' roles involves more than dissemination of information and, instead, requires active promotion and support for clinicians to implement them (Proctor et al., 2009). Findings in this thesis identified several key ways that management could do this.

One way that management can clearly communicate their priorities and expectations to consumers is through systems that are friendly to family-focused practice as discussed in the previous section. Clear role descriptions and procedures for working with parents would also be beneficial, which can be communicated through policy. Although several publications provide guidelines for undertaking family-focused practice with parents (Australian Infant Child Adolescent Family Mental Health Association, 2004; Goodyear et al., 2015; Mottaghipour & Bickerton, 2005), it is not clear that these have been made available or directly communicated by

management as required practice. Thus, organisations need to back policies in this area with actions to ensure that practices are being implemented. Collection of data relating to family-focused practice within organisations would hold clinicians accountable to use them. Ideally, management would report on these findings and use them to make organisational decisions such as the allocation of funding and other resources. These actions would clearly demonstrate the priority of family-focused work within adult mental health services.

9.6.3 Support within organisations

The findings in this thesis highlight the importance of clinicians receiving support from within their organisations when working with parents. Working with parental mental illness is complex and participants shared how helpful it is to engage in reflective discussion with other staff. These discussions can be beneficial for the development of family-focused skill and help clinicians manage various emotional reactions that they may have when working with parents. Thus, supported reflective discussion is beneficial for the wellbeing of clinicians and to promote effective practices with parents.

This supportive discussion can be promoted through a variety of avenues. Case-review meetings could provide opportunities to discuss issues relating to consumers' parenting. Participants benefited from access to family-focused consultation, whether this is through direct supervision or specialists such as FaPMI coordinators. Informal peer reflection about family-focused issues might also be promoted. Although it may be possible for some clinicians to actively obtain this professional support for family-focused practices themselves, it would be optimal for management to encourage and formalise ongoing discussion of family-focused practice across professional networks through the allocation of time and resources.

9.6.4 Clinician attitude and stance

It is necessary for clinicians to manage attitudes and emotional reactions in their work with parents in order to adopt a professional stance that is effective in meeting the needs of parents and children. The findings from this thesis suggest that it is beneficial for clinicians' to develop an empathic perspective of parents and children which acknowledges the difficulties experiences by each, but also appreciates their strengths. Likewise, it is essential for clinicians to recognise that parents with a mental illness are capable of being good parents when provided with appropriate supports.

There is a need for resources to support clinicians to manage their emotional reactions and to develop a positive stance for working with parents. The evaluation of the LT e-learning resource highlighted the benefits of directly providing clinicians with a clear family-focused stance. Future training could also be enhanced by explicitly outlining the underlying stance being adopted in the training. There is also need to develop a comprehensive, best-practice framework relating to the stance required to work optimally with parents who have a mental illness, which can then be backed by manages and promoted through formal supports and systems within organisations.

9.6.5 Specific skill and knowledge

Clinicians need opportunities to develop specific knowledge and skill for working with parents who have a mental illness. One avenue for developing this skill and knowledge is through training. The evaluation of the LT e-learning resource indicated that clinicians benefit from training that is skills based, focuses on practical applications and provides resources for implementation. Thus it is recommended that future training focus on these aspects rather than just background information. Training should also be followed-up with practical implementation

support such as preparation time and supervision. Findings from this thesis suggest three areas that training and supervision could focus on are skills for (i) engaging with parents and families (ii) raising sensitive topics such as child wellbeing concerns and, (iii) assessing the impact of parental mental illness on parenting, family dynamics and child wellbeing.

9.7 Recommendations for future research

The studies in this thesis make a valuable contribution to the literature about clinicians' experiences of supporting parents with a mental illness in the adult mental health sector. However, there are still many areas that require further research. It would be beneficial to examine clinicians' experience of other areas of family-focused practice with parents. This might include clinicians' interactions with children and other family members (formal and informal) or how they might (or might not) consider children when initiating compulsory treatment and/or discharge of parents from their service. Research is warranted to examine additional initiatives to promote family-focused practices such as practice guidelines and the support received by FaPMI coordinators. Further research could also examine the experiences of particular groups of clinicians, such as specific professional groups (e.g., psychologists, social workers, mental health nurses), clinicians from regional and rural locations or clinicians who are (or are not) parents themselves since these factors may impact on the use of family-focused practices (Grant, Reupert, Maybery & Goodyear, 2019).

The perspectives of parents and families are also critical to examine. Research in this area could focus on the types of family-focused practices (or lack of) received by parents and family members, how these were experienced, what gaps were seen and how these might be rectified. This includes research to investigate the needs, wants and experiences of children when a parent is receiving treatment through the adult mental health sector.

The majority of studies in this thesis utilised an IPA framework. Future studies could examine aspects of clinicians family focused practices with alternative qualitative methodologies. This might include grounded theory research or ethnographic studies. Clinicians' practices may also be examined through particular theoretical frameworks such as an ecological model or models of implementation science. This would allow for methodological triangulation of the findings.

It is also necessary to conduct quantitative studies to examine the experiences of clinicians' across the Australian adult mental health workforce, and overseas. Experiences and professional needs could be compared across groups of clinicians, such as professions, age groups, experience levels, genders and geographic locations. Measures of clinician experience may be developed to assist with larger sample studies and to assess the needs of clinicians to find further information that may be used to inform targeted training and supports.

Audit studies would provide valuable findings about the support received by parents by mental health services, not reliant on clinician self-reports. These could use case notes or other observable data sources within organisations to investigate clinicians' family-focused practices in the Australian adult mental health sector. Auditing family-focused practice could also investigate which organisational structures promote or hinder family-focused practice.

It is necessary to investigate the work and experiences of other professionals within adult mental health services. There has been no research to date relating to the work of supervisors when consumers are parents. The perspectives of managers are another perspective that warrants further examination. Thus, a more holistic understanding can be developed by examining the perspectives of multiple stakeholders in the workplace.

