Research proposal

Registered Psychiatric Nurse's practice with mentally ill parents and their children/families within general adult mental health services in Ireland

Candidate

Anne Grant
Faculty of Medicine, Nursing and Health Sciences
Monash University
Student ID: 23445432

Supervisors – Dr Darryl Maybery and Dr Andrea Reupert

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Abstract

Up to fifty percent of mental health service users may be parents (Howe *et al*., 2009). A parent's mental illness may adversely affect their parenting capacity and stress from the parenting role can jeopardise their mental health (Royal College of Psychiatrists, 2012). Difficulties in parenting tend to occur at times of relapse and during the acute phase of the parent's mental illness and can adversely affect both the parent and their children/families' well-being on a temporary and on an ongoing basis (Gopfert *et al.*, 2004; Maybery & Reupert, 2009a). The ability of mental health professionals, including Registered Psychiatric Nurses (RPN), to respond to children and family issues, when the service user is a parent, is an important point of intervention for such families (Maybery & Reupert, 2008). However there is limited knowledge about RPN's family focused practice (FFP) with mentally ill parents and their children/families.

This national study will utilize a mixed methods approach to examine RPN's FFP. In the first phase the researcher utilized a clustered random sampling approach to access 600 RPNs in 12 mental health services in Ireland (practicing within acute admission units and community mental health services). Data was elicited using a workforce questionnaire designed to measure FFP, devised by Maybery *et al*., (2006, 2009a, 2012), and adapted for use in the Irish context. In the second phase, a subsample of RPNs from the quantitative sample, (n = 12 - 16), will be invited to expand upon the findings of the questionnaire. It is anticipated that this study will develop understanding of RPN's FFP with mentally ill parents and their children/families within general adult mental health services. The findings may be used as a starting point for future research in both the national and international context; with an ultimate aim of developing RPN's capacity to meet the needs of mentally ill parents and their children/families in this context.

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1 Introduction

The central aim of this research is to examine RPN's FFP, with mentally ill parents and their children/families, within general adult mental health services in Ireland, so as to develop an understanding of RPN's practice in this context. Section one provides background literature to highlight the prevalence of parental mental illness and its implications for both parents and their children/families. It concludes by noting the importance of mental health professionals intervening to support mentally ill parents and their children/families. Section two describes a framework – Falkov's Family Model (Falkov, 1998), which can be used by mental health professionals, including RPNs, to facilitate them to support mentally ill parents and their children/families within general adult mental health services. Section 3 outlines the Research design and methodology. Section 4 details ethical considerations. Finally, section 5 describes the approach that will be employed to disseminate the findings.

1.1 Background to the study

This sequential mixed methods study, the first of its kind in Ireland, will examine RPN's FFP with mentally ill parents and their children/families within general adult mental health services. This study is set against the background context of concerns and policy developments for the well-being of mentally ill parents and their children/families.

With the modernization of mental health services, in Ireland and elsewhere, individuals who are mentally ill are able to spend more time in the community and have greater opportunities to face normal developmental life tasks, including parenting (Diaz Caneja & Johnson, 2004). Epidemiological studies demonstrate that up to 23% of all families have, or have had, at least one parent with a mental illness (Maybery & Reupert, 2009). Moreover, number of service users of adult mental health services, who are parents has increased and it is estimated that between 25 and 50% of adults known to mental health services have children (Farrell *et al*., 1999). Although estimates of prevalence vary widely, even the

lowest of these rates would indicate that parenting is a substantial issue that needs to be addressed among adults with a mental illness (Mowbray *et al*., 2001; Oskouie *et al*., 2012).

Similar to other countries, in Ireland, only broad estimates can be made of the number of mentally ill parents and children affected by 'parental mental illness' as there is no Irish wide collection of data regarding people with parenting responsibilities who attend mental health services (Somers, 2007). In order to obtain approximate numbers of mentally ill parents and children in their care data on family characteristics and psychological distress/mental illness obtained from the most recent census (Central Statistics Office, 2006) and various reports were collapsed and from this figures were extrapolated to the percentage of adults in the general population who are/were mentally ill. Within the general population there are approximately 131 0012 (1.3) million parents in Ireland and approximately 157 201 of these parents will experience mental illness. The projected figures from the total population aged 18 years and over also suggest that:

- 10% of the population (n = 320,381) people will attend the general practitioner for mental health problems and 131, 001 of these people will be parents,
- 5% of the population (n = 160,190) people will attend outpatient clinics and 65, 500 of these people will be parents,
- 1.6% of the population (n = 51,261) will attend day centres and 20,960 of these people will be parents and,
- 0.6% of the population (n = 19,222) will use inpatient mental health facilities over a one year period and 7,860 of these people will be parents.

As the above figures were based on the general population, obtained from the Central Statistics Office, 2006 census and HRB (O Doherty *et al*., 2010), they provide only a rough estimate of percentage of mentally ill parents in Ireland and their use of health services for mental health issues in a given year. However from these statistics it is clear is that a significant number of people within Ireland are experiencing psychological distress and that a significant number are also parents of one or more children under the age of 18; approximately 41% of people who have mental illness are parents. Hence, approximately 124, 324 children in Ireland are likely to have one or more parents with a mental illness. These estimates are also likely to be conservative. These figures regarding prevalence of

parental mental illness and parent's use of mental health services provide a firm basis for RPNs addressing the needs of mentally ill parents and their children/families and for examining RPNs FFP in this context.

Although mentally ill parents value their parenting role and perceive that it promotes their recovery and integration within their communities (Gopfert *et al*., 2004), the literature also suggests that a substantial number experience varying degrees of difficulty in fulfilling their parenting responsibilities due to their mental illness (Maybery & Reupert, 2010; Gopfert *et al*., 2004). These difficulties in parenting tend to occur at times of relapse and during the acute phase of their mental illness and can adversely affect their own and their children's well-being on a temporary and on an ongoing basis (Murray *et al*., 2011; Gopfert *et al*.2004).

A parent's mental illness can adversely affect their child(rens') mental, physical and social well-being (Maybery & Reupert, 2011) and up to eighty percent of parents with enduring mental illness (EMI) may lose custody of one or more children on a temporary or permanent basis as a consequence (Joseph *et al*., 1999). Stress associated with parenting may also precipitate a relapse of the parent's mental illness or prevent or prolong their recovery (Gopfert *et al*., 2004). Parental mental illness may also lead to socio economic disadvantage and family discord and disorganisation (Beardslee *et al*., 1998); this further compounds difficulties in parenting with resultant adverse effects for the parent and their children/families. Consequently, families affected by parental mental illness are identified as among the most vulnerable in our community (Murray et al., 2011; Maybery & Reupert, 2011; Beardslee *et al*., 1998). In sum it has been stated that, "Parental mental illness therefore poses a very substantial public health challenge to many communities" (Gopfert *et al*., 2004, p.xiv).

