



MONASH University

**Exploring the implementation and sustainability of Let's
Talk about Children – a model for family-focused practice in
adult mental health services**

Sustainability and Let's Talk

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MAVP (Aid and Development), BAppSc (OccTher)

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Monash Rural Health, Faculty of Medicine, Nursing and Health Sciences

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Abstract

Background: Let's Talk about Children (Let's Talk) is a brief family-focused intervention that promotes family relationships and the wellbeing of parents with a mental illness and their children. While Let's Talk has been implemented in adult-focused services, it faces the same challenges as other family interventions in being difficult to introduce and sustain in Adult Mental Health Services (AMHS). Multiple barriers to the integration of family-focused practice in AMHS have been identified in the literature but little is understood of what enables sustainability of practice. Implementation and sustainability research in complex healthcare settings requires multiple levels of measurement to explore the interrelated factors influencing practice outcomes within their context.

This research follows-up eight AMHS that participated in a four-year randomised controlled trial (RCT) in Victoria, Australia that investigated the efficacy of Let's Talk on recovery outcomes for parents with a mental illness. Sustainability was explored in this thesis by considering the continuing practice of Let's Talk by practitioners and the organisational capacity to support Let's Talk practice. The research in this thesis utilised a participatory approach to co-produce the applied knowledge to inform service and workforce development.

Aim: This research aims to investigate the key elements for sustainability of Let's Talk in AMHS, in Victoria, Australia by exploring the question: 'what is important for sustainability of Let's Talk in AMHS?' This was addressed in two sub-questions: i) 'what sustainability has occurred in practitioners' Let's Talk practice and the organisation's capacity to support Let's Talk practice?', and ii) 'what key elements are critical for the sustainability of Let's Talk practice and organisational capacity?'

Methodology: A participatory mixed method design was employed which embedded quantitative research within a predominantly qualitative method in four consecutive phases. Using semi-structured interviews, Phase 1 explored the implementation process with leadership from the organisations participating in the RCT to enable a contextual understanding of what had been sustained. Phase 2 used quantitative and qualitative approaches to establish the AMHS' current capacity to support Let's Talk and practitioners' use of Let's Talk during and since the RCT. A participatory case study in Phase 3 explored influences on sustainability in one AMHS which had capacity to support Let's Talk and in which practitioners were continuing to deliver the practice. A co-design workshop in Phase 4 applied the collated findings from the previous phases to develop a set of recommendations for implementing Let's Talk for sustainability in AMHS.

Findings: AMHS are complex organisations that work within continuously changing contexts. This series of studies found that sustainability is a nonlinear process affected by shocks and setbacks. Strategic implementation with internal overseeing personnel was found to enable ongoing, deliberate attention to overcome hurdles to service delivery. Paradigm conflicts in the funding and service directives embedded within AMHS were also found to affect family-focused service delivery. These conflicts included individual vs family focused approach, acute vs recovery or preventative work, and mental health promotive vs risk averse frames of reference. Practitioners' continued use of Let's Talk was found to be linked to the organisation's capacity to support practice. Organisations that made structural and procedural changes to enable the fit of Let's Talk had practitioners with continued practice.

Conclusion: Sustainability of Let's Talk in AMHS requires ongoing attention at both the practitioner and the organisational level. Implementing for sustainability requires the consideration of the alignment of Let's Talk with the organisation's visions, identity and other initiatives. Multi-level leadership support to provide the authorising environment for Let's Talk practice and the practical support to apply Let's Talk to the organisation's everyday practice was also required. Additionally, infrastructure to train and support practitioners' delivery of Let's Talk, and the utilisation of data to target and monitor delivery and outcomes can support practice delivery in the context of continuous change.

Moreover, the thesis findings contribute to understanding sustainability as a non-linear process of continual adjustment between the organisation and the intervention that require multilevel contextual measurement. In doing so, the thesis also illuminates the need for dynamic approaches to the development of evidence-based practices that can accommodate the need for their co-evolution in situ and clear identification of their mechanisms of change.

Declaration

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.

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Publications during enrolment

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Thesis including published works declaration

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 is sustainability of a family-focused practice, Let's Talk about Children, in AMHS. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Rural Health under the supervision of Dr. Melinda Goodyear and two external supervisors, Dr. Brendan O'Hanlon and Associate Professor Bente M. Weimand.

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 6-8 my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
6	Leadership perspectives on key elements influencing implementing a family-focused intervention in mental health services	Published	60%; analysed all the transcripts and led the write-up of the paper. Contributed to the refining of the manuscript, reviewed the drafts and contributed to the write-up	1) Melinda Goodyear conceptualized study, conducted interviews, confirmed analysis, contributed to refining analysis, interpreting results and drafting the manuscript. 25% 2) Brendan O'Hanlon contributed to refining analysis, interpreting of results and drafting the manuscript. 5% 3) Bente M. Weimand contributed to refining analysis, interpreting of results and drafting the manuscript. 10%	No

7	Practitioners' application of Let's Talk about Children intervention in adult mental health services	Published	80%; conceived the study, developed the measures, collected and analysed the data, interpreted the results, drafted and refined the paper	<p>1) Brendan O'Hanlon contributed to the interpretation of the results, the refining of the manuscript, reviewed drafts and contributed to the write up. 5%</p> <p>2) Bente M. Weimand contributed to the interpretation of the results, the refining of the manuscript, reviewed drafts and contributed to the write up. 5%</p> <p>3) Melinda Goodyear oversaw the analysis and contributed to the interpretation of the results, the refining of the manuscript, reviewed drafts and contributed to the write up. 10%</p>	No
7	Continued capacity: Factors of importance for organizations to support continued Let's Talk practice – a mixed-methods study	Published	80%; conceived the study, developed the measures, collected and analyses the data, and drafted the paper.	<p>1) Bente M. Weimand contributed to the interpretation of the results and the refining of the manuscript, reviewed drafts, and contributed to the write up. 5%</p> <p>2) Brendan O'Hanlon contributed to the interpretation of the results and the refining of the manuscript, reviewed drafts, and contributed to the write up. 5%</p> <p>3) Melinda Goodyear oversaw the analysis and contributed to the interpretation of the results and the refining of the manuscript, reviewed drafts, and contributed to the write up. 10%</p>	No

8	An Explanatory Model of Factors Enabling Sustainability of Let's Talk in an Adult Mental Health Service: a participatory case study	Published	50%; designed and led the research, generated and analysed data, developed and defined the list of influencers and developed the explanatory model. Led the write-up of the paper.	<p>1) Brendan O'Hanlon contributed to the design of the research, refining of the manuscript, reviewed drafts and contributed to the write up. 7%</p> <p>2) Bente M. Weimand contributed to the design of the research, refining of the manuscript, reviewed drafts and contributed to the write up. 7%</p> <p>3) Fran Boyer generated and analysed data, developed and defined the list of influencers and developed the explanatory model. Contributed to the refining of the manuscript, reviewed drafts and contributed to the write up. 5%</p> <p>4) Georgia Cripps generated and analysed data, developed and defined the list of influencers and developed the explanatory model. 3%</p> <p>5) Lisa Gill generated and analysed data, developed and defined the list of influencers and developed the explanatory model. 3%</p> <p>6) Brooke Paisley generated and analysed data, developed and defined the list of influencers and developed the explanatory model. Contributed to the refining of the manuscript, reviewed drafts and contributed to the write up. 5%</p> <p>7) Sian Pietsch generated and analysed data, developed and defined the list of influencers and developed the explanatory model contributed to the</p>	No
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				refining of the manuscript, reviewed drafts and contributed to the write up. 5% 7) Brad Wynne generated and analysed data, developed and defined the list of influencers and developed the explanatory model, contributed to the refining of the manuscript, reviewed drafts and contributed to the write up. 5% 8) Melinda Goodyear contributed to the design of the research, refining of the manuscript, reviewed drafts and contributed to the write up. 10 %	
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I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature:

Date: 16/11/2020

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:

Date: 16/11/2020

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Abbreviations

AMHS - Adult Mental Health Services

CAMHS - Child and Adolescent Mental Health Service

CFIR - Consolidated Framework for Implementation Research (Damschroder & Lowery, 2013)

COPMI - Children of Parents with a Mental Illness

EBP - Evidence-Based Practice.

EFT - Effective Full Time

FaPMI - Families where a Parent has a Mental Illness

Let's Talk - Let's Talk about Children. An evidence-based family-focused practice that promotes family relationships and the wellbeing of parents with a mental illness and their children

LRG - Local Research Group. A group of staff within AMHS who worked in partnership in phase three of this research, who are not employed as researchers

MHCSS - Mental Health Community Support Services

MHDS - Mental Health Disability Support.

MIRF - Mental Illness Research Fund

PDRSS - Psychiatric Disability and Rehabilitation and Support Services

RCT - Randomised Control Trial

Glossary of terms

How language is used is a powerful tool to shape understanding. The research in this thesis is situated within adult mental health services providing clinical services within a primarily medical model. In this setting, disturbances of mental health are understood within a psychiatric framework and defined as mental illness rather than mental health issues, challenges or problems. While there are many people who prefer not to identify with their experience as an 'illness', the language of illness is embedded within the service provision and in positions such as FaPMI Coordinators. Additionally, the field of research about the parenting role of people using adult mental health services and their children has had a psychiatry foundation and the term mental illness predominantly used. This is seen in terms such as Children of Parents with a Mental Illness (COPMI), parental psychiatric disorder and parental mental illness. Mindful of the tension this term creates, mental illness is used within the thesis but where possible a person-centred approach to language is used and a parent experiencing mental health issues is described as a parent-consumer.

AMHS - Adult Mental Health Services are clinical services focused on assessment and treatment of people with a mental illness (<https://www2.health.vic.gov.au/mental-health/mental-health-services>). Adult Mental Health Services are a specialist clinical public service for people with a severe mental illness, including significant levels of disturbance and psycho-social disability; service includes acute inpatient and continuing care facilities (Maybery et al., 2017; State of Victoria, 2018)

Consumer - a term used in Australian mental health services to refer to a person with direct experience of mental illness who has or is receiving mental health services (<https://www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers>)

Carer - a term used in Australian mental health services to refer to a person, including family members and people under 18 years of age who provide support, assistance and/or personal care to someone with a mental illness (<https://www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers>)

EBP - Evidence-Based Practice/s. Used in this thesis synonymously with evidence-based interventions or innovations

Family Support Services - State Government funded services that promote the safety, stability and development of vulnerable children, young people and their families, and build capacity and resilience for children, families and communities (<http://www.dhs.vic.gov.au/about-the->

department/plans,-programs-and-projects/programs/children,-youth-and-family-services/family-services-program)

Family-Focused Practice - an umbrella term to define practice that incorporates working with people in the context of their 'family' as defined by themselves (Foster et al., 2016). This is discussed in more detail in Chapter 4 of this thesis

FaPMI coordinator - A Victoria state government funded service development position located within each AMHS. The aim of the coordinator role is to build the capacity of the AMHS and their network partners in Victoria, Australia to support families where a parent has a mental illness (State Government of Victoria, 2007, 2016)

Influencers - Factors that have an influence on sustainability

MHCSS - Also known as Mental Health Disability Support (MHDS) or Psychiatric Disability and Rehabilitation and Support Services (PDRSS). Non-clinical services provided by the non-government sector which focus on activities and programs that help people manage their own recovery and maximise their participation in community life (<https://www2.health.vic.gov.au/mental-health/mental-health-services>)

Mental illness - medical term used to describe a cluster of conditions related to a significant disturbance of mental health as result of disordered thought, mood, perception and/or behaviour which impact an individual's functioning. Identified by diagnosis

Micropolitics - How power and resources are used by individuals or small groups to influence behaviour by shaping the attitudes, desires, perceptions and judgements of others to bring advantage (Scherer, 2015)

Practitioner - a person engaged in professional role to work with the parent-consumer including but not exclusive to nurses, social workers, psychologists, occupational therapists and doctors. Also described as a clinician in some settings.

Wicked Problem - Term first used by Ritter and Webber (1973) to describe problems for which there is no simple answer due to their interrelated social, cultural, planning and/or policy complexity. Such a problem has many ways of defining and therefore approaching it, meaning that outcomes are difficult to foresee.

Chapter 1 Introduction

1.1 Statement of research problem

Mental illness has the potential to impact families. The symptoms, treatment and social consequences of the illness, such as unemployment, poverty and stigma, add considerable strain on parents and position their families to be at risk of adverse outcomes. Family relationships, and parent and child wellbeing are all impacted through interrelated factors (Reupert & Maybery, 2016). Consideration of these factors has led to increasing awareness of the importance of family-focused practices for families where a parent has a mental illness. There is growing evidence that these family-focused practices have an impact on protecting and promoting resilience in children (Goodyear et al., 2015; Maybery & Reupert, 2009; Siegenthaler et al., 2012) and in supporting mental health recovery and parenting roles (Awram et al., 2017; Beardslee et al., 2007; Foster et al., 2016; McKay, 2004, 2010; Reupert et al., 2012). Additionally, family-focused practice has been increasingly included in government and service providers' policy and practice guidelines (Foster et al., 2016; Goodyear et al., 2015; Nicholson et al., 2015). However, there remain significant challenges for Adult Mental Health Services (AMHS) embracing it in standard practice due to barriers at the level of the worker, the organisational and the intervention (Maybery et al., 2016; Maybery & Reupert, 2009). AMHS' typically work within a biomedical professional-centred approach (Foster et al., 2016) that comprises a clinical workforce with limited skills and knowledge in family-focused practice (Maybery et al., 2014; Maybery et al., 2016; Maybery & Reupert, 2006), as well as an individualised funding structure (Fadden, 2006; Goodyear et al., 2015). While these barriers for the utilisation of family-focused practice in AMHS are known there is little known about sustaining such practices in these settings.

An intervention that has showed potential to be implemented in AMHS is the brief Let's Talk about Children intervention (Solantaus & Toikka, 2006), referred to hereafter as Let's Talk. This intervention engages with parents with a mental illness, with the aim of empowering the parent in their parenting role, enabling them to support their children by drawing on their family's social networks and accessing different services as required (Solantaus et al., 2015; Solantaus & Toikka, 2006). In this way Let's Talk serves as both a recovery tool for the parent and as a health promotion tool for the whole family.

In Australia, Let's Talk was chosen as an intervention that could help to achieve the minimum standard of family-focused practice appropriate for all staff (Goodyear et al., 2015; Maybery & Reupert, 2006) with an emerging evidence-base and a seemingly simple and time efficient method (Maybery et al., 2017). It was piloted in AMHS and psychiatric rehabilitation settings, before being

trialled in three sectors: AMHS, the non-government Mental Health Community Support Services (MHCSS) and family support services as part of a randomised controlled trial (RCT) funded by the Mental Illness Research Fund (MIRF) of the State Government of Victoria, Australia (Maybery et al., 2017). Following delivery of Let's Talk, both parents and practitioners reflected positively on the program, and preliminary findings show promising impacts on mental health recovery, parenting stress and therapeutic alliance (Goodyear et al., 2016).

Implementation supports were incorporated as part of the research trial, to assist with translating Let's Talk into practice in participating services. Previous studies indicated that delivery of family-focused practice in AMHS required skilled and supported staff (Maybery et al., 2014; Maybery et al., 2012; Maybery & Reupert, 2006, 2009) within an authorising environment (Berry & Haddock, 2008; Eassom et al., 2014; Maybery, Foster, et al., 2015). As a result, the implementation strategy of the RCT included engaging service management and establishing local trainers. These trainers received ongoing coaching in their role to provide training and supervision at the service. Despite these implementation investments, services had significant challenges embedding Let's Talk into sustained practice.

Over recent years, numerous studies have focused on the complexity and difficulty of translating implementation of health interventions into sustainable practice (Damschroder et al., 2009; Fixsen et al., 2013; Fixsen et al., 2009; Fixsen et al., 2005; Greenhalgh, Robert, Macfarlane, Bate et al., 2004; Scheirer, 2013; Scheirer & Dearing, 2011). Stirman et al. (2012) argued that an intervention can be considered sustained if, after the initial implementation, there is maintenance of the core elements in practice and adequate capacity to support the continued practice of these elements. With this in mind, sustainability in this research focused on the continuation of practitioners' practice of Let's Talk and the organisational capacity to support practice after the original training and research focus was completed.

In order to enable better outcomes through effective practices, Scheirer and Dearing (2011) argued that a deeper knowledge of sustainability is required. They advocated that sustainability can only be understood through exploring the innovation in the contexts within which they are implemented (Scheirer & Dearing, 2011). In a significant review of literature on uptake and continuation of healthcare innovations, Greenhalgh, Robert, Bate et al., (2005) noted that the most serious gap in the literature was exploration on what processes enabled sustainability. They also advocated the need to address these issues through research that focused on whole-system processes using approaches such as participatory action research or realistic evaluation that can build a rich understanding of the complexity through in-depth mixed methodology studies.

1.2 The local context

Adult Mental Health Services (AMHS) in Victoria, Australia

Mental health services in Australia are primarily administered by state governments. In Victoria, specialist clinical services are provided by Adult Mental Health Services (AMHS) as part of a wider network of systems delivering services on an area-wide basis within 21 geographically defined catchment areas – 13 metropolitan, 8 rural (State of Victoria, 2006). These provide community-based and inpatient care for adults aged 16-64 years with severe mental illnesses or disorders that are associated with significant levels of disturbance, or disability that prevents other services from adequately treating or managing them (State of Victoria, 2006). The most common diagnoses given to adults receiving services from AMHS are schizophrenia and mood disorders such as depression and bipolar disorder. Other common diagnoses include stress and adjustment disorders, personality disorders and anxiety disorders (State of Victoria, 2018). It is common for people to have coexisting difficulties such as substance use disorders and physical health issues (State of Victoria, 2006).

The workforce in AMHS typically comprises nurses (approximately 60%), allied health workers including social workers, psychologists, occupational therapists (approximately 20%), medical staff (approximately 10%), administration staff and a growing number of consumer and carer peer workers (State of Victoria, 2014b, 2018). There is a strong emphasis on service delivery through multidisciplinary teams and the skill mix across regions, services and program types varies (State of Victoria, 2014b).

Reforms beginning in 2014, documented the concept of recovery as a key principle underpinning treatment and care that aimed to minimise long-term disability by supporting people to use and build on their personal strengths, resourcefulness and resilience. The reforms voiced the need for services to be responsive to people's unique circumstances, needs and preferences, and highlighted the significance of family, carers and support people (State of Victoria, 2014b). This included the need to strengthen workforce capability for identifying and responding to the needs of parents with a mental illness and their children (State of Victoria, 2014a, 2014b). This saw the expansion of the existing FaPMI strategy to a fully funded state-wide program (State Government of Victoria, 2007, 2016). The FaPMI program placed service development staff within each AMHS to build the capacity of mental health services and other network services to reduce the impact of a parent's mental illness on all family members through the use of non-direct services (State Government of Victoria, 2007, 2016). Such non-direct services might include: the provision of professional development for the workforce, the creating of changes to the organisational systems or the development of partnerships for service delivery. Furthermore, in 2014, the Parliament of Victoria enacted a new

Mental Health Act that enshrined the needs of children of parents with a mental illness as an underlying principle for work in mental health care (Tchernegovski et al., 2017). Principle (j) within the Act states ‘children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected’ (*Mental Health Act 2014 (Vic)*, Part 2:11, p.26.).

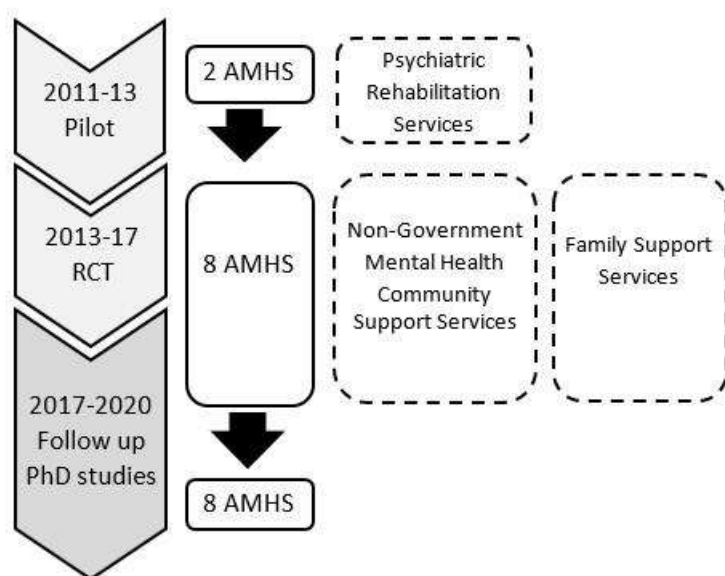
Let’s Talk in AMHS in Victoria, Australia and the RCT

While Let’s Talk is extensively discussed in the chapter on the literature of Let’s Talk and family-focused practice (Chapter 4), the Australian context of Let’s Talk is presented here.

Let’s Talk began in Australia with a workshop on the Let’s Talk method presented by Professor Tytti Solantaus and William Beardslee at a conference on family mental health in October 2010 in Adelaide, Australia. This workshop spawned pockets of work across Australia that adopted the intervention in AMHS. In Victoria, a supported implementation pilot of Let’s Talk was undertaken between July 2011 and July 2013 in AMHS and psychiatric rehabilitation settings as part of a broader implementation project for a range of family interventions (The Bouverie Centre, 2015; see Figure 1). Adding to this momentum, the Victorian government funded the four-year supported implementation RCT exploring Let’s Talk as a recovery tool for parents with a mental illness.

Between the years 2013-2017, two AMHS that participated in the previous supported implementation pilot and six other AMHS participated in the RCT of Let’s Talk, together with non-government MHCSS and family support services (see Figure 1). The RCT had an overarching implementation strategy designed by the research team in conjunction with a statewide specialist family service, the Bouverie Centre. The strategy influenced which services engaged in the RCT and framed the support provided during the research process. Recruitment to the study was by means of an expression of interest process requiring senior management to commit to implementation. The Bouverie Centre developed and delivered training for local master trainers and provided them with standardized materials with which to deliver training in Let’s Talk in their setting. The Centre also offered coaching and support to master trainers in each service. Local execution of the implementation plans within each AMHS varied from service to service. The research in this thesis builds on the work in this RCT, following up these eight Victorian AMHS in four phases between the years 2017-2020 (see Figure 1).

Figure 1: Study of Let's Talk in Victoria, Australia



Alongside these studies, Australian government funding enabled an Australian adaptation of Let's Talk and the development of an e-learning resource for mental health practitioners across Australia. This was coordinated by the Children of Parents with a Mental Illness (COPMI) national initiative in conjunction with Professor Tytti Solantaus and a reference group that included mental health practitioners, researchers, parents with mental illness and family members (Tchernegovski et al., 2015). This e-learning resource was reviewed and updated and is now freely accessible online from the National Workforce Centre for Child Mental Health (Emerging Minds)¹.

1.3 Addressing the research problem

The research in this thesis builds on the previous knowledge of the effectiveness and the implementation of Let's Talk to contribute towards addressing the gap in the knowledge of sustaining Let's Talk specifically and family-focused practice in AMHS more broadly. The thesis aims to investigate key elements for sustaining Let's Talk by answering the overall question: what is important for the sustainability of Let's Talk in AMHS? Working in partnership with AMHS, the research is undertaken within a participatory theoretical paradigm and executed through four phases using five mixed method studies. The context and implementation process in the eight Victorian sites is explored first before sustainability is investigate in relation to the continuation of the core elements of Let's Talk and the AMHS capacity to support continued practice. Working in partnership with the Victorian AMHS FaPMI coordinators, findings from the previous four studies are

¹ <https://emergingminds.com.au/training/online-training>

converged to expand their generalisability and build a more complete understanding of key elements for sustaining Let's Talk. Understanding sustainability of Let's Talk contextually, in partnership with those involved in the settings creates a window into the exploration of sustainability of other family-focused practices. Through the use of a sustainability lens to investigate a single intervention (Let's Talk) this thesis progresses the limited knowledge on sustainability of other family-focused practice in AMHS more broadly. By applying the conceptual frameworks of sustainability to practice, the thesis also contributes to what is known about its nature and approaches needed to enable the sustainability of evidence-based practice (EBP) in healthcare settings.

1.4 The situated self

The position of the researcher influences what knowledge is valued, how the world is viewed and how the generation of knowledge is approached (Creswell, 2014; Denzin & Lincoln, 2013a). A researcher comes to their question and the research problem with experiences that shape world views, beliefs and opinions that cannot be separated from the inquiry process and the resulting interpretation of the inquiry (Denzin & Lincoln, 2013a; Herr & Anderson, 2005). A process of reflection, identification and acknowledgment of the position of the researcher can assist in bringing to the foreground assumptions and beliefs that might otherwise be left invisible to the knowledge generation process (Bergold & Thomas, 2012 ; Denzin & Lincoln, 2013a). Below, I explore my situated self in relation to the research undertaken for this thesis.

My approach and understanding of this research problem is situated within my personal experience. I come to this research almost opportunistically. My work as a FaPMI (Families where a Parent has a Mental Illness) coordinator has focused on developing the capacity of a service system to better respond to the needs of families where a parent has a mental illness in a metropolitan region of Victoria, Australia. This work gave me an opportunity to introduce a small pilot study and then participate in the research trial of Let's Talk in AMHS in Victoria, Australia. The work of implementation in real-world settings within a context of changing government policies and service structures gave pause for reflection on what was important to sustain a seemingly simple intervention. As a result of this involvement, I was well positioned to take up the opportunity to explore sustainability at the end of the research trial.

These reflections highlighted tension between the different questions and goals of the researcher and those in the research setting. As a person embedded within a service to enable ongoing capacity to support families where a parent has a mental illness, my questions were: "where does the intervention fit into the existing service structures? What can it be aligned to within the service that

will give it credibility and authority? What will support its sustainability?” The research team, tasked with getting the required numbers of parents and families within a limited timeframe, worked to implement Let’s Talk across multiple sites while attempting to minimise the impact of extraneous factors. A service’s engagement with the research focused on outcomes for their own service, such as enabling their practitioners to access the training and their parents to access the intervention. The researcher, however, working at arm’s length to the service outcomes, was focused on determining the effectiveness of the intervention as a recovery tool. These different standpoints are not often voiced and can result in further tensions that can sideline evidenced-based practices as not workable in real-world settings. Gold et al. (2006) suggest that while difficult, greater collaboration for joint knowledge production is vital to enable shifts in mental health systems. It is with this imperative that I, emboldened yet cautious, stepped forward into the space of the researcher and researched.

My training in occupational therapy draws me to see the world in occupational terms with a vision of “enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life” (Townsend & Polatajko, 2007, p. 2). Drawing from the occupational therapy and occupational science literature, people are viewed as occupational beings and having access to meaningful occupations that are valued and give purpose is understood as a human right and important to health (Hammell, 2008; Pereira, 2017; Wilcock & Hocking, 2015). Occupations are defined as the way people occupy their time and include a range of daily life activities that people either collectively or individually, need, want or have to do (Wilcock & Hocking, 2015; Wilding & Whiteford, 2007). It is from this perspective that parenting occupations are understood. For some populations, the ability to participate in these daily occupations of life is restricted by complex interrelated layers of barriers that relate to the person, the occupation and the environment.

Viewing my work as a FaPMI coordinator in AMHS through these lenses allowed me to see how people with a mental illness experience marginalisation from parenting and family-life occupations by the lack of opportunities and resources to meaningfully engage in them. Additionally, systems of care have historically been blind to the existence of parents with a mental illness or viewed them through a risk rather than a strengths lens, resulting in an undermining of their agency (Awram et al., 2017; McKay, 2004, 2010). A population-based approach to occupational therapy contributes to community transformation through occupation, supporting the health and wellbeing of populations (Hyett et al., 2019; World Federation of Occupational Therapists, 2019). This approach that emphasises building community capacity for health promotion and illness prevention is underpinned by community engagement, partnership and joint ownership, and embodied by trust, respect and reciprocity (World Federation of Occupational Therapists, 2019; World Federation of Occupational Therapists et al., 2017). Importantly, research from this approach has been identified as a priority

area for the occupational therapy profession (Mackenzie et al., 2019; World Federation of Occupational Therapists et al., 2017). These tenets provide a foundation for both my work as a FaPMI coordinator and this research. These lenses position me to focus on service systems and view the research as a collaborative tool for enabling just systems.

My work in the aid and development sector strongly shapes my interest in what creates sustainable change. Evaluations of mental health community projects that I have done in India and Afghanistan focused on what sustainability looks like at the end of the project. My experiences on these projects led me to be interested in looking at what needs to be tweaked to enable the transformation that was envisioned. Frameworks of community development embedded in participatory action and rights-based approaches are part of the collection of lenses that frame my views. From these experiences, I've developed a scepticism towards neat models and easy answers to wicked problems.

Belief systems shape world views, and central to my values and the way I see the world is my Christian faith. In me, this has cultivated a desire for justice, compassion for the vulnerable and has influenced my career choices and perspectives. It orients me towards an approach for knowledge and learning that is collective, participatory and enables power sharing. It has led me to positions that can influence change on a small and large scale and gives me an underlying hopefulness for the transformation towards wholeness that enables flourishing. The belief that God is already at work in the world making things new enables me to participate in my small corner knowing there is something bigger at work. As I bring this lens into my work of system transformation that enables families where a parent has a mental illness to flourish, I can afford the long-term view that is required for the slow cogs of organisational change. This puts me in a position to value the collective and seek hopeful stories of change.

On top of these, my interest and work in the area of families where a parent has a mental illness is grounded in sharing life with family and friends with mental illness. It is to the privilege of journeying in life with them that I owe the wisdom gained by the reality checking of real-life situations.

As explained here, I come to the research with a range of positions that include being an insider within one AMHS, part of a statewide FaPMI coordinator network, friend and family to parents with mental illness, community development practitioner, occupationally oriented, and a person with faith as a foundation. These multiplicities of perspectives shape the research design, data collection, analysis and interpretation and so need to be acknowledged and held in tension to support greater transparency. Multiple methods of critical appraisal and reflexivity have been utilised in this research process which are outlined in more detail in the research methods chapter (see Chapter 5).

1.5 Thesis overview

This chapter has outlined the statement of the research problem, the context of the research setting how the research will address the research problem and the place of myself as the researcher. This is the first of five chapters that form the first section of the thesis that document the foundations underpinning the research.

The second chapter in this section presents the theoretical paradigm of participatory research, defining the axiology, ontology and epistemology of this research (Chapter 2). Following this, a chapter each is presented on the concept of sustainability (Chapter 3) and on the intervention, Let's Talk (Chapter 4). Chapter 5 then draws together these four foundational chapters to detail the research aim and methodology.

The middle section of the thesis presents the four phases of the research and their studies that make up this thesis (Chapter 6-9). Each phase's chapter begins with an overview of the phase and how it contributes to the research overall before presenting the studies associated with that phase. Three of these phases include papers published which detail the methods, findings and implications of each of these four studies. Each phase's chapter concludes with presenting how the findings from this phase contributes to answering the research question.

The thesis concludes with a final chapter discussing the contribution of the research and presenting implications of the findings integrated across the thesis (Chapter 10).

Chapter 2 Theoretical paradigm: participatory research

Research occurs within a frame of reference that shapes the reason for the exploration - axiology, how reality is understood - ontology and the way knowledge is produced - epistemology (Creswell, 2014; Denzin & Lincoln, 2013b; Kuhn, 1970). Influenced by my experiences and perspectives as a researcher embedded within AMHS, noted in the previous chapter (Chapter 1), a participatory research paradigm was chosen to frame this research. The choice of paradigm was also influenced by the literature on sustainability which advocates for the value of context-rich research that builds the capacity of health services (Greenhalgh, Robert, Bate, et al., 2004) as explained in Chapter 3. The lack of sustainability of family-focused practice in AMHS exemplifies the complexity of implementing and embedding new practices into healthcare settings that require whole-system understandings. Participatory research's collaborative approach allows for the development of knowledge about sustainability in collaboration with those within the AMHS settings and is suited to the complexity of real-world investigation.

This chapter presents the history and definitions of participatory research before outlining how it is used as a theoretical paradigm in this research, setting the foundation for the methodology described in Chapter 5.

2.1 Participatory research history

Participatory research grew out of diverse threads of social inquiry that challenged the dominant paradigms to develop more politically informed and socially engaged forms of knowledge creation (Brydon-Miller, Kral, Maguire, Noffke, & Sabhlok, 2013). Developing in different ways across countries, disciplines and research goals, participatory research has origins in both collective action and emancipatory practice (Cargo & Mercer, 2008; Macaulay, 2016). Its trajectory has been strongly influenced by social movements for transformation such as civil rights and the voices of groups often excluded from knowledge production, i.e. Indigenous or First peoples, people in poverty, females and African-Americans (Brydon-Miller et al., 2013; Cargo & Mercer, 2008; Kemmis & McTaggart, 2005; Macaulay, 2016). Such voices have raised critiques of assumptions of knowledge being value free. In more recent years, participatory research has shifted from a method of study to an overarching research approach (Cargo & Mercer, 2008). Participatory research has played a significant role in research in education, public health and health promotion for its promotion of social justice, knowledge translation and self-determination (Macaulay, 2016).

2.2 Participatory research defined

Participatory research is to be understood as an umbrella term that encompasses a range of approaches with an underlying premise of inclusivity that values active engagement in the research process by those affected by the research (Cargo & Mercer, 2008). Rather than a method or methodology, it is seen as an orientation to research that determines the research parameters (Cargo & Mercer, 2008; Kemmis & McTaggart, 2005; Minkler, 2005; Wallerstein & Duran, 2006).

From its beginning, participatory research has been concerned with the relationship between power and knowledge (Bozalek, 2011; Brydon-Miller et al., 2013). By design, it works to democratise the power of knowledge through engaging non-traditional researchers as equitable partners in knowledge generation (Kemmis & McTaggart, 2005). In doing so, participatory research sheds light on the way the power that is woven into the fabric of society is used to shape what is valued and valid. Understanding reality within these micropolitics allows for more equitable knowledge to be generated (Ozanne & Saatcioglu, 2008). This drive for knowledge generation in partnership with those affected by the issue being studied also better enables the application of this knowledge to generate a change in public health and practices (Cargo & Mercer, 2008).

Participatory research advocates that practice develops over time as it is constructed and reconstructed through social discourses, actions and action consequences (Kemmis & McTaggart, 2005). As such, research is seen as a social process of collaborative learning that creates space for what Kemmis and McTaggart (2005) describe as communicative action. It is through this communicative action that transformation of practice, understandings and situations is enabled. As a result, participatory research posits that there is no divide between practice and theory. Instead participatory research operates on the premise that applied research can both build theories and solve practical problems (Ozanne & Saatcioglu, 2008).

Core elements of participatory research that set it apart from other action research or collaborative approaches are empowerment, capacity building and ownership, all of which are enabled by mutual respect and trust within the partnership (Cargo & Mercer, 2008). For participatory research, the context has prominence and involves learning about “the real, material, concrete and particular practices of particular people in particular places” (Kemmis & McTaggart, 2005, p. 564) which makes practices accessible for reflection, discussion and reconstruction.

While participatory research is often known for its social justice and self-determination practice, one of its three primary drivers is translation of knowledge into action (Cargo & Mercer, 2008). The process of exploring practices by those involved in these practices and collectively producing real-

world knowledge related to their own circumstances increases the legitimacy and the applicability of the knowledge to practice (Cargo & Mercer, 2008; Kemmis & McTaggart, 2005).

2.3 Use of participatory research in this thesis

This next section outlines how a participatory research paradigm is applied in this research. Firstly, the assumptions of the research are made explicit and their role in shaping the methodology is explored. Subsequently, an explanation is given of how this research addresses participatory research's core tenets of co-creation of knowledge and participation.

Participatory research paradigm's assumptions and this research

Implicit assumptions are bound within a paradigm that relate to the value of knowledge (axiology), the way reality is understood (ontology) and the way knowledge is produced (epistemology). How these have shaped and directed this research is discussed below.

The reason for or value of the knowledge (Axiology)

A participatory research approach values knowledge that improves human welfare. Underpinning this research is the goal of improving access to the benefits of an evidence-based practice for families in which parents have a mental illness. Guided by a participatory approach, this research worked in partnership with AMHS to address the challenges of sustaining Let's Talk in order to achieve this outcome.

How the research understands reality (Ontology)

Adopting a participatory research approach leads the research to understand reality as co-created, context bound, relational and situated. Additionally, a participatory research approach understands social reality as historically constructed and shaped by micropolitics (Ozanne & Saatcioglu, 2008).

As a result, the study of sustaining Let's Talk has collaboratively explored both Let's Talk and AMHS in their contexts. Consequently, AMHS are seen as organisations that act within a diverse set of internal and external systems that overtly or covertly constrain or enable their ability to sustain Let's Talk. Likewise, Let's Talk is understood as an intervention that is developed, implemented and researched within contexts that shape its sustainability.

How knowledge is produced (Epistemology)

A participatory research approach results in viewing knowledge as evolving in context through collaboration. A recursive process of education, reflection and action is utilised to enable the analysis of the everyday cultural, social and political processes that are needed to promote social change (Ozanne & Saatcioglu, 2008).

In this research, AMHS are collaborators in knowledge creation rather than subjects or objects and have joint ownership of the knowledge generated. As collaborators, the production of knowledge benefits from their contextual view while also building their capacity for the analysis of the everyday processes that might influence on-going sustainability of Let's Talk. As the quality of the partnership (depth, representation, engagement) matters to the legitimacy of the knowledge it is discussed in more detail below, as well as in Chapter 5.

Shaping methodology

Out of the orientation, drivers and values of participatory research, a diverse range of methodologies, study designs and methods emerge, using both quantitative and qualitative data (Brydon-Miller et al., 2013; Cargo & Mercer, 2008). Rather than the application of fixed techniques, participatory research practices employ different methods and techniques from different traditions to shed light on different aspects of what is being studied (Kemmis & McTaggart, 2005). In Carter and Little's (2007) model for qualitative research, methodologies are presented as "idealised reconstructed logics" (p. 1324) and they argue that these are rarely used in their pure form. Instead, each research situation needs its own solution that requires an iterative shaping process between the methodology and the objectives, research question and design. They propose that clearly understanding the epistemology shapes the methodology and enables researchers to use it in a nuanced, flexible way.

The aim of this research, to understand the keys to sustainability of a family-focused practice in adult mental health services, lends itself to a methodology that enables the capture and analysis of data that give a clear empirical picture of *what* sustainability has occurred as well as a deep exploration of *how* that has occurred. Mixed method research combines elements of quantitative and qualitative research approaches to find the best tools to answer the research questions and to work within a variety of paradigms (Teddle & Tashakkori, 2013). Its iterative and cyclical approach, and focus on the research question for determining the methods are complementary to participatory research. As the emphasis of this research is to understand the breadth and depth of key elements of sustainability, qualitative methods with an embedded quantitative component have been employed, as explained further in Chapter 5.

Schell et al. (2013) advocate that to understand what has led to program sustainability, it is critical to assess the characteristics of the organisation and its place in the larger service system context. Taking this into consideration, the exploration of how sustainability has been able to occur in AMHS utilised a participatory case study. This design allows for a holistic exploration of complexities in real-world contexts (Thomas, 2011), utilises a range of data types converged in analysis (Baxter & Jack,

2008) and can engage with participants in the research process of analysis and interpretation to enable the findings to be put to use within their own setting (Israel et al., 2006; Minkler, Vasquez, Warner, Steussey, & Facente, 2006; Simons, 2009).

Co-creators of knowledge

The study of family-focused practice in AMHS has been a focus in the literature, particularly about what needs to change in these settings to protect children and build family resilience (Foster et al., 2016; Maybery et al., 2016; Maybery & Reupert, 2006, 2009). Service delivery for mental health has traditionally been divided into age groups and this is often mirrored in other service delivery models to families which tend to focus on the child or the adult (Maybery & Reupert, 2006). AMHS are defined by the adult population they work with, which differentiates them from other types of mental health services such as child mental health services. Those clear boundaries, however, can create a false perception of homogeneity. While in the literature AMHS are understood to be complex agencies with layers of barriers impeding desired change in family-focused practice (Foster et al., 2016; Lauritzen & Reedtz, 2015; Maybery et al., 2016; Maybery & Reupert, 2006, 2009), the diversity within them can be lost. Lopez and Kopelowicz (2003) suggest that amongst the missing voices in implementation of family interventions are those of the administrators and service providers, resulting in a loss of attention on the particularities of the local setting.

Lauritzen and Reedtz (2015) argue for new researcher and practitioner engagement to build knowledge translation, with researchers working more closely with those in the field. Participatory research's emphasis on context-specific communicative action makes it a good fit for this thesis as the success (or its lack) of sustainability of health interventions seems to be inextricably tied up with the practitioner and the context within which they work (Greenhalgh et al., 2005). By placing AMHS as co-creators of the generation of knowledge, they can become active players in changing their world, rather than objects of study and situations that need change as determined by others (Westerlund, 2018).

In participatory research, the researcher is not a neutral facilitator, but plays an active role in the learning action process and can be seen as a co-participant. Rather than offering technical advice, they are advocates and animators of change aiming to establish or support the development of a space for collaborative communicative action (Kemmis & McTaggart, 2005). The exploration of the sustainability of Let's Talk, sits within a context of concerted work to bring about better outcomes for families where a parent has a mental illness in which I participate as FaPMI coordinator. Investigation of actual practice typifies the focus for participatory research, with participants collectively investigating their own field in order to transform their world (Kemmis & McTaggart,

2005). Interest in the keys to sustained practice and continued capacity has emerged from my learnings in service development roles within AMHS and my continued questioning to understand more fully how to support practice change for longevity. An overarching qualitative participatory research framework values the subjective, context-rich participant's views as critical to understanding the phenomenon being studied.

Nature of participation

Participation in research under a participatory research paradigm can have a wide scope, with different participants playing different roles at different points in the research (Cargo & Mercer, 2008). Rather than a closed group of fixed members, participation is seen as an open and inclusive network (Kemmis & McTaggart, 2005). The emphasis is on equitable partnerships rather than being equal in the context of the challenges of participation (Cargo & Mercer, 2008). Cargo and Mercer (2008) suggest that in some situations limited time, expertise or interest can contract the non-traditional research partner to working on only parts of the research: at the beginning, shaping the study questions and overall design, and at the end, interpreting and applying the findings. AMHS, as time poor services, are likely to find the research process challenging to fit into an already pressured context. There is, however, an emphasis within AMHS policy and standards to further their understanding of how to sustain evidence-based practice (State of Victoria, 2013).

As previously discussed in the introduction (Chapter 1), AMHS are clinical specialist mental health services made up of a range of staff providing direct and support services. Using the Cargo and Mercer's (2008) framework of questions to guide the identification of the optimal mix of partners, key partners included: practitioners with continued practice of Let's Talk, managers overseeing or involved in implementation, FaPMI coordinators, AMHS lived experience workers, quality management personnel, and people with authority within the AMHS (see Table 1: Identification of optimal mix of partners matrix).

The identified partners were engaged through a range of participation opportunities to optimise the value of the research while balancing the time commitment for participants. The range of opportunities enabled participation across the spectrum of the research process: i) shaping the purpose and scope of the research, ii) enabling research implementation and fit to context, and iii) supporting the interpretation and application of research outcomes (Cargo & Mercer, 2008). Additionally, partnerships were created to provide opportunities for reflexivity. An overview of these partnerships in relation to the phases of the research can be seen in Chapter 5.

Table 1: Identification of optimal mix of partners matrix

Guiding questions ^a for identification of partners	Identified partners
1.1. Who are the <i>end users and beneficiaries</i> of the <i>research products</i> ^b	AMHS as the end users are needed to ensure the framework fits their setting
1.2. What is the <i>added value of their participation</i> in the partnership?	
2. Which academic disciplines should be represented in the partnership to address the <i>ecological complexity of the determinants of and solutions</i> to the identified public health issue?	Academics in the field of families where a parent has a mental illness from a range of disciplines
3. Who needs to be involved in the partnership to ensure that <i>the values driving the research</i> ^c are respected in the planning and implementation of the research?	Managers overseeing or involved in implementation, practitioners with continued practice, FaPMI coordinators
4. Who needs to be involved in the partnership to ensure that <i>the research results will be translated into practice and action</i> ?	Managers overseeing or involved in implementation, practitioners, quality management personnel, FaPMI coordinators
5. Who needs to be involved in the partnership to ensure that <i>the research can be implemented with a balance of scientific integrity, social and cultural relevance</i> ?	AMHS representatives, methodological specialists
6. Who needs to be involved in the partnership to ensure that <i>the utilization of resources and assets from the community of interest</i> are maximized during each phase of the participatory research process?	FaPMI coordinators
7. Who needs to be involved in the partnership to <i>facilitate sustainability of the (a) research products, (b) capacity, (c) relationships, and (d) infrastructure</i> ?	AMHS management and authorising personnel, research and quality staff within service, workforce development staff, FaPMI coordinators
8. Which other stakeholders could be involved to help the partnership <i>achieve its goals and objectives without compromising its values</i> ?	AMHS lived experience workforce personnel that are able to represent FaPMI
^a Optimal mix of partners' questions taken from Cargo and Mercer (2008)	
^b Research product in this research is the framework for sustainability of Let's Talk developed for AMHS	
^c Values driving this research is Knowledge Utilisation	

Partnerships involved across the whole of the research included the PhD supervisory triad, an advisory group and a critical friend:

- The *PhD supervisory triad* provided both a reflexive and research partnership. The triad included academics from diverse disciplines with a wide range of expertise and experiences in research methodology, implementation, work with families and mental health services.

This range of expertise underpinned the rigor of the research methodology. Additionally, this breadth of knowledge provided opportunities to challenge assumptions found in the research process and findings, and explore areas of conflict, enhancing its applicability.

- An *advisory group* including a practitioner, manager, FaPMI coordinator and methodological specialists met quarterly throughout the whole research process to advise on the overall design and data collection. The group also acted as a space for reflection that promoted accountability.
- A *critical friend* was engaged as another reflexive practice partnership. A critical friend is described as a trusted person who can ask provocative questions (Costa & Kallick, 1993) and provides a point of tension between support and critique for the researcher (MacBeath & Jardine, 1998). A clearly defined relationship with a commitment to a focused task enables the role to work cooperatively to empower the researcher to greater reflection and new insights (Swaffield & MacBeath, 2005; Williams & Todd, 2016). The critical friend chosen was a researcher within a different state's mental health system who could provide contextual understanding without being too close to the material being researched. The monthly hour-long dialogues provided a safe space to reflect on the methodology, probe the analysis, question the findings and examine their applicability to the setting.

Partnerships created for specific phases of the research to support the research process included the following:

- *FaPMI coordinators across the eight AMHS involved in the RCT.* The coordinators were key partners in Phase two and three of the research during which sustainability was explored in the AMHS sites. They shaped the fit of the research and built the recruitment of the appropriate participants for each context.
- *A Local Research Group from within the AMHS.* The group engaged in Phase three's participatory case study which explored sustainability in-depth at that site, partnered with the researcher in the data collection, analysis and interpretation process. The group was made up of AMHS staff identified by the AMHS management and FaPMI coordinator as fitting the categories in the optimal mix of partners as appropriate to their setting, as seen in Table 1.
- *FaPMI coordinators from all AMHS.* In Phase four's co-design workshop that aimed to expand the generalisability of the findings and build a more complete picture, coordinators were invited to partner in the interpretation and application of the findings from each of the previous phases.

The roles of the researcher and participants have ethical considerations as well. Rather than just the researcher having ownership and control of data and engaging the participant in a contractual arrangement, Brydon-Miller et al. (2013) suggest that participatory research uses a system of community covenantal ethics which is built on “reciprocal relationships of responsibility, collaborative decision making and power sharing” (p. 355). Cargo and Mercer (2008) suggest that mutual trust and respect is integral to partnership development and important work is required to establish this in the engagement phase. As a researcher embedded within a group of system change workers within AMHS, there was already a foundation for this relationship development based on the existing mutual trust and respect. Regardless of this, such relationships cannot be taken for granted and a commitment to critical reflection and cultural humility was important to ensure these relationships continue to be able to embrace the tenets of equitable partnerships (Cargo & Mercer, 2008). In the research aims and methodology chapter (see Chapter 5), the section on ethical consideration describes more on how these were attended to.

2.4 Theoretical paradigm summary

Adding to the contextual understanding of the research problem and myself as the researcher (Chapter 1), this chapter lays the foundations for what knowledge is valued and how it will be generated. As discussed in this chapter, participatory research is the overarching paradigm through which sustainability of Let’s Talk in AMHS is explored in this thesis. As an orientation to research that gives priority to context it can support investigation of complex real-world settings. The development of knowledge in partnership with those who will use it, facilitates knowledge translation and supports its use in implementation studies. From the groundwork laid in these first two chapters of the thesis, the subsequent two chapters explore how the literature on sustainability (Chapter 3) and Let’s Talk (Chapter 4) lay the foundation for the research design in Chapter 5.

Chapter 3 expands on the literature on sustainability, using it to provide a conceptual lens through which to understand the aim of the research.

Chapter 3 Conceptual lens: sustainability

Building on the foundation previously presented in this thesis (Chapters 1 and 2), this chapter explains the concept of sustainability as it is studied in this research. The chapter begins with defining sustainability and placing it within the broader body of knowledge about how innovations and evidence-based interventions are applied in practice settings. Following this, aspects that are important to consider for research into the sustainability of Let's Talk are discussed. The chapter concludes with a description of the approach used to measure sustainability and the specific frameworks, models and tools used that will guide this research question and design.

3.1 Defining sustainability

In its simplest form, 'sustain-ability' is the ability to sustain. Sustainability is focused on the degree to which the intervention can continue to deliver its planned benefits. Expanding this further, an intervention can only deliver its planned benefits if it has practitioners able to faithfully deliver it, who are in turn supported by organisations that can enable them to deliver its core elements. This results in three distinct aspects to sustainability: continued benefits, continued practice and continued capacity (Stirman et al., 2012).

Consistent with Stirman et al. (2012), this research explores i) the extent to which the elements of Let's Talk have been maintained including how they have been adapted, and ii) the capacity of the organisations to continue to support Let's Talk delivery.

3.2 Sustainability and implementation science

Sustainability, in the context of introducing innovations into healthcare settings, is part of the fast expanding body of knowledge of implementation science. The focus of this field is to promote the understanding of how to bridge the gap between developing evidence-based programs and having these programs provide consistent benefits to their intended recipients. Implementation science has arisen from a diverse range of disciplines and theories including studies in psychology, sociology, complexity science, knowledge utilisation, organisational systems, communications, development, health promotion and evidence-based medicine (Greenhalgh et al., 2005; Moullin, et al., 2015; Nilsen, 2015). Fitting within a broader body of knowledge associated with putting knowledge to use, it is closely related to terms such as knowledge utilisation, knowledge translation and knowledge exchange (Graham et al., 2006). Implementation is seen to be part of a diffusion-dissemination-implementation continuum that builds from a passive to active process of change (Fixsen et al., 2009; Greenhalgh, Robert, Macfarlane, et al., 2004; Nilsen, 2015).

Whilst the development of a cohesive terminology in implementation science has been challenging, some core concepts for consideration include those relating to the process of implementation, the selected innovation, the context into which the innovation is being implemented and influencing factors, strategies and measures (Moullin et al., 2015). The process of implementation is commonly broken into different stages from choosing an innovation through to sustaining it in practice. The context into which the innovation is being implemented can be understood on different levels including the team, organisation and local environment to the greater external economic and political system. Influencing factors are sometimes described as determinants or constructs, and are known elements that enable or inhibit implementation. These elements could be characteristics of the intervention, the process, the context or the people. Strategies are mechanisms applied to factors related to implementing the innovation that are then assessed by measures to evaluate the effects of the implementation (Moullin et al., 2015). These core concepts create the building blocks for theories, frameworks, models and tools for the study or execution of implementation.

Theories, frameworks and models

A great number of theories, frameworks and models have been developed that incorporate different aspects of these core concepts of implementation to suit the setting or focus (Greenhalgh et al., 2005; Moullin et al., 2015; Nilsen, 2015). There is a blurring of definitions between theories, frameworks and models in the implementation literature and at times the term 'framework' is used to include all (Moullin et al., 2015). Nilsen (2015) suggests frameworks delineate the components of a phenomena, theories provide explanations of phenomena and models describe a phenomena in a deliberate simplification. As consistency of terminology is challenging, the purpose for which they were developed or used can also be illuminating. Nilsen (2015) categorised theories, frameworks and models as being developed and used for three purposes:

- i. *Describing and/or guiding the process of translating research into practice*, which has resulted in process models that give 'how-to' guides. One such model is the Knowledge to Action framework (Graham et al., 2006).
- ii. *Understanding and/or explaining what influences implementation outcomes*, which has resulted in the development of determinant frameworks and implementation theories. Determinant frameworks identify and describe factors that impact implementation and commonly create clusters under domains. These include the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), Scheirer & Dearing's (2011) generic conceptual framework for sustainability and the Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health

Service Delivery and Organisation developed by Greenhalgh , Robert, Macfarlane, et al. (2004).

- iii. *Evaluating implementation*, which has resulted in the development of evaluation frameworks and models that identify aspects of implementation that could be utilised to measure or monitor implementation outcomes. One such model is the National Health Service (NHS) Sustainability Model (Maher, Gustafson, & Evans, 2007).

Some frameworks have multiple purposes such as the Active Implementation Frameworks (Fixsen et al., 2005). This framework aims to guide the implementation process (Blase, Dyke, Fixsen, & Bailey, 2012), describe the determinants (core implementation components; Fixsen et al., 2009) and provide evaluative tools, such as *Stages of Implementation Analysis: Where Are We?* (Blase, van Dyke, & Fixsen 2013) and *Implementation Drivers: Assessing Best Practices* (Fixsen , Blase, Naoom, & Duda, 2015).

Moullin et al. (2015) suggested that as the frameworks, theories and models differ in focus and are commonly designed to target specific concepts within implementation (stage, domain or determinant), more than one framework, theory or model may be required to fit a particular application to cover the range and depth of concepts needed.

More than an outcome/distinct entity

Within theories, frameworks and models of implementation science, the focus on sustainability has been scarce and tended to be viewed solely as an outcome of an implementation process (Greenhalgh, Robert, Bate, et al., 2004; Greenhalgh et al., 2017; Proctor et al., 2015).

This has arisen, in part, due to the traditional model of intervention development that has followed a process of developing evidence-based practices through rigorous efficacy trials under research conditions before being translated into real-world settings using implementation frameworks or models. Effectiveness of both the intervention and the implementation strategy is commonly studied while controlling for the context, with sustainability as an outcome of the implementation process (Chambers et al., 2013; Hawe, 2015; Proctor et al., 2015).

Greenhalgh et al. (2005) found that the process of assimilation (defined as adoption at the collective level i.e. team or organisation) was an organic, messier course of moving back and forth through stages, punctuated by various unpredicted setbacks, surprises and shocks. This more fluid thinking about sustainability considers that, due to a range of complex reasons, the process can pause, slow or even stop at different times but the trajectory might not be lost completely. As a result, the capture of the extent and quality of sustainability is important (Hunter et al., 2017) and some

suggest that sustainability be understood as a continuum, requiring continued effort to support the journey through changing contexts (Chambers et al., 2013; G. P. Martin et al., 2012; Van de Ven, 2017).

Stirman et al. (2012) argued for sustainability to be studied as a phenomenon distinct from being solely an outcome of an implementation process. Rather, they suggest that study of sustainability should explore the long-term use of the innovation within its context and take into account its integration into current practice, adaptations made and its ability to continue to achieve desired outcomes (Stirman et al., 2012).

Complexity

Greenhalgh et al.'s (2005) seminal review of diffusion, spread and sustainability of health innovations found few studies set out to study implementation and sustainability in their complexity. Instead, most chose to focus on a few determinants/factors in isolation from their context. There is, however, a growing call to see the context as essential to the development of both useful interventions and successful implementation strategies (Chambers et al., 2013; Chambers & Norton, 2016; Greenhalgh et al., 2005; Hawe, 2015). Greenhalgh, Robert, Macfarlane, et al. (2004) argued that in controlling the broader context into which the innovation is being implemented, studies miss vital parts of the picture that might lead to the success or otherwise of the innovation's implementation. Furthermore, Chambers et al. (2013) argued that sustainability was the result of continuously adjusting the fit of the intervention and organisation at multiple levels, rather than as the end of a translation process.

Supporting this view is the idea that health organisations are complex self-organising systems, made up of systems within systems that interact in unpredictable continuously changing ways (Plsek & Greenhalgh, 2001; Shiell et al., 2008). Working with this lens leads to exploration of sustainability as a process to understand the interplay between the system and the innovation being implemented, rather than various factors on their own (Stirman et al., 2012). This ecological approach to research is recommended by Greenhalgh, Robert, Macfarlane, et al. (2004).

