A Study of Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland

Technical Report and Study Appendices

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Introduction

Parental mental illness (PMI) and, or substance use problems, are major public health issues as they may negatively impact children. Conversely, childrens' experiences and difficulties may impact parents' mental health. Consequently, family relationships should be an important focus for clinicians, managers, researchers and policy makers (Beardslee, Solantus, Morgan, Gladstone & Kowalenko, 2012). There is increasing evidence, within the past 15 years, that Family Focused Practice (FFP) can be beneficial for families, including children, when parents have mental illness and, or substance use problems (Beardslee et al., 2012; Cooper & Reupert, 2017; Siegenthaler, Munder & Egger, 2012).

For the purpose of this report, FFP refers to interventions which attempt to identify and address the needs of parents and children in relation to child welfare and parental mental health and, or substance use problems. Early intervention to promote family functioning is also key. These interventions may not necessarily be provided to the whole family. In some cases they may be provided to just one person in the family, but the focus has to be on both parental mental health and, or substance use problems AND child welfare issues.

Since the commencement of the Think Family NI programme in 2009 a wide range of initiatives have been developed and implemented, across Northern Ireland (NI), to promote Health and Social Care (HSC) professionals' FFP, in response to families when parents have mental illness and, or substance use problems (See p.37 - 39 of this report for overview of key initiatives). While there is limited information internationally about extent of FFP (Grant, Goodyear, Maybery & Reupert, 2016) and inter disciplinary differences in FFP (Maybery et al., 2014), there is an absence of studies that directly compare FFP across services including adult mental health and children's services. There has also been limited evaluation of Think Family NI initiatives to date.

In 2016 the Health and Social Care Board (HSCB) commissioned Queen's University Belfast (QUB), in conjunction with Ulster University, to conduct a two-year baseline

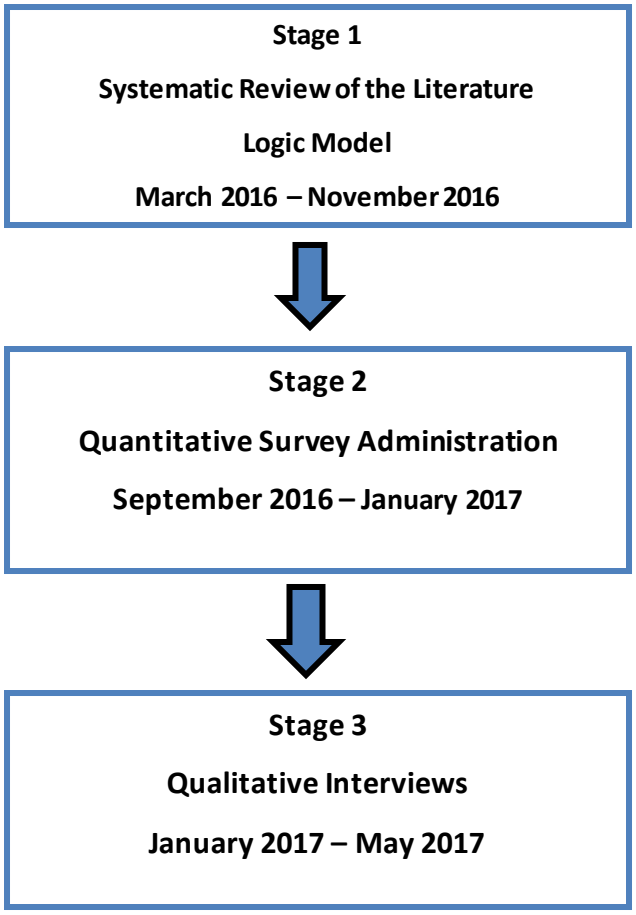
study with three parts. The first part entailed a systematic review of the literature and development of a logic model. A logic model is a graphical representation of the relationships between the resources, activities, outputs and outcomes of a program of work. A mixed methods study was then conducted in the second and third parts to examine FFP in adult mental health and children's services from multiple perspectives (i.e. HSC professionals and service users).

Our findings provide evidence on the current state of Think Family NI initiatives and will inform ongoing and future development and evaluation of FFP within the five HSC Trusts. Figure 1.1 provides an overview of stage completion and timelines for the three parts of this project.

The technical report can be read alongside the Summary and, or Main report and provides a more comprehensive overview of the study methodology from stages two and three followed by accompanying appendices which links to both the final Main Report and shorter Summary Report.

Figure 1.1

Study Stage Completions & Timelines



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Glossary of Terms

AMH	Adult Mental Health
CAMHS	Child and Adolescent Mental Health Services
C&PSP	Children and Young Peoples Strategic Partnership
DoH	Department of Health
DV	Dependent Variables
FFMHPQ	Family Focused Mental Health Practice Questionnaire
FFP	Family Focused Practice
FIT	Family Intervention Team
HSC	Health and Social Care
HSCB	Health and Social Care Board
IV	Independent Variable
M	Mean Score
n	Number (i.e. quantity or sum)
NI	Northern Ireland
PI	Principal Investigator
PMI	Parental Mental Illness
SCIE	Social Care Institute for Excellence
SD	Standard Deviation
TFM	The Family Model
QUB	Queen's University Belfast
UK	United Kingdom

Study Methodology

Research Aims and Questions:

The current study set out to measure, (1) the extent, nature and scope of HSC professionals' FFP, (2) factors that predict, facilitate and/or hinder it and (3) how it may be further promoted. Perspectives of both HSC professionals and parents who have mental illness and, or substance use problems, were sought.

The research questions include:

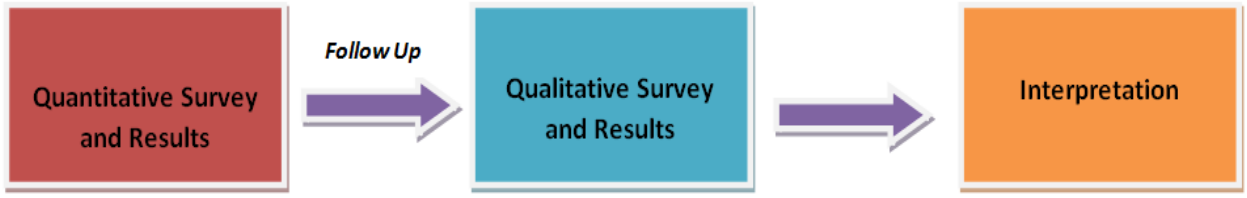
1. What is the extent of HSC professionals' FFP in adult mental health and children's services with parents who have mental illness, their children and families?
2. What are the significant predictors of HSC professionals' FFP?
3. What are the significant differences, if any, between HSC professionals' FFP in adult mental health and children's services?
4. What is the nature and scope of HSC professionals' FFP?
5. What are parents' experiences of HSC professionals' FFP?
6. What factors, if any, facilitate and, or hinder HSC professionals' FFP? And if so how?
7. How might FFP be further developed in Northern Ireland?

Research Design:

The study design followed the format of a sequential mixed methods design. This involved the collection and analysis of quantitative data followed by the collection and analysis of qualitative data. The qualitative data helped explain and elaborate upon, the quantitative results (Creswell & Clark, 2007). In this way, both methodologies complement and extend each other, by addressing the research question(s) from different perspectives. See figure 2.1 below for overview.

Figure 2.1:

Process of Sequential Mixed Methods Design



Quantitative Survey

Participants: HSC Professionals:

In the quantitative component, the survey was distributed to Approx. 3585 HSC professionals within adult mental health and children's services across the five HSC Trusts.

Inclusion criteria for health care professionals in adult mental health services:

- Members of the multi-disciplinary team, over 18 years of age, in the professional disciplines of nursing, social work, psychology, psychiatry and allied health professionals. Adult mental health professionals who practiced in either acute in-patient admission units and community mental health services (in five main areas including Single point of access, Day Hospital, CRHT, Mental Health Services and Addiction Services).
- Professionals employed on a permanent or temporary basis, full time or part-time in acute admission units, providing a 24 hours service; all periods of duty were included in the data collection. Additionally, participants were required to have provided services to one or more parents who have mental illness in the last 12 months.

Inclusion criteria for social care professionals in children's services:

- Social care professionals, over 18 years of age, who provide service in three children's services (Gateway teams, FIT and 16+ Teams). They should be employed on a permanent or temporary basis, in a full time or part-time capacity.

- Additionally, in order to participate in interviews, participants require previous, (within the last twelve months), or current experience of providing services to children who have a parent with mental illness.

The minimum number of HSC professionals needed to complete the survey (*n* = 878) was determined by various factors, including: the size of the population to which results are generalisable to, the results of previous research and particularly findings from previous use of the Family Focused Mental Health Practice Questionnaire (FFMHPQ) in different populations and the overall purpose of the current study; which is to compare two groups of health and social care professionals with regard to their FFP. Hence, a two sample comparison of means was used to estimate the overall sample size. We ensured that the characteristics of respondents reflected the population of health and social care professionals who fulfilled the inclusion criteria. To promote maximum variation and to secure sample access, a principal investigator (PI) for each Trust was identified along with an independent point of contact for the study.

A total of 1088 survey questionnaires were accessed by HSC professionals, a response rate of 30%. However, 119 of these were ineligible based on study inclusion, exclusion criteria; 48 surveys completed by trainees and support workers and 71 surveys completed by professionals in ineligible service areas (e.g. disability services) were excluded. Due to significant missing information, 101 cases were also removed from the dataset as more than 90% of the survey had not been completed and would not be suitable for inclusion in final analysis. The final sample comprised 868 HSC professionals, a response rate of 24.2%. Additional information regarding the sample characteristics for the quantitative component is reported on p.17.

Survey Measure:

The survey used within the current study consisted of three sections. Section one included demographic items (i.e. regarding respondents Trust and service area), section two included items from the FFMHPQ which is designed to measure professionals' FFP and section three included items which aimed to capture HSC professionals' experience of working with parents.

The Family Focused Mental Health Practice Questionnaire (FFMHPQ):

The FFMHPQ was developed by Maybery et al. (2006; 2012) and further refined by Grant (2014). Professionals responded to 14 family focused subscales on a seven point Likert Scale (ranging from strongly disagree to strongly agree). Table 2.1 shows the 14 subscales along with definitions and an example item from each.

Subscales are represented by mean scores derived from response to individual items within each of the subscales. A low, medium or high score on any particular subscale is interpreted according to the particular dimension of FFP that that particular subscale is designed to measure. However, a low score suggests a reduced family focus and a high score increased family focus. Each of the individual subscales are conceptually distinct from one another but together they measure various dimensions of FFP.

Table 2.1:

The FFMHPQ subscales, subscale definitions, Cronbach reliabilities and items for current study

Subscale (alpha reliability)	Subscale Definition	Example item from scale
Support to carers and children (α = .46) (DV)	The level of information, advocacy and referral provided to carers and children.	Rarely do I advocate for the carer's and/or family when communicating with other professionals regarding the service user's mental illness
Family and parenting support (α =.50) (DV)	Providing resources and referral information to consumers and their families	I provide written material (e.g. education, information) about parenting to service users
Assessing the impact on the child (.59) (DV)	How well the worker assesses the impact of the parent illness on the child/ren	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse
Connected-ness (α =.70) (DV)	Workers assessment of parent awareness of child connectedness	I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. peers, school)
Referrals (α = .59) (DV)	Referring family members to other programs to.	I refer service user's to parent-related programs (e.g. parenting skills)
Interventions to promote parent's mental health (α =.78) (DV)	Workers' interventions to reduce the impact of the service user's parenting role on their mental health	I assess the impact of the service user's parenting role on their mental health
Co-worker support (α =.70) (IV)	The support from other workers regarding family focused work	I often receive support from co-workers in regard to FFP
Time and workload (α =.66) (IV)	Time or workload issues regarding family focused practice	The workload is too high to do family focused work
Professional development (α =.66) (IV)	There are opportunities for professional development regarding working with families	Professional development regarding FFP is not encouraged at my work place
Worker confidence (α =.75) (IV)	The level of confidence the worker has in working with families, parents and children	I am not confident working with children of service users
Training (α =.76) (IV)	Worker willing to undertake further training	I should learn more about how to assist service users about their parenting and parenting skills
Confidence around parenting and children generally (α =.90) (IV)	Confidence around own children	In general I am very happy with my parenting
Skill and Knowledge (α =.75) (IV)	Worker skill and knowledge regarding impact of parental mental illness on children.	I am skilled in working with service users in relation to maintaining the well-being and resilience of their children

Workplace Support (α =.73) (IV)	The workplace provides support for family focused practice	My workplace provides mentoring to support HSC professionals undertaking FFP

Reliability and Validity of FFMHPQ:

Psychometric information of the subscales is detailed in a paper published in the Archives of Psychiatric Nursing (Maybery et al. 2012). The measure has excellent content and construct validity and good internal subscale reliability (Maybery et al. 2012). As the FFMHPQ was devised for use in the Australian context, with a variety of professional disciplines (e.g. psychologists, psychiatric nurses, social workers), it required minor adaption and testing in the NI context. Accordingly, the Principal Investigator (PI) adapted the language of the FFMHPQ for HSC professionals practicing within adult mental health and children's services in NI, in consultation with the project team, advisory committee and developers of the original instrument. Additional demographic items were included (i.e. regarding Trust area and service employed). In conjunction with the developers of the instrument and the literature, two new subscales were designed to measure HSC professionals' confidence around their own children (confidence around parenting and children generally) and interventions to reduce the impact of the parenting role on parental mental health (interventions to promote parents' mental health). See Table 2.1 above for more detail of subscale definitions and example of items.

The validity of the FFMHPQ outside the Australian adult mental health service context was also established. Validity of the subscales in the NI context was established by a panel of experts, pilot study, principle FFMHPQ administration and internal consistency reliability indexes. Initially an advisory panel assessed the items in the FFMHPQ subscales for their content validity. Panel members were selected for their expertise in FFP and PMI. All the items were deemed relevant and therefore retained. The FFMHPQ was then piloted with ten HSC professionals in the Northern Trust (5 from children's services and 5 from adult services) not included in the study to evaluate the clarity of the questions and their layout. The main changes made to the FFMHPQ involved further refinement to the structure and language used particularly in relation to section three of the survey.