Although it is indisputable that a parent's mental illness may have serious and often adverse effects on the child, this is often not reflected in clinical service provision (O Brien *et al*., 2011; Gopfert *et al*., 2004). However, mentally ill parents and their children/families are potentially an easily identifiable group that would be widely responsive to preventive interventions (Foster *et al*., 2012;

Beardslee *et al*., 2008; Onwuegbuzie 2004a, 2004b). Research has clearly and repeatedly demonstrated the benefits of family focused practice to the service user, as well as his or her children and other family members (Helja *et al*., 2012; Maybery & Reupert 2010a). As such, mental health professionals have a unique opportunity to alleviate suffering and prevent costly long-term social outcomes if they can identify and support mentally ill parents and their children/families early on.

Statutory services, such as adult mental health services, have the potential to support mentally ill parents in their parenting role as these services provide mental health care to parents when they are likely to encounter greatest difficulties in parenting such as during an acute exacerbation of their mental illness (Gopfert *et al*., 2004). Hence with mounting concerns regarding the well-being of mentally ill parents and their children/families, in Ireland and elsewhere, there is an ever increasing desire in policy and practice for mental health professionals, including RPNs, practicing within general adult mental health services, to engage in FFP.

However, there is limited knowledge about RPN's FFP with mentally ill parents and their children/families from an international perspective (Korhonen *et al*., 2010, 2009a; Davies, 2004, Thompson & Fudge, 2004), and an absence of research on this topic in the Irish context (see appendix 2 for outline of existing research).

Korhonen *et al*., (2008) contends that the parent's admittance to psychiatric care may be an opportunity for RPN's to discuss parenting issues and for the parent's usually unidentified children to become visible and accessible for intervention. This suggests that the topic of parental mental illness and mental health service response to this issue is of relevance to RPN's and that they do have a role to play in supporting mentally ill parents and their children/families. Registered Psychiatric Nurses practicing within adult community mental health services are particularly well placed to facilitate mentally ill parents and their children/families because they may spend a significant proportion of their time with service users within their home environment and have knowledge of the daily lives of parents (Slack & Webber, 2007; Davies, 2005; Gillam *et al*., 2005; Devlin & O Brien, 1999). Davies (2005)

suggests that working in a community setting with mentally ill low-income mothers and their children provides RPNs with an ideal forum to promote mental health of both mothers and their children by creating and enacting strategies that target the mother's mental illness and their children's development, enhancing the developmental and mental health trajectory of both. They are also often the first point of contact for mentally ill parents who are receiving services from adult mental health services and are often in the best position to provide the intensive home based supports required by mentally ill parents and their children/families (Foster *et al*., 2004; Handley *et al*., 2001; Devlin and O'Brien, 1999). Slack and Webber (2007) also noted that RPN's practicing within adult community mental health services have more opportunity to address services user's parenting roles than RPN's practicing within in patient settings. This is because the use of the case management approach or care co ordination approach in community mental health services allows RPNs to employ a broader social perspective/model of practice. Hence this enables RPNs to move beyond a purely medical focus and to address problems in the service user's wider social environment, such as their parenting role and family issues.

Devlin and O'Brien, (1999) were one of the first writers to contend that community psychiatric nurses have an opportunity to support mentally ill parents and their children/families because of the community based nature of their work. They argued that community psychiatric nurses can play an important role in advocating for parents and their children and in supporting the psychosocial environment in the family. They also indicated that community psychiatric nurses are well placed to progress support programs, given their opportunity to develop close and ongoing relationships with parents, their families and the wider community. As community psychiatric nurses care for mentally ill parents within their home environment it enables community psychiatric nurses to observe the parents interactions with their children and with other family members. Hence community psychiatric nurses have a relatively unique opportunity to directly assess the impact of the 'parental illness' upon children/families and to identify points for intervention. The opportunity that the community psychiatric nurse has to observe family functioning in the course of addressing the parent's mental

health needs, enables them to initiate and implement strategies that may prevent the onset of disorder in children and reduce the burden of the mental illness upon the family (Devlin and O'Brien, 1999). Devlin and O'Brien, (1999) conclude that although:

> It would be inappropriate to regard nurses as de facto child protection or family support workers, as they have neither the training, the resources nor the time to undertake the task effectively…they are in a unique position to assess families, identify problems and initiate timely intervention (Devlin and O'Brien, 1999).

The research exploring mental health professionals' perspectives of their FFP, with mentally ill parents and their children/families, (appendix 2) is primarily focused on identifying barriers that impede FFP (Korhonen *et al*., 2009; Maybery and Reupert, 2006). Hence there is a gap in knowledge about the actual process, behaviours and activities of RPN's FFP.

Although a limited body of research suggests that mental health professionals are beginning to address service users' parenting roles, to varying degrees, (Korhonen *et al*., 2009; Somers, 2007, Maybery & Reupert, 2006; Thompson & Fudge, 2005; Davies, 2004; Diaz-Caneja and Johnson, 2004; Bibou-Nakou, 2003; Gillam *et al*., 2003;Stanley e*t al*., 2003; Handley *et al*., 2001; Devlin and O'Brien, 1999), there is increasing evidence that mental health professionals experience varying degrees of difficulty in engaging in FFP (Maybery & Reupert 2009; Rutherford *et al*., 2009; Korhonen *et al*., 2009; Slack & Webber 2008; Maybery & Reupert 2006;Thompson &Fudge 2005; Davies 2004, Gillam *et al*., 2003; Byrne *et al*., 2001). This research therefore corroborates the perspectives of parents and children that barriers to FFP are generated by the mental health care system, by the mental health professionals working within the health system and by mentally ill parents and their children/families (Korhonen *et al*., 2008).

The recent recommendations within Irish mental health policy, A Vision for Change, (DoHC, 2006), regarding mentally ill parents and their children/families make it all the more imperative that the gap in knowledge surrounding RPN's FFP, with mentally ill parents and their children/families, be addressed. Whilst this study will have close parallels to the work in Australia (i.e. utilizing a

questionnaire devised in Australia by Maybery & Reupert 2006, 2010b, 2012) to benchmark RPN's FFP the questions posed in this study are unique and make important extensions to the recent research posed in Australia and Canada. This study will expand upon existing research by examining FFP in a more comprehensive manner, than has been done previously, and with different groups of RPNs, including those practicing within acute admission units and those practicing within 4 areas within community mental health services.

Obtaining benchmark data in the Irish context will also allow comparisons to be drawn between Ireland and Australia and provide a basis for future ongoing collaboration; with an ultimate aim of developing RPN's capacity to meet the needs of mentally ill parents and their children/families. The findings will result in recommendations which will be used to develop RPN's FFP with mentally ill parents and their children/families on a national basis. Information from this research can also be used to develop and advance policy and educational programmes with the ultimate aim of expanding health care professional's capacity to engage in FFP. Of greatest importance is that effectively identifying, supporting and intervening with the children and family members of those with a mental illness is a crucial way that the intergenerational transmission of mental illness can be reduced and/or prevented.

1.2 Aims of proposed research

The central aims of this study are to:

1. Benchmark RPN family focused practices, with mentally ill parents and their children/families, from the perspective of RPN's practicing within acute admission units and in four areas of community mental health services in Ireland.