Additionally, as discussed in more depth in the next chapter (Chapter 4), the body of research on implementation of family work in AMHS identifies multiple layers influencing implementation and sustainability (Eassom et al., 2014; Maybery et al., 2016). As a result, a multifaceted view is suggested as necessary to enable sustainable change (Fadden, 2006; Isobel, Allchin, et al., 2019; Maybery, Foster, et al., 2015). A lens of complexity leads this research on sustainability of Let's Talk to look at outcomes on multiple levels that can account for the context.

Fidelity

Hawe (2015) and Chambers et al. (2013) also argued that the terminology of translation and dissemination, and the traditional model of intervention development and implementation, assumes that evidence-based practices are optimised prior to implementation in controlled settings and that any alterations are a threat to intervention effectiveness. Such assumptions can result in interventions that are effective under controlled conditions but are unable to fit the complex, evolving systems of real-world settings or produce the promised benefits for clients, practitioners or the setting (Chambers et al., 2013).

Chambers et al. (2013), alternatively suggested that to enable sustainability, evidence-based practices needs to be optimised in context and be seen as a recursive process of continual development, evaluation, and refinement. Adaptations within this view might then be seen not as threats to fidelity, but what is required to enhance outcomes while also supporting sustained use (Chambers et al., 2013; Hawe, 2015).

This dance between the fit and fidelity of interventions is acknowledged in the literature as a challenge for implementing evidence-based practices (Dearing, 2008; Hawe, 2015). On one hand, the faithful delivery of an intervention is important for the delivery of its associated benefits. On the other hand, the adaptation of an intervention to fit the setting or the intended population is important for its sustained use (Dearing, 2008).

Understanding how an evidence-based practice works can enable the delivery of what is essential for the outcomes, while still adapting it to fit the context (Dearing, 2008). Understanding what is essential to the evidence-based practice's outcomes is variously described as core functions (Patient-Centered Outcomes Research Institute, 2019), core components (Blase & Fixsen, 2013) or critical ingredients (Bond et al., 2000). These articulate the purpose of the intervention's activities and how the activities create the desired change and as such describe the core mechanisms of change (Kirk et al., 2019). When these are clearly understood and communicated, it is argued that the intervention's activities or forms (Kirk et al., 2019) can be tailored to fit the context while still delivering the core mechanisms and thereby not compromising the effectiveness of the evidence-based practices (Dearing, 2008).

Defining these core mechanisms of change for interventions, however, is neither easy nor common (Blase & Fixsen, 2013). Program manuals or protocols more commonly articulate the intervention's activities or forms and program developers may not have defined all the core mechanisms that produce the desired outcomes (Blase & Fixsen, 2013; Kirk et al., 2019). To work within this reality, Braithwaite et al., (2018) suggest that measurement of effective adaptation in an iterative fashion

may be helpful. Consequently, measuring sustainability of an intervention needs to look beyond the continued practice as manualised. Sustainability measures also need to attend to modifications, as without these a key sustainability outcome might be missed (Stirman et al., 2012). This suggests that this research on sustainability of Let's Talk needs to understand what modifications were made to Let's Talk and why these were made.

Key influencers of sustainability

As factors related to the planning and execution of implementation contribute to sustainability, there is overlap between factors that influence initial implementation success and those influencing sustainability (Lennox et al., 2017). Factors that appear to particularly influence sustainability have been identified as factors in the domains of the organisational and wider context, the innovation itself, the process of implementation and the setting's capacity to sustain (Damschroder et al., 2009; Stirman et al., 2012).

3.3 Measuring sustainability

Multifaceted measurement is important for sustainability to ensure that the intended impact is being measured. An intervention continuing to be delivered is of no use unless it provides the promised benefits. A policy or training program is of no use if it does not equip practitioners to faithfully deliver the program.

The definitional measure of sustainability described by Shediak-Rizkallah and Bone (1998) has been identified as the basis of most studies on sustainability (Scheirer & Dearing, 2011; Stirman et al., 2012). This definition describes three areas of measurement: if beneficial services are being delivered to clients, if the intervention is maintained in an identifiable form (albeit modified), and if the organisation has the capacity to deliver the intervention after the initial implementation. Stirman et al. (2012) summarised these measures as continued benefits, continued practice and continued capacity.

As the continued benefits of Let's Talk for parent-consumers and their families is part of the study in the RCT (Maybery et al., 2017), this aspect was outside the scope of this research. Instead, this research focused on i) continued practice of Let's Talk by practitioners, as defined by practitioners still delivering the core elements of Let's Talk with parent-consumers, and ii) continued capacity of the organisation to support Let's Talk practice, as defined by having organisational systems and structures in place that support practitioners to faithfully deliver Let's Talk.

The measurement of continued practice and continued capacity was guided by frameworks, models and tools from the implementation science literature as discussed below.

3.4 Frameworks, models and tools shaping this research

Two main frameworks guided the exploration of the research. As the evidence for Let's Talk is still emerging, there are many unknowns about factors that are critical for implementing and sustaining it. A determinant framework, the CFIR (Damschroder et al., 2009), was chosen to guide the research as it captures a comprehensive range of constructs to consider (refer to Figure 2). To give direction for how these constructs can aid sustainability, Scheirer and Dearing's (2011) generic conceptual framework for sustainability was additionally selected (see Figure 3). This framework identifies independent and dependent variables relevant to sustainability and proposes relationships between constructs.

As neither of these frameworks included tools for evaluation, evaluative tools from other frameworks and models were selected to support the development of tools for the individual studies that contribute to this research. Two assessment tools from the Active Implementation Frameworks – *Stages of Implementation Analysis: Where Are We?* (Blase et al., 2013) and *Implementation Drivers: Assessing Best Practices* (Fixsen et al., 2015) – were selected for their applicability to the focus of the study. An evaluative tool in the Sustainability Model (Maher et al., 2007), with its focus on practical application, also contributed to the development of the measure of organisational capacity in Phase two (Study 3).

Each of these frameworks, models and tools is discussed in more detail below.

Consolidated Framework for Implementation Research (CFIR)

The CFIR endeavoured to consolidate the key constructs from published implementation theories (Damschroder et al., 2009). It distilled the constructs into five domains: intervention/program characteristics, outer settings, inner settings, characteristics of the individuals involved, and the process of implementation (Damschroder et al., 2009). Each of these five domains has varying numbers of constructs and sub-constructs. The result is a detailed framework that enables researchers to drill down and finely examine different areas. The framework itself does not propose any theories about relationships between constructs, other than indicating they are interrelated. Through the consolidation of constructs, the CFIR aims to promote theory development and verification about what works where and why (Damschroder et al., 2009). The developers were not advocating for all domains or constructs to be examined, but for the researcher to decide which components are most important to shed light on their current work. This framework was used in the RCT (Maybery et al., 2017) to frame semi-structured interviews of leaders and implementers.

For the review of key elements for sustainability for Let's Talk, this framework, with its detailed identification of constructs, gave clarity about components to examine. A conceptual map applying these CFIR constructs to the existing RCT (Maybery et al., 2017) identified what was known and provided a structure to consider questions that would frame the investigation in this research. These are outlined in Figure 2.

Scheirer & Dearing's (2011) generic conceptual framework for sustainability

Scheirer and Dearing's (2011) generic conceptual framework for sustainability was developed to guide the research and evaluation of health program sustainability by providing definitions and measures. Based on the literature, they proposed that measuring a program's continuation gave a limited understanding of sustainability and detailed six conceptualisations of sustainability outcomes: i) continuation of benefits for clients, ii) continuation of program activities; iii) continuation of partnerships developed, iv) maintaining new organisational policies or practices, v) sustained attention to the issues and vi) program diffusion or replication.

Hypothesised relationships between these potential sustainability outcomes and three clusters of factors identified to affect sustainability were drawn into a conceptual framework as seen in Figure 3. The three clusters included factors relating to the characteristics of the intervention, factors in the organisational setting and factors relating to the wider environment. These factors affecting sustainability were suggested to be impacted by the intervention and the organisation's capacity, prior relationships and partnerships (known as *inputs* in the framework). The availability of financial resources is additionally identified as impacting the factors influencing sustainability.

The framework posed questions pertinent for this research's understanding of sustainability of Let's Talk, creating a structure for identifying what is important for sustainability of Let's Talk in AMHS.

The following questions were developed through the use of this framework (also see Figure 3):

- What was the prior organisational capacity and how might that have influenced its ability to sustain Let's Talk?
- What access to resources has been needed for Let's Talk and how has that been achieved?
- What accommodating changes were made within the organisation in response to implementing Let's Talk?
- What adaptive processes are there between Let's Talk, the organisation and the environment?
- How has the social, policy, financial and environmental context influenced sustainability of Let's Talk?

Active Implementation Frameworks/National Implementation Research Network (NIRN) assessments

The Active Implementation Frameworks were initially based on a synthesis of the literature by Fixsen et al. (2005) which was further developed by the National Implementation Research Network (NIRN) into an integrated approach supporting implementation of evidence into practice. It represents a comprehensive set of frameworks that cover the development or identification of innovations, implementation drivers, implementation stages, improvement cycles and implementing teams. Within the frameworks there are practical tools for the process of implementation (Blase et al., 2012) as well as tools for evaluation that can be used by an implementation facilitator leading an implementation team during the process of implementation.

While the frameworks are designed as a coordinated approach to steer implementation rather than to retrospectively evaluate an implementation plan, two assessments provided guidance for this research. Prompts and questions from the Stages of Implementation Analysis: Where Are We? (Blase et al., 2013) and the Implementation Drivers: Assessing Best Practices (Fixsen et al., 2015) contributed to the development of the organisational audit that was used for assessing organisational capacity in Phase two (Study 3). These assessments enabled the research to capture detail on the process of engagement and implementation, and in identifying drivers used by the AMHS during the RCT and currently.

Sustainability model

The Sustainability Model and Guide (Maher et al., 2007) was developed by the National Health Service (NHS) in the UK, as a self-assessment tool to support healthcare leaders to implement and sustain effective improvement initiatives. It identified 10 factors that increase the likelihood of sustainability and continuous improvement, clustered under three domains: process, staff and organisation (Doyle et al., 2013; Maher et al., 2007). The factors were derived from literature, healthcare experts and staff within the NHS, using a coproduction approach (Doyle et al., 2013; Maher et al., 2007). The guide was designed to be used by a team at three different points in the process of implementing a specific intervention: the planning, initial piloting and soon after improvement has been implemented. Each factor is scored based on one of four statements represented by a weighted numerical score for each level that are then entered into a master score system.

Whilst it has been criticised for its complexity and lack of focus on the outer context (Doyle et al., 2013), it was chosen for use in this research for its ability to identify measures of aspects of

sustainability in a language that could be translated to practice. A selection of these factors guided the development of the organisational audit in Phase two (Study 3).

Figure 2. Consolidated Framework of Implementation Research (CFIR; Damschroder et al., 2009) as applied to Let's Talk RCT (Maybery et al., 2017)

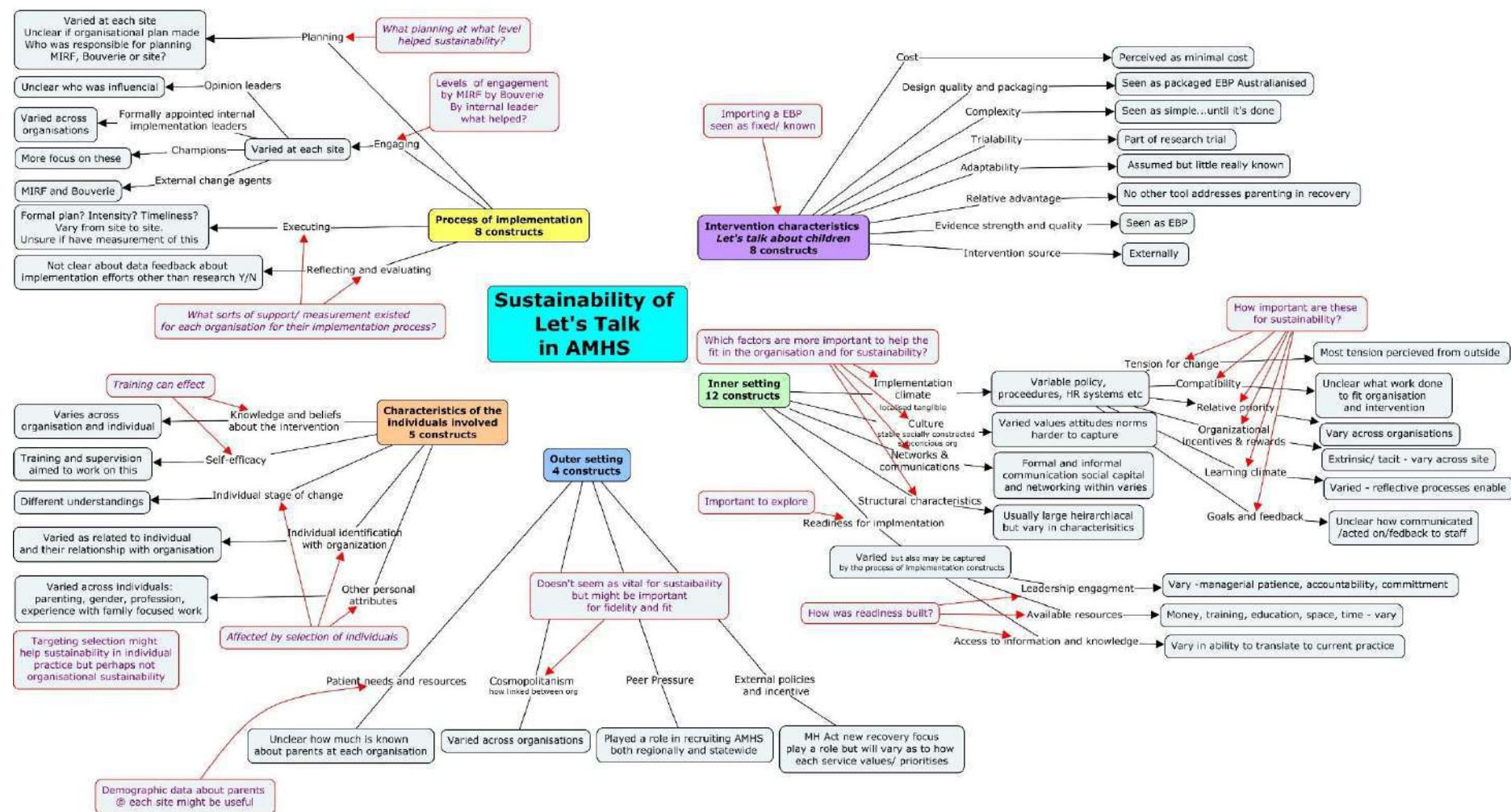
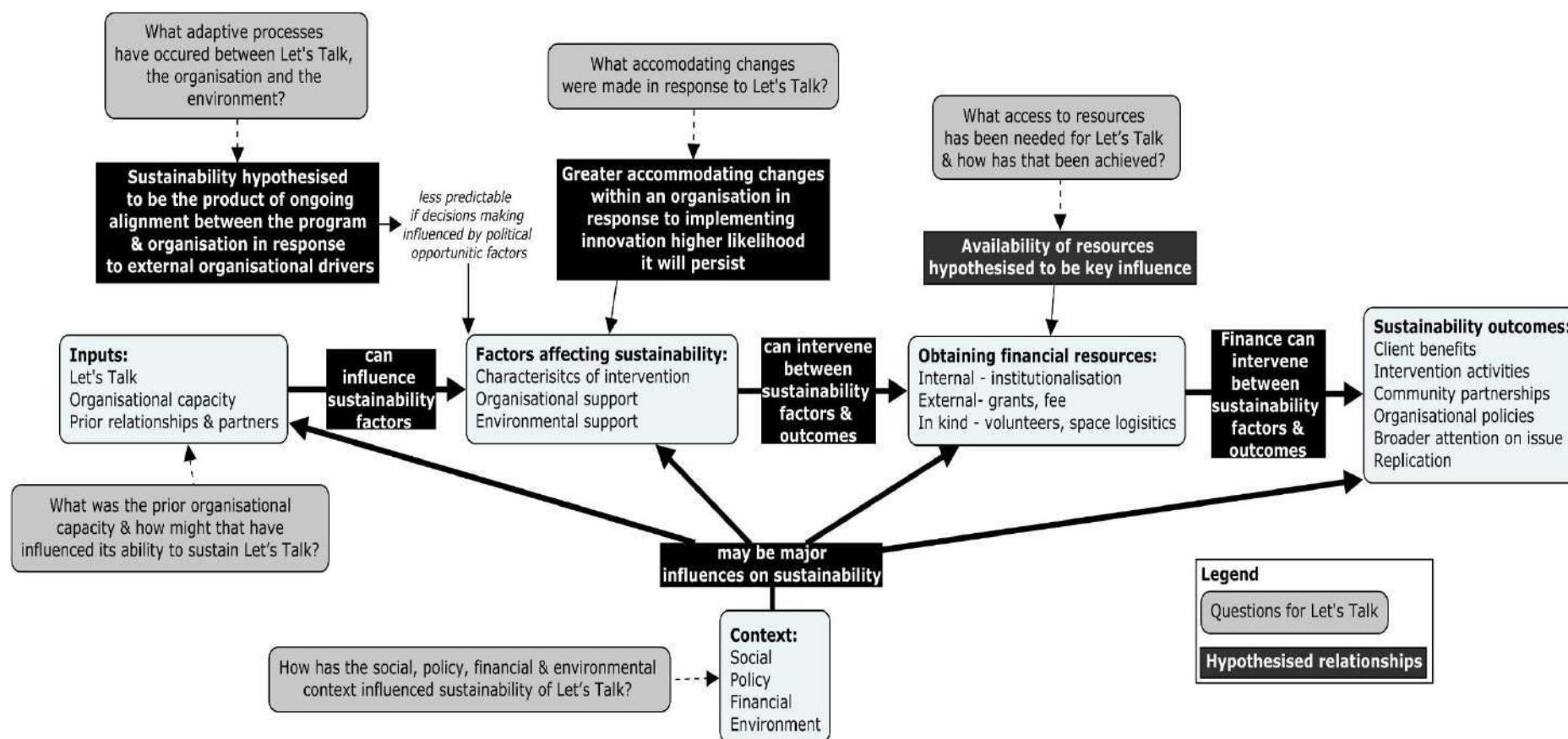


Figure 3. Scheirer & Dearing's (2011) generic conceptual framework for sustainability applied to Let's Talk



3.5 Conceptual lens summary

This chapter is the third of five chapters that form the first section of the thesis. The previous two chapters outlined the context (Chapter 1) and defined the foundational paradigm (Chapter 2) for the research. Building on these, this chapter explained the lens for understanding sustainability used in this research.

This chapter identified the importance of the context for the study of sustainability and the need to use a method that allows for exploring complexity. Multifaceted measurement with theoretical underpinning is recommended. Sustainability needs to be measured by more than the existence or not of the intervention. Rather, measurement of the presence and extent of the intervention's core elements, including the identification and explanation of adaptations made, is required. Additionally, consideration of the setting's capacity to support the continued delivery of benefits is important.

Applied to this research, investigating the sustainability of Let's Talk will need to understand the context of the implementation process and the organisational capacity of the eight AMHS to support the practice. A clear understanding of the core elements of Let's Talk and its mechanism of change will need to be established before being able to measure the extent these elements and any adaptations are present in the eight AMHS.

In the next chapter (Chapter 4), the literature on Let's Talk is presented within the context of on family-focused practice in mental health, exploring what is known about its core elements and mechanism of change. This is the last chapter that lays the foundation for the research design. Chapter 5 then draws together these four foundational chapters to outline the research aims and methodology in detail.

Chapter 4 A review of the literature: Let's Talk and its place in family-focused practice in mental health

This is the fourth of five chapters that lay the foundation for the research of this thesis. Following the previous chapters on the context (Chapter 1), the theoretical paradigm (Chapter 2) and the conceptual lens for understanding sustainability (Chapter 3), this chapter presents the literature on Let's Talk explored within the context of family-focused practice in mental health.

Using seminal texts and key literature, as well as recent reviews from the field, a brief summary of the literature on family-focused practice in mental health presents the bidirectional relationship between mental illness and families before giving an overview of family work in mental health. A literature review of Let's Talk is then presented as situated within this concept of work with families in the mental health field. Key literature on Let's Talk was sourced through Google scholar, Psycinfo and Medline databases. Additional peer-reviewed and grey literature was found through "snowballing techniques" (Greenhalgh & Peacock, 2005) and direct contact with Let's Talk developers and implementers across the world. Given so few articles were published, no exclusion criteria was applied except being published in English and that it met the criteria of being related to the implementation and sustainability of Let's Talk. This chapter has been updated as the thesis has developed.

The purpose of Let's Talk is to promote family mental wellbeing while also mitigating and/or preventing mental health issues for both parents and children (Solantaus & Toikka, 2006). Consequently, Let's Talk is discussed as fitting into the broader category of family work that focuses on early intervention. The study of sustainability requires consideration of the 'what' that is being implemented, to whom, by whom and within what setting. For that reason, this chapter explores Let's Talk following its development, presenting a summation of its evidence as well as unpacking the contextual nature of the evidence base, and how fidelity is currently understood. Let's Talk, like many other evidence-based interventions (Kirk et al., 2019), does not as yet have the mechanisms that make it effective clearly defined, and as a result, this chapter describes a broad base of literature to develop a clear frame for the exploration of what might support sustainability of Let's Talk in AMHS.

4.1 Family-focused practice in mental health

Mental illness and families

Mental illness has the potential to interrupt relationships. Mood changes, disordered thinking and disturbed perception can impact function and may result in changed behaviour such as social withdrawal, lowered motivation, poor self-care, irritability and unusual actions. Such changes can be difficult for the person and those around them to fully comprehend. This can lead to complicated communications, greater potential for misunderstandings and relational disengagement (Solantaus & Toikka, 2006; Solantaus et al., 2009). Treatment and the recovery process can interfere with establishing and maintaining relationships. The absences created by hospital admissions (McKay, 2004) and the focus on one's own recovery needs (Awram et al., 2017) can make relationships within families more difficult to maintain and keeping in contact with people outside immediate family challenging. Relationships are further impacted by stigma. Negative community attitudes about the value and capability of people with mental illness lead to self isolation or other's withdrawal, shrinking the social networks of people with mental illness and their family members (Larson & Corrigan, 2008; Reupert & Maybery, 2015). Added to this, the self-stigma they also experience can lessen their willingness to seek help and silence communication within the family (Hinshaw, 2004; Riebschleger et al., 2014).

The impact of mental illness is often felt the most in the complex network of intimate relationships, with higher rates of social isolation and poorer quality of life for the family caregivers (Bland & Foster, 2012; Hayes et al., 2015; Weimand et al., 2013). Within families, children are the most vulnerable to disruptions in family life. The parent-child relationship is the foundational frame of reference for the child's interpretation of the world. It is within these relationships that their development occurs and their wellbeing is shaped (Isobel, Goodyear et al., 2019; Martinsen et al., 2019; Solantaus et al., 2015; Thompson, 2014).

Although estimating the prevalence of parenthood for people with mental illness is challenged by differing definitions and data collection methods (Maybery, Nicholson, & Reupert, 2015), rates are similar to those without mental illness across the globe (Biebel et al., 2004; Bonfils et al., 2014; Ruud et al., 2019). In Australia, up to 23% of children are estimated to be living with at least one parent with a mental illness (Maybery, Reupert, Patrick et al., 2009; Reupert & Maybery, 2016). Not all of these families will have contact with AMHS, however, there are many who do. In a meta-analysis of international studies on prevalence of parent-consumers within AMHS, the range in most studies fell between 20.4% to 38.5% with two other studies identifying lower (12.2%) and higher (45%) extremes (Maybery & Reupert, 2018). Before 2000, however, the parenting role of people with

mental illness and the needs of their children were largely unseen by mental health services and had accordingly been under-represented in research and not considered in service delivery (Cowling, 1996; McKay, 2004; Nicholson, 2014)

Parenting is a significant life occupation (Diaz-Caneja & Johnson, 2004) and it can be both motivating and challenging for a parent's mental health recovery (Awram et al., 2017; Nicholson, 2010).

Parenting, while rewarding, involves the challenges of managing daily tasks and meeting children's needs which can put pressure on their recovery process (Awram et al., 2017; Perera, Short, & Fernbacher, 2014). At the same time, parenting can connect people with a mental illness to others in a normalising way (Diaz-Caneja & Johnson, 2004) and provide a positive sense of identity and motivation to stay well (Awram et al., 2017; Perera et al., 2014).

With the intertwined nature of parenting and mental health, family life can also be affected (Falkov et al., 2016). Many factors affect the dynamics of all families over time. The parent and child live within a social context that contributes to the shaping of family life. Children have different needs as they grow and develop that require different parenting skills and resources in different amounts of intensity. The interplay between child, parent and family in their social context is multidirectional; child wellbeing affecting parents and parent wellbeing affecting children (Naughton et al., 2019; Nicholson, 2014; Reupert, Maybery, & Nicholson, 2015). Similarly, social disadvantage decreases mental health and mental illness increases disadvantage for families (Funk et al., 2010; Reupert & Maybery, 2007).

Mental illness has the potential to confound the relational interplay and bring adverse outcomes in families, with low cohesion, poor communication, marital disharmony and separation, as well as interrupted parent-child relationships more common in families where a parent has a mental illness (Campbell et al., 2012; McFarlane, 2016; McKay, 2004; Reupert & Maybery, 2016). As well as the result of treatment such as hospital admissions or extended residential rehabilitation, parent-child relationships be interrupted when a parent loses custody of their. Parents with mental illness are more likely to have contact child protection services and lose custody of their children (Kaplan et al., 2019, Nicholson et al., 2001). Such interruptions are known to have long lasting psychological impacts on parents (Hine et al., 2018; Kenny et al., 2015; McKay, 2004) and significant health and wellbeing challenges for children (Kaplan et al., 2019; Nathanson & Tzioumi, 2007; Royal Australasian College of Physicians (RACP; 2006) creating further adversity within families.

Family functioning is affected less by the specifics of any disorder and more by the severity of symptoms, the time of onset and psychosocial adversities (Fudge et al., 2004; Reupert & Maybery, 2007). The degree the illness impacts daily life, through such things as redistribution of roles,

increasing caregiving, stigma and social disadvantage, affects the degree to which it impacts family functioning (Pedersen & Revenson, 2005; McFarlane, 2016).

This disruption that mental illness can bring to family life, and the potential of genetic transfer for some mental illnesses results in intergenerational vulnerability for children (Hosman et al., 2009). There is considerable evidence that these children are at risk of developing mental health difficulties and of disruption to their wellbeing more broadly (Beardslee et al., 2011; Hosman et al., 2009; Rutter & Quinton, 1984). As a group, compared to other children, they have poorer outcomes in the areas of psychological health, educational achievements, developmental outcomes and behavioural management that can continue into adult life (Reupert & Maybery, 2016). Within this group, however, there is diversity and not all children are impacted and those that are, are not impacted in the same way (Australian Infant Child, Adolescent and Family Mental Health Association, 2004; Mowbray et al., 2004; Solantaus & Toikka, 2006). While exposure to risks can result in adverse outcomes, the impact of adversity can be buffered by common protective processes such as reducing exposure or impact of risk, reducing the negative impact cycle, increasing self-esteem and self-efficacy, and promoting positive relationships (Resnik & Taliaferro, 2011; Rutter, 1999). Research on resilience highlights that resilience is however, not the simple balancing of risk and protective influences (Rutter, 2012; Ungar, 2012). It is, instead a dynamic multilayered process of interaction between the individual and their environment that does not assume linear relationships or universal outcomes (Rutter, 2012; Solantaus et al., 2015; Ungar, 2012).

Furthermore, Gladstone et al., (2006) advocate that the predominant narrative that leads to viewing children through a lens of risk or resilience diminishes the complex relationships in families marked by reciprocity and in doing so undermines children's agency in their own experience. Families where a parent has a mental illness also describe close bonds between parents and children marked by mutual caregiving and a development of maturity, social competency and empathy in children (Gladstone et al., 2011; Seeman, 2015; Solantaus-Simula et al., 2002).

As child outcomes are woven into family functioning, parent illness type is similarly less predictive of children's wellbeing than the impacts on the child and family's life caused by the multifaceted complexities noted above (Hosman et al., 2009; Reupert & Maybery, 2016; Rutter, 1987). As previously touched on, the research has concentrated on the mechanisms for these impacts and on mitigating factors that can provide buffers for children and promote wellbeing (Foster, O'Brien, & Korhonen, 2012; Reupert & Maybery, 2016; Solantaus et al., 2015; van Doesum & Hosman, 2009).

Family work and mental illness

Definitions and explanations

How mental health services relate to families of people with mental illness is described and defined in a range of ways that display a spectrum of family types, engagement and focus (Foster et al., 2016). The pyramid of family care developed by Mottaghipour and Bickerton (2005) suggests that family interventions, such as family therapy requiring specialised skills, are only needed by a few families. They also argue that the work of communication, collaboration and education is the foundational work at the base of the pyramid which is needed by all families and is within the scope of all AMHS workers. This work, sometimes called family inclusion (Wonders et al., 2019) or family involvement (Eassom et al., 2014), engages families directly in the treatment and care of the person with a mental illness.

Foster et al.'s (2016) review poses another way to consider work with families which is described as family-focused practices. Unlike family interventions, such as family psychoeducation (Lucksted et al., 2012; McFarlane, 2016), family-focused practices include both direct and indirect work with families encompassing approaches, programs, interventions, models and frameworks (Foster et al., 2016). Originating from work where the child was the consumer, family-focused practice incorporates working with the parent-consumer to support their children. Foster et al. (2016) suggest that a single conceptualisation of family-focused practices is complicated by lenses of 'family of origin' verses 'family of procreation' or 'family of choice' that have been used to describe family structures or types. These lenses have led to stressing different aspects to the work, with the emphasis in practices focused on family of procreation on prevention of intergenerational transmission of mental illness (Foster et al., 2016). They advocate for a 'whole of family' view that can encompass the parent-consumer's multiple family relationships. Family-focused practices, also known as family-centred or family-oriented practices, are the attitudes and actions of practitioners that stem from the beliefs that 'family', as defined by themselves, are a pivotal resource for each other (Foster et al., 2016). To encompass all of these concepts, the term 'family work' is used here in the broad sense of how services working with people with mental illness are mindful of, include and engage with families, including the needs of parent-consumers and children.

There is strong evidence that working with families can change the trajectory of the illness and improve recovery in adult mental health (Eassom et al., 2014; Falloon, 2003; Glick et al., 2011; Pitschel-Walz et al., 2001). Over more than 40 years, a great deal of research into developing and testing models for working with families affected by mental illness has occurred. Some of the principal models include behavioural family management, family psychoeducation and brief family educational models (Chakrabarti, 2011; McFarlane, 2016; Pharoah et al., 2010). This research

typically focused on schizophrenia, however some research has been done in how these models are applicable to other illnesses (Falloon, 2003; McFarlane et al., 2003). The focus of that research has also tended to be on the ‘family of origin’ of the person experiencing mental illness while the parenting role of the consumer and the needs of their children have not received specific attention. More recently, families where a parent has a mental illness, as a cohort of family-focused practice, have been gaining increasing attention of researchers and practitioners (Foster et al., 2016).

The two foci of family work in mental health services are to improve the outcome for the person with the mental illness and reduce distress in family members while building their resilience and wellbeing (Dixon et al., 2001; Mottaghipour & Bickerton, 2005; Wyder & Bland, 2014). Core elements include helping families understand mental illness, supporting the healing of relationships within families and building the networks of support needed by all family members. Mottaghipour and Bickerton (2005), in their pyramid of family care, advocate that family work can be integrated into everyday practice for all practitioners. With the provision of training, resources and organisational support, all practitioners can meet families’ needs for information, communication, and education on coping skills and dealing with crisis (Mottaghipour et al., 2006).

These understandings of family work in AMHS provide the parameters for family work focused on families where a parent has a mental illness. Maybery, Foster, et al. (2015) advocate that family-focused care for parents with a mental illness “respects the role of the family, and recognises the impact of the parent’s mental health on their parenting, children and other family members” (p. 303). In addition to the core elements above, parents with a mental illness and their children need services to attend to the parent-child relationships (Cooklin, 2013; Nicholson, 2010) and utilise effective prevention programs for improving outcomes for children (Marston et al., 2016; Siegenthaler et al., 2012). Effective interventions for this population include psychoeducation directed at both parents and children, adapting parenting behaviour to improve family functioning through increasing parent agency and skill building, and improving family communication particularly about mental illness (Marston et al., 2016). One of the interventions highlighted in these studies is Let’s Talk, which is explored in detail below.

Sustainability of family work

Despite the strong evidence base, family work in any form is not commonly integrated into standard practice in AMHS (Berry & Haddock, 2008; Fadden & Heelis, 2011; Maybery et al., 2016) and levels of contact between practitioners and families is low (Glynn, 2012). As discussed in Chapter 3, sustainability of an intervention requires practitioners to faithfully deliver it and organisational support for its delivery. Practitioners’ delivery of family work, has been explored in the literature as

rates of uptake and continued use after its introduction, and barriers for the reasons for poor uptake and use. Facilitators to the use of family work in AMHS has also been explored. These three aspects of measurement of sustainability are discussed below.

i. Uptake and continued use

Practitioner uptake of working with families is most commonly found in studies of the use of family interventions as part of treatment for schizophrenia. These studies note uptake rates varying from between 0 to 53% (Bucci et al., 2016). This range is in part related to the method in which data is collected with some collected through research using file audits, practitioner self-report measures and surveys of families while others using local self-auditing processes. Additionally, the lack of clarity as to what is being measured is suggested as a potential explanation for the variation, with some measuring families being offered an intervention, others focusing on practitioners delivering interventions or families receiving an intervention (Bucci et al., 2016; Ince, Haddock, & Tai, 2016).

Uptake and continued use data are scarce in studies of interventions specific for families where a parent has a mental illness. Only three studies provided rates of use across different interventions and settings. One of these was a pilot study of a parenting and mental illness psychoeducation program in the Netherlands that reported on promising levels of uptake with 59% of practitioners talking about parenthood (Potijk et al., 2019). However, this study only measured uptake at one time-point.

A longitudinal study in Norway is tracking uptake and continued use of two interventions, The Family Assessment Form and Child Talks, introduced to support the new legal requirement to identify and support children of patients in adult-focused services (Lauritzen et al., 2018; Reedtz, Lauritzen et al., 2012). They noted high (65%) use of The Family Assessment Form (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014b), with use increasing (72%) after two years in a follow-up study (Lauritzen et al., 2018). In contrast, 31% of practitioners offered the intervention Child Talks to support children, and 25% went on to deliver it (Lauritzen et al., 2014b) with no significant increase after two years in the follow-up study (Lauritzen et al., 2018).

In another study in Finland, participants (n=35) who were chosen to be trainers in the Effective Child and Family intervention suite were tracked for six months after training finished to find they all had started using the interventions in their work (Toikka & Solantaus, 2006).

The differing contexts, time studied or implementation strategies applied may help to understand the variations in these uptake rates. Comparison is also made difficult due to the lack of clarity in what is being measured. Ince et al. (2016) suggested clearer reporting procedures that differentiate

between services being offered and those being delivered would support future comparison and implementation efforts.

ii. Barriers

Alongside examining practitioner uptake, studies have also explored the barriers to the use of different types of family work in AMHS (Berry & Haddock, 2008; Fadden & Heelis, 2011; Maybery et al., 2016). Common barriers have been identified in a number of interrelated domains relating to the practitioner, the organisation, the intervention and the family.

Practitioners' lack of skill, knowledge and confidence to engage in family work has been highlighted in numerous studies with a suggestion that their undergraduate training inadequately equips them for engaging families (Bucci et al., 2016; Fadden, 2006; Grant et al., 2019; Maybery et al., 2016; Michie et al., 2007). The ability to engage with and hold the needs of multiple family members simultaneously has been identified as a particular skill and confidence barrier for AMHS practitioners' uptake of all types of family work (Fadden, 2006; Karibi & Arblaster, 2019; Tchernegovski et al., 2018; Weimand et al., 2013). Additionally, barriers are noted that are specific for working with families in which a parent has a mental illness. The practitioners' limited attention to the importance of the role of parenting and its interaction with mental health excludes it from practitioner-parent interactions (Awram et al., 2017; McKay, 2004). Practitioners' lack of understanding of the possible impacts of mental illness of children, and their lack of skill in directly engaging a parent-consumer to effect change for their child are also noted as barriers (Maybery & Reupert, 2009; Tchernegovski et al., 2018). The work with this population is further complicated by practitioner perception that talking about parenting and children is a sensitive topic (Solantaus et al., 2009).

Organisational and system barriers to family work are seen in a lack of prioritisation in leadership, policy, service design and funding. These barriers then limit access to time and resources to support and monitor practice or do not foster cultures that support delivery of family work (Bucci et al., 2016; Fadden, 2006; Grant et al., 2016; Grant & Reupert, 2016; Karibi & Arblaster, 2019; Maybery, Foster, et al., 2015). Intervention related barriers pertain to its perceived value, its fit with the intended population or the organisational setting (Ince et al., 2016).

Lastly, barriers relating to families' own reluctance to take up opportunities to engage with practitioners is documented as being influenced by their time limitations, the relationship with the person with the mental illness, as well as their own or others' previous experiences of family work in AMHS (Berry & Haddock, 2008; Glynn, 2012; Ince et al., 2016; Maybery, Foster, et al., 2015). A historical view of family being the source of the onset of mental health problems can leave families

worried about being blamed and reluctant to engage with mental health services (Falloon, 2003; Glynn, 2012, Smith & Velleman, 2002). Parent-consumers have additional barriers when it comes to engaging with practitioners about their families. As noted earlier, the self-stigma about their capability to parent well reduces their likelihood to seek help for themselves or their children. Furthermore, the high prevalence of parents with a mental illness having contact with child protection services and experiencing the removal of their child, make parents more likely to protect their family from the view of professionals for fear of loss of custody (Kaplan et al, 2019; Nicholson et al, 2001; Maybery & Reupert, 2009).

An additional barrier for the delivery of family work specifically focused on families where a parent has a mental illness is the configuration of services. The work of AMHS is with adults, focused on the mental illness and executed through an individualistic paradigm (Ackerson, 2003; Biebel et al., 2015). The wellbeing of children, conversely, is seen as the domain of family and child focused services. For AMHS to attend to the needs of their consumers as parents and their children, Solantaus and Puras (2010) suggest that funding models and practice has to expand to prioritise prevention, health promotion and families. Subsequent literature suggests that there is growing awareness of the challenges that this poses and a shift is being seen to promote family-focused work in government and service provider policy and practice guidelines (Foster et al., 2016; Goodyear et al., 2015; Isobel, Allchin, et al., 2019; Nicholson et al., 2015). Despite this, there still remain significant challenges for AMHS to embrace practices that support parents with a mental illness and their children in standard practice (Maybery et al., 2016). Implementing such family work in AMHS requires attention to the complexity of both the work and the service system.

iii. Facilitators

Common elements that facilitate implementation of family work in AMHS have been identified in the domains of the organisation, the implementation process, the practitioner and the family (Berry & Haddock, 2008; Eassom et al., 2014; Maybery, Foster, et al., 2015). Organisational engagement and a match with its mission, values and activities has been advocated as pivotal for implementing family work (Berry & Haddock, 2008; Eassom et al., 2014; Maybery, Foster, et al., 2015).

By supporting senior management to show strong leadership, prioritisation within the dominant medicolegal focus enabled family work to be delivered (Berry & Haddock, 2008; Eassom et al., 2014). Prioritisation was also enabled through the integration of family work into job descriptions, staff appraisals, organisational policies, plans and reporting (Berry & Haddock, 2008; Eassom et al., 2014; Maybery, Foster, et al., 2015).

An implementation process that included management, practitioners and people with lived experience in the design, development and delivery of family work, decreased family resistance and encouraged its delivery (Berry & Haddock, 2008; Fadden & Heelis, 2011). Having key people across different levels of the organisation supporting implementation was also seen as important (Berry & Haddock, 2008; Bucci et al., 2016; Fadden, 2006). Such key roles included practice level champions, providing peer support for implementing practitioners, and internal implementers or coordinators to liaise between practitioners and managers as well as carrying out tasks such as writing policies, overseeing training and liaising with management (Berry & Haddock, 2008; Bucci et al., 2016; Fadden, 2006). Multifaceted implementation strategies that target the different layers of factors (organisational, workforce, child and family) are suggested to enable workforce change to incorporate family work (Isobel, Allchin, et al., 2019; Maybery, Foster, et al., 2015).

The skills and confidence of practitioners to deliver family work was facilitated by focused training that included people with lived experience, and post-training support. Methods such as consultations, reflective practice, supervision and co-work supported practitioners in maintaining a dual focus of the needs of different family members (Berry & Haddock, 2008; Bucci et al., 2016; Karibi & Arblaster, 2019; Tchernegovski et al., 2018). Additionally, practitioners' use of family work specifically with families where a parent has a mental illness, was facilitated by being a parent themselves (Grant et al., 2019; Korhonen et al., 2010) and by understanding the impact a parent's mental illness can have on children (Goodyear et al., 2017; Grant et al., 2016; Lauritzen et al., 2014a; Maybery et al., 2016).

Families engaging in working with practitioners was facilitated by an awareness of the opportunity or availability of a service that was a good fit for the family's needs (Fadden, 2006; Wonders et al., 2019). Family uptake was also aided when the family work was co-developed and/or delivered in collaboration with lived experience (Berry & Haddock, 2008). In light of the history of family blaming, stigma and child removal, feeling safe and positive about engaging in family work with AMHS is an additional facilitator of engagement, especially for parent-consumers and their families (Berry & Haddock, 2008; Pihkala et al., 2012; Solantaus et al., 2015; Ueno et al., 2019).

This research in AMHS on the uptake, barriers and facilitators across the spectrum of family work is an important backdrop for the study of sustainability of Let's Talk in AMHS. The following section outlines the development of and evidence base for Let's Talk to establish a clear understanding of what it is and the context in which it has been used, so as to lay a foundation for the study of its sustainability in AMHS, in Victoria, Australia.

4.2 Introducing Let's Talk

The Finnish, *Lapset puheeksi*, or in English, Let's Talk about Children (Let's Talk), is a family-focused practice with a specific emphasis on the parenting role and the needs of their children. It is described as a "low threshold public health intervention" (Solantaus et al., 2015, p. 243) because it is brief, low resource-intensive and has been applied in different settings (Beardslee et al., 2012; Solantaus & Toikka, 2006). It has been translated and utilised across a range of countries and cultures including Sweden, Greece (Giannakopoulos et al., 2015;), Japan (Ueno et al., 2019), Australia (Goodyear et al., 2016; Karibi & Arblaster, 2019; Maybery et al., 2019) and the USA (Nicholson & English, 2019). While there is a growing evidence base for its efficacy and adaptability, a clear understanding of the mechanisms of change that make Let's Talk effective is yet to be articulated. In the absence of this, the study of sustainability of Let's Talk therefore requires a contextual view of its development, its evidence base and how fidelity is currently understood. By looking at the context around the delivery of the manualised tasks, a clearer picture can be gained of how practitioner, organisational and cultural factors might contribute to Let's Talk's effectiveness and sustainability. The next section unpacks the conceptual and contextual base from which Let's Talk developed and includes a description of the different forms of Let's Talk that are reported in the literature. After this, a synopsis of the evidence base is presented before each study is detailed to understand its contextual nature. Finally, the documentation of fidelity is explored and discussed after which the chapter ends with a summary of how this information shapes the methodology for the study.

Background and development

Let's Talk was part of a promotive and preventative approach to child wellbeing that was introduced across Finland into mental health services for adults in 2001 (Solantaus et al., 2009). The Effective Child and Family (ECF) program (in Finnish *Toimiva lapsi & perhe -työ*) aimed to equip health services to meet the minimum standards of the Finnish Child Welfare Act to address dependent children's need for care and support (Solantaus & Toikka, 2006; Solantaus et al., 2009). It included a suite of tools as documented in Table 2. Foundational training of 17 days each year for two years was initiated to equip the Finnish mental health workforce to deliver the ECF (Beardslee et al., 2012; Solantaus & Toikka, 2006). This training gave a basic background to the impacts of mental illness, parenting, family life and child development, and included training in the ECF program's whole suite of interventions as well as implementation and supervision (T. Solantaus, personal communication, Feb 13 2020). The basic ECF training was later refined to 11 days over one year including six days for theory and five for supervision of practice (Niemelä et al., 2010). The training covered the suite of

Table 2: Effective Child and Family program's suite of tools

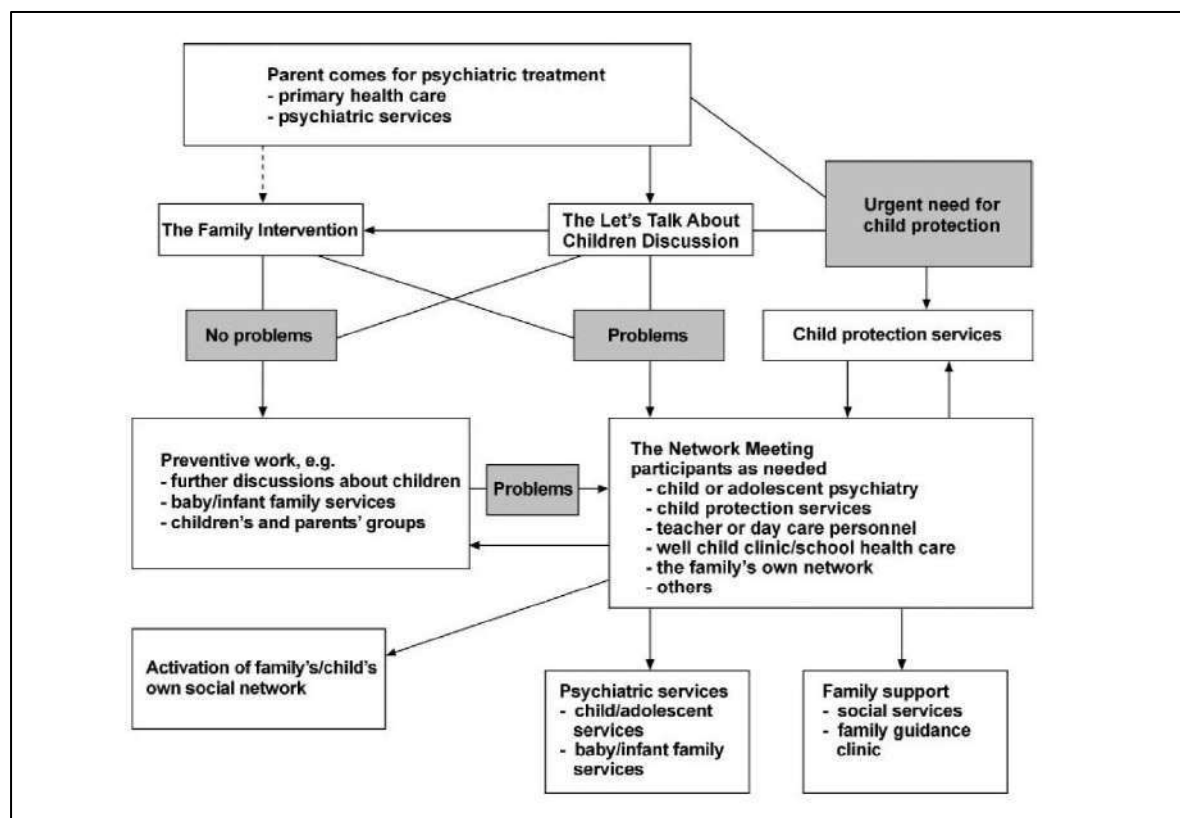
ECF suite of tools ^a	Purpose	Details
Let's Talk about Children Discussion (LT-D)	Map child's life & develop an action plan to promote child's wellbeing	2-3 structured conversations between parent & practitioner. These include an invitation, and two structured conversations using an age-appropriate log (Niemelä et al., 2010)
Let's Talk about Children Network meeting (LT-N) also known as Effective Family Network meeting (EFN)	Build a network around the child & family	Parent & practitioner identify people to help facilitate wellbeing of the child i.e. family's own network of supports & services such as child psychiatry, school, housing (Väisänen & Niemelä, 2005).
Information booklets for parents & young people (Solantaus & Toikka, 2006).	Self-guided psychoeducational material	<p><i>How can I help my children?</i> A guidebook for parents with mental health problems or issues (Solantaus 2002)</p> <p><i>How can I care for my children?</i> A guidebook for parents struggling with drug or alcohol use (Solantaus 2010)</p> <p><i>What's up with our parents?</i> A guidebook for young people whose parents have a mental health problem (Solantaus 2005)</p>
Family Talk Intervention (FTI) also known as The Effective Child & Family Intervention (ECFI)/Beardslee Family Intervention, Family Intervention, Preventive Family Intervention (PFI) or Let's Talk Family intervention	Facilitated family conversations by practitioner	A 6-8 session practitioner-led intervention that facilitates conversations between parents and children about the impact of the mental illness on family life (Beardslee et al., 1993)
Vertti child and parent group activities ^b	Peer support group program	A 10-week parallel peer support psychoeducation group for children and their parents (Söderblom & Inkinen, 2018)
^a information and links to training can be found at https://mieli.fi/en/development-projects/effective-child-and-family-work		
^b ECF training does not include training in this program		

ECF interventions as well as recognising common problems in children and youth's psychosocial wellbeing (Niemelä et al., 2010).

Initiated for use in adult psychiatry, by 2003 the ECF program was extended to physical health settings and general hospital psychiatry supporting families affected by parental cancer (Niemelä et al., 2010), physical health, substance use problems, economic problems, poverty, criminality by 2011 and refugee status by 2013 (Beardslee et al., 2012). Its acceptability in Finland led to the publishing of recommendations for health services on promotive activities for children of parents with a mental illness as well as the defining of pathways for children and families in AMHS – see Figure 4. (Solantaus, 2005; Solantaus & Toikka, 2006).

Let's Talk was developed as a brief parent intervention that met the requirements of the Finnish law. As such, it could serve as 'practice as usual' for an active control alternative to a more resource intensive preventative family intervention called Family Talk Intervention (FTI; Beardslee et al., 1993; Solantaus et al., 2010). Let's Talk was created to fit a health system with limited capacity to provide intensive family treatment for all consumers who were parents (Solantaus & Toikka, 2006). So as to be used in adult-focused services, Let's Talk was designed to be delivered by professionals with no experience or training in child development and assessment in the course of their ordinary work (Solantaus & Toikka, 2006).

Figure 4. Pathway for children and families in adult psychiatry in Finland. Reproduced from Solantaus & Toikka, 2006, p.42. Used with permission from Taylor & Francis.



Let's Talk takes an ecological understanding of child resilience and wellbeing that sees the child in the context of their relationships with their environment (Solantaus et al., 2015). Central to Let's Talk is engaging parents in the support of their children. It works from the assumption that families are key resources for supporting child wellbeing and that everyday interactions are the stage on which child development plays out (Solantaus et al., 2010). Let's Talk's development was informed by international interventions for families where a parent has a mental illness including a Dutch mini-intervention and the Preventative Family Intervention developed in the USA (Beardslee et al., 2007) as well as practice within the Finnish context and culture (Solantaus & Toikka, 2006).

As noted in Table 3 and Figure 5, Let's Talk changed and developed over time. Initially, Let's Talk (LT-1) was described as a conversation with parents about their children, and included the provision of guidebooks (Solantaus et al., 2009). A Let's Talk Network meeting (LT-N) was additionally developed to further address the strengths and vulnerabilities identified in the LT-1 through linking the child and family to support (Solantaus, 2017; Solantaus & Toikka, 2006; Väisänen & Niemelä, 2005). After the end of a RCT on the ECF, Let's Talk was described as a series of structured conversations including an introduction invitation and set of two discussions utilising a structured log (LT-D) (Niemelä et al., 2010; Toikka & Solantaus, 2006; Ueno et al., 2019; T. Solantaus, personal communication, May 26 2019). Subsequently, Let's Talk was adapted to use as a public health intervention with the general population in Finland. This incorporated a whole-of-region approach to services working together to support the everyday life of a child, as part of a national strategy to enable children to receive the services they need in their developmental environments (Kujala et al., 2017; Niemelä et al., 2019; Solantaus, 2012, 2016; Solantaus & Niemelä, 2016). In this approach, new versions of the log were developed to facilitate the parent and teacher (and child as appropriate) to jointly map out the child's life with the aim of creating support for the everyday life of the child. This was called the Let's Talk about Children Service Model (LT-SM) and utilised LT-D and LT-N in a two-step model (Niemelä et al., 2019).

Let's Talk is now supported across Finland in two different environments: the child's development context where the child spends their everyday life such as school and kindergarten, and settings that provide services for the child, parent or family. Service settings may include those that are providing treatment or care such as psychiatric services, palliative care units, consultation psychiatry, child protection (Solantaus & Niemelä, 2016) or promotive services such as maternal and child health services or community health services. Municipalities can be supported to implement Let's Talk, as it is one of the approved evidence-based practices in a National Child and Family Services Change

Program (2016-2018)². Additionally, an e-learning centre on the ECF program is provided as part of a national mental health hub³. The Finnish developers have assisted in translating the program and training resources for use in other cultures and contexts including the Australian version that was used in the RCT trial.

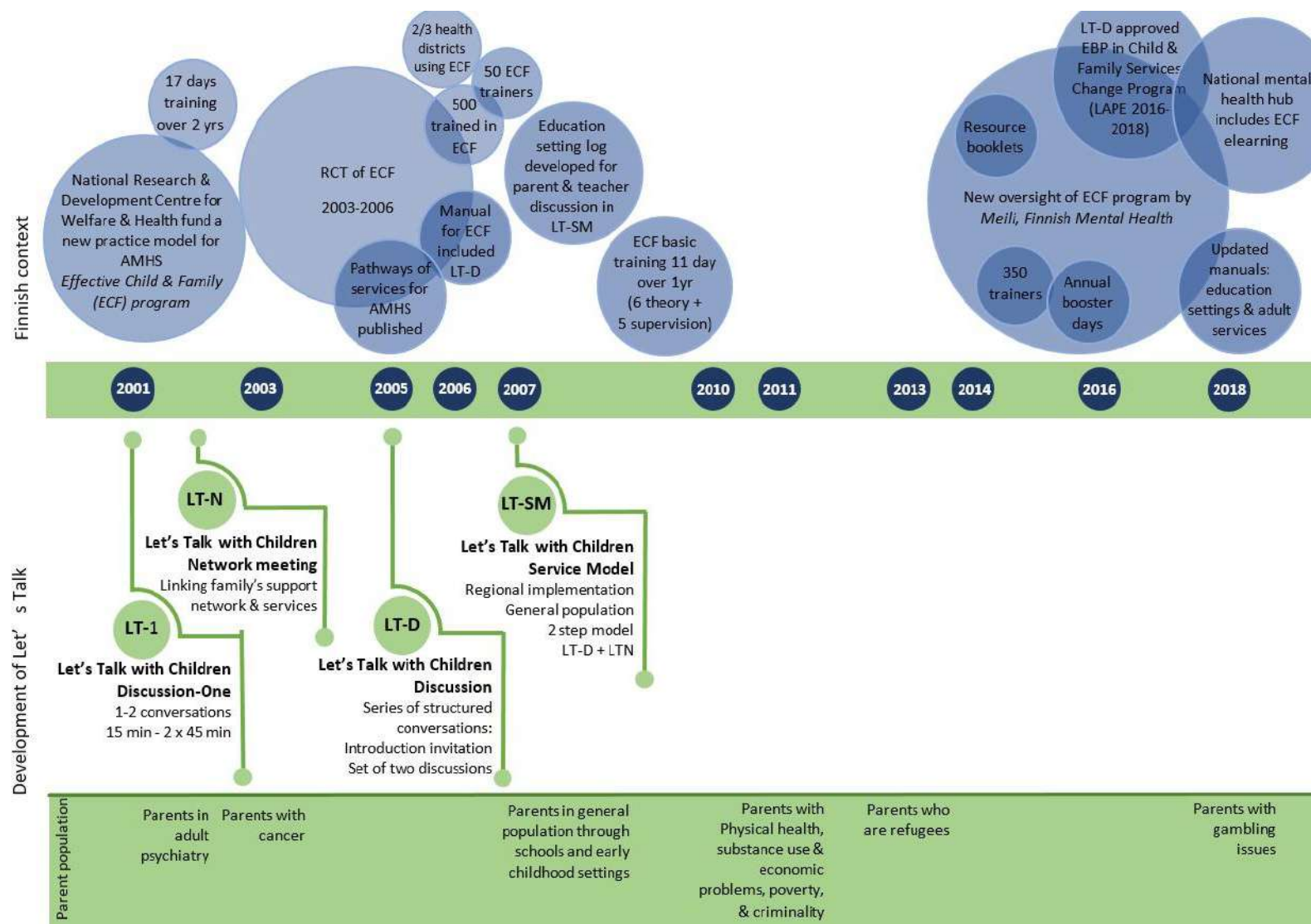
² <https://www.kasvuntuki.fi/>

³ <https://www.mielenterveystalo.fi/>

Table 3: Descriptions of the versions of Let's Talk

Let's Talk about Children Versions	Details
Let's Talk about Children Discussion-One (LT-1)	Early version of Let's Talk with a conversation guide but without the structured log. Documented as conversations with parents about their children and providing parents with the guidebooks taking between one 15 min or two 45 min sessions. All practitioners, however, used more than 15 min (Solantaus et al., 2009) with 75% using one full session and 24% using two sessions (Solantaus et al., 2010).
Let's Talk about Children Discussion (LT-D)	<p>Structured version of Let's Talk using a series of 2-3 structured conversations including an introduction invitation and set of two discussions (LT-D) (Niemelä et al., 2010; Solantaus et al., 2015; Toikka & Solantaus, 2006; Ueno et al., 2019). Discussion 1 uses an age-appropriate structured log to assist the parent to map the strengths and vulnerabilities within the everyday encounters and routines in the child's life (Solantaus et al., 2015). Discussion 2 builds on the previous discussion exploring how the parents can promote the child's wellbeing through building resilience in the systems around the child.</p> <p>Utilised in two different settings:</p> <ol style="list-style-type: none"> 1. Child development & education. Early childhood, primary schools & high schools each have own log. 2. Service settings including both in treatment or care settings (i.e. psychiatric services, palliative care units, consultation psychiatry, child protection) and in promotive settings (i.e. maternal child health, community health). Six age-appropriate logs
Let's Talk about Children Network meeting (LT-N) also known as Effective Family Network meeting (EFN)	An extension to LT-D that facilitates linking the child and family to support by building a network around the child. Used after LT-D, the parent identifies people including the family's own network of supports as well as services such as child psychiatry, school, housing etc. that may be able to help facilitate the wellbeing of the child. (Solantaus, 2017; Solantaus & Toikka, 2006; Väisänen & Niemelä, 2005).
Let's Talk about Children Service Model (LT-SM)	Use of Let's Talk for collective impact through working in whole regions. Regional implementation strategy starts with community engagement and includes establishing a regional senior management group to enable service coordination and collaboration, as well as local management groups to oversee local implementation (Kujala et al., 2017; Niemelä et al., 2019). Includes the two-step model of Let's Talk: the parent and worker first use LT-D to chart the child's everyday life and develop an action plan to enhance strengths and support vulnerability. If a second step is needed, the LT-N is used to broaden the network of support for the child and family (Niemelä et al., 2019).