Furthermore, it is necessary to extend this research into other mental health and primary health sectors, such as private practice, child and adolescent mental health services and general practice settings. This broad range of services are points of contact and support for parents with a mental illness and/or their children. The varying contexts of these services are likely to result in different experiences and clinicians who work there. Identification of the similarities and differences of clinicians' experiences and needs across these sectors can inform the development of family-focused policy, training and other resources in general and for specific sectors.

9.8 Conclusions

This thesis highlights important aspects of clinicians' experiences of working with parents who have a mental illness in the adult mental health sector. This work is specialised, emotionally complex and influenced considerably by organisational factors. Based on the findings of this thesis, five key domains were identified which impact on clinicians' use of family-focused practices. These are organisational structures, management attitude and communication, support within organisations, clinicians' attitude and stance and specific skill and knowledge. These domains were used to make recommendations to promote and support clinicians to deliver family-focused practices to parents with a mental illness.

An increased uptake of family-focused practices in adult mental health services would have many positive implications. Parents would be better supported in their parenting roles and be in a position to better address parenting stresses, which is beneficial for their mental health. The needs of children would become visible and preventative measures would be implemented to promote their wellbeing. Clinicians could also benefit through the satisfaction experienced when they see parents and families managing well. These benefits provide an impetus to

continue striving for consistent widespread employment of family-focused practices across adult mental health services.

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Appendices

- A. Ethics Approval Documents
- B. Explanatory Statements
- C. Consent Forms and Demographic Questionnaires
- D. Interview Schedules
- E. Example Section of Coded Interview Transcript
- F. Family-Focused Workforce Questionnaire

Appendix A: Ethics approval documents



Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: CF14/3321 - 2014001764

Project Title: The matter of mental illness and parenting: Experiences of adult mental health professionals who work with parents with a mental illness

Chief Investigator: Assoc Prof Andrea Reupert

Approved: **From:** 13 November 2014

To: 13 November 2019

Terms of approval - Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
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. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require 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.

A blue ink signature of Professor Nip Thomson, written in a cursive style.

Professor Nip Thomson
Chair, MUHREC

cc: Assoc Prof Darryl Maybery, Mr Phillip Tchernegovski



MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: CF14/3179 - 2014001730

Project Title: Adult mental health workers' response to legislation changes regarding the children of parents receiving mental health services

Chief Investigator: Assoc Prof Andrea Reupert

Approved: **From:** 24 October 2014

To: 24 October 2019

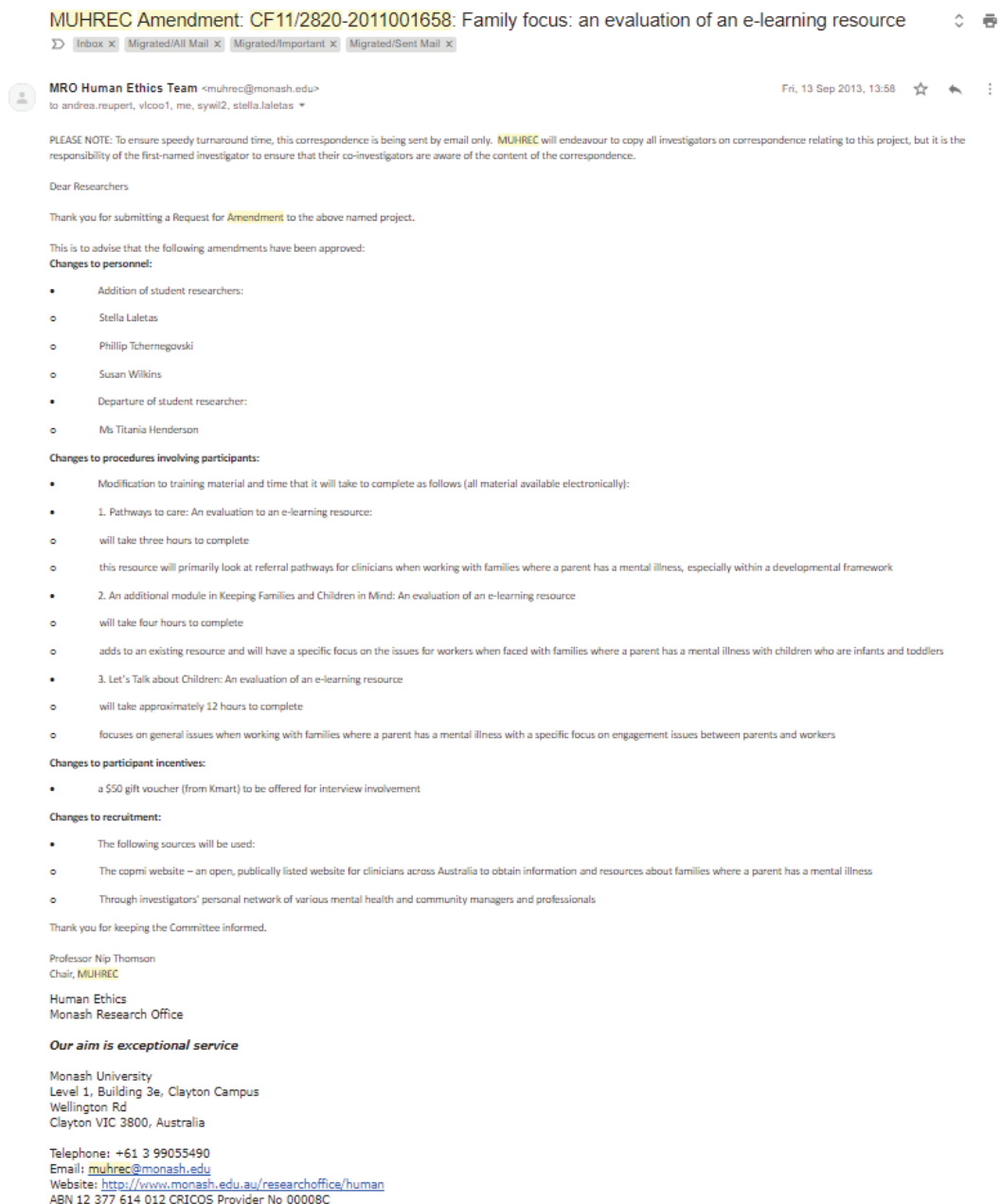
Terms of approval - Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
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. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require 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.