2. Identify the significant predictors of RPN's Family Focused Practice.

3. Establish if there are differences between RPN's Family Focused Practice in acute admission units and RPN's Family Focused Practice in community mental health services.

4. Compare and contrast the survey findings obtained in Ireland with those of Maybery *et al*., (2009) in Australia.

5. Develop recommendations addressing the future development of RPN's family focused practice, with mentally ill parents and their children/families, within the context of education, policy, practice and research.

2 Overview of the Conceptual Model that informs this research

The Crossing Bridges Family Model, developed by Dr Adrian Falkov (1998), forms part of the theoretical underpinning of this research. The Family Model incorporates developmental, family, social and mental health domains which can be used to facilitate an exploration of the issues for families in which a parent experiences mental illness and to illuminate the range of parent-child-professional interactions (Falkov in Gopfert *et al*., 2004). Utilising six domains, the Family Model attempts to show how interaction between adult mental health issues, the child and parenting issues is complex and multidirectional (Goodman & Gotlib 1999).

The components of the Falkov model illustrate how the mental health and wellbeing of the children and adults in a family, where a parent is mentally ill, are intimately linked. Adult parental mental illness can adversely affect the development, mental health and in some cases the safety, of children (an adult/parent – to – child influence) (domain 1 → 2). Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers (a child- to – parent influence) (domain 2 → 1). Growing up with a mentally ill parent can have a negative influence on the quality of that person's adjustment in childhood and in adulthood, including their transition to parenthood (a childhood-to-adulthood lifespan and family influence) (1 → 3). Adverse circumstances (poverty, lone parenthood, social isolation, stigma) can negatively influence both adult/parent and child mental health and generate resilience (an environment – to – family influence).

Falkov has also recently adapted the model by developing two additional domains (A Falkov, personal communication, 23rd September, 2012). These include services for children and adults (domain 5) and cultural influences and broader social and community networks (domain 6). Domain 5 indicates that the quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members (a service – to – family influence). Domain 6 indicates that the above (five) principles and their interactive relationships all occur within a

broader social network encompassing cultural and community influences (a broader, more distal, environment – to –family influence).

It is evident that the interactions between various components in the Family Model are not simple or unidirectional. The way that the mental illness impacts on the parent may affect their parenting style, which in turn influences the child's behaviour and emotional response and this feeds back into how the parent parents. Similarly, the child's presentation (intelligence, behaviour, and personality) may affect the parent's style of interaction or parenting and the effectiveness or otherwise of this may in turn impact on the amount of stress the parent experiences and thus perhaps on their mental health.

The family situation becomes more complex again if more than one child is involved. Additionally, over time, the complexity and multi-directionality become more complex as the child's behaviour impacts on the parent's mental health, the parent's mental health impacts on his or her parenting and the parent's mental state and style of parenting affect the child's behaviour (Ruah Community Services, 2008). How these core domains interact and influence each other determines the quality of the individual's adjustment within his or her family, as well as the adequacy of the whole family's adaption to living with a mentally ill member (Falkov cited in Gopfert *et al*., 2004).

With regard to its use within the clinical context the Family Model has shown itself to be both durable over time, adaptable across service, agency and country settings and meaningful to practitioners of varied backgrounds, experience and training. In recent years it has also shown itself to be understandable and valued by families. The model forms the cornerstone of the Crossing Bridges training programme which has been utilised in various countries including Australia, Canada and the UK to inform and facilitate practitioners in various settings to engage in FFP. For example, the Crossing Bridges training materials aims to inculcate a family perspective in both adult mental health services and child welfare services in addition to promoting better understanding and FFP skills in staff working in these areas. Crossing Bridges also aims to encourage effective collaboration for the benefit

of mentally ill parents and their children/families and to raise awareness of how local organizational systems can work in order to develop co-ordinated services to meet the needs of family members (Falkov, 1998). The model forms the cornerstone of the New South Wales (NSW) Children of Parents with a mental illness (COPMI) implementation plan and the establishment of a 'minimum standards approach' in adult mental health services in NSW. In the UK, the approach by the Social Care Institute for Excellence (SCIE) "to parental mental health and child welfare has its basis in the Family Model" (SCIE, 2012:2).

As this is a new and exciting paradigm/area, the researcher deliberated over use of several frameworks, including Bronfenbrenner's (1979), Nicholson and Henry's (2003) and Hosman *et al.*, (2009), before selecting 'The Family Model' as the primary model to inform and underpin her research. This model is particularly appropriate as it considers both mentally ill parents and their children/families and highlights the link between parenthood and mental illness. It considers the needs of both children and parents through identifying the reciprocal relationship between a parent's mental illness and their children's wellbeing and children's needs and wellbeing and their parent's mental health. It also considers the role of general adult mental health services in supporting mentally ill parents and their children/families. Additionally, Falkov continues to refine and develop the model in response to its application in various practice contexts and the latest developments in the model are to be published in a family handbook in late 2012.

The Family Model also embodies principles underpinning other related models such as Bronfenbrenner's Ecologcal Theory (1979), Hosman *et al.*, (2009) Developmental Model of Transgenerational Transmission of Psychopathology and Nicholson and Henry's (2003) conceptual model of Parent-child Functioning and Potential Intervention Targets. These three models share similar components with that of the Family Model in that they address the impact of a child's immediate environment, including family environment and parenting, on their development. They also address the impact of children's wider environments including community and institutional supports, social

networks and professional care. However they do not explicitly address the impact of parenthood on parent's mental health. Hence, as the impact of parenthood and the parenting role on the service user's mental health is largely absent in the literature and as Falkov's Family Model is one of the few models that explicitly highlight this dimension it appears a particularly appropriate framework to guide this research.

3 Research design and study methodology

3.1 Research Design

As there is limited international research, and an absence of Irish studies exploring RPN's FFP with mentally ill parents and their children/families, a descriptive exploratory approach in conjunction with a sequential mixed methods design (explanatory, complementary, follow up design) is employed, to address the research aims and questions. A number of reasons are behind the selection of a mixed methods approach in this study, based on the nature of the research questions and on the writings of others in relation to the strengths of the mixed methods approach (Creswell & Plano Clark, 2007;), Creswell, 2007; Brewer & Hunter 2006; Giddings & Grant 2006; Johnson & Onwuegbuzie, 2004 & Onwuegbuzie & Leech, 2004).