As part of creating the 19 subscales for the current study, the 26 negatively worded items were reversed. Reliability of the subscales internal consistency was tested (See Appendix I). Ten of the 19 subscales had weak reliabilities denoted by Cronbach alpha values under .7. Given the extent literature surrounding this established instrument and validity and reliability of past scores (Maybery et al. 2012), it was agreed that a total of 14 subscales would be retained for later statistical analysis. The five subscales that were removed included; *Location issues, Policy and procedures, Engagement issues, Service availability and Inter-professional Practice.*

Survey Administration Procedure:

Dissemination of the survey among HSC professionals was achieved in three main ways, (1) online (via Survey Monkey), (2) 4 workshops in each Trust and (3) hard copies of the survey was circulated by PI to those who did not attend workshops and who did not wish to complete online versions.

At the outset, two members of the research team arranged and met with previously identified Trust based Principal Investigators' (PI), who worked generally as Adult Mental Health leads. The team also met with Trust Children's Assistant Directors (AD's) and team leads within each Trust and sector to provide an overview of the project, project activities and roles and responsibilities. PI's, AD's and teams leads agreed to work together on the promotion of the study, inform staff of the project activities and help with arrangement of workshops, including agreed times, dates and venues. It was also agreed that the PI's would act as the direct contact for information and material dissemination among services and staff included in the study. Table 2.2 provides a breakdown of the agreed role and responsibilities of respective Trust PI's. Figure 2.2 provides detail of the flow of study communication between the research team and each of the Trusts regarding study activities.

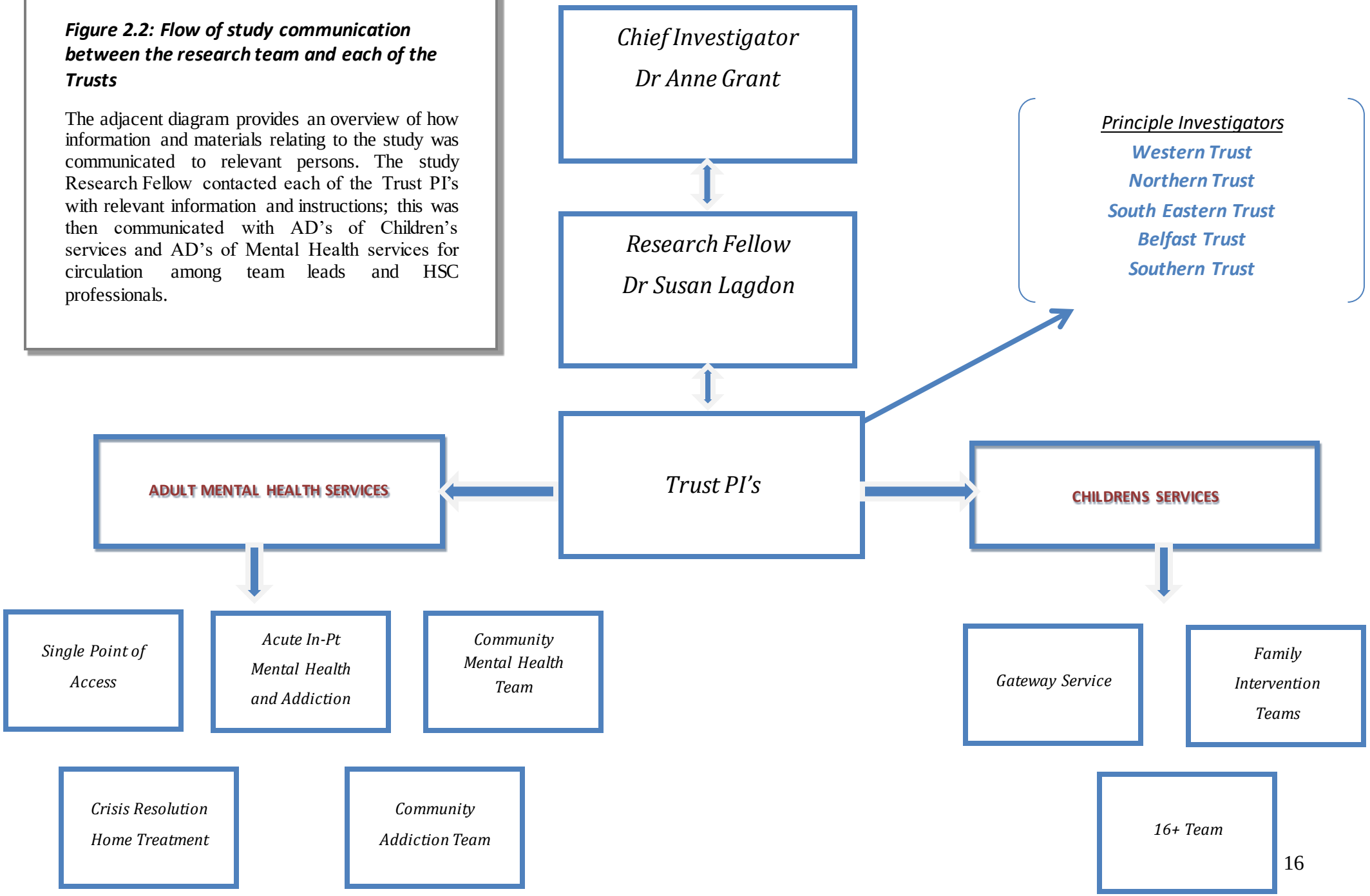
Table 2.2:

Role of Trust Principal Investigator in Study

Overall Project Support	➢ PI's and Team leads raised awareness of the study and promoted study activities
Workshops	➢ Assisted with arrangements of workshops including agreed times, dates and venues with respective Trust areas ➢ Promoted workshop attendance among HSC staff
Surveys	➢ Circulated online and hard copy versions of the survey among HSC professionals and encouraged survey completion ➢ Reminded staff during data collection period to complete a survey and return to research team if needed
Interviews	➢ Each Trust PI with the support of Team leads and Direct Care providers helped identify service users to take part in an interview

Figure 2.2: Flow of study communication between the research team and each of the Trusts

The adjacent diagram provides an overview of how information and materials relating to the study was communicated to relevant persons. The study Research Fellow contacted each of the Trust PI's with relevant information and instructions; this was then communicated with AD's of Children's services and AD's of Mental Health services for circulation among team leads and HSC professionals.



Online Survey Administration to HSC professionals*: September 2016 – January 2017*

A pre notice email was sent to all eligible HSC professionals making them aware of upcoming workshops and also that the research team would be recruiting for the completion of the online and hard copy survey and interviews. This was followed by an email flyer and link to the survey two weeks later. Reminder emails were sent to HSC professionals monthly regarding accessing and completing the survey.

Hard copy survey Administration to HSC professionals*: September 2016 – January 2017*

Emails to HSC professional team leads indicated that a hard copy of the survey could be sent to teams for completion and returned to the research team via the Trust PI or provided prepaid envelopes.

Workshops with HSC Trust Staff*: September - November 2016*

HSC professionals could register to attend a workshop by contacting pre identified administration staff in each of the five HSC Trusts. Once registered, HSC professionals were reminded of the date, time and venue for the workshop that they had registered to attended.

The research team held four workshops with HSC professionals within each of the five HSC Trusts in order to share learning regarding family focused practice, promote the study and aid with survey data collection. On each of the days two workshops of two hours duration were provided. HSC professionals across both sectors were encouraged to attend one of these. Workshop attendance varied between 20 – 70 attendees depending on venue capacity. The first 30 minutes of the workshop was used as time for HSC professionals to complete the study survey in line with data collection if they wished. The remainder of the workshop was then used to provide attendees with an overview of issues relating to PMI for parents and children and an overview of Think Family theory / frameworks including The Family Mode (TFM) (Falkov, 1998, 2012). This was followed by small group activities which involved adult mental health and children's service professionals discussing the enablers and barriers to their FFP and information sharing across groups.

The Demographic Profile of HSC Professionals within the Current Study

The following section outlines the first group of findings; relating to demographic profile of HSC professionals who responded to the survey, including their employment and practice context and education and training.

HSC Professionals' Employment and Practice Context:

Generally, the HSC workforce within each Trust area includes a greater number of respondents from the Belfast Trust, followed by Western Trust, South Eastern Trust, Southern and Northern Trust. The Northern Trust has the smallest number of respondents. The FFMHPQ was distributed to the approximate population of HSC professionals who fulfilled the inclusion criteria practicing in adult mental health and children's services across the five HSC Trusts (*n* = 3585). However, the precise number of HSC professionals who meet the inclusion criteria in these service areas is unknown by the HSCB. The total final sample of HSC professionals taking part in the current study (*n* = 868) was derived from all five HSC Trusts and included professionals from both adult mental health (*n* = 493) and children's social care services (*n* = 316) (*Missing* information regarding service area = 59). Table 2.3 below details the number of participants from each Trust who completed the FFMHPQ.

Table 2.3:

Completed Surveys by Trusts

Trust	Number of Completed Surveys *n*
Belfast	227
South Eastern	163
Western	167
Southern	160
Northern	151
Total	868

Table 3.3, in Appendix J, provides a breakdown of the study sample by Trust, discipline and service area. The largest number of responses were obtained from

community mental health teams (28%), followed by family intervention teams (18.1%), acute mental health and addictions inpatient services (9.3%), gateway (9.3%), community addictions teams (6.5%), 16+ (5.3%), crisis resolution home treatment (4.4%) and single point of access (0.9%). Given the variety of titles and terms attributed to different services across each Trust, the survey offered professionals the option to note their service area under a specialist mental health service or other category (15.2%). Such services included for example unscheduled care, Cognitive Behavioural Therapy (CBT) and those working within family centres.

A range of professions across these service areas participated. The most common profession was Social Worker (*n* = 473, 54.5%) followed by Nurse (*n* = 293, 33.8%). Other professions included Allied Health professionals (*n* = 44, 5.1 %), Psychiatrists (*n* =33, 3.8 %), Psychologists (*n* = 12, 1.4%) and Other, for example, CBT Therapist (*n* = 13, 1.5).

Adult Mental Health Professionals' Employment and Practice Context. Most professionals worked within adult mental health services (*n* = 493); these included Nurses (*n* = 278), Social Workers (*n* = 124), Psychiatrist (*n* = 33), Psychologists (*n* =9), Allied Health professionals (*n* = 40) and those who selected the 'Other' category (*n* = 9). The most common Agenda for Change Band was band 6 (*n* =*n* = 214, 43.4 %,), followed by band 7 (*n* = 152, 30.8%). A few professionals (*n* = 20, 4.1%) reported at band 8 indicating a managerial role. The mean length of time practicing as a professional was 17 years (M = 17.03, SD = 11.01) with the majority of adult mental health professionals currently working on a full time basis (*n* = 427, 86.6%), with few respondents working part time (*n* = 64, 13%) or job sharing (*n* = 2, 0.4%). On average, professionals worked in their current position for 6.6 years and most worked on day shifts (*n* = 371, 75.3%). Most people practiced within mixed urban/rural settings (*n* = 211, 42.8%) and the rest practiced in an urban area (*n* = 190, 38.5%) or rural area (*n* = 90, 18.3 %) only.

Overall, 45.3% (*n* = 218) of adult mental health professionals reported spending time each week delivering services within the home environment, most spending between 0 - 40% (*n* = 97, 55.1%) followed by 50-100% in the home environment (*n* = 79,

44.9%). This wide range most likely reflects the diverse nature of each of the services and service delivery, with 78.7% of adult mental health professional respondent's working in a community based setting, whilst 21.3% worked within in-patient services.

Children's Service Professionals' Employment and Practice Context. In contrast to adult mental health services, the majority of professionals indicating that they worked within children's services (*n* = 316) reported as Social Workers (*n* =312), with a small percentage of Nurses (*n* = 2), Allied Health professional (*n* = 1) and 'Other' (*n* =1, Family Therapist). The most common Agenda for Change Band was band 6 (*n* =182, 57.6%), this was followed by band 7 (*n* = 78, 24.7%). A small minority of professionals (*n* = 19, 6%) reported at band 8. The mean length of time practicing as a professional was 10.4 years (M = 10.04, SD = 8.92) with the majority of children's services professionals currently working on a full time basis (*n* = 292, 92.4%), with a small minority working part time (*n* = 19, 6%) or job sharing (*n* = 4, 1.3%).

On average, professionals had worked in their current position for five years. With regards to service location, children's services professionals predominantly worked within an urban setting (*n* = 150, 47.5%) whilst 37.7% (*n* = 119) worked within either an urban and rural setting or rural only setting (*n* = 45, 14.2 %). Overall, 53% (*n* = 164) of children's service professionals reported spending time each week delivering services within the home environment, of which with the majority reporting spending between 0- 40% (*n* = 80, 70.2%) followed by 50-100% in the home environment (*n* = 34, 29.8%). This wide range most likely reflects the diverse nature of each of the services and service delivery.

Quantitative Survey Data Analysis

Steps Taken in Cleaning the Data and in Creating Subscales:

The survey was completed by HSC professionals using one of two formats, either online or hard copy. A database was created in SPSS for data entry of hard copy surveys; this database was later amalgamated with the online database of completed online surveys. Once both datasets had been merged, correct value range was checked. Additionally, every 25th hard copy survey was audited and the data compared with the SPSS input data in order to ensure quality and consistency of manually entered data.

With regard to the FFMHPQ Likert Scale, "not applicable" scores were treated as missing values as it is assumed that if the item had been applicable the respondent would have responded in the same way as other professionals. Responses on the FFMHPQ assisted the development and later assessment of the FFP subscales. In order to address missing data within the FFMHPQ and ensure a more robust dataset for analysis, an expectation maximization algorithm was employed. The expectation maximization algorithm enables parameter estimation in probabilistic models with incomplete data by computing probabilities for each possible completion of the missing data (Do & Batzoglou, 2008). In other words, the algorithm uses the data available to determine an expected value to replace the missing data. This algorithm was used as opposed to other methods to deal with missing values because it is the simplest and most reasonable approach to doing so.

The Statistical Package for the Social Sciences (SPSS, Version 24) was used to analyse the quantitative data. This involved the use of descriptive and inferential statistics including ANOVA, MANOVA and hierarchical multiple regression. These methods are used to describe the sample characteristics and to determine the extent of FFP, differences in FFP between services and factors that predict FFP. Outcomes of statistical analysis are fully discussed in the final Main report.