Professor Nip Thomson
Chair, MUHREC

cc: Assoc Prof Darryl Maybery, Mr Phillip Tchernegovski

Ethics approval for the final study was applied for as an amendment to an existing study because multiple family-focused resources were being evaluated by other research students. At the time that this study was being completed, amendments approvals were granted via email. Below is the approval email for the final study in this thesis.



Appendix B: Explanatory statements

EXPLANATORY STATEMENT

Research Title: Experiences of adult mental health professionals who work with parents with a mental illness

My name is Phillip Tchernegovski and I am conducting a research project with Dr Andrea Reupert (Associate Professor in the Faculty of Education) and Dr Darryl Maybery (Director in the School of Rural Health) towards a Master of Psychology/PhD degree at Monash University. This means that I will be writing a thesis which is the equivalent of a book.

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researcher at phillip.tchernegovski@monash.edu.

What does the research involve?

Participation involves completing a 20-40 minute telephone interview. The interview will focus on your thoughts and experiences of working with parents with a mental illness. If you agree, the interview will be audio-recorded and transcribed by the researcher or a professional service. You will be provided with a transcript of the interview, which you may amend if you consider any sections to be misrepresentative or identifying (of you personally, consumers or your organisation). You will have two weeks to respond to this. Please inform one of the researchers if more time is required.

You will also be provided with a consent form and brief demographics survey to return. Alternatively this can be completed verbally at the time of the interview.

Consenting to participate and withdrawing from the research

Your consent will be recorded prior to completing the interview. You are free to withdraw from the research at any stage until you have approved your interview transcript. Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University.

Please check that your supervisor/workplace management approves of your participation in this study and that it aligns with your organisation's own ethical requirements.

Possible benefits and risks to participants

We cannot guarantee that you will receive any benefits from this research, however, possible benefits may result in a more thorough understanding and dissemination of worker views. It is hoped that the availability of this information will inform workplace resourcing, support and development for the workforce in the current transition and future policy.

It is not expected that completing the interview will cause you any discomfort, but if this does occur please inform the researcher who will modify, pause or stop the interview process. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your ongoing supervisor or call lifeline on 131 114.

Confidentiality

None of the information that you provide will be revealed to another person in any form which identifies you. The research findings will be reported as part of a PhD thesis and may be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications. The researcher will remove any identifying information prior to analysing the content of interviews. Additionally, you will be provided with a transcription of the interview to amend any information that may identify yourself or your organisation. You will have two weeks to provide this feedback, but if you need longer, please let one of the research team know. Your participation status will not be communicated to employees.

Storage of data

Storage of paper documents will adhere to the University regulations and data will be kept on University premises in a locked cupboard/filing cabinet for 5 years. All electronic information will be stored in password protected computer for a period of 5 years, and will only be accessible by the researchers named on this form.

Results

If you would like to receive a summary of the results of this study please let the researcher know during the interview or contact any of the researchers listed on this explanatory statement.

Complaints

Should you have any concerns or complaints about the conduct of this research, you are welcome to contact:

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Building 3e
Research Office
Monash University VIC 3800
Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Project ID: CF14/3321 - 2014001764

For further information:

If you would like any further information concerning this project, you can contact any of the researchers listed below.

Thank you,

Phillip Tchernegovski

Student Researcher
Krongold Centre
Faculty of Education
Clayton Campus
Monash University
phillip.tchernegovski@monash.edu

Assoc Prof Andrea Reupert

Chief Investigator
Krongold Centre
Faculty of Education
Clayton Campus
Monash University
andrea.reupert@monash.edu

Assoc Prof Darryl Maybery

Co-Researcher
School of Rural Health
Monash University
PO Box 973
Moe 3825
Email: darryl.maybery@monash.edu

EXPLANATORY STATEMENT FOR ADULT MENTAL HEALTH WORKERS

Research Title: Adult mental health workers' response to legislation changes regarding the children of parents receiving mental health services

My name is Phillip Tchernegovski and I am conducting a research project with Dr Andrea Reupert (Associate Professor in the Faculty of Education) and Dr Darryl Maybery (Director in the School of Rural Health) towards a Master of Psychology/PhD degree at Monash University. This means that I will be writing a thesis which is the equivalent of a book.

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researcher at phillip.tchernegovski@monash.edu.

What does the research involve?

You are invited to take part in this research that aims to identify views and implications for adult mental health workers to recent reforms to the Mental Health Act in Victoria, Australia regarding the children of parents receiving mental health services.

Participants will be provided with a consent form and brief demographic questionnaire to complete and return prior to completing a 20-40 minute interview. The interview will focus on your impressions of the change to the legislation and your views of what implications this has for your work. If you agree, the interview will be audio-recorded and transcribed by the researcher or a professional service. You will be provided with a transcript of the interview, which you may amend if you consider any sections to be misrepresentative or identifying (of you personally, consumers or your organisation). You will have two weeks to respond to this. Please inform one of the researchers if more time is required.

Consenting to participate and withdrawing from the research

If you agree to participate in this research, please complete the demographics and consent forms, and return them to the researcher on one of the contact details listed on the form. You are free to withdraw from the research at any stage until you have approved your interview transcript. Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University.

Please check that your supervisor/workplace management approve of your participation in this study and that it aligns with your organisation.

Possible benefits and risks to participants

We cannot guarantee that you will receive any benefits from this research, however, possible benefits may result in a more thorough understanding and dissemination of worker views. It is hoped that the availability of this information will inform workplace resourcing, support and development for the workforce in the current transition and future policy.

It is not expected that completing the interview will cause you any discomfort, but if this does occur please inform the researcher who will modify, pause or stop the interview process. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your ongoing supervisor or call lifeline on 131 114.