As previously noted, In order to elicit quantitative data in the first phase of the study the researcher utilised a questionnaire which was originally developed in Australia by Mayberry *et al*., (2006, 2009b) and further refined by Maybery *et al*., (2012), for use with a range of mental health professionals working within adult mental health services. Surveys are a very traditional way of conducting research and are commonly used to collect quantitative data (Plano Clarke, 2007). Although questionnaires are occasionally described as being sterile and unimaginative they are particularly useful for non – experimental descriptive designs that seek to describe reality (Creswell & Plano Clarke, 2007). They are a very convenient way of collecting useful comparable data from a large number of individuals and in particular, certain types of factual, descriptive information, the hard evidence (Cresswell & Plano Clarke, 2007). For instance, questionnaires may be appropriate for identifying broad trends in a population (Creswell and Plano Clark 2007) and for acquiring information regarding the prevalence, distribution and interrelationships of variables within a population (Cresswell & Plano Clarke, 2007). Likewise, questionnaires are frequently used to collect information on attitudes and behaviour. The questionnaire is also a useful way to compare 2 or more groups in relation to the phenomena under

consideration, and in this case to determine what predicts RPN's FFP within different groups of RPNs. The questionnaire allows a systematic examination of relationship between independent variables (predictor variables) such as biographic data, work related characteristics and individual attributes and dependent variable – FFP behaviours, skills, activities, knowledge and attitudes.

However, attempting to isolate or measure caring in clinical practice by using a quantitative approach on its own ignores the complexity, reality and processes of caring in everyday practice. Given the limited ability of questionnaires to grapple with multi-faceted situations (Thompson & Fudge, 2005), follow up interviews will be used to expand upon and help to explain the information obtained in the questionnaires. Creswell and Plano Clark (2007:32) state that:

> When only one approach to research (quantitative or qualitative) is inadequate by itself to address the research problem, mixed methods research is the preferred design (Creswell & Plano Clark, 2007:32).

The mixed methods, sequential, explanatory, follow up design consists of two distinct phases: quantitative followed by qualitative (Creswell & Plano Clarke, 2007). In this design, a researcher first collects and analyses the quantitative data. The qualitative data are collected and analysed second in the sequence and help explain, or elaborate upon, the quantitative results obtained in the first phase.

Whilst each research method stands alone, both methodologies have the potential to complement each other and address the research question(s) in its entirety. The quantitative component is designed to examine the factors that predict RPN's FFP and to determine whether there are differences between RPN's FFP in acute admission units and within community mental health services. The qualitative component will explore the process of RPN's FFP with mothers who have EMI. In particular, the qualitative component will build upon the significant findings from the first phase of the study and explore the intricacies, process and context of RPN's FFP. The qualitative component will also elicit RPN's perspectives as to how they can best support mentally ill parents and their children/families. In this respect both methods deal with different aspects of the research question(s) with the quantitative component measuring the factors that predict RPNs FFP and the qualitative component addressing the

contextual aspects and process of engaging in FFP. Although the focus of the interview will be shaped by the quantitative data analysis, there will be additional scope for the researcher to explore and capture RPN's experiences of the day-to-day reality of caring for mothers with EMI as they perceive it.

The sequential mixed methods design is also used to select participants for inclusion in the second phase of the study. The researcher is interested in selecting only those RPN's who have previous (within 12 months of data collection) or current experience of delivering nursing care to mothers with EMI, within acute admission units and community mental health services and who achieved high scores in the dependent variable subscales in the workforce questionnaire. Hence, the quantitative information obtained in the 1st phase is used to identify and purposefully select RPNs for a follow – up, in- depth, qualitative study in a subsequent phase (Creswell & Plano Clark, 2007).

As there is an absence of knowledge in Ireland regarding RPN's FFP with mentally ill parents and their children/families an approach that enables an in-depth exploration as well as a generalisation of the findings to the wider population of RPN's working within general adult mental health services, will best address this gap. However, despite the many advantages of employing a mixed methods approach, its use may pose various challenges for researchers.

3.2 Challenges in employing a mixed methods approach

Despite its value, the use of a mixed methods approach poses considerable challenges for the researcher (Creswell & Clark, 2007). Completing mixed methods research demands flexibility in the operationalisation of methods whilst it also requires that the researcher know about the different methods being used and how to merge two distinct paradigms. The researcher has commenced this study as a novice researcher and has had to become familiar with quantitative and qualitative methods in completing the study. The researcher also has to clearly present each part of the process in order to permit the reader to understand the different procedures and how each component and phase of the

study relate to one another. It will also take time and resources to collect and analyse both quantative and qualitative data (Creswell & Clark, 2007).

Some of the difficulties in utilizing a mixed methods design are tempered by the fact that the researcher is using an explanatory design. The explanatory design is considered the most straightforward of the mixed methods designs (Creswell & Plano Clark, 2007). Its two phase structure makes it straightforward to implement because the researcher conducted the two methods in separate phases and collected only one type of data at a time. Furthermore, the final report will be written in two phases, making it straightforward to write and providing a clear delineation for readers. The researcher also perceives that adopting a pragmatic research paradigm will facilitate her to employ a mixed methods approach as it helped to overcome difficulties associated with drawing upon and merging two distinct paradigms.

Although there is debate about which paradigms provide a foundation for mixed methods research it is argued that the particular worldview philosophy most congruent with the principles of mixed method research is pragmatism (Denscombe, 2008; Bryman, 2007; Cresswell & Plano Clark, 2007; Morgan, 2007; Cresswell, 2003; Seale, 1999; Tashakkori & Teddie, 1998). Pragmatism is a set of ideas related to employing what works best, using diverse approaches and valuing both objective and subjective knowledge (Creswell & Clark, 2007) and hence its philosophy inspires researchers to employ both qualitative and quantitative methods of data collection and analysis. Alternatively, pragmatists such as Tasakkori and Teddlie (1998) argue that methods are selected based on what is required to answer the research question(s). Thus, the focus of pragmatism is on finding answers to a research question(s) in a way that is practically viable (Onwuegbuzie & Leech, 2005).

3.3 Sampling and participants

3.3.1 Sample size, selection and access

The population for this study is RPNs practicing within general adult mental health services in Ireland within acute admission units and four distinct areas of community mental health services, including community mental health nursing services, homecare, day hospital and day centres. There are 31 general adult mental health services in Ireland. A clustered random sampling approach was utilized to select 12 of these mental health services and within each service Directors of Mental Health Nursing (DoMHN) facilitated access to 600 RPNs who met inclusion criteria within acute admission units (n = 300) and community mental health services (n = 300). Fifty questionnaires were distributed within each mental health service; 30 to RPN's practicing within acute admission units and 20 to RPNs practicing within CMHTs. 346 RPN's completed the questionnaire, representing a 57.7% response rate overall. 56.1% of respondents were practicing within acute admission units and 43.9% were practicing within the 4 areas within community mental health services identified above.

In the second phase a sub sample of RPNs (n=12 - 16) who completed the questionnaire and who have current or recent experience of delivering nursing caring to one or more mothers with EMI will be invited to participate in semi-structured interviews to expand upon the findings from the first phase. Potential participants (n = 54) expressed their interest in undertaking an interview through providing their contact details to the researcher through completing an information slip that was included with but separate to the questionnaire. Although these respondents are self-selecting, the researcher will invite those with high scores in the workforce questionnaire as detailed above

3.3.2 Sample size

The sample size estimation for this study 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 questionnaire in different populations and the overall purpose of the current study which is to compare two groups of RPNs with regard to their FFP. As this study aims to compare two distinct groups of RPNs – namely RPNs practicing within Community Mental Health services and RPNs practicing in acute admission units and has used an existing questionnaire, devised by Maybery *et al*., (2006, 2011, 2012), to collect quantitative data, a two sample comparison of means was used to estimate the overall sample size.