Checking Assumptions of Multiple Regressions:

The required sample was calculated based on the formula outlined by Tabachnick and Fidell (2007), of N > 50+8 cases per independent variable (IV), suggesting a

minimum sample size of *n* = 170. The sample size was sufficiently large for the series of multiple regressions to be performed within adult mental health and children's services (*n* = 868) and following on from this within each distinct service, i.e. adult mental health services (*n* = 493) and children's services (*n* = 312). As much of the analysis involved regression, correlations between six dependant variable subscales, seven independent variable subscales and other key independent variables were calculated to illustrate simple relationships between all variables and to check for multicollinearity and singularity. The correlations are presented in Appendix I. Correlations between the IV's were substantially less than .70. Therefore the multicollinearity assumption for regression was not violated and singularity assumption was met (Field, 2009). Similarly, the table also shows that these assumptions were also not violated between the six dependent variables.

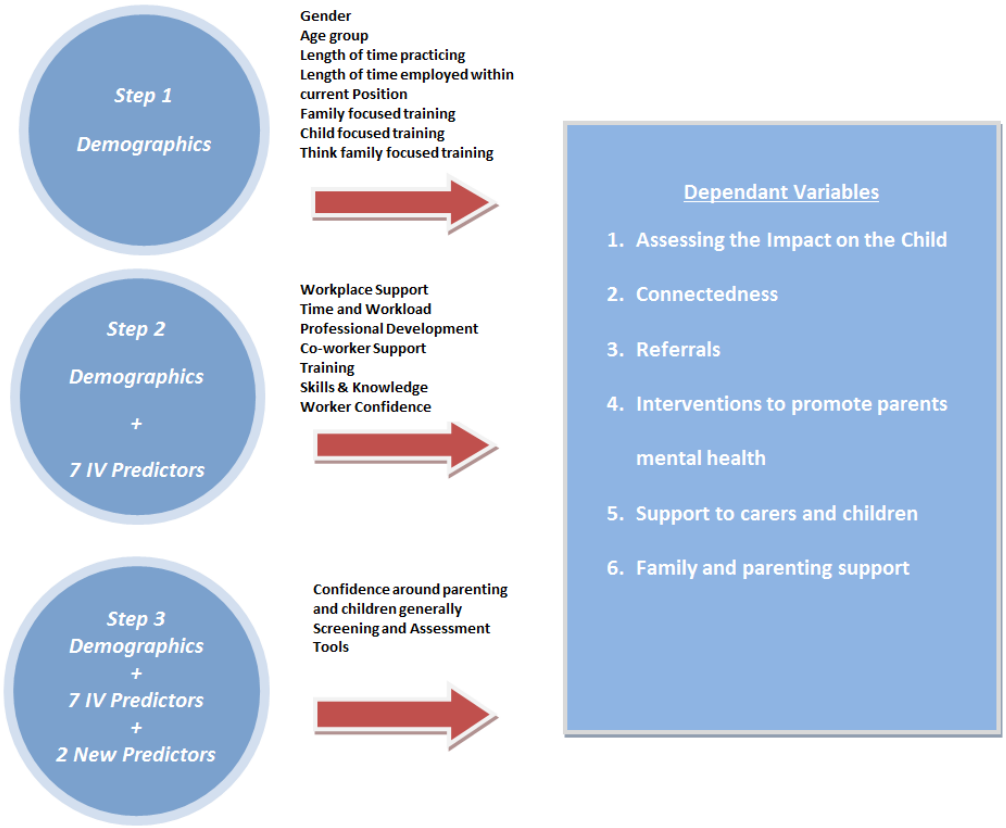
Predicting HSC professionals' FFP - Multiple Regression Analysis:

Hierarchical multiple regression was used to assess how well seven subscales, within the FFMHPQ (section two of the survey), predicted six behavioural subscales measuring family focused activities, after controlling for the influence of seven known predictor variables. Six behavioural subscales in the FFMHPQ (*support to carers and children, family and parenting support, interventions to promote parents' mental health, assessing the impact on the child, connectedness* and *referrals)* were employed in the regressions as dependent variables (DV). In performing the hierarchical multiple regression for each dependent subscale, all demographic variables such as *age, gender, length of time practicing, length of time in current experience, family training, child training* and *Think Family training* were entered into block (step) one to control for the effect of these variables. The block of predictors entered at step two included the known predictors (derived in part from a review of the literature) which comprised of seven independent variable (IV), including subscales *workplace support, time and workload, professional development, co-worker support, training, skill and knowledge* and *worker confidence*. Block three included two new predictors that have recently emerged in the literature as potentially important variables. These were *confidence around parenting and children generally* and *screening and assessment tools facilitating FFP*.

The analyses were repeated for each of the six DV's subscales and aimed to determine the significant predictors of the dependent variables. The 16 IV's were entered into regression equations for each of the six DV's. The variables were entered in three blocks, the order based on previous literature. This order is illustrated in Figure 3.1 Below.

Figure 3.1:

Overview of the Hierarchical Multiple Regression Model



All regressions were later rerun with a dummy variable reflecting type of service (i.e. adult mental health versus children's) in a final step. The dummy variable was a dichotomous variable that included professionals in adult mental health and children's services. The analysis was run as a final step to determine if type of service impacts upon FFP. The analyses provided a rationale for later t-tests that compared the two groups (See Main Report, p.83).

Qualitative Interviews

Interviews: HSC professionals

Semi-structured interviews with a subsample of HSC professionals (*n* = 30), in adult mental health and children's services, across all five Trust were undertaken to explore significant findings from the FFMHPQ and systematic review and to expand upon findings in relation to:

- The nature and scope of HSC professionals' FFP with parents, who have mental illness, their children and families.
- Enablers and barriers of FFP.
- Future potential developments in FFP.

HSC professionals taking part in an interview were identified via self-selection. Inclusion criteria for HSC professionals wishing to take part in an interview remained the same as the criteria for those completing a survey (See p.8).

Participants indicated willingness to undertake an interview by completing an interview volunteer form (See Appendix B) which could be found at the end of the FFMHPQ and returning the completed volunteer form to the research team. Interviews predominantly took place on Trust premises with a few taking place at QUB. Interviews lasted on average 60 minutes with all participants completing a consent form (See Appendix C) before the interview to indicate the understood the purpose of the interview and agreed to take part. With participant permission, all interviews were recorded with a digital audio recorder and subsequently transcribed.

Interviews: Service Users

Semi-structured interviews were also conducted with service users (*n* = 21) receiving adult mental health and children's services or a combination of both services from across all five Trust areas.

Inclusion criteria for service users in adult mental health services included:

- Parents of dependent children (aged 18 or less) receiving treatment in one of the five services identified above and who have capacity to give informed consent.

Inclusion criteria for service users in children's services included:

- Parents of children who are using one of the three services identified above who have mental illness themselves.
- Parents must be in a position to provide informed consent.

The interview schedule was informed by previous literature and the research questions. We explored service users' experiences of HSC professionals' FFP. Interviews provided additional key perspectives to that of HSC professionals in relation to HSC professionals' FFP. Interviews focused in particular on service users' perspectives of (1) their needs regarding FFP, (2) experiences of receiving FFP and (3) barriers and enablers of FFP. In addition, key findings from the systematic review were also further explored with service users. Please see Appendix F, G & H, for summary of both professionals and service users' interview questions (i.e. Topic Guides).

The safety and well-being of service users was a paramount consideration of the research. Service users were provided with information about the study and a volunteer forms (See Appendix D) by their key worker. Services users who wished to take part in an interview completed the volunteer form and returned this to the research team via a pre-paid envelop or by consenting for their key worker to pass on their contact information to the research team. Service users who decided to voluntarily participate in interviews were offered the opportunity to meet at a venue suitable to them and to have a person who could support them available should they wish. All service users provide consent (See Appendix E) before the interview began. Service users were also offered a copy of their interview transcript and the opportunity to make any additional comments to elaborate on points they have made. All service users participating in an interview received £30 worth of One-4-All vouchers to acknowledge their time and any expenses or inconvenience caused by their involvement in the research.

Achieving Meaningful Service User Involvement in Research Design:

From the outset, it was important that this research approached service user involvement and engagement in a spirit of openness and meaningful collaboration. At the heart of this was the need to avoid engagement that was tokenistic (Esmail, Moore & Rein, 2015). Any service users had to feel that this type of involvement was in line with established good practice (McLaughlin, 2009: Duffy, 2006) and genuinely *collaborative* (Lathlean et al, 2006; Haggerty et al, 2003; Hanley et al, 2004; Sweeney, 2009; McLaughlin, 2009). Mc Laughlin's definition of this type of collaborative approach seems consistent with our team's endeavours when he remarks: "Collaboration implies a degree of ongoing service user involvement with an explicit understanding that it is possible to indicate how service user involvement has impacted upon the study" (2009, p.7). Therefore, we approached and involved service user representatives in an important advisory capacity working closely with the research team in key aspects of research design. We also worked closely with service user representatives in the design (wording of questions) of interviews to be used with service users. In the latter, a member of the research team worked closely with two people from a service user background where the real focus was on how the interview would be experienced and felt by those service user respondents participating in these. This type of empathic focus is aligned with Beresford's observations about the particular insights which people with lived experience can bring to research due to their "personal and collective experience of policy, practice and services" (2000, p.493).

The research team's approach to achieving meaningful and genuine user involvement was also guided by an ethic of care position (Ward & Gahagan, 2012). Originating in feminist philosophy, this approach underscores the: "interconnected principles of attentiveness, responsibility, competence, responsiveness and trust as a requisite for 'good care'" (Ward & Gahagan, 2012, p. 183). In applying these ethics of care/good care principles to collaborative research, the team members were therefore very attuned to issues such as: differing experiences of researchers and service users, differing skills and knowledge, power differences, etc. The research team was therefore mindful about not trying to achieve any sense of "false equality" in working with service users in this research context but more focused on

navigating: “a pathway through…our different but equal contributions” (Ward and Gahagan, 2012, p.185). The ethic of care position therefore allowed open discussion within the research process about expert and service user/experiential knowledge that would ultimately and meaningfully recognise the diverse types of expertise that we as a team in our joint endeavours brought to the overall research process (Ward & Gahagan, 2012). The research team’s ethic of care position would therefore result in: “…a thoughtful and considered nurturing of capacities” (Hugman, 2005, p. 69) “…teased out in the context of relationships” (ibid: 71) with user researchers. In practice, this meant that in our research study, service users would be involved in managing the research and co-designing research tools (interviews, participant information and consent protocols) and in proofing aspects of the final report for accessibility.

Qualitative Data Analysis

Thematic analysis was used to create core constructs from the qualitative (textual) data through a systematic method of reduction and analysis (Miles & Huberman, 1994). In undertaking the thematic analysis an essentialist, realist perspective was used (Silverman, 2010) and meanings considered first in individual transcripts and then across the whole data set. The qualitative data analysis computer software package NVivo 11 was employed to help organise the data and to ensure methodological rigour by establishing credibility, transferability, dependability and confirmability using techniques suggested by Lincoln and Guba (1985).

The full process of thematic analysis constitutes six distinct though highly interconnected steps (Miles & Huberman, 1994). Figure 5.1 provides a visualisation of the thematic analysis process:

Figure 5.1:

Braun and Clarke's model of Thematic Analysis (Howitt, 2013, p182)

The process of thematic analysis started by initially familiarising ourselves with the data. This was then followed by a data reduction process which involves developing basic themes or start codes and working inwards toward a global theme. Once basic themes are identified, they can then be categorised according to the underlying story they were telling; these become the organising themes (Attride-Stirling, 2001, p.385). After reviewing a number of transcripts a coding framework was developed. The coding framework was then used to identify initial concepts that reduced the 'chunks' of information into the most reasonable themes/sub themes across all transcripts. Using NVivo 11, the researchers were than able to generate a coding table which displayed global themes and subthemes which were supported by multiple quotations below each from across transcripts which represented the same codes. These tables helped the researchers review the themes and subthemes and confirm findings. A final framework was agreed by the research team and themes and subthemes were given fix labels and defined throughout the results section. Four

members of the research team reviewed and independently coded a random selection of transcripts. An inter-coder discussion took place between the research team helping to confirm results.

Ethical Considerations

The study was conducted in accordance with the statement of ethical practice and standards set out by the Declaration of Helsinki and in line with current QUB processes and regulations (Please See: http://www.qub.ac.uk/Research/Governance-ethics-and-integrity/Research-integrity/). Ethical approval was granted by ORECNI and Research Governance permission obtained from the five HSC Trusts. QUB was the acting sponsor of the research and ensured that governance and indemnity procedures were in place. Approval from the aforementioned bodies was granted between February 2016 and September 2016. Honorary contracts and Access NI checks were issued for all project team members involved in data collection.

In the quantitative component HSC professionals were informed of the details of the study in online explanatory statements; implied consent was obtained through participation in the completion of the, online or hard copy, anonymous questionnaire. They were told that their participation in interviews was contingent upon them returning the completed FFMHPQ and a form with their contact details which was included with their FFMHPQ. In the qualitative component, prior to commencing the interview, both HSC professionals and parents were invited to complete an informed consent form. Maintaining participants' confidentiality is often a major ethical concern of interpretive research because of the intimate nature of the research (King & Horrocks, 2010) but was maintained through the use of pseudonyms and changing specific contextual details that could possibly reveal the identity of the participant.

Study Limitations

There were several weaknesses with this research that limit the generalizability of the findings. This study provides data about a little studied phenomenon and the design included several important threats to the study's validity. In particular, while

the FFMHPQ had documented validity and reliability in the Australian and Norwegian context (Lauritzen, 2014; Maybery et al., 2012), there was poor reliability of the majority of subscales in the NI context (i.e. most of the subscales had reliabilities greater than .60, with eight subscales greater than .70). This poor reliability may be largely explained by a lack of sensitivity of HSC professionals to FFP and their limited understanding of concepts being measured. Future researchers need to be cognisant that the reliability of a scale in one context may not necessarily transfer to another context and factor this into their study designs. Furthermore, while the first study identified eleven predictors of FFP these only explained between 21.5 percent and 34.4 percent of variance across the six FFP behavioural subscales measured; suggesting that a considerable amount remains unexplained, offering fertile ground for future research.