Confidentiality

None of the information that you provide will be revealed to another person in any form which identifies you. The research findings will be report as part of a PhD thesis and may be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications. The researcher will remove any identifying information prior to analysing the content of interviews. Additionally, you will be provided with a transcription of the interview to amend any information that may identify yourself or your organisation. You will have two weeks to provide this feedback, but if you need longer, please let one of the research team know. Your participation status will not be communicated to employees.

Storage of data

Storage of paper documents will adhere to the University regulations and data will be kept on University premises in a locked cupboard/filing cabinet for 5 years. All electronic information will be stored in password protected computer for a period of 5 years, and will only be accessible by the researchers named on this form.

Results

If you would like to receive a summary of the results of this study please let the researcher know during the interview or contact any of the researchers listed on this explanatory statement.

Complaints

Should you have any concerns or complaints about the conduct of this research, you are welcome to contact:

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Project ID: CF14/3179 - 2014001730

For further information:

If you would like any further information concerning this project, you can contact any of the researchers listed below.

Thank you,

Phillip Tchernegovski

Student Researcher

Krongold Centre

Faculty of Education

Clayton Campus

Monash University

phillip.tchernegovski@monash.edu

Assoc Prof Andrea Reupert

Chief Investigator

Krongold Centre

Faculty of Education

Clayton Campus

Monash University

andrea.reupert@monash.edu

Assoc Prof Darryl Maybery

Co-Researcher

School of Rural Health

Monash University

PO Box 973

Moe 3825

Email: darryl.maybery@monash.edu



Research Title: Adult mental health workers' response to legislation changes regarding the children of parents receiving mental health services

My name is Phillip Tchernegovski and I am conducting a research project with Dr Andrea Reupert (Associate Professor in the Faculty of Education) and Dr Darryl Maybery (Director in the School of Rural Health) towards a Master of Psychology/PhD degree at Monash University. This means that I will be writing a thesis which is the equivalent of a book.

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researcher at phillip.tchernegovski@monash.edu.

What does the research involve?

You are invited to take part in this research that aims to identify views and implications for adult mental health workers to recent reforms to the Mental Health Act in Victoria, Australia regarding the children of parents receiving mental health services.

Participants will be provided with a consent form and brief demographic questionnaire to complete and return prior to completing a 20-40 minute interview. The interview will explore your own perspective, and your impression of the perspectives of the workers that you supervise, towards the change to the Mental Health Act. The interview will also consider implications for adult mental health workers, and for your supervision of them. If you agree, the interview will be audio-recorded and transcribed by the researcher or a professional service. You will be provided with a transcript of the interview, which you may amend if you consider any sections to be misrepresentative or identifying (of you personally, consumers or your organisation). You will have two weeks to respond to this. Please inform one of the researchers if more time is required.

Consenting to participate and withdrawing from the research

If you agree to participate in this research, please complete the demographics and consent forms, and return them to the researcher by one of the methods listed on the forms. You are free to withdraw from the research at any stage until you have approved your interview transcript. Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University.

Please check that your supervisor/workplace management approve of your participation in this study and that it aligns with your organisation.

Possible benefits and risks to participants

We cannot guarantee that you will receive any benefits from this research, however, possible benefits may result in a more thorough understanding and dissemination of worker views. It is hoped that the availability of this information will inform workplace resourcing, support and development for the workforce in the current transition and future policy.

It is not expected that completing the interview will cause you any discomfort, but if this does occur please inform the researcher who will modify, pause or stop the interview process. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your ongoing supervisor or call lifeline on 131 114.

Confidentiality

None of the information that you provide will be revealed to another person in any form which identifies you. The research findings will be report as part of a PhD thesis and may be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications. The researcher will remove any identifying information prior to analysing the content of interviews. Additionally, you will be provided with a transcription of the interview to amend any information that may identify yourself or your organisation. You will have two weeks to provide this feedback, but if you need longer, please let one of the research team know. Your participation status will not be communicated to employees.

Storage of data

Storage of paper documents will adhere to the University regulations and data will be kept on University premises in a locked cupboard/filing cabinet for 5 years. All electronic information will be stored in password protected computer for a period of 5 years, and will only be accessible by the researchers named on this form.

Results

If you would like to receive a summary of the results of this study please let the researcher know during the interview or contact any of the researchers listed on this explanatory statement.

Complaints

Should you have any concerns or complaints about the conduct of this research, you are welcome to contact:

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Project ID: CF14/3179 - 2014001730

For further information:

If you would like any further information concerning this project, you can contact any of the researchers listed below.

Thank you,

Phillip Tchernegovski

Student Researcher

Krongold Centre

Faculty of Education

Clayton Campus

Monash University

phillip.tchernegovski@monash.edu

Assoc Prof Andrea Reupert

Chief Investigator

Krongold Centre

Faculty of Education

Clayton Campus

Monash University

andrea.reupert@monash.edu

Assoc Prof Darryl Maybery

Co-Researcher

School of Rural Health

Monash University

PO Box 973

Moe 3825

Email: darryl.maybery@monash.edu

An evaluation of an e-learning resource: Let's Talk About Children

Explanatory Statement

My name is Phillip Tchernegovski and I am conducting a research project with Dr Andrea Reupert (senior lecturer in the Faculty of Education) towards a Master of Psychology at Monash University. This means that I will be writing a thesis which is the equivalent of a short book.

This project has funding from the national COPMI initiative, (AICAFMHA) via the Australian Government to evaluate an exciting new training resource, called Let's Talk about Children, specifically designed for mental health professionals working with families affected by parental mental illness. Your input into this project will be used to assist the COPMI initiative to further refine the resource.

You have been identified as a mental health professional. Many people with mental illness have children. Hence, it is important that practitioners, such as yourself, have the skills and knowledge to intervene appropriately with clients who are parents and their families. We would like to offer you the opportunity to be involved in training in this area, and the accompanying pilot evaluation.