Calculated using G*Power	
t tests - Means: Difference between two independent means (two groups) **Analysis: A priori: Compute required sample size**	
Effect size	**0.379**
Level of Significance	**0.05**
Power	**90%**
Allocation ratio	**1**
Tails	**1**
Sample size group 1	**120**
Sample size group 2	**120**
Total sample size	**240**

To achieve a sample size (n = 120) in each group, and assuming a minimum response rate of 40%, a questionnaire was distributed to 300 RPN practicing in acute admission units and 300 RPNs practicing within four distinct areas within community mental health services. Please see appendix 1 for questionnaire. It was anticipated that by using a clustered random sampling approach to recruit RPNs practicing within 12 mental health services, on a national basis, that RPN's would be of different ages, sexes, have various years of experience and educational qualifications and be practicing within different

services and in different circumstances in terms of roles, resources and geographical locations. Participants were recruited in Dublin, Ireland's capital, and outside of Dublin in both rural and urban locations, enabling access to services for people in both lower and higher socioeconomic circumstances. This allowed for maximum variation in the sample of RPNs in both groups.

In the second phase of the study, purposeful sampling will be used to select 12-16 RPNs who completed the survey in the first phase to participate in semi-structured interviews. Please see appendix 3 for topic guide. Participants will be randomly placed in order and interviewed until data saturation occurs. Purposeful sampling is warranted in the second phase of the study as the researcher wants to target only those RPN's, within acute admission units and community mental health services, who have delivered nursing care to mothers with EMI and who, as previously noted, have achieved high scores in the dependent subscales within the workforce questionnaire. Semi-structured interviews will be designed to explore the process of RPN's FFP and the significant predictors obtained in the questionnaire. Hence the researcher will purposefully choose the informants, since the judgment of the researcher in this matter is of greater importance than procuring a probability sample (Sarantakos, 1998). It is recognised that apart from the inclusion criteria no control will exist over those who will volunteer to take part in follow up interviews in the second phase of the study. The researcher clearly outlined in the participant information sheet (appendix 4) that accompanied the questionnaire, that RPN's did not have to volunteer for an interview if they did not want to.

To fulfill inclusion criteria, to participate in the second phase of the study, RPN's must have recent or current experience of delivering nursing care to mothers who have EMI, within acute admission units or community mental health services, within adult community mental health services. RPNs must also have notified the researcher of their intention to participate in the second phase of the study through completing a separate slip included with, but separate to, the questionnaire they completed in the first phase of the study. Involving the same participants in more than one phase of a study is in keeping with

the principles of sample selection in sequential mixed methods research (Cresswell & Plano Clark 2007).

The suitability of RPNs to participate in the first phase of the study and thereby the second phase of the study was determined by the researcher in consultation with DoMHN and Clinical Nurse Managers (CNM) nationally, in advance of approaching the informants. As the researcher had to rely on the DoMHN or CNM to identify RPNs who meet the study inclusion criteria, and thereby had no direct control over recruitment, distribution of a participant information letter and clarification of selection criteria helped to ensure consistency of recruitment. Prior to data collection a number of informal meetings with DoMHN were conducted nationally in order to inform them and to explain the purpose of the study.

As previously noted, only those RPNs practicing within community mental health services, in the 4 areas previously identified, and RPNs practicing within the acute admission units were invited to participate. In the first phase, all RPNs practicing within acute admission units (at Staff Nurse, Clinical Nurse Specialist (CNS), and Clinical Nurse Manager (CNM) 1 & 2 Grade) and within day hospitals, day centers, community mental health nursing services and homecare services (at CNS, Community Mental Health Nurse (CMHN)/Community Psychiatric Nurse (CPN), CNM 1 & 2 & Staff Nurse grade), who were employed on a permanent or temporary basis, in a full time or part time capacity were invited to participate. In the second phase, only those RPNs who have recent (within the last twelve months) or current experience of delivering nursing care to mothers with EMI and who have completed the questionnaire in the first phase will be invited to participate.

3.3.3 Pre study fieldwork

As previously noted, substantial and sustained preparatory fieldwork with stakeholders was of absolute importance to enable the researcher to, promote an understanding of the relevance of the study, scope out the proposed study to detect issues that may adversely affect the data collection process, and to enlist the cooperation of DoMHN, CNMs and Practice Development Coordinators to access RPNs and to distribute questionnaires to RPNs who fulfilled the inclusion criteria. Enlisting the cooperation of stakeholders was particularly important considering the researcher planned to undertake a national study to examine RPN's FFP in a time of economic downturn and restructuring, resource issues and recruitment embargos within the profession and mental health services in general. Preparatory fieldwork was also important considering the researcher needed to achieve a response rate of at least 40%, from both services and that it was preferable that Do MHN facilitated RPNs to complete their questionnaires whilst on duty. In addition, as previously noted, the literature suggested that RPNs practicing in acute admission units, may be less sensitized to FFP than RPNs practicing in community mental health services and therefore perceive the topic to have less immediate relevance to their practice (Slack & Webber, 2008); therefore requiring extra effort on the part of the researcher to generate interest in her research and to obtain a sufficient number of respondents in this group.

Because adult mental health services are widely distributed throughout Ireland the researcher needed to promote her study in a variety of ways and mediums to try to inform as many RPNs and their managers as possible of the relevance of the study to their practice. This preparatory work to promote the study was in addition to the work undertaken during the initial face to face contact with all of the DoMHN, CNM and RPN in each of the selected CMHTs and acute admission units. Prior to data collection the researcher advertised the forthcoming study through presenting her research through verbal, written and poster format at various conferences, including the Community Mental Health Nursing Association's Annual Nursing Conference (appendix 5) and the Irish Institute of Mental Health Nurses annual symposium conference (appendix 5). The researcher also published an overview of her

study in the HSE digital repository - Lenus, in the National Institute of Health Sciences Research Bulletin. The researcher also created a webpage (www.parentalmentalillness.info) to provide detail of her study, including ongoing updates of progress. Through this extensive preparatory fieldwork, the researcher was able to generate a satisfactory response to her study. 64.7% of RPNs practicing in acute admission units and 50. 7% of RPNs practicing within community mental health services choose to respond, thereby enhancing the capacity to generalise the findings to the wider population of RPNs.