Figure 5. The development of Let's Talk in the Finnish context



4.3 Evidence base for Let's Talk

The emerging evidence base of Let's Talk is derived from a set of discrete research endeavours in diverse settings beginning in Finland and now including Greece, Japan and Australia. The variety of settings included adult mental health settings both clinical and non-government, general hospital psychiatry, child and family services and universal settings. The research has also encompassed a range of populations that included families where a parent has depression, bipolar disorder, life threatening cancer, schizophrenia, schizoaffective disorder, borderline personality disorder, anxiety, post-traumatic stress disorder, gambling and other co-occurring issues. The early studies were of the initial version of Let's Talk (LT-1) and later have been on the manualised intervention of two or three sessions (LT-D) designed for either treatment or universal settings. In some studies, Let's Talk has been included as part of a suite of interventions. The focus of the studies has been on the effectiveness, safety and acceptability of Let's Talk in its different forms, in different settings and in different populations. There are no existing studies that have set out to study the sustainability of Let's Talk.

Summary of evidence base

Overall, Let's Talk has been found to be acceptable for parents (Maybery et al., 2019; Solantaus et al., 2009; Ueno et al., 2019) and for practitioners (Karibi & Arblaster, 2019; Niemelä et al., 2010; Tchernegovski et al., 2015). Outcomes have been documented for parents, family and child wellbeing (Solantaus et al., 2015) and recommendations for implementation have been made (Toikka & Solantaus, 2006). Additionally, from the context of other studies, some limited information about the sustainability of Let's Talk can be gleaned.

Parenting outcomes

Parenting outcomes include greater self-acceptance (Solantaus et al., 2009; Ueno et al., 2019) and wellbeing (Maybery et al., 2019; Niemelä et al., 2012; Solantaus et al., 2009; Ueno et al., 2019), and increased motivation for mental health treatment (Solantaus et al., 2009; Ueno et al., 2019). Let's Talk also resulted in improved confidence in parenting (Solantaus et al., 2010; Solantaus et al., 2009; Ueno et al., 2019) with less guilt and worries about their children (Solantaus et al., 2010; Solantaus et al., 2009; Ueno et al., 2019). Improvements were also seen in parents' confidence in the child's and family's future (Solantaus et al., 2009) and improvements in their own social support (Giannakopoulos et al., 2013).

Family outcomes

Family wellbeing improvements were seen with improved family communication (Maybery et al., 2019) and mutual understanding in the family (Solantaus et al., 2009).

Child outcomes

Outcomes for children were seen later than the parent and family improvements, at 10-18 months after Let's Talk was delivered. These improvements included decreased anxiety and increased behaviours that promote relationship building (Solantaus et al., 2010). An increase in the positive and functional thinking that supports improvements in emotional and depressive symptoms was additionally seen (Punamäki et al., 2013).

Implementation outcomes

Implementation outcomes highlighted that it was feasible for practitioners to use in their settings (Niemelä et al., 2010; Solantaus et al., 2009; Ueno et al., 2019) and increased their enjoyment at work (Toikka & Solantaus, 2006). The training also increased practitioners' knowledge and skill in supporting families and parents (Karibi & Arblaster, 2019; Tchernegovski et al., 2015; Toikka & Solantaus, 2006). This resulted in improving practitioners' ability to assess a parent's understanding of their children, assess the impact on children and work together with the parent to address impacts and provide resources and referrals where necessary (Karibi & Arblaster, 2019; Tchernegovski et al., 2015). In two studies, parents were asked when Let's Talk should be offered on a phased illness continuum (*acute phase–early treatment phase–late treatment phase–‘recovery’ phase*). Parents recommended that it be delivered early (Solantaus et al., 2009) and late (Ueno et al., 2019) in the treatment phase rather than in the acute or 'recovery' phases.

Sustainability outcomes

While there is no focused study of sustainability outcomes for Let's Talk, some conclusions about its continued delivery and the organisations' continued capacity to support delivery can be drawn from the studies in Finland. Practitioners are documented as continuing to use of a suite of interventions which included Let's Talk five years after implementation in Finland (Toikka & Solantaus, 2006). The paper had no record of adaptation made or the quality of practitioners' delivery of Let's Talk to be able to draw any conclusions about how faithfully Let's Talk continued to be delivered. Although there is no detail, some organisational capacity for the sustainability of ECF can be presumed from the papers on its use with families affected by parental cancer as it is documented as being used in routine practice for more than seven years in the region (Niemelä et al., 2010; 2012). The continued capacity for training practitioners can be surmised from Toikka & Solantaus's (2006) study which indicated that the majority of the initial 30 master trainers had trained others. Solantaus & Toikka's (2006) paper gave additional information about organisational capacity for training practitioners, indicating that there was a pool of 50 trainers across the country and more than 500 practitioners trained in Let's Talk. Further evidence of organisational capacity to support sustainability of Let's Talk can be seen by two papers. Solantaus (2005) and Solantaus and Toikka, (2006) both reported

that recommendations were being written into service-level guidelines that endorsed Let's Talk's use with every parent seeking help with mental health issues.

While the above summary shows a robust evidence base, clarity about what works for whom and in what setting is found in the detail of the individual studies from Finland, Europe, Asia, and Australia. The specificities of these studies present the detail needed to understand the development and spread of Let's Talk so as to explore sustainability contextually. Accordingly, the expanded explanation below is provided first for the Finnish studies and then studies outside Finland.

Establishing effectiveness of different versions of Let's Talk used in different settings in Finland

The three ways Let's Talk has been studied in Finland⁴ has provided a base for the evidence of its effectiveness as a prevention and promotion tool for families and has given insights to its development, spread and sustainability. Firstly, a RCT studied the early version of Let's Talk (LT-1) within the suite of ECF interventions in a population of parents with mood disorders and their children. This RCT included a series of sub-studies that differentiated Let's Talk's effectiveness from the other ECF interventions, established its ability to fit into Finnish AMHS and documented the spread of the suite of ECF interventions (Punamäki et al., 2013; Solantaus et al., 2010; Solantaus & Toikka, 2006; Solantaus et al., 2009; Toikka & Solantaus, 2006). Secondly, the more structured version of Let's Talk (LT-D) was studied within the suite of ECF interventions, in a population of parents with life threatening cancer and their children (Niemelä et al., 2016; Niemelä et al., 2012; Niemelä et al., 2010). These studies document the method of the structured version of Let's Talk and give evidence of the spread of the ECF interventions across Finland and into other populations of families where a parent is experiencing distress. More recently, the collective impact work with Let's Talk (LT-SM) was studied in one Finnish municipality (Niemelä et al., 2019) and is documented in a protocol to be part of a longitudinal study in Finland (Kujala et al., 2017). These studies document the expanded version of Let's Talk utilised across municipal child and family services aimed at the universal population, highlighting its acceptability and spread across Finland. These three waves of study on Let's Talk are expounded below.

The Finnish RCT of the ECF, including LT-1 (2003-2006)

The RCT in Finland compared LT-1 with the FTI (Beardslee et al., 2007) within psychiatric and mental health clinics from 16 health care units in eight regional health organisations (including capital city/smaller cities/rural settings). The study sample of 119 single and dual parents with primary

⁴ https://www.mielenterveystalo.fi/aikuiset/itsehoito-ja-oppaat/oppaat/lapset_puheeksi/Pages/Tutkimuksia_LP-menetelm%C3%A4st%C3%A4.aspx

diagnosis of mood disorders with at least one child between eight and 16 years old were randomly allocated to either FTI (60) and LT-1 (59) (Punamäki et al., 2013; Solantaus et al., 2010). The RCT comprised of a number of sub-studies (see Box 1; Punamäki et al., 2013; Solantaus et al., 2010; Solantaus & Toikka, 2006; Solantaus et al., 2009; Toikka & Solantaus, 2006) some of which documented outcomes for both FTI and LT-1 interventions and some differentiated between the interventions.

In summary, the studies in the RCT showed LT-1 as being feasible to be implemented in Finnish AMHS as part of routine care which resulted in ongoing discussions about family and children for most parents. It was deemed safe to use as it did not increase stigma or cause harm (Solantaus et al., 2009). Improvements after LT-1 were seen in child, parent and family wellbeing. Both the FTI and LT-1 showed similar benefits for children with decreasing emotional symptoms and improving prosocial behaviour. These same benefits were not seen until follow up (10-18 months) for the LT-1 cohort which is later than those receiving the FTI. LT-1 was also effective at shifting children's tendency to blame themselves for parental problems with an increase in positive and functional cognitive attribution that was not seen in FTI (Punamäki et al., 2013). The benefits reported for parents, specific for LT-1, included decreased worry, increased parental understanding, reduced guilt and increased confidence in their family and children's future (Solantaus et al., 2010; Solantaus et al., 2015). There were also benefits seen with mutual understanding in the family (Solantaus et al., 2009).

These studies highlight how the establishment of the effectiveness of Let's Talk and its spread and sustainability occur within a broader suite of interventions, training and supports into AMHS across Finland. As noted in the background and development section above, this early version of Let's Talk (T-1) tested in the RCT was further developed to include a more structured approach to mapping the child's life.

Box 1: Sub-studies of the RCT on the ECF program that included LT-1

Solantaus et al. (2009) aimed to establish the safety and effectiveness of delivering LT-1 and FTI in adult-focused services, and explored the experiences of families who were randomised between the groups, comparing measures at baseline (one to three weeks before the intervention) and post-intervention (one to three weeks after). A complete data set included 90 families (45 FTI/45 LT-1). The custom-developed measure asked parents to rate on a five point Likert scale their relationship with the practitioners, the usefulness of the intervention and the impact of the intervention on self-understanding, mutual family understanding, parenting, future orientation, well-being, treatment motivation and child-related worries. It reported that parents

recommended LT-1 be carried out during their treatment phase early or later (35%/35%) rather than when acutely unwell or in 'recovery' after treatment (15%/8%). Both interventions were reported to improve self-understanding, understanding in the family, parenting skills and confidence, future hope and were equally effective in identifying children needing further support. Improvements for LT-1 specifically, were seen in decreased feelings of guilt and worries about children and increased understanding of their children, ideas for parenting, and confidence in their child and the family's future. Ongoing discussions about family and children in the clinical setting after LT-1 were reported by 83% of parents (Solantaus et al., 2009). This study established positive outcomes for parents and displayed how it is safe and possible to deliver child-centred preventative interventions in real-world AMHS settings.

Solantaus et al. (2010) studied the effectiveness of FTI and LT-1 on children's psychosocial symptoms and prosocial behaviours, comparing parent-reported measures of children at baseline, four, 10 and 18 months post-intervention. Child-focused measures included the Strengths and Difficulties Questionnaire (SDQ) and Screen for Child Anxiety Related Emotional Disorders (SCARED). The sample included reports on 149 children with a complete data set of 83 (43 LT/40FTI). A key finding of the study was that the same benefits for children were found in both interventions, but with the benefits in the LT-1 cohort seen 10-18 months post-intervention which is later than in the FTI group (four months). The improvements encompassed both a decrease in emotional symptoms and an increase in promotive factors. These included a significant decrease in children's anxiety, marginal decrease in hyperactivity and an increase in the prosocial behaviours needed to solve interpersonal relationships and promoting relationships. This study established the effectiveness of both interventions on child mental health with the benefits seen later with LT-1 than FTI.

Punamäki et al. (2013) examined the effectiveness of FTI and LT-1 in changing the tendency of children of depressed parents to attribute their parent's problems to themselves, and hence the intervention's effectiveness as preventative tools in changing children's depressive and emotional symptoms. It used child and parent reported measures on cognitive attribution style (CASQ-R), depression (CDI) and emotional symptoms (child and mother reported SDQ) at baseline, four, 10 and 18 months post-intervention with a sample of 109 families with depression (53FTI/56 LT-1) representing 145 children (76 FTI 69 LT). Cognitive attributions are linked to depressive symptoms and are measured by scoring how a child attributes good and bad events in life looking at three dimensions: personalisation (internal vs external), permanent (stable [always] or unstable [temporary]) and persuasive (global [catastrophizing] vs specific; Thompson et al., 1998). Negative attributions are seen in more "internal-stable-global attributions for bad events" and

“external-unstable-specific attributions for good events” (Thompson et al., 1998, p. 168).

Contrary to the hypothesis, LT-1 rather than FTI, increased positive and functional cognitions between the 10 month and 18 month follow-up period. These positive attributions were confirmed to play a mediating role for child-reported emotional symptoms and partially for depressive symptoms in this study. Punamäki et al. (2013) propose that effectiveness of the briefer LT-1, rather the FTI, may be due to the intervention being directed primarily to parents, rather than the whole family. The shifting of the child’s understanding that they are not the cause of the parent’s problems is suggested to be the result of the parent reinforcing this in everyday life rather than via a practitioner delivery in a therapeutic setting. They suggest that the long time to see the effects (10-18 months) is the result of the parent needing to integrate the thinking into everyday relationships and practices that then affect the child (Punamäki et al., 2013). This study established LT-1 as effective for promoting improved family communication and child mental health through improved parent agency.

Implementation, spread and sustainability outcomes of the ECF were also reported in Toikka and Solantaus’ (2006) study of the experiences of pioneer practitioners of the ECF training (n= 45) and also in Solantaus and Toikka’s (2006) documentation of the ECF. These outcomes focus on the effect of training on practitioners and on the national spread of the ECF program. As these report outcomes of the whole ECF, not differentiating between the different interventions, the outcomes for Let’s Talk alone are less clear. Five years after the initial implementation, the remaining practitioners (n=36) were surveyed about their experiences of the training (Toikka & Solantaus, 2006). In the sample of 30 respondents, the study found that while the new working methods brought more stress at work, they did not experience any negative change in coping with their workload, and there was a strong positive change in their experience of joy at work (Toikka & Solantaus, 2006). The practitioners described an increase in knowledge and skills especially in supporting family and parents with mental illness. The questionnaire found all had used the suite of new practices in their work and 77% had trained others (Toikka & Solantaus, 2006).

Solantaus and Toikka (2006) documented the spread of the ECF five years after initial implementation. They indicated that there were 50 trainers across Finland and two thirds of the health districts’ psychiatric units had practitioners trained in the preventative methods. They equate this to 500 practitioners being trained in both FTI and Let’s Talk and ‘countless practitioners’ trained in Let’s Talk (Solantaus & Toikka, 2006). The result of this spread enabled the issuing of recommendations for Finnish health services that described pathways of services (see Figure 4) and included the endorsement of the Let’s Talk method being used with every

parent seeking help for mental health issues (Solantaus, 2005; Solantaus & Toikka, 2006). These recommendations were reported to being developed into service-level guidelines across the country. Solantaus and Toikka (2006) also report that the ECF had spread beyond Finland's borders and is now included in a work package for child and adolescent mental health recommended by the European Union commission. This study highlighted how the ECF interventions were able to be scaled and sustained within the Finnish context and had effected change in the Finnish health system. The focus on scaling and sustainability in the studies by Toikka and Solantaus (2006) and Solantaus and Toikka (2006) are directed at the ECF intervention suite within which LT-1 is embedded.

The LT-D

The shift to the more structured approach to Let's Talk, LT-D, which included the log to chart the child's protective factors, is acknowledged in the study of the ECF suite of interventions with parents with life threatening cancer and their children (see Box 2). The studies showed the ECF interventions as being applicable for use in general hospital psychiatry and cancer treatment settings, with improvements seen in the psychological symptoms of parents. These studies document the development and spread of the suite of ECF interventions across Finland and its adaptation for different populations. It is in these studies that the method of LT-D as being a set of two to three discussions is detailed. These studies also hint at practitioners continued use and organisational capacity to sustain the ECF through the documentation that it has been in use in the area for seven plus years.

Box 2: Studies documenting LT-D

Niemelä et al. (2010) studied the use of the ECF interventions in general hospital psychiatry. The ECF program is documented as encompassing the expanded version of Let's Talk including the log charting the child's protective factors (LT-D), the FTI and the EFN (LT-N) meeting. A narrative enquiry explored the experiences of seven practitioners (psychiatric nurses n=4, mental health nurses n=2, social worker n=1) using the interventions when working with parents with cancer. The paper documents that these interventions had been in use as a routine part of cancer treatment in Oulu, Finland since 2003. The authors stated that the study found the interventions were '*valid and reliable for child and family-centred work in populations with parents with serious illness*' and enabled age-appropriate support for children. It found that practitioner's collaboration with other services and adjustments in their use of the interventions to meet the family's circumstances was essential for outcomes for children and families (Niemelä et al., 2010). One such adjustment included switching intervention after the death of a parent to meet directly

with the child. This study highlighted the expansion of the ECF program in Finland to general hospital psychiatry and to populations such as parents with life threatening cancer as well as their continued use in routine practice.

Niemelä et al. (2010, 2012) refer to an RCT that included LT-D with families with a parent with a serious somatic illness in Finland, entitled *Struggle for life: a preventive trial in families with a life-threatening illness*. The ECF program had been adapted and used in routine practice for this population in the study setting since 2003 and included the structured version of Let's Talk (LT-D), FTI, psychoeducational material and guidebook adapted for parents with cancer, and the LT-N meeting (Niemelä et al., 2010, 2016). The study evaluated the effectiveness of adapted ECF interventions to address the needs of children of parents with cancer (Niemelä et al., 2010, 2012). Sixty families seen at two settings in Oulu were randomised between LT-D and FTI, and a comparison group receiving treatment as usual from another setting. As well as custom-developed questionnaires for family demographics and children's risk and protective factors, the study collected psychological wellbeing information on family members using the following standardised measures: children's depression inventory (CDI), the symptom checklist 90 (SCL-90), strengths and difficulties (SDQ), parent adolescent communication scale (PACS), sense of coherence scale (SOC) and illness attitude scale (IAS; Niemelä et al., 2012). These measures were completed for baseline (retrospective data prior to parent's illness), before the intervention and four, 10 and 18 months after the intervention (Niemelä et al., 2012). The effects of LT-D and FTI on psychiatric symptom profiles of ill and healthy parents at baseline before the intervention, and four months after the intervention are reported in a pilot phase (Niemelä et al., 2012). A significant decrease was seen in the severity of psychological symptoms for the sample of 10 families which included eight patients (mothers) and nine spouses (one mother/eight fathers). It also compared the sample with the Finnish general population and the Finnish psychiatric outpatient population finding that the participants had a symptom profile comparable to the psychiatric population at baseline that decreased to the same as the general population four month's post-intervention. As the pilot reports on the outcomes of the two interventions together, the implications for Let's Talk specifically are less clear. The studies, however, document the continued use of Let's Talk as part of the ECF in routine practice across a region and draw focus to its use in Finland as part of a suite of programs aimed at improving the wellbeing for children in families experiencing distress.

The LT-SM

The progression to Let's Talk being used as part of a population-level mental health promotion strategy (LT-SM) is acknowledged in studies by Niemelä et al. (2019) and Kujala et al. (2017). These studies document the two-step Let's Talk method which includes the structured version of Let's Talk (LT-D) and the Let's Talk Network meeting (LT-N), and also registers new versions of the logs in the LT-D for use in educational settings. These give a context for Let's Talk's acceptability in Finland and the results of the reductions in child welfare referrals show its effectiveness in promoting child wellbeing. The use of Let's Talk is detailed in these studies against a backdrop of cross-sector collaboration in municipalities with multilevel implementation support and regular data collection, which is seen as important for its sustained use.

Box 3: Studies on LT-SM

Niemelä et al. (2019) report on the use of the LT-SM in one Finnish municipality looking at the collective impact on referrals to child welfare services. This whole-of-region approach uses Let's Talk in universal services to support child wellbeing. Education settings and health and social services utilise the LT-D with the option of LT-N as needed. The region's implementation of the LT-SM included the installation of a multi-agency management group providing the administrative and political leadership for collaboration. This provided a one-contact service that coordinated ground-level service collaboration for the LT-N, investment in workforce education of the Let's Talk method and trainer training, as well as population-level communication through media and institutions (Niemelä et al., 2019). Using population-based data regarding referrals to child welfare over a seven-year period, it demonstrated a significant drop in referrals in the region after the implementation of LT-SM, while referrals for the whole-of-country continued to rise.

Kujala et al. (2017) presented a protocol for a longitudinal study to build on the above population-level study. The quasi-experimental ecological study was to be implemented in over 30 urban, rural and sparsely populated municipalities in northern Finland between 2014 and 2018. The study proposed to collect population data, child welfare statistics and data from hospital registers for a baseline, and then annually over four years, linking it with annual data collection of LT-D and LT-N carried out in education and service settings. There are no published results as yet from this study.

Studies of Let's Talk outside Finland

The study of Let's Talk outside of Finland has used the structured manualised version (LT-D) as documented in Solantaus et al. (2015) as its starting point. It has been studied alone without a comparison (Karibi & Arblaster, 2019; Tchernegovski et al., 2015; Ueno et al., 2019; von Doussa et

al., 2017), as an active control within a set of interventions (Giannakopoulos et al., 2013, 2015) and on its own with a control of 'practice as usual' (Maybery et al., 2017, 2019).

In Greece, Giannakopoulos et al., (2013, 2015) studied Let's Talk with the FTI (Beardslee et al., 2007) with parents with mood disorders (see Box 4).

In Japan, Let's Talk was piloted with a small sample of parents with mood disorders looking at safety and feasibility for the Japanese context (see Box 5; Ueno et al., 2019).

The Australian studies used Let's Talk in controlled studies against practice as usual with parents with a broad range of mental illnesses (see Box 6; Maybery et al., 2017, 2019). Let's Talk was also piloted in the gambling sector in Australia (see Box 7; von Doussa et al., 2017) and its use in an adult community mental health setting is documented by Karibi and Arblaster (2019; see Box 8).

There is little comment on the sustainability of Let's Talk from these studies and multifaceted measurement identified as important for measuring sustainability is missing. Practitioners continued use of Let's Talk after implementation is not documented in any studies and only a cursory mention is made of some aspects of organisational capacity to support practice (Karibi & Arblaster, 2019; von Doussa et al., 2017). The studies in their documentation of implementation and adaptation processes however, add to understanding the contextual picture of what enables Let's Talk to be used that is important for the study of its sustainability.

There is little description of how Let's Talk was adapted for use in Greece or Japan in the studies, however, the pilot study in Japan documented the views of parents, highlighting its applicability in their context (see Box 5; Ueno et al., 2019). The Australian Let's Talk e-learning training is described in Tchernegovski et al.'s (2015) study of the effectiveness of the resource on practitioner knowledge and skills (see Box 9), but little is described of the adaptation of Let's Talk itself. Karibi and Arblaster's (2019) study of practitioners' experiences of an enhanced face-to-face training of Let's Talk described practitioners adapting Let's Talk by delivering it without the structured log and reducing the number of sessions to fit into the pressured workplace (see Box 8). The Australian gambling sector study describes the process required to adapt it to the sector with the addition of an extra handout to guide discussions with children about gambling and addictions (von Doussa et al., 2017). None of these studies document how the adaptation impacted outcomes for parents, children and families.

These studies add to the evidence base of Let's Talk's effectiveness and acceptability for different populations and settings and, importantly, give a window to its applicability outside the Finnish health and welfare systems. By parents indicating their interest in continuing to include parenting

and children in ongoing treatment, the study by Ueno et al., (2019) addresses one of the barriers to the use of family work in practice. In both the Tchernegovski et al. (2015) study of the online training and the Karibi and Arblaster (2019) study of the more intensive face-to-face workshop, practitioners identify their need for support to apply the training to practice. Suggestions were made such as incorporating opportunity for practice into training, observing others' use Let's Talk and post-training follow-up. Both studies also raised questions about how family-focused practice can fit into Australian mental health systems. Karibi and Arblaster (2019) suggested attention was needed on time constraints, high caseloads and the tension between responding to child protection concerns and the therapeutic relationship. The von Doussa et al. (2017) study raised implementation issues important for the uptake and sustaining of Let's Talk in the gambling sector, suggesting that the authorising environment within and around the organisation impacts practitioners' use.

Each of these studies provide useful perspectives that can help direct the investigation of what is important for sustaining Let's Talk in ordinary practice in AMHS in Australia. In their definitions of Let's Talk, these studies also create a clearer picture of the development of Let's Talk as an intervention and thus provide more pieces of the puzzle that helps to define its fidelity.

Box 4: Controlled study in Greece

Similar to the study of Let's Talk in Finland, a RCT in AMHS in Greece studied a suite of interventions that included Let's Talk as documented in a protocol (Giannakopoulos et al., 2015). The RCT compared Let's Talk to FTI (Beardslee et al., 2007) in a population of parents with depression with the aim of understanding factors that predict improved child outcomes and explore child health related quality of life with parents' mental health symptoms (Giannakopoulos et al., 2015). In addition to a questionnaire measuring parents' experience with and perceived impact of the intervention, the study used Becks Depression Inventory- short form (BDI-SF) and Spielberger State Anxiety Inventory as standardised measures of parents' symptoms. Parents support from others was measured by Social Adjustment Scale-Parental Role, the Family Assessment Device-General Functioning Subscale and Oslo Social Support Scale. The latter was also completed by children about their self-perceived support from others. Children's emotional behavioural problems was measured by parents and children completing the Strengths and Difficulties Questionnaire (SDQ). Children's quality of life was measured by the Screen for Child Anxiety Related Emotional Disorders (SCARED) and KIDSCREEN—27. Additionally, Children's Depression Inventory (CDI) was completed by children.

In this study, Let's Talk is described as a child-focused manualised structured discussion with a parent to assess a child's situation/status and inform parents on how to support their children

(Giannakopoulos et al., 2015). Early results at four months post-intervention show both interventions significantly improving family functioning, child outcomes (depression, anxiety, emotional/behavioural problems) and parent outcomes (parental depression and anxiety, parent social support; Giannakopoulos et al., 2013; Solantaus et al., 2015). Both interventions significantly decreased the proportion of parents with poor social support, however, the proportion of children with poor social support and families with poor parent-child relations only significantly decreased in the FTI group (Giannakopoulos et al., 2013). While adding to the evidence base of Let's Talk's effectiveness (identifying improvements in parent social support), the early results give little insight to the implementation and sustainability of Let's Talk.

Box 5: Piloting Let's Talk in Japan

A pilot study of the structured version of Let's Talk examined the safety, feasibility and perceived benefit of using Let's Talk with parents with mood disorders in outpatient mental health services in Japan (Ueno et al., 2019). Nine parents with depression or bipolar disorder completed a depression measure (BDI-II) and a questionnaire modelled on the study by Solantaus et al. (2009) before and after participating in Let's Talk. Let's Talk is described in this study in keeping with LT-D – as a manualised psychoeducation intervention that comprises a preliminary discussion and two subsequent discussions that include completing the log to map strengths and vulnerabilities in the child's life, and the development of promotive strategies.

Ueno et al. (2019) found that most parents recommended Let's Talk be carried out later in the treatment phase (56%) rather than early in treatment or the acute or 'recovery' phases (11%/11%/22%). All parents reported finding Let's Talk as helpful with none indicating harmful experiences. All reported positive changes to motivation for mental health treatment and greater confidence in parenting. Most also indicated improvements in self-acceptance, their own wellbeing, and having less worries about their children. Most parents (89%) reported wanting to continue to discuss parenting and children in their treatment (Ueno et al., 2019).

This pilot study confirmed Let's Talk's applicability to facilitating conversations about parenting and children in AMHS in Japan, which resulted in parents' improved motivation for treatment and confidence in parenting. In doing so, the study extended the evidence base beyond a Finnish context. While identifying these applicability and implementation aspects, as a pilot study focused on safety and feasibility it provides limited insight to sustaining Let's Talk in regular practice.

Box 6: Controlled studies of the structured Let's Talk in Australia

A quasi-experimental study compared outcomes for 20 parents receiving Let's Talk to a waitlist control group of 19 parents (male n=3, female n=36) in two AMHS and a Psychiatric Rehabilitation and Support Service (Maybery et al., 2019) in Australia. Parents were described as having a range of mental illnesses including depression, bipolar disorder, schizophrenia, schizoaffective disorder, borderline personality disorder, anxiety, and post-traumatic stress disorder. Let's Talk was described as a two to three session manualised psychoeducational intervention. The study used two standardised measures of family functioning and parenting stress, the Family Assessment Device (FAD) and Parenting Stress Scale (PSS), used at baseline and four to six weeks post-intervention, as well as interviews with 18 parents who had received Let's Talk. Both groups showed improvements in parenting and family functioning. Parents reported that Let's Talk helped them gain insight into their illness, their parenting and family, leading to improved family communication. Additionally, parents suggested a need for greater support for their parenting role from their practitioner (Maybery et al., 2019; The Bouverie Centre, 2015).

A protocol reported in Maybery et al. (2017) details a two-arm parallel RCT for 192 parents with a mental illness and their families, engaged in one of three types of services: AMHS, non-government MHCSS and family welfare services in Victoria, Australia. The study randomises practitioners for training who then offer it to parents and compare this to a practice-as-usual control. Training uses the Australian four-module online course described in Tchernegovski et al. (2015) as well as a four-hour face-to-face training session. The aim of the study was to investigate the efficacy of Let's Talk on recovery outcomes using measures of recovery (Recovery Assessment Scale), parenting (Parental Stress Scale/Parenting Self-Agency Measure), family functioning (General Functioning Index) and quality of life (SF-12v2) over three time periods; pre- and post-intervention and at a six-month follow-up. The protocol also details an economic evaluation. There are no outcomes published from this study as yet.

Box 7: Trial of Let's Talk in the gambling sector

von Doussa et al.'s (2017) qualitative study reports on the trial of Let's Talk in the gambling support sector, examining the applicability of the intervention and training material for the sector. The paper describes the six-month process of adapting Let's Talk and the trial of its use over four months by nine practitioners. Practitioners were trained using the Australian online training, as described in Tchernegovski et al. (2015), with an additional day of face-to-face training. Adaptation of Let's Talk included the development of additional material addressing talking with children about parental gambling as well tips for having difficult conversations as a

family. The study suggests that training material should be targeted to the sector to reduce disengagement and that post-training support was important to encourage practitioners' use of Let's Talk. Mixed results were found regarding implementation suggesting that authorisation within the organisation was important for practitioner uptake. The study also suggests that understanding how the model connects to practitioner's everyday practice may support adaptation while upholding the fidelity of the model. There were no details of practitioners use of Let's Talk or of outcomes for parents.

Box 8: Australian practitioners' experience of a Let's Talk face-to-face training workshop

A qualitative study explored 10 adult community mental health practitioners' experiences of an enhanced face-to-face training in Let's Talk and its impact on practice (Karibi & Arblaster, 2019). The five social workers, two psychologists, two nurses and one occupational therapist had completed the training between 6 months and 3 years prior to being interviewed. The results highlighted that while the workshop improved their skills and awareness of the parenting role, it was not sufficient for them to feel confident to implement Let's Talk independently. The results additionally indicated that practitioners commonly adapted Let's Talk by delivering it as semi-structured conversations without the log. The study only explored practitioners' experiences of the workshop with no details documented of how many practitioners delivered Let's Talk after the workshop or the impact of adaptations on outcomes for families. The study highlighted that practitioners needed support to apply Let's Talk to practice in their settings. Practitioners' confidence was increased through having an opportunity to practice and see others use Let's Talk. This was further supported by the presence of internal supports such as COPMI coordinators and team champions. Implementation issues that made Let's Talk challenging in AMHS were also noted including high caseloads, workplace pressures and the difficulty balancing child protection concerns and building rapport and trust.

Box: 9 Pilot study of Australian Let's Talk e-learning resource

Tchernegovski et al. (2015) report on a mixed method pilot study of the impact of the Australian Let's Talk e-learning resource on the family-focused practice of practitioners from a range of services including Child and Adolescent Mental Health Service (CAMHS), community mental health, non-government MHCSS, AMHS, primary mental health and private practice. Twenty-one practitioners completed a shortened version of the Family-Focused Mental Health Questionnaire (FFMHQ) and the Family-Focused Worker Questionnaire (FFWQ) before and after undertaking the online training. Eight practitioners also completed telephone interviews. Results showed the

training as effective in enhancing practitioners' attitudes, knowledge, skills and confidence in working with parents with a mental illness, as well as increased understanding of the interconnection between a mental illness, parenting and child wellbeing. A significant impact was seen in the areas of assessing parents' understanding of children, providing referral and resources, assessing the impact of the illness on the children, and working with parents to address that impact. The study also highlighted some anticipated implementation issues related to organisational endorsement and support of the use Let's Talk.

4.4 Fidelity of Let's Talk

As discussed in more detail in Chapter 3, a challenge in the implementation of evidence-based practices is the tension between fidelity to the model, which is understood as the delivery of the intervention as it was intended, and adaptation to fit the context. While adaptation can promote the use and spread of an intervention, faithful delivery (fidelity) of what makes the evidence-based practices effective allows for confidence in the replication of its outcomes (Kirk et al., 2019; Rabin et al., 2008). The identification of the core mechanisms of change of an evidence-based practice is seen as vital in order to study its spread or continuation (Blase & Fixsen, 2013; Kirk et al., 2019).

Consequently, it is important for the study of the sustainability of Let's Talk to understanding its core mechanisms of change. However, the description of Let's Talk as reported in the different studies and papers, displays its emerging nature as it has been adapted to different contexts. This has, as a result, complicated defining and measuring the fidelity of Let's Talk.

Descriptions of fidelity of Let's Talk and its measures

In the earliest version of Let's Talk, described for the Finnish RCT (LT-1), fidelity was described as a discussion about children with the parent for a minimum of 15 minutes in one session (Solantaus et al., 2009). Fidelity was measured by the review of a practitioner's logbook records of sessions (Solantaus et al., 2010), which indicated 76% of families had one session and 24% had two sessions, all of which exceeded 15 minutes (Solantaus et al., 2010; Solantaus et al., 2009).

The Greek study doesn't clearly define fidelity but describes Let's Talk as a manualised discussion about children for a minimum of 15 minutes and maximum of two sessions of 45 minutes each, referencing the description in Solantaus et al. (2010) (Giannakopoulos et al., 2015). This study cites a fidelity logbook as a measure of fidelity (Giannakopoulos et al., 2015).

Let's Talk, as described in the Kid's Strengths manual for Europe, does not define fidelity as such, but indicates that the "method is a compilation of thematic discussions about children...during two

discussion sessions” (Pretis, 2010, p. 16). It advocates for adherence to all the manual’s topics for discussion while suggesting there is no single correct way to discuss children (Pretis, 2010, pp. 16, 18). It describes it as a flexible model that in some cases might be done in one discussion or may need two.

Fidelity for the adapted Let’s Talk in the Japanese study was measured through review of the log and parent feedback. Ueno et al. (2019) describe fidelity as being met if discussion had followed the log charting a child’s everyday life (home, school, leisure and related to parenting) in session one and two, as determined by the log completion. To complement this, parents were asked if the discussion included how the child’s strengths could be enhanced and vulnerabilities supported (Ueno et al., 2019).

The Australian e-learning resource⁵ does not specify any fidelity measures in the training with the assessments at the end of each module being a measure of understanding the key elements, principles and background of Let’s Talk. The Australian RCT protocol described Let’s Talk as a two to three session intervention with parents involving a discussion about their children’s strengths and any concerns the parent might have. It emphasises the practitioners’ clinical stance of empowering parents in their parenting role in order to build their confidence, understanding and skills to play an active promotive role in their family (Maybery et al., 2017). It described measuring fidelity through attendance at practice development sessions and completion of a fidelity checklist (Maybery et al., 2017). The fidelity checklist included recording the type, content and duration of each session completed (M. Goodyear, personal communication, 2020).

Core principles and tasks of Let’s Talk

The above information leads us to understand that Let’s Talk has two core tasks. Firstly, the identification of strengths and vulnerabilities in the routines and everyday encounters in the child’s life and, secondly, using that information to develop a plan to promote child wellbeing through supporting strengths and mitigating vulnerabilities.

While the importance of these tasks is highlighted clearly in the definitions of fidelity above, it would appear that *how* the discussions are facilitated is also important to fidelity. The success of the program, as emphasised by Solantaus et al. (2009), is based on being able to carry out respectful and sensitive discussions with parents about children and parenting. Reviewing the literature on Let’s

⁵ <http://elearning.emergingminds.com.au>

Talk, two core principles appear to govern the way in which Let's Talk is delivered: the pivotal role of the parent and the conversation as method.

The parent is understood to be an expert in their child's and family's life (Beardslee et al., 2012; Emerging Minds, 2017) and through creating space for discussion about the children, the practitioner's role is to empower the parent to support their children themselves (Solantaus et al., 2015). The use of the log supports the parent to identify the strengths and vulnerabilities surrounding the child and identify promotive actions to support their wellbeing (Ueno et al., 2019). This task is supported by the stance of a practitioner (Emerging Minds, 2017) that engages the parent as an active agent in their own families, allowing them to decide how support for their children fits their situation (Pretis, 2010; Solantaus, 2017).

The second core principle is that the method of Let's Talk is the conversation. As well as engaging the parent in ways to enhance strengths and support vulnerabilities for their children, core to Let's Talk is equipping the parent to build mutual understanding of the adversity being experienced and shared problem solving in families (Solantaus, 2017). Punamäki et al. (2013) argued that a key to the improved outcomes for children in their study was the way Let's Talk filters through the parent to the child via everyday parent-child interactions. This requires an emphasis on equipping the parent for ongoing dialogue with their children through a give-and-take process between parents and children, rather than one of giving information (Solantaus, 2017; Solantaus et al., 2015). This dialogical style is reflected in the approach the practitioner uses with the parent in Let's Talk, creating space for conversations around the prompts in the log rather than follow a question and answer format.

In these studies, measurement of fidelity is described as practitioners' adherence to the core tasks of Let's Talk. Measures used included attendance at practice supervision, completion of practitioner log-books (Maybery et al., 2017), audits of session records (Ueno et al., 2019) or questions to parents about their experiences of the sessions and its outcomes such as in Solantaus et al. (2009) and Ueno et al. (2019). Fidelity measures using core tasks rely on clear articulation of the relationship of the tasks to the mechanisms for change so as to know that the essence of the intervention is being delivered even if adaptations are made (Kirk et al., 2019). While some of the measures described in the studies of Let's Talk may also elicit information about practitioners' adherence to its core principles, it is not a clearly documented intention of the measures. In this way, the lack of clearly articulated mechanisms of change for Let's Talk complicate fidelity measurement and the study of its sustainability.

Let's Talk as understood in this research

For the purpose of this thesis, Let's Talk is understood as a series of 45-60-minute structured discussions between a parent and their regular practitioner that includes a preliminary discussion, and two subsequent discussions. The preliminary discussion introduces Let's Talk, offering the parent the opportunity to discuss their child's wellbeing and family life in a few conversations. Discussion one uses an age-appropriate log to support the parent to map the child's life exploring strengths and vulnerabilities in the domains in which they interact. Discussion two then focuses on developing a plan to promote the child's wellbeing and a more harmonious family life.

4.5 Literature Review summary

This chapter presented the literature on Let's Talk within the context of family work in mental health. Establishing what Let's Talk is, as it was introduced into Australian AMHS, and the context in which it was introduced is an important springboard on which to study the sustainability of Let's Talk in AMHS in Victoria, Australia.

The establishment of Let's Talk in Finland was part of an interconnected government-funded and endorsed movement introducing a suite of interventions to enable the AMHS to meet its legal requirements of attending to the needs of children of patients. Adaptation happened in practice with practitioners as it was developed, and while its effectiveness was established. These contextual adaptations shaped Let's Talk to fit into the Finnish system. In Australia, while its adaptation to an Australian context was done in partnership with a body of lived experience and field experts, its introduction was as a pilot and its trialling was done as a single evidence-based intervention. Consequently, the study of sustainability in Australian AMHS will need to explore how the fit of Let's Talk to Australian systems and structures might have shaped sustainability. Furthermore, in the absence of clearly articulated core mechanisms of change for Let's Talk, exploration will need to include details of what has been sustained before being able to explore key elements that have enabled that sustainability.

Building on the last chapter, this chapter lays the foundation to see how sustainability of Let's Talk needs to be contextually understood. Possible influences of sustainability in AMHS in Victoria might include the way Let's Talk was understood in Australia, the implementation process engaged as part of the RCT, the organisational systems and structures to support its use, and the context in which Victorian AMHS are situated.

This chapter is the fourth of five chapters of the first section of the thesis that establish the foundations for the research on sustainability of Let's Talk. The following chapter builds on these previous four foundational chapters to detail the research aim and methodology.

Chapter 5 Research overview and methodology

This last chapter in the first section of the thesis details the aim and methodology of the research founded on the previous four chapters. The gap in knowledge of sustaining family-focused practice in AMHS was acknowledged in Chapter 1. Despite its strong evidence base, and the known barriers and facilitators, little is understood about what the key elements might be for sustaining the work in everyday practice. The emerging evidence base of one family-focused practice, Let's Talk, identified it as a practice that can be utilised in AMHS with outcomes known for parents, children and families, however there is little understood about its sustainability. An exploration of the key elements of sustainability of one intervention can provide insight into sustaining family-focused practice more broadly.

A participatory research paradigm was identified in Chapter 2 as a theoretical paradigm that could assist in the knowledge translation process. Working in partnership with AMHS for the research process could build their ownership and understanding of sustaining Let's Talk and create knowledge that would be more easily applied to their practice.

Chapter 3 presented the sustainability literature as a conceptual lens for the research. It defined sustainability as practitioners continuing to faithfully deliver Let's Talk, enabled by organisations with the capacity to support its delivery thus requiring multifaceted measurement. In the absence of a clear understanding of the mechanisms of change for Let's Talk as documented in Chapter 4, measurement would need to establish the extent and nature of practitioners' delivery and the organisation's capacity to support continued delivery. The CFIR (Damschroder et al., 2009) and Scheirer and Dearing's (2011) generic conceptual framework for sustainability, discussed in Chapter 3, highlighted the importance of exploring sustainability within the context of the implementation process. The different contexts within which the study and development of Let's Talk has occurred, acknowledged in Chapter 4, further informed this point.

This chapter draws all this together to present an outline of the research aim, questions and design before detailing the methodological framework. A summary of mixed methods research and its use in this thesis is presented. An overview is then provided of each phase of the research, including the methods used for data collection, participation and data analysis. The chapter concludes with a consideration of how the research addresses ethical and quality issues.

5.1 Research aim

This research aims to investigate the key elements for sustainability of Let's Talk in AMHS, in Victoria, Australia in order to inform service and workforce development to achieve better outcomes for families where a parent has a mental illness.

5.2 Research question

This research aim is explored through the question: what is important for sustainability of Let's Talk in AMHS?

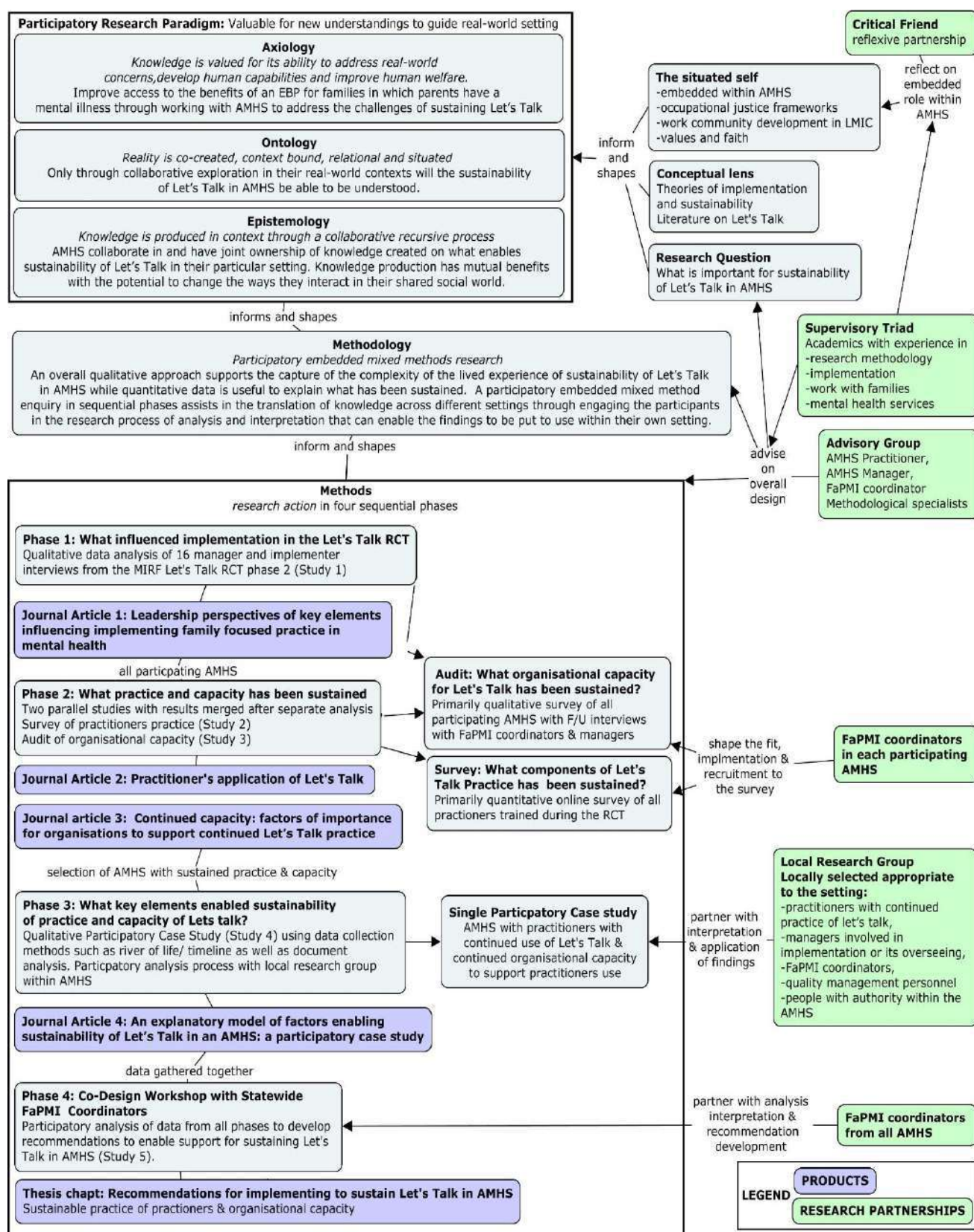
In order to understand this, it is vital to first understand what sustainability has occurred as a result of the Let's Talk RCT trial before exploring key elements from how this has occurred. This question has therefore, been further divided into two sub-questions:

1. What sustainability has occurred in the practitioner's Let's Talk practice and the organisation's capacity to support Let's Talk practice?
2. What key elements are critical for the sustainability of Let's Talk practice and organisation capacity?

5.3 Research design

The research question and participatory research framework influenced the research design, which incorporates a quantitative component within a primarily qualitative study. As a consequence, an embedded mixed method design (Creswell, 2014) was employed within a participatory approach. Sequential phases of the research were used to first establish what sustainability had occurred and then deeply explore how and why that sustainability occurred to determine critical key elements (see Figure 6).

Figure 6. Research design within participatory research paradigm



5.4 Mixed method design

Mixed method designs integrate different research methods to produce a more complete picture of the phenomenon (Bryman, 2016). Teddlie and Tashakkori (2013) assert that an essential characteristic of mixed method research is “methodological eclecticism” (p. 136). More than just combining methods, they describe this as selecting and integrating the most appropriate components of qualitative and quantitative methods in order to more thoroughly investigate a phenomenon. Methods can be combined sequentially, such as by using qualitative data to inform quantitative measures (explore), or needing quantitative data explained by qualitative data (explain; Creswell, 2014). Methods can also be combined to see how they match or give a more complete picture (converge; Creswell, 2014).

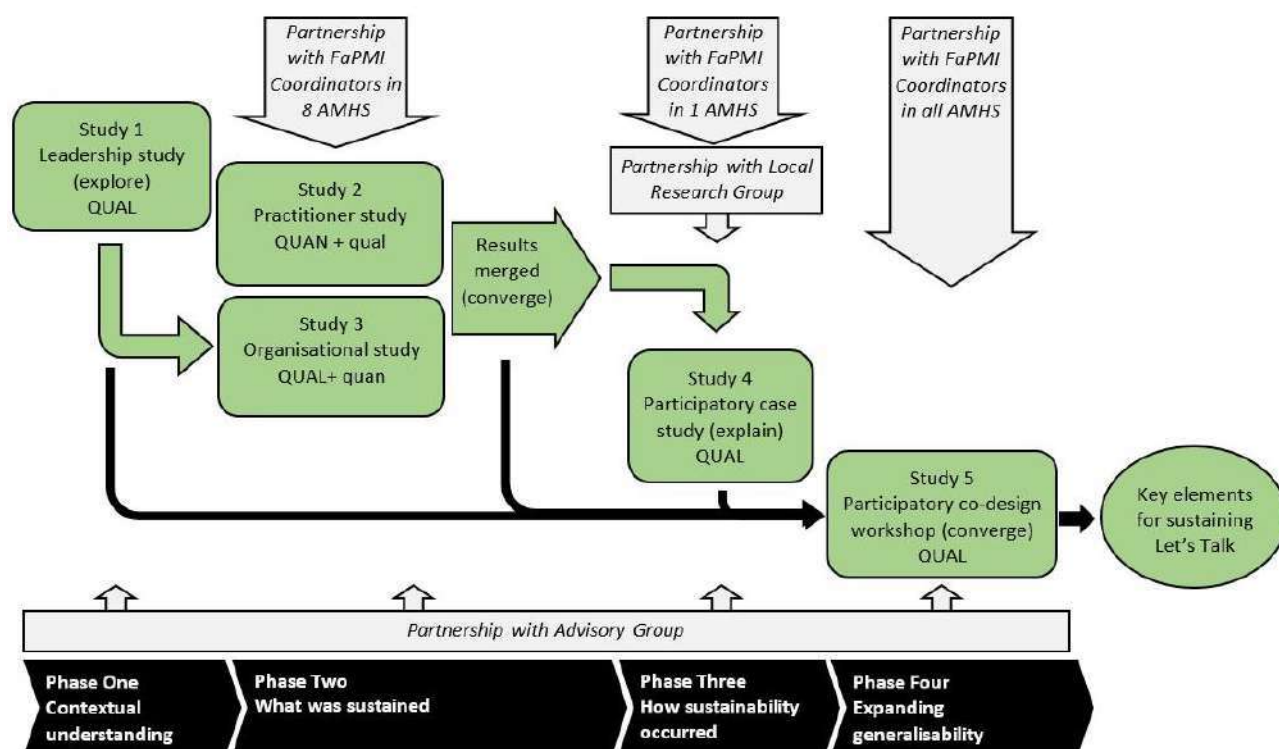
In mixed method research, the research questions determine the design. These are typically broad umbrella questions followed by more specific sub-questions (Teddlie & Tashakkori, 2013). The specifics in the sub-questions is what then determines the choices for method by picking the best tools to answer them.

This research’s question, ‘what is important for sustainability of Let’s Talk in AMHS’, needed to be broken into sub-questions to help to answer the specifics of ‘what has been sustained’ and ‘what key elements were critical’. As sustainability is being explored in the context of sustained practitioners’ Let’s Talk practice and sustained organisational capacity, each sub-question has two layers that reflect these constructions. The ‘what has been sustained’ sub-question led to a greater focus on quantitative data, establishing what practice and organisational capacity is currently there. The ‘what key elements were critical’ sub-question led us to explore how the established sustainability had been able to occur and if identified elements could be generalisable to other settings. This required deeper exploration that could take account of the specific contexts that may have influenced the sustainability of Let’s Talk practice, and so prioritised a greater focus on a qualitative approach.

The different phases of the research integrated qualitative and quantitative data in different ways (see Figure 7). Initially, the qualitative data in the leadership study (Study 1) was used to explore the setting and the implementation process, in order to inform and shape the measures for phase two’s organisational study (Study 3). The two studies in phase two separately analysed the quantitative data in the practitioners study (Study 2) and the quantitative and qualitative data in the organisational study (Study 3) before converging the results for combined analysis. After this, in phase three, the qualitative data in the participatory case study (Study 4) was used to explain the sustainability that had occurred in phase two. Then, the co-constructed qualitative data developed

in phase four's participatory co-design workshop (Study 5) converged the quantitative and qualitative data from the previous phases to develop a more complete picture of key elements for sustaining Let's Talk.

Figure 7. Overview of multiphase embedded mixed methods design of the research



5.5 Methods and phases of the research

The four phases of the study, outlined in Figure 6 and Figure 7, are sequential, with each phase building on the last to address the aim of the research. Table 4 presents an overview of the five studies executed in the four phases with their aim and methodological choices.

Phase one

The first phase developed contextual understanding through exploring leadership perspectives on key elements influencing implementation of Let's Talk (Study 1) in the previous RCT study (Maybery et al., 2017). A qualitative thematic analysis (Braun & Clarke, 2006) was applied to semi-structured interviews with managers and implementers that were engaged in the trial. The study used data previously collected during the RCT and applied an inductive analysis before deductively analysing the data using the constructs identified by the CFIR (Damschroder et al., 2009). The results were used to inform how to measure the organisational capacity in phase two.

Phase two

The second phase established what had been sustained in the eight AMHS sites involved in the RCT study by mapping both the practitioners' practice of Let's Talk and each organisation's capacity to support the practice in two parallel studies. A quantitative survey was used to establish the application of Let's Talk by trained practitioners (Study 2). The study employed statistical analysis using frequencies, summations, chi-square tests, one-way ANOVA, linear regression and multinomial logistic regression. The open-ended questions were analysed using content analysis (Elo & Kyngäs, 2008). A separate study (Study 3) established the implementation process that occurred in each organisation and their current capacity to support Let's Talk using a primarily qualitative organisational audit. The audit was informed by implementation frameworks and tools (Blase et al., 2013; Damschroder & Lowery, 2013; Fixsen et al., 2015; Maher et al., 2007). Data were collected via a questionnaire and telephone interviews, and a deductive content analysis (Hsieh & Shannon, 2005) was applied using constructs identified in the implementation and sustainability literature.

The results from the organisational audit (Study 3) were then examined in the context of the practitioner study (Study 2) to investigate the role of organisational factors for the differences seen in practitioners' delivery of Let's Talk. The AMHS current organisational score was used to explore differences and patterns between organisations with and without practitioners with continued use of Let's Talk. The results from these studies were used to determine which AMHS to study in more depth in the next phase to understand the sustainability that had occurred.