Additionally, interview data collected here, represents a selection of HSC professionals and services users' views of FFP and this may not be a reflection of other HSC professionals' actual practice (Lauritzen et al., 2014). For example, the HSC professionals in Children's services, who participated in this study, practiced in community based services and may have had more of an opportunity to engage with both parents and child(ren). In addition, while the practices of five professional groups are shown here, a further weakness is that not all professional groups operating within the contemporary mental health setting were represented in this study. Occupational therapists and family support workers were not included. These limitations should be noted when generalizing these results to other locations and professions, for example those working within 'Looked After' Children's services. A further limitation of the current study is related to not addressing interrelated issues from the outset, such as domestic violence, although this did arise during interviews with both professionals and service users.

Study Materials

Appendix A: ***Family Focused Mental Health Practice Questionnaire (FFMHPQ)***

Health and Social Care Professionals' Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland

CYPSP
Children & Young People's Strategic Partnership

HSC Health and Social Care Board

Queen's University Belfast

Ulster University

Since 2012 Think Family Northern Ireland (NI) has become core business for the Health and Social Care Board (HSCB) under the structure of the Children and Young People's Strategic Partnership (CYPSP). This has resulted in a range of activities and projects designed to improve health and social care professionals' understanding of family focused practice (FFP) and multidisciplinary working, while also improving the interface between services.

The aim of this survey is to gain an understanding of your practice with parents who have mental illness, their dependent children (18 or under) and other adult family members. The survey also explores your practice with other adult family members (including parents whose adult children have mental illness).

For the purpose of this study mental illness refers to a wide range of mental health conditions and disorders that affect mood, thinking and behaviour. Examples of mental illness include depression, anxiety disorders, schizophrenia, personality disorders and substance misuse.

The term **FFP is equal to Think Family**. Either term is generally used within this research to describe the process of working with parents who have mental illness around issues related to parenting with a mental illness, which may affect their parenting capacity and their own and their dependent children's wellbeing. It also entails working with dependent children whose parents have mental illness to support them to cope with their parents' mental illness. Your practice in relation to adult carers in general is also considered.

While adult mental health professionals are asked to consider their practice with parents who have mental illness using adult mental health services, social workers in children's services should focus on their practice with parents who are receiving treatment for mental illness from either adult mental health services or primary care services, such as a GP. The survey can be completed even if you have no current or previous experience of caring for parents who have mental illness and/or for dependent children whose parent has/had mental illness. It is designed to rate your:

1. Perspective about statements relating to your knowledge and skill about family issues,

2. Interest in engaging in FFP to support children whose parent has mental illness, parents who have mental illness and families,

3. Perception of organisational policy and supports for FFP, and your level and type of FFP undertaken in your work, if any.

What is involved? This survey has three parts and will take up to 35 minutes to complete. There are no right or wrong answers; we are simply interested in obtaining feedback on health and social care professionals' FFP and organisational support for FFP. The findings will generate understanding of health and social care professionals' perspectives of FFP which can be used to shape future family focused initiatives in adult mental health and children's services in line with feedback. This important study has been approved and supported by your Trust and where possible may be completed during working hours

We would like to emphasise that your involvement is VOLUNTARY and to maintain your ANONYMITY please do not put any identifying information on the survey. Data collected as part of the survey will be held for 10 years and may be used within a number research studies. Remember that your responses are anonymous and confidentiality will be protected.

PART 1: Demographics

The purpose of this part of the survey is to establish background information about you and the position /role that you have within your organisation. Please answer all of the following questions.

1.1 Which of the following describes how you think of yourself?
Tick one box only

Female	[ ]
Male	[ ]
In another way	[ ]

1.2 What age are you? _____ (years)

1.3 How long have you been practicing as a qualified and registered health and social care professional? (Please indicate in how many Weeks, Months or Years?)"

(Please indicate either weeks, months or years) _____ (weeks)

_____ (months)

_____ (years)

1.4 What is your professional discipline?

Please tick all that apply

Nurse	[ ]
Social Worker	[ ]
Psychiatrist	[ ]
Psychologist	[ ]
Allied Health Professional	[ ]

Other (please specify) _____

1.5 Have you had any family-focused training?
Tick one box only

YES [ ]

NO [ ]

If **yes** please detail when
(i.e. undergraduate and/or
post qualifying), type,
length of training & if accredited.

_____

_____

_____

_____

1.6 Have you had any solely child-focused training?
Tick one box only

YES [ ]

NO [ ]

If **yes** please detail when
(i.e. undergraduate and/or
post qualifying), type,
length of training & if accredited

_____

_____

_____

1.7 Have you had any Think Family focused training?

YES [ ]

NO [ ]

If **yes** please detail when (i.e. undergraduate and/or post qualifying), type, length of training & if accredited

_____

_____

_____

1.8 If you work in Children's Social Care Services have you received any training in relation to adult mental health?
Tick one box only

YES [ ]

NO [ ]

If **yes** please detail when (i.e. undergraduate and/or post qualifying), type, length of training & if accredited

_____

_____

_____

1.9 Which HSC Trust are you currently employed by?
Tick one box only

Belfast Health & Social Care Trust	[ ]	Southern Health & Social Care Trust	[ ]
South Eastern Health & Social Care Trust	[ ]	Northern Health & Social Care Trust	[ ]
Western Health & Social Care Trust	[ ]		

1.10 In which service area are you currently working in? Tick one box only
(Note: We understand that the terms used below to describe each of the services may not exactly fit with your Trust. We would ask you to select the service which best describes your area of work. If you cannot do this using the list below, please use the 'Other (Please specify)' Option

Acute In-Pt Mental Health and Addiction Services	[ ]	Community Mental Health Team	[ ]
Crisis Resolution Home Treatment	[ ]	Single Point of Access	[ ]
Community Addiction Team	[ ]	16+ Team	[ ]
Family Intervention Team	[ ]	Gateway Service	[ ]

Specialist mental health service (Please specify) _____

Other (Please specify) _____

1.11 How long have you been working in your current position?

(Please indicate either weeks, months or years) _____ (weeks)

_____ (months)

_____ (years)

1.12 Where is your service located? (Tick urban if your service is predominantly based in a city setting) Tick one box only

Predominantly Rural Location [ ]

Predominantly Urban Location [ ]

Urban & Rural Location [ ]

1.13 On what basis are you currently employed?
Tick one box only

Full-time [ ]

Job Share [ ]

Part – time (No job share) [ ]

Other (Please specify) _____

1.14 How long on average would a service user be involved in your service?
Tick one box only

Less than a week [ ]

Between 1 – 4 weeks [ ]

Up to six months [ ]

More than six months [ ]

1.15 Which Agenda for Change band are you currently employed at?

(Please specify) _____

1.16 If you are an adult mental health professional what rota are you currently working on?
Tick one box only

Day duty [ ]

Night duty [ ]

Both rotas [ ]

N/ A [ ]

1.17 Are you primarily involved in delivering direct care to service users?
Tick one box only

YES [ ]

NO [ ]

If **yes,** please specify number of service users or cases you are responsible for _____ (number)

1.18 Do you spend a percentage of your time each week delivering care within the service user's home environment?
Tick one box only

YES [ ]

NO [ ]

If **yes**, please specify percentage of time spent in the home environment_____ (per week)

1.19 Are you or will you be acting as a CHAMPION resource for your team? (A Champion has a formal role and responsibility for providing Think Family information, promoting joint working between services and identifying any obstacles to better cooperation).
Tick one box only

YES [ ]

NO [ ]

PART 2: Family Focused Mental Health Practice Questionnaire Subscales

The following scale is a standardised tool designed to rate the extent to which you agree or disagree with statements regarding FFP. While the majority of items are related to FFP in relation to parents who have mental illness, their children and families, some items relate to FFP in relation to adult carers in general. Please refer to your experience in your current position and provide a response for every item regardless of whether you have current, previous or no experience of caring for parents who have mental illness or for children whose parent(s) have mental illness. If you have no experience of caring for parents who have mental illness and/or for their children, please tick the not applicable (N/A) option for those items that ask you to comment on your actual activities with parents who have mental illness, their children and families.

In responding to the questions below, please use the following scale which ranges from (1) strongly disagree to (7) strongly agree and includes a (N/A) not applicable category. For each question, please circle the answer (number) that best corresponds with your experience.

Not applicable		**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neither agree or disagree**	**Slightly Agree**		**Agree**		**Strongly agree**
N/A		**1**	**2**	**3**	**4**	**5**		**6**		**7**
1	My workplace provides mentoring to support health and social care professionals undertaking FFP	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
2	In my area we lack services (e.g. other agencies) to refer children to in relation to their parent's mental illness (i.e. programs for children)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
3	There is no time to work with children whose parent has mental illness or substance misuse around issues related to parental mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
4	Government policy regarding FFP is very clear	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
5	Professional development regarding FFP is not encouraged at my work place	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
6	I often receive support from co-workers in regard to FFP	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
7	I regularly have family meetings (not therapy) with parents who have mental illness and their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
8	I am not confident working with mentally ill parents on their parenting skills	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
9	I don't provide information to the carer and/or family about the service user's medication and/or treatment	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
10	Many parents who have mental illness do not consider their illness to be a problem for their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
11	I am able to determine the developmental progress of children whose parent(s) has mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
12	I sometimes wish that I was better able to help parents discuss the impact of their mental illness on their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
13	I am knowledgeable about how parental mental illness impacts on children.	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	1	2	3	4	5	6	7

14	There are no parent-related programs (e.g. parenting skills) to refer parents with mental illness to	N/A	1	2	3	4	5	6	7
15	I am able to determine the level of importance that parents who have mental illness place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)	N/A	1	2	3	4	5	6	7
16	I do not refer children whose parent has mental illness to child focused (e.g. peer support) programs (other than child and adolescent mental health)	N/A	1	2	3	4	5	6	7
17	Working with other health and social care professionals enhances my FFP	N/A	1	2	3	4	5	6	7
18	My workplace does not provide mentoring to support health and social care professionals undertaking FFP	N/A	1	2	3	4	5	6	7
19	Due to location it is difficult to coordinate families and children with the required services	N/A	1	2	3	4	5	6	7
20	My workload is too high to do family focused work	N/A	1	2	3	4	5	6	7
21	At my workplace, policies and procedures for working with parents who have mental illness on family issues are very clear	N/A	1	2	3	4	5	6	7
22	My workplace provides little support for further training in FFP	N/A	1	2	3	4	5	6	7
23	In my workplace other workers encourage FFP	N/A	1	2	3	4	5	6	7
24	I provide written material (e.g. Think Family educational resources, leaflets) about parenting to parents who have mental illness	N/A	1	2	3	4	5	6	7
25	I am not confident working with families of service user's	N/A	1	2	3	4	5	6	7
26	Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the service users' mental illness	N/A	1	2	3	4	5	6	7
27	Discussing issues for the service user with others (including family) would breach their confidentiality	N/A	1	2	3	4	5	6	7
28	I am able to assess the level of children's involvement in their parent's symptoms	N/A	1	2	3	4	5	6	7
29	I should learn more about how to assist parents who have mental illness with their parenting	N/A	1	2	3	4	5	6	7
30	I do not have the skills to work with parents who have mental illness about how parental mental illness impacts on children and families	N/A	1	2	3	4	5	6	7
31	There are no family therapy or family counselling services to refer parents who have mental illness and their children to	N/A	1	2	3	4	5	6	7
32	I am able to determine the level of importance that parents who have mental illness place on their children maintaining strong relationships with other family members (e.g. other parent, siblings)	N/A	1	2	3	4	5	6	7

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	1	2	3	4	5	6	7

33	I refer parents who have mental illness to parent-related programs (e.g. parenting skills)	N/A	1	2	3	4	5	6	7
34	Children and families ultimately benefit if health and social care professionals work together to solve the family's problems	N/A	1	2	3	4	5	6	7
35	There is time to have regular contact with other agencies regarding parents, families or children (i.e. interface groups such as family support hubs)	N/A	1	2	3	4	5	6	7
36	I regularly provide information (including written materials) about mental health issues to children whose parent(s) has mental illness	N/A	1	2	3	4	5	6	7
37	Rarely do I consider if referral to peer support program (or similar) is required by children whose parent(s) has mental illness	N/A	1	2	3	4	5	6	7
38	Children often do not want to engage with me about their parent's mental illness	N/A	1	2	3	4	5	6	7
39	I would like to undertake future training to increase my skills and knowledge for working with children whose parent(s) has mental illness	N/A	1	2	3	4	5	6	7
40	I am not experienced in working with child issues associated with parental mental illness	N/A	1	2	3	4	5	6	7
41	I am not able to determine the level of importance that parents who have mental illness place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)	N/A	1	2	3	4	5	6	7
42	Team-working skills are essential for all health and social care professionals providing family-focused care	N/A	1	2	3	4	5	6	7
43	I often consider if referral to parent support programme (or similar) is required by parents who have mental illness	N/A	1	2	3	4	5	6	7
44	I would like to undertake training in future to increase my skills and knowledge about helping mentally ill parents with their parenting	N/A	1	2	3	4	5	6	7
45	I am skilled in working with parents who have mental illness in relation to maintaining the wellbeing and resilience of their children	N/A	1	2	3	4	5	6	7
46	I want to have a greater understanding of how to work within the multidisciplinary team to support children and families	N/A	1	2	3	4	5	6	7
47	I provide education sessions for adult family members (e.g. about the illness, treatment)	N/A	1	2	3	4	5	6	7
48	I am not confident working with children whose parent(s) has mental illness	N/A	1	2	3	4	5	6	7
49	I am knowledgeable about the key things that parents who have mental illness could do to maintain the wellbeing (and resilience) of their children	N/A	1	2	3	4	5	6	7

Not applicable	Strongly Disagree	Disagree	Slightly Disagree	Neither agree or disagree	Slightly Agree	Agree	Strongly agree
N/A	1	2	3	4	5	6	7