3.3.4 Access to the sample in the first phase and distribution of the questionnaire

Direct contact with the DoMHN, to obtain the contact details of all the RPNs who meet the study inclusion criteria, was required as neither An Bord Altranais, the All Ireland Association of Community Mental Health Nurses or the National Council for Nursing and Midwifery provided a complete and up to date list of RPN's practicing with acute admission units or CMHT's. Therefore the researcher was unable to establish the identity of these RPNs without the support of a link person in the local area. It was also anticipated that the link person may be able to provide useful support to encourage the response rate. Accessing RPN's, through DoMHN, constituted a major piece of work as there was such varied organisational structures from one area to another (Mc Cardle, 2007). However, the researcher perceived that this was the best way to obtain an accurate and representative sampling frame; DoMHN, with their knowledge of local organisational structures, were best placed to identify those RPN's who practice within acute admission units and within the 4 areas within community mental health services. As the DoMHN are the only people who compile, maintain and manage an accurate and up to date list of the RPNs in the various areas, accessing RPNs through DoMHN ensured that the sample surveyed represented all the members of the organisation. Providing DoMHN with details regarding inclusion and exclusion criteria also helped to ensure that the survey was not distributed indiscriminately to RPNs who fell outside of the study population. Collaborating with DoMHN thereby assisted the researcher to

minimize or omit coverage problems and support the contention that the sample survey results represent all members of the population.

3.4 Data Collection Procedures

3.4.1 Instruments

As previously noted, in the first phase, 600 RPNs were invited to complete the family focused mental health practice questionnaire (appendix 1) (Maybery, Goodyear & Reupert, 2012) (adapted for use in the Irish context) on a national basis within a cross sectional design. The central aim of the anonymous questionnaire was to determine what factors predicted RPN's FFP. The questionnaire can be completed by RPNs who have current and/or previous experience of caring for service users who are/were parents and by RPNs who have no such experience. It was estimated that the questionnaire would take 20 - 25 minutes to complete.

The researcher decided to use a previously established questionnaire as opposed to developing her own questionnaire because she perceived that the questionnaire devised by Maybery and Reupert (2006) and further refined by Maybery *et al*., (2012), had the capacity to address her research question(s). Additionally she was aware that developing an instrument with sound psychometric properties is a complex and time consuming activity (Creswell & Plano Clark, 2007). Maybery and Reupert (2006) are in the process of testing the reliability and validity of their questionnaire and because it has been tested in both Australia and Canada there is normative data available as a baseline for the researcher to compare her results with and thereby creating the foundations for ongoing comparative research between the 3 countries.

The original multidimensional measure contained a 7 point Likert scale and used 49 items within 17 subscales to determine mental health professional's training needs, interests and behaviour regarding family focused mental health practices. Items were designed to reflect FFP in adult psychiatric services

according to workplace policy and management, worker attitude, knowledge and skill and service user and family engagement related factors. The 17 subscales focus upon workforce support, location issues, time and workload, policy and procedures, professional development, co worker support, family and parenting support, worker confidence, support to carers and children, engagement issues, assessing the impact on children, training, skill and knowledge, service availability, connectedness and interprofessional practice.

Although Maybery & Reupert's survey had the capacity to partially address the question(s), aim and objectives, in the current study, it required minor modification to enhance its appropriateness for use in the Irish context and to enable the current researcher to develop and expand upon Maybery and Reupert's research. That said, in order not to compromise the integrity of Maybery and Reuperts's scale and to enable comparison of findings, modifications were kept to a minimum (Dillman *et al*., 2009). Minor modifications were made to the wording and layout of the questionnaire as per Dillman's Total Design Method (TDM) (2009). Two additional subscales were added including interventions to promote parent's mental health and confidence around parenting and children in general. As previously noted, Falkov indicated that comprehensive FFP entails mental health professionals addressing the parent's mental health. Korhonen *et al*., (2008, 2009a, 2009b, 2010) found that those RPNs who were parents themselves, felt more confident about engaging in FFP. Items were also added in the final part of the questionnaire to measure the amount and type of FFP RPNs undertake in the normal course of their work. These items helped to quantify the extent to which RPNs engage in FFP within a particular time frame and how they done this. This aspect was not sufficiently addressed by Maybery and Reupert (2006, 2012), yet it is an important to factor in interpreting RPN's responses and the information will also be invaluable for managers and policy makers. Data from these items enabled the researcher to estimate and report the average number of service users who are parents on RPN's caseloads, the frequency of contact with service users and their children and whether or not RPNs discussed/addressed parenting.

Data collection for the first phase occurred between September 2011 and June 2012. The researcher visited each of the 12 mental health services, to explain the purpose of the study to RPNs and to distribute the questionnaire. The researcher also left questionnaires with the DoMHN and/or CNM to distribute to those RPNs who were not on duty whilst she visited the acute unit or CMHT. As the questionnaire was anonymous the researcher did not have access to the names of RPNs. RPNs were asked to return the questionnaire, in a sealed envelope, directly to the researcher or to the DoMHN as they preferred.

As previously noted, in the second phase a subsample of RPNs from the quantitative sample (approx n = 22 – 16), who have experience of caring for mothers who have EMI, will be invited to expand upon the findings of the questionnaire.

The semi structured topic guide will focus on 3 broad areas including: the nature and context surrounding RPN's family focused practices, their capacity to engage in FFP and their perceptions as to how their capacity to support mentally ill parents and their children/families may be further developed. Information will be sought regarding the type of service RPNs practice in, the nature of the mother's clinical diagnosis, socio economic circumstances, the number and ages of the mother's children, whether or not they are lone parents, whether they are primary carers and whether they have experienced temporary loss of custody of their child or children. This information will help to contextualise RPN's practice and also facilitate the researcher to interpret the findings. Information will also be sought about significant predictors that emerged from the first phase of the study such as the impact of skill and knowledge, confidence, service location and gender in engaging in FFP.

The researcher will also take brief field notes during the interviews and expanded on these notes following the completion of each of the interviews to ensure complete and thorough findings. The context of the interview will be described in the field notes as well as any factors that might have influenced the data collection process. For example, the environment in which the interview took place, observations regarding the demeanour of the participant, and the dynamics of the interview.

RPN's who volunteer to take part in interviews and who have high scores on the workforce questionnaire will be placed in rank order. Each RPN was contacted on receipt of their acceptance to be interviewed and will be contacted shortly before their interview date. Participants will be informed of what the interview will entail

and any questions they have will be answered via telephone prior to the interview. They will be reminded that their confidentiality will be maintained at all times and informed that they can withdraw from the interview at any time without giving a reason. All RPN's will be informed that interviewing will stop upon saturation of data. RPN's were advised that if this were the case they would be informed and if they still wished to take part in an interview they could do so. RPN's who will not be required for interview will be contacted by telephone and informed of this.