The training: Let's Talk about Children

An e-learning resource has been developed, Let's Talk about Children, which will take approximately 4 hours to complete. Let's Talk about Children outlines the various skills required to support a parent, who has a mental illness, and presents how a practitioner might build rapport with parents when discussing parenting issues. The resource is self-paced, and interactive, and uses audio and video material, over four modules.

As the resource is still being developed, in order to undertake the training you also need to be available in the evaluation component of the project.

The Evaluation for Let's Talk about Children:

You would be asked to complete the workforce questionnaire before you undertake the training. You will be asked to complete the same questionnaire, immediately after training. The questionnaire asks you a series of questions about your knowledge and skill regarding working with families where a parent has a mental illness. Each questionnaire takes about 15 minutes to complete so doing the two will take approximately 30 minutes.

Being in the training and the evaluation is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you are not able to withdraw once the questionnaire has been electronically submitted.

Additionally, you may also like to participate in a one hour interview, sometime after you complete the training. We are prepared to pay you \$50 Kmart gift voucher if you choose to also participate in the interview. Interview participation will be arranged after completion of the training and will be held at a time and place to be negotiated, either over the phone or face to face. Sample questions include:

- What did you learn, if anything, as a result of doing the training?
- In what ways, if any, do you think the resource will change the way you practice?

If you choose to participate in an interview, it will be audiotaped with your permission. You will be provided with a copy of your interview transcript and given an opportunity to change/delete/add any information you consider appropriate, for up to two weeks. You may withdraw from the interview at any time prior to approving your interview transcript.

All information reported will be de-identified and at no times will names or the names of organisations be reported.

Storage of the data collected will adhere to the University regulations and kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

If you would like to be informed of the aggregate research finding, please contact Dr. Andrea Reupert at andrea.reupert@monash.edu. The findings are accessible for 12 months only.

If you would like to contact the researchers about any aspect of this study, please contact The Chief Investigator:	If you have a complaint concerning the manner in which this research CF11/2820 – 2011001658 being conducted, please contact:
Dr. Andrea Reupert, Senior lecturer and psychologist Institute of Human Development & Counselling Krongold Centre Faculty of Education Clayton Campus Monash University, Vic 3800 Telephone: 03 9902 4587 Fax: 03 9905 5127 andrea.reupert@monash.edu	Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@monash.edu

Thank you, we appreciate your time in this study.

Yours,

Phillip Tchernegovski
Student Researcher
ptch1@student.monash.edu

Dr. Andrea Reupert
Senior lecturer and psychologist
P.O. Box 6,
Clayton Campus
Monash University Vic 3800
Australia
andrea.reupert@monash.edu

Appendix C: Consent forms and demographic questionnaires

CONSENT FORM

Research Title: The matter of mental illness and parenting: Experiences of adult mental health professionals who work with parents with a mental illness

Chief Investigator: Assoc Prof Andrea Reupert

Co-Researcher: Assoc Prof Darryl Maybery

Student Researcher: Phillip Tchernegovski

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project. I understand that the project is voluntary. I understand that I will be provided with a transcribed copy of my interview. I also understand that I can withdraw at any point prior to approving my interview transcript. I have been given approval by my workplace management to participate.

I consent to the following:	Yes	No
I agree to be interviewed by the researcher	<input type="checkbox"/>	<input type="checkbox"/>
I agree to allow the interview to be audio-taped	<input type="checkbox"/>	<input type="checkbox"/>

Participant Name: _____

Participant Signature: _____

Date: _____

Preferred contact details:

Email: _____

Telephone: _____

Please complete and return to the student researcher, Phillip Tchernegovski

Email: phillip.tchernegovski@monash.edu

Fax: 03 9905 5127

Post: Phillip Tchernegovski

Krongold Centre

Faculty of Education

Clayton Campus

Monash University, Vic 3800

About you

Research Title: The matter of mental illness and parenting: Experiences of adult mental health professionals who work with parents with a mental illness

1. Your age: _____
2. Your gender
 - ☐ Male
 - ☐ Female
 - ☐ Other/not stated
3. Your employment role:
 - ☐ Adult mental health worker - Main profession:
 - ☐ Psychologist
 - ☐ Psychiatrist
 - ☐ Social Worker
 - ☐ Mental Health Nurse
 - ☐ Occupational Therapist
 - ☐ Other (Please specify) _____
 - ☐ Supervisor - Main profession of the workers you supervise:
 - ☐ Psychologist
 - ☐ Psychiatrist
 - ☐ Social Worker
 - ☐ Mental Health Nurse
 - ☐ Occupational Therapist
 - ☐ Other (Please specify) _____
4. Which of the following best describes your main work setting:
 - ☐ Crisis Team
 - ☐ Outpatient Department
 - ☐ Inpatient Department
 - ☐ Critical/Intensive Care unit
 - ☐ Psychiatric Rehabilitation Unit
 - ☐ Private Clinic
 - ☐ Other (Please specify) _____
5. Which of the following best describes the location of your workplace?
 - ☐ Urban/Suburban
 - ☐ Regional
 - ☐ Rural
6. Years of professional experience
 - a. In adult mental health? _____
 - b. Working with children? _____

CONSENT FORM

Research Title: Adult mental health workers' response to legislation changes regarding the children of parents receiving mental health services

Chief Investigator: Assoc Prof Andrea Reupert

Co-Researcher: Assoc Prof Darryl Maybery

Student Researcher: Phillip Tchernegovski

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project. I understand that the project is voluntary. I understand that I will be provided with a transcribed copy of my interview. I also understand that I can withdraw at any point prior to approving my interview transcript. I have been given approval by my workplace management to participate.