50	I am able to identify how parenthood can precipitate a parent's mental illness	N/A	1	2	3	4	5	6	7
51	I am able to identify how parenthood can influence a parent's mental illness	N/A	1	2	3	4	5	6	7
52	I assess the impact of the parenting role on the parent's mental health	N/A	1	2	3	4	5	6	7
53	I suggest practical strategies to facilitate parents who have mental illness to manage the dual demands of their parenting role and their mental illness or substance misuse	N/A	1	2	3	4	5	6	7
54	I understand how to use Falkov's Family Model to guide my FFP	N/A	1	2	3	4	5	6	7
55	I perceive that Falkov's Family Model can guide my FFP	N/A	1	2	3	4	5	6	7
56	I would need to undertake future training to increase my skills and knowledge for using Falkov's Family Model in practice	N/A	1	2	3	4	5	6	7
57	The regional child protection procedures are clear about when I should be concerned that a parent's mental illness is impacting negatively on a child	N/A	1	2	3	4	5	6	7
58	There is no time to work with families	N/A	1	2	3	4	5	6	7
59	I discuss the impact of family functioning, on children's well-being, with the service user's adult family members/carers	N/A	1	2	3	4	5	6	7
60	I would classify my interaction with children whose parent has mental illness as planned, purposeful involvement with therapeutic intervention	N/A	1	2	3	4	5	6	7
61	Parents generally do not want to engage with me about the impact of their mental illness on their children	N/A	1	2	3	4	5	6	7
62	Discussing the impact of parental mental illness on children with parents who have mental illness would compromise rapport with them	N/A	1	2	3	4	5	6	7
63	Insufficient numbers of health and social care professionals (i.e. nurse, social worker, clinical psychologist) in my service reduces worker's capacity to address parenting issues	N/A	1	2	3	4	5	6	7
64	I am clear about the thresholds for instigating a formal child in need (UNOCINI) assessment when a parent's mental illness is impacting on their child	N/A	1	2	3	4	5	6	7
65	I do not understand how to use Falkov's Family Model to guide my FFP	N/A	1	2	3	4	5	6	7
66	I know what to do if I was concerned that a parent's mental illness was having a significant negative effect on a child	N/A	1	2	3	4	5	6	7

67. If you have chosen N/A to any of the previous questions in the Family Focused Mental Health Practice Subscales, can you tell us why?

There is some evidence to suggest that health and social care professionals who are, or have been, parents of dependent children (under 18) may feel more comfortable and/or able to address mentally ill parent's parenting roles than those without experience of parenting (Grant, 2014; Korhonen et al., 2010). The following questions focus on how comfortable you are regarding parenting and children generally. If you do not have children please indicate N/A to questions 68 & 69

68	In general I am very happy with my parenting.	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
69	I have confidence in my parenting skills	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
70	I feel comfortable around other people's children (e.g. friends, family)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

71 Would you like to make any additional comments regarding your FFP and/or organisational support for FFP?
Tick one box only

YES [ ]

NO [ ]

If **yes** please elaborate

_____

_____

_____

_____

Please proceed to Part 3

PART 3: Professional experience of working with parents, who have mental illness, their children and families and perspectives of Think Family initiatives

The purpose of this part of the survey is to establish the extent of your professional exposure and experience in caring for parents who have mental illness, their children and adult family members. It also seeks your perspective of key Think Family initiatives. The term 'dependent children' is used to describe children under the age of 18. Please answer all of the following questions irrespective of whether you have professional experience of caring for parents who have illness, their children and/or adult family members. The majority of items can be completed irrespective of which setting you are practicing in, i.e. Adult Mental Health or Children's Services. Please respond according to the setting you are in.

3. 1 Currently do you provide professional services to parents who have mental illness and/or their dependent children? (Tick one box only)

YES	[ ] (Please specify number you are currently involved with) ____
NO	[ ]
Not Sure	[ ]

3.2 Have you previous experience of providing professional services to parents who have mental illness and/or their dependent children?
Tick one box only

YES	[ ]
NO	[ ]
Not Sure	[ ]

3.3 In your current position how regularly do you provide services to parents who have mental illness or their dependent children?
Tick one box only

Daily	[ ]	Few times a Year	[ ]
Weekly	[ ]	Never	[ ] → (**Go to 3.6**)
Monthly	[ ]		

3.4 During the last week did you discuss issues related to parenting with parents who have mental illness?

Yes [ ] → (**Go to 3.6**)

No [ ] → (**Go to 3.5**)

3.5 What factors and/or circumstances(s), if any, deterred you from discussing parenting?
(Please specify)

_____

_____

_____

_____

3.6 In the past week did you have face to face contact with a child(ren) whose parent has mental illness?
Tick one box only

Yes [ ]

No [ ] → (**Go to 3.9**)

3.7 Did you discuss issues related to their parent's mental illness?
Tick one box only

Yes [ ] → (**Go to 3.9**)

No [ ]

3.8 What factors and/or circumstances(s), if any, deterred you from discussing issues associated with parental mental illness? (Please specify**)**

_____

_____

_____

_____

3.9 Are you aware of the Regional Joint Adult & Children's Services Protocol?
Tick <u>one</u> box only

Yes	[ ]
No	[ ] → (**Go to 3.13**)

1.10 Does the Regional Joint Adult & Children's Services Protocol enable your FFP?
Tick <u>one</u> box only

Yes	[ ]
No	[ ] → (**Go to 3.12**)

3.11 How does the Regional Joint Adult & Children's Services Protocol enable your FFP? (Please specify and <u>go to 3.13</u>**)**

_____

_____

_____

3.12 What suggestions would you make for strengthening the Regional Adult & Children's Services Joint Protocol?

_____

_____

_____

_____

3.13 Does current screening and assessment documentation (including UNOCINI – Appendix 1) facilitate you to address parents and children's needs in relation to parental mental illness?
Tick one box only

Yes	[ ]
No	[ ] → (**Go to 3.15**)

3.14 How does screening and assessment documentation facilitate your FFP?
(Please specify and go to 3.16**)**

_____

_____

_____

_____

3.15 What suggestions would you make for screening and assessment documentation to facilitate your FFP?

_____

_____

_____

_____

3.16 Are you aware of Falkov's Family Model?
Tick one box only

Yes [ ]

No [ ] → (**Go to 3.19**)

If **yes** how did you learn
About the Family Model

_____

_____

3.17 Do you use Falkov's Family Model in your work?
Tick one box only

Yes [ ]

No [ ] → (**Go to 3.18**)

If **yes** how do you use
the Family Model (please
specify by providing examples
and go to 3.19)

_____

_____

_____

3.18 If you do not use Falkov's Family Model Can you tell us why?

_____

_____

_____

_____

3.19 If working in <u>Adult Mental Health Services</u> do you support adult family members including parents who have adult children with mental illness?
Tick <u>one</u> box only

Yes [ ]

No [ ] → (**Go to 3.20**)

If you work in children's services please Go to 3.21

If **<u>yes</u>** how do you support adult family members (please specify by providing examples and <u>go to 3.21</u>)

_____

_____

_____

_____

3.20 If working in <u>Adult Mental Health Services</u> why do you not support adult family members?

_____

_____

_____

_____

3.21 If you have current, or recent, experience (within the last 12 months) of caring for one or more parents who have mental illness and/ or substance misuse, or have experience of caring for their dependent children would you be willing to take part in a semi-structured interview in order to discuss your experiences further?
Tick <u>one</u> box only

Yes [ ] (Please complete the Interview Volunteer slip & forward with your questionnaire)

No [ ]

Have you any additional comments that you would like to make regarding the capacity of other Think Family initiatives to promote FFP (i.e. Champion Model, Think Family Practitioner) and/or how FFP could be further promoted? If yes, please elaborate in the box below.

Thank you for completing this questionnaire. Your contribution in this research is greatly appreciated. Please return your completed questionnaire online or by freepost in the envelope provided to:

Dr Susan Lagdon
School of Nursing and Midwifery
97 Lisburn Rd
Belfast
BT9 7BL
N. Ireland

Email: ThinkFamilyNIStudy@Gmail.Com

Appendix B. ***Interview Volunteer Form – Health and Social Care Professionals***

Health and Social Care Professionals' family focused practice with parents who have mental illness, their children and families in Northern Ireland

Interview Volunteer Form

If you have current or recent experience (within the past 6 months) of providing services to a parent who has mental illness and/or substance misuse issues (or their children) and would be willing to take part in an interview, please complete the Interview Volunteer Form below. Please then forward it with your questionnaire via internal mail in the self-addressed envelope provided. Dr Susan Lagdon in QUB will arrange to collect your sealed enveloped from your Trusts point of contact for the study. To ensure that your response to the questionnaire remains anonymous Dr Lagdon will separate your interview volunteer from your questionnaire. If you complete this form and agree to participate in an interview your confidentiality will be maintained.

The interview will provide an opportunity for you to give additional detail about your perspectives of support provided to parents who have mental illness, their children and families and capacity of health and social care professionals to engage in family focused practice. It will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the audio recorder to be turned off. All of the information that you provide will be confidential including your name and responses. Your response will be combined with those of other health and social care professionals regionally.

If you decide to participate in a semi-structured interview and complete the Interview Volunteer Form below and return it to me, on receipt of the form, Dr Susan Lagdon will contact you by telephone or email, whichever you prefer, in order to arrange a time and place to meet. Your participation in a semi-structured interview would be greatly appreciated and will make a difference to the outcome of the study.

Yes I would like to take part in a semi-structured interview:

My name is:

Professional Discipline (please specify) _____

I am currently practicing in the following type of service (please tick all that apply and specify area)

(a) Adult Mental Health Services [ ] (specific area) _____
(b) Children's Service [ ] (specific area) _____

My contact telephone and /or email address are as follows:

Telephone number: _____

E-mail address: _____

I would prefer to be contacted by (Please Tick)

Telephone [ ] Email [ ]

Thank you for completing the Interview Volunteer Form, Please forward this document to us using the details below:

Email Address: ThinkFamilyNIResearchStudy@Gmail.Com

Email Subject: HSC Professional Volunteer

Appendix C. ***Consent form HSC Professionals***

(H&SC Professional) CONSENT FORM

Participant Identification Number:_____

Title of Project:	Health and Social care Professionals' Family Focused Practice with parents who have mental illness their children and families in Northern Ireland
Chief Investigator:	Dr Anne Grant
Study Number:	R4737NUR

Please initial box

1. I confirm that I have read, or had read to me, and understand the information sheet dated 20/3/16, version 1.0 for the above study. I have had the opportunity to ask questions and these have been answered fully. ☐
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my legal rights or medical care being affected. ☐
3. I understand the study is being conducted by researchers from Queen's University Belfast and University of Ulster and that my personal information will be held securely on University premises and handled in accordance with the provisions of the Data Protection Act 1998. ☐
4. I understand that data collected as part of this study may be looked at by authorized individuals from Queen's University Belfast and the HSC Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information. ☐
5. I agree to take part in the above study. ☐
6. I understand that what is discussed during the interviews is confidential with the exception that if I disclose information that indicates that I am at risk of harming myself or others, or in danger of being harmed by someone else, the researcher is legally obliged to pass on this information. ☐
7. I understand the interviews will be tape recorded and there is a possibility of direct quotation being used in publications. ☐

_____	_____	_____
Name of Participant (please print)	Signature	Date
_____	_____	_____
Name of Person Taking Consent (please print)	Signature	Date

Chief Investigator or Researcher Contact details:

Appendix D. ***Interview Volunteer Form – parents who have mental illness and/or substance use problems using adult mental health services and whose children are using children's services***

Health and Social Care Professionals' family focused practice with parents who have mental illness, their children and families in Northern Ireland

Interview Volunteer Form

If you are a parent who has a mental illness and using adult mental health services and your child is currently receiving children's services; and you would be willing to take part in an interview, please complete the Interview Volunteer Form below and forward it to the Chief Investigator (Dr Anne Grant) in the stamped self-addressed envelope provided. If you complete this form and agree to participate in an interview your confidentiality will be maintained.

The interview will provide an opportunity for you to talk about your perspectives of support provided to you, your children and family by social care professionals in children's services. It will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the audio recorder to be turned off. All of the information that you provide will be confidential including your name and responses. Your response will be combined with those of parents who are receiving children's services within the five Health and Social Care Trusts in Northern Ireland.

If you decide to participate in a semi-structured interview and complete the Interview Volunteer Form below and return it to me, on receipt of the form, I will contact you by telephone or email, whichever you prefer, in order to arrange a time and place to meet. Your participation in a semi-structured interview would be greatly appreciated and will make a difference to the outcome of the study.

Yes I would like to take part in a semi-structured interview:

My name is: _____

I am currently receiving the following type of service (please tick all that apply and specify area)

(a) Adult Mental Health Services [ ] (specific area) _____
(b) Children's Service [ ] (specific area) _____

My contact telephone and /or email address are as follows:

Telephone number: _____

E-mail address: _____

Appendix E. ***Service User Consent Form***

(Service User) CONSENT FORM

Participant Identification Number:_____

Title of Project:	Health and Social care Professionals' Family Focused Practice with parents who have mental illness their children and families in Northern Ireland
Chief Investigator:	Dr Anne Grant
Study Number:	R4737NUR

Please initial box

1. I confirm that I have read, or had read to me, and understand the information sheet dated 20/3/16, version 1.0 for the above study. I have had the opportunity to ask questions and these have been answered fully. ☐
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my legal rights or medical care being affected. ☐
3. I understand the study is being conducted by researchers from Queen's University Belfast and University of Ulster and that my personal information will be held securely on University premises and handled in accordance with the provisions of the Data Protection Act 1998. ☐
4. I understand that data collected as part of this study may be looked at by authorized individuals from Queen's University Belfast and the HSC Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information. ☐
5. I agree to take part in the above study. ☐
6. I understand that what is discussed during the interviews is confidential with the exception that if I disclose information that indicates that I am at risk of harming myself or others, or in danger of being harmed by someone else, the researcher is legally obliged to pass on this information. ☐
7. I understand the interviews will be tape recorded and there is a possibility of direct quotation being used in publications. ☐

_____	_____	_____
Name of Participant (please print)	Signature	Date
_____	_____	_____
Name of Person Taking Consent (please print)	Signature	Date

Chief Investigator or Researcher Contact details:

Appendix F. ***Adult Mental Health Professionals' Topic Guide***

Adult Mental Health Professionals' Topic Guide

Health and Social care professionals' practice with parents who have mental illness, their children and families in Northern Ireland

Preamble

Thank you for agreeing to participate in this interview.