3.4.2 Reliability and Validity

In using an established instrument the researcher must consider the validity and reliability of past scores, whether the items fit the research question (s) and whether adequate scales are used to report the information (Creswell & Plano, Clark, 2007). The family focused mental health practice questionnaire has been developed over 7 years and is designed for use in adult mental health settings. This questionnaire is a collaboration of Maybery, Goodyear, Reupert, Victorian FaPMI coordinators and Dr. Rob Lees and Dr Grant Charles from British Columbia, Canada and the 49 items are considered to have excellent theoretical, content and face validity (Maybery & Reupert 2011, 2012) (please see http://www.copmi.net.au/ee/wforce/index_wforce.html for psychometric details). Data has been collected from 308 adult mental health workers from mental health services across ten regions in Victoria (Australia) between 2008 – 2010. With regard to reliability, Cronbach's alpha coefficients are reported between 0.70-0.90 for most of the subscales. Three of the 14 existing subscales had low reliabilities (location .41, engagement issues .42 and support to carers and children .58). In the current study 5 additional items were added to these subscales in an attempt to increase their reliability as recommended by Maybery and Reupert (2011). This included adding 2 items in support to carers and children, 1 item in location issues and 2 items in engagement issues. Reliability analysis was run on the subscales when used in the Irish context and this resulted in 6 of the subscales being excluded in the analysis due to poor reliability. Although there are similarities between the Australian and Irish adult

mental health systems, the validity of the questionnaire in one country may not necessarily transfer to another (Drennan, 2008). Furthermore, Maybery and Reupert's (2006, 2009,2012) questionnaire was designed for use by all mental health professionals and not specifically for use by RPN's. Reliability and validity of the additional items in the questionnaire, including the two additional subscales, were established by both a panel of experts and a pilot study conducted in Dublin South Central Mental Health Services with 9 RPN practicing within an acute admission unit and 6 Community Mental Health Nurses.

The semi-structured interview will also be piloted with an RPN from each area within Dublin South Central Mental Health Services. The interview topic guide will facilitate an in-depth exploration of the process of RPN's FFP and the factors that facilitate and/or hinder RPN's FFP.

3.4.3 Analysis

In the first stage descriptive and inferential methods of analysis were employed using the statistical package for the social sciences (SPSS 20). These methods were used to describe the sample characteristics and to then compare subgroups of participants (e.g. RPNs practicing in acute versus community settings) on subscales from the family focused workforce questionnaire using independent t tests, Annova and Mancova. Hierarchical multiple regression was also used to determine significant factors that predict RPN's FFP.

In the second phase, to facilitate systematic qualitative data analysis, an analytical process known as Thematic Networks will be used in conjunction with Nvivo (9) The Thematic Networks technique is a robust and highly sensitive tool for the systematization and presentation of qualitative analysis (Attridge & Stirling 2001). Thematic networks facilitate the disclosure of each step in the analytical process, aids the organisations of the analysis and its presentation and allows a sensitive, insightful and rich exploration of a text's overt structures and underlying patterns (Attridge &Stirling

2001). Thematic networks employ established, well-known techniques in qualitative analysis and entail web-like illustrations (networks) that summarise the main themes constituting a piece of text (Attridge & Stirling 2001). Thematic networks is classified as an Inductive bottom up approach – more akin to more detailed complex qualitative analysis method such as grounded theory or phemenology and is particularly suitable considering the limited knowledge on RPN's FFP. A bottom up analytical method will facilitate the researcher to explore emerging themes in conjunction with priori themes. The bottom up approach entails a much more complex and detailed analysis and entails the researcher being much less prescriptive at the outset than if he/she were to employ a top down approach. Data analysis in the bottom up approach tends to be more emergent and less predefined. Hence, at the outset, although the topic guide will direct the analysis, to some extent, the researcher will keep an open mind and be alert to emerging themes. In this respect, thematic networks is positioned somewhere between a top down and bottom up approach and is characterised by its systematization and the richness of the exploration that this process allows (Stirling, 2001).

Integration of the quantitative and qualitative findings is critical in mixed methods research (Creswell & Plano Clark, 2007; Wilkins & Woodgate, 2008). As this study will employ a partially mixed methods design the quantitative and qualitative elements will be conducted sequentially. The quantitative and qualitative data will be connected and integration will occur at two stages. In the case of this study the researcher obtained quantitative results that will lead to the subsequent collection and analysis of qualitative data. The findings from hierarchical multiple regression suggests that service location, skill and knowledge, gender and confidence around parenting and children in general are key predictors of RPN's FFP. Hence RPNs with high scores on the dependent variable subscales within the workforce questionnaire will be invited to expand upon these findings with attention given to these particular predictors within the semi structured interview. As the findings from the questionnaire are used to develop a framework for the subsequent interviews, integration will flow from quantitative data analysis into qualitative data collection.

Although, the findings will be presented for each phase of the study separately, data from the questionnaires and interviews will also be integrated with each other in the discussion section which will span over one chapter. Within this chapter the quantitative and qualitative findings will be discussed in separate sections and then they will be integrated in a final section. This chapter will also highlight points of intersection, difference and tension between the findings of both groups of participants highlighting the commonalities and tensions in perspectives between RPN's working within acute admission units and community mental health services.

3.4.4 Maintaining confidentiality of the data

In terms of the first component of the study anonymity was maintained as respondents were instructed not to include any identifying information on the survey – ensuring their anonymity. RPNs who wanted to participate in a semi-structured interview could complete an interview volunteer slip that came with, but was separate to, the questionnaire. The name and address of these volunteers will remain confidential and will only be used for contact purposes. Following all interviews, transcriptions will only be identifiable by code and access to the raw data will be restricted to the researcher. All information will be held within a locked cabinet in the principle researcher's office. Five years after the study has been completed all identifying information will be destroyed. Tape recordings of the participant's voices will also be destroyed within five years of completion of this study. Although the research knowledge will lead to publications in peer reviewed journals, conferences and books for the benefit of others, individual questionnaire or identifiable quotes from transcripts will not at any time be published. It is the intention of the researcher to report results collectively; therefore the identity of informants will remain confidential.

4 Ethical Considerations

All researchers are expected to adhere to ethical principles in their research and ethics is central to all aspects of a research study from commencement to completion (Goodwin *et al*., 2003). This section will discuss the ethical considerations underpinning this study.

At the outset of this study, ethical approval was sought for the first and second phase of the study from both DoMHN in the 12 mental health services and from the University College Dublin (UCD) Human Research Ethics Committee (HREC) (appendix 7). In addition for the second phase of the study ethical approval was also sought from Monash University Human Research Ethic Committee (MUHREC) (appendix 12). In phase one, the researcher formally applied to the HREC in UCD for a full review of the questionnaire, topic guide and supporting documentation. Although this research is considered low risk, and as such fulfilled the criteria for exemption from full review, the researcher applied for full ethical review and approval, which was subsequently granted.

The researcher obtained a full ethical review for various reasons. First, the researcher perceived that the support and approval of UCD HREC, including the use of UCD letter head, was very important to the research project. Such support indicates to research participants that the project is approved by an Irish authority and offers the stamp of approval of the researcher's employer, UCD. Considering that this research was being completed to fulfill the requirements for a PhD in Monash University in Australia, it was anticipated that full approval, from UCD HREC, would provide DoMHN with additional reassurance that the researcher had the necessary plans and resources in place to meet the ethical requirements; in turn this helped to facilitate the researcher to access RPNs through DoMHN. In addition it was perceived as important to obtain ethical approval through UCD HREC because the research is being undertaken in Ireland and ethics of the study should be given due consideration in that jurisdiction as there may be local nuances or ethical circumstances outside of Monash university's awareness that may have impacted upon the research in Ireland.