Phase three

The third phase explored how sustainability had occurred in one AMHS that had practitioners with sustained Let's Talk practice and had organisational capacity to support Let's Talk. A single participatory case study was used to develop an explanatory model (Study 4). This method was chosen because it allows for complexities to be studied in-depth in their real-world context by engaging participants in the research process of analysis and interpretation (Simons, 2009). Data were co-constructed through five workshops with a local team of practitioners, management and lived experience staff. Following Wolcott's (1994) approach for transforming data through description, analysis and interpretation, a participatory thematic analysis was used to identify key influences at that AMHS. Inductive analysis was first applied to build a localised understanding of what had been important for sustainability of Let's Talk. These 'influences' were then refined by deductive analysis against constructs and drivers from three implementation and sustainability frameworks; CFIR (Damschroder et al., 2009), Scheirer & Dearing's (2011) generic conceptual framework for sustainability and the Active Implementation Frameworks (Blase et al., 2012). The relationships between the 'influencers' were then mapped against the relationships posed in

Scheirer & Dearing's (2011) generic conceptual framework for sustainability, to develop an explanatory model.

Phase four

The fourth phase developed a more complete picture of what is important for sustainability of Let's Talk by using a participatory co-design workshop (Study 5) to expand the generalisability of the previously collected data. The workshop drew on co-constructed data of the experiences of FaPMI coordinators, data from all previous phases as well as a summation of implementation and sustainability literature. A multi-stage participatory framework analysis guided by Srivastava and Thomson (2009) deductively developed consolidated recommendations applicable to other AMHS for implementing and sustaining Let's Talk.

Table 4: Overview of phases and studies in the thesis

Phase	Study	Study aim	Study design	Participants/ informants	Data collection	Data analysis
1	Study 1: Leadership perspectives on implementing Let's Talk	To explore leadership perspectives on key elements influencing implementation of Let's Talk during the RCT study	Qualitative study using semi-structured interviews	Managers and implementation leads (n=16)	QUAL: Semi-structured interviews (previously collected during RCT study)	Inductive and deductive thematic analysis, using the CFIR (Braun & Clarke, 2006)
2	Study 2: Practitioner application of Let's Talk	To establish how trained practitioners from eight AMHS applied Let's Talk during and post the RCT	Quantitative survey including open-ended questions	Trained practitioners from eight AMHS (n=73)	QUAN + qual: Questionnaire with open-ended questions	Statistical analysis using frequencies, summations, chi-square tests, one-way ANOVA, linear regression & multinomial logistic regression Content analysis of open-ended questions (Elo & Kyngäs, 2008)
	Study 3: Organisational capacity to support Let's Talk	To establish the implementation process and the current organisational capacity to support Let's Talk at the eight AMHS.	Qualitative study using audit tool and interviews	FaPMI coordinators (organisational audit & follow up interview) (n=8) Managers (interview n=5)	QUAN + qual: Questionnaire with open-ended questions with follow-up telephone interviews Semi-structured telephone interviews	Deductive content analysis (Hsieh & Shannon, 2005)

3	Study 4: Single case study of sustained practice and capacity	To build an explanatory model to explain how sustainability occurred in one AMHS	Participatory single case study	Local AMHS research group (n=6)	QUAN & QUAL: Co-constructed data from five workshops & documents	Participatory thematic inductive & deductive analysis using Scheirer & Dearing's (2011) generic conceptual framework for sustainability (Wolcott, 1994)
4	Study 5: Co-design workshop developing recommendations	To expand the generalisability of previous phases and develop a more complete picture of what is important for sustainability of Let's Talk	Participatory convergent mixed method study	Statewide FaPMI coordinators (n=20)	QUANT & QUAL: Co-constructed data from workshop Data from all phases	Deductive multi-stage participatory framework analysis (Srivastava & Thomson, 2009)

5.6 Data sources and management

Multiple data sources are utilised in mixed method research to inform and build a more complete picture of the phenomenon (Bryman, 2016). In this research, qualitative data were sourced from interviews (Studies 1 and 3), questionnaires (Studies 2 and 3), documents (Study 4) and participatory workshops (Studies 4 and 5), while quantitative data were sourced from questionnaires (Study 2) and documents (Study 4). Audio recordings were taken of interviews (Studies 1 and 3) and participatory workshops (Studies 4 and 5) and photos were taken of the outcomes of participatory activities (Studies 4 and 5). While transcripts were made of interviews from Study 1, all other audio-visual material was coded directly in combination with notes taken in the interview or material generated in the workshop to support greater accuracy in meaning, as suggested by Collins et al. (2019), Halcomb and Davidson (2006) and Tessier (2012). In some of the studies, this was supported by tools that can store and combine different data collections such as Microsoft OneNote (2013; Study 3) and NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018; Studies 4 and 5).

While in one study (Study 1) the qualitative data were gathered and analysed in isolation, the goal of using quantitative and qualitative data was to create a more complex picture through comparison, triangulation and cross validation. As a result, data collected in one study was used in the analysis of another study. For example, the organisational capacity study (Study 3) drew on the quantitative data collected on practitioners' application of Let's Talk (Study 2) to compare with the qualitative data, cross-validating the results on what was important for sustainability. This cross-use of data sources is also seen in the case study (Study 4) where a subsection of the quantitative data collected in the practitioner study (Study 2) and the qualitative data collected in the organisation study (Study 3) was triangulated with other service data collected from service documents to validate results and build consistency.

5.7 Data analysis

This research used a combination of data analysis approaches to achieve the overall focus on the phenomenon being studied, 'what is important for the sustainability of Let's Talk'. Mixed method research uses an iterative cyclic approach that can include both inductive and deductive logic. The research process can begin at any point on the cycle which includes using inductive reasoning from grounded results and deductive reasoning from abstract theory or frameworks (Teddle & Tashakkori, 2009). This research employed both inductive approaches, to explore what was important for sustainability of Let's Talk from the contexts being studied, and deductive approaches, using concepts known to impact implementation for sustainability from the CFIR (Damschroder et

al., 2009), Scheirer & Dearing's (2011) generic conceptual framework for sustainability, the Sustainability Model (Maher et al., 2007) and the Active Implementation Frameworks (Blase et al., 2012).

The thesis, overall, has been guided by Wolcott's (1994) approach of transforming data through description, analysis and interpretation. Rather than discrete or sequential, these three processes were iterative and addressed throughout the research phases. This approach suits investigation of a phenomena within its context and has been used within participatory forms of research (Simons, 2009). The approach is flexible, allowing for the incorporation of different analytical strategies to build a more complete picture. In this research, analysis methods applied to the qualitative data included thematic analysis guided by Braun and Clarke (2006; Studies 1 and 4), content analysis guided by Elo and Kyngäs (2008; Study 2) and Hsieh and Shannon (2005; Study 3), and framework analysis guided by Srivastava and Thomson (2009; Study 5). Additionally, descriptive and statistical analysis was applied to the quantitative data in this research (Studies 2, 3 and 5). These analytical strategies were chosen to address the specifics of the different studies as noted above and the detail can be seen in Table 4. The iterative process of description, analysis and interpretation was also utilised at a whole-research level with the interpretation in one study providing part of the description in another.

5.8 Participants and participation

Participatory research, as discussed in depth in Chapter 2, co-creates knowledge with those affected by the research. The word 'participation' in this research is focused on the different configurations of research partners who have participated in this co-creation of knowledge. These research partners are outlined in the chapter on the theoretical paradigm (Chapter 2) and can be seen in the research design Figure 6. Additionally, each study also had participants or informants that had been the source of the data collected. In some studies, the participants may also have been members of one of the categories of research partners, such as the FaPMI coordinators from the eight AMHS who were the participants or informants in the organisational study (Study 3) and research partners for phases two to four. In other studies, the participants were not direct research partners, such as all practitioners trained in Let's Talk during the RCT (Study 2). An outline of all participants for each study can be found in Table 4.

5.9 Ethical approvals, considerations and rigour

Banks and Brydon-Miller (2019) argue that traditional ethical considerations in research are focused on the 'human subjects' of research that assume a distinction between the researcher and the

researched. In participatory research, however, the research production process actively challenges assumptions of expertise and the systems of power that create these distinctions. Consequently, ethical considerations in participatory research are not limited to the protection of harm of participants but intertwined in the knowledge production process (Banks & Brydon-Miller, 2019). In this thesis therefore, consideration of ethical research practice is interwoven with methodological quality and rigour.

In this section, the ethical approvals underpinning this research are documented before addressing how ethical and quality issues are considered. These are explored through participatory research's interconnected core values and principles: participation, collective co-creation of knowledge, creating impact beyond academic knowledge, the primacy of local context and reflexivity (Springett, Wright, & Roche, 2011). Finally, quality in the context of mixed methodology is discussed and applied to this research.

Ethical Approvals

As a requirement for research to uphold high ethical standards and protect the rights and wellbeing of people involved in the research, ethical approval for the initial studies in this research (Studies 1-4) was obtained from Monash University Human Research Ethics committee as amendments to the project: Developing an Australian-first recovery model for parents in Victorian mental health and family services (Maybery et al., 2017). This project was initially identified as CF13/3301 - 2013001719 and in changing to an electronic ethics review management became ID 4536 in 2017 (see Appendix A). This project also had ethical approval from eight individual health service ethics committees. As project ID 4536 expired in January 2019, approval for the last phase of the research (Phase 4; Study 5) was obtained from Monash University Human Research Ethics committee as the project: Sustainability and Let's Talk about Children (ID: 19848) on the 5 June 2019 (see Appendix B).

Participation

Ethics and quality in participatory research are concerned with how participation occurs across the research process (Cargo & Mercer, 2008). As noted in Chapter 2, enabling equitable partnerships by focusing on who needs to participate when can ensure participation adds value to the research and the partners while not adding unnecessary burden. To support this balance and to aid with transparency, identification of participants in this research used Mercer et al.'s (2008) guidelines for participatory research. Participation across the three areas of the research process as specified in the guide was addressed through the different partnerships as noted in Table 5. The Advisory Group, with its mix of partners that met less intensively, were able to contribute to the whole research process through shaping the purpose and scope, enhancing the study designs, influencing

methodological choices, enabling contextual implementation, enriching interpretation and supporting application. The FaPMI coordinators from the eight AMHS were pivotal in phase two (Studies 2 and 3) to contextualise and test the methods of data collection, and enable recruitment of participants and the completion of measures. The Local Research Group in one AMHS that partnered only for one study (Study 4) worked in partnership to identify and co-construct data as well as interpret, apply and disseminate the results. Participants from the whole FaPMI coordinator network partnered with me and my supervisors in the co-design workshop (Study 5) to interpret and apply the results contextually. Through participation in each of these partnerships, members also gained a deeper knowledge of practice within their own services and of implementation and sustainability thus supporting the ethical stance of reciprocity.

Table 5. Partnerships across the research process

	Shaping the purpose and scope of the research	Research implementation and context	Interpretation and application of research outcomes
Advisory Group	✓	✓	✓
FaPMI coordinators (8 AMHS)		✓	✓
Local Research Group		✓	✓
All FaPMI coordinators			✓

Aware of my need to minimise harm and uphold the rights of those participating in research, the studies engaged with all participants and research partners on the basis of voluntary engagement with informed written consent. Even with these clear process in place not all relational issues can be foreseen. Participatory research draws on what is described as covenantal ethics (Brydon-Miller et al., 2013) to address ethical issues as they arise through enacting an ethical stance and working through collaborative reciprocal relationships (MacFarlane & Roche 2019). Such relationships require mutual trust and respect between the researcher and those participating in the research which in turn support empowerment, capacity building and joint ownership (Cargo & Mercer, 2008).

As noted in Chapter 2, mutual trust and respect were assisted by being part of statewide network of FaPMI coordinators which supported collective ownership of the research and facilitated recruitment. At the same time, there was a need for me to balance these close relationship with clear boundaries to ensure that people could contribute as much or as little to the process as they were willing and feel free from coercion. Clear terms of reference and procedures for

communication were established as part of the engagement process for all the research partnerships: Advisory Group, FaPMI coordinators and the Local Research Group (Appendix C, D and E). The co-developed documentation was tailored to the specific context as suggested by Kalsem (2019). These documents outlined the responsibility of myself to lead and drive the partnership process to enable a culture of co-learning and reflexivity. They also outlined my responsibility to deliver written communication in the form of minutes of advisory meetings, summaries of sessions, explanatory statements and terms of reference documents.

Informal communication via email and phone calls was used to support the participation of all members of the groups. Ethical navigation was required to determine how to interpret missed deadlines or communication and how actively to pursue follow-up contact. While a lack of communication could be interpreted as a lack of interest or a wish to withdraw, as a researcher embedded within the same settings I also knew how my intentions could be sidelined by workplace pressures where research was an extra activity. I used that inside knowledge, the established relationship and compassionate interactions to navigate this with the different partners throughout the research process.

Additional ethical considerations in partnerships require thought about anonymity, privacy and confidentiality. The documents above outlined the boundaries for the confidential use of data, the de-identification of individual participants and their organisation, and mechanisms to support privacy. Individual anonymity was upheld through assigning participants with identifiers (roles in Studies 1, 3 and 4; numbers in Study 2). Organisations were identified only by number and general descriptors related to size and type of location providing some level of anonymity. However, for those working closely within these system, these characteristics may still have enabled identification. To address this, people in authority within the organisations had opportunity to construct the identifying data being used (Studies 3 and 4).

Anonymity may be undesirable as well as not possible in participatory research. There is tension between being able to credit the contributions in the co-developed knowledge to those in the partnership and protecting their identity. Anonymity can perpetuate power imbalances in research through masking the co-researchers role, and robbing them of the credit for their work (Kalsem, 2019). In this research, the Local Research Group members decided to co-author a journal publication as the means to disseminate the results of their work in the case study (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). This resulted in the identification of them, and by default, their organisation. While the initial terms of reference for the partnership outlined a possibility of anonymity, this was renegotiated as part of the partnership process and individuals chose to opt-in

to both the authoring and being identified by name. While this raises ethical dilemmas about the rights of the individual verse the rights of the organisation, in this case, there was limited risk and potential advantage for the organisation due to the strength-based nature of the inquiry focusing on facilitators for sustainability.

Collective co-creation of knowledge

Co-constructed knowledge is valued in participatory research for its capacity to build knowledge that addresses real-world issues that can be more easily applied, as it can enable faster translation of knowledge to practice (Cargo & Mercer, 2008). The generation of co-created knowledge requires the building of trusting spaces that pay attention to the power dynamics and enable different voices to be valued (Springett et al., 2011). My role as the researcher was to build mutual trust and respect with the various partners and to work at enabling space for different voices to be heard through analysing the power dynamics and working to address these. For example, power disparity was most evident in the Local Research Group (Study 4), with some having the freedom to arrange their own diaries and the confidence that their opinions counted, such as the quality manager, senior and middle manager, and the FaPMI coordinator. In contrast, others who had jobs tied to service delivery and a concentrated view of practice, such as the practitioner and lived experience worker, had more difficulty attending and as a result a diminished sense of the value of their voice. To offset this, I acknowledged the power disparity in the first meeting and collectively developed group norms. I used participatory activities that enabled equity of sharing. I also actively followed up absent participants between meetings and incorporated their voice into communication for the next meeting.

Another way in which the co-creation of knowledge was facilitated was through communication with partners that gave them timely opportunity to contribute. I created flexible opportunities for communication with the FaPMI coordinators from the eight AMHS in phase two by utilising methods they preferred (phone, email, text) at times that suited them with a non-judgmental stance. As a result of these strategies, partners' contribution to the measures (Studies 2-5) helped to anchor the data collection to practice, while their involvement in the interpretation and application of the results (Studies 4 and 5) built knowledge they could apply in their settings.

Creating impact beyond academic knowledge

A principle intent of participatory research is to create social change as part of the research process (Springett et al., 2011). This can take different forms depending on the research focus but ideally would include development or learning for the partners as well as the intended research outcomes (Springett et al., 2011). In addition to engaging partners for their expertise in shaping research,

participatory research expects that researching *with* people rather than *about* them creates reciprocal benefits. The engagement of partners in this research had an explicit goal of building the capacity of the FaPMI coordinators in future implementation and sustainability workforce development initiatives. The choice of methods for Study 4 and 5 created space for sharing what had been learnt in the other studies, and building participants' knowledge and understanding through communicative action. The evaluation done in Study 5 (documented in Chapter 9) highlights how the research process achieved this.

Primacy of local context

Supporting the value of co-constructed knowledge for real-world issues is the importance placed on learning about the real-world of particular people, in a particular time and place (Kemmis & McTaggart, 2005). Overall, this research's attention to what sustainability had occurred in the eight AMHS and how that had occurred, focused on understanding the real experiences of the AMHS. The data collection method in the organisational study (Study 3) allowed for context rich information enabling contextual categorising. The method of the participatory case study (Study 4) was chosen to explore in-depth the particulars of how sustainability had occurred in one AMHS. Furthermore, the participatory co-design workshop (Study 5) was designed to apply the knowledge developed to the local context of the participants.

Reflexivity

Underlying the principles of participation and knowledge creation in participatory research is the need to be aware of the role of the researcher in constructing meaning (Springett et al., 2011; Banks & Brydon-Miller, 2019). Reflexivity is the process in which the researcher intentionally pays attention to the values, biases, beliefs and positioning they bring to the research and knowledge creation process (Denzin & Lincoln, 2013a).

As acknowledged in the introduction (Chapter 1), I come to the research with multiple positions that adds a layer of complexity and potential conflicts. My insider position as FaPMI coordinator within one of the eight AMHS participating in the research, affords me the privilege of understanding the structure and mechanisms of the system and an already established trust within the network. It does also, however, create the potential to lead me to assumed knowledge and unchecked interpretations. Situated within an AMHS, I am also part of the context being studied. My actions as an internal service development coordinator are being examined within the exploration of what enables sustainability.

This was additionally heightened in phase three when the organisation selected to partner in the case study was the one in which I work. While providing some advantage given the deep knowledge

of the organisation, it resulted in some tension in both my role as researcher and as FaPMI coordinator. I was exposing myself as an inexperienced researcher in a setting where I had established credibility in my substantive role, while I was simultaneously exposing my work to scrutiny by my co-workers cum co-researchers. Utilising participatory research processes within collaborative relationships created multiple opportunities for checking my assumptions and interpretation. Furthermore, assuming a position of humility and an openness to critique allowed for candid conversations within those relationships.

Several methods of critical appraisal and reflexivity, identified in Chapter 2 assisted in this process. The PhD supervisory process has served as a formal monthly process in which my assumptions were challenged and I was encouraged to explore areas of conflict. Additional weekly to fortnightly meetings with my principal supervisor supported this process. The Advisory Group's quarterly meeting created an opportunity to review what I have learnt through perspectives of different AMHS. A critical friend provided a non-Victorian perspective and reflective space to explore the role of the participant-researcher and allowed for my assumptions to be challenged. Lastly, the use of reflexive research memos created space for my own reflections on how my positioning, values and beliefs shaped the research process, which I was then able to further reflect on in the above supportive structures.

Quality in mixed methods research

Quality issues in mixed methods research are explored in relation to the legitimacy of the blending of methods and the validity for the quantitative and qualitative components of the research (Bryman, 2016; Creswell, 2014). As noted in the mixed methods design section above, the research design used in this study follows logically from the research questions supporting the legitimacy of the blending of methods. The collection and analysis of different sorts of data (quantitative and qualitative questionnaire results, documents, interview transcripts, audio recordings and notes) provided triangulation of sources. Credibility was supported by the participatory process of communicative action which creates legitimacy for those involved or affected (Kemmis & McTaggart, 2005). Member checking (Studies 3, 4 and 5) also supported credibility through verifying the data collected. Dependability was supported by having multiple researchers involved in the participatory analysis process (Baxter & Jack, 2008). The Advisory Group's input across the whole study enabled the design, collection methods and analysis to be grounded in practice wisdom as well as providing a reflexive process. Working with a Local Research Group served to build peer reviews into the analysis process, and locally helped to ensure that what was gained was transferable to practice in that setting. The input from the statewide FaPMI coordinator network gave valuable insight to the

relevance of the findings for real-world settings, building transferability across contexts. Lastly, the breadth of method expertise within the supervisory team gave methodological rigour to the research process.

5.10 Research methodology summary

This research utilised an embedded mixed method design within a participatory paradigm to study the sustainability of the Let's Talk intervention after its implementation in AMHS during a RCT. The knowledge translation benefit of a participatory process lends itself to implementation research. Additionally, participatory research is well suited to my dual role of researcher in a service development role within an AMHS. The research sub-questions exploring 'what sustainability has occurred' and 'what key elements are critical for the sustainability' led to mixed methods being an appropriate design choice. Four sequential phases of research, which include five studies, were used to build an understanding of the context, establish what was sustained, explore what enabled sustainability and expand generalisability of the findings. Multiple data sources were used to build a deeper understanding of key elements for sustaining Let's Talk in AMHS. Both inductive and deductive analysis were applied in an iterative process of transforming data through description, analysis and interpretation (Wolcott, 1994). Utilising a participatory research paradigm, quality and ethics considerations are intertwined for both protecting the participant and in producing knowledge.

This is the final chapter of the first section of the thesis. The chapters that follow document the four sequential phases of the research and their studies (Chapters 6-9). Each chapter explains the purpose of the phase, giving an overview of how it contributes to the research aim, after which the study or studies are detailed. In three of these phases (Chapters 6, 7 and 8), the study's methods, findings and implications are presented in the form of published journal articles. Each chapter concludes by integrating the new knowledge gained into the growing understandings of key elements for sustaining Let's Talk in AMHS.

Chapter 6 Phase one: What influenced implementation in the Let's Talk RCT

This chapter outlines the first phase of the research in which a qualitative study was used to understand leadership perspectives on implementing Let's Talk as part of an RCT. The chapter first explains the background to this phase, giving a short synopsis of the study and highlighting its importance to the overall research. The study's methods, findings and implications are then detailed in the paper published in Volume 27, Issue 5 of the *Journal of Psychiatric and Mental Health Nursing* on 2 Feb 2020 (see p.87–98; Allchin, Goodyear, et al., 2020). The chapter finishes with a summary explaining how the study's findings and implications are used in the next phase of the research.

6.1 Background and relationship to the thesis

As noted in the previous chapter, this research aims to investigate the key elements for sustainability of Let's Talk in AMHS, in Victoria, Australia by following eight services after its supported implementation during an RCT (Maybery et al., 2017). The aim is explored through the research question: what is important for sustainability of Let's Talk in AMHS, and its two sub-questions i) what sustainability has occurred in practitioners' Let's Talk practice and the organisation's capacity to support Let's Talk practice? and ii) what key elements are critical for the sustainability of Let's Talk practice and organisation capacity?

Exploring sustainability from within a participatory research paradigm places importance on the local context. Consequently, before studying 'what sustainability had occurred', phase one explored the context of implementation during the RCT from the perspective of those involved in overseeing it locally, in order to help frame the inquiry in the future phases.

6.2 Study synopsis

Aims and method

Phase one aimed to identify key elements that influenced the process of implementation of Let's Talk from a leadership perspective. Sixteen (m=9, f=8) semi-structured interviews with people in leadership or lead implementer roles were conducted in the final year of the RCT by Melinda Goodyear and Phillip Tchernagovski from the RCT research team. Leadership was represented from all participating organisations which included AMHS, MHCSS (also known as Psychiatric Disability and Rehabilitation and Support Services [PDRSS] or Mental Health Disability Support [MHDSS]) as well as Child and Family Services. The interview schedule (Appendix F) informed by the CFIR, explored leaders' views of Let's Talk and their experience of implementation barriers and enablers through

open-ended questions with prompts. A qualitative thematic analysis inspired by Braun and Clarke (2006) was used to develop themes, first inductively and then deductively against the CFIR constructs.

Findings and implications

The study found that the changing environment, leadership levels, roles and approaches to change, as well as the readiness of practitioners and parents influenced the implementation of Let's Talk during the RCT. From these findings, it is suggested that engaging leadership in the implementation process needs to take into account the different roles of senior and middle managers and their influence. Additionally, further research is suggested to understand the dynamic relationship between parent and practitioner readiness for trialling Let's Talk (Allchin, Goodyear, et al., 2020).

6.3 Paper 1: Leadership perspectives on key elements influencing implementing a family-focused intervention in mental health services

The study's methods, findings and implications can be found in the paper published in the *Journal of Psychiatric and Mental Health Nursing*. The complete paper is included over the page.

Citation: Allchin, B, Goodyear, M, O'Hanlon, B, Weimand, BM. (2020), Leadership perspectives on key elements influencing implementing a family-focused intervention in mental health services. *Journal of Psychiatric Mental Health Nursing*, 27(5),616–627. <https://doi.org/10.1111/jpm.12615>



Leadership perspectives on key elements influencing implementing a family-focused intervention in mental health services

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Accessible Summary

What is known on the subject?

- Family-focused interventions in Adult Mental Health Services (AMHS) address the needs of families where a parent is diagnosed with a mental illness. One of these interventions is the "Let's Talk about Children" programme (Let's Talk) (Solantaus & Toikka, 2006 *International Journal of Mental Health Promotion*, 8(3), 37).
- There is limited implementation knowledge on family-focused interventions.
- A body of research to better understand the transfer of evidence-based interventions into everyday practice has identified multiple influencing elements. The Consolidated Framework for Implementation Research (CFIR) has combined these known elements from research into five domains of influence.
- Elements that influence the implementation of evidence-based practice are inter-related and need to be understood in combination.
- Understanding different stakeholder perspectives on implementation in real-world settings helps to understand uptake, challenges and opportunities.

What the paper adds to existing knowledge?

- As the first study to document leadership's perspectives of implementing Let's Talk, this paper contributes to the evidence base on their role in implementing family-focused practice models in mental health.
- There are specific roles of leadership that need to be addressed to support implementing Let's Talk in changing environments.
- Leadership's knowledge of Let's Talk and approach to change influences implementation.
- Questions are raised about the role the readiness of the parent and the impact that the dynamic process between the practitioner and parent has on implementing Let's Talk.

What are the implications for practice?

- Engaging leadership needs to address the influence of their different organizational roles in shaping implementation for Let's Talk.
- Further research is needed to understand the dynamic process between parent and practitioner that influences readiness for trialling Let's Talk.

Abstract

Introduction: Different stakeholder's perspectives are needed to understand challenges and opportunities in implementing and sustaining evidence-based practices (EBP) in real-world settings.

Aim/Question: To identify leadership perspectives on key elements influencing the process of implementation of Let's Talk about Children (Let's Talk), a family-focused practice for practitioners working with parents diagnosed with a mental illness.

Method: Semi-structured interviews were conducted with 16 service managers and implementation leads, to establish their views on key elements influencing implementation of Let's Talk during a randomized controlled trial. A thematic analysis applied both inductive and deductive approaches, using the Consolidated Framework for Implementation Research (CFIR).

Results: Impacts to effective translation to practice were grouped into three broad themes with eight subthemes: inner and outer setting impacting organization, leadership affecting readiness and parent and practitioner readiness.

Discussion: The findings suggest that specific roles for leadership are vital to implementation within an environment of constant change, and more attention is needed to understand the dynamics of parent and practitioner readiness for delivering Let's Talk.

Implications for practice: Different leadership roles need to be engaged to sustain Let's Talk in changing real-world environments. The dynamic processes between parent and practitioner are suggested to influence readiness and need further research.

KEYWORDS

consolidated framework for implementation research (CFIR), implementation, leadership, let's talk about children, managerial support, parents diagnosed with a mental illness

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6 | RELEVANCE STATEMENT

This study gives insight into leadership in mental health about how to support nurses, as the majority of practitioners in the mental health workforce, to address their hesitancy and expand their remit to work with parents diagnosed with a mental illness in a more strength-based manner through the implementation of Let's Talk.

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CONFLICT OF INTEREST

The authors declare they have no conflict of interest.

AUTHOR CONTRIBUTION

BA analysed all the transcripts and led the write-up of the paper. MG conceptualized the study. MG and PT conducted the interviews. MG confirmed the thematic analysis. BW and BOH contributed to the refining of the analysis and interpretation of results in drafting the manuscript. BA, MG, BOH and BW contributed to the refining of the manuscript, reviewed the drafts and contributed to the write-up.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study obtained ethical approval through both Monash University Human Research Ethics Committee on 29 January 2014 (approval number: CF13/3300120130017) and the individual ethics committees of seven other regional health authorities.

DATA AVAILABILITY STATEMENT

Please contact Melinda Goodyear at Melinda.goodyear@monash.edu for data requests.

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exclusively quantitative questionnaire, these results highlighted the need to collect quantitative data in the context of qualitative data, to enable AMHS to explain their setting's implementation process and the context of the infrastructure they had in place to support the practice of Let's Talk.

In the next chapter (Chapter 7), the thesis shifts to establish what was sustained by mapping both the practitioners' practice of Let's Talk (Study 2) and each organisation's capacity to support the practice (Study 3), which is the focus of phase two.

Chapter 7 Phase two: What practice and capacity has been sustained

This chapter outlines the second phase of this research in which two parallel studies were used to establish what was sustained in the eight AMHS. The focus of this phase is the first research sub-question: what sustainability has occurred in practitioners' Let's Talk practice and the organisation's capacity to support Let's Talk practice?

Firstly, the chapter gives an overview of the purpose of the phase, explains the relevance of this phase to the research overall and presents a synopsis of the two parallel studies. Each study's methods, findings and implications are then detailed in two papers published in Volume 29 Issue 5 and 6 of the *International Journal for Mental Health Nursing* on 25 September 2020 (see p.105–117; Allchin, O'Hanlon, Weimand, & Goodyear, 2020) and 11 November 2020 (see p.119–131; Allchin, Weimand, et al., 2020). The chapter concludes by presenting what was learnt about what sustainability occurred in the eight AMHS by converging the results of the two parallel studies before explaining how this informed the next phase of the research (Phase 3).

7.1 Overview and relationship to the thesis

In order to understand what was important for sustaining Let's Talk in AMHS, the research had to first establish an understanding of what was sustained following the RCT. As discussed in the chapter on the conceptual lens of sustainability (Chapter 3), sustainability was explored in this research as continued practice and continued capacity (Stirman et al., 2012). Consequently, the focus of this phase was to establish i) the extent to which the elements of Let's Talk had been maintained by practitioners, including how they had been adapted, and ii) the capacity of the organisations to continue to support Let's Talk delivery.

Given the importance of context in participatory research, this phase needed to see what is sustained in the context of what was implemented and how practitioners had applied Let's Talk over time. This led to the phase having two parallel studies: one establishing practitioners' application of Let's Talk and the other establishing each AMHS' implementation process and its organisational capacity to support Let's Talk. In this phase, the Advisory Group, along with the FaPMI coordinators from each of the eight AMHS, partnered in the development and implementation of the studies. A synopsis of the two parallel studies is presented next, followed by their respective papers detailing each study's methods, findings and implications.

7.2 Study 2 synopsis: Practitioner application of Let's Talk

Background, aims and method

During the RCT a master trainer model was used to train practitioners in the eight AMHS with local trainers within each AMHS being selected and supported by FaPMI coordinators (Maybery et al., 2017). Each service had a local plan for implementing Let's Talk, resulting in a varying number of practitioners trained in each service and practitioners being trained at different points through the RCT. FaPMI coordinators from each of the eight AMHS partnered in the process of developing and testing the quantitative questionnaire in this study as well as identifying and recruiting the participants. The questionnaire contained three categories of questions: i) practitioners' demographics, ii) training and support they received, and iii) their application of Let's Talk. The questionnaire was piloted for content and online usability by FaPMI coordinators and/or practitioners (Appendix G). Each FaPMI coordinator identified a list of trained practitioners still employed at the service which was consolidated with the research database. Each practitioner was then invited to participate, via email, in an online questionnaire. Quantitative data were analysed using statistical analysis that included frequencies, summations, chi-square tests, one-way ANOVA, linear regression and multinomial logistic regression. Qualitative data were analysed using content analysis (Elo & Kyngäs, 2008).

Findings and implications

The study is the first to document AMHS practitioners' application of Let's Talk after training. As a result, it established a baseline about practitioner uptake and continued use of Let's Talk that can be used for future implementation. The study found that practitioners' use of Let's Talk was influenced by their gender, profession, access to support, time since training and the percentage of parents on their caseload. The findings suggest that practitioners' uptake and continued use of Let's Talk might be enhanced through targeted selection and building tailored post-training supports. These findings can aid AMHS implementation endeavours to improve parents' access to the benefits of Let's Talk.

7.3 Study 3 synopsis: Organisational capacity to support Let's Talk

Background, aims and method

Building on the findings in phase one (Study 1), this study sought to establish the capacity of the organisations to continue to support Let's Talk delivery in the context of the local implementation process. As noted in the previous chapter, the study design was developed in consultation with the

Advisory Group, resulting in an organisational audit tool with follow-up telephone interviews with FaPMI coordinators for clarification and with managers for context.

The audit tool was a self-administered questionnaire that was informed by three implementation and sustainability frameworks: the CFIR (Damschroder et al., 2009), the Sustainability Model (Maher et al., 2007) and two NIRN assessments - *Stages of implementation analysis: Where are we?* (Blase et al., 2013) and *Implementation drivers: Assessing best practices* (Fixsen et al., 2015). The questionnaire was divided into three parts: i) demographic details of the participant and organisation, ii) questions about the implementation process, and iii) questions about the current capacity of organisations to support Let's Talk. A semi-structured interview for managers explored the implementation of Let's Talk and the organisation's usual methods of supporting practice development. The questionnaire was then refined after testing with FaPMI coordinators for content relevance and useability (Appendix H). The qualitative and quantitative data from the questionnaire, and telephone interviews were analysed together using a deductive content analysis (Hsieh & Shannon, 2005) against constructs identified in the implementation and sustainability literature.

Findings and implications

Two key elements of the organisation's implementation approach were identified in the study as their intentions for implementation at engagement, and making changes to fit Let's Talk into their service. The current capacity of organisations to support Let's Talk was mapped against nine components. The study found that organisations more commonly had overseeing staff, collected data, and had infrastructure for practice support. Least common components were knowing if practitioners were using Let's Talk, having training infrastructure, using the data that they collected and having a governing policy or practice guideline for Let's Talk.

The findings from this study were compared with data from the practitioners' application study (Study 2). Using the AMHS with sustained practice (defined as practitioners' delivering Let's Talk in the past 12 months) services with practitioners currently delivering Let's Talk had higher current organisational capacity scores. These services had also all made changes to their organisational structures to support Let's Talk practice.

The findings from this study suggest that addressing organisational capacity is important for sustained practice of Let's Talk. Oversight of implementation by internal support staff appears to support organisational capacity through data collection and practice support. Whole-of-organisational support, however, seems to be needed in order to integrate the complex internal systems that are required. These findings provide AMHS with practical guidance for sustaining Let's Talk.

7.4 Paper 2: Practitioners' application of Let's Talk about Children intervention in adult mental health services

This paper presents the methods, findings and implications of the quantitative study on the application of Let's Talk by practitioners of the eight AMHS who were trained during the RCT. It was published in Volume 29, Issue 5 of the *International Journal of Mental Health Nursing* on 25 September 2020. The complete paper can be found over the page.

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ORIGINAL ARTICLE

Practitioners' application of Let's Talk about Children intervention in adult mental health services†

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ABSTRACT: Family-focused interventions can improve outcomes for families where a parent has a mental illness. One such intervention, Let's Talk about Children (Let's Talk), is a series of parent–practitioner conversations in adult mental health with demonstrated improved outcomes for child, parent, and family well-being. This study used a questionnaire to understand the application of Let's Talk by n = 73 trained practitioners from eight adult mental health services who were previously involved in a randomized controlled study in Victoria, Australia. Data were analysed to establish the application of Let's Talk, and statistical analyses were undertaken to identify what influenced practitioners' delivery of Let's Talk. The study details how practitioners used Let's Talk and indicates that most used it as designed, with the majority offering it to parents and approximately 40% delivering it. The findings indicate there is a decline over time in both the number of practitioners using Let's Talk and the number of deliveries over time. Practitioners' use of Let's Talk was influenced by their gender, profession, access to support, time since training, and caseload. The article discusses the implications of these results for sustaining Let's Talk in adult mental health services. While this study gives a baseline of practitioners' application of Let's Talk, further exploration of the experience of practitioners and parents as well as other system factors will be helpful to understand barriers and enablers to continued practice.

KEY WORDS: families where a parent has a mental illness, implementation science, Let's Talk about Children, mental health, mental health services, parenting.

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RELEVANCE FOR CLINICAL PRACTICE

While known benefits of Let's Talk include improved outcomes for families, children and parents in families where a parent has a mental illness, it is difficult to integrate family-focused interventions into everyday practice in AMHS. This study explores practitioners' application of Let's Talk after training. Understanding practitioners' use of Let's Talk helps AMHS build provisions such as enhanced post-training support, to boost uptake and continued use enabling parents with a mental illness to access the benefits of the intervention.

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ETHICAL APPROVAL

Ethics approval was granted by Monash University Human Research Ethics committee (ID. 4536) and also the eight individual health service ethics committees.

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7.5 Paper 3: Continued capacity: factors of importance for organisations to support continued Let's Talk practice – a mixed methods study

This paper presents the methods, findings and implications of the mixed methods study on organisational capacity of the eight AMHS. After presenting the findings based on the analysis of its own data, the paper also presents a discussion on the findings merged with the previous practitioners' application paper. This paper was published in Volume 29 Issue 6 of the *International Journal of Mental Health Nursing* on 11 November 2020. The complete paper can be found over the page.

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ORIGINAL ARTICLE

Continued capacity: Factors of importance for organizations to support continued Let's Talk practice – a mixed-methods study

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ABSTRACT: Sustainability is a desired outcome of implementation. Understanding how organizations support new practices after implementation is important for sustainability. Let's Talk about Children (hereby referred to as 'Let's Talk'), a family-focused intervention with parents with a mental illness, improves family, parent, and child outcomes. Little is understood about how organizations support sustained practice. The study aimed to (i) understand the implementation process that occurred in eight adult mental health services during a previous randomized controlled trial; (ii) establish their continued capacity to embed Let's Talk; and (iii) explore links between organizational capacity and sustained delivery by practitioners. This mixed method study used a questionnaire and individual interviews to collect data on the implementation process and current organizational capacity to support Let's Talk 12 months after the randomized controlled trial. Links between organizational capacity and the adult mental health services with practitioners' continuing to use Let's Talk in the past 12 months were explored. Services with higher current organizational capacity scores had practitioners currently delivering Let's Talk. These services had all made changes to their organizational structures to support Let's Talk practice. All services experienced significant changes during and after implementation, influencing sustainability of Let's Talk. Addressing organizational capacity appears to be important to enable sustainability of Let's Talk implementation endeavours. Real-world settings are constantly changing systems requiring ongoing tracking and adjustments to understand and support sustainability. Internal service development staff appear to support the shaping of organizational capacity to support Let's Talk; however, broader organizational support is needed for change within a complex system.

KEY WORDS: implementation, Let's Talk about children, mental health, organizational capacity, sustainability.

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Authorship statement: All authors contributed to the design and oversight of the study. BA conceived the study, developed the measures, collected and analyses the data, and drafted the paper. MG oversaw the analysis. BA, MG, BOH, and BW contributed to the interpretation of the results and the refining of the manuscript, reviewed drafts, and contributed to the write up.

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RELEVANCE TO CLINICAL PRACTICE

While sustaining new practices after implementation is known to be challenging, this study has provided practical guidance for AMHS to sustain Let's Talk. Internal service development staff appear to support continued organizational capacity through overseeing implementation, influencing data collection, and providing opportunity for practice support. Integration of the complex internal systems is needed to use consumer–parent data to drive service delivery and support the training and monitoring of practitioners' use of Let's Talk. This integration may be possible through senior leadership engagement and supportive policy frameworks.

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SUPPORTING INFORMATION

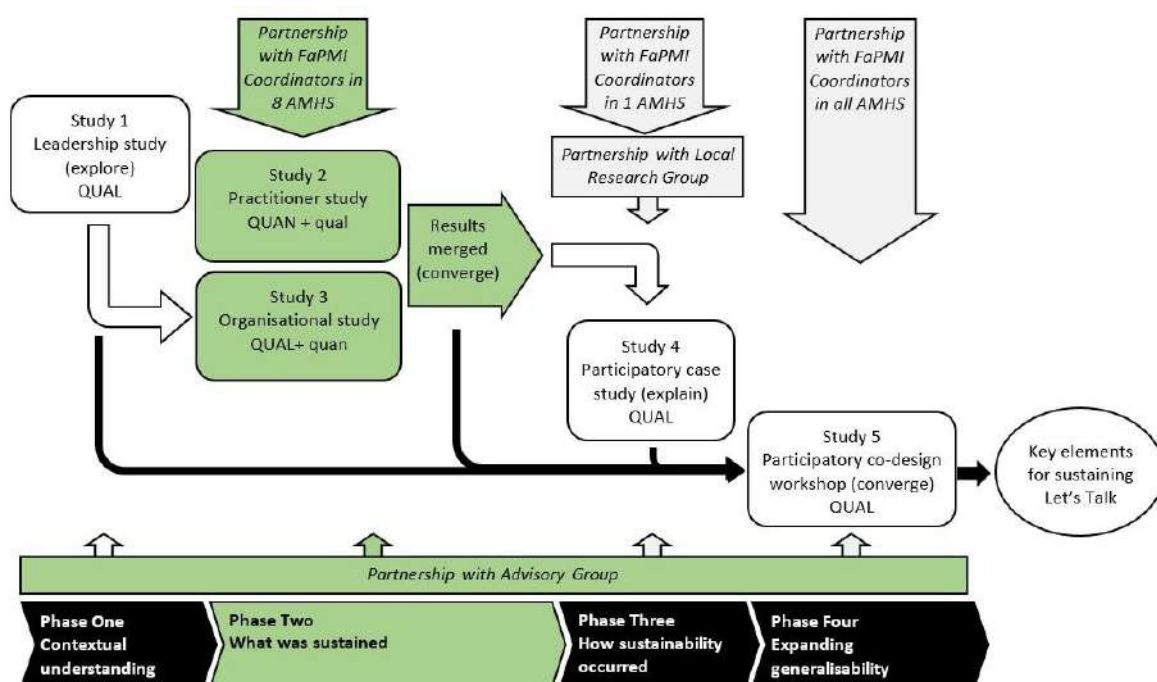
Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Questionnaire and Semi-structure Interview schedule

7.6 Phase two summary

These two parallel studies separately established sustained practice (Study 2) and sustained capacity (Study 3) of the eight AMHS. The merging of the two studies' results enabled this phase to establish what had been sustained in the eight AMHS (see Figure 9).

Figure 9. Phase two in the multiphase embedded mixed methods design



The practitioner study (Study 2) identified that most practitioners delivered Let's Talk as it was described in the manual with the majority of modifications related to supporting engagement with the parent (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). Based on outcomes found in previous studies of Let's Talk, anticipated benefits to parents could be expected from delivering Let's Talk as manualised. Five of the eight AMHS had practitioners who had either offered or delivered Let's Talk to parents on their case load within the past 12 months. In one of those five services, parents had only been offered Let's Talk rather than having it delivered. The remaining four services were therefore identified as having practitioners who had continued practice in sustaining key elements of Let's Talk (Allchin, O'Hanlon, Weimand, & Goodyear, 2020).

The organisational capacity study (Study 3) identified each organisations' capacity to support Let's Talk practice with an organisational capacity score (Allchin, Weimand, et al., 2020). While there was no cut off in the organisational capacity score to identify an organisation as having sustained capacity, the merging of the two studies' results found that organisations with higher capacity scores

had practitioners still delivering Let's Talk. The capacity that seemed to be more important was making changes to their organisational structures to support Let's Talk practice.

Having established what sustainability had occurred, the research shifts to the second sub-question of 'what key elements were critical'. In order to answer this sub-question, one of the four identified AMHS with sustained practice and organisational capacity were invited to collaborate in a participatory case study to explore how the established sustainability had been able to occur. That was the focus of phase three and is described in the next chapter (Chapter 8).

Chapter 8 Phase three: What key elements enabled sustainability of practice and capacity of Let's Talk

This chapter outlines the third phase of this research which used a participatory case study to explore how sustainability had occurred in one of the four AMHS that had practitioners continuing to use Let's Talk and a higher organisational capacity to support Let's Talk. The chapter first gives an overview of the phase, a synopsis of the study and then explains the relevance of the study to the overall research. The study's method, finding and implications are then presented in the paper published in the *International Journal of Mental Health Systems* on 9 July 2020 (see p.137–156; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). The chapter concludes by explaining the significance of what was learnt in the study for the next phase of the research.

8.1 Overview and relationship to the thesis

Having established what had been sustained in the eight AMHS, the focus of this phase was to understand how and why that sustainability had occurred. A participatory case study (Study 4; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020) was chosen to build an explanatory model of what had enabled one AMHS to be able to have practitioners with sustained practice of Let's Talk and their organisational capacity to support the practice. Case studies allow for exploration of complex entities in their real-world context (Thomas, 2011) and explanatory models are useful for explaining how and why something has happened (Yin, 2009) while also illuminating complexity that can support sustainability (Davidoff, 2019).

8.2 Study 4 synopsis: An explanatory model of factors enabling sustainability of Let's Talk in an Adult Mental Health Service

Background, aims and method

A Local Research Group was established to partner in this phase to co-construct the explanatory model. This partnership was chosen to integrate their contextual understandings into the knowledge building (Simons, 2009) and also to support local knowledge development in the AMHS. The Local Research Group, selected by the FaPMI coordinator and senior manager, included practitioners, quality and operational management personnel, a FaPMI coordinator and a lived experience worker. Through a series of five participatory workshops, each 1 ½ to 2 hours long, data were co-constructed, collected from documents and analysed. Analysis followed Wolcott's (1994) approach for transforming data through description, analysis and interpretation. Key influences at that AMHS

were inductively identified to build a localised understanding of what had been important for sustainability of Let's Talk. These were then compared against implementation and sustainability frameworks including the CFIR (Damschroder et al., 2009), Scheirer & Dearing's (2011) generic conceptual framework for sustainability and the Active Implementation Frameworks (Blase et al., 2012) to deductively refine the influencers, map interrelationships and patterns and develop an explanatory model.

Findings and implications

The findings created an explanatory model of influencers of sustained practice and capacity at the AMHS highlighting their intertwined nature. The model identified how a foundation was established for the factors affecting sustainability through the existence of resources and the organisation's prior capacity. There were three categories of factors affecting sustainability: the parent-consumer, the organisation and the practitioners. Each of these worked in combination to support sustainability and all of these were also enabled by the broader external context. The study found that the nature of sustainability was a messy process that included setbacks and the restarting of implementation.

The findings suggest that sustainability is the result of multiple factors working together and might be more likely when Let's Talk is linked to the existing organisational identity, capacity, structures and relationships. Supporting mutual adaptations to improve the fit of Let's Talk to the organisation might also make sustainability more likely.

The study's findings can support AMHS in the implementation of Let's Talk by giving a picture of real-world sustainability of Let's Talk within the context of a changing internal and external environment that requires ongoing attention.

Reflexive note

As noted in the findings and discussion in Paper 4 (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020), individuals within the organisation shaped its direction and culture. It is important to note that as a researcher embedded in this AMHS, I was one of these individuals. As postulated by this paper and the thesis overall, however, my presence alone would not have enabled the level of sustainability the organisation showed. A supportive existing organisational capacity gave a foundation for the introduction of Let's Talk. This included an organisational identity that valued research and a history of family, children and carer support, existing influential relationships in the field and existing organisational structures to support family work. Added to this, the ownership and engagement of leadership gave the authorising environment that enabled my role to influence organisational functioning. This in turn created an opportunity for re-implementation plans to be developed and

systems to monitor use. It must be noted though that my passion and research interest however, would have certainly strengthened the organisation's capacity to sustain Let's Talk.

8.3 Paper 4: An explanatory model of factors enabling sustainability of Let's Talk in an Adult Mental Health Service: a participatory case study

This paper was written in collaboration with the Local Research Group and presents the methods, findings and implications of the participatory case study of one AMHS. It was published on 9th July 2020 in the *International Journal of Mental Health Systems*.


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RESEARCH

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An explanatory model of factors enabling sustainability of let's talk in an adult mental health service: a participatory case study

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Abstract

Background: While effective interventions have been developed to support families where a parent has a mental illness in Adult Mental Health Services, embedding and sustaining them is challenging resulting in families not having access to support. This study developed an explanatory model of influencers that had enabled sustainability of the Let's Talk intervention in one service.

Methods: A participatory case study was used to build an explanatory model of sustainability at the service using theoretical frameworks. Qualitative and quantitative data was collected about practitioner's practice and the organisation's implementation process and capacity to support practice. A local research group worked with the researcher using a transforming data approach through description, analysis and interpretation.

Results: Influencers were grouped into four major categories: (1) *External social, political and financial context*, (2) *Resources*, (3) *Prior organisational capacity* and (4) *Sustainability Factors*. The last category, *Sustainability factors*, was divided into three subcategories: (4.1) *Practitioner* (4.2) *Organisation* and (4.3) *Parent-Client*. These categories form part of an explanatory model for the key influencers of continued practitioner practice and organisational capacity to support practice.

Conclusions and implications for practice: In this case study, the pre-existing organisational context along with practitioner, organisation and parent-client factors operated together to influence sustainability. The results suggest that sustainability is more likely to be supported by both linking Let's Talk to existing organisational identity, capacity, structures and relationships and by supporting mutual adaptations to improve the fit. Additionally, by understanding that setbacks are common and ongoing adjustments are needed, implementers are able to have realistic expectations of sustainability.

Keywords: Sustainability, Let's Talk, Case study, Adult Mental Health, Participatory research

Background

Research in the past two decades highlights how families are faced with greater challenges in their day to day lives when a parent experiences mental illness [1, 2]. The symptoms and treatment can disrupt a parent's ability to attend to their children's needs, disturbing the parent-child relationship required for healthy child development [2, 3]. Changes in roles and responsibilities in families can additionally complicate family dynamics [4]. The

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consequential intergenerational mental health challenges in families, including poorer outcomes for children, has led to a call for mental healthcare practices to take family-oriented perspectives [4–6]. As a result, a wide range of effective interventions tailored to different needs, population and settings has been developed [7, 8].

Let's Talk about Children (Let's Talk) was developed as part of a public health initiative for adult psychiatric services in Finland. It is a series of conversations between the practitioner and parent that bring into focus the well-being of their children while supporting the parent's role in enabling everyday family life in the context of adversity [9–11]. Studies of Let's Talk have focused primarily on the safety and feasibility of its use [12, 13], outcomes for children and parents [14, 15] and changes to practitioner's practice after training [16–18]. Let's Talk has been adapted for Australian use with freely available online training and resources (emergingminds.com.au). It was piloted and used with supported implementation in a randomised control trial (RCT) in Victoria, Australia [19, 20].

Adult Mental Health Services (AMHS) in Victoria, Australia, provide specialist clinical care for people with severe mental illness or disorders through a range of service models. One-third to one-fifth of people receiving services from AMHS are estimated to be parents of dependent children [5, 21, 22]. While parents are a significant percentage of AMHS service recipients, interventions for families where a parent has a mental illness, such as Let's Talk, are not yet part of their regular service delivery. Organisational and practitioner factors have been identified as contributing to this gap. The models of practice common in AMHS are driven by policy and funding that focus on the adult as an individual and work in episodes of care to manage a crisis [23]. Furthermore, gaps in practitioners' skills, knowledge and confidence to work with families [24–26], perpetuated by a lack of regular access to parents on their caseload [27], have limited the use of these interventions in everyday practice. To mitigate these, the growing body of research into implementation [28, 29], has been applied to practices for supporting parents with a mental illness [19, 30]. Sustaining such practices, however, has had less focus. It is not known what aspects of sustainability are generic to any implementation in AMHS and which may be specific to family-focused practices such as Let's Talk. Understanding how to embed and sustain effective interventions is important for enabling families to access the support they need as part of routine mental health practices [31].

Sustainability can be understood as an ongoing adaptation process that enables the fit of an intervention within a changing context [32]. Sustainability is a desired outcome of an implementation process so that end-users

continue to receive the benefits provided by the intervention, delivered by practitioners who are continuing to use the intervention, within a system that supports practitioner's use [33]. Studying sustainability of Let's Talk, therefore, requires a focus on both the practitioner's practice and the organisation's mechanisms to support practitioners use.

Greenhalgh and Papoutsi [34] advocate that health service research needs study designs that understand organisations as complex systems with dynamic interactions that also interrelate with the implementation process. Explanatory models developed from case studies can explore how and why something has happened within the complexities of real-world contexts through retrospective storytelling that provide descriptive examples of a change process [35–40]. Participatory approaches generate real-world knowledge collectively with those involved in the practices. This process can increase the legitimacy and the applicability of that knowledge to practice [41–43]. Taking a participatory approach to developing an explanatory model engages participants in the research process of analysis and interpretation to enable the findings to be put to use within their own setting [43–45]. As the research on the sustainability of health practices is yet to be applied to Let's Talk, a participatory case study building an explanatory model of the sustainability journey within a real-world setting can support theory development in this area [46].

Study aims

This study aimed to develop an explanatory model of influencing factors (influencers) that enabled sustainability of Let's Talk in an AMHS with continued Let's Talk practice. Two research questions framed the investigation; (i) what influencers enabled continued use of Let's Talk by practitioners and (ii) what influencers enabled the continued organisational capacity for an AMHS to support practitioner's sustained use of Let's Talk.

Method

Study context

A supported implementation pilot of Let's Talk was undertaken in Victoria, Australia in AMHS and psychiatric rehabilitation settings during 2011–2013 [20]. Following this, Let's Talk was trialled with implementation support as part of a four-year RCT in Victorian AMHS, non-government community mental health and family support services (2013–2017) [19, 47].

Subsequent to this, two follow up studies of the eight AMHS engaged in the RCT, explored practitioners' application of Let's Talk after training [27] and the organisational capacity to support Let's Talk practice [48]. The practitioner-focused study identified four AMHS with

practitioners continuing to use Let's Talk in the preceding 12 months [27]. The organisational capacity focused study scored organisations on their capacity to support Let's Talk practice [48].

The current study builds on these previous studies by exploring what enabled sustainability of Let's Talk within one of these AMHS which had practitioners continuing to use Let's Talk and a higher capacity score (see Fig. 1).

Theoretical approach

Using two levels of measures recommended by Scheirer and Dearing [33], this study measures sustainability as the degree to which (i) the intervention continues to be delivered in an identifiable form (albeit modified), and (ii) the organisation has capacity to support its use after its initial implementation [32, 33, 49]. Sustainability is explored as a dynamic entity (continuous adjustment of fit between the intervention and the organisation) rather than static (there or not). This view is informed by complexity thinking that understands organisations such as health care services, as dynamic, living, social systems [34, 35].

Design

A participatory case study was used to develop an explanatory model of influencers enabling sustained practice and capacity [39, 43]. This study design was chosen as it could position the AMHS participants as co-creators of the generation of knowledge, enabling them to be active players in changing their world [39, 50, 51]. Participatory research can have a translation to practice advantage as

the knowledge is co-constructed by those affected by it, thereby increasing its applicability to the practice setting [41]. AMHS have commonly been the object of, or the settings of, studies that have identified layers of barriers impeding desired change in family-focused practice as determined by others [24, 52–55]. Developing the explanatory model in partnership with the AMHS provided an opportunity for them to apply implementation science to their practice and reflect on their own sustainability journey while contributing to the production of knowledge for the scientific community [51].

The participatory approach utilised a group of key staff from within the organisation as a Local Research Group (LRG), to co-construct knowledge with the primary researcher who held a dual role as both a researcher and participant (as a service development worker within the AMHS). Selection of staff to the LRG was guided by Cargo and Mercer's [41, p. 331] "optimal mix of partners" questions to maximise the breadth of perspectives and opportunities for translation to practice. As a result the roles identified for the LRG included: a practitioner with continued practice of Let's Talk, a manager involved in the implementation, a FaPMI (Families where a parent has a mental illness) coordinator, Quality and Safety management personnel and a senior manager within the AMHS.

Three sustainability and implementation frameworks guided the conceptual structure of the explanatory model to provide a stronger basis for theory generation [56, 57]. These included the Consolidated Framework for Implementation Research (CFIR) [58], the Active Implementation Frameworks (AIF) [59], and the Generic Conceptual Framework for Sustainability [33].

The CFIR and the AIF provided constructs and drivers for consideration [58, 60]. The CFIR identifies key constructs compiled from implementation research across five domains; intervention/program characteristics, outer settings, inner settings, characteristics of the individuals involved and the process of implementation [58]. The AIF are designed to steer an implementation process and includes five frameworks covering the development or identification of innovations, implementation drivers, implementation stages, improvement cycles and implementing teams [61, 62].