I consent to the following:	Yes	No
I agree to be interviewed by the researcher	<input type="checkbox"/>	<input type="checkbox"/>
I agree to allow the interview to be audio-taped	<input type="checkbox"/>	<input type="checkbox"/>

Participant Name: _____

Participant Signature: _____

Date: _____

Preferred contact details:

Email: _____

Telephone: _____

Please complete and return to the student researcher, Phillip Tchernegovski

Email: phillip.tchernegovski@monash.edu

Fax: 03 9905 5127

Post: Phillip Tchernegovski

Krongold Centre

Faculty of Education

Clayton Campus

Monash University, Vic 3800

About you

Research Title: Adult mental health workers' response to legislation changes regarding the children of parents receiving mental health services

1. Your age: _____
2. Your gender
 - ☐ Male
 - ☐ Female
 - ☐ Other/not stated
3. Your employment role:
 - ☐ Adult mental health worker - Main profession:
 - ☐ Psychologist
 - ☐ Psychiatrist
 - ☐ Social Worker
 - ☐ Mental Health Nurse
 - ☐ Occupational Therapist
 - ☐ Other (Please specify) _____
 - ☐ Supervisor - Main profession of the workers you supervise:
 - ☐ Psychologist
 - ☐ Psychiatrist
 - ☐ Social Worker
 - ☐ Mental Health Nurse
 - ☐ Occupational Therapist
 - ☐ Other (Please specify) _____
4. Which of the following best describes your main work setting:
 - ☐ Crisis Team
 - ☐ Outpatient Department
 - ☐ Inpatient Department
 - ☐ Critical/Intensive Care unit
 - ☐ Psychiatric Rehabilitation Unit
 - ☐ Private Clinic
 - ☐ Other (Please specify) _____
5. Which of the following best describes the location of your workplace?
 - ☐ Urban/Suburban
 - ☐ Regional
 - ☐ Rural
6. Years of professional experience
 - a. In adult mental health? _____
 - b. Working with children? _____

Consent and demographic information for the forth study were collected through an online Qualtrics survey. Below are screenshots of the consent and demographics sections of the survey. Participants supplied a code, rather than identifying themselves by name to protect their confidentiality.

Welcome to the evaluation of the *Let's Talk about Children* e-learning resource.
We really appreciate your time and energy on this resource.

For participation in this study, we require your consent to the following:

I agree to take part in the Monash University research project to evaluate the *Let's Talk about Children* e-learning resource. I have read the [Explanatory statement](#), which I am able to keep for my records. I understand that I am agreeing to:

- undertake the Let's Talk about Children training
 - complete the workforce questionnaire before and after the training
- I will also be given the opportunity to participate in an interview after completing the post-training questionnaire.

I understand that my participation is voluntary and I can choose not to participate in part, or all, of the project and am free to withdraw up until my questionnaire responses have been submitted electronically. I have discussed my involvement with my onsite supervisor. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. I understand that data from the project will be kept in a secure storage and accessible to the researcher. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

- ☐ Yes, I agree with the above statements and would like to participate
- ☐ No, I do not want to participate

>>

To start, we would appreciate you completing a questionnaire. This should take about 15 minutes. At the end of the questionnaire you will be directed to the e-learning website. Two weeks after you have been sent this link we will send you a link to a post-training questionnaire.

Your questionnaire responses are anonymous so we ask that you choose a code to match your responses before and after doing the training. Please use a nick name that you will remember that is not identifiable. Suggestion: the day and month you were born plus the first three letters of your middle name. Eg, If born on the 28th of April and middle name is John so the code would be 2804joh

You will need to remember your code for the post- training questionnaire.

Please enter your code below.

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Demographic Information

Your age

Your gender

- ☐ Male
- ☐ Female
- ☐ Other

In which state/territory is your workplace?

- ☐ ACT
- ☐ NSW
- ☐ NT
- ☐ QLD
- ☐ SA
- ☐ TAS
- ☐ VIC
- ☐ WA

Which of the following best describes the location of your workplace?

- ☐ Urban/Suburban
- ☐ Regional
- ☐ Rural

Which type of organisation best describes your *main* workplace?

- ☐ Medicare Local / Primary Mental Health Care
- ☐ Adult Mental Health
- ☐ Child and Adolescent Mental Health
- ☐ Other (please specify)

What is your *main* profession?

- ☐ Psychiatric Nurse
- ☐ Social Worker
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Occupational Therapist
- ☐ Medical Officer
- ☐ Carer or Consumer Consultant
- ☐ Child Care Worker/Manager
- ☐ Other (please specify)

Employment Status

- ☐ Full-Time
- ☐ Part-Time (please show how many hours/week)
- ☐ Other (please specify and show how many hours/week)

Years of professional experience working in mental health?

Years of professional experience working with parents?

Years of professional experience working with children?

What other COPMI (Children of Parents with a Mental Illness) training have you completed?

☐ 'Keeping Families and Children in Mind' e-learning resource

☐ 'Family Focus' e-learning resource

☐ Other (please specify)

☐ None

What is your highest qualification completed?

☐ High School

☐ Certificate

☐ Diploma

☐ Degree

☐ Graduate Diploma/Honours

☐ Masters

☐ Doctorate/PhD

☐ Currently undertaking training (please specify)

Appendix D: Interview schedules

Interview schedule for Chapters 4 and 5

1. What is it like to work with consumers who are parents?
2. How, if at all, is your work different when a consumer is a parent compared to when a consumer is not a parent?
3. What emotions, if any, do you experience when working with parents?
4. Do you consider the needs of the parent *and* the needs of the child? If so, what is that experience like?
5. How do/would you feel if the needs of the child seemed to be at odds with the needs of the parent?
6. How would you feel if a parent said something that suggested their child was not safe?
7. How do you feel about delivering interventions that address parenting?
8. What have your experiences been like when a consumer is receiving another service for family matters or their parenting (such as a family services organisation)? (Or what do you think this would be like?)
9. How do you feel when a parent is discharged?
10. Are there any other aspects working with consumers that have been important experiences for you?
11. Would you like to add anything else?

Interview schedule for Chapter 6

1. How did you find out about the changes in the Act?
2. What were your impressions of the Act?
3. What do you think the Act says, if anything, about how to work with consumers who are parents?
4. Are you aware of the principle relating to dependents of consumers? What do you think about this principle? (If not aware of it, read to participant: ‘children, young persons and dependents of parents receiving mental health services should have their needs, wellbeing and safety recognised and protected’).
5. What was your experience of the MHA being introduced into your organization?
6. How, if at all, has the MHA influenced your practice? How, if at all, has the MHA influenced practice within your service?
7. How, if at all, has the MHA influenced your practice with consumers who are parents?
8. What other influences are there, if any, on how you work with parents?
9. Would you like to add anything else?