I would like to digitally audio record this interview – please let me know if you are content with this. (If participant/s agree with digital audio recording and consent forms have been received, then switch the digital audio recorder on).

Good morning, my name is Anne Grant and I am a mental health nurse and lecturer in mental health in the school of Nursing and Midwifery in Queen's University, Belfast.

Thank you for agreeing to participate in this study, I appreciate your time in this.

The aim of the study is to explore your views on your practice with parents who have mental illness or substance misuse, their dependent children and families.

I need to let you know that your participation in this research is entirely your choice and even though you are participating you can withdraw from the project at any time without giving a reason, and it's also entirely up to you whether you want to answer all of my questions. So if there is a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

Finally, all the data that I collect from you will be treated in a confidential manner, so I'll be removing all information that identifies you from the transcript, and you can check that yourself because you'll be receiving a copy of the transcript before I do any analysis on it. So you can make any changes to it. During the course of your interview should you disclose examples of unsafe practice (either your own or a colleagues) I have a duty to inform to your manager.

It is important that you know that there will be no disadvantage or penalties if you chose not to be involved in the study.

Do you have any questions or concerns about any of this?

I first need to know:

Your position? Title? Service?

And a brief description of your duties? How long have you performed that role?

Family Focused Practices:

- Do you find out if your service user is a parent? Why or why not?
- What do you do, if anything, when you know a service user is a parent? Can you tell me more about that?
- How, if at all, do you decide to become involved with the children of parents who have mental illness (MI) or substance misuse? Can you tell me more about that and what your involvement entails?
- How, if at all, do you decide to become involved with other family members of parents who have MI or substance misuse? Can you tell me more about that and what your involvement entails?
- How do you think a parent's MI could impact on their parenting or substance misuse?
- How do you think being a parent could impact on a parent's MI or substance misuse?
- What is your role, if any, in supporting parents in these potentially negative interactions?
- How do you think a parent' MI or substance misuse could impact on other adult family members?
- What is your role, if any, in supporting adult family members?
- What do you understand by the term family focused practice?

Capacity of adult mental health professionals to engage in family focused practice?

- Do you think that the care you provide meets the needs of parents who have mental illness or substance misuse? The needs of their children and families? Can you tell me more about this?
- Are there needs of parents that are not being met that should be? And how could these needs be met?
- Are there needs of children that are not being met that should be? And how could these needs be met?
- Are there needs of adult family members that are not being met that should be? And how could these needs be met?
- What factors, if any, facilitate you in meeting the needs of parents who have mental illness or substance misuse? The needs of their children? The needs of families? Can you tell me more about this?
- What factors, if any hinder you in meeting the needs of parents who have mental illness or substance misuse? The needs of their children? The needs of their families? Can you tell me more about this?
    - Essential skills and knowledge required to engage in family focused practice (FFP)?
    - Confidence in addressing service user's parenting role?
    - Impact of service setting on engaging in FFP?
    - Impact of Think Family initiatives, including: Champion Model (Northern Trust), education regarding the Family Model (FM), refinement of assessment documentation in line with the FM and provision/use of A5 cards (all HSCT), Joint Protocol (all HSCT), UNOCINI appendix (all HSCT), family support hubs (all HSCT), educational resources for parents and children (all HSCT).

How may adult mental health professionals' capacity to support parents who have mental illness or substance misuse, their children and families be further developed?

- What might help you in working with parents who have mental illness or substance misuse? Their child(ren)? Other family members?
- On the basis of your experience, describe what competencies and behaviours are essential to enable adult mental health professionals to effectively support parents, who have mental illness or substance misuse, their children and families?
- What other knowledge or skills do adult mental health professionals need to work with parents who have mental illness or substance misuse, their children and families?
- How, if at all, may health and social care provision for parents who have mental illness or substance misuse, their children and families be further developed? Specific examples?

Closing questions

- Are there any topics which I did not address which you would have liked, or expected, me to have asked/discussed?
- Is there anything you would like to clarify for me?

Thank you for your time, I really appreciate your effort and energy. I will be in touch to give you the interview transcript. What is the best way to get this back to you? If you think the information is incorrect or might identify you, I would encourage you to change or delete this and ensure I get it back.

Appendix G. ***Social Care Professionals' Topic Guide***

Health and Social care professionals' practice with parents who have mental illness, their children and families in Northern Ireland

Preamble

Thank you for agreeing to participate in this interview.

I would like to digitally audio record this interview – please let me know if you are content with this. (If participant/s agree with digital audio recording and consent forms have been received, then switch the digital audio recorder on).

Good morning, my name is Anne Grant and I am a mental health nurse and lecturer in mental health in the school of Nursing and Midwifery in Queen's University, Belfast.

Thank you for agreeing to participate in this study, I appreciate your time in this.

The aim of the study is to explore your views on your practice with children whose parent(s) have mental illness or substance misuse, their parent who has mental illness and other family members.

I need to let you know that your participation in this research is entirely your choice and even though you are participating you can withdraw from the project at any time without giving a reason, and it's also entirely up to you whether you want to answer all of my questions. So if there is a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

Finally, all the data that I collect from you will be treated in a confidential manner, so I'll be removing all information that identifies you from the transcript, and you can check that yourself because you'll be receiving a copy of the transcript before I do any analysis on it. So you can make any changes to it. During the course of your interview should you disclose examples of unsafe practice (either your own or a colleagues) I have a duty to inform to your manager.

It is important that you know that there will be no disadvantage or penalties if you chose not to be involved in the study.

Do you have any questions or concerns about any of this?

I first need to know:

Your position? Title? Service?

And a brief description of your duties? How long have you performed that role?

Family Focused Practices:

- Do you find out if children using your service have a parent with mental illness (MI)? Why or why not?
- What do you do, if anything, when you know a child has a parent with MI? Can you tell me more about that?
- How, if at all, do you decide to become involved with parents who have MI? Can you tell me more about that and what your involvement entails?
- How, if at all, do you decide to become involved with other family members of children whose parent(s) have MI? Can you tell me more about that and what your involvement entails?
- How, if at all, do you think a parent's MI could impact on their parenting? And children?
- What is your role, if any, in supporting children and their parent(s) in these potentially negative interactions?
- How, if at all, do you think being a parent could impact on a parent's MI? What is your role, if any, in supporting children and their parents in these potentially negative interactions?
- What do you understand by the term family focused practice?

Capacity of social care professionals to engage in family focused practice?

- Do you think that the care you provide meets the needs of parents who have mental illness? The needs of their children and families? Can you tell me more about this?
- Are there needs of children who have parents with mental illness that are not being met that should be? And how could these needs be met?
- Are there needs of parents who have mental illness and other adult family members that are not being met that should be? And how could these needs be met?
- What factors, if any, facilitate you in meeting the needs of children with parents who have mental illness? The needs of their parents? The needs of families? Can you tell me more about this?
- What factors, if any, hinder you in meeting the needs of children with parents who have mental illness? The needs of their parents? The needs of families? Can you tell me more about this?
    - Essential skills and knowledge required to engage in family focused practice (FFP)?
    - Confidence in addressing needs of children whose parent(s) have mental illness?
    - Confidence in addressing parenting role and impact of mental illness on parenting?
    - Impact of service setting on engaging in FFP?
    - Impact of Think Family initiatives, including: Champion Model (Northern Trust), education regarding the Family Model (FM), refinement of assessment documentation in line with the FM and provision/use of A5 cards (all HSCT), Joint Protocol (all HSCT), UNOCINI appendix (all HSCT), family support hubs (all HSCT), educational resources for parents and children (all HSCT).

How may social care professionals' capacity to support children whose parent(s) have mental illness, their parents and other family members be further developed?

- What might help you in working with parents who have mental illness? Their child(ren)? Other family members?

- On the basis of your experience, describe what competencies and behaviours are essential to enable social care professionals to effectively support parents, who have mental illness, their children and families?
- What other knowledge or skills do social care professionals need to work with parents who have mental illness, their children and families?
- How, if at all, may health and social care provision for parents who have mental illness, their children and families be further developed? Specific examples?

Closing questions

- Are there any topics which I did not address which you would have liked, or expected, me to have asked/discussed?
- Is there anything you would like to clarify for me?

Thank you for your time, I really appreciate your effort and energy. I will be in touch to give you the interview transcript. What is the best way to get this back to you? If you think the information is incorrect or might identify you, I would encourage you to change or delete this and ensure I get it back.

Appendix H. ***Service User Topic Guide*** - Note: *This Topic guide varied slightly if parents where only availing of adult services or only children services.*

Topic Guide – Parents who have mental health issues and who are using both Adult Mental Health and Children's Services

Health and Social care professionals' practice with parents who have mental health issues, their children and families in Northern Ireland

Thank you for agreeing to participate in this interview.

Would you mind if I digitally audio record this interview – please let me know if you are content with this. (If participant/s agree with digital audio recording and consent forms have been received, then switch the digital audio recorder on).

Good morning, my name is Anne Grant and I am a registered mental health nurse and lecturer in Mental Health in the school of Nursing and Midwifery in Queens University, Belfast.

Thank you for agreeing to participate in this study, I appreciate your time in this.

The aim of the research is to explore your views on the services you receive from adult mental health and children's services and particularly whether and how these services meet your needs and that of your children and family.

I need to let you know that your participation in this research is entirely your choice and even though you are taking part you can withdraw from the project at any time without giving a

reason, and it's also entirely up to you whether you want to answer all of my questions. So if there is a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

Finally, all the information that I collect from you will be treated in a confidential manner, so I'll be removing anything that identifies you from the written recording, and you can check that yourself because you'll be receiving a copy of the transcript before I do any analysis on it. So you can make any changes to it.

During the course of your interview should you disclose examples of unsafe practice I have a duty to inform your service provider manager (e.g. professional misconduct, unprofessional behaviour, etc.)

It is important that you know that there will be no disadvantage or penalties if you chose not to be involved in the study.

Do you have any questions or concerns about any of this?

Interviewer should check with the parent that they are in a good/stable place to answer questions and are not feeling vulnerable.

I first need to know:

How long have you been using adult mental health services? And children's services? And a brief description of why you are using both services?

Needs of service users and/or their families:

- How, if at all, do you think your mental health issues could impact on your parenting skills? and your children? How, if at all, do you think being a parent could impact on your mental health?
- How, if at all, may health and social care professionals support you and your children?
- How, if at all, do you think your mental health could impact on adult family members?
- What role, if any, should health and social care professionals play in supporting your adult family members?

Capacity of health and social care professionals to engage in family focused practice?

- Do you think that the care provided by health and social care professionals meets (a) your needs as a parent who has mental health issues, (b) the needs of your children, and (c) the needs of your other adult family members? Can you tell me more about this from your experience of using both services?
- Do your children have needs that should be met by adult mental health services that aren't at present? What are they? How could these be met?
- Do your children have needs that should be met by children's services that aren't at present? What are they? How could these be met?
- Are the needs of your adult family members being met? If not, how do you feel mental health services could help with this?
- What is the impact, if any, on you/and your family of being able to talk to professionals in both adult mental health services?
- What is the impact, if any, on you/and your family of being able to talk to professionals in children's services?
- What factors hinder health and social care professionals in meeting your needs as a parent with mental health issues, the needs of your children and needs of other adult family members? Can you tell me more about this?
- What factors enable health and social care professionals in meeting your needs as a parent with mental health issues, the needs of your children and needs of other adult family members? Can you tell me more about this?

How may health and social care professionals' capacity to support parents who have mental health issues, their children and families be further developed?

- What might help health and social care professionals in working with parents who have mental health issues? Their child(ren)? Other family members?
- On the basis of your experience of receiving adult mental health and children's services what knowledge, skills and behaviours do health and social care professionals need to be able to effectively support you and your family?
- What other knowledge or skills do health and social care professionals need to work with parents who have mental health issues, their children and families?
- How, if at all, may health and social care services for children who have a parent with MI, their parent (s) and families be further developed? Specific examples?

Closing questions

- Are there any topics which I did not address which you would have liked, or expected, me to have asked/discussed?
- Is there anything else you would like to ask me?

Thank you for your time, effort and energy. I really appreciate it. What is the best way for me to send you a copy of the written questions and answers? If you think the information is incorrect or might identify you, I would encourage you to change or delete this and ensure I get it back.