The Generic Conceptual Framework for Sustainability that was developed by Scheirer and Dearing [33] guided the model development through providing measures and definitions of sustainability and informing how the identified influencers may have aided sustainability. Scheirer and Dearing [33] proposed that sustainability needs a more complex understanding than if the program had continued or not and detailed six conceptualisations of sustainability outcomes. These include: continuation of

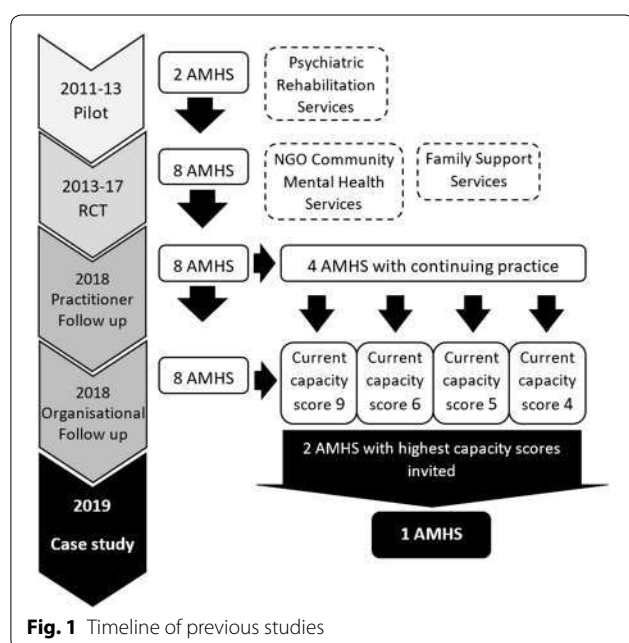


Fig. 1 Timeline of previous studies

benefits for clients, continuation of program activities; continuation of partnerships developed, maintaining new organisational policies or practices, sustained attention to the issues and lastly program diffusion or replication [33]. Additionally, they identified three clusters of factors that affect sustainability; the characteristics of the intervention, factors in the organisational setting and factors relating to the wider environment. The Generic Conceptual Framework for Sustainability draws these key factors and potential sustainability outcomes together into hypothesised relationships. Sustainability outcomes are hypothesised as being impacted by inputs, such as the intervention and the organisation's capacity, prior relationships and partnerships, which influence the three clusters of factors that affect sustainability.

Sample and setting

Four of the eight AMHS engaged in the four-year RCT in Victoria, Australia [19] were identified as having practitioners with continued use of Let's Talk [27]. The two of these four AMHS with the highest current organisational capacity score as identified in the organisational-focused follow-up study [48] were invited to participate in the case study. One of these two invited AMHS agreed to participate. See Fig. 1: Timeline of previous studies.

The study site was a large metropolitan AMHS that provides mental health assessment and interventions for people aged 25–65 years with severe mental illness in six bed-based and four community-based settings. The 75 acute beds have approximately 2190 admissions per year and 6480 clients are seen annually in the community by 300.7 effective full time (EFT) workers. Acute, continuing care, rehabilitation and specialist services are provided through a recovery model by a workforce that includes nurses, social workers, occupational therapists, psychologists, medical and lived-experience staff. Prior to any engagement of Let's Talk, the AMHS had existing organisational structures that supported practice with family, children and carers such as an overarching policy, capacity building roles, peer support programs and a mandatory training module. The AMHS engaged in a 1-year research pilot of Let's Talk in 2012 [20] as an opportunity to improve family-focused practice, and trial how Let's Talk could fit within current structures. The AMHS also identified Let's Talk as a tool that could assist the organisation move towards recovery-oriented care.

At the end of the pilot, senior management committed to participate in the four-year RCT of Let's Talk [19] and began a series of changes to embed Let's Talk within the model of care across the community and rehabilitation teams. These measures included: developing a Let's Talk implementation committee and plan, creating a practice guideline directing Let's Talk practice, adapting

clinical forms and procedures, establishing Let's Talk data collection codes and identifying a Let's Talk training and support strategy. During the 4-year trial, the AMHS experienced significant internal changes with the introduction of the new Victorian Mental Health legislation requiring new systems, intensive retraining of staff and adaptations to everyday work. There was also significant regional growth resulting in more teams, staff changing positions and alterations to key management roles. These factors took focus away from implementation of Let's Talk resulting in a re-implementation strategy in 2015. Another renewal occurred in 2017 with the review of the practice guideline after more shifts in key personnel had resulted in the interruption of implementation oversight.

During the RCT (2014–2015), the AMHS ran eight Let's Talk training sessions for 107 practitioners and managers in the rehabilitation and community treatment teams. Data extracted from the follow-up study of practitioners in the eight AMHS engaged in the RCT [27], found the AMHS had 14 practitioners (seven Social Workers, three Occupational Therapists, three Nurses and one Psychologist) identified as partially delivering or completing Let's Talk, with seven delivering Let's Talk in the previous 12 months. Eight out of the 14 also had previous training relevant to working with families and parents including two with formal postgraduate degrees.

Training and support continue to be offered at the AMHS with seven Let's Talk training sessions run in 2017–2018 for 54 practitioners. Seven out of nine teams had practitioners currently using Let's Talk at the time of the study, as obtained from the AMHS three-monthly Let's Talk data records. Let's Talk was offered to 39 parents by 28 practitioners, with 16 practitioners starting or completing Let's Talk with 18 parents in that time. Of the 28 practitioners who offered Let's Talk, eight practitioners offered it to more than one parent. Half of those practitioners who offered it to multiple parents had mixed outcomes from the offer; refusal, started Let's Talk and/or completion of Let's Talk. There were also ten practitioners where all offers of Let's Talk were declined.

Procedure

The senior manager and FaPMI coordinator at the case study site identified and invited eight staff to participate in the LRG based on the criteria in the design above. Two of the practitioners invited were unable to be released, leaving a group of six plus the researcher. Prior to attending the first meeting, the researcher engaged the members via email and sent a companion guide outlining definitions, the study context, method and known data and guidelines for group engagement to enable reflexivity. Attendance of the LRG at each session varied from four to six, as detailed in Additional

Table 1 Case study outline: session example

Session no.	Session objective	Tasks	Activities	Measure of aim met	Measure of participation process
2 (1.5 h)	Develop a shared understanding of continued practice and capacity	Re-establish team cohesion Review collected data Practitioner use Implementation documents Introduce the Generic conceptual framework for sustainability used for coding Identify influencers of continued practice Identify influencers of continued capacity	Warm-up by FaPMI coordinator Review practitioner data—phase 2 and current data Review assumptions and ideas raised in implementation journey activity Create space for further questions to be raised Gave a rationale for using General conceptual framework for sustainability for coding data from implementation journey activity and presented developing theme matrix Each brainstorm with own sticky notes (initial at bottom). Different colour for practice and capacity Place on the wall so can be seen by all Cluster influencers into categories using group consensus	More questions raised	Analysis of sticky notes Framelaps and audio End of session feedback form
3 (1.5 h)	Compare key influencers to literature	Re-establish team cohesion Present established frameworks that have shaped the theme matrix Review and refine developing themes matrix	Warm-up Present the CFIR, Active Implementation Frameworks and refresh re General conceptual framework for sustainability Pairs reviewed a section of themes, their description and data to check: Themes reflected the data If the themes picked up on what they had wanted to convey about key influencers Decide if theme should be kept, rolled into another or removed	Refined theme matrix with descriptions matching data	Framelaps and audio Work done in each pair End of session feedback form

file 1: 1.1 Local Research Group Participants & Attendance. Where possible the primary researcher engaged absent participants between sessions.

Five sessions were coordinated over an 11 week period between Feb and April 2019. The face to face sessions ran for 1.5–2 h per session at the case study site. Each session included a warm-up activity to help with group cohesion, a reflection time on the knowledge generated previously and data collected in-between, as well as an activity to meet the session objective. The first two sessions focused on data generation through developing a shared understanding of the implementation process (session 1) and developing a shared understanding of influencers of continued practice and capacity (session 2). The last three sessions focused on analysis and interpretation through comparing the identified key influencers to literature (session 3), prioritising key influencers (session 4) and refining the explanatory model and future planning (session 5). A detailed session plan for each meeting was developed outlining the objective, core tasks, activities and measures and is attached as an Additional file 1: 1.2 Case Study Session Outline. However an example of session two and three can be seen in Table 1.

The researcher with the LRG followed Wolcott's [63] approach of transforming data through description, analysis and interpretation. These three processes, which are neither discrete nor necessarily sequential [43], were addressed in this study through a series of four cyclical phases; (1) developing a timeline of implementation, (2) document collecting, (3) concept mapping and (4) explanation building [43].

- (1) Develop a timeline of implementation: Firstly a collective understanding of the process of implementation at that site was developed. Using the River of life tool [64], the LRG with the researcher pictorially documented the implementation journey highlighting key influencers and identifying gaps in the knowledge that needed further data (i.e. identifying practitioners continuing to use Let's Talk) (Session 1–2). During this phase, the LRG identified documents that could give further information about that journey such as implementation plans, communication memos and snapshot data about current use of Let's Talk.
- (2) Document collection: The researcher collected identified documents and used the questions raised in the previous session to review and summarise the content. Summarised data was tabled at the next session. (Session 1–3). Reflective notes and memos were made by the researcher after each session and in relation to data collected (Session 1–5).

- (3) Concept mapping: The LRG with the researcher compared the generated and collected data against the three identified implementation and sustainability frameworks to refine the influencers and map interrelationships and patterns (Session 2–4).
- (4) Explanation building: The LRG with the researcher built the influencers, patterns and interrelationships into an explanatory model and explored its meaning to them as individuals and for the service (Session 3–5).

Data collection

Case studies collect data from multiple sources with flexibility to make adjustments as the process develops, enabling depth and triangulation of evidence [39]. Beginning with data gathered from the two follow up studies of AMHS services [27, 48], this case study also used evidence from three other sources: (i) data generated in meetings including a timeline of implementation, collectively agreed on influences as well as audio and photographic records of each session (ii) the primary researcher's reflective notes and summary memos from meetings and (iii) organisational documents including implementation plans, policy, service memos, snapshot audits of practice and training plans (see Table 2).

Audio-recording were not transcribed but were used directly, as inspired by Halcomb and Davidson [65], to check for consistency of emerging explanations with participants' descriptions. All data were entered into NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018) as it can support diverse data collection and direct data management.

Data analysis

Thematic analysis, a theoretically flexible approach [66], was used to identify patterns across all data. Analysis began during data collection, as the emerging explanatory story was compared in an iterative process against constructs from frameworks of sustainability [33, 39, 43, 58, 61]. In participatory case study analysis, the process of participation determines what the data is and how it fits with the theory and frameworks. As a result model development process is interwoven with the final results. The analysis process included a back and forth pattern of group activities generating and analysing data and the researcher reviewing and analysing data between meetings. Each meeting began with the researcher presenting data and analysis back to the group for discussion to support rigor and reflexivity.

The researcher created an initial framework after inductively coding data from session one. This data included the pictorial description of the timeline and

Table 2 Table of documents

Document	Purpose
2012 Practice guideline Let's Talk about Children	Guide for regular clinical practice with service targets of use and monitoring
2013 Let's Talk and RCT implementation process 2012–2013	To oversee research and establishment process
2013 Let's Talk implementation process action plan Oct 2013	
2013 Let's Talk implementation process timeline	
2014–2015 Let's Talk training records	Recording training sessions and attendees
2015 05 Let's Talk Memo	Communication with staff about activities of RCT research and implementation
2015 06 Let's Talk Memo	
2015 07 Let's Talk Memo	
2016 05 Let's Talk sustainability Excel sheet	Let's Talk use monitoring tool
2017 Let's Talk implementation tasks 2017	Re-establish implementation process
2017 03 Briefing paper AMHS Let's Talk sustainment plan	Re-establish implementation process
2017 04 Let's Talk memo sent	Communication with staff about expectations of and support for practice
2017 Let's Talk implementation timeline 2017	Re-establish implementation process
2018 04 Let's Talk Memo	Communication with staff about expectations of, and support for practice
2018 11 Let's Talk Memo	
2019 01 Let's Talk Memo	

process of implementation of Let's Talk along with the initial identification of key influences as developed by the LRG. The session's audio was used for clarification. Coding was facilitated through the use of NVivo. The key influencers that were generated by the LRG in session two, were thematically coded by the researcher resulting in adaptation of the emerging framework. In subsequent meetings, the codes and framework were reviewed in the light of frameworks of sustainability [33, 58, 61] and refined by the researcher together with LRG to categorise and define the influencers and develop an explanatory model. The final model was reviewed by all researchers and agreed upon in its entirety.

Results

The process and method of the study, as previously described, form part of the findings of the case study. The influencers and the explanatory model will be presented next, including relationships identified between the influencers. Direct quotes from the participants were not collected as part of the data but where possible examples from the raw data generated by participants will be included to illustrate how the model was developed. The two research questions resulted in a common collection of influencers which were developed into the explanatory model.

Identification of influencers

The finalised list of influencers agreed to by the LRG were organised under four major categories informed by the Generic Conceptual Framework for Sustainability [33]. These categories included (1) *External social, political*

and financial context, (2) *Resources*, (3) *Prior organisational capacity* and lastly (4) *Sustainability Factors* which was divided into three subcategories of factors: (4.1) *Practitioner*, (4.2) *Organisation* and (4.3) *Parent-Client*. The first three categories of influencers, relating to the external environment, the pre-existing organisational structures and the resource context, reflected the context into which the implementation of Let's Talk occurred. During the development of the implementation journey in session one, the LRG identified this context, as creating a fertile ground into which the implementation could take place. Within the category of *Prior organisational capacity*, for example, the organisation's *Existing relationships and partnerships* within the field of families, children and carers were identified by the LRG as influencing the organisation's access to resources and its openness to opportunities to engage in new innovations relating to family-focused practice. In a further illustration, the LRG identified that within the category of the *External social, political and financial context*, a window of opportunity occurred with the establishment of statewide mental health reforms. In specifying the responsibilities of AMHS to support children of parents receiving their services, the reforms provided an authorising environment to integrate interventions like Let's Talk into practice. In another example, within the category of *Resources*, the LRG identified how access to the new online resources for Let's Talk provided free modules of training for practitioners and free resources for parents making the intervention's implementation more affordable.

The three subcategories of *Sustainability factors* reflected how the practitioners, the organisation itself

and parent-clients influenced the implementation and sustaining of Let's Talk. For example, the LRG described how practitioners using Let's Talk had acted as role models for other practitioners and normalised the work as part of standard practice. Accountability structures within the organisation were described by the LRG as communicating priority and generating data that was used to drive practice change. The LRG identified that when parent-clients specifically requested assistance with parenting and children, practitioners were prompted to use the practice (see Table 3).

Explanatory model

Work on the explanatory model commenced after the development of the implementation timeline and initial identification of influencers in session one. The researcher and the LRG selected the Generic Conceptual Framework for Sustainability [33] to inform the model development, due to the alignment of its components and structure to the focus in session one on what occurred prior to implementing Let's Talk. The final explanatory model describes what had enabled practitioners continued use of Let's Talk and the organisational capacity to support its use at that AMHS.

The model illustrates how the existence of *Resources* and the established *Prior organisational capacity* created a foundation for *Factors affecting sustainability*. The *Prior organisational capacity* was defined by their existing structures, relationships and partnership, organisational ownership of the implementation process and prior organisational identity. The *Factors affecting sustainability*, whilst described in three categories; the *Practitioner*, the *Organisation* and the *Parent-Client*, were understood by the LRG to work in synergy to provide the sustained outcome. All of these influencers were described as being situated within a broader *External, social, political and financial context* in which a number of coinciding events acted as enablers (see Fig. 2).

Relationships

While the LRG worked to define each influencer as a unique entity, a number of influencers were identified as interconnected. For example, the *Organisational identity* as a family-oriented service that values lived experience was seen through *Accountability structures* such as the Family, Children and Carers Policy and the Mental Health Program's Consumer, Carer, Family and Children Advisory Committee which communicated prioritisation of work such as Let's Talk. These additionally were understood by the LRG to give frameworks for *Leadership accountability* by providing expectations for leaders to enact policy and strategic directions which was

supported by having reporting expectation. These relationships were defined and are represented in Table 4.

Prioritisation of influencers

Each member of the LRG was asked to identify five key influencers impacting practitioner use and five key influencers impacting organisational capacity. These were plotted against the explanatory model as a way of highlighting differences and agreement of group members as well as exploring the influencer's impact on practice as opposed to organisational capacity (see Fig. 3).

As seen in Fig. 3, practitioner use was understood to be impacted by both *Practitioner* and *Organisational* sustainability factors while organisational capacity was impacted primarily by *Organisational* sustainability factors and the *Prior organisational capacity*.

Discussion

This study developed an explanatory model of what enabled sustainability of Let's Talk in one AMHS through exploring influencers that enabled (i) practitioner's continued use of Let's Talk and (ii) the organisation's capacity to support continued practitioner use. The model was developed through a participatory process in partnership with people in the setting in which the model can be applied. In this way, the model generation process is as important as the final product, as it is developed to enhance sustainability in real-world AMHS settings in ways identified by those who work with them.

While specific to Let's Talk, the explanatory model has implications for any innovation in AMHS settings. The explanatory model particularly highlights how the organisation's history contributed to enabling sustainability. Alignment between the organisation and an innovation is known to increase the likelihood of sustainability [37] and in this setting, Let's Talk was seen as a continuation of previous practice with family, children and carers. The organisation's pre-existing influential relationships and partnerships in the field of family, children and carers, enabled organisational openness to a new innovation and access to resources for implementation of Let's Talk. This suggests that Let's Talk is more likely to be sustained when linked to an organisation's pre-existing identity, capacity, structures and relationships.

The complex and multifactorial nature of sustainability influencers displayed in the model is consistent with the sustainability and implementation literature [37, 58, 61, 67]. At this AMHS, sustained practitioner practice was understood as being particularly influenced by both practitioner and organisational factors. *Practitioner identity*, *Characteristics* and *Existing models of practice* (i.e. family-centred approaches) shaped their interest, influenced who was on their caseload and affected their likelihood

Table 3 Descriptions of enabling influencers of continued organisational capacity and practitioner use

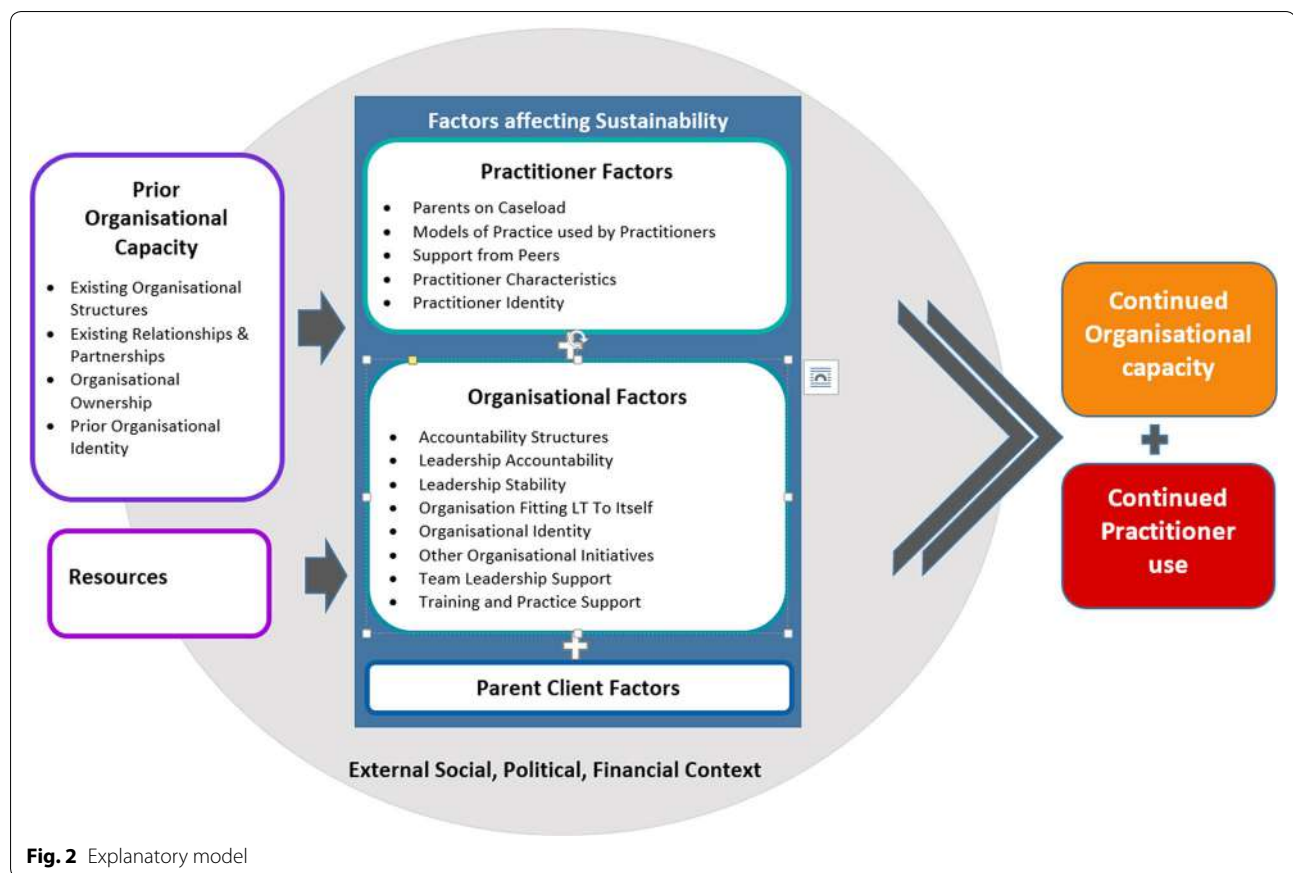
Category	Enabling influencer	Description
External social, political, financial context	External social, political, financial context	A new political and policy direction (new MH Act, Recovery frameworks, increased MH funding), new national workforce initiative (COPMI (Children of Parents with a Mental Illness) online resource development) and a new research agenda (Government funded RCT on recovery and parenting) were external context enablers for the organisation and the intervention
Prior organisational capacity: organisation history prior to implementation	Existing organisational structures	Existing organisational structures to support family, children and carer focused work enabled the new intervention to fit. These structures included family, children and carer specific capacity-building roles within the organisation for over 10 years, as well as policy and mandatory training systems to uphold policy
	Existing relationships and partnerships (organisational bridging social capital)	Influential relationships and partnerships enabled prior and continued organisational capacity through bridging the organisation to opportunity and innovation in the field of family, children and carers (training, research, resource development, expanded relationships with universities, government, international experts)
	Organisational ownership	Organisational ownership of implementation was enabled through the development of own implementation vision and plans and being a steering partner in the research
	Prior organisational identity	Organisational reputation and brand prior to implementation was already family, children and carer focused with a history of carer support that included children's voices, of parent-focused work and programs for children. The organisation's identity also included using research for learning
Resources	Resources	Funding, staffing or other resources enabled sustained practice and organisational capacity. Growth funding increased practitioner to client ratio and enabled recovery resources. Research brought funding, attention to issue and resources for data and analysis. National workforce initiative enabled accessibility through high quality, standardised online training and free resources for parents
Sustainability factors: practitioner: factors about the practitioners that enable sustainability	Parents on caseload	Practitioner's opportunity to use Let's Talk was influenced by having parents on their caseload. While demographics of region/team affect % of parents, practitioner's previous experience, interests and comfort can result in self-selection of parent clients
	Models of practice used by practitioners	A person, parent and family-focused model of practice that attends to relationships enabled practitioners to incorporate parenting and recovery into their work.
	Support from peers	Other practitioners doing Let's Talk provided role models, normalised the work, built acceptability and critical mass amongst peers and enabled practitioners to see it is possible to do within pressures of everyday work
	Practitioner characteristics	Practitioners professional interests, prior experience & training in family, children and carer work and life/personal experience influenced use
	Practitioner identity	Practitioners are enabled to use Let's Talk when they are connected and have satisfaction in their role, identify as a good practitioner and have individual accountability for their practice

Table 3 (continued)

Category	Enabling influencer	Description
Sustainability factors: organisational: sustainability influencers related to the organisation	Accountability structures	Having organisational structures to drive accountability supported the sustainability of organisational capacity and practitioner use. Such organisational structures included a driving committee embedded into the organisational hierarchy, capacity development personnel and system embedded into the service, a policy communicating priority and core business, systems monitoring policy use, data being used as a driver of practice and compliance with policy
	Leadership accountability	An expectation of leaders to lead was supported through involvement in training, reporting and support systems and reflected in adherence to strategic directions, policy and programs
	Leadership stability	Stability in leadership allowed for organisational memory and continued commitment, while new leadership within stability brought new energy
	Organisation fitting the intervention to self	Adaptations were made by the organisation to better the fit of Let's Talk such as integrating documentation, system prompts, policy development and data reports
	Organisational identity	Let's Talk was aligned with the organisation's reputation and brand which included a recovery family-oriented culture that valued lived experience and had connections, strategic partnerships and relationships that enabled learning and innovation. These were upheld by leadership and reflected in strategic directions, policy and programs
	Other organisational initiatives	There is a synergy between other initiatives active in the organisations that supported use such as peer leadership, introducing a recovery model and a focus on data documentation
	Team leadership support	All levels of leadership (including informal) supported sustained practice through buffering changes at internal/external level to manage workload, aiding workforce stability, upholding priority set by the organisation, holding practitioners to account and creating a culture that was open to practice and that can see how it could fit into current practice
	Training and practice support	The organisation had regular and accessible training that was integrated into data systems and other training. The selection of participants was purposeful and delivery methods incorporate peer facilitators. There were post-training reflective spaces and support that linked to other initiatives and gave attention to measure and build competency
Sustainability factors: parent client		The parent client's stage of recovery and willingness to request help with parenting and children influenced uptake

to deliver Let's Talk. *Training and practice support* built competence and confidence, while *Team leadership* reinforced service priorities, created expectations and communicated how Let's Talk fitted into everyday practice. Leadership's role in understanding interventions and problem solving to support integration into everyday practice has been acknowledged as pivotal for successful implementation and sustaining practice change [68–72].

Continued capacity to support practitioners' use of Let's Talk was understood in this AMHS as being mainly influenced by a combination of organisational factors such as *Organisational identity*, *Accountability structures* and *Leadership accountability*. Having an identity as a recovery and family-oriented organisation provided a context for making Let's Talk a priority. The accountability structures further communicated that priority



through committees, policy and reporting systems. This created expectations and built accountability systems for leadership. These reflect leadership's role in communicating priorities and establishing an organisational culture open to change [68, 73]. Changes made to documentation, policy and systems to fit the intervention to the AMHS, represent the mutual adjustment of the innovation to the setting and the setting to the innovation, identified as a key for sustainability [33, 49].

While leadership is a critical director of organisational culture [69, 74], the explanatory model explored the influence individuals can have in shaping the organisation and its culture. Organisational culture and identity attracts individuals with certain models of practice and practitioner identity. At the same time, however, organisations are made up of individuals that bring their unique skills and connections that can shape the direction of an organisation. In this AMHS, experienced family-focused practitioners contributed to the organisational culture and identity through influencing policy development, introducing new service delivery models and linking the organisation to innovation through research partnerships. Practitioner's identity and existing practice models are not easily changed by training and practice

support, so staff selection is advocated to ensure practitioners have the desired characteristics [75]. Whilst an emphasis on family-focused practice is not an explicit staff selection criteria in this AMHS, the model development process illuminated how this could support future sustainability of Let's Talk. Additionally, attention in the recruitment process to the individual's relationships and connections can enable organisations to create a bridge to new resources and opportunities [76], strengthening sustainability.

Many of the influencers identified by the LRG are common to implementing and sustaining practice change more broadly, however, there were aspects that were specific to Let's Talk. Most LRG members did not rate *Parent-client factors* as highly influencing sustainability of Let's Talk and where it was seen, it was influencing practitioner practice. LRG reflections suggested that help-seeking for parenting and children may not be common in AMHS. Stirman et al. [37] reflect that consumers of mental health services are often unaware of evidence-based psychosocial treatments and their perspectives on implementation and sustainability are underrepresented in theory and research. While people with lived experience of mental health issues have been central to the

Table 4 Relationships between influencers

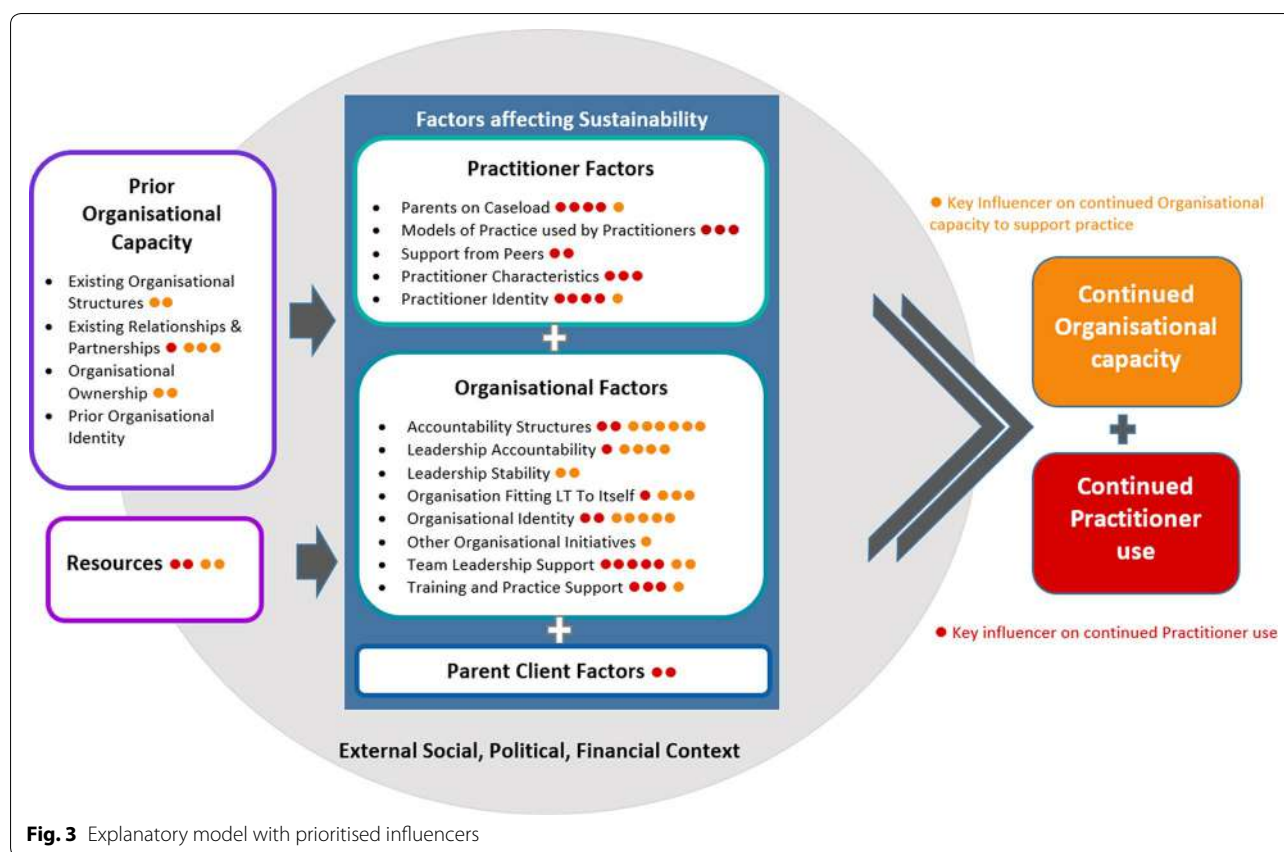
Influencer	Influencer	Relationship
Organisational identity	Leadership accountability	Organisational identity created a structure to enable leadership accountability to be upheld and leadership upheld the organisational identity
	Accountability structures	The accountability structures were expressions of the organisational identity (i.e. policy communicating priority and core business)
	Practitioner identity	The idea that the individuals in an organisation shape the organisational identity and culture and yet the organisational identity/branding attracts certain sort of people. Need a certain amount of individuals who value and do family-focused practice for the organisation to continue to represent their projected identity
	Team leadership support	Organisational identity shaped the leadership opportunities and way leaders led
	Existing relationships and partnerships	Having relationships and partnerships with universities built an identity of a learning culture, brought in new ideas and helped the organisation have a brand of learning culture. Existing relationships and partnerships have a continuous role in the organisation's identity
Practitioner identity	Existing relationships and partnerships	Practitioner identity shaped the relationships and partnerships the organisation had, while at the same time the organisation's relationships and partnerships provided opportunities for workers to expand and grow in their identity
	Parents on Caseload	Practitioner's interests, sense of who they are and how they practice influenced the sort of clients they are allocated
Parents on caseload	Team leadership support	Leadership had mechanisms to shape caseload and enable practitioners to have parents on their caseload
Accountability structures	Leadership accountability	Accountability structures are mechanisms for accountability while Leadership accountability relates to people. Leaders held to account helped to uphold the accountability structures and the structures enabled leaders to be able to be held to account
Resources	External social, political and financial context	Increase in focus on mental health in state government lead to growth funding across the state giving the service more funding and enabling changes to practice (more staffing/new positions/new models)

development of recovery models and there is a growing focus on co-development in health care [77–80], these results suggest that further research on how parent-clients can influence practitioner's Let's Talk practice and drive organisational capacity would seem warranted. The reflective space created by the participatory process of the model development, enabled the AMHS to consider how to utilise the perspectives of people with lived experience to further sustainability.

The influencers and model highlight the intertwined nature between factors, reinforcing the need to embrace complexity [34] and explore sustainability and implementation in ways that look at the 'whole' system. Often sustainability efforts can be immobilised by a 'blame game', wherein individuals are blamed for not adopting new practices or organisational barriers are identified as limiting individuals uptake of new practices. Without the intention to understand the parts within their context, it is easy for one of those sets of factors to be positioned as 'the reason' an intervention is not sustained, blocking fruitful exploration and problem-solving. The case study method allowed for an 'in depth' exploration of the complexity of sustainability of

Let's Talk in this AMHS and highlighted the interaction of the multilevel influencers that may impact sustainability of any innovation in an AMHS setting.

The development of the explanatory model gave an opportunity to apply implementation and sustainability concepts to practice. In the process, it illuminated the nature of sustainability. While charting the timeline of implementation, it became apparent that much change had occurred. Political and policy fluctuations changed the external environment, while internally, the organisation was shaped by changes to structure and personnel at all levels. This resulted in a need for reviewing and restarting implementation plans and building understanding in all levels of leadership in order to enable team leadership support, leadership accountability and accountability structures. Understanding that the implementation of new practices happens within a constantly changing environment [32, 37, 81], allows organisations to build realistic expectations that anticipate and plan for the ongoing adjustments that are needed to fit an intervention to current practice. Recognising this is part of real-world implementation can preserve hope, help to keep momentum through



disruptions and guide monitoring and accountability structures.

Using an explanatory model to explore what had enabled sustainability even in the context of multiple barriers, was seen by the LRG as an encouraging way to focus on the next steps in their sustainability journey of Let's Talk. The process gave the organisation an opportunity to look at what had worked well, what the current status of the intervention was and what could be leveraged in the future. Consistent with other strengths-based inquiry and participatory research models [82], the research process itself built a sense of empowerment that facilitated application of research, highlighting the usefulness of research processes that build participant's capacity.

Strengths and limitations

This case study's development of an explanatory model gives rich insight to mechanisms at work within one service which can inform future implementation planning in other AMHS. While applicable to other settings, the study only attempts to explain how sustainability of Let's Talk occurred in one setting.

The LRG were selected for their own unique perspectives, rather than representing a group of people. The workplace demands resulted in varying members of the

LRG being able to attend the five meetings, limiting the breadth of input to the discussion and development of the model. This was mitigated by the researcher communicating between meetings to share the process of the session and gain the absent members unique perspective.

While barriers or challenges to sustainability were also discussed, there was no attempt to balance the barriers with the enablers of sustainability. Instead, the development of an explanatory model of sustained practice focused on what had enabled the sustained practice and capacity that the organisation had within the context of these barriers.

Conclusions

Implementing practice change is difficult in health settings with changing environments and many known barriers. Existing literature has a limited focus on what happens after implementation of family-focused interventions in AMHS and little is known about what helps to sustain practice of Let's Talk. The explanatory model developed in this study offers a picture of what influenced sustainability in one AMHS in the context of real-world barriers. The reflective space also extended to consideration of how this model could be used to implement and sustain other clinical practices.

Historically there has been a strong focus on what gets in the way of family-focused practice and very little on what supports uptake and sustainability. As seen in this study, a positive inquiry approach that looks for enablers and strengths has the potential to build enthusiasm and momentum within the organisation, aiding the sustainability quest. Learning across multiple levels allows for different voices to be heard, bringing richer learning and more opportunities for supporting change. By focusing on what helps to sustain practice, organisations can amplify strategies that have already helped whilst working within the already known barriers to sustainability. Whilst the findings have implications for implementing and sustaining Let's Talk, they also have broader implications for sustaining any change process in AMHS settings.

Supplementary information

Supplementary information accompanies this paper at <https://doi.org/10.1186/s13033-020-00380-9>.

Additional file 1. Case Study participation details (1.1) and session outline (1.2).

Abbreviations

AMHS: Adult Mental Health Services; CFIR: Consolidated Framework for Implementation Research; EFT: effective full time; FaPMI: Families where a Parent has a Mental Illness; Let's Talk: Let's Talk about Children Intervention; LRG: Local Research Group; RCT: randomised control trial; Influencers: factors influencing sustainability.

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Authors' contributions

BA designed and led the research in consultation with supervisors MG, BOH & BMW. BA in partnership with the Local Research Group (FB, GC, LG, BP, SP, BW) generated and analysed data, developed and defined the list of influencers and developed the explanatory model. BA led the write-up of the paper. FB, BP, SP, BW, MG, BOH & BMW contributed to the refining of the manuscript, reviewed drafts and contributed to the write up. All authors read and approved the final manuscript.

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Availability of data and materials

The data that support the findings of this study are available from Melinda Goodyear at Melinda.goodyear@monash.edu but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of Melinda Goodyear.

Ethics approval and consent to participate

This study obtained ethical approval both through Monash University Human Research Ethics Committee on January 29 2014 (approval number CF13/3300120130017) and the Eastern Health ethics committee (Reference No:E11-1112)

Consent for publication

Not applicable.

Competing interests

The authors declare they have no conflict of interest.

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Additional file 1.1: Local Research Group Participants & Attendance

Participant	Gender	Meeting 1	Meeting 2	Meeting 3	Meeting 4	Meeting 5	Notes
Senior Manager	M	✓	✓	✓	✓	✓	
Quality & Safety	F	✓	✓	✓	✓	✓	
Parent	F	Unable to participate	✓	Unable to participate	Unable to participate	✓	Met with researcher before meeting 2 to catch up & by phone after meeting 4
Manager	F	Unable to participate	✓	✓	Annual leave	Unable to leave operational work	Clarified and fine-tuned influencer definitions and prioritised key influencers via email after meeting 4 and 5
FaPMI	F	✓	✓	✓	✓	✓	
Clinician F	F	✓	Annual leave	✓	Not rostered on	Unable to leave clinical work	Clarified, fine-tuned influencer definitions and prioritised key influencers via email after meeting 4 and 5
Clinician S	F						Not able to be released from duties
Clinician J	F						Not able to be released from duties
Researcher	F	✓	✓	✓	✓	✓	
Total		5	6	6	4	5	

Additional file 1.2: Case Study Session Outline

Session No.	Session objective	Tasks	Activities	Measure of aim met	Measure of participation process
Pre-session email	Engage local research team in aim	Establish relationship with researcher	Overview of the study and where the case study fits		
		Establish an understanding of participants role	TOR	TOR signed	
1 (2 hrs)	Develop a shared understanding of implementation process	Establish a cohesive research team (20 min)	Introductions - name, role at Service, Engagement in LT at Service 2 truths and a lie Develop group rules Identify dual-purpose - research and service	Members participating	End of session feedback from participants via online qualtrics survey
		Establish a shared understanding of the aim of case study (10 min)	Answer Q about the overview of the study, and where the case study fits		Reflective journal for the researcher
		Establish a shared understanding of implementation journey identifying influences on practice and capacity (40 min)	<i>River of life tool</i> (Fisher & White, 2018; United Nations Institute for Training and Research (UNITAR), 2013) Together identify a time frame for the journey Each to identify points of local influence of practice and capacity as seen from their perspective within the river(rocks/ whirlpools) Identify external influences outside the river Raise questions that need more information for	Completed Implementation journey	Video session Audio recording
		Establish what other information is important/ add value that sits outside the group and the phase 2 data. (10 min)	Present Service's data on practice and organisational capacity Raise questions that need to collect more information for	List of other data to collect	
2 (1.5 hrs)	Develop a shared understanding of influencers of continued practice and capacity	Re-establish team cohesion	Warm-up by FaPMI coord		
		Review collected data <ul style="list-style-type: none"> practitioner use implementation journey implementation documents 	Review practitioner data - phase 2 and current data. Review assumptions and ideas raised in implementation journey activity Create space for further questions to be raised	More questions raised	Analysis of sticky notes Framelaps and audio End of session feedback form

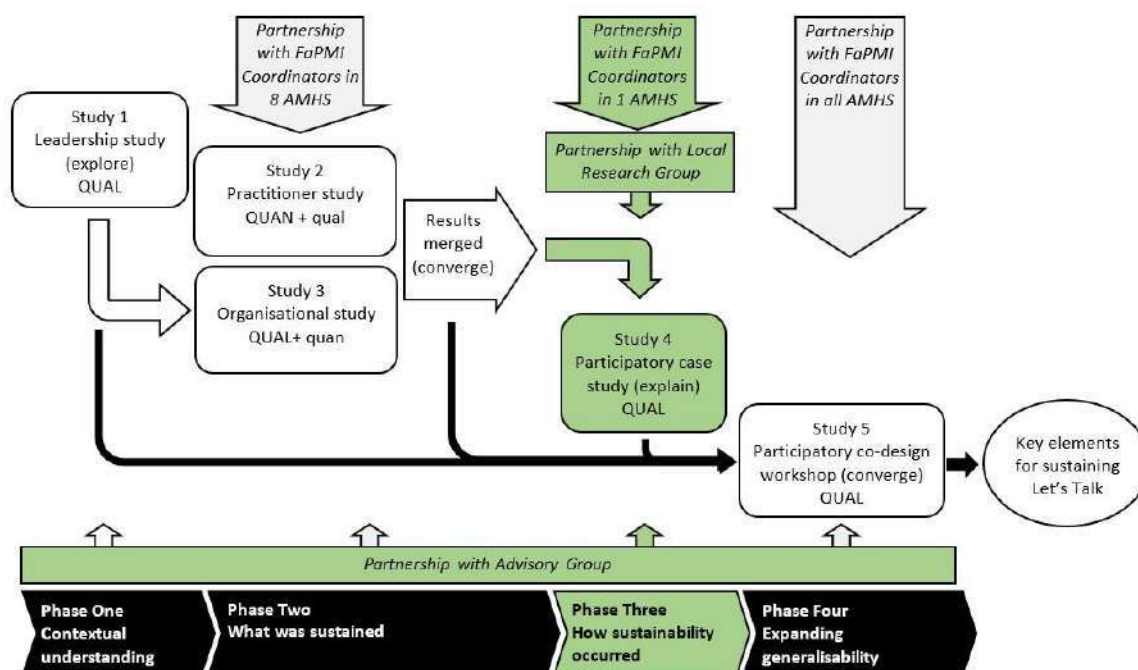
Session No.	Session objective	Tasks	Activities	Measure of aim met	Measure of participation process
		Introduce the generic framework for sustainability used for coding	Gave a rationale for using general framework for sustainability for coding data from implementation journey activity and presented developing theme matrix		
		Identify influencers of continued practice	Each brainstorm with own sticky notes (initial at bottom). Different colour for practice and capacity	Matrix of influencers	
		Identify influencers of continued capacity	Place on the wall so can be seen by all Cluster influencers into categories using group consensus		
3 (1.5 hrs)	Compare key influencers to literature	Re-establish team cohesion	Warm-up	Refined theme matrix with descriptions matching data	Framelaps and audio
		Present established frameworks that have shaped the theme matrix	Present the CFIR, active implementation and refresh re general framework for sustainability.		Work done in each pair
		Review and refine developing themes matrix	Pairs reviewed a section of themes, their description and data checking <ul style="list-style-type: none"> • themes reflected the data • if the themes picked up on what they had wanted to convey about key influencers. • Decide if theme should be kept, rolled into another or removed 		End of session feedback form
4 (2 hrs)	Prioritise key influencers	Re-establish team cohesion	Warm-up	Summation matrix	Priorities from each team member
		Review the explanatory model	Present model of themes based on the generic framework for sustainability for discussion of its fit to the organisation		End of session feedback form
		Review influencers matrix	Review and refine themes and description matrix of influencers of both practitioner use and organisational capacity		
		Identify key influencers	Each have 5 dots to allocate on the matrix as ones they see as 5 most important for practitioner use and 5 most important for organisations capacity		

Session No.	Session objective	Tasks	Activities	Measure of aim met	Measure of participation process
5 (1.5 hrs)	Refine the explanatory model and plan future	Re-establish team cohesion (15 min)	<p>Warm-up - 3 questions</p> <p>Share 1 question at a time</p> <ul style="list-style-type: none"> Something important did this morning Some question came to the group with today For this process not to feel unfinished what do you think we need to do today <p>Follow up from last time - what about LT that enabled sustaining</p>		
		Review model of key influencers (10 min)	<p>Review of key influencers model</p> <p>Similarities/ Surprises/ differences & why</p>		
		Explore purpose for model/ the So What (35 min)	<p>So What- individually consider</p> <ul style="list-style-type: none"> What could be the impact of the explanatory model from their standpoint - what is its purpose What is the most important learning from the influencer matrix and explanatory model <p>Share as a group</p>	Purpose list	Purpose from each member
		Establish an action plan - what next (20 min)	<p>Given these purposes and potential impact, what actions does who have to take</p> <p>Brainstorm into action plan identifying actors, audience and timeframe</p>	Action plan	Feedback form:

8.4 Phase three summary

This phase applied a sequential explanatory mixed methods process (Creswell, 2014) that used a qualitative method to explain the quantitative data. The participatory case study of one AMHS (Study 4; Allchin, O’Hanlon, Weimand, Boyer, et al., 2020) was used to explain the converged findings of phase two (Studies 2 and 3; see Figure 10).

Figure 10. Phase three in the multiphase embedded mixed methods design



There is little known about what sustainability of Let’s Talk looks like in real-world settings. This study contributed to addressing the research aim to investigate the key elements for sustainability of Let’s Talk in AMHS, in Victoria, Australia by developing an explanatory model of the sustainability of Let’s Talk in one AMHS.

While this study developed a picture of influencers of sustainability in the context of real-world barriers in one AMHS, a case study method only attempts to explain the particular setting in which it is accomplished. In order to understand key elements for sustaining Let’s Talk in AMHS more broadly, there was a need to see how the learning from the research findings would apply to other settings. That was the focus of phase four of this research which is explained in the next chapter (Chapter 9).

Chapter 9 Phase four: Drawing sub-studies together

This chapter outlines the fourth and final phase of this research which used a participatory co-design workshop (Study 5) to expand the generalisability of the knowledge generated in the previous phases. Phase four considers the overarching question of the thesis ‘what is important for sustainability of Let’s Talk in AMHS?’ by drawing together the findings from the studies in each of the previous phases (Studies 1-4). Firstly, the chapter presents the background to this study before articulating the workshop’s aims and methods. The workshop’s outcomes are then presented in three parts: the recommendations developed, generalisability of knowledge and the workshop’s impact. The workshop’s outcomes in regard to their relevance for AMHS is then discussed. The chapter ends with a summary of the co-design workshop’s learnings and outcomes and outlining the relevance of the study to the thesis.

9.1 Background

As discussed in detail in the chapters on theoretical paradigm (Chapter 2) and the research aim and methodology (Chapter 5), this research occurs within a participatory research paradigm directing the research design and the resulting studies. As a result of this epistemological position, knowledge is generated in partnership with AMHS so as to increase the legitimacy and application of knowledge to practice (Cargo & Mercer, 2008; Kemmis & McTaggart, 2005). Additionally, knowledge is valued for its ability to address real-world issues with practical solutions (Heron & Reason, 1997; Ozanne & Saatcioglu, 2008).

It was important in this fourth phase, therefore, to collectively produce real-world knowledge with AMHS that can be generalised to their own circumstances and equip them with the knowledge to put to practical use beyond this thesis (Westerlund, 2018; Westerlund et al., 2019). FaPMI coordinators are unique personnel to AMHS in Victoria, Australia. They are important positions within the mental health system with a specific service-development role focused on enabling AMHS to improve their response to families where a parent has a mental illness (State Government of Victoria, 2007, 2016). These roles were identified as key partners within AMHS for this fourth phase to generate applied knowledge about the research findings to date (Studies 1-4). In the reciprocity of participatory research, their partnership was to bring their skills and practical knowledge to interpreting and applying the findings of the previous phases, as well as to equip them with practice knowledge of implementation and sustainability that could enhance their role as key system-change agents within AMHS.

Each of the phases leading to this fourth phase had been designed to generate knowledge to help address the overall aim, answering the question ‘what is important for sustainability of Let’s Talk in AMHS?’ through its two sub-questions. Phase one and two focused on the sub-question ‘what was sustained?’. Phase one sought to understand leadership perspectives on the workings of real-world implementation. Phase two built a picture of what was sustained in regard to practitioners’ use of Let’s Talk and organisation structures to support practice.

Phase three shifted to focus on the second sub-question of ‘what key elements were critical’. It used a participatory case study design to explore one service’s experience of the journey of implementation in order to understand what had been important along the way that lead to the sustainability that was achieved.

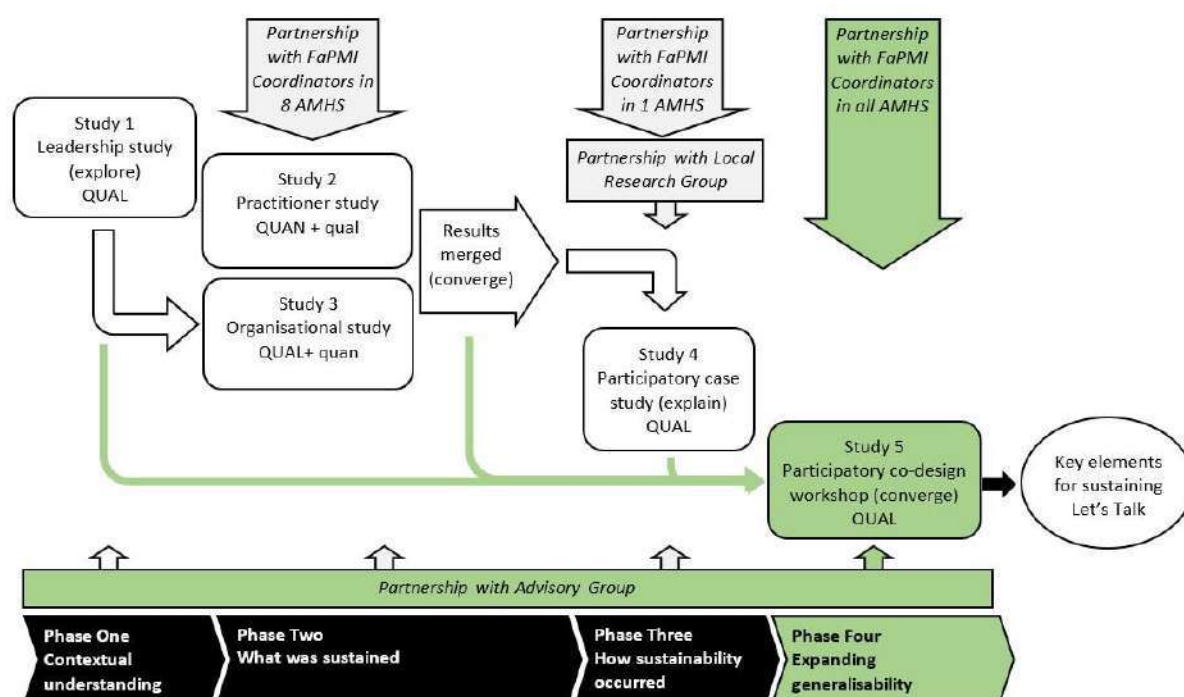
The learnings from phases one to three indicated that AMHS’ viewed how to enable the adoption and integration of new practices differently. Some saw policy frameworks, practice guidelines and clear key performance indicators as the primary way to drive practitioners to incorporate new practices. Others prioritised investing in the individual practitioner through recruitment/selection, training, mentoring, and supervision to enable practitioners to assimilate a new practice. While the case study of one AMHS gave rich information about what had enabled it to sustain the use of Let’s Talk, there was a need to assess whether elements identified in one setting could be generalised across other AMHS where there may be differing approaches to support workforce development.

The intention of phase four was to question whether what had been learnt from each of the phases and the literature was generalisable beyond the academic and situational bounds they were created within. Furthermore, phase four’s role was to then collaboratively build practical recommendations that could be applied to future endeavours to implement and sustain Let’s Talk in practice (Westerlund, 2018; Westerlund et al., 2019). As a result, this final phase of the research converged the findings from each of the other studies (1-4) through a participatory process (Study 5) as shown in Figure 11.

9.2 Aim

The three aims of phase four were to i) explore the generalisability of the findings developed in previous phases to AMHS within Victoria, Australia, ii) develop practical recommendations for implementing Let’s Talk for sustainability, and iii) build the understanding and engagement of FaPMI coordinators and AMHS in practical implementation science.

Figure 11. Phase four in the multiphase embedded mixed methods design



9.3 Method

A participatory workshop structure, co-designed with the overall Advisory Group, was used to assess the generalisability of the knowledge generated in phase one to three, and co-create recommendations for implementing, upscaling and sustaining Let's Talk with the statewide FaPMI service development workforce in AMHS. Central to the workshop was the use of a conversational knowledge-sharing process called a World Café (Brown, et al., 2005). In this method, small groups of people engage in a structured conversation facilitated by a table host for a set period of time, before switching tables to different but related discussion topics. This process has been previously used in participatory research as a data collecting method (Koen, et al., 2014) and as a tool for applying theory to practice (O'Connor & Cotrel-Gibbons, 2017). This method fitted the aims of the phase as it engages participants in dialogue as a means for exploring, expanding and analysing information (Brown et al., 2005). In this case, the World Café method was used to build on participants existing knowledge of implementation, integrate the knowledge developed in the previous studies and explore how it could be applied to the settings in which they work. Two of my research supervisors assisted in running the World Café activity through facilitating structured conversations as table hosts.

Ethical approval

This study obtained ethical approval through Monash University Human Research Ethics Committee on 5 June 2019 (Project ID 19848; see Appendix B).

Participants

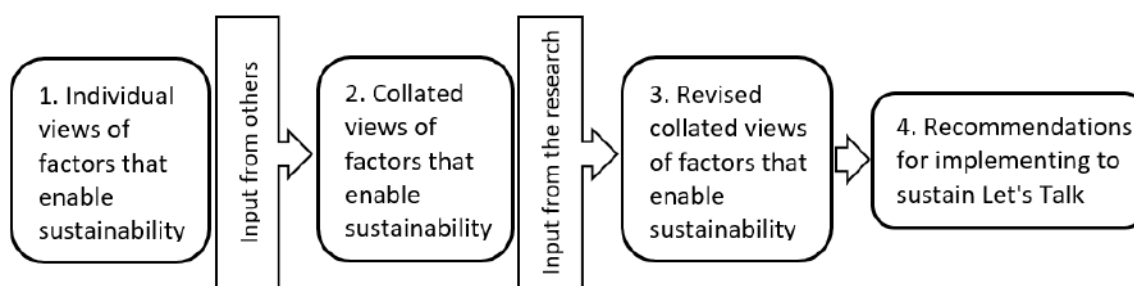
The co-design workshop's 20 participants included FaPMI coordinators in 13 AMHS in Victoria, Australia and one statewide coordinator, representing five rural/regional services, eight metropolitan services and one statewide service. Four AMHS were represented by multiple coordinators, with a regional and a metropolitan AMHS each having two coordinators, and the two large metropolitan AMHS each having three. The majority of participants were female (n=18) and had professional backgrounds in social work (n=11), nursing (n=5) and occupational therapy (n=4). With the exception of a statewide coordinator, participants were employed in service development positions within AMHS to build the capacity of the region to respond to families where a parent has a mental illness (State Government of Victoria, 2007, 2016). Within their roles, they had implemented a range of interventions, training and service delivery activities. Some had many years' experience in their role while others had been recently employed.

Procedure

An invitation to the co-design workshop, which included an explanatory statement, consent and terms of reference was sent to all Victorian FaPMI coordinators via the statewide coordinator (see Appendices D and I). Participants opted in via email, followed by the return of the signed the consent form.

Through a collection of activities (see Appendix J), participants progressed through a series of stages that moved from exploring their own views on factors that supported sustainability, to the development of recommendations for implementing Let's Talk in order for it to be sustained (see Figure 12).