Interview schedule for Chapter 6

1. Why were you interested in this e-learning resource?
2. What are your thoughts about the training?
3. If anything, what was the most valuable aspect of the 'Let's Talk about Children' training for you?
4. What did you learn, if anything, as a result of doing the training?
5. Has the resource changed any attitudes or ways of looking at clients/consumers that you previously had?
6. Have you noticed any changes to the way you practice since doing the training?
7. In what ways, if any, do you think the resource will change the way you practice in the future?
8. Are there any past or current clients/consumers who you would use this intervention with?
9. In general, how would you decide which clients/consumers to use this intervention with?
10. If anything, what aspects of your workplace would assist you to use 'Let's Talk about Children'?
11. If anything, what changes to the 'Let's Talk about Children' intervention or training would make it easier to use in your current workplace?
12. Do you have any other feedback about the resource or how you may use it?
13. Is there anything else you would like to add?

Appendix E: Section of coded interview transcript

Q: To start off, can you tell me a bit about how you found out about the new mental health act?

A: Well it was, obviously we were all kept in the loop all the way and then when it was rolled out, researched it ourselves and obviously the organisation encouraged us and provided us with time to research it.

Commented [PT1]: Promotion of MHA within organisations

Commented [PT2]: Allocation of resources by management

Q: So when you said you were kept in the loop was that before the Act was introduced formally?

A: Yeah. As much as in the loop as we could be because the Government's pretty slack about it- Considering with a new Mental Health Act they were, well they dilly dallied around it a lot-

Commented [PT3]: Issues with initial development of MHA

Q: Yeah?

A: So they didn't actually give us any idea of, we knew it would be more consumer focussed but that is all we knew. We didn't know where it was heading, how it was going, that kind of thing. We didn't know, yeah it was constantly put off and then as soon as it was out we were told it was going to be amended.

Commented [PT4]: Lack of clear information in lead up to introduction to the MHA

Commented [PT5]: Delays to introduction of the MHA

Commented [PT6]: Lack of consistency/predictability in introduction of the MHA

Q: Okay.

A: So it wasn't, it was about as clear as mud to be honest.

Commented [PT7]: Lack of clarity in introduction to the MHA

Q: Okay, did that impact on your ability to put it into practice?

A: It caused confusion I think because the old Mental Health Act was very, it was more restrictive and we certainly saw evidence of people bending the rules of the new Act. So it was, yeah, I guess, not me personally because I've always been, I'm a very strong advocate for consumers but when we saw it and we saw that it could be bent at will if that makes sense.

Commented [PT8]: Prime difference relating to restrictive practices (not related to FFP)

Q: Can you give an example of what you mean by bending it?

A: That if people were on the edge of being, that they didn't quite meet the whole criteria for an assessment order, that, there's certainly things may have been exaggerated that would enable an assessment order to be completed.

Commented [PT9]: Clinicians able to bend rules of new act

Q: Okay.

A: Whereas with a bit more hard work potentially it, a management plan could have been formulated with the consumer, but that being said, that's kind of like hindsight if you know what I mean.

Commented [PT10]: New act not leading to new act because of interpretation in how it is used

Q: Okay.

A: When you saw the presentation the next day it was different to what was seen on the day.

Q: Are you saying there was resistance to that change?

A: Yeah, yep. Because we went from quite a, a known entity so to speak with the old Mental Health Act to a, it wasn't very clear when it was rolled out. The websites weren't up until the last hurrah. So you couldn't actually give yourself prior knowledge really until it was there.

Commented [PT11]: Lack of clarity in the MHA causing inconsistency in how it is used

Commented [PT12]: Delays in resources for implementing the MHA (including information)

Q: My particular area of focus for my study is parents with a mental illness and work with them. So some people have said that the new Act is a more family friendly. Would you agree with that?

A: Having not worked with a lot of families as in, well parents with, or children with a parent's mental illness or even people that's got a mental illness, I don't know, I think it puts a lot, I would have to say the opposite. It puts a lot more onus back on the family. So we're seeing, in my belief we're seeing higher carer burn out.

Commented [PT13]: Ned MHA puts more pressure on families

Q: Okay.

A: Whereas now we've got, whereas before in the Mental Health Act we could say okay we can, we'll do a respite admission dah, dah, dah, dah, dah, and now it makes it quite difficult to do that particularly if the consumers not on board.

Commented [PT14]: Influence on families perceived as mainly through rules on restrictive practices

Q: Okay so is that higher threshold for admission putting more burden onto carers?

A: Yes definitely-

Q: Is that what you're saying yeah?

A: Yes, there's more, there's more responsibility put onto the carers now whereas, sometimes they're already at the end of their tether and now it's like well sorry they don't meet criteria. We know you're worn out, they don't want an admission, but sorry its back onto you guys now.

Commented [PT15]: MHA framed towards the needs of consumer at expense of the needs of families through less support unless the consumer wants it

Q: Okay. I'm actually interested in one of the principles from the Act just because it's really closely linked to my area that I'm studying. Do you know the principle relating to the children of parents receiving services?

A: I'm not actually familiar with that part specifically.

Commented [PT16]: Not familiar with principle J

Q: It says that children, young persons and dependants of parents receiving the mental health services should have their needs, wellbeing and safety recognised and protected. What does that mean to you?

A: That, basically you empower them to have a choice-

Q: Empowering the children?

A: Yeah and so that's the process of the advanced statement is including the consumer and all the significant others on what they want. It's, the advanced statement's not about what just the consumer wants it's about anything or anyone sorry that the consumer's mental illness impacts. So by, having, listing significant others of the consumer particularly to children involved in the process plan because, Mum or Dad might want you to stay with Uncle Harry but Uncle Harry terrifies you. You'd rather stay with Joe Blow. So it's, what I'm trying to say it's completely collaborative.