Quantitative Survey Findings: Additional Tables

Appendix I: ***Correlations between Family Focused and Associated Demographic Variables***

Pearson's Product –Moment Correlations between Family Focused and Associated Demographic Variables

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1.	Assessing the Impact on the Child (DV)																						
2.	Family & Parenting Support (DV)	.233**																					
3.	Support to Carers & Children (DV)	.181**	.424**																				
4.	Connectedness (DV)	.443**	.272**	.348**																			
5.	Referrals (DV)	.262**	.406**	.320**	.284**																		
6.	Interventions To Promote Parents Mental Health (IV)	.182**	.227**	.276**	.380**	.149**																	
7.	Workplace Support (IV)	.117**	.271**	.271**	.144**	.256**	.121**																
8.	Time and Workload (IV)	.160**	.262**	.419**	.151**	.242**	.059	.265**															
9.	Professional Development (IV)	.090**	.264**	.317**	.130**	.227**	.117**	.560**	.318**														
10.	Co-Worker Support (IV)	.048	.322**	.219**	.173**	.139**	.145**	.461**	.199**	.444**													
11.	Training (IV)	.070*	.018	-.037	.073*	.087*	-.026	-.155**	-.057	-.154**	-.091**												
12.	Skills & Knowledge (IV)	.421**	.320**	.442**	.525**	.328**	.459**	.211**	.229**	.208**	.151**	-.092**											
13.	Worker Confidence (IV)	.302**	.196**	.350**	.320**	.274**	.161**	.154**	.199**	.226**	.050	-.076*	.507**										
14.	Confidence around Children Generally (IV)	.025	.009	.034	.085*	.053	.096**	.037	.036	-.027	.050	.015	.115**	.109**									
15.	Gender (IV)	.102**	.041	.009	.078*	.012	.067*	.042	.024	-.003	.008	-.024	.073*	.022	.045								
16.	Age (IV)	-.067*	.082*	.041	.064	-.057	.120**	-.035	.062	.058	.016	-.181**	.061	.002	.022	.035							
17.	Family-Focused Training (IV)	-.102**	-.147**	-.120**	-.138**	-.105**	-.111**	-.148**	-.095**	-.150**	-.102**	.063	-.258**	-.152**	-.002	.008	-.133**						
18.	Child-Focused Training (IV)	-.107**	-.002	-.035	-.068*	-.061	.049	-.057	-.051	-.072*	-.062	-.008	-.144**	-.131**	-.018	-.047	.054	.396**					
19.	Think Family Focused Training (IV)	-.071*	-.122**	-.088*	-.108**	-.078*	-.113**	-.157**	-.051	-.223**	-.092**	.099**	-.172**	-.115**	.025	-.051	-.161**	.389**	.208**				
20.	Adult Mental Health Training (IV)	-.231**	-.124**	-.090*	-.182**	-.207**	.004	-.078	-.141**	-.067	-.114**	-.108**	-.226**	-.244**	-.036	-.022	.015	.277**	.286**	.184**			
21.	Length of Experience (IV)	-.129**	.045	.063	.015	-.087*	.106**	-.021	.072*	.037	.058	-.209**	.035	-.042	.025	-.004	.810**	-.079*	.125**	-.148**	.049		
22.	Length of Time in Current Position (IV)	-.016	.057	.000	.059	-.043	.090	-.088	.021	-.036	-.037	-.070	.096	-.039	-.001	-.026	.514	-.038	.035	-.110	-.015	.576	
23.	Screening and Assessment Documentation Facilitate FFP	-.064	-.057	-.124**	-.106**	-.126**	-.054	-.135**	-.094*	-.056	-.094*	-.054	-.096*	-.061	-.068	-.039	.112**	.016	.050	.026	.074	.100**	.101**

****. Correlation is significant at the 0.01 level (2-tailed), *. Correlation is significant at the 0.05 level (2-tailed).**

Appendix J. ***Breakdown of the Survey Related Study Sample by Trust, Discipline and Service Area where Known***

Table 3.3

Breakdown of the study sample by Trust, Discipline and Service Area Where Known

Trust	Acute In-Pt MH & Addiction Services N	Crisis Resolution Home Treatment N	Community Addictions Team N	Community MH Team N	Single Point of Access N	FIT N	16+ N	Gateway N	Specialist Mental Health Service or Other
Belfast Trust									
Nursing	14	2	5	25	1	0	0	0	16
Social Work	3	0	0	20	0	56	16	20	23
(Missing = 2)									
Psychiatrist	1	0	0	2	0	0	0	0	3
Psychologist	0	0	0	0	0	0	0	0	1
Allied Health Professional	0	0	0	5	0	0	0	0	3
Other	0	0	0	1	0	0	0	0	7
(Missing = 1)									
TOTAL	**18**	**2**	**5**	**53**	**1**	**56**	**16**	**20**	**53**
South East Trust									
Nursing	22	12	9	30	1	0	0	0	6
Social Work	2	4	3	14	1	17	5	3	11
(Missing = 1)									
Psychiatrist	3	1	0	2	0	0	0	0	1
Psychologist	0	0	0	0	0	0	0	0	2
Allied Health Professional	2	1	0	1	1	0	1	0	6
(Missing = 1)									
Other	0	0	0	0	0	0	0	0	1
TOTAL	**29**	**18**	**12**	**47**	**3**	**17**	**6**	**3**	**27**
Western Trust									
Nursing	9	3	10	16	0	0	0	0	2
(Missing = 2)									
Social Work	1	1	3	14	0	39	8	21	20

(Missing = 3)									
Psychiatrist	2	1	0	3	0	0	0	0	1
Psychologist	0	0	0	0	0	0	0	0	2
(Missing = 1)									
Allied Health Professional	1	0	0	2	0	0	0	0	0
Other	0	0	1	0	0	0	0	0	1
TOTAL	**13**	**5**	**14**	**35**	**0**	**39**	**8**	**21**	**26**
Southern Trust									
Nursing	11	8	14	30	1	0	0	0	8
(Missing = 8)									
Social Work	0	1	2	14	2	15	6	15	1
(Missing = 4)									
Psychiatrist	1	1	1	1	0	0	0	0	0
Psychologist	1	0	0	0	0	0	0	0	1
Allied Health Professional	2	0	3	7	0	0	0	0	1
(Missing = 1)									
Other	0	0	0	0	0	0	0	0	0
TOTAL	**15**	**10**	**20**	**52**	**3**	**15**	**6**	**15**	**11**
Northern Trust									
Nursing	0	1	2	20	0	0	0	0	5
Social Work	5	2	3	23	1	30	10	22	3
(Missing = 3)									
Psychiatrist	1	0	0	7	0	0	0	0	1
Psychologist	0	0	0	0	0	0	0	0	4
Allied Health Professional	0	0	0	5	0	0	0	0	*2*
Other	0	0	0	1	0	0	0	0	*0*
TOTAL	**6**	**3**	**5**	**56**	**1**	**30**	**10**	**22**	***15***

Appendix K. ***Overview of Adult Mental Health and Children Service Professional's Education and Training***

Table 4.1

Overview of Adult Mental Health Professional's Education and Training

Professional Discipline	Yes Family Focused Training	Yes Child Focused Training	Yes Think Family Focused Training
Nurses	*n* = 81	*n* = 67	*n* = 55
(Missing n = 13)	(29.1%)	(24.1%)	(19.8%)
Social Workers	*n* = 53	*n* = 62	*n* = 38
(Missing n = 6)	(42.7%)	(50%)	(30.6%)
Psychiatrist	*n* =15	*n* = 16	*n* = 9
(Missing n = 1)	(45.5%)	(48.5%)	(27.3%)
Psychologists	*n* = 7	*n* = 6	*n* = 2
	(77.8%)	(66.7%)	(22.2%)
Allied Health Professionals	*n* = 10	*n* = 11	*n* = 5
(Missing n = 3)	(25%)	(27.5%)	(12.5%)
Other	*n* = 3	*n* = 2	*n* = 1
	(33.3%)	(22.2%)	(11.1%)

(% within Professional Discipline)

Table 4.2

Overview of Children's Services Professional's Training

Professional Discipline	Yes Family Focused Training	Yes Child Focused Training	Yes Think Family Focused Training	Adult Mental Health Training
Nurses	*n* = 2 (100%)	*n* = 2 (100%)	*n* = 2 (100%)	*n* = 1 (50%)
Social Workers *(Missing = 4)*	*n* = 138 (44.2%)	*n* = 171 (54.8%)	*n* = 63 (20.2%)	*n* = 169 (54.1%)
Allied Health Professionals	*n* = 0 (0%)	*n* = 0 (0%)	*n* = 0 (0%)	*n* = 1 (100%)
Other	*n* = 1 (100%)	*n* = 0 (0%)	*n* = 0 (0%)	*n* = 1 (100%)

(% within Professional Discipline)

Appendix L. ***Extent of HSC Professionals' Involvement with Parents and their Children***

Table 4.4

How Long on Average Would a Service User be Involved with a Particular Service?

	Acute In-Pt MH & Addiction Services	**Crisis Resolution Home Treatment**	**Community Addictions Team**	**Community MH Team**	**FIT**	**Single Point of Access**	**16+**	**Gateway**	**Specialist MH Service or Other**
Less than a week	*n* = 2	*n* = 2	*n* = 0	*n* = 2	*n* = 0	*n* = 3	*n* = 0	*n* = 0	*n* = 8
Between 1 -4 weeks	*n* = 32	*n* = 25	*n* = 6	*n* = 3	*n* = 0	*n* = 3	*n* = 0	*n* = 80	*n* = 15
Up to six months	*n* = 34	*n* = 10	*n* = 29	*n* = 52	*n* = 13	*n* = 2	*n* = 0	*n* = 1	*n* = 36
More than six months	*n* = 13	*n* = 1	*n* = 21	*n* = 184	*n* = 144	*n* = 0	*n* = 45	*n* = 0	*n* = 73

(Note: n = 839, Missing = 29)

Appendix M. ***Extent of Professionals' Exposure to Parents who have Mental Illness and their Children by Service***

Table 4.3

Extent of Professional's Exposure to Parents who have Mental Illness and their Children by Service

Variable	Acute In-Pt MH & Addiction Services	Crisis Resolution Home Treatment	Community Addictions Teams	FIT	Community MH Teams	Single Point of Access	16+	Gateway	Specialist MH Service or Other
Currently provide services to parents who have mental illness and or their dependent children *(n = 721, Missing = 147)*									
Yes	*n* = 39 (48.1%)	*n* = 32 (84.2%)	*n* = 33 (58.9%)	*n* = 106 (67.5%)	*n* = 190 (78.2%)	*n* = 6 (75%)	*n* = 22 (47.8%)	*n* = 57 (70.4%)	*n* = 70 (53%)
No	*n* = 24 (29.6%)	*n* = 2 (5.3%)	*n* = 11 (19.6%)	*n* = 22 (14%)	*n* = 30 (12.3%)	*n* = 1 (12.5%)	*n* = 12 (26.1%)	*n* = 14 (17.3%)	*n* = 16 (12.1%)
Not Sure	*n* = 4 (5%)	*n* = 1 (2.6%)	*n* = 3 (5.4%)	*n* = 8 (5.1%)	*n* = 5 (2.1%)	*n* = 0 (12.5%)	*n* = 2 (4.3%)	*n* = 2 (2.5%)	*n* = 9 (6.8%)
Missing	*n* = 14 (17.3%)	*n* = 3 (7.9%)	*n* = 9 (16.1%)	*n* = 21 (13.4%)	*n* = 18 (7.4%)	*n* = 1 (0%)	*n* = 10 (21.7%)	*n* =8 (9.9%)	*n* = 37 (28%)
Previous experience providing service to parents who have mental illness and or their children *(n =, 719 Missing = 149)*									
Yes	*n* = 47 (58%)	*n* = 29 (76.3%)	*n* = 34 (60.7%)	*n* = 109 (69.4%)	*n* = 197 (81%)	*n* = 7 (87.5%)	*n* = 26 (56.5%)	*n* = 61 (75.3%)	*n* = 85 (64.4%)
No	*n* =16 (19.8%)	*n* = 4 (10.5%)	*n* = 10 (18%)	*n* = 21 (13.4%)	*n* = 25 (10.2%)	*n* = 0 (0%)	*n* = 9 (19.5%)	*n* = 9 (11.2%)	*n* = 9 (6.8%)
Not Sure	*n* =5 (6.2%)	*n* = 2 (5.2%)	*n* = 3 (5.3%)	*n* = 4 (2.6%)	*n* = 2 (0.8%)	*n* = 0 (0%)	*n* = 1 (2.2%)	*n* = 1 (1.2%)	*n* = 1 (0.8%)
Missing	*n* = 13 (16%)	*n* = 3 (8%)	*n* = 9 (16%)	*n* = 23 (14.6%)	*n* = 19 (8%)	*n* = 1 (12.5%)	*n* = 10 (21.8%)	*n* = 10 (12.3%)	*n* = 37 (28%)
How regularly do you provide services to parents who have mental illness or their dependent children *(n = 714, Missing =154)*									
Daily	*n* = 38 (46.9%)	*n* = 25 (65.8%)	*n* = 22 (39.3%)	*n* = 32 (20.4%)	*n* = 100 (41.2%)	*n* = 3 (37.5%)	*n* = 9 (19.6%)	*n* = 15 (18.5%)	*n* = 28 (21.2%)
Weekly	*n* = 8 (9.9%)	*n* = 5 (13.2%)	*n* = 17 (30.4%)	*n* = 57 (36.3%)	*n* = 60 (24.7%)	*n* = 2 (25%)	*n* = 12 (26.1%)	*n* = 26 (32.1%)	*n* = 31 (23.5%)

Monthly	*n* = 4 (4.9%)	*n* = 2 (5.3%)	*n* = 1 (1.8%)	*n* = 26 (16.6%)	*n* = 41 (16.9%)	*n* = 0 (00%)	*n* = 9 (19.6%)	*n* = 19 (23.5%)	*n* = 8 (6.1%)
Few times a Year	*n* = 10 (12.3%)	*n* = 2 (5.3%)	*n* = 1 (1.8%)	*n* = 10 (6.4%)	*n* = 11 (4.5%)	*n* = 1 (12.5%)	*n* = 2 (4.3%)	*n* = 3 (3.7%)	*n* = 15 (11.4%)
Never	*n* = 7 (8.6%)	*n* = 0 (0%)	*n* = 6 (10.7%)	*n* = 8 (5.1%)	*n* = 12 (4.9%)	*n* = 1 (12.5%)	*n* = 4 (8.7%)	*n* = 9 (11.1%)	*n* = 12 (9.1%)
Missing	*n* = 14 (17.3%)	*n* = 4 (10.5%)	*n* = 9 (16.1%)	*n* = 24 (15.3%)	*n* = 19 (7.8%)	*n* = 1 (12.5%)	*n* = 10 (21.7%)	*n* = 9 (11.1%)	*n* = 38 (28.8%)
Last week discuss issues relating to parenting with parents who have mental illness *(n = 667, Missing = 201)*									
Yes	*n* = 29 (35.8%)	*n* =14 (36.8%)	*n* = 28 (50%)	*n* = 94 (59.9%)	*n* = 139 (57.2%)	*n* = 3 (37.5%)	*n* = 16 (34.8%)	*n* = 53 (65.4%)	*n* = 51 (38.6%)
No	*n* = 31 (38.3%)	*n* = 21 (55.3%)	*n* = 12 (21.4%)	*n* = 33 (21%)	*n* = 79 (32.5%)	*n* = 3 (37.5%)	*n* = 16 (34.8%)	*n* = 12 (14.8%)	*n* = 33 (25%)
Missing	*n* = 21 (25.9%)	*n* = 3 (7.9%)	*n* = 16 (28.6%)	*n* = 30 (19%)	*n* = 25 (10.3%)	*n* = 2 (25%)	*n* = 14 (30.4%)	*n* = 16 (19.8%)	*n* =48 (36.4%)
Past week face-to-face contact with a child(ren) whose parent has mental illness *(n = 718, Missing = 150)*									
Yes	*n* = 7 (8.6%)	*n* = 6 (15.8%)	*n* = 6 (10.7%)	*n* = 88 (56.1%)	*n* = 42 (17.3%)	*n* = 1 (12.5%)	*n* = 24 (52.2%)	*n* = 38 (46.9%)	*n* = 21 (15.9%)
No	*n* = 60 (74.1%)	*n* = 29 (76.3%)	*n* = 41 (73.2%)	*n* = 47 (29.9%)	*n* = 182 (74.9%)	*n* = 6 (75%)	*n* = 11 (23.9%)	*n* = 35 (43.2%)	*n* = 74 (56.1%)
Missing	*n* = 14 (17.3%)	*n* = 3 (7.9%)	*n* = 9 (16.1%)	*n* = 22 (14%)	*n* = 19 (7.8%)	*n* = 1 (12.5%)	*n* = 11 (23.9%)	*n* = 73 (9.9%)	*n* = 37 (28%)
Past week face-to-face contact with a Child(ren) did you discuss their parents mental illness *(n = 268, Missing = 600)*									
Yes	*n* = 4 (4.9%)	*n* = 1 (2.6%)	*n* = 3 (5.4%)	*n* = 57 (36.3%)	*n* = 17 (7%)	*n* = 0 (0%)	*n* = 12 (26.1%)	*n* = 23 (28.5%)	*n* = 14 (10.6%)
No	*n* = 11 (13.6%)	*n* = 8 (21.1%)	*n* = 5 (8.9%)	*n* = 32 (20.4%)	*n* = 38 (15.6%)	*n* = 1 (12.5%)	*n* = 14 (30.4%)	*n* = 15 (18.5%)	*n* = 13 (9.8%)
Missing	*n* = 66 (81.5%)	*n* = 29 (76.3%)	*n* = 48 (85.7%)	*n* = 68 (43.3%)	*n* = 188 (77.4%)	*n* = 7 (87.5%)	*n* = 20 (53.5%)	*n* = 8 (9.9%)	*n* = 105 (79.5%)