Figure 12. Workshop process



The first stage created a space to enable participants to reflect on and consolidate their own knowledge and experience. Drawing on their experience, participants diagrammatically charted their own perspectives of factors that enabled family-focused practice to be sustained in AMHS. This process served to honour the experience and wisdom of the participants, which is an important aspect of participatory research (Cargo & Mercer, 2008). Additionally, the process contributed to raising participants' awareness of how their views might shape the knowledge generation process (Brown et al., 2005; Denzin & Lincoln, 2013b).

In the second stage, working in four small groups (n=4 or 5), participants were asked to develop a consolidated collection of the most significant ideas for sustaining family-focused practice. This involved them defining and documenting the most significant factors with a rationale for their choice and presenting it back to the whole group. This process was used to build a working alliance for the World Café that encouraged listening and challenged a single 'right way', to enable a cross pollination of ideas (Brown et al., 2005). This stage was used to establish a collective framework for the group to use to deductively review the findings from the previous studies of the research.

In the third stage, participants were presented with the research findings and the literature prior to revising their consolidated views of factors that enable sustainability. Initially they were presented with a summation of the findings from implementation and sustainability literature, and of each of the three phases of the research via a presentation (Appendix K), with an accompanying *Workshop Companion Guide* (Appendix L). After the presentation to set the context, the World Café participatory method (Brown et al., 2005) was utilised to work with each section of the material. Using conversations to create knowledge and listening together for insights, each small group worked with a facilitator on one section of the material (Brown et al., 2005). Together they reflected on key factors learnt from that material to consider whether it could be generalised to their setting and explore how it aligned or challenged their current significant factors list. The groups rotated around each of the four sections of learnings. After working through each section, each group met to consolidate their discussions from each of the tables, along with their previously identified key factors for sustaining Let's Talk practice.

In the final stage, the collective knowledge and insight gained in each small group was made visible and actionable. In the World Café method, the conversation is the process of regenerating the images we hold in order to enable new action (Brown et al., 2005). Each group presented their consolidated key factors and identified key recommendations that would support the implementation of Let's Talk in AMHS in order to sustain practitioners' practice and organisational capacity.

At the end of the session participants were asked to complete a questionnaire exploring how useful the process and the final recommendations were to them in their setting. Additionally, the participants self-reported any changes in their knowledge and confidence about implementation and sustainability as a result of the workshop.

Measure

The process and outcomes of the workshop served as measures against the generalisability of the previous phases' findings and the development of practical recommendations. Measurement of the effectiveness of the workshop to build FaPMI coordinators' understanding and engagement in practical implementation science used a custom-built questionnaire administered at the end of the workshop (see Appendix M). The questionnaire was developed in partnership with the Advisory Group and sought participant's views on the format and purpose of the workshop, their perception of their participation in the workshop, the application of the research to their practice and the workshop's impact on their knowledge and confidence about implementation and sustainability.

Analysis

Two analysis processes were used in the study. Firstly a multi-stage participatory framework analysis guided by Srivastava and Thomson (2009) was applied to develop a consolidated set of enablers for sustainability and explore generalisability. The staged analysis process involved developing and refining a framework of factors that enable sustainability.

Firstly, each small group consolidated their individually identified factors into a framework by collectively prioritising each of the factors according to their importance for enabling sustainability.

Secondly, each group reviewed the four sections of new material from the research findings and the literature against their consolidated factor framework, questioning if the new data aligned with or challenged it.

Thirdly, each group checked the framework against their own implementation experience and the context within which they worked in order to check its generalisability and develop a revised framework of key factors for sustaining Let's Talk practice. Each group also explored how to apply these key factors to their settings, identifying key recommendations.

Next, each group presented their framework and the key recommendations to the wider group to develop a consolidated list of recommendations across all the groups.

Lastly, the primary researcher put the consolidated recommendations developed with the wider group, together with the data from each of the small groups (chart-sheets and audio) into QSR International's NVivo software (QSR International Pty Ltd. Version 12, 2018) for further analysis. The

primary researcher further condensed and categorised the data deductively against the two components of sustainability – practitioner and organisation – recommended by Stirman et al. (2012). The refined recommendations were then sent back to the participants for review and changes were incorporated (see Table 6).

In a second separate analysis process, participants' questionnaire responses were analysed to explore the impact of the workshop on FaPMI coordinators using frequencies, summations and a deductive content analysis informed by Elo and Kyngäs (2008). The data was placed into a matrix using the questions from the custom-built questionnaire to frame the analysis before categories were developed from the qualitative data.

9.4 Outcomes

In keeping with participatory approaches, the previously described workshop process and analysis form part of the outcomes of the study. The workshop's outcomes presented below are focusing on the concrete outputs and are divided into three parts: i) the consolidated recommendations, developed in the World Café process, ii) outcomes related to the generalisability of findings from the previous studies of the research, and iii) the impact of the workshop on FaPMI coordinators.

Recommendations developed

The co-design workshop's major outcome focused on using the research from the previous phases to co-develop recommendations for future implementation and sustainability efforts. The purpose of the recommendations was to guide FaPMI coordinators to implement Let's Talk in their own settings to enable it to be sustained.

The final consolidated set of recommendations is categorised into two focus areas: recommendations that attend to the practitioners who will use Let's Talk, and recommendations that attend to the organisational structures and implementation process (see Table 6).

Generalisability of previous phases' findings to AMHS in Victoria

During the third stage of the workshop process described above, the small groups of participants reviewed the presented material against their own implementation experience and context to ascertain its generalisability to their setting. The knowledge developed in the previous research phases were seen as able to be generalised across AMHS settings in Victoria, Australia. Some site-specific considerations were also documented as the groups were feeding back recommendations to the wider group.

Location

Rural FaPMI coordinators highlighted the need to consider location for service delivery. Rural practitioners are often visiting parents in their own homes or local café's due to the difficulties of accessing clinics in rural and remote communities. This brought up the need to consider how practitioners and parents might find appropriate locations that could give the privacy needed to have conversations about their children.

Critical mass

Having critical mass within a team or service was seen as a challenge for sites with small teams within large AMHS and for rural or small AMHS. Training enough practitioners to enable parents to have access to the intervention might equate to training one fifth of staff, as parents make up approximately 20% of caseloads in AMHS. One fifth of a small team might equate to training one practitioner and this may result in a lack of critical mass to influence momentum. As a result, the endorsing and supporting aspects of critical mass might need to be replaced with other processes of endorsement and support in these settings.

Table 6: Recommendations for implementing Let's Talk

A focus on the practitioners who will use Let's Talk
<ol style="list-style-type: none"> 1. Select practitioners: seek specific skills needed for Let's Talk; recruit with that in mind 2. Balance access and opportunity to deliver Let's Talk: consider the minimum number of practitioners needed for parents to be offered Let's Talk; factor in issues such as team size, % of parents on caseload, staff retention 3. Build practitioner capacity: identify and build competence in the underlying core fundamentals of parent-, family- and children-focused work. Proactively address practitioner confidence in practice. 4. Target support for practitioners: focus support to enable practitioners to complete their first delivery of Let's Talk and then continue to practice. Tailor support to their learning style, environment and skill level; embed within supervision structures. Consider the critical mass of trained practitioners needed to endorse practice. 5. Reinforce the non-perfect: paint realistic visions of practice by using real stories of practice to help practitioners see how it can be done in their own setting. 6. Expect, embrace and monitor adaptations: adaptations can enable practitioners' use of Let's Talk within the constraints of their setting, their style or models of working and parent readiness. However, monitoring outcomes is necessary to ensure that adaptations produce the outcomes desired and fidelity is not compromised.
A focus on the organisational structures and implementation process
<ol style="list-style-type: none"> 1. Adjust strategies used for implementing Let's Talk to fit the changing organisational environment: be clear of the goal of implementing and proactively troubleshoot challenges, finding new ways to work around these to meet the end goal(s). 2. Use data: collect and use data on practitioner use of Let's Talk, parent uptake, and outcomes and implementation challenges. Build communication loops to enable decision making and support practitioners use (i.e. report challenges to decision makers, showcase practitioners use for peer encouragement). 3. Align Let's Talk within the organisation: link the practice of Let's Talk with other organisational initiatives, models and frameworks to enable practitioners and management alike to see how Let's Talk complements and contributes to the other work to be done. 4. Support all levels of leadership: build understanding on all levels of leadership; tailor messages to leadership types focusing on what is important for them to be able to lead within their role. 5. Shape organisational identity: build a focus on families, parenting and children into organisational culture through embedding within position descriptions, orientation and clinical review structures. Create expectations that Let's Talk can and will be done. 6. Adjust organisational systems and structures: make adjustments to enable Let's Talk practice by considering practitioner skills, time needed and locations for service delivery (i.e. models of care, allocation systems).

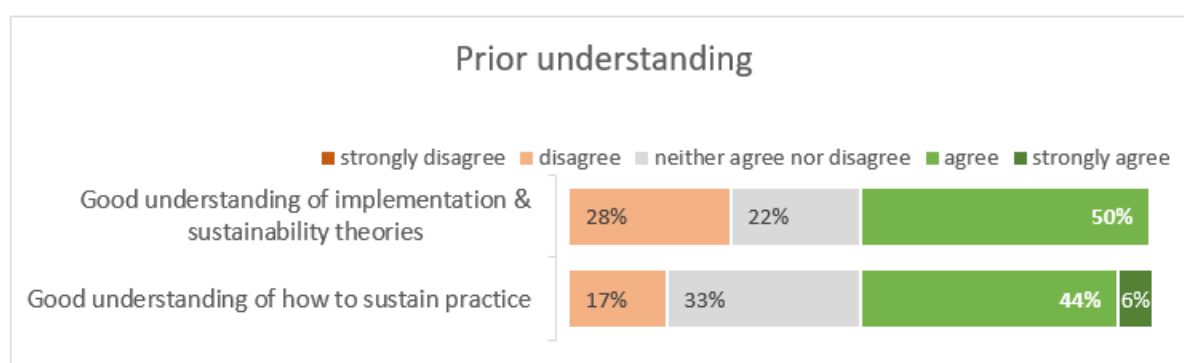
Workshop impact on FaPMI coordinators

Of the 20 participants, 18 completed questionnaires about the co-design workshop's contribution to their own learning. The self-reported questionnaire measured the workshops impacts on i) their understanding and engagement in implementation science and ii) their participation.

Building understanding and engagement in practical implementation science

Many participants came to the workshop with an established understanding about implementation and sustainability. As seen in Figure 13, half the participants reported they had a good understanding of theories on implementation and sustainability and of how to sustain practice.

Figure 13. Participants views of their prior understanding of implementation and sustaining practice (n=18)



Even with their high base-level, after the workshop the vast majority of participants reported that they had gained more strategies and confidence. They identified having more strategies to support Let's Talk, implement and sustain new practice as well as to apply research to practice (see Figure 14). They also indicated greater confidence in their ability to implement for sustainability and more confidence to communicate keys for implementing and sustaining new practice (see Figure 15).

Figure 14. Participants views of the impact of the workshop on strategies for implementing and sustaining new practice (n=17)



Figure 15. Participants views of the impact of the workshop on confidence in implementing/sustaining new practices and communicating what is important (n=18)



Participant responses also displayed their application of implementation science concepts to their work. Participants were asked to indicate a strategy they will action in the next six months and identify an indicator of its achievement or success. Of the 17 responses, participants indicated strategies in five areas: packaging information, using data, adaptable implementation, engaging leadership and practitioner support.

- i. *Packaging information:* Understanding the importance of synthesizing and presenting information to enable the buy-in from different audiences was reflected in the responses. For example, one strategy noted summarising the key research outcomes and highlighting strengths that are relevant for families to generate more interest in and discussion about Let's Talk.

- ii. *Using data:* The awareness of collecting and using data in feedback loops was also identified in the strategies. For example, one participant suggested that developing a baseline of practitioners' knowledge could help guide early support for Let's Talk practice.
- iii. *Adaptable implementation:* The need to use multiple strategies was indicated by participants. One participant, for example, reported planning to mix up their strategies and suggested consulting with people with lived experience to develop an implementation plan.
- iv. *Engaging leadership:* The importance of engaging leadership at multiple levels was reflected in many responses. One participant identified that they planned to schedule meetings with middle management and team leaders to explore possibilities so as to result in clear support, guidance and direction for staff. Another planned to ask for more accountability from management to enable improved information about Let's Talk for practitioners.
- v. *Practitioner support:* A number of strategies also reflected the importance of post-training support for practitioners. For example, one participant suggested that they planned to focus on how they can support people to implement Let's Talk within the two months following training. Another suggested utilising role modelling to influence practice change. Another planned to look at the supervision structure for staff around family work in order to meet the staff support needs associated with Let's Talk.

Additionally, participant responses also indicated that they could generalise the knowledge they had learnt in the workshop to other family-focused practices they implement beyond Let's Talk, such as Single Session Family Consultation.

Three main themes emerged from the participants' comments on the most valuable aspects of the co-design workshop: the collaborative process ("a great collaboration, mix of research and discussion"); learning about the evidence ("Hearing about the PhD with links to literature, leadership, practitioners and case examples. Helped think through culture change discussions"); and being able to participate in generating knowledge while confirming existing knowledge ("...some new ideas and some of my practices being validated").

Participation

Participants were also asked about their experience of the workshop in relation to its purpose, their contribution and the usefulness of the outcome. Nearly all participants either agreed or strongly agreed to the purpose being clear, the objectives being met and the outcome being useful to FaPMI work. The majority also believed they made a significant contribution to the workshop (see Figure 16).

Figure 16. Workshop participation and purpose



9.5 Discussion of the results in phase four

The workshop applied the knowledge established in the previous phases of the research, confirming that it could be generalised across AMHS in Victoria, Australia. The recommendations co-developed with FaPMI coordinators, enabled the knowledge to be applied to support the implementation and sustaining of Let's Talk. Additionally, the process of the workshop also benefited participants by building on their understanding of and engagement in implementation and sustainability of Let's Talk.

FaPMI coordinators are agents of change, supporting shifts in practice to enable better outcomes for families where a parent has a mental illness (State Government of Victoria, 2007, 2016). The broad scope of their work dictates that the end focus is on facilitating broader practice change. While they might utilise the implementation of a single intervention, such as Let's Talk, as a tool to support such shifts in practice, it will be one strategy amongst many. This makes their role different to those who are primarily focused on implementing a discrete intervention or innovation over a fixed period of time (Bauer & Kirchner, 2019; Fixsen et al., 2009). There is less known about ongoing capacity building roles in implementation science literature where the focus is mainly on the implementation of discrete interventions in research settings (Chambers, Pintello, & Juliano-Bult, 2019; Westerlund et al., 2019). As a result, these roles are often studied within a specific research context or in a restricted time period. These findings therefore provide opportunities to understand how strategies could be implemented to support ongoing change as scaffolded by localised change agents.

The language and structure of the co-produced recommendations could be understood as a reflection of the FaPMI coordinators' unique position as internal capacity builders within AMHS. The

recommendations, as a distillation of a range of levers under the two categories of practitioner and organisation, may fit their need for flexible application to their local setting. As a result, unlike a structured implementation guide, these recommendations may be seen as a flexible tool that suits the ongoing nature of their roles within a service.

FaPMI coordinators' service-development role has a core emphasis on sustainability, resulting in them building, supporting and/or renewing organisational readiness to implement interventions such as Let's Talk. As organisations are constantly changing (Chambers et al., 2013), this might include a range of activities at multiple levels. At the policy level, that might mean exploring how Let's Talk can align with the organisation's initiatives and directions. At the leadership level, it might include re-engaging leadership after personnel changes and/or embedding Let's Talk within the organisation's systems and structures. At the practitioner level, building and supporting practitioner's skill development might be needed and using demand from parent-consumers to highlight the need for Let's Talk. As a result, the recommendations can support the FaPMI coordinator to address the readiness of their service with the appropriate strategies for their current circumstances. The future overseeing of implementing to sustain Let's Talk in AMHS in Victoria will be a joint venture between AMHS, FaPMI coordinators and the statewide FaPMI team. The recommendations developed and the implementation knowledge and skills gained in this phase has contributed to the tools and capacity building strategies that can enhance their roles.

Westerlund et al. (2019) suggest that the gap in use of implementation science in healthcare settings requires the development of user-friendly tools that can be utilised by healthcare practitioners. Whilst the recommendations have made some progress on equipping FaPMI coordinators with implementation tools to implement and sustain Let's Talk, the recommendations could be further developed to go beyond conceptual or aspirational ideas in line with Westerlund et al. (2019) recommendations. The different strategies could detail definitions and connect with helpful resources that can enable the strategies to be enacted. Additionally, the recommendations could be complemented by tools, such as the USA's National Implementation Research Network (NIRN) tool, *Stages of Implementation Analysis: where are we up to?* (Blase et al., 2013) or the UK's Sustainability Model and guide (Maher et al., 2007). Whilst these are more aimed at implementing a discrete intervention or innovation, they could guide the FaPMI coordinator to identify the status quo within their AMHS, clarify what they are aiming to do and develop an action plan with clear allocation of roles, responsibilities and measures.

The co-design workshop was focused on developing a targeted practical implementation tool for sustaining Let's Talk that was generalisable across all AMHS in Victoria. The findings from the post workshop questionnaire, however, would suggest that FaPMI Coordinators saw how the strategies

identified in the Let's Talk recommendations could be applied to supporting other family-focused practice. In this way the development of key elements important for sustaining one intervention, Let's Talk, can contribute to the knowledge gap about sustainability of family-focused practice more broadly.

While this phase draws on previous studies of strategies to support practice change, there is more to understand in order to support sustainability of Let's Talk practice. Further research is required to understand the specific skills needed by practitioners to complete a delivery of Let's Talk. Developing a clearer understanding of the core functions or mechanisms of Let's Talk would also contribute to training guidelines and fidelity measures. This greater understanding of Let's Talk's core mechanisms will additionally help to ensure that adaptations don't undermine the desired outcomes.

9.6 Phase 4 summary

This phase of the research builds on the previous phases to co-develop applied knowledge relevant to service development personnel within AMHS, resulting in recommendations that can be used as a basis for an applied implementation tool. As AMHS are complex organisations that use myriad overt and implicit mechanisms to drive practitioners' practice, these recommendations can be used to direct these mechanisms to support the implementation and sustaining of Let's Talk. Further work is needed in detailing and linking the recommendations to other resources to support their use. Local implementers will need to translate the recommendations to their setting by assessing their current state and being clear what they are working towards before they can use the recommendations to plan their next steps. For sustaining Let's Talk in AMHS there is a need for those plans to be accompanied by clear allocation of roles, responsibilities and measures.

Relevance for the thesis

This chapter is the last of four chapters in the middle section of the thesis that present the four phases of the research (Chapters 6-9). Chapter 6 documents a contextual understanding of the implementation of Let's Talk during the RCT that was developed in phase one through a qualitative study of leadership perspectives (Study 1). Chapter 7 presents what was sustained in the eight AMHS as established in phase two through two parallel studies (Study 2 and 3). Chapter 8 reports on an explanatory model of one AMHS journey to sustainability that was developed in a participatory case study (Study 4) in phase three. This chapter (Chapter 9) documents the co-production of implementation recommendations to support Let's Talk sustainability as developed in the co-design workshop (Study 5) of phase four.

The study in this phase contributed to the investigation of the key elements for sustainability of Let's Talk in AMHS, in Victoria, Australia. Building on the findings from each of the previous phases, this phase utilised the partnership with FaPMI coordinators to co-develop recommendations that could be applied in their work and were generalisable to AMHS across Victoria, Australia. As a result, this phase helped to draw together answers to the overall research question of 'what is important for sustainability of Let's Talk in AMHS?'

In the final chapter of the thesis (Chapter 10), the aim of the research and the consolidated learning from all the phases will be revisited before presenting key elements for sustaining Let's Talk in AMHS, exploring what has been learnt about sustainability and providing recommendations for practice and research.

Chapter 10 Discussion

A new lens can create fresh perspectives on old ways of seeing. There is limited knowledge of the sustainability of family-focused practices in health care. Lasting change in AMHS is a story hidden from view. By bringing different conceptual lenses together, this thesis illuminated this story to bring new knowledge and understandings about how to promote lasting and sustained practice change. Bringing new voices through working within a participatory approach and applying the lens of the concept of sustainability to family-focused practice, this thesis has developed a realistic picture of sustainability and identified key elements that promote it. This body of work integrating knowledge from disparate fields, is an important building block for the future study of family-focused practice.

This final chapter draws together the research of the thesis and discusses the major outcomes and implications in the context of the literature. To help position the research findings, reflections on the methodological strengths and limitations of the thesis are first discussed. Next, how the studies' findings have addressed the aim and their contribution to the body of knowledge is outlined. Subsequent to this, research findings on what we know about sustaining Let's Talk and the implications for its translation to practice are presented. The chapter concludes with the broader scope of what this thesis contributes to the understanding of the concept of sustainability and knowledge base on sustainability of family-focused practice.

10.1 Methodological reflections: strengths and limitations

Strengths and limitations are inherent in any methodological choices employed in research. As the specific methodological reflections for each study are noted in their related chapters (Chapters 6-9), this section discusses strengths and limitations from the perspective of the overall research design and execution.

Participatory research

A core strength of this research is its use of multiple research partnerships across the different studies. These partnerships added value to the research's design, implementation process, as well as the interpretation and application of the findings. These different configurations of participation utilised throughout the research process strengthened the quality of the findings.

Who should participate, and how is a foundational issue of quality in participatory research (Bergold & Thomas, 2012; Cargo & Mercer, 2008; Mercer et al., 2008). Identification of participants and partnerships, based on an integrative practice framework (Cargo & Mercer, 2008), provided a strong evidence base for the partnership selection. The clear documentation of the roles of the different

partnerships and the relationships between each of these, supported the research's rigour by providing an audit trail. Such intentional and transparent choice of partners supports the confirmability of the research (Korstjens & Moser, 2018; Mercer et al., 2008). The resulting matrix of research and reflexive partners, as presented in Table 7, provided authentic partnership across the spectrum of the research process and reflects the focus on open networks of equitable partnerships in participatory research (Cargo & Mercer, 2008; Kemmis & McTaggart, 2005).

The participation of both the advisory group and the FaPMI coordinators in the designing of data collection methods enabled the research to measure what was intended in a form that was practical to collect. Such co-development of measurement tools increases the accuracy and reliability of the data collected (Cargo & Mercer, 2008).

Table 7: Research and reflexivity partnerships

Partnerships	Research process			Reflexivity
	Shaping the purpose and scope	Implementation and context	Interpretation and application of outcomes	
Advisory group	✓	✓	✓	✓
FaPMI coordinators (8 AMHS)		✓	✓	
Local research group		✓	✓	
All FaPMI coordinators			✓	
Supervisory triad	✓	✓	✓	✓
Critical friend				✓

Furthermore, incorporating member checking processes into the data collection process for all the studies helped to confirm that what had been collected was true from the participants' perspectives (Korstjens & Moser, 2018). This, along with the collaborative analysis and interpretation processes employed in studies four and five, build on the value and quality of the research. These collaborative processes enhanced the credibility of the findings and their ability to be applied to the real-world settings they are intended to serve (Bergold & Thomas, 2012).

Additionally, the contextual understanding of sustainability of Let's Talk developed through a participatory research approach has enabled the findings to be grounded within the complexities of real-world settings. This advantage of participatory research (Cargo & Mercer, 2008), has allowed a richer understanding than could have been gained through other means, thus strengthening the transferability of the research findings.

The multiple layers of reflexive partnerships provided triangulated opportunities for critical reflection on my role as an embedded researcher (Kemmis & McTaggart, 2005). The Advisory Group, with its expertise in the field and in participatory research, provided an external accountability role through the communal covenant that emphasised power sharing through reciprocal relationships (Brydon-Miller et al., 2013). The role of a 'critical friend', with its embedded tension between unconditional support and unconditional critique (MacBeath & Jardine, 1998), provided an opportunity for robust discussion with someone familiar with the work and field, but with enough distance to probe assumptions. The different experiences and expertise of the triad of supervisors brought to the reflective process diverse understandings of reality. Their intimate knowledge of the research, combined with their diverse perspectives, enabled a robust reflection on the research process and my assumptions and assertions to be rigorously explored (Bergold & Thomas, 2012). In combination, these opportunities enabled the four types of reflective practice that support quality in participatory research – personal reflection, reflection on the social relationships, reflections on the context the research is embedded within, and reflection on the process of research (Bergold & Thomas, 2012).

While participation is a core strength of this research, it was not without issues. The issue of who participates also raises questions about who decides which voices are needed. Whilst the review by Cargo and Mercer (2008) provided an evidence base for decision making about appropriate partnerships, as the researcher, I had the power to make that selection. As AMHS are complex organisations with dynamic interactions, it is difficult for any one group of people to represent the broad range of voices needed to adequately capture its complexity. In hindsight, the lack of presence of medical staff may have limited a greater exploration of the influence of the medical model on the paradigm conflicts identified in Study 1 (Allchin, Goodyear, et al., 2020). Additionally, increased representation of practitioners in the Local Research Group may have resulted in a greater understanding of the enablers of practitioners' practice that has been highlighted as a need for future research in Study 2 (Allchin, O'Hanlon, Weimand, & Goodyear, 2020).

In reality, who participates is also constrained by practical limitations (Cargo & Mercer, 2008). Take, for example, phase three's Local Research Group. Those who could consistently attend the five sessions were those who could control their own diaries and had the power to determine their day-to-day activities, such as a senior manager. Those working on the ground with the practicalities of case management had more difficulty attending sessions within working hours. This was seen by two practitioners not being able to attend throughout the whole process. While work was done to incorporate the voices of those who couldn't attend a session, the result was an imperfect version of the communicative action as all voices could not contribute in real-time.

Additionally, the real-world time-constraints of AMHS staff at all levels leaves little time for reflection on practice. Ideally, the partnership in the analysis and interpretation process seen in phase three and four would have benefited from a longer period of engagement with the data than was possible in the settings. Whilst not tokenistic, if utilised more, the expertise in the partnerships could have enriched the depth of understanding on sustainability of Let's Talk.

Mixed methods research

Another strength of the research is in its use of mixed methods, as described in Chapter 5. The methods in this research follow logically from the research questions and are combined in a process of phases to build a better understanding of sustainability of Let's Talk. As recommended by Creswell (2014), a visual model explaining the logic of the methods is outlined in Chapter 5 (see Figure 7). Triangulation of methods and data types in this way, can provide a more complex picture than could be gained by either quantitative or qualitative research on their own (Creswell, 2014; Teddlie & Tashakkori, 2013). The qualitative study in phase one (Allchin, Goodyear, et al., 2020) was used to explore the implementation context, giving important information to inform the measures used in phase two. The converging of the quantitative and qualitative studies in phase two (Studies 2 and 3; Allchin, O'Hanlon, Weimand, & Goodyear, 2020; Allchin, Weimand, et al., 2020) triangulated the data to strengthen the understanding of what had been sustained in the eight AMHS, as noted in the summary of Chapter 7. This integrating of the quantitative and qualitative method in phase two to establish what had been sustained, reinforced the credibility of these findings. The participatory case study in phase three (Study 4; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020) enabled a richer description of how sustainability had occurred in one AMHS to be developed, supporting the finding's transferability. The transferability was strengthened by the convergence of all the data in a participatory co-design workshop (Study 5) in phase four. As a result, key elements for sustaining Let's Talk have been built on a combination of qualitative and quantitative data, thus strengthening the credibility, dependability and transferability of the findings (Korstjens & Moser, 2018; Teddlie & Tashakkori, 2013).

While a greater understanding of what enables sustainability of Let's Talk has been established, this research has illuminated the need for other knowledge that was not within the capacity of this set of studies to obtain. The primarily quantitative knowledge gained about practitioners' application of Let's Talk (Allchin, O'Hanlon, Weimand, & Goodyear, 2020), and the in-depth case study of one service (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020) led to an awareness that hearing practitioners' own narratives may have been missing. Limitations on research time and capacity, however, meant that this was out of the scope of the research design. The decision to concentrate on two levels of sustainability, sustained practice and sustained capacity (Stirman et al., 2012), led to

narrowing the research design to focus on practitioner application data and the organisational capacity and context. Parent perspectives and family outcomes were identified as out of scope in this research as they are the focus of other studies connected to the RCT (Maybery et al., 2017). This resulted in limited exploration of the reciprocal relationship proposed between the parent-consumer and practitioners' readiness in phase one (Allchin, Goodyear, et al., 2020), and the question of how adaptations affected outcomes in phase two (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). These areas could be the focus of future research.

The literature review of Let's Talk and the combined findings about sustainability also illuminated the gap in understanding the central mechanisms of Let's Talk that enable the expected outcomes (i.e. the core functions of an intervention). Such knowledge of core mechanisms could possibly enable more sustained use of Let's Talk by enabling its greater integration into everyday practice in real-world settings through adaptation, while maintaining fidelity to its core mechanisms. As a result, the knowledge gained in understanding sustainability, while making a great contribution, is still an incomplete picture that requires more attention.

10.2 Building the knowledge base

Participatory research is grounded in knowledge built to find solutions to real-world issues. The research aim and questions of this thesis are situated in an applied setting exploring the sustainability of a particular practice. The following section outlines how the research in this thesis has generated knowledge to address the challenge of sustaining Let's Talk in AMHS that has limited parents' access to this evidence-based family-focused practice.

This thesis used a series of sequential phases of research that aimed to investigate the key elements for sustaining Let's Talk in AMHS. This aim was answered through the research question, 'what is important for sustainability of Let's Talk in AMHS?' and its two sub-questions: i) 'what sustainability has occurred in practitioners' Let's Talk practice and the organisations' capacity to support Let's Talk practice?' and ii) 'what key elements are critical for the sustainability of Let's Talk practice and organisation capacity?'

The research took place within a participatory research paradigm, described more fully in Chapter 2. Participatory research values knowledge for its ability to address real-world issues while providing reciprocal benefits to those working in partnership within the knowledge creation process (Cargo & Mercer, 2008; Kemmis & McTaggart, 2005; Ozanne & Saatcioglu, 2008). The literature on sustainability described in Chapter 3, was used as a conceptual lens to define the way sustainability was explored (continued practice and continued capacity; Stirman et al., 2012) and provide an analytical framework (Damschroder & Lowery, 2013; Fixsen et al., 2005; Maher et al., 2007; Scheirer

& Dearing, 2011). The work builds on previous research documenting the development and evaluation of family-focused practice in AMHS and Let's Talk in particular, as described in Chapter 4. Each of the sequential phases and their respective studies (Chapters 6-9) generated knowledge to address the research's overall aim (see Table 8).

Table 8. Summary of the research's aims and findings

Phase	Aim	Study	Study Findings
1	Explore the implementation context to build measures for establishing what had been sustained	Study 1: Leadership perspectives on implementing Let's Talk	<ul style="list-style-type: none"> ○ Implementation interrupted by changes in both internal and external context, resulting in the need for constant re-focusing ○ Confirmed leadership vital to lead change, and defined roles of different levels of leadership ○ Parallel process of practitioner and parent readiness was proposed
2	Establish what had been sustained in the eight AMHS	Study 2: Practitioner application of Let's Talk Study 3: Organisational capacity to support Let's Talk	<ul style="list-style-type: none"> ○ Most practitioners used Let's Talk but number of deliveries declined overtime ○ Complete vs partial delivery more difficult ○ Caseload access important consideration ○ Sustained capacity linked to organisation's intention to implement and changes made to fit Let's Talk ○ Complex system responses less common (i.e. using data collected; training systems that know if practitioners are trained) <p>Converged findings Studies 2 & 3</p> <ul style="list-style-type: none"> ○ 4 AMHS had practitioners still delivering Let's Talk ○ Higher organisational capacity linked with continued practice
3	Explain how one AMHS had sustained practice and capacity	Study 4: Single participatory case study of sustained practice and capacity	<ul style="list-style-type: none"> ○ Sustainability more likely if anchoring to existing organisational identity and structures, and supporting mutual adaptations to improve the fit between the organisation and Let's Talk. ○ Sustainability occurred in the context of a changing internal and external environment that required ongoing attention
4	Expand generalisability of previous phases and develop a more complete picture of what is important for sustainability of Let's Talk	Study 5: Co-design workshop developing recommendations	<ul style="list-style-type: none"> ○ Findings generalisable to other AMHS setting ○ Flexible recommendations developed that can be adapted to suit the local context and used as basis for an applied implementation tool ○ FaPMI coordinators gained understanding of and skills in applying implementation science

Phase one

Phase one's qualitative study exploring leadership perspectives (Study 1) provided a contextual view of the implementation of Let's Talk that was used as a tool for shaping the study of what sustainability had occurred in phase two in Study 3 (see Figure 7 and Table 8). It highlighted how the eight AMHS approached implementation differently during the RCT. The findings also showed how interruptions as a result of internal organisational changes and changes within the wider external contexts required constant revising of, and sometimes restarting, implementation (Allchin, Goodyear, et al., 2020). The importance of context to the study of sustainability of Let's Talk drawn from these findings is congruent with literature on sustainability, which advocates for it to be explored in ways that can acknowledge complexity in healthcare settings (Braithwaite et al., 2018; Greenhalgh et al., 2005).

Conflicts in the paradigms within which AMHS work were identified as challenging the implementation of Let's Talk (Allchin, Goodyear, et al., 2020). The policy and funding framework, and medical service delivery models drew practitioners to be the expert in the practitioner-consumer interaction, to work in episodes of care to manage crisis, and primarily focus care on the individual and on minimising risk. These were seen to be in conflict with the policy reform agenda for mental health services that call for a focus on recovery-focused family-inclusive preventative mental health practice. Such a practice expects practitioners to build therapeutic relationships, give control to consumers and consider the individual in their context (Allchin, Goodyear, et al., 2020). These findings add weight to other research about paradigm conflicts present in AMHS settings that affect the use of family-focused practice (Falkov et al., 2016; Felton, et al., 2018; Karibi & Arblaster, 2019; Korhonen et al., 2010; Price-Robertson, et al., 2016).

Building on existing literature on the importance of leadership for creating change (Floyd & Wooldridge, 1997; Heyden et al., 2017; Kerrissey et al., 2017), the findings illustrated the different roles leadership have in the implementation process. Middle management were identified as having a role of translating new interventions into everyday practices, while senior leadership provided an authorising environment (Allchin, Goodyear, et al., 2020).

In addition, the findings questioned the idea that parents were passive recipients of Let's Talk and proposed that the readiness of the practitioner and parent were intertwined (Allchin, Goodyear, et al., 2020). This adds weight to existing literature that considers how to integrate the bidirectional relationship between practitioner and recipient in implementation frameworks (Zubkoff, et al., 2016).

Phase two

Phase two addressed the first sub-question, establishing what had been sustained in the eight AMHS following participation in the RCT, using continued practice and continued capacity as a measure of sustainability (Stirman et al., 2012). Using this dual approach for understanding sustainability and the participatory research paradigm, two parallel studies were carried out to establish practitioners' practice and organisational capacity. The findings of the two studies were then converged (see Table 8). As establishing what had been sustained required a contextual understanding, what was implemented and how practitioners had applied Let's Talk over time were also explored within each context. Data collection and participant recruitment for phase two was supported by partnership with FaPMI coordinators within the eight AMHS.

The quantitative practitioner study (Study 2) generated new knowledge by establishing the first documentation of practitioners' application of Let's Talk. This knowledge will help to form a baseline for future implementation endeavours. Building on the existing literature on family interventions that are not focused on the parenting role, the findings differentiated the application of Let's Talk by whether it was offered or delivered (Bucci et al., 2016; Ince et al., 2016). The study established that five of the eight AMHS had practitioners who had applied Let's Talk with parents in the previous 12 months. One of those five AMHS, however, only recorded Let's Talk as being offered, rather than offered and delivered (Allchin, O'Hanlon, Weimand, & Goodyear, 2020).

While most practitioners were found to have used Let's Talk, the number of deliveries declined overtime (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). The interaction between a low and fluctuating percentage of parents on practitioners' caseloads was found to be an influence. The opportunity to utilise Let's Talk may be restricted by large gaps of time between use due to practitioners having few or no parents on their caseload. This has the potential to undermine the ongoing confidence and competence of practitioners in the delivery of Let's Talk (Allchin, O'Hanlon, Weimand, & Goodyear, 2020).

While most practitioners delivered Let's Talk as described in the manual, one third made adaptations to fit the intervention to parent-consumer needs or their respective service models (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). Adaptations to fit service models echoes other literature that suggests adjustments are needed to incorporate interventions into everyday practice while still adhering to what is core for the mechanisms of change (Greenhalgh & Papoutsis, 2018). Building on mental health literature, adapting to address parent-consumer needs is identified as key to developing the therapeutic alliance needed in mental health work (Dziopa & Ahern, 2009; D. J. Martin, Garske, & Davis, 2000).

The mixed methods study on organisational capacity (Study 3) established the eight AMHS capacity to support Let's Talk in the context of their implementation approach. The study design was informed by leadership perspectives on implementation (Study 1; Allchin, Goodyear, et al., 2020) and input from the Advisory Group. In documenting each organisation's implementation approach, two key elements appeared to influence AMHS sustained capacity to support Let's Talk: i) their intention for implementation, and ii) whether they had made organisational changes to fit Let's Talk to their service (Allchin, Weimand, et al., 2020). These findings are congruent with literature on sustainability, which identifies that organisational adjustments to fit the intervention supports sustainability (Proctor et al., 2011; Scheirer & Dearing, 2011).

Mapping AMHS current organisational capacity to support Let's Talk across nine domains found three common organisational capacities: overseeing staff, collecting data, and infrastructure for practice support. The least common capacities were found to be knowing if practitioners were using Let's Talk, having training infrastructure, using the data that they collected and having a governing policy/practice guideline for Let's Talk (Allchin, Weimand, et al., 2020). These latter organisational capacities have been identified in other studies as important for sustainability of evidence-based practices in health services (Lennox et al., 2017; Markström et al., 2018; Stirman et al., 2012). While the most common capacities appear to be influenced by the work of internal service development staff, the least common capacities usually require complex interconnected systems with broad organisational support, a theme documented in the literature on complexity in implementation (Braithwaite et al., 2018).

The findings from these parallel studies (Studies 2 and 3) were converged, comparing each AMHS' current organisational capacity to AMHS with practitioners delivering Let's Talk in the previous 12 months. The converged findings showed that AMHS with higher organisational capacity scores were more likely to have practitioners continuing to deliver Let's Talk. Similarly, Markström et al. (2018) found that the presence of a greater number of implementation components corresponds with greater likelihood of program survival. This phase established that four AMHS had practitioners still delivering Let's Talk (as opposed to offering Let's Talk) and had higher organisational capacity scores.

Phase three

Focusing on the second sub-question, phase three identified critical elements for the sustainability of Let's Talk by exploring how one AMHS had sustained practice and capacity (see Table 8). In partnership with AMHS staff as a Local Research Group, a participatory case study (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020) was used to develop an explanatory model of what had enabled sustainability in their service within the context of known barriers. The model documented

influencers related to the external context, resources, the prior organisational capacity and a set of sustainability factors associated with the practitioner, the organisation and the parent-consumer. The study findings suggest that sustainability is more likely to occur when Let's Talk implementation is anchored to an organisation's existing identity, capacity, structures and relationships and when mutual adaptations are made to improve the fit (Allchin, Weimand, et al., 2020).

Additionally, the study found that sustainability occurred in the context of a changing environment that required ongoing attention. This suggests that setbacks and continued adjustments are common expectations within sustainability. These findings concur with the implementation literature that takes complexity into account (Braithwaite et al., 2018; Greenhalgh & Papoutsis, 2018; Shiell et al., 2008). The findings also challenge reductionist thinking in implementation science that assume a linearity and predictability of the implementation process and that it can be understood through the research of isolated factors, devoid of its context (Hawe, 2015).

This study built on existing conceptual and theoretical literature about the sustainability process (Scheirer & Dearing, 2011) by developing an explanatory model and thus allowing insight into real-world application. Additionally, the study contributes to a gap in the literature on family-focused practice where there are no clear pictures of what sustained practice looks like in applied settings (Isobel, Allchin, et al., 2019).

Phase four

The previous phases explored the context of implementation during the RCT (phase one), established what sustainability had occurred (phase two) and built an explanatory model of one AMHS with sustained practice and capacity (phase three). The findings from these three phases highlighted that the implementation approach and the context were important factors shaping sustainability. As a result, phase four used a co-design workshop to explore the generalisability of the findings to a broad range of AMHS settings in Victoria, Australia (see Table 8). This final phase further contributed to addressing the research's second sub-question, 'what key elements are critical for the sustainability of Let's Talk practice and organisation capacity?'

Working in partnership with FaPMI coordinators from across the Victoria, Australia, phase four converged the data of the previous phases to develop practical recommendations for future implementation endeavours for sustaining Let's Talk. In the process, the study built the FaPMI coordinators skills in applying implementation science to practice. The findings suggest that the previous learnings across the phases are applicable to other AMHS settings in Victoria, Australia with some additional site-specific consideration.

The co-designed recommendations incorporated a range of implementation levers related to supporting practitioners' continued practice of Let's Talk, and supporting organisational capacity to support Let's Talk practice. The content of the recommendations build on the current body of knowledge from the sustainability literature by applying them to the specific practice of Let's Talk and the specific setting of AMHS in Victoria, Australia. In doing so, this study is a response to Westerlund et al. (2019) call for the application and use of implementation science in practice. Whilst developed as a practical implementation tool, these recommendations would need to be applied locally to address each particular context.

Through developing the skills of FaPMI coordinators as change agents within AMHS, the study contributed to the knowledge generation processes that can help to bridge the praxis-knowledge gap identified in the literature on implementation science (Westerlund et al., 2019). Additionally, the development of co-designed implementation recommendations for Let's Talk contributes to the call from implementation science for the development of user-friendly tools for practical application of implementation science methods (Westerlund et al., 2019).

10.3 What we know about sustaining Let's Talk

In the process of developing knowledge to address a situated real-world issue, the thesis findings progress our understanding on sustaining Let's Talk as documented in 10.3, 10.4 and 10.5. A summation of the evidence of what is known is presented in this section, a framework of how the knowledge can be applied in practice is offered in 10.4 and gaps in knowledge on Let's Talk that are important for understanding sustainability are raised in 10.5.

From the findings in this thesis it is clear that sustainability of Let's Talk is multilayered. Influences relating to the practitioners, the organisations, the wider context and the implementation process all impacted sustainability. Moreover, these influences were seen to interact between these layers in keeping with an ecological perspective.

Influencing practitioners

Practitioners' use of Let's Talk was influenced by their gender, profession and access to parents on their caseload. The practitioners' ability to adapt Let's Talk to both the parent-consumer's needs and the working model of their team, additionally influenced their use of the practice. Furthermore, practitioners who used practice support where it was available showed increased delivery of Let's Talk (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). There may also be influences that were not explored in these studies but are noted in other literature on family-focused practice, such as practitioners' skills and knowledge of the impact of mental illness on parents, children and families (Grant et al., 2019; Maybery et al., 2016). Practitioners' ability to hold a dual perspective while

working with an individual is another influence of family-focused practice noted by Tchernegovski et al. (2018).

From the studies in this thesis, practitioners' use of Let's Talk was also influenced by their interface with the organisation and their interface with the parent-consumer. The team's workload and the allocation systems seemed to affect a match between a trained practitioner and the availability of parent-consumer (Allchin, Weimand, et al., 2020; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). Additionally, how practice support is structured impacted a practitioner's use of it (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). It was also proposed that parent-consumer uptake impacts practitioners' uptake in a reciprocal relationship (Allchin, Goodyear, et al., 2020). While the influence of this reciprocal relationship has not as yet been explored for Let's Talk (Allchin, Goodyear, et al., 2020), the importance of the relationship in developing a therapeutic alliance is well-known in the mental health field (Sandhu et al., 2015). Together these interfaces impact practitioners' opportunity and confidence to use Let's Talk in AMHS.

Organisational influences

The organisational structures that support practitioners' use of Let's Talk also have an impact on sustainability. Sustained focus on implementing Let's Talk was enabled by internal implementers who facilitated the organisation to refocus after setbacks or disruptions (Allchin, Goodyear, et al., 2020). Adjustments in organisational structures to accommodate Let's Talk were seen in all AMHS that had practitioners continuing to use it (Allchin, Weimand, et al., 2020; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). Organisational ownership of the implementation process is proposed to be the catalyst for such adjustments (Allchin, Weimand, et al., 2020). The ownership was seen in senior leadership communicating organisational priority through policy or practice guidelines and middle management enacting policy through guiding practitioners to understand how Let's Talk fitted into their everyday work (Allchin, Goodyear, et al., 2020; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). These leadership roles were also important drivers for change through the development of organisational structures such as training and support infrastructure, data collection systems, reporting systems (Allchin, Goodyear, et al., 2020; Allchin, Weimand, et al., 2020; Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). Feedback loops between these structures enabled organisational adjustments to support sustainability, for example, data on parent-consumer numbers within the service was used to identify the number and location of practitioners needed for training. Data on practitioners' application of Let's Talk after training led to the development of tailored systems to support Let's Talk practice (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020).

Influences in the wider context

The wider context that the organisation works within additionally impacts sustainability. AMHS function within a policy and funding context that shapes the way practitioners work by creating priorities and measuring outcomes. During the RCT, reforms in the mental health sector shifted priorities to recovery-focused care and enshrined the need for adult-focused services to respond to the needs of children of parent-consumers in the principles of the Mental Health Act (*Mental Health Act 2014 (Vic)*; Tchernegovski et al., 2017). These changes in this wider context enabled AMHS to fit an intervention such as Let's Talk into the remit of their work (Allchin, Goodyear, et al., 2020). These same reforms, however, also compromised the implementation of Let's Talk by creating competition for time, attention and resources. In some services, this interrupted or ceased the delivery of Let's Talk (Allchin, Goodyear, et al., 2020), challenging its sustainability. Additionally, the funding frameworks and service delivery models dictated by the wider context were noted to hold paradigm conflicts for recovery-focused and family-inclusive preventative mental health care that affected practitioners' use of Let's Talk. The mixed messages about what was a priority gave uncertainty about the use of Let's Talk in AMHS settings (Allchin, Goodyear, et al., 2020). Whilst these conflicts derived from the wider context were not within the control of the AMHS or the practitioner, accountability structures and team leadership support were seen as assisting AMHS to hold these in tension to enable sustained use within the barriers (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020).

Implementation influences

The implementation context for Let's Talk is another layer affecting sustainability. In these eight AMHS in Victoria, Let's Talk was introduced as a standalone evidence-based intervention in the context of a RCT with implementation support. The project was led by a university working in partnership with service delivery agencies, as well as workforce development agencies that build capacity around working with families (Maybery et al., 2017). The study's implementation strategy determined the selection of sites through an expression of interest process that enlisted organisational authorisation to ensure Let's Talk was delivered within a supportive environment. Implementation support was structured around training and coaching site-based master trainers who provided onsite practice support (Goodyear et al., 2016; Maybery et al., 2017). While the local implementation teams or committees were recommended, localised implementation that was put in place differed site by site (Allchin, Weimand, et al., 2020).

The introduction of the RCT followed a one-year supported implementation project undertaken by the Bouverie Centre, in partnership with AMHS (The Bouverie Centre, 2015). Whilst research conditions may have complicated the delivery of Let's Talk in AMHS, its implementation fitted within the framework encouraged by the Victorian Government's FaPMI service development program.

Additionally, the federal government-funded agency, COPMI/Emerging Minds was simultaneously adapting Let's Talk to an Australian context in partnership with Professor Tytti Solantaus (Finland) and a reference group of mental health practitioners, researchers and people with lived experience. This work resulted in the development of free online training and resource booklets for parents and young people (Tchernegovski et al., 2015). This government-level endorsement, support by the Bouverie Centre and engagement of some AMHS in the research partnership, created authorisation and credibility that supported Let's Talk's sustainability.

There was not, however, widespread engagement in Let's Talk by AMHS across the state (eight out of the 21 AMHS in the state engaged in the study). As noted above, a tension exists in AMHS between the aspirational commitment to family work and the individualised funding and practice models, resulting in interventions such as Let's Talk not being seen as core work (Allchin, Goodyear, et al., 2020). In addition to this, where family work was encouraged, Let's Talk is one of a number of different approaches that may be competing for implementation focus. This lack of engagement was seen in half of the AMHS having no intentions to implement Let's Talk beyond the research trial (Allchin, Weimand, et al., 2020). From one perspective, it is perhaps legitimate for AMHS to wait for the results of the research trial to ascertain whether the intervention will work in their local setting. Yet this raises questions of what 'working' might mean for the intervention moving forward. Given adaptations in the local setting are pivotal to whether or not the intervention can be sustained, it is hard to separate the intervention being seen as working, from the willingness of local-level investment in implementing the intervention. Reinforcing the importance of the implementation context, three of the four AMHS that engaged in the research with the intention to integrate Let's Talk into their services had practitioners continuing to use Let's Talk in the 12 months after the RCT (Allchin, Weimand, et al., 2020). Furthermore, the importance of intention to implement was also seen in the connection of Let's Talk to the AMHS pre-existing identity, capacity, structures and relationships in those organisations. This connection was understood as being pivotal to its sustainability in that service (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020).

It is worth also considering the importance of the implementation context of Let's Talk in Finland, where the program was first developed. In Finland, Let's Talk was first implemented as part of a suite of interventions introduced as part of a whole-of-system change embracing a preventative and promotive family-focused approach to address gaps in practice. It began with an intensive training program about the need for family interventions as well as in the interventions themselves, prior to being used in a RCT under research conditions (Toikka & Solantaus, 2006, T. Solantaus, personal communication, Feb 13 2020). As a result, the suite of interventions were being established as new practices for AMHS rather than interventions to be trialled in their own right. Furthermore, Let's Talk

was introduced as part of a suite of skills for practitioners to use to address the needs of families that was integrated into new practices (Toikka & Solantaus, 2006, T. Solantaus, personal communication, Feb 13 2020). As noted in the chapter detailing the background of Let's Talk (Chapter 4), Let's Talk also continued to evolve, being formalised and shaped by the context in which it was being used. Whilst this developing picture of Let's Talk has made clarity in regards to fidelity a challenge, it is perhaps the intervention's adaptability to fit the context that has enabled sustainability in Finland.

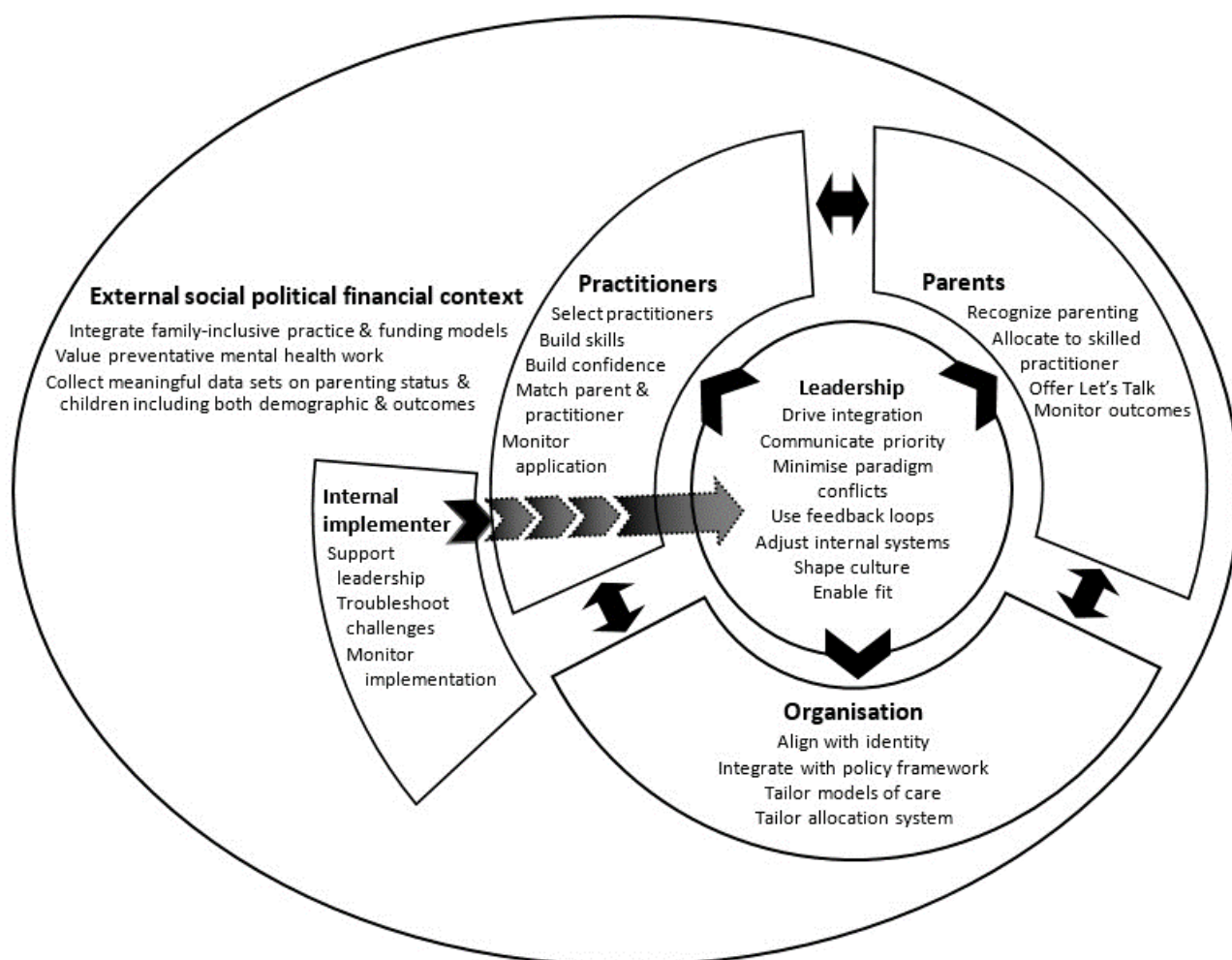
10.4 Key elements for sustaining Let's Talk

Building on the above findings detailing what is known about sustaining Let's Talk, this section presents a framework for how this knowledge can be applied in practice. The studies in this thesis identified that sustainability of Let's Talk is influenced by elements related to the parent, practitioner, the organisation, the wider context and the implementation context. Importantly, the multilayered nature of the influences suggest that sustainability of Let's Talk is dependent on the synchronicity between these key elements.

A parent cannot be offered Let's Talk if the practitioner allocated to them is not trained in the method. Without a system to identify consumers as parents, skilled practitioners may not be allocated parents. A skilled practitioner will find it difficult to maintain confidence if they are only rarely allocated a parent. Without a monitoring system, there will be no way of knowing if parents are being offered Let's Talk to know if it is being sustained. If the wider systems do not fund work with families or prioritise preventative mental health, an organisation may find it difficult to integrate Let's Talk into their model of care. Conversely, a training program does not ensure sustainability as trained practitioners may not use their new skills in practice. A system for identifying the parental status of consumers will in itself not ensure that they are allocated to trained practitioners, or have practitioners who are endorsed with the time and scope to use their skills. These are each part of the picture of sustainability but on their own will not enable sustainability. They are required to be applied in combination.

The framework as noted in Figure 17 highlights the complexity of sustaining an intervention such as Let's Talk and how the key elements are interconnected. Each section of the framework is explained in detail below:

Figure 17: Key elements for sustaining Let's Talk



Recognise, allocate and measure outcomes for parents

Recognition of a consumer's parental status can allow for service delivery to be tailored to address their and their children's and family's needs. Knowledge of prevalence of parenting amongst the organisation's consumers could be used to drive the number and location of skilled practitioners needed to adequately enable parents to access Let's Talk. Organisations can support parents by allocating them to practitioners with the skills and confidence to deliver Let's Talk. Recognition of parenting status also allows the organisation to apply appropriate outcome measures that assist them in monitoring if the services delivered give the expected benefits for parents, children and families. Additionally, attending to the reciprocal relationship between the parent and the practitioner, which is perhaps similar to the therapeutic alliance, may help to support a match that enables Let's Talk to be delivered.

Select, support and monitor practitioners

The selection of Let's Talk practitioners should take into account factors such as access to parents on their caseload, the practitioners' skills and knowledge of the impact of mental illness on parents, children and families, as well as their ability to hold a dual perspective while working with an individual. While gender and profession were seen to influence practitioners use of Let's Talk, restricting training to female social workers would seem impractical and limiting. It would also appear unlikely to achieve the outcome of sustainability of Let's Talk in AMHS given the restricted availability of social workers in the current workforce (State of Victoria, 2018). Building practitioners' skills and confidence to use Let's Talk would appear to require flexible practice support that is co-developed so it is tailored to fit practitioners' specific needs. Monitoring practitioners' application of Let's Talk is additionally suggested to provide a feedback loop that can help to identify support needs and address fidelity issues.