Commented [PT17]: Advanced statement should reflect what the whole family wants

Commented [PT18]: Children to be involved in advanced statement

Q: Okay.

A: And it's got to be a collaborative process. It can't just be one person's view, it's got to be everybody. Every human that's involved in the care, everyone's got to have a voice.

Commented [PT19]: Advanced statement as collaborative with whole family

Q: Yep, great. So taking the voices of children into consideration through advanced statements is one thing for that principle. What else, if anything, do you think the workers needs to do in order to meet that principle?

A: Having that open, transparent communication and have, be allowed the time to actually develop the relationship and rapport with the, not only consumer but the consumer's significant others. Particularly children, they're not, as I said they're already wary, they're already watching from the outline thinking I'm going to be taken off dah, dah, dah or I'm going to be placed here or I'm going to be placed there. Throw a bit of stigma for just the shits and giggles and they're going to be quite avoidant.

Commented [PT20]: Building relationship with family (including children)

Commented [PT21]: Awareness of concerns of children of being removed

Q: Okay.

A: I can remember back in my case management days that the consumer, yeah, you, they would accept you more than the consumer's significant others and getting that, I guess taking the threat out of it. Does that make sense?

Commented [PT22]: Addressing child's concerns of parent and the services involved

Appendix F: Family-focused workforce questionnaire

Family focused mental health practice questionnaire: Evaluation version

(Maybery, Goodyear & Reupert, 2010)

Knowledge and skill where a parent has a mental illness. We are interested in your level of knowledge, skill and confidence when working with parents and families where the parent has a mental illness. We are also interested in evaluating changes due to the training you receive using the 'Online Resource'. Please note that the term consumer-parent refers to a parent with a mental illness. For each of the sentences below please circle the answer that best corresponds to how you are able to work with such individuals and families (if at all). There are no right or wrong answers. Use the following scale as a guide to your answer.

	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	I am knowledgeable about how parental mental illness impacts on children and families (sk1)					N/A	1	2	3	4	5	6	7
2	I am able to determine the developmental progress of the children of my consumer-parents (aic1)					N/A	1	2	3	4	5	6	7
3	I regularly have family meetings (not therapy) with consumer-parents and their family (fp1)					N/A	1	2	3	4	5	6	7
4	I am not confident working with consumer-parents about their parenting skills (wc1)					N/A	1	2	3	4	5	6	7
5	I don't provide information to the carer and/or family about the consumer-parent's medication and/or treatment (sc1)					N/A	1	2	3	4	5	6	7
6	Many consumer-parents do not consider their illness to be a problem for their children (ei1)					N/A	1	2	3	4	5	6	7
7	Working with other health professionals enhances my family-focused practice (ic1)					N/A	1	2	3	4	5	6	7
8	I do not have the skills to work with consumer-parents about how parental mental illness impacts on children and families (sk2)					N/A	1	2	3	4	5	6	7
9	I am not able to determine the level of attachment/bond that consumer-parents have with their children (pmi1)					N/A	1	2	3	4	5	6	7
10	I am not experienced in working with child issues associated with parental mental illness (sk3)					N/A	1	2	3	4	5	6	7
11	I am not able to determine the level of importance that consumer-parents place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school) (cs3)					N/A	1	2	3	4	5	6	7
12	I provide written material (e.g. education, information) about parenting to consumer-parents (fp2)					N/A	1	2	3	4	5	6	7
13	I am not confident working with families of consumer-parents (wc2)					N/A	1	2	3	4	5	6	7
14	Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the consumer-parent's mental illnesses (sc2)					N/A	1	2	3	4	5	6	7
15	Discussing issues for the consumer parent with others (including					N/A	1	2	3	4	5	6	7

family) would breach their confidentiality (ei2)

16	Children and families ultimately benefit if health professionals work together to solve the family's problems (ic2)	N/A	1	2	3	4	5	6	7
17	I am skilled in working with consumer-parents in relation to maintaining the wellbeing and resilience of their children (sk4)	N/A	1	2	3	4	5	6	7
18	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse (aic2)	N/A	1	2	3	4	5	6	7
19	I regularly provide information (including written materials) about mental health issues to the children of consumer-parents (fp3)	N/A	1	2	3	4	5	6	7
20	I am not confident working with children of consumer-parents (wc3)	N/A	1	2	3	4	5	6	7
21	I am not knowledgeable about the key parenting issues for consumer-parents (pmi2)	N/A	1	2	3	4	5	6	7
22	Rarely do I consider if referral to peer support program (or similar) is required by my consumer-parent's children (sc3)	N/A	1	2	3	4	5	6	7
23	The children often do not want to engage with me about consumer parents mental illness (ei3)	N/A	1	2	3	4	5	6	7
24	I am skilled in working with consumer-parents regarding their parenting (pmi3)	N/A	1	2	3	4	5	6	7
25	I am knowledgeable about the key things that consumer-parents could do to maintain the wellbeing (and resilience) of their children (sk5)	N/A	1	2	3	4	5	6	7
26	I am able to determine the level of importance that consumer-parents place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance) (c1)	N/A	1	2	3	4	5	6	7
27	Team-working skills are essential for all health professionals providing family-focused care (ic3)	N/A	1	2	3	4	5	6	7
28	I don't feel confident to counsel consumer-parents about parenting and their mental health problem (pmi4)	N/A	1	2	3	4	5	6	7
29	I often consider if referral to parent support program (or similar) is required by consumer-parents (fp4)	N/A	1	2	3	4	5	6	7
30	I am able to determine the level of importance that consumer-parents place on their children maintaining strong relationships with other family members (e.g. other parent, siblings) (c2)	N/A	1	2	3	4	5	6	7
31	I want to have a greater understanding of my profession in a healthcare team approach to working with children and families (ic4)	N/A	1	2	3	4	5	6	7
32	I provide education sessions for adult family members (e.g. about the illness, treatment) (fp5)	N/A	1	2	3	4	5	6	7

Thank you for completing the questionnaire

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