(% within Service were Known)

Appendix N. ***HSC Professionals' Awareness of Current Screening and Assessment Tools***

Table 4.23

Screening and Assessment Tools Facilitate Professionals' FFP

Professional Discipline	Yes Screening & Assessment Documentation Facilitates Addressing Needs of Parents & Children	No Screening & Assessment Documentation does not Facilitates Addressing Needs of Parents & Children
Nurses	*n* = 175	*n* = 65
(Missing n = 53)	(59.72%)	(22.1%)
Social Workers	*n* = 304	*n* = 91
(Missing n =78)	(64.3%)	(19.2%)
Psychiatrist	*n* = 16	*n* = 5
(Missing n =12)	(48.5%)	(15.2%)
Psychologist	*n* = 5	*n* = 2
(Missing n =5)	(41.7%)	(16.6%)
Allied Health Professionals *(Missing n =6)*	*n* = 26 (13.6%)	*n* = 12 (27.3%)
Other	*n* = 9	*n* = 0
(Missing n =4)	(69.2%)	(0%)

% within Professional Discipline were Known

Appendix O. Systematic Review of the literature: Methodology

The systematic review focuses on primary research reporting the outcomes of adult mental health, substance misuse and children's services to the needs of families in which parent/s have needs related to mental health problems and/or or substance misuse. This includes responses to the parents, children and family carers but, to be included, the intervention had to be focused on the family (at least one parent and child). In other words it could be provided to only one person but the intervention had to address the needs of at least both a parent and a child. The PRISMA Statement (Liberati et al., 2009) is to be used as a guideline for reporting the review findings.

Note: It is important to acknowledge from the start that, although this review provides a relatively broad scope by exploring parental mental health and substance misuse problems across both child welfare and adult mental health services, it does not consider other important factors, perhaps most obviously, domestic violence. Nonetheless, although not comprehensive the issues in this review are still of vital importance.

Types of included studies

Any controlled study (RCTs and quasi-randomised, quasi-experimental and controlled observational studies), Cross-sectional and observational studies, Qualitative studies that explored the acceptability and impact of intervention, and any study that asked for participant views.

Definition of study design

Randomized Controlled Trial: Individuals followed in the trial are *actively assigned* to one of two (or more) alternative forms of intervention or health care, using an entirely random method of allocation (such as computer random number generator).

Quasi-Randomised Trial: Individuals followed in the trial are *actively assigned* to one of two (or more) alternative forms of intervention or health care, using a quasi-random method of allocation (such as alternation, date of birth, or case record number)

Quasi-experimental Study: Individuals followed in the study are *actively assigned* to one of two (or more) alternative forms of intervention or health care, using a non-random method of allocation (such as assignment based on experimenter's choice).

Controlled Observational Study: Individuals followed in the study are receiving one of two (or more) alternative forms of intervention or health care. However, they are *not actively assigned* to the alternative forms of intervention or health care. The control group is likely to comprise those who were not offered the intervention, or who refused to participate in the intervention.

Uncontrolled Study: All Individuals followed in the study are given the *same treatment* or health care, and simply followed for a period of time to see if they improve, with no comparison against another group (control group) that is either taking another treatment or no treatment at all.

Where no controlled effectiveness studies are identified, other study designs will be considered for the purposes of informing the development of future research. Finally, case studies, descriptive studies, editorials, opinion papers, evaluations of pharmacological or physical interventions will be included if of particular relevance.

Acceptability

For this part of the review, studies that asked participants for their views were included, irrespective of study design or data type. Any studies that provided quantitative data on non-participation, withdrawal and adherence rates were included as part of the effectiveness synthesis. We imposed no restrictions on design for this synthesis as long as the study was about family-focused interventions for treating the consequences of parental mental health problems and/or substance misuse.

Types of participants

Parents who have mental health problems or substance misuse, their children, families and adult family members in receipt of adult mental health and children's services.

Intervention

Family-focused practice, in any setting, for parents with mental health problems and/or substance misuse and their children and family members. The intervention has to be specifically family focused so general interventions for mental health problems and substance misuse are not be included unless they have a family focused aspect to them. Studies comparing interventions with no-treatment arms, waitlist-control groups, 'treatment as usual' and 'other active treatment controls' are included.

Types of outcome measure

To be included studies must report the outcome of the interventions. These include:

Primary: Psychological distress/mental health (depression and anxiety, psychosis, self-harm); depression; social functioning including parenting, attachment and relationships with family and others; substance misuse; treatment adherence

Secondary: acceptability; quality of life; child welfare interventions; hospital admissions

Publication types

For practical and resource reasons the review searches were limited to English and to studies from 1998, the year in which Falkov's Family Model was introduced.

Search methods for identification of studies

Electronic Searches

Studies were identified by searching the following databases

1. Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and 1946 to current.
2. Embase (Ovid), 1974 to current.
3. CINAHL PsycINFO, 1806 to current.
4. Science Citation Index (Web of Science)
5. Social Sciences Citation Index (Web of Science)
6. ERIC (EBSCOhost), 1966 to current
7. Cochrane Central Database of Controlled Trials (CENTRAL)
8. Cochrane Database of Systematic Reviews
9. Database of Reviews of Effectiveness (DARE)
10. Health Management Information Consortium
11. Database of Promoting Health Effectiveness Reviews
12. Trials Register of Promoting Health Interventions
13. Campbell Library of Systematic Reviews
14. International Clinical Trials Registry Platform (ICTRP)
15. ClinicalTrials.gov
16. UK Clinical Research Network Study Portfolio

Searching other resources

Grey literature was also searched including unpublished sources and reports via OpenGrey, searching in the internet (using Google and Google Scholar) and browsing the websites of relevant UK government departments and charities (Mental Health Foundation, Barnardo's, NSPCC, Action for Children, Childline, Depression Alliance, MIND, Anxiety UK, NSPCC, SANE, Turning Point, Ascert, Children of Parents with Mental illness, Praxis, Northern Ireland Association for Mental Health). These sites were searched using a selection and combination of search terms as appropriate. Reference lists of studies that met the inclusion criteria were also checked. Finally, experts in the field were contacted to obtain additional studies.

Electronic searching – Key Terms

A number of search terms were incorporated into the search strategy in order to maximise the inclusion of studies in the review. This included terms were devised to capture the Population (Mental disorders, substance-related disorders, family, alcoholics, drug users, child of impaired parents, adult children, dual diagnosis (Psychiatry), child, parents), the Intervention (Mental health services, Child welfare services) and study design (all designs were included but their quality assessed). Electronic databases medical subject headings (MeSH) were also utilised during searches.

Search Strategies*:*

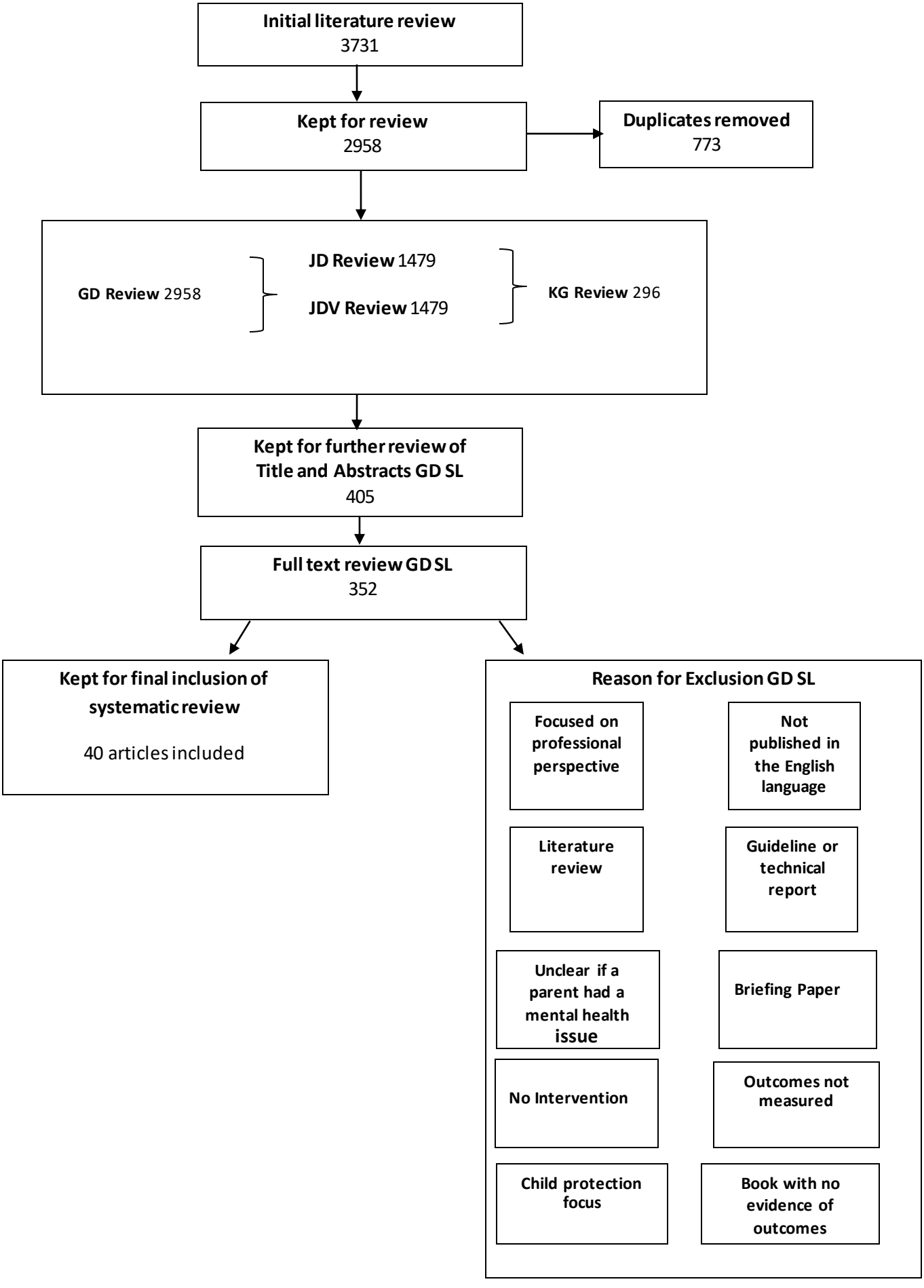
The general strategy was mental health problems/illness and/or substance abuse/misuse AND parental AND intervention - with the possible variations for each
So, for example, for mental health problems/illness: ((Mental* or Psychiatri*) AND (Health* or Ill* or Disorder* or problem*))

For substance abuse/misuse: (drug* or polydrug* or substanc* or alcoh* or *tranquiliz* or *narcot* or * abus* or *opiat* or *street drug* or *solvent* or *inhalan* or *intoxi*)
For parental: (parent* or mother* or father* or carer* or care-giv* or caregiv* or care giv* or guardian*)
For interventions: (train* or educat* or promot* or program* or skill* or group* or support* or teach* or learn* or interven* or therap*)

Systematic Data Synthesise:

Using the search terms as previously described, the initial search for literature yielded >3700 articles. All article references were transferred to EPPI Reviewer 4 which is a web based management software system, here duplicates were removed. Article titles were screened for eligibility using the inclusion and exclusion criteria by reviewer GD with most relevant articles retained for abstract review. Two further reviewers (JD & JDV) assessed 50% each of the article titles and abstracts retained in EPPI to ensure reliability of assessment, with a further random 10% sample of all articles assessed by reviewer KG. After initial review of relevance and agreement by all reviewers on inclusion, 405 articles were retained for further assessment of titles and abstracts. A further 53 articles were removed based on second observations. When article abstracts provided insufficient information, full text was obtained if possible for further consideration. 352 articles were retained for full text review by reviewers GD and SL. Based on eligibility criteria 64 full text articles were assessed for quality appraisal using criteria adopted from the critical appraisals skills programme (CASP, 2012). After final review of full text articles, 40 studies were included for the systematic literature review. See Figure 1.1 for overview of review process and final included articles. Extracted data included information relating to the author reference and publication date, sample population, study setting and design, intervention type and summary of main findings.

Figure 1.1: *Overview of Review Process and Final Included Articles*



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