Integrate within organisation identity and structures

Aligning Let's Talk within the organisational identity and integrating it into policy structures would appear to help sustain Let's Talk. Integrating parent, child and family-focused work into the organisational identity is suggested to enable models of care to be tailored to fit Let's Talk, and support the incorporation of core competencies relevant to Let's Talk into position descriptions. Anchoring Let's Talk into organisational policy supports its continued use through times of change and the development of infrastructure to enable Let's Talk practice. Organisational infrastructure suggested to be important for sustaining Let's Talk includes practitioner training, support and monitoring systems, as well as parent recognition and allocation systems. Furthermore, incorporating whole-of-family wellbeing and outcome measures could possibly help to reinforce a preventative mental health focus which may facilitate Let's Talk practice.

Leadership to drive sustainability

Organisational ownership appears to facilitate the internal adjustments that support the integration of Let's Talk and enable its sustainability. This would imply that leadership embedded within the organisation needs to own and drive the change process. Adjustments to complex, internal structures appear to need whole-of-organisation commitment that requires leadership at multiple levels. At a higher level this appears to include communicating this work as a priority, developing training and support infrastructure, creating feedback loops and reporting systems. At the level of middle management this appears to include building cultures that promote recovery-focused family-inclusive mental health practice, facilitating the translation of Let's Talk into everyday practice and utilising the feedback loops to support practice. Held together, the multiple levels of leadership and

the structures they provide appear to help to minimise paradigm conflicts that exist for Let's Talk practice.

Local support for implementation and sustainability

Having an internal implementer to support leadership in the implementation process would appear to help support sustainability. The presence of the internal implementer can be an anchor to the priority of the work and provide resources for leadership to build practitioners' skills and confidence. Working with leadership, they can assist in monitoring implementation through feedback loops that can enable ongoing adaptation of implementation processes to support sustainability.

Incorporate family-inclusive preventative mental health care in the wider context

The integration of a family-inclusive, preventative lens into recovery-focused mental health practice in the wider context would also appear to support sustainability of Let's Talk. The mixed messages on priority for delivery of Let's Talk that are generated from the wider context could perhaps be lessened by funding and practice models that allow for working with families rather than individuals. This could be further reinforced through reporting measures that account for parent, children and family outcomes and that emphasise resilience and wellbeing rather than risk.

10.5 Research implications for Let's Talk

Additional to what is known about Let's Talk and how that can be applied, the findings from the studies in this thesis highlighted gaps in knowledge that are important for sustainability. There is a need to understand the mechanisms that are core to the identified parent, child and family outcomes of Let's Talk. Understanding these core mechanisms will enable the co-evolution of the practice in real-world settings that supports sustainability whilst maintaining the fidelity of Let's Talk. Kirk et al.'s (2019) step-by-step method may provide guidance to identify core mechanisms. Clearer understanding of its core mechanisms could also help establish clearer guidelines for training and monitoring fidelity of Let's Talk.

Furthermore, the studies highlighted a gap in the understanding of what enables practitioners' use and parents' uptake of Let's Talk in everyday practice in AMHS. Practitioner and parent perspectives on enablers could help to shed light on understanding the reciprocal relationship proposed between the practitioner and parent, and on how this influences practice.

10.6 The nature and study of sustainability

In addition to the thesis findings for the particular context and particular intervention, the research in this thesis contributes to our understanding of sustainability as a construct and its future study. The studies in this thesis collectively highlight the nature of sustainability as a nonlinear process with shocks and setbacks. Braithwaite et al. (2018) postulated that translating evidence to practice occurs within settings consisting of their own ecosystem, with complex established yet changing patterns of activities and relationships between multiple actors. They suggested that effecting change in healthcare systems needs to work within the reality of their changing states, describing them as Complex Adaptive Systems (CAS). This description from complexity science, encompasses ideas of self-organisation and being able to adapt and learn from experience, thus changing in unpredictable patterns (Braithwaite et al., 2018; Long et al., 2018; Paine & Peters, 2011; Plsek & Greenhalgh, 2001). Rather than a linear process with sustainability as the end point and a universal set of barriers and enablers, applying a lens of CAS to health systems emphasises a need for ongoing refocusing, monitoring and adjustments that fit a local context (Chambers et al., 2013).

A core understanding developed from this thesis was how sustainability occurred within an implementation process in shifting environments with shocks and setbacks, displaying this nonlinear process. The implementation process was not like inserting a fixed, complete evidence-based practice into a number of stable settings, but more of one that required ongoing local adjustments. Events in the outer context shifted the policy focus, changing the priority and the attention of the AMHS (Allchin, Goodyear, et al., 2020). There were also changes in the inner context such as organisational restructures and changes to models of practice and new management, all of which changed the organisations identity, culture and priorities (Allchin, Weimand, et al., 2020). Eighteen percent of the 211 staff trained during the RCT had shifted out of the organisation and some of those who were still at the organisation had changed roles (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). Each of these internal and external factors affected the organisational readiness for implementation, influencing sustainability.

Consequently, this thesis elucidates the work of Braithwaite et al. (2018) through a tangible example while also further developing the family-focused practice knowledge base through bringing this lens for effecting lasting change in AMHS. While it might be tempting for researchers and implementers to attempt to control out the anomalies in the environments, they are pivotal to understanding the sustainability of evidence-based practices in real, complex, ever-changing organisations. Instead implementers and researchers need to equip organisations to work within the nonlinear process towards sustainability through enabling their ownership and building their skills to pay attention to the changing environments as suggested by Long et al (2018). Sustainability is dependent on them being able to support the fit between the organisation and the evidence-based practice by making

the adjustments to the setting to fit the intervention (Scheirer & Dearing, 2011) and to the intervention to fit the setting (Chambers et al., 2013; Hawe, 2015).

As an example, organisational adjustments to fit the intervention were identified in this thesis to be pivotal to sustainability. AMHS with continued practice of Let's Talk had all made some organisational adjustments to fit Let's Talk into their organisation (Allchin, Weimand, et al., 2020). This reinforces Scheirer & Dearing's (2011) argument that greater organisational adjustment to accommodate an innovation increases the likelihood of the innovation's sustainability. Likewise it supports the position that Braithwaite et al. (2018) made that the context is intrinsic to what makes an improvement effort effective and sustained.

Adjusting the innovation to fit the setting was likewise seen in this thesis as linked to its sustainability. Approximately one third of practitioners had made adaptations to Let's Talk to fit with their parent-consumers' needs or their services settings (Allchin, O'Hanlon, Weimand, & Goodyear, 2020). While this adaptation could appear counter to the idea of evidence-based practice, there are strong arguments for evidence-based practices to be optimised in situ to enable sustainability (Chambers et al., 2013; Hawe, 2015). This approach suggests that evidence-based innovations are not so much 'implemented' into settings but that there is a co-evolution process that occurs in the implementation journey whereby new knowledge is generated (Hawe, 2015; Leykum et al., 2007).

While adaptations of an evidence-based practices to fit a setting appear important for its sustainability, this does raise questions about fidelity, as discussed in the chapter on conceptual lens (Chapter 3). It is argued that for fidelity to be upheld the mechanisms of change that make an intervention effective need to be clearly understood (Kirk et al., 2019; Patient-Centered Outcomes Research Institute, 2019). Understanding these core mechanisms of change enables adaptations in the activities of the intervention so that they do not compromise the expected benefits or result in the delivery of something that can no longer be identified as that evidence-based practice (Blase & Fixsen, 2013; Dearing, 2008; Kirk et al., 2019; Patient-Centered Outcomes Research Institute, 2019). There are few, if any, family-focused practices where the mechanisms of change are clearly articulated, as innovations are most commonly described by their core activities (form; Marston et al., 2016). Take for example Let's Talk, as noted in Chapter 4, the core mechanisms that produce the benefits for parents, children and family are not yet clear, making contextual adaptation and the measurement of fidelity more challenging. As a result, in order to build family-focused evidence-based practices that can be sustained in AMHS, greater attention to, and definition of, their core mechanism of change is required.

Furthermore, Braithwaite et al. (2018) advocate that efforts to improve practice, shift from a focus on intervention fidelity to one of effective adaptation that fits services and produces the desired benefits. As a result, to understand sustainability more fully, the measuring of the benefits alongside adaptations of interventions is necessary. This, however, poses a challenge for evidence-based family-focused practices where there are benefits to track for multiple actors that might be seen over different periods of time. Take for example, Let's Talk, where the benefits for children were seen 18 months after delivery (Punamäki et al., 2013; Solantaus et al., 2010), much later than the benefits for parents. Such longitudinal measurement would be difficult to integrate into everyday practice in AMHS, where the episodic care determines a short cyclical engagement. New collaborative ways to measure outcomes may need to be explored.

The findings from this research substantiate how sustainability can only be understood through a multilayered view of factors (Stirman et al., 2012). Greenhalgh and Papoutsi (2018) suggested that single-factor or single-level exploration fail to address important interactions and contextual issues essential to understanding sustainability. In this research, the combined findings from phase two (Studies 2 and 3) emphasise a set of implementation and organisational factors including leadership, use of data and localised adaptations to fit Let's Talk to the service, as important for sustaining practitioners' delivery of Let's Talk (Allchin, O'Hanlon, Weimand, & Goodyear, 2020; Allchin, Weimand, et al., 2020). Likewise, in phase three the sustainability of Let's Talk practice and organisational capacity were seen as intertwined with factors in the wider context within which the AMHS operated (Allchin, O'Hanlon, Weimand, Boyer, et al., 2020). Additionally, across these studies, the implementation approaches seen in the AMHS were shaped by their particular context. Without the multilayered contextual view explored in these studies, important enablers of sustained practice would have been missed.

This view through the interconnected multilayered factors leads to new ways of thinking about the work of embedding family-focused practice in AMHS. The thesis findings would suggest that there is a need for embracing complexity rather than looking in isolation at components, such as a specific model, staff training or the identification of parents. As seen in this research, AMHS are more likely to focus on individual components such as collecting data on parents or training and supporting staff that can be executed in isolation rather than interconnect the components within the service system (Allchin, Weimand, et al., 2020). Such interconnection, such as using data collected about parenting status to identify the number of practitioners to train, is a more complex adaptive process and requires the whole-of-organisation engagement to achieve. It would follow that building these complex organisational capacities within AMHS that can be utilised beyond a specific intervention will be an important investment for the sustainability of new practices into the future.

10.7 Research implications for understanding sustainability

This thesis demonstrated how research of real-world use and continued use of an intervention is important to add to what is known from studies on targeted implementation. The thesis findings would suggest that a bumpy road to sustainability could be expected with implementation being a non-linear process. Consequently, point-in-time measures of uptake and continued use of practice will give limited understanding on their own and research will need to embrace the unique context within which the practice is being used.

Additionally, whether sustainability is possible for an innovation is intertwined with its development process. The results in this thesis suggest that the application of implementation science and complexity thinking may support the development of innovations that can be sustained (Long et al., 2018). Dynamic approaches to the design of evidence-based practice, such as family-focused practice, that acknowledge the co-evolution of practices in situ may support their establishment and continuation in health care settings such as AMHS. Such approaches need interventions that are able to articulate the core mechanisms or functions, rather than just their tasks, so that they can be adapted to local contexts, enabling them to be applied to localised, everyday practice. Approaches will also need to be able to measure factors from multiple levels within their context, over long periods of time in order to fully understand and support sustainability.

10.8 Conclusion

The work in this thesis draws on diverse bodies of knowledge to shed light on the real-world challenge of sustaining a family-focused practice in AMHS after initial implementation. As a result of these studies, a greater understanding of the key elements for sustaining the particular intervention, Let's Talk, has been developed. These key elements can provide a framework for AMHS and the wider context that they work within to enhance the likelihood of Let's Talk being sustained. Moving forward, these key elements could be co-developed into a practical implementation tool for AMHS, such as Let's Talk practice guidelines.

Additionally, the knowledge generated in this research process has provided an opportunity to consolidate what is known about Let's Talk, giving greater insight into the core practices and principles important for its outcomes. Knowledge about Let's Talk warrants further development, however, so that the core mechanisms of change can be clearly articulated. Doing so will provide a stronger foundation for both fidelity and sustainability.

Furthermore, the studies have illuminated the nature of sustainability of evidence-based practice like family-focused practice in real-world settings. Providing realistic pictures of sustainability equips

health care settings, for instance AMHS, to implement in the world they inhabit and to set in place the structures required to enable sustainability.

Of ultimate importance, however, and the reason for which I embarked on this journey, is my hope that by understanding sustainability more fully, parents with a mental illness in contact with AMHS, as well as their children and families, will have greater access to the benefits of family-focused practices such as Let's Talk.

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Monash Ethics: Addition as researcher to existing project

From: **MRO Human Ethics Team** <muhrec@monash.edu>

Date: 25 October 2016 at 15:18

Subject: MUHREC Amendment CF13/3301 - [2013001719](#) - Developing an Australian-first recovery model for parents in Victorian mental health and family services

To: darryl.maybery@monash.edu, melinda.goodyear@monash.edu

PLEASE NOTE: To ensure speedy turnaround time, this correspondence is being sent by email only. MUHREC will endeavour to copy all investigators on correspondence relating to this project, but it is the responsibility of the first-named investigator to ensure that their co-investigators are aware of the content of the correspondence.

Dear Researchers

Thank you for your request for amendment, submitted on 25/10/2016.

This is to advise that the following amendment has been approved as outlined in your application. A brief summary of the changes is included below:

Changes to Personnel

- Mrs Becca Allchin added to project as student investigator

Approved Documents

- Revised Explanatory Statements
- Revised Consent Forms

Thank you for keeping the Committee informed.

Human Ethics Team

Human Ethics

Monash Research Office

For applications submitted prior to the 6 July 2016, please note that we are not able to process amendments to these projects for the next 2 - 3 weeks.

Souheir Houssami, PhD - Executive Officer - Tel: +61 3 990 52052

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ABN 12 377 614 012 CRICOS Provider No 00008C

Monash Ethics: Amendments after migration to electronic Ethics Review Manager (ERM)



Rebecca Allchin <rebecca.allchin@monash.edu>

Amendment Approval - 4536

donotreply@infonetica.net <donotreply@infonetica.net>

8 February 2018 at 13:22

To: darryl.maybery@monash.edu

Cc: melinda.goodyear@monash.edu, andrea.reupert@monash.edu, Henry.vonDoussa@monash.edu, Rebecca.Allchin@monash.edu, ptch1@student.monash.edu, ejthomp@deakin.edu.au

Dear Professor Darryl Maybery

Project Title: Developing an Australian-first recovery model for parents in Victorian mental health and family services

The amendment has been assessed and approved by the Human Ethics Committee

Please log into the ethics and compliance portal using the link below to access the details of this project.

<https://ethicsapps.monash.edu>



Rebecca Allchin
<rebecca.allchin@monash.edu>

Amendment Approval - 4536

donotreply@infonetica.net <donotreply@infonetica.net>

28 August 2018 at 09:40

To: darryl.maybery@monash.edu

Cc: darryl.maybery@monash.edu, Henry.vonDoussa@monash.edu, melinda.goodyear@monash.edu, Rebecca.Allchin@monash.edu

Project Title: Developing an Australian-first recovery model for parents in Victorian mental health and family services

Project ID: 4536

Expiry Date: 29/01/2019

Dear Researchers

The amendment has been assessed and approved by Human Ethics Committee

Please log into [Ethics Review Manager](#) (ERM) to view the project details.

Kind Regards,

Human Ethics Committee



Monash University Human Research Ethics Committee

Approval Certificate

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 ID: 19848
Project Title: Sustainability and Let's Talk about Children
Chief Investigator: Dr Melinda Goodyear
Approval Date: 05/06/2019
Expiry Date: 05/06/2024

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 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 letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved projects including changes to personnel must not commence without written approval from MUHREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of five years.

Kind Regards,

Professor Nip Thomson

Chair, MUHREC

CC: Mrs Rebecca Allchin

List of approved documents:

Document Type	File Name	Date	Version
Supporting Documentation	Phase 4 invitation	08/02/2019	1
Explanatory Statement	Monash Explanatory Statement MIRF Sustainability phase 4	08/02/2019	1
Consent Form	Monash Explanatory Statement MIRF Sustainability phase 4	08/02/2019	1
Consent Form	TOR FaPMI Coordinators v2	08/02/2019	v2
Supporting Documentation	Ethics Amendment- New application summary April 2019	29/04/2019	1

Sustainability and Let's Talk PhD Advisory Group Terms of Reference

1 Context of participatory research partnerships in this PhD

A participatory research approach is being used to understand the context of sustainability of *Let's Talk* in Adult Mental Health Services (AMHS). This approach is being used due to its ability to support knowledge translation. There are three configurations of research partnerships being employed in this research;

- An advisory group comprising of a practitioner, AMHS manager, FaPMI coordinator and methodological specialist to advise on overall design and data collection,
- FaPMI coordinators from AMHS involved in the RCT study(MIRF let's Talk) to help ensure that the research tools fit the context and support the recruitment of the appropriate participants for each context for phase 2-4
- A local research team at AMHS selected for deeper exploration via case study (phase 3), will be identified as appropriate to the setting, to partner in the interpretation and application of findings. Members of such a team may include but not be limited to;
 - practitioners with continued practice of let's talk,
 - managers involved in implementation or its overseeing,
 - FaPMI coordinators,
 - FaPMI peer workforce
 - quality management personnel
 - senior leadership within the AMHS

2 Aim of Advisory Group

The advisory group provides insight and perspective to the researcher about aspects of the whole design and development of the research. Each member brings their own expertise that can provide the researcher with awareness and understanding of aspects of methods of research, implications of research implementation and important contextual and cultural understanding. This process aims to improve the credibility and validity of the research outcomes and their fit for services.

3 Membership

A core membership will consist of an AMHS practitioner who has utilised Let's Talk, an AMHS manager, a FaPMI coordinator and methodological specialist. Other members may be invited as gaps are identified. Membership is voluntary.

4 Acknowledgment and Confidentiality Obligations

Participatory research is built on equitable partnerships that acknowledge the different expertise of different partners. Mutual trust and respect are integral to good partnerships. As a result the researcher has a responsibility to ensure that contributions by the Advisory Group are appropriately acknowledged in any public documentation and will not be used for personal gain outside the constructs of the PhD. Likewise members of the Advisory Group have a responsibility to not use information gained for personal gain, acknowledging that material viewed and developed through the consultation process forms part of the researcher's documentation as fulfilment of the PhD and cannot be further distributed without consultation and consent.

5 Tenure

The advisory group will run for the duration of the PhD study which is expected to be completed by end of 2019. As members are representing a skill and experience set in their role on the advisory group, a change to role during the period of tenure that may affect their continued capacity to advise will be considered and negotiated as required.

6 Meetings

Meetings will occur via Zoom either video or teleconference. It is envisaged that the advisory group will meet for 1-1.5 hrs roughly quarterly at a time mutually arranged.

7 Administration

The meetings will be chaired by the researcher who will prepare and send an agenda and any pre reading to the advisory group not less than 1 week before the meeting. Action Notes will be developed by the Chair and sent not more than 1 week after the meeting. These notes will also be distributed to the researchers supervising team.

I confirm that I have read the Terms of Reference for Advisory Group and agree to abide by Acknowledgment and Confidentiality Obligations

Name

Title

Signature

Date / /

Sustainability and Let's Talk PhD

Terms of Reference for Research Partnership with FaPMI Coordinators

1 Context of participatory research partnerships in this PhD

A participatory research approach is being used to understand the context of sustainability of *Let's Talk* in Adult Mental Health Services (AMHS). This approach is being used due to its ability to support knowledge translation. There are three configurations of research partnerships being employed in this research;

- An advisory group comprising of a practitioner, AMHS manager, FaPMI coordinator and methodological specialist to advise on overall design and data collection,
- FaPMI coordinators the FaPMI Coordinator Network of Victoria to help ensure that the research tools fit the context and support the recruitment of the appropriate participants for each context for phase 2-4
- A local research team at AMHS selected for deeper exploration via case study (phase 3), will be identified as appropriate to the setting, to partner in the interpretation and application of findings. Members of such a team may include but not be limited to;
 - practitioners with continued practice of let's talk,
 - managers involved in implementation or its overseeing,
 - FaPMI coordinators,
 - FaPMI peer workforce
 - quality management personnel
 - people with authority within the AMHS

2 Aim of Research Partnership with FaPMI Coordinators

The researcher will collaborate with the FaPMI Coordinator Network in Victoria throughout phase 2-4 of this study, to help ensure that the research tools fit the context and support the recruitment of the appropriate participants for each context for phase 2-4. The collaboration in each phase will take on different forms;

- In Phase 2 the FaPMI coordinator in services involved the RCT will have input into the design and distribution strategy of the two questionnaires (about practice of practitioners and capacity of service). They may also act to facilitate and support the engagement of the participants.
- In Phase 3, the FaPMI coordinator in AMHS selected for phase 3 will assist to identify key personnel for the local research team. They will also contribute as a member on the local research team.
- In Phase 4 the FaPMI Coordinators Network will have input to the analysis and interpretation process for the development of the framework

3 Membership

FaPMI Coordinators are key personnel in AMHS working to develop and sustain workforce capacity in the area of Families where a parent has a mental illness. FaPMI coordinators from FaPMI Coordinator Network will be invited to participate as research partners in phases 2-4.

4 Tenure

The research partnership with FaPMI Coordinators will run for the duration of the PhD study which is expected to be complete by end of 2019.

5 Partnership

A number of consultations will be held with FaPMI coordinators via state-wide meetings, email and Zoom (via telephone or video) at pivotal points throughout the research. The researcher will work in partnership with the FaPMI Coordinators to facilitate recruitment to phase 2 and in those AMHS selected for phase 3 prior to the development of the local research team.

6 Acknowledgment and Confidentiality Obligations

Participatory research is built on equitable partnerships that acknowledge the different expertise different partners. Mutual trust and respect are integral to good partnerships. As a result the researcher has a responsibility to ensure that contributions by the FaPMI Coordinator Network are appropriately acknowledged in any public documentation and will not be used for personal gain outside the constructs of the PhD. Likewise the FaPMI Coordinators have a responsibility to not use information gained for personal gain, acknowledging that material viewed and developed through the consultation process forms part of the researcher's documentation as fulfilment of the PhD and cannot be further distributed without consultation and consent.

7 Administration

The consultations will be chaired by the researcher who will prepare and send an agenda and any pre reading to the FaPMI Coordinators not less than 1 week before the consultation. Action Notes will be developed by the Chair and sent not more than 1 week after the consultation. All other partnership meetings will have actions notes written and sent to all those in attendance. These notes will also be distributed to the researcher's supervising team.

I confirm that I have read the Terms of Reference for Research Partnership with FaPMI Coordinators and agree to abide by Acknowledgment and Confidentiality Obligations

Name

Title

Signature

Date / /

Sustainability and Let's Talk PhD

Terms of Reference for AMHS Local Research Team

1 Context of participatory research partnerships in this PhD

A participatory research approach is being used to understand the context of sustainability of *Let's Talk* in Adult Mental Health Services (AMHS). This approach is being used due to its ability to support knowledge translation. There are three configurations of research partnerships being employed in this research;

- An advisory group comprising of a practitioner, AMHS manager, FaPMI coordinator and methodological specialist to advise on overall design and data collection,
- FaPMI coordinators from AMHS involved in the RCT study(MIRF let's Talk) to help ensure that the research tools fit the context and support the recruitment of the appropriate participants for each context for phase 2-4
- A local research team at AMHS selected for deeper exploration via case study (phase 3), will be identified as appropriate to the setting, to partner in the interpretation and application of findings. Members of such a team may include but not be limited to;
 - practitioners with continued practice of let's talk,
 - managers involved in implementation or its overseeing,
 - FaPMI coordinators,
 - FaPMI peer workforce
 - quality management personnel
 - people with authority within the AMHS

2 Aim of Local Research Team

In Phase 3 the researcher with the local FaPMI Coordinator will identify a local research team in selected AMHS. The local research team will work with the researcher to guide the case study process and co-construct a contextually understanding of the continued practice and continued capacity. This will involve a process of identifying data to be collected, reviewing and clarifying constructs and their relationship in context and interpreting and applying the findings for their setting. Each member of the research team brings unique expertise and experience that can enable a broad and deep understanding to be developed that can be useful to the AMHS.

3 Membership

Members of local research team will be selected as appropriate to the specific setting and may include but not be limited to;

- practitioners with continued practice of let's talk,
- managers involved in implementation or its overseeing,
- FaPMI coordinators,
- FaPMI peer workforce
- quality management personnel
- people with authority within the AMHS

4 Tenure

The research partnership with local research team will run for the duration of Phase 3 PhD study which is expected to be between August 2018 and April 2019.

5 Process of Engagement

The researcher and the local research team will meet regularly to guide the study through a series of phases to check on the progress, draw together understanding and assess if different data is needed

to build explanation. The role of the researcher and local research team is outlined in the phases below

- **Develop time line of implementation:** The researcher will meet with the local research team to develop a collective understanding of the process of implementation at that site. During this phase the team will identify documents that will give evidence for that story, and key people to interview.
- **Interviews and document collection:** The researcher will begin interviewing those identified. Interviews will use an interactive process such as timelines and be recorded. These will be reviewed and mapped by the researcher against the theoretical framework. Documents will be gathered and reviewed by the researcher making reflective notes and memos.
- **Concept mapping:** Drawing together the interview data, document data and the researcher's notes, the researcher with the local research team will map the data against the theoretical framework to code, identify themes and map interrelationships and patterns.
- **Explanation building:** The themes, patterns and interrelationship developed will be interpreted to make meaning out of the analysis by the researcher and local research team.

6 Acknowledgment and Confidentiality Obligations

Participatory research is built on equitable partnerships that acknowledge the different expertise different partners. Mutual trust and respect are integral to good partnerships. As a result the researcher has a responsibility to ensure that contributions by the local research team are appropriately acknowledged in any public documentation and will not be used for personal gain outside the constructs of the PhD. Likewise the local research team have a responsibility to not use information gained for personal gain, acknowledging that material viewed and developed through the consultation process forms part of the researcher's documentation as fulfilment of the PhD and cannot be further distributed without consultation and consent.

7 Administration

The researcher or delegate (supervisor) will act as Chair of the local research team. The researcher will lead and drive the research partnership process to enable a culture of co-learning and reflexivity. The analysis process will be led by the researcher to bring about agreement through consultation with local research team, returning to the data and theory for review and revision. The Chair will schedule meetings, prepare and send an agenda and any pre reading prior to each meeting. Action Notes will be developed by the Chair and shared with the team. These notes will also be distributed to the researcher's supervising team.

I confirm that I have read the Terms of Reference for AMHS Local Research Team and agree to abide by Acknowledgment and Confidentiality Obligations

Name

Title

Signature

Date

/ /

Study 1: Semi-structured interview schedule Let's Talk Managers/ Supervisors

Interview preamble

Thank you for agreeing to participate in this interview. The aim of this interview is to gain a sense of how you found the implementation of Let's Talk intervention at your service, its strengths and any issues you might have encountered.

I just need to check that you signed the information statement that was given to you? I also need to let you know that your participation in this research is entirely your choice, and it's also entirely up to you whether you want to answer all of my questions. So if there's a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

Finally, all the data that I collect from you will be treated in a confidential manner, so I'll be removing all information that identifies you from the transcript in the analysis. Any questions so far? Even though I understand that you have provided consent to having this interview being taped, I would like to ask you again, whether you are okay with having the interview audio-taped? (If yes, switch on tape recorder)

Questions (Incorporating the Consolidated Framework for Implementation Research (Damschroder et al., 2009))

Views of the intervention

We would like to understand current views and perceptions regarding the Let's Talk approach to working with parent-clients.

- Can you tell me a bit about what you think of the Let's Talk Intervention?

Prompt for potential barriers/enablers

- What are the advantages of the intervention compared to other ways of working? (Intervention characteristics - relative advantage)
- How strong do you think the evidence base is for this intervention? How do you know this? How valid do you think the model is to achieve the desired outcomes? (Intervention characteristics - evidence strength and quality)
- How suitable do you think the intervention is for the local context? (Intervention characteristics and Inner setting- compatibility/adaptability)
- How easy or difficult do you think it is to use the intervention as it is intended? (Intervention characteristics - complexity)
- What was useful about the Let's Talk intervention?
 - What changes, if any, would you like to see, in the intervention?
 - Was there anything missing?
 - What issues, if any, do you have with the intervention?
- How relevant is the intervention for a recovery oriented treatment approach?
 - What may need to change for Let's Talk to fit within a recovery framework?
 - What is your understanding of recovery for parents with a mental illness?

Barriers and Enablers

What was the experience of implementing the intervention at your service? How did it go?

- Now that your organisation has been involved in LT, what changes if any have occurred in your own organisation? For example, in terms of policy, intake and so on?
- What are the barriers / challenges to working in the way described by the intervention?

Prompt for specific barriers:

- Is the intervention appropriate for parent-clients at your organisation? (Outer setting - patient needs and resources)
- How are the principles of LT aligned to the philosophy of your organisation, if at all?
- Do you do another intervention/or is something else equally as good or better? if so, what? (Intervention characteristics - relative advantage)
- How does the way that other workers' use/view the intervention influence the use of the intervention by an individual practitioner, e.g. how much do workers influence each other in what they do and advocate? (Inner setting (Culture) - influence of others, organisational culture)
- How do external policies and regulations impact on the way the LT works, if at all? (Outer setting - external policies and incentives)
- How do the other priorities in your role/organisation influence the use of the intervention, if at all? (Inner setting (Implementation Climate) - relative priority)
- How does the availability of resources impact on the way in which the intervention might work, if at all? What resources are necessary here? (Inner setting (Readiness for Implementation) -available resources)
- What would you need, to be able to work in the way required by the intervention?

Prompt for specific facilitators:

- How might leadership (e.g., a champion from within your organisation/profession) make it easier to adopt the intervention, if at all? (Inner setting – Readiness for Implementation - leadership)
- How might organisational support influence the use of the intervention, if at all? (Inner setting (Culture) - influence of others, organisational culture)
- How might access to information/knowledge impact on the delivery of the intervention, if at all? (Inner setting (Readiness for Implementation) - access to information)

That is all the questions I have for you about the LT intervention. Are there any other comments, issues or concerns you would like to make about this? I will be sending you a transcript of this interview for you to check and delete any information you think might be potentially identifiable or to add anything you might like to add. Thank you so much for your time. We appreciate it.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, 4(1), 50. doi:10.1186/1748-5908-4-50

Practitioner Questionnaire- Follow Up

Developing an Australian-first recovery model for parents in Victorian mental health and family services

Follow up survey for Practitioners at services that have implemented Let's Talk about Children

You are invited to participate in this follow up study because you are a practitioner who was trained in Let's Talk about Children in a service participating the randomised control trial research project, RCT study (MIRF Let's Talk). This follow up study is a component of a broader focus on Sustainability and Let's Talk being undertaken as part of a PhD program by Becca Allchin supervised by Dr. Melinda Goodyear, Dr. Brendan O'Hanlon and Dr. Bente Weimand.

Your participation will involve completion of a follow up worker questionnaire (either online or on hard copy) to examine the views of practitioners undertaking the Let's Talk intervention. The questionnaire takes about 20 mins to complete. You may have completed components of this study in a prior phase of research. You will be asked a series of questions relating to the process of training in and using Let's Talk and to complete components of the family-focused health practice questionnaire.

We are interested in your honest feedback about your activities and your organisation. There is no right or wrong answers. Further information is provided in the Monash Explanatory Statement Practitioner MIRF Sustainability that can be accessed by clicking on the link or contacting the research team through one of the contact details listed below. Any questions can also be directed to the research team

Dr. Melinda Goodyear: 99056115, melinda.goodyear@monash.edu

Becca Allchin: 0427348545, rebecca.allchin@monash.edu

Your Consent

I have been asked to participate in the follow up questionnaire to the study named "Developing an Australian-first recovery model for parents in Victorian mental health and family services". I have read and understood the explanatory statement and I hereby consent to participate by completing the series of questions relating to the process of training in and using Let's Talk and to complete components of the family-focused health practice questionnaire. I am aware that I can withdraw my participation up until I have submitted the questionnaire online.

I agree to the above statement

☐ Yes

☐ No

Signature.....

If you would like any assistance with this questionnaire, the research team will be happy to assist.

Dr. Melinda Goodyear: 99056115, melinda.goodyear@monash.edu

Becca Allchin: 0427348545, rebecca.allchin@monash.edu

Firstly, we would like to know a bit about you and your work role.

Today's date: _____

Age in years? _____

Gender? _____

Are you a parent yourself?

☐ Yes

☐ No

Which of the following best describes your working hours?

☐ Full time

☐ Part time (please specify how many hours per week _____)

☐ Other (please specify how many hours per week _____)

Which organisation/service do you work for? (Please indicate your **main** area of work)

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____ Mental Health Service

☐ _____

☐ Other (Please specify) _____

Is this the service you were in when you trained in Let's Talk?

- ☐ Yes
- ☐ No (please name the service trained in) _____

Which team do you work in?

- ☐ Community treatment
- ☐ Bed based acute
- ☐ Triage/ acute treatment)
- ☐ Bed based Rehabilitation
- ☐ Community Rehabilitation
- ☐ Integrated team
- ☐ Other (Please specify) _____

What is your main professional?

- ☐ Psychiatric Nurse
- ☐ Social Worker
- ☐ Psychiatrist
- ☐ Medical Officer
- ☐ Psychologist
- ☐ Occupational Therapist
- ☐ Welfare Worker
- ☐ Other (Please Specify) _____

What is your main work role?

- ☐ Manager
- ☐ Practitioner/ Clinician
- ☐ Other (Please Specify) _____

Years of experience in your current role? _____

Previous training relating to supporting parents of dependent children with mental illness:

What is the highest educational qualification that you have completed?

- ☐ High School
- ☐ Certificate
- ☐ Diploma
- ☐ Degree
- ☐ Graduate diploma/honours
- ☐ Masters
- ☐ Doctorate/PhD

Are you currently undertaking training for a qualification?

- ☐ No
- ☐ Yes (Please specify qualification type as above)

About Let's Talk

What date did you do training in Let's Talk intervention? _____

What training did you do?

- ☐ Online only
- ☐ Face to face by Bouverie only
- ☐ Face to face by local service only
- ☐ Online and face to face by Bouverie
- ☐ Online and face to face by local service
- ☐ Other (Please describe) _____
-

Did Let's Talk training help you deliver Let's Talk?

- ☐ Not at all
- ☐ A slight extent
- ☐ A moderate extent
- ☐ A great extent
- ☐ A very great extent
- ☐ N/A
-

- In what way?

Were Individual or Group Practice Support/Supervision Sessions offered at your service to discuss Let's Talk:

☐ Yes

☐ No

If Yes,

- Did you use them?

- Did you find them helpful?

☐ Not at all

☐ A slight extent

☐ A moderate extent

☐ A great extent

☐ A very great extent

-
- In what way?

Did anything else help you deliver Let's Talk

Regardless of whether you have delivered Let's Talk or not, did the training help you deliver family focused practice more generally?

- ☐ Not at all
- ☐ A slight extent
- ☐ A moderate extent
- ☐ A great extent
- ☐ A very great extent
-

- In what way?

How long after the training did you first use the Let's Talk intervention?

- ☐ Never
- ☐ Weeks _____
- ☐ months _____

- If never, what would have helped you to use Let's Talk in your work?

(if Never, please go to Family focused Health Practice Questionnaire)

Of those that you offered Let's Talk to, what types of diagnosis had they been given? (tick all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Psychosis
- ☐ Bipolar
- ☐ Borderline personality disorder
- ☐ Schizophrenia
- ☐ Other _____
-

How many people have you done Let's Talk about Children with **in the first 12 months** of being trained? none=0

- ☐ Complete Let's Talk; Preliminary discussion, Discussion 1 & Discussion 2 ____ (no. people)
- ☐ Preliminary discussion only ____ (no. people)
- ☐ Preliminary discussion & Discussion 1 only ____ (no. people)
- ☐ N/A
-

- In this time please estimate the percentage of your caseload that were parent clients? __%
-

How many people have you done Let's Talk about Children with **in the second year** since being trained? none=0

- ☐ Complete Let's Talk; Preliminary discussion, Discussion 1 & Discussion 2 ____ (no. people)
- ☐ Preliminary discussion only ____ (no. people)
- ☐ Preliminary discussion & Discussion 1 only ____ (no. people)
- ☐ N/A
-

- In this time please estimate the percentage of your caseload that were parent clients? __%

How many people have you done Let's Talk about Children **with in the last 12 months**? none=0

- ☐ Complete Let's Talk; Preliminary discussion, Discussion 1 & Discussion 2 ____ (no. people)
- ☐ Preliminary discussion only ____ (no. people)
- ☐ Preliminary discussion & Discussion 1 only ____ (no. people)
- ☐ N/A

- In this time please estimate the percentage of your caseload that were parent clients? __%

If you have not continued to use Let's Talk, what would have helped you to continue to use Let's Talk in your work?

At what point in your work with the client did you offer Let's Talk: (tick all that apply)

- ☐ Initial engagement
- ☐ Established relationship
- ☐ Just prior to discharge
- ☐ Other _____

Did you deliver Let's Talk as described in the training?

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never
- ☐ N/A
-

Did you make adaptations?

- ☐ Yes
- ☐ No
- ☐ N/A

If Yes:

- In what way did you modify it?

-
- What was the benefit of the modification?

Family Focused Health Practice Questionnaire

(Maybery, Goodyear & Reupert, 2015)

This survey focuses upon health worker skill and knowledge, workplace policies and procedures, time, workload and location problems, opportunities for professional development and engagement and confidence issues in relation to working with parents with illnesses, their families and children. Questions also focus on the capacity and interest that workers have to work with families and children of parent-consumers (e.g. clients/patients) of health and welfare services. For each question below please select the answer that best corresponds with your experience. Please note that the term 'family work' is used generally to describe the process of working with parents and/or their family members where the parent has a mental illness.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
My workplace provides supervision and/or mentoring to support workers undertaking child-related work in regard to their consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In my area we lack services (e.g. other agencies) to refer children to in relation to their parent's illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is no time to work with families or children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Government policy regarding family focused practice is very clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Professional development regarding family focused practice is NOT encouraged at my work place	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often receive support from co-workers in regard to family focused practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am NOT confident working with consumer-parents about their parenting skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many consumer-parents do NOT consider their illness to be a problem for their children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to determine the developmental progress of the children of my consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
I sometimes wish that I was better able to help consumer-parents, discuss the impact of their illness on their children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am knowledgeable about how parental illness impacts on children and families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are no parent-related programs (e.g. parenting skills) to refer consumer-parents to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My workplace does NOT provide supervision and/or mentoring to support workers undertaking family focused practices (<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Due to location it is difficult to coordinate families and children with the required services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The workload is too high to do family focused work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At my workplace, policies and procedures for working with consumer-parents on family issues are very clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My workplace provides little support for further training in family focused practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In my workplace other workers encourage family focused practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am NOT confident working with families of consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discussing issues for the consumer parent with others (including family) would breach their confidentiality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to assess the level of children's involvement in their parent's symptoms or issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
I should learn more about how to assist consumer-parents about their parenting and parenting skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do NOT have the skills to work with consumer-parents about how parental mental illness impacts on children and families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are no family therapy or family counselling services to refer consumer-parents and their families to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is time to have regular contact with other agencies regarding families or children or consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The children often do NOT want to engage with me about consumer parents illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would like to undertake future training to increase my skills and knowledge for working with the children of consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am not experienced in working with child issues associated with parental illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would like to undertake training in future to increase my skills and knowledge about helping consumer-parents with their parenting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am skilled in working with consumer-parents in relation to maintaining the wellbeing and resilience of their children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am NOT confident working with children of consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
I am knowledgeable about the key things that consumer-parents could do to maintain the wellbeing (and resilience) of their children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am NOT able to determine the level of attachment/bond that consumer-parents have with their children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am NOT knowledgeable about the key parenting issues for consumer-parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am skilled in working with consumer-parents regarding their parenting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't feel confident to counsel consumer-parents about parenting and their health problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any further comments?

Thank you for your time. We really appreciate your participation.

If you have any questions, please do not hesitate to contact us.

Becca Allchin M: 0427348545 E: rebecca.allchin@monash.edu

Dr. Melinda Goodyear Ph: 9055 6115 E: melinda.goodyear@monash.edu

Managers Semi Structured Interview: Indicative Questions- Follow Up

Developing an Australian-first recovery model for parents in Victorian mental health and family services

Follow up survey for FaPMI Coordinators and Managers/implementers at services that have implemented Let's Talk about Children as part of the RCT Study (MIRF *Let's Talk*)

You are invited to take part in this follow up study because you are a FaPMI coordinators and managers/implementer in a service participating in the randomised control trial research project, RCT study (MIRF *Let's Talk*). This follow up study is a component of a broader focus on *Sustainability and Let's Talk* being undertaken as part of a PhD program by Becca Allchin supervised by Dr. Melinda Goodyear, Brendan O'Hanlon and Bente Weimand.

Your participation will involve completion of organisation focused questions to understand more about the process of implementation utilized by the service and the continued capacity to support let's talk. The questions will be sent prior to arranging a semi structured interview to enable you to gather the information required.

We are interested in your honest feedback about your activities and your organisation. There is no right or wrong answers. Further information is provided in the Monash Explanatory Statement Organisation MIRF Sustainability that can be accessed by clicking on the link or contacting the research team through one of the contact details listed below.

Any questions can also be directed to the research team

Dr. Melinda Goodyear: 99056115, melinda.goodyear@monash.edu

Becca Allchin: 0427348545, rebecca.allchin@monash.edu

Your Consent

I have been asked to participate in the follow up questionnaire to the study named "Developing an Australian-first recovery model for parents in Victorian mental health and family services". I have read and understood the explanatory statement and I hereby consent to participate by completing the series of questions relating to implementation of and continued capacity to support Let's Talk. I am aware that I can withdraw my participation up until I have submitted the questionnaire online.

I agree to the above statement

☐ Yes

☐ No

Signature.....

If you would like any assistance with this questionnaire, the research team will be happy to assist.

Dr. Melinda Goodyear: 99056115, melinda.goodyear@monash.edu

Becca Allchin: 0427348545, rebecca.allchin@monash.edu

Firstly, we would like to know a bit about your service.

Today's date: _____

1. How would you describe the area your service works across?
 - Rural
 - Metro
 - Regional
 - Other _____
2. How would you describe the size of your service?
 - a. Beds numbers _____
 - b. Community Centres/ Teams _____
 - c. EFT _____
3. How would you describe your Service Configuration?
 - a. separate community teams
 - b. integrated/ teams
 - c. other _____

Which organisation/service do you work for? (Please indicate your **main** area of work)

- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____ Mental Health Service
- ☐ _____
- ☐ Other (Please specify) _____

We would like to know a bit about you and your role

Age in years? _____

Gender? _____

What is your main professional?

- ☐ Psychiatric Nurse
- ☐ Social Worker
- ☐ Psychiatrist
- ☐ Medical Officer
- ☐ Psychologist
- ☐ Occupational Therapist
- ☐ Welfare Worker
- ☐ Other (Please Specify) _____

Which of the following best describes your working hours?

- ☐ Full time
- ☐ Part time (please specify how many hours per week _____)
- ☐ Other (please specify how many hours per week) _____

What is your main work role?

- ☐ Manager
- ☐ FaPMI Coordinator
- ☐ Other (Please Specify) _____

Years of experience in your current role? _____

Previous training relating to supporting parents of dependent children with mental illness:

What is the highest educational qualification that you have completed?

- ☐ High School
 - ☐ Certificate
 - ☐ Diploma
 - ☐ Degree
 - ☐ Graduate diploma/honours
 - ☐ Masters
 - ☐ Doctorate/PhD
-

Are you currently undertaking training for a qualification?

- ☐ No
- ☐ Yes (Please specify qualification type as above _____)

Are you a parent yourself?

- ☐ Yes
- ☐ No

Questions about the implementation of Let's Talk

1. When did your service engage with Let's Talk trial? _____

2. How did your service become engaged with Bouverie's pilot of LT and /or the MIRF RCT (*CFIR IS readiness - leadership engagement /implementation climate -tension for change*)

☐ request from university

☐ senior management interested Role? _____

☐ key personnel interest Who? _____

☐ other _____

1. Why did the service engage? _____

2. What was required to engage? _____

3. When your service engaged with the pilot or trial what plans did it have regarding implementing and/or continuing Let's Talk and who's plans were they? (manager/ local implementer /external researcher/ at what level)

4. Since engaging in RCT has there been any major changes to structure of organisation or leadership? (*CFIR inner setting -structural characteristics readiness, Outer setting - external policy & incentives*) _____

1. If so what? _____

5. Did external services provide support for implementation? (*training, practice development, implementation planning, implementation meeting/ guidance, guidesheets, monitoring*) (*CFIR process of implementation external change agents*)

1. Bouverie 0 1 2 3 4 5 6 NA
(0 no support -6 lot of support)

List the sort of support _____

2. Monash Uni 0 1 2 3 4 5 6 NA
(0 no support -6 lot of support)

List the sort of support _____

3. Other? 0 1 2 3 4 5 6 NA

(0 no support -6 lot of support)

Who? _____

List the sort of support _____

6. What internal support was given to implementation at your organisation (*CFIR process of implementation, inner setting - readiness*)

1. What role did leadership have in implementation? (senior, middle, line, clinical, other) _____

2. Was there allocation of key implementation personnel?

Describe _____

3. Was a formal plan developed?

1. If so who was involved ? _____

2. Did it help ? Y/N Comment _____

How? _____

3. Is it ongoing ? Y/N Comment _____

4. How did implementing LT fit within service priorities?

4. Was an implementation 'committee' established?

1. If so what was it's role and reporting structure?

2. How often did it met? _____

3. What staff were on it (level, role)? _____

4. How long did it/has it met for? _____

5. Were there any changes made to either LT or to organisational practice to enable better fit your organisation? Y/N if so what?

7. How were practitioners selected

○ self-select,

○ chosen by management,

i. if so Why were these practitioners chosen? _____

○ chosen by team type/ profession,

i. if so which _____

ii. Why were these team/ professions chosen? _____

iii. % of staff from these teams trained?

○ chosen by FaPMI coordinator, other .

i. if so Why were these practitioners chosen? _____

8. who trained practitioners (tick all that apply)

○ Bouverie

○ local trainers,

○ Other external trainers. Who? _____

9. what training did practitioners have

○ Online only

○ Face to face only

○ Online and face to face

○ Modeling only

○ Other (Please describe)

10. what post training support for practicing LT were staff given
- none
 - formal supervision integrating LT practice
 - group
 - individual,
 - reflective LT practice support
 - group
 - individual,
 - 1:1 mentoring/ modelling/ shadowing Describe _____
 - nothing structured but staff member/ manager available Who _____
 - other _____
11. Did your organisation make a decision to not continue using LT? Y/N
1. If no why? _____

The next questions are to understand about the organisations current capacity to support Let's Talk

12. Does your organisation collect and/or report on data about parent consumers and their children (*prevalence, outcomes, other*)?
1. If yes what? _____
2. Is this data used to target LT in any way? If yes how? _____
13. Is there a training and development infrastructure to identify
1. gaps in practitioners skills and knowledge for Let's Talk - Y/N
1. if yes what _____
2. practitioners use of Let's Talk - Y/N
1. if yes what _____
14. Are there mechanisms for practitioners to get support and feedback on their practice and performance in Let's Talk practice? Y/N
- i. if so what? _____
15. Are there policies and procedures to support let's talk practice? (*intake, allocation, job descriptions, supervision, training, KPI's/Targets, quality improvement,*) Y/N
- New? What, when developed, who had input? _____
 - Existing adapted? What, when adapted, who had input? _____
 - Existing are adequate? What? _____
16. Does let's talk fit into the goals and strategic aims of the organisation - Y/N
1. How? _____
2. How is this communicated? _____
17. Do you have personnel responsible for currently overseeing the implementation and /or sustaining of Let's Talk? Y/N
1. If yes who? (role/ level) _____
18. What is the understanding of LT by leadership (level/ role)? _____
19. What is the role of leadership (senior, middle, line, clinical) in supporting Lets Talk (*authorizing, monitoring, promoting, other*) and how is that seen?
- _____
20. Does the maintaining of let's talk practice rely on specific individual or group of people, technology, finances to keep it going? List below:

21. What is communicated to parents consumers, practitioners, leadership about LT and how?

22. Are there other ways your organisation supports LT practice? _____

23. Do you have any further comments?

Thank you for your time. We really appreciate your participation.
If you have any questions, please do not hesitate to contact us.
Becca Allchin M: 0427348545 E: rebecca.allchin@monash.edu
Dr. Melinda Goodyear Ph: 9055 6115 E: melinda.goodyear@monash.edu

Follow up semi structured interview schedule for managers/ implementer

Purpose to follow up answers of questions above, gather an understanding of how the organisation works at supporting practice change generally thus giving context for how it looks for Let's Talk

1. Tell me more about what plans did your service had regarding implementing and/or continuing Let's Talk when you engaged in the trial. (*trial in specific part of service, launch broader implementation,*)
 - a. Are they different now?
2. Tell me more about the different stakeholders (clients parents, workers, line managers, senior management) and what was done to engage them
3. Tell me more about what your service did to help the fit of Let's Talk (*integration into service model & systems, adapt LT*)
4. Tell me more about how your service implements other initiatives and supports new practices? (*How does this process fit normal processes*) (*CFIR Inner setting -culture, readiness, learning culture*)
5. What feedback systems does your service have of any intended changes to reinforce benefits and progress, and initiate further action and inform decision making (what did/ does that look like for Let's Talk)? (*how do they have to know if it being done? If it is benefiting parents? (monitoring systems/ support & supervision to workers)*)
6. Tell me more about how your service supports the practice of Let's Talk? (*enable capacity for Practitioners to practice, enable access and benefits for parents*)



EXPLANATORY STATEMENT

Let's Talk Follow Up Focus Group (Co-Design Workshop)

Project: Follow up study to developing an Australian-first recovery model for parents in Victorian mental health and family services

Dr. Melinda Goodyear
Research Fellow and MIRF Project Manager
School of Rural Health/Monash University Department of Rural and Indigenous Health
Telephone +61 3 9905611
Email: Melinda.goodyear@monash.edu.au

You have been invited to take part in this follow up focus group as FaPMI Coordinators.

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 via the phone number or email address listed above.

What does the research involve?

The research project (RCT trial (MIRF *Let's Talk*)) that was developed to determine the effectiveness of a new intervention for families known as *Let's Talk about Children* is in its final stage. Over the past five years the project has followed services, practitioners and families in different services across Victoria through their use of the intervention. The findings will assist in future program development for supporting families in these circumstances.

You are invited to take part in this follow up focus group to the RCT trial (MIRF *Let's Talk*). FaPMI coordinators are being invited to participate in developing recommendations to enable the continued support for and/or use of *Let's Talk about Children*. This follow up study is a component of a broader focus on *Sustainability and Let's Talk* being undertaken as part of a PhD program by Rebecca Allchin supervised by Dr. Melinda Goodyear, Brendan O'Hanlon and Bente Weimand.

This phase of the study will use a participatory approach to apply the findings of other phases of the study to real world settings and expand the relevance of the knowledge developed thus far. The study is a participatory research project where the researcher works with participants to develop meaning together. The focus group will use a co-design workshop with the participants to develop recommendations to enable support for sustaining *Let's Talk about Children* practice. The one day workshop will present the literature and data from other phases of the study and work together with the participants to build recommendations for Adult Mental Health Services for how to sustain practice and capacity. Please refer to the accompanying Terms of Reference (TOR) for more details.

Process of engagement

Your participation as part of the focus group will involve a one day meeting with the researcher to guide the study through a series of steps that will explore participant's existing knowledge of system change, present the data from other phases of the study and through consensus building activities develop recommendations.

Consenting to participate in the project and withdrawing from the research

By participating in the focus group you are consenting to participate as a contributor and co-researcher in this research study. You are free to withdraw from the project at any point, however once your data has been entered anonymously it will not be able to be extracted.

Possible benefits and risks to participants

There are no direct benefits intended to each individual from participating in this project, however there is an expectation that this process will benefit the statewide implementation of *Let's Talk about Children* by raising awareness and creating space for reflection on sustaining practice change. We hope to the recommendations better help the development of programs for families in these circumstances. We do not think your participation will result in any discomfort.

Confidentiality

No information that you give to us will be revealed to another person in any form which identifies you without your permission. All data collected will be de-identified and reviewed by members for checking. It will be digitally recorded such as auto recording of the focus group and taking photos of constructed diagrams, brainstorm, frameworks and mind maps. A report of the study may be submitted for publication or used in conference presentations, but individual participants will not be identifiable in such a publication. Participant's role of co-researcher will be acknowledged in any report either anonymously or identified if permission is given. Anonymous data collected may be used for other purposes and due to its anonymity, you will not be named and cannot be identified in any way.

Storage of data

Storage of the data collected 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 and student's supervisors.

Results

If you would like to receive a summary of the results of this study please let the researcher know by contacting Dr. Melinda Goodyear ph 9905611.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics (MUHREC):

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

Thank you,

Becca Allchin, Dr Melinda Goodyear, and Assoc Prof Darryl Maybery

CONSENT FORM

Let's Talk Follow Up Focus Group (Co-Design Workshop)

Project: Follow up study to Developing an Australian-first recovery model for parents in Victorian mental health and family services

Chief Investigator: Assoc Prof Darryl Maybery

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 and have signed the Terms of Reference. I also understand that I can withdraw at any point prior to the collection of data.

I consent to the following:	Yes	No
I agree to participate in the focus group (co-design workshop) to work with the researcher	<input type="checkbox"/>	<input type="checkbox"/>
I agree with the terms of reference attached	<input type="checkbox"/>	<input type="checkbox"/>
I agree to allow the focus group to be recorded (audio-taped & photography)	<input type="checkbox"/>	<input type="checkbox"/>

Name of Participant _____

Position of Participant _____

Participant Signature _____ Date _____

Preferred contact details:

Email:

Mobile phone number:

Other phone number:

Sustainability, Practice Change and Let's Talk Co-Design Workshop Planner

19 July 2019- 9.00- 3.30

Three aims of Phase four's Co-Design workshop (Study 5) were to:

- i) explore the generalisability of the findings developed in previous phases to AMHS within the State of Victoria, Australia
- ii) co-develop practical recommendations for implementing Let's Talk for sustainability
- iii) build understanding and engagement in practical implementation science by the FaPMI coordinators and AMHS.

Facilitator: Becca Allchin

World Café Table Hosts: Dr. Mel Goodyear, Dr. Brendan O'Hanlon and Rose Cuff

	Objective	Task	Activity	Resources Needed
Pre workshop		Introduction to the research	Explanatory statement and TOR	
30 min	Engage FaPMI coordinators in study objectives	Establish collaborative working environment	Welcome Getting focused activity: <ul style="list-style-type: none"> • line of knowledge of LT • line of experience of LT • Line of knowledge of implementation • Line of experience of implementation Development of rules for the day TOR	<i>Sign in sheet</i> <i>TOR</i> <i>Explanatory statement</i> <i>Whiteboard & markers</i>
		Establish understanding and expectations of participants role	Overview of the study and where the Co-Design workshop fits into whole research Aim and outline of the day	<i>Handout</i> <i>PowerPoint</i>
1 hr	Develop working framework for deductive analysis	Explore individual participant's current understanding of sustaining practice	Chart their own opinions of factors that support/ enable sustaining practice initially at beginning using a visual tool: weighted arrows to indicate factors that support and factors that undermine sustaining practice towards or away from the centre 'Sustaining Practice and capacity'	<i>Paper</i> <i>Pens/ textas</i> <i>Example of completed one</i>
		Explore FaPMI group's current understanding of key factors in sustaining practice	Discuss in 4 small groups and develop a consolidated collection of most significant ideas (adaptation of most significant change method) for FaPMI focused practice <ol style="list-style-type: none"> a. Define the most significant factors b. Explain why choose those ones- how important, how ranked and why c. Write up on chart paper and present to whole group Each group feedback to whole group	<i>Sticky notes</i> <i>Chart paper</i> <i>Blue tack</i>
Morning tea				

2 hrs	Establish understanding of knowledge gained from PhD	Summarise knowledge from previous studies & literature	In large group, present and discuss the key data gained from literature & three phases of the PhD	<i>Powerpoint handouts</i>
<i>lunch</i>				
1 hr 15 min	Review knowledge generated in PhD re ability to generalise and apply to their setting	Deductive analysis of evidence gained from PhD against their working framework (current knowledge of key factors in sustaining practice)	<p>World Café #1 Break into 4 groups and look at one of the sets of data -table of literature, manager interviews, survey of practitioners & audit of services and case study. Group explores if that challenges or aligns with their original opinions, does it add anything and do they wish to change their original chart</p> <p>World Café #2 Move tables as a group and look at the next set of data -table of literature, manager interviews, survey of practitioners & audit of services and case study. Group explores if that challenges or aligns with their original opinions, does it add anything and do they wish to change their original chart</p> <p>World Café #3 Move tables as a group and look at the next set of data - table of literature, manager interviews, survey of practitioners & audit of services and case study. Group explores if that challenges or aligns with their original opinions, does it add anything and do they wish to change their original chart</p> <p>World Café #4 Move tables as a group and look at the next set of data - table of literature, manager interviews, survey of practitioners & audit of services and case study. Group explores if that challenges or aligns with their original opinions, does it add anything and do they wish to change their original chart</p> <p>In each group consolidate group understanding about what learnt. What confirmed and what challenged to develop new group understanding</p>	<p><i>Group's original chart from above Chart paper textas</i> <i>Sets of data (table of literature, manager interviews, survey of practitioners & audit of services and case study)</i></p> <p><i>Group's original chart from above Chart paper textas</i> <i>Sets of data (table of literature, manager interviews, survey of practitioners & audit of services and case study)</i></p> <p><i>Group's original chart from above Chart paper textas</i> <i>Sets of data (table of literature, manager interviews, survey of practitioners & audit of services and case study)</i></p> <p><i>Group's original chart from above Chart paper textas</i> <i>Sets of data (table of literature, manager interviews, survey of practitioners & audit of services and case study)</i></p> <p><i>Group's Material from each table</i></p>
<i>Mini break for toilet and bring back coffee for working afternoon tea</i>				

45 min	Consolidate knowledge generated in PhD into recommendations applicable across AMHS	Establish FaPMI group's new understanding of key factors for sustaining Let's Talk practice	Present back to the whole group their new consolidated understandings and recommendations. Collectively develop key recommendations to support sustaining Let's Talk practice and organisational capacity.	<i>Blue tack White board</i>
30 min	Finalise workshop	Plan future action & Evaluate workshop	Where to next - what else want to do with this Feedback form	<i>Feedback form</i>
Post workshop	Refining recommendations	Condense & consolidate recommendations	Researcher wrote up the recommendations and returned to FaPMI coordinator group for review and revision	<i>Chart sheets Record of whiteboard Audio</i>

Sustainability and Let's Talk: Evidence so far

CO-DESIGN WORKSHOP

BECCA ALLCHIN

Study of Sustainability and Let's Talk

PhD followed up the 8 Adult Mental Health Services & practitioners trained

4 phases

- Phase 1 – hearing from leadership
- Phase 2 – Follow up of practitioners and organisations in RCT
 - 2.1 trained practitioners survey
 - 2.2 audit of organisational capacity to support
- Phase 3 – explanatory model of 1 service's continued use & capacity
- Phase 4 – develop recommendations for implementing LT for sustained outcomes

Participatory design

Mixed methods

What did we learn from the literature

Multiple domains impact sustainability

The parts only make sense within the whole – complexity theories helpful

Sustainability only understood in context

A non linear staged journey

Hard to sustain – requires ongoing tweaking

Adaptation likely

Need to measure at multiple levels

There are some key agents

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learning from the literature cont.

Key agents that enable sustainability

- Internal implementer
- Leadership
- Monitoring & Data
- Training & support

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Phase 1: leadership interviews

Implementation approach matters

Context impacts

Implementation hampered by conflicts of paradigms

Leadership affects readiness

Parent & practitioner readiness

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Phase 2.1 Practitioners practice

Practitioners use over time

Who it was offered to

If adapted

Type of Let's Talk use over time

- Type= offering (intro only), partial, complete

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Practitioner's use of Let's Talk

Most used LT (n=43, 59%) and of those who used LT:

- most did more than only offer it (n=30, 70%)
- Within 2 months (72%)

	Types of Let's Talk delivered			Any part of Let's Talk delivered
	Offer only	Partial	Complete	
No of practitioners delivering	32	16	19	43
% of practitioners	43%	21.9%	26%	59%
Times delivered	1-29	1-29	1-11	1-58
Mean times delivered	5.20	4.38	3.29	6.95
Delivered more than 1	75% n=24	62.5% n=10	73.7% n=14	77% n=33
Delivered 2-5 times	47% n=15	49.9% n=8	57.8% n=11	47% n=20

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Who offered Lets Talk to

Offered to parents with range of diagnosis

Diagnosis	No. offered LT	%
Depression	27	20%
Anxiety	18	13%
Psychosis	17	12%
Bipolar	23	17%
BPD	18	13%
Schizophrenia	30	22%
Other	5	4%
	138	100%

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When it was offered

	No. of practitioners	Most offered during established engagement
During initial engagement	10	
During established engagement	45	
Prior to discharge	3	

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Adapted or not?

Majority delivered as described: always or most of the time (n=34 56%).

1/3rd made adaptations (n=21, 34%)

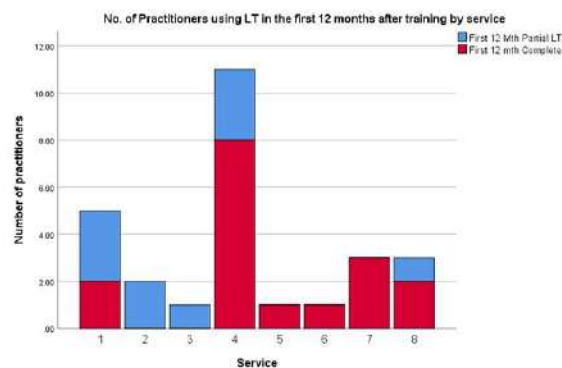
- To enable engagement
 - Changing language
 - Flexible delivery style
- To the log: since been incorporated into the model
- To style of delivery to help integrate into usual work

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No. of practitioners using LT: first 12 months

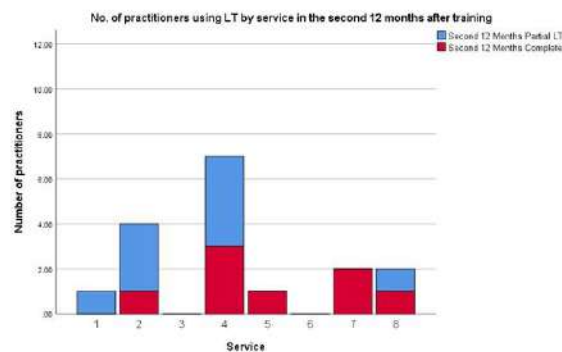


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No practitioners using LT: second 12 months

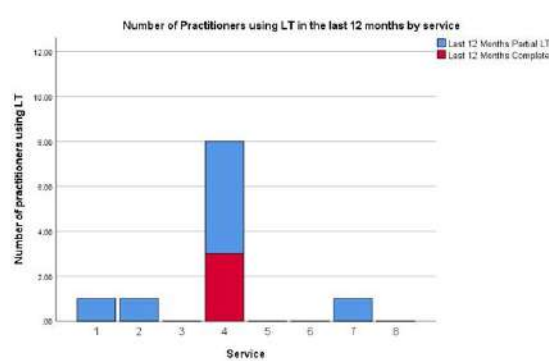


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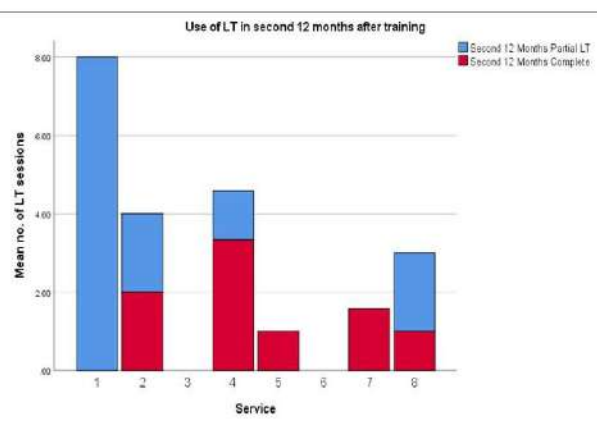
No. of practitioner using LT: last 12 months



How many times on average a practitioner used LT: first 12 months



How many times on average a practitioner used LT: second 12 months

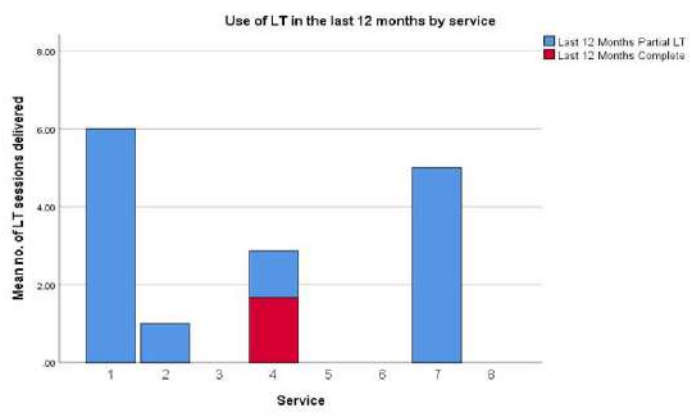


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How many times on average a practitioner used LT: last 12 months



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Parents offered Let's Talk

299 parents were offered Let's Talk over all time points

- 166 introduced (by 32 practitioners)
- 70 partial delivery (by 16 practitioners)
- 63 complete (by 19 practitioners)

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FFMHPQ scale & use of Let's Talk

	N	Mean	SD	Offer only		Partial		Complete	
				r _s	p	r _s	p	r _s	p
1. Workplace Support	62	4.49	1.690	.007	.955	.158	.221	.220	.085
2. Location issue	62	4.50	1.328	-.163	.204	.005	.966	-.053	.684
3. Time and Workload	62	4.27	1.321	-.090	.486	.003	.980	.140	.278
4. Policy and procedures	63	4.78	1.191	-.063	.625	-.024	.852	.167	.191
5. Professional Development	63	4.94	1.427	-.177	.164	.084	.514	.135	.291
6. Co-worker support	61	4.57	1.210	.059	.653	.018	.893	-.048	.714
10. Worker Confidence	63	5.28	1.236	.021	.870	.120	.347	.343**	.006
12. Skills and Knowledge	61	5.24	.934	.197	.129	.235	.068	.469**	.000
13. Assessing impact on the child	59	4.51	1.347	.065	.626	.174	.187	.327*	.011
14. Connectedness	59	5.30	.924	.143	.278	.139	.292	.271*	.038
15. Engagement issues	53	4.08	.917	-.144	.304	-.034	.810	.069	.623
16. service Availability	62	5.23	1.126	.135	.297	.160	.214	.191	.138
17. Training	57	4.78	.976	.385**	.003	-.036	.793	.106	.433
18. Parenting with a MH problem	63	5.13	1.074	.197	.121	.264*	.037	.397**	.001

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Phase 2.2 Organisational capacity

Organisation demographics

Implementation process

Current capacity to support LT

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Organisational audit demographics

Service	Metro/ Rural	Type of Service Delivery	IT first engaged	Service Changes	Data collected		
					Audit	Interviews	
						FaPMI Coord	Manager
1	Rural	Integrated teams sep. intake	2015	Minor	✓	✓	✓
2	Regional	Integrated teams sep. intake	2014	Major	✓	✓	✓
3	Regional	Integrated teams sep. intake	2014	Major	✓	✓	
4	Metro	Separate community teams	2012	Minor	✓	✓	✓
5	Regional	Integrated teams sep. intake	2015	Minor	✓	✓	✓
6	Metro	Integrated teams sep. intake	2015	Major	✓	✓	
7	Metro	Integrated teams sep. intake	2012	Major	✓	✓	✓
8	Regional	Integrated teams incl. intake	2014	Major	✓	✓	

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Current Organisational Capacity

Service	Metro/ Rural	Current capacity									Each Service's Capacity Components Total
		Collect data*	Use data to target LT	Training gap data & infrastructure	Practitioner use data	Practice support infrastructure	Policy/ procedures	Fits goals and strategic plan	Over seeing personnel	Leadership role	
1	Rural	✓	✓			✓			✓		4
2	Regional	✓	✓			✓		✓	✓	✓	6
3	Regional										0
4	Metro	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
5	Regional	✓		✓		✓		✓	✓	✓	6
6	Metro					✓			✓		2
7	Metro					✓	✓	✓	✓	✓	5
8	Regional	✓							✓		2
Components Total		5	3	2	1	6	2	4	7	4	

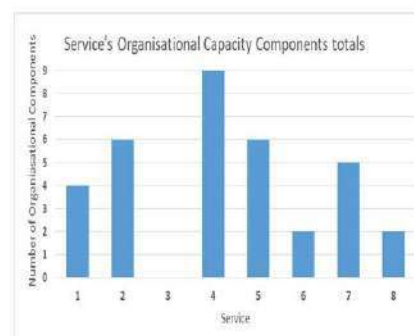
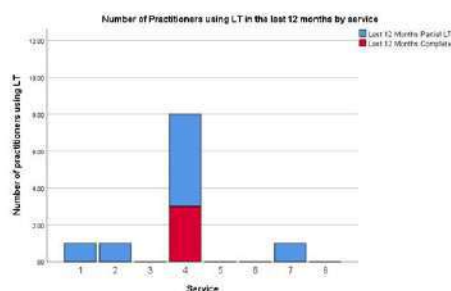
* other than *living with children* question on PR1

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Continued Practice and Capacity



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Phase 3: Explanatory model of continued use

Participatory case study

Local research group

5 meetings

Develop explanatory model

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Current practice snapshot

Not all practitioners continue to use... but...

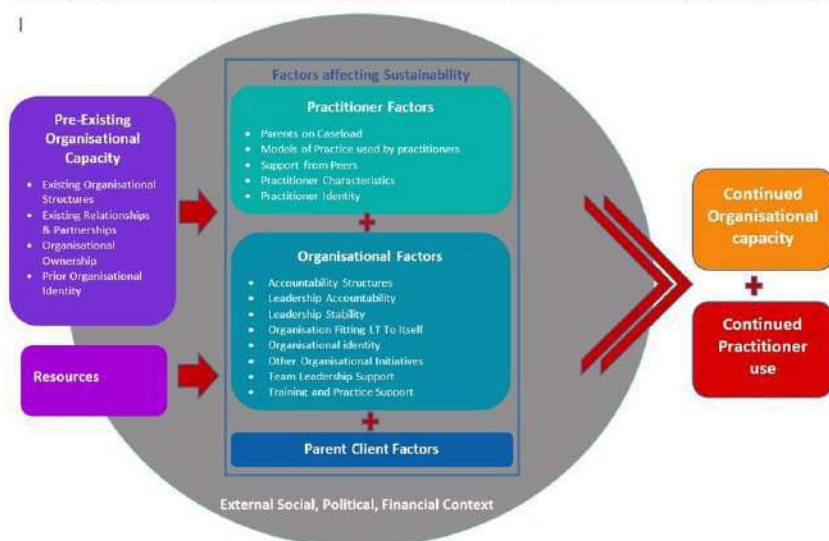
- parents take up 07/9 teams have practitioners who use LT
- Almost 1/3 practitioners, deliver to more than 1
- 46% offer to go on to do LT
- All professions represented but more SW
- Delivery not just about practitioner's skills and capacity... but practitioner factors may impact

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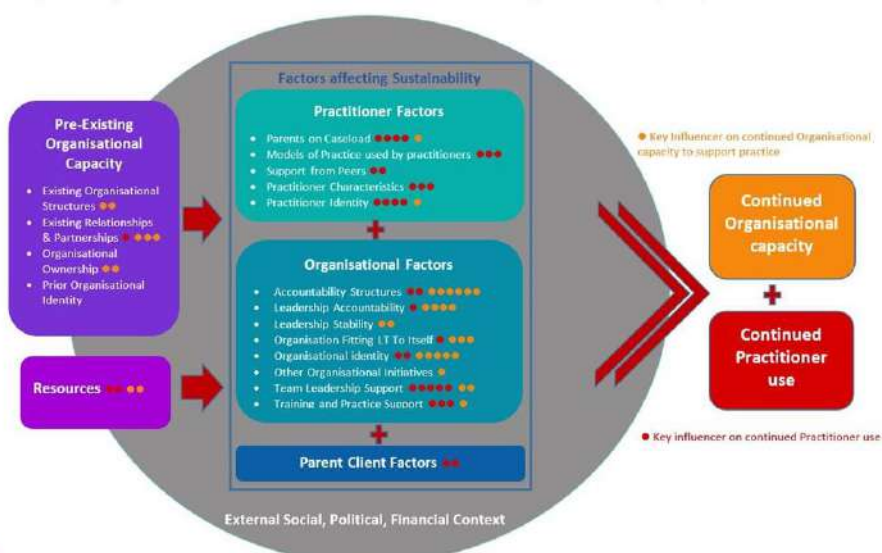
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Explanatory model of influences that enabled Continued Organisational Capacity & Practitioner Use



Explanatory model of influences that enabled Continued Organisational Capacity & Practitioner Use



LRG learnings

People contribute to organisational identity

Accountability systems need active leadership and Vis versa

Organisational and practitioner factors are both important for continued use

Need to implement strategically

Reflecting across levels brings new insights

Advocate for Parenting in recovery

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Use as identified by service

Bring greater knowledge and understanding

Help identify factors that can be leveraged

broader application than Let's Talk

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Possible strategies service identified

Develop leadership

Target staff recruitment

Explore how to leverage parent-client factors more

Connect service initiatives

Support and encourage cross organisational partnerships & relationships

Adapt data collection systems

Explore practitioners who use LT re what enables

Use data to target communication

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Lots of information....

Now over to you....

- does this challenge or align with your original opinions,
- does it add anything
- Do you wish to change their original chart

On to theWorld Cafe

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Sustainability and Let's Talk Phase 4 Co-Design Workshop Companion Guide

Thank you for your participation in this study. This little booklet is aimed to give you a little bit of information to assist you in your role in the Co-Design workshop. Participatory research works on the underlying principle that knowledge creation done in partnership between researchers and practice can help to develop practical as well as scholarly outcomes.

The material in this document is for the purpose of Co-Design workshop, Phase 4 in the PhD study of Sustainability and Let's Talk undertaken by Becca Allchin supervised by Dr. Melinda Goodyear, Dr. Brendan O'Hanlon and Dr. Bente Weimand. It can also be used for the individual learning for FaPMI coordinators attending. As noted in the terms of reference that participants signed, the material is not for wider distribution as this forms part of the data for the PhD and has not been published as yet. The references at the end and the learning from the literature at the beginning can be distributed but it is important that participants respect the sensitive nature of the collected data. Any public documentation of the material developed in the Co-design workshop will have further consultation and ensure that contributions by the FaPMI Coordinator Network are appropriately acknowledged

Below is where you'll find the hopefully useful information.

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2	Purpose of each phase.....	3
3	Some definitions	3
4	Learning from literature.....	4
5	Phase 1: learning from leadership interviews.....	5
6	Phase 2	6
6.1	Survey of practitioners trained	6
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7	Phase 3: learning what enabled one service's continued capacity and practice	11
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1 PhD Overview

This PhD study began in Oct 2016 as a follow up to the randomised control study of Let's Talk across Victoria. This study aims to understand more about how to sustain the practice in Adult Mental Health Services. Pithy details are listed below, and [Figure 1: PhD Overview](#) gives a detailed picture of the four phases with the participatory partnerships (green), and expected outcomes (purple)

- **Aim:** Deepened understanding of key elements for sustainability of Let's Talk about Children in Adult Mental Health Services
- **Conceptual Lens:** Sustainability as a constructed reality
- **Theoretical Paradigm:** Participatory Research
- **Methodology:** Embedded Mixed Method (Quantitative research embedded within an primarily Qualitative methodology)
- **Method:** 4 sequential phases
- **Research partnerships:** Advisory group overall, FaPMI coordinators (phase 2-4), Local research team within AMHS for case study (phase 3)

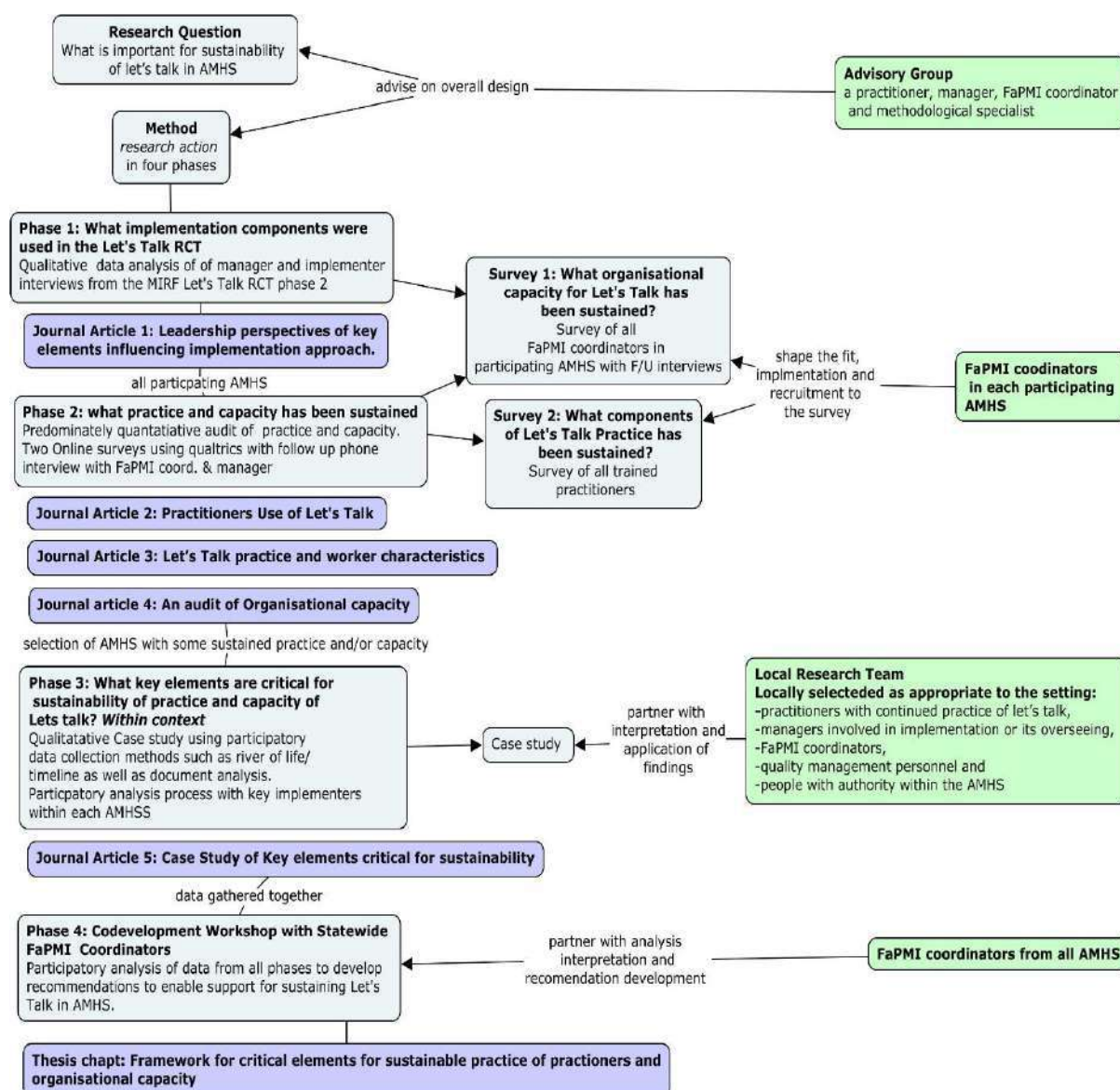


Figure 1: PhD Overview

2 Purpose of each phase

Each phase of the study builds on the last to build our understanding of what enables sustainability of Let's Talk. *Figure 2: Purpose of each Phase and how they relate* outlines each phase's purpose and how they build on each other.

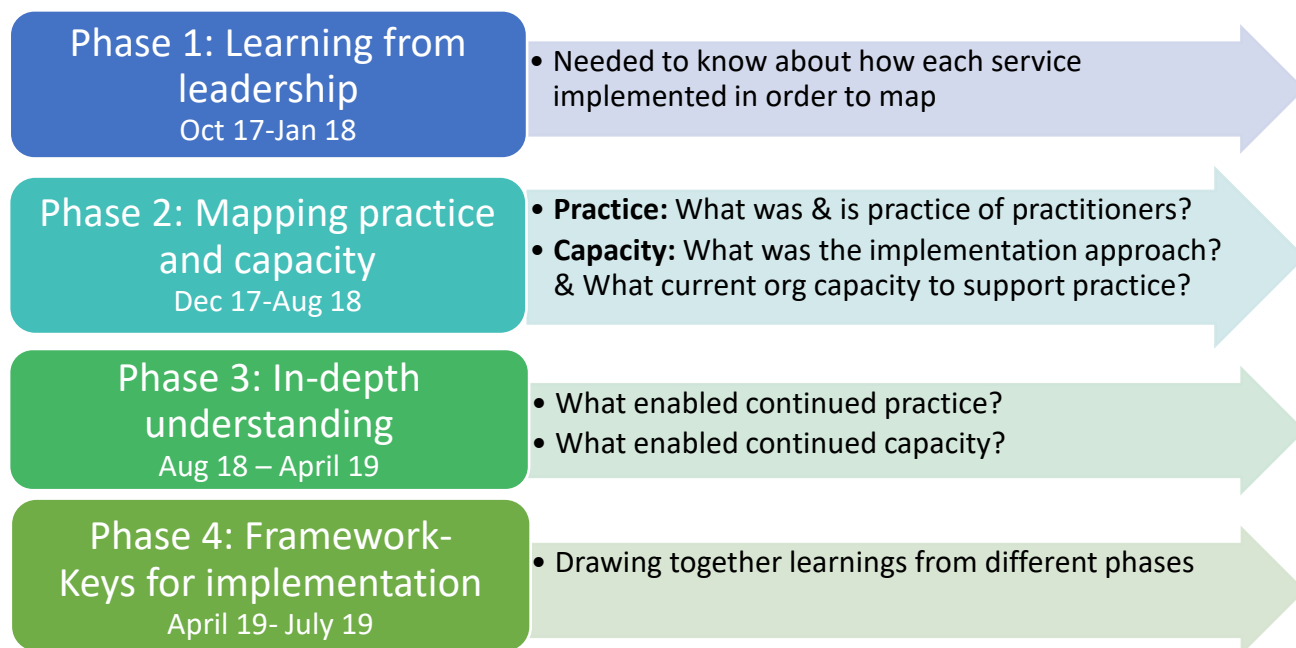


Figure 2: Purpose of each Phase and how they relate

3 Some definitions

Implementation is the process of putting in place interventions

Sustainability is focused on the degree the intervention is continued to be *delivered, embedded* in the setting and has *capacity built* into support it. It is explored in this study as a dynamic entity (sustained in some parts, by some people, in some settings at some times) rather than static (there or not). This view is informed by complexity theory that understands organisations such as health care services, as dynamic, living, social systems where the interdependence and interactions between the system's elements create the whole (Anderson, Crabtree, Steele, & McDaniel, 2005)

Measures of sustainability need to look at multiple levels including

- if beneficial services are being delivered to clients (*not studied in this PhD as in the RCT*),
- if the intervention is maintained in an identifiable form (albeit modified) and
- if the organisation has the capacity to deliver the intervention after the initial implementation (Scheirer & Dearing, 2011)

Let's Talk about children (Let's Talk) is a series of conversations between the practitioner and parent that bring into focus the wellbeing of their children and supporting the parent's role in enabling everyday family life in the context of adversity (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012; Solantaus, Reupert, & Maybery, 2015; Solantaus & Toikka, 2006)

Continued practice of Let's Talk by practitioners is defined by practitioners still using the Let's Talk interventions with their clients

Continued capacity of the organisation to support Let's Talk practice is defined by organisations that have structures in place that enable it to support practice.

Let's Talk Delivery is divided into three types: Introduction only/Offering, Partial and Complete (See *Table 1*). Introduction Only/ offering equates to doing only the preliminary discussion, in effect just offering Let's Talk. Partial Let's Talk delivery offers let's talk and does the discussion 1 which uses the age appropriate log to guide the conversation to map out the strengths and vulnerabilities of each child. Complete let's Talk builds on the Partial delivery of Let's Talk to have a further conversation to integrate what arose as vulnerabilities into some action plan.

Table 1: Types of Let's Talk Delivery

Let's Talk Type	Component of Let's Talk		
	Preliminary Discussion	Discussion 1	Discussion 2
Introduction Only/ Offering	✓		
Partial	✓	✓	
Complete	✓	✓	✓

4 Learning from literature

From the implementation and sustainability literature we know already that:

Sustainability is impacted by multiple factors—(Damschroder et al., 2009; Stirman et al., 2012)

- Consolidated Framework for Implementation Research (CFIR) defines 5 **domains**; inner, outer, intervention, implementation process and people (Damschroder et al., 2009) and there multiple components in each domain
- Different **drivers** impact implementation - Active implementation Framework defines three drivers; leadership (right strategy to use to deal with technical, adaptive challenges), organisation (facilitative administration, systems intervention, decision support data system), competency (selection, training, coaching, Ax of performance)(Blase, Dyke, Fixsen, & Bailey, 2012)

The parts only make sense within the whole —(Braithwaite, Churruca, Long, Ellis, & Herkes, 2018; Greenhalgh & Papoutsis, 2018; J. E. Reed, Howe, Doyle, & Bell, 2018; R. Reed, King, & Whiteford, 2015). Focusing on only one area/ component means might miss the interactions of other components that impact. Complexity theories helpful to understand AMHS as complex living organisations.

Sustainability only understood in context – need ecological view (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Nothing happens in a vacuum; Organisational history, changes to policy, funding, frameworks all impact the trajectory.

A nonlinear staged journey (Greenhalgh, Robert, Bate, Macfarlane, & Kyriakidou, 2005). While there are stages described for implementation that help make sense of what might be doing and what needs to be done, what actually happens in real world settings is organic, more messy course of moving back and forth through stages punctuated by various unpredicted setbacks, surprises and shocks

Hard to sustain – requires ongoing tweaking (Chambers, Glasgow, & Stange, 2013; Martin, Weaver, Currie, Finn, & McDonald, 2012; Van de Ven, 2017). As the context shifts, the strategies to help sustain need to shift.

Adaptation likely (Aarons, Miller, Green, Perrott, & Bradway, 2012; Chambers & Norton, 2016; Stirman et al., 2012; Stirman, Miller, Toder, & Calloway, 2013). Adjustments to the intervention and/or the organisation are needed to enable the fit to everyday practice and can be about the content or the process. Need to understand impact adaptations have on outcomes desired

Need to measure at multiple levels (Scheirer, 2005; Scheirer & Dearing, 2011; Stirman et al., 2012) Measuring continued use is only part of the picture. Need to also need to know how practitioners are supported to use – the organisational structures that support, but also need to know if what is being done actually is producing the changes you aim for.. Adaptations may improve or make the practice useless

There are some key agents for enabling and sustaining change

- Internal implementer who plays a local implementation leadership role, holding the bigger picture, picking up the pieces and refocuses when interrupted
- Leadership (Aarons, 2006; Aarons & Sommerfeld, 2012; Stirman, Gutner, Langdon, & Graham, 2016) at multiple levels and types (Floyd & Lane, 2000; Heyden, Fourné, Koene, Werkman, & Ansari, 2017)
 - Senior leadership creates priority, gives authority (embeds within policy, structures), enables resources (funding/ resources) and adapts system structures (Stirman et al., 2016)
 - Middle management enacts priority, helps the fit between the intervention and organisation, helping practitioners make sense of how can be used in practice, activates the facilitative administration (data monitoring, reporting loop), trouble shooting systemic barriers (Kerrissey, Satterstrom, Leydon, Schiff, & Singer, 2017)
 - Informal peer leadership helps champion the work, helping it be seen to be able to work in workplace
- Monitoring & Data (Bucci, Berry, Barrowclough, & Haddock, 2016; Ince, Haddock, & Tai, 2016; Wolpert & Rutter, 2018) helps to know what is happening – who is trained, if they use it, who is it used with, who is not in order to help tracking change and to inform decision making
- Training & support (Herschell, Kolko, Baumann, & Davis, 2010; Lyon, Stirman, Kerns, & Bruns, 2011) needed to build skills for practitioner, support use of skill and build confidence and competency. Practice support helps practitioners make sense of the new work into the old through trouble shooting challenges to practice (Kerrissey et al., 2017), enabling adaptation/ modification (Greenhalgh & Papoutsi, 2018) and overcoming hesitancy.

5 Phase 1: learning from leadership interviews

From the leadership interviews we learnt 5 things:

- The approach taken for Implementation matters: More likely to put structures in place that enable sustainability if the organisation has vision that they implementing Let's talk as an *intervention* rather than only as an *intervention in a research trial*
- Context impacts: What started implementing into was a different organisation by the end of the 4 years due to external policy and funding changes and internal restructures (some related to the external changes some just their own). Changes take attention, energy and resources away from implementation, resulting in interruption, set-backs and restarting the implementation process.
- Implementation of Let's Talk was hampered by 3 conflicts of paradigms seen in the values and practice of the work:
 - Family centred work is valued but the funding models are individual centred.
 - The pressured system leads to prioritising the acute needs while there is an aspirational value for recovery and prevention focused work
 - Collaborative practitioner/ parent team work vs risk assessment framework of child reporting (equal vs less equal)

- Readiness for implementing is affected by leadership and we learnt 4 things:
 - Managers juggle multiple priorities of which Let's Talk is only one thus making it hard for them to give it the attention needed to know about Let's Talk and how to implement it
 - all levels of leadership are important to engage with
 - senior managers are needed for authorising and prioritising. Policy development/ integration into policy signalled that Let's Talk was endorsed and valued
 - middle managers are needed for enacting policy and enabling priority – vital for enabling fit to service's everyday practice
 - Those that felt change imposed on less ownership for outcomes and gave less direction
 - Internal implementer such as FaPMI coordinators, enables readiness through refocusing attention on and holding motivation for Let's Talk
- From leaderships perspectives parents & practitioners readiness affects how let's talk is used but also using let's talk affected their readiness for other interventions
 - Parent readiness is impacted by how they are affected by and managing life stressors, stability of MH, perceived safety of relationship.
 - Practitioner readiness for Let's Talk was impacted by their skills in interventions such as Let's Talk (good engagement skills, comfortable with parenting and therapeutic interventions) and the workplace practices (organisation stability, reflective practice, critical mass). Mentoring, modelling and practice support helped to build confidence, trouble shoot and support adaptation to fit setting. Using Let's Talk impacted practitioner readiness for other practice (recovery, other delicate conversations)
 - A dynamic relationship was suggested between parent and practitioner readiness with practitioner's hesitancy limiting and being reflected in parents responses. Yet parents' readiness not was not just something that a practitioner can shape.

6 Phase 2

6.1 Survey of practitioners trained

Counting the practitioners who delivered Let's Talk:

- Most used Let's Talk 59% (n=43) of which most went on to do more than only offer it (n=30, 70%).
- Most practitioners did more than only offer it (n=30, 70%).
- Most who did deliver any part of LT did so within 2 months (72%).
- Most who delivered it, delivered it more than 1 time with the mean time of delivery dropping as more components of LT are delivered.

	Types of Let's Talk delivered			Any part of Let's Talk delivered
	Offer only	Partial	Complete	
No of practitioners delivering	32	16	19	43
% of practitioners	43%	21.9%	26%	59%
Times delivered	1-29	1-29	1-11	1-58
Mean times delivered	5.20	4.38	3.29	6.95
Delivered more than 1	75% n=24	62.5% n=10	73.7% n=14	77% n=33
Delivered 2-5 times	47% n=15	49.9% n=8	57.8% n=11	47% n=20

1The number of practitioners delivering the different types of LT overlaps

It was delivered to parents with common diagnosis found in AMHS: depression (n=27, 20%), anxiety (n=18, 13%), Psychosis (n=17, 12%), Bipolar (n=23, 17%), BPD (n=18, 13%), Schizophrenia (n=30, 22%), other (n=5, 4%).

Most practitioners offered let's talk during established engagement (n=45)

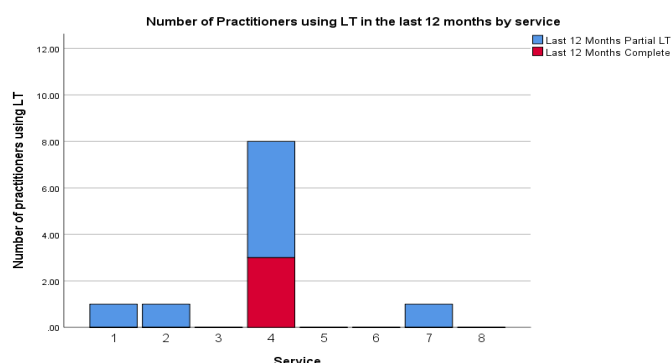
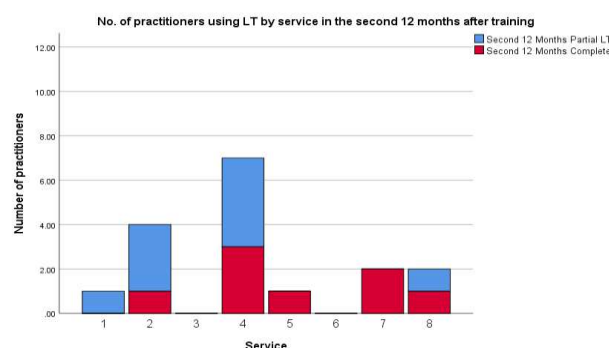
Adaptations: Majority delivered LT as it was described always or most of the time (n=34 56%). Approx. third stated they had made adaptations (n=21, 34%). Majority described making adaptation to enable engagement:

- changing language to suit a parent's cultural or educational needs or their acuity
- Flexible delivery style (smaller chunks over longer period) to fit parent acuity or / condensed to fit family availability
- Some described **adaptations to the log** that have now been incorporated into the model – reduction of repetition of questions

Some talked about **adapting style of delivery to help integrate** into usual ways of working

No. of practitioners using Let's Talk overtime:

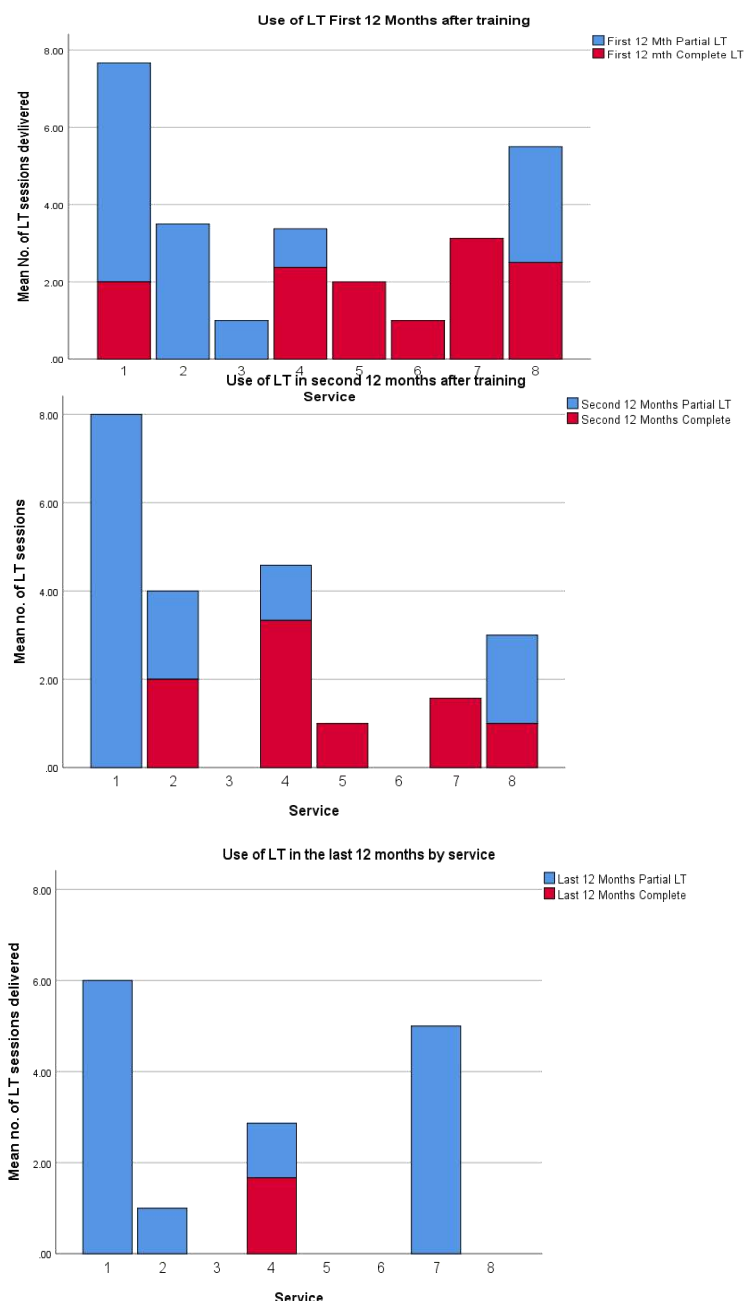
All services had practitioners who used Let's Talk in the first 12 months and most had practitioners doing the complete Let's Talk and the second 12 months shows a decline except service 2. The last 12 months shows a decline in number of practitioners using Let's Talk except for Service 4. Four services have practitioners with continued practice. Three of those services have only 1 practitioner



Average use of Let's Talk over time

By counting the types of LT use we also found out how many times those practitioners used LT at each service

These next graphs look at the mean no. of sessions (Partial or complete, excluding introducing) at each service over the three time periods (*the mean is commonly understood as the average - Add the numbers together and divide by the number of numbers*). This tells us how many times on average a practitioner used LT



So we know that over all time points 299 parents were offered LT:

- 166 introduced to LT (by 32 practitioners) (not counted when talking about delivery or continued use of LT)
- 70 partial delivery (by 16 practitioners)
- 63 complete (by 19 practitioners)

We also found out a little about the practitioners and their workplaces in the study and the relationship to their use of LT by using the Family focused MH practice questionnaire. The numbers are small and hence we need to be careful of making sweeping statements. This told us that:

- There were no correlations for any of the organisational support focused subscales 1-6 which is different to other papers using FFMHPQ. this might relate to the fact that the LT practice was built within a supported implementation process that might have mitigated some of these organisational barriers

There were however medium significant correlations seen between:

- Delivering only the Introduction and worker wanting further training (could mean that those who didn't get past introducing it identified a need for further training)
- Delivering Part of Let's Talk and the subscale 18 - a workers ability to address parenting issues within the context of mental illness

			Offer only		Partial		Complete	
	N	MeanSD	r _s	p	r _s	p	r _s	p
1. Workplace Support	62	4.49 1.690	.007	.955	.158	.221	.220	.085
2. Location issue	62	4.50 1.328	-.163	.204	.005	.966	-.053	.684
3. Time and Workload	62	4.27 1.321	-.090	.486	.003	.980	.140	.278
4. Policy and procedures	63	4.78 1.191	-.063	.625	-.024	.852	.167	.191
5. Professional Development	63	4.94 1.427	-.177	.164	.084	.514	.135	.291
6. Co-worker support	61	4.57 1.210	.059	.653	.018	.893	-.048	.714
10. Worker Confidence	63	5.28 1.236	.021	.870	.120	.347	.343**	.006
12. Skills and Knowledge	61	5.24 .934	.197	.129	.235	.068	.469**	.000
13. Assessing impact on the child	59	4.51 1.347	.065	.626	.174	.187	.327*	.011
14. Connectedness	59	5.30 .924	.143	.278	.139	.292	.271*	.038
15. Engagement issues	53	4.08 .917	-.144	.304	-.034	.810	.069	.623
16. service Availability	62	5.23 1.126	.135	.297	.160	.214	.191	.138
17. Training	57	4.78 .976	.385**	.003	-.036	.793	.106	.433
18. Parenting with a MH problem	63	5.13 1.074	.197	.121	.264*	.037	.397**	.001

6.2 Audit of Organisations

Learnt about the capacity of the organisations into which the implementation happened through an audit of components known to help implementation and sustained practice learnt from the literature and leadership interviews earlier

Three parts to the audit

- Organisation demographics
- Implementation process
- Current capacity to support LT

5 services had major changes to their organisational structure during the period of implementation such as complete change of management personnel or structure, the others had minor changes such as changes to models of care, meeting structure or some personnel

Service	Metro/ Rural	Type of Service Delivery	LT first engaged	Service Changes	Data collected		
					Audit	Interviews	
						FaPMI Coord	Manager
1	Rural	Integrated teams sep. intake	2015	Minor	✓	✓	✓
2	Regional	Integrated teams sep. intake	2014	Major	✓	✓	✓
3	Regional	Integrated teams sep. intake	2014	Major	✓	✓	
4	Metro	Separate community teams	2012	Minor	✓	✓	✓
5	Regional	Integrated teams sep. intake	2015	Minor	✓	✓	✓
6	Metro	Integrated teams sep. intake	2015	Major	✓	✓	
7	Metro	Integrated teams sep. intake	2012	Major	✓	✓	✓
8	Regional	Integrated teams incl. intake	2014	Major	✓	✓	

The current capacity to support practice was divided into 9 areas.

- Collecting data about parent consumers and their children
- Using the parent data to target LT
- Data or infrastructure to know of gaps in practitioners skills and knowledge
- Data or infrastructure to know if practitioners used Let's talk or not
- Mechanisms for practitioners to get support or feedback on their practice or performance in LT
- policies/ procedures that support LT (intake, allocation, job descriptions, supervision, training, KPI's/Targets, quality improvement etc.)
- Fitting goals and strategic aims of org. – how and how communicated
- Having personnel who oversee implementation/ sustaining
- Leadership supporting

		Current capacity									
Service	Metro/ Rural	Collect data*	Use data to target LT	Training gap data & infrastructure	Practitioner use data	Practice support infrastructure	Policy/ procedures	Fits goals and strategic plan	Overseeing personnel	Leadership role	Each Service's Capacity Components Total
1	Rural	✓	✓			✓			✓		4
2	Regional	✓	✓			✓		✓	✓	✓	6
3	Regional										0
4	Metro	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
5	Regional	✓		✓		✓		✓	✓	✓	6
6	Metro					✓			✓		2
7	Metro					✓	✓	✓	✓	✓	5
8	Regional	✓							✓		2
Components Total		5	3	2	1	6	2	4	7	4	

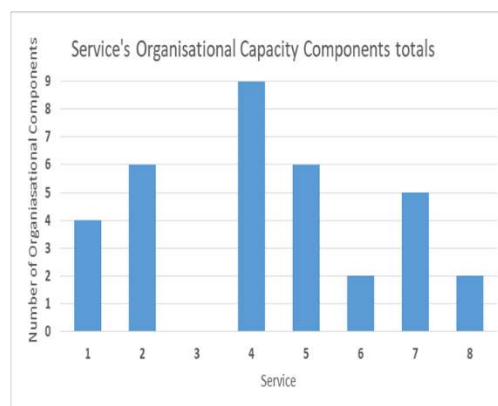
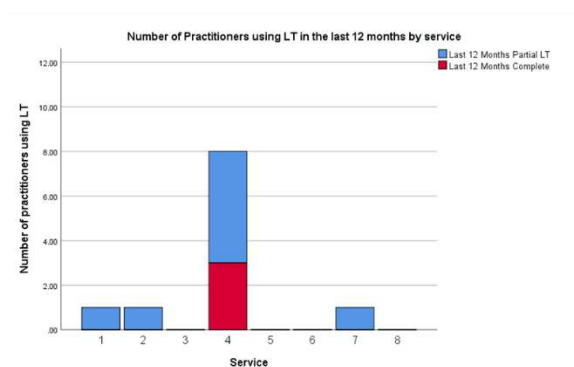
* other than *living with children* question on PR1

The capacity components that more of the services had included

- having an overseeing personnel,
- collecting data
- infrastructure for practice support. The later was not necessarily focused on LT but incorporated mentoring, secondary consults and group reflective practice.

The capacity components that fewer Services had included

- knowing whether practitioners were using LT,
- training infrastructure that helped to target training when needed,
- using the data they collect regarding parents/families to target use of practice
- having policy/ procedures govern delivery of LT.



3 of the 4 Services with continued practice had the highest score in current capacity

Noting here that with the exception of service 5 continued practice and capacity appear to be linked. Services with a 4 and above had some continued practice

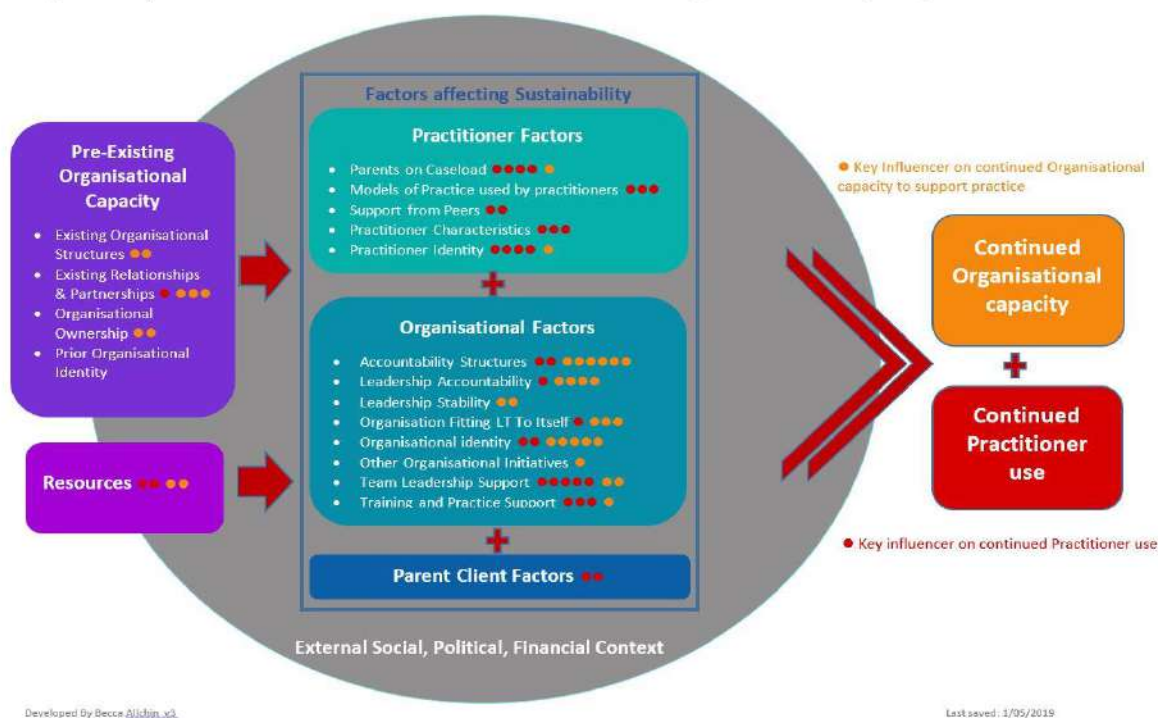
7 Phase 3: learning what enabled one service's continued capacity and practice

Services 4 and 2 were invited to participate in a case study to further understand what enabled their continued capacity and continued practice, however only service 4 was able to take up the offer

Adding to the data from the survey in phase 2, data was collected on current use from the routine 3 monthly snapshot data (Practitioner use of Let's Talk Nov 2018 summary) – telling us about the practitioner's use of LT across teams and professions. This tells us that

- most teams have practitioners who can deliver components LT (7 out of 9)
- Almost 1/3 who deliver LT deliver it to more than parent
- 46% of the parents offered LT (18 of 39) went on to participate in LT
- All professions are representing in those who can deliver LT (with greater number of SW)
- Delivery of LT is not just about the practitioner skills/ capacity (those that delivered LT to multiple parents had mixed results – refusal/ partial or completed)
- there may be a practitioner factors for some of the refusals (10 practitioner only had refusals)

Explanatory model of influences that enabled Continued Organisational Capacity & Practitioner Use



Descriptions of Enabling Influences of Continued Organisational Capacity and Practitioner Use

Name	Description
External social, political, financial context	A new political & policy direction (new MH Act, Recovery frameworks, increased MH funding), new national workforce initiative (COPMI online resource development) and a new research agenda (Government funded RCT on recovery & parenting) were external context enablers for the organisation and the intervention
Prior Organisational Capacity	Organisation history prior to implementation.
Existing Organisational structures	Existing organisational structures to support family children and carer focused work enabled the new intervention to fit. These structures included family children and carer specific capacity building roles within the organisation for over 10 years, policy and mandatory training systems to uphold policy.
Existing Relationships and Partnerships (Organisational Bridging Social capital)	Influential relationships and partnerships enabled prior and continued organisational capacity through bridging the organisation to opportunity and innovation in the field of family children and carers (training, research, resource development, expanded relationships with universities, government, international experts).

Name	Description
Organisational ownership	Organisational ownership of implementation was enabled through development of own implementation vision & plans and being a steering partner in the research
Prior Organisational Identity	Organisational reputation and brand prior to implementation was already family children and carer focused with a history of carer support that included children's voices, of parent focused work and programs for children. The organisation's identity also included using research for learning.
Organisational Factors	Sustainability influences related to the Organisation
Accountability structures	Having organisational structures to drive accountability supported the sustainability of organisational capacity and practitioner use. Such organisational structures included a driving committee embedded into the organisational hierarchy, capacity development personnel and system embedded into the service, a policy communicating priority and core business, systems monitoring policy use, data being used as driver of practice and compliance with policy
Leadership accountability	An expectation of leaders to lead is supported through involvement in training, reporting and support systems and reflected in adherence to strategic directions, policy and programs
Leadership stability	Stability in leadership allowed for organisational memory and continued commitment while new leadership within stability brought new energy.
Organisation fitting the intervention to self	Adaptations were made by the organisation to better the fit of the intervention such as integrating documentation, system prompts, policy development and data reports
Organisational identity	The intervention is aligned with the organisation's reputation and brand which includes a recovery family oriented culture that values lived experience and has connections strategic partnerships and relationships that enables learning and innovation. These are upheld by leadership and reflected in strategic directions, policy and programs.
Other organisational initiatives	There is a synergy between other initiatives active in the organisations that support use such as peer leadership, introducing a recovery model and a focus on data documentation
Team Leadership support	All levels of leadership (including informal) support sustained practice through buffering changes at internal/ external level to manage workload, aiding workforce stability, upholding priority set by organisation, holding practitioners account and creating a culture that is open to practice and that can see how it can fit into current practice
Training and practice support	The organisation has regular and accessible training that is integrated into data systems and other training. The selection of participants is purposeful and delivery methods incorporate peer

Name	Description
	facilitators. There is post training reflective spaces and support that link to other initiatives and give attention to measure and build competency.
Parent client	The parent client's stage of recovery and willingness to request help with parenting and children influences uptake
Practitioner Factors	Factors about the practitioners that enable sustainability
Parents on Caseload	Practitioner's opportunity to use Let's Talk is influenced by having parents on their caseload. While demographics of region/ team affect % of parents, practitioner's previous experience, interests and comfort can result in self-selection of parent clients
Models of practice used by practitioners	A person, parent and family focused model of practice that attends to relationships enables practitioners to incorporate parenting and recovery into their work
Support from peers	Other practitioners doing Let's Talk gives role models, normalises the work, builds acceptability and critical mass amongst peers and enables practitioners to see it is possible to do within pressures of everyday work.
Practitioner characteristics	Practitioners professional interests, prior experience & training in family children and carer work and life/ personal experience influence use
Practitioner identity	Practitioners having a good connection and satisfaction with role and their own identity as a good practitioner supported by individual accountability enables use
Resourcing	Funding, staffing or other resources enabled sustained practice and organisational capacity. Growth funding decreased practitioner to client ratio and enabled recovery resources. Research brought funding, attention to issue and resources for data & analysis. National workforce initiative enabled accessibility through high quality, standardised online training and free resources for parents

As a group they identified a number of things they learnt in the process of doing the study:

- People contribute to organisational identity
- Accountability systems need active leadership and Vis versa
- Organisational and practitioner factors are both important for continued use
- Need to implement strategically
- Reflecting across levels brings new insights
- Advocate for Parenting in recovery

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Sustainability & Let's Talk Phase 4: Co-design workshop

Participant feedback form

Q1 The purpose of the workshop was clear

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q2 The activities used in the workshop helped to meet its objective

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q3 I made a valuable contribution to the workshop

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q4 The workshop developed something useful for a FaPMI Coordinator

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q5 Before we met today I already had a good understanding of how to sustain practice

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q6 Before we met I already had a good understanding of implementation and sustainability theories

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q7 a) From this workshop I have more strategies that I can apply in my work that can help...

About	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Support Let's Talk					
Example:					
Implement new practice					
Example:					
Sustain new practice					
Example:					
Apply research to practice					
Example:					
Other*					
Please define					

Q7 b) Using the knowledge from today's workshop, one strategy I will action in the next 6 months is...**Q7 c) What could be an indicator of success or achievement of that selected strategy above?**

Q8. After today's workshop I am more confident that something I implement will be sustained

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q9. After today's workshop I am more confident that I can communicate within my service about what is important for implementing/ sustaining new practice.

- ☐ Strongly agree (5)
- ☐ Somewhat agree (4)
- ☐ Neither agree nor disagree (3)
- ☐ Somewhat disagree (2)
- ☐ Strongly disagree (1)

Q10 What did you find most valuable about participating in the workshop?

Q11 What did you find least valuable about participating in the workshop?

Q12 Do you have any other feedback about the process of the workshop, the research project or the content developed?