Receiving ethical approval from UCD did not automatically mean that access to participants would be granted by DoMHN (Treacy & Hyde, 1999); therefore, consent from these gatekeepers was required. After ethical approval was granted from UCD, the researcher contacted the DoMHN in each of the 12 mental health services randomly selected. This necessitated seeking written support from the DoMHN responsible for each acute unit and CMHT sampled to access RPNs. As previously noted, following receipt of ethical approval in UCD, the researcher contacted each of the DoMHN by telephone to provide them with information about the study and to make the necessary arrangements to visit them in person (individually and in groups) to discuss possible access to RPNs and distribution of the questionnaire. The researcher also sent each DoMHN an information pack. This included a cover letter (appendix 6) outlining the purpose of the study, an information sheet for participants (appendix 4), a copy of the criteria for inclusion of RPNs, and a copy of the questionnaire (appendix 1). Each of the RPN informants, via the researcher and/or the DoMHN, were also given an information pack which included a cover letter outlining the purpose of the study, the questionnaire, an interview volunteer form (appendix 8) and an addressed envelope for return of the questionnaire.

The study poses minimal risk as RPN's volunteered to complete an anonymous questionnaire and to participate in semi-structure interviews. Approximately 12 – 16 RPNs will be invited to volunteer to participate in semi-structured interviews and as these will be linked to the questionnaire it will not be possible for these RPNs to remain anonymous. Every effort will be taken to maintain their confidentiality and they were advised about this in the interview volunteer form (appendix 8) and the informed consent form (appendix 9). Talking about, describing and providing written information about work practices is a responsibility of publicly funded adult mental health services and accordingly, the mental health professionals who work within them. Whilst it is acknowledged that face to face interviews may be considered more intrusive than surveys it is not considered that the nature of the questions used in this study is sensitive or intrusive. There are also considerable benefits to participating. RPNs may be alerted to the importance of addressing service users' parenting roles and

will make judgments about their capacity to do so. This in turn may motivate them to consider ways to improve their practice in this context which may ultimately lead to improvements in services for mentally ill parents and their children/families.

Time is the only factor that may be considered intrusive for some RPNs. It was estimated that it would take RPNs between twenty and twenty five minutes to complete the questionnaire and up to one hour to complete the semi-structured interview. In the participant information sheet, RPNs were informed about the time required to respond/participate and assured that that their participation was entirely voluntary and contingent upon them returning the completed questionnaire and or participating in the semi-structured interview. The information sheet also outlined the aims of the study and informed RPNs of the measures that would be taken to ensure their anonymity should they volunteer to respond. As no identifying information was collected from RPNs they were identified and therefore their privacy was not violated.

Although face to face interviews are not anonymous the confidentiality of the information provided will be assured through not disclosing the individual or organisational names in reporting the findings and through appropriate storage of data. The process of audio taping interviews is clearly outlined in the information letter and participant's permission to tape their interview will be obtained at the start and checked throughout the interview. Participants will be given the option to not have their interview taped and assured that they can terminate their interview at any given time without giving a reason. Participants will also be invited to verify the summary of their interview with an invitation to delete and/or change any part of this, a process known as member checks (Attridge & Stirling 2001).

If in the unlikely event that an RPN may get upset during the interview the researcher will stop the interview and recommence it only when and if the RPN is ready to continue. Interviewees will also be contacted two weeks after the interview to check if there is anything further related to the interview that they would like to discuss. No potential or actual harm is thought to be imposed on participants (from interviews) consequently, there is no need to offer or make provision for counseling. In reporting

findings the names and locations of organisations or RPN's will not be reported. Consequently, if there are service gaps, not one organisation will be highlighted but will instead be reported as a general issue

The researcher does not perceive that she needs RPNs to complete a consent form for use of the questionnaire in the first phase; return of the completed questionnaire (anonymously) by RPNs will imply their consent. The pre notice letter (appendix10) and participant information sheet provided the researcher with an opportunity to provide RPNs with the necessary information regarding the use and purpose of the questionnaire. Written consent will be obtained for the semi-structured interviews in the second phase of the study. Participants will consent to participate in interviews by completing and returning an interview volunteer form which will be included with (but separate) to their questionnaire. Prior to commencing the interview the participants will be asked to complete an informed consent form.

5 Dissemination of findings

Dissemination of findings is an essential part of the research process (Cresswell & Plano Clarke, 2007). The findings of this study will also be of interest to service providers in areas other than mental health services, those with responsibility for supporting families, the education sector, the voluntary sector, service users and all those with service planning and policy development responsibilities.

The researcher consulted with CSTAR and the literature for guidance on how to devise and implement a dissemination plan on a national and international basis using a variety of mediums to researchers, educators, service organisations, consumers, carers, support and advocacy groups and others. The researcher anticipates that she will include various dissemination methods including written text; electronic and web-based tools; and oral presentations at organisations meetings and conferences. The researcher will also be mindful of the need to use existing resources, relationships, and networks fully to help her implement her dissemination plan.

The first priority in any dissemination plan is returning results to study participants. Dissemination to any other stakeholder group must take place following this first step. To disseminate the findings to RPNs and their managers in Ireland the researcher will also present her findings at conferences widely attended by RPNs and their managers and utilise the sources referred to in promoting the study in the initial fieldwork. The researcher will also visit a proportion of the CMHT's and acute admission units sampled to verbally present her findings and she will distribute a written report to all sites involved, for circulation by DoMHN.

The researcher will also create flyers, posters, brochures, or research briefs about her research project and findings which will offer a concise and visually-appealing way to disseminate information to broad audiences. These can be distributed at conferences, and will also be given to mental health charities, advocacy groups, and other stakeholders who contributed to the study. As most organisations have access to electronic resources the researcher will also distribute a newsletter summarizing her

study findings, via DoMHN, as this is an ideal way to update study participants and participating agencies.

The researcher will also present her findings at international conferences which are both nursing and interdisciplinary in nature and publish at least five papers in a variety of international peer reviewed journals. The researcher will also target conferences that are organized for groups with a particular interest in issues surrounding parental mental illness, such as the Social Care Institute for Excellence (SCIE) and the Parental Mental Health and Child Welfare Network in the United Kingdom. Additionally, the researcher will present her findings at COPMI conferences in Australia, Canada and elsewhere. Finally, research results are often utilized to advocate for legislative and policy change and the researcher will disseminate her findings to both legislators and educators, using the array of mediums previously discussed. Ensuring that a summary of the research findings is available to all of the participants of the researcher's study, if they would like it, is also a way to show them what value their participation has added to the research process (Cresswell & Plano Clarke 2007). Furthermore, if DoMHN and consumer support groups have copies of the summary of the findings they can be prepared for any media interest and can contribute to any debate (Cresswell & Plano Clarke 2007).

It has been argued by MacGuire (2006) that there is an onus on service management to implement research findings through a process of appropriate change management. This suggests that the use of evidence in practice is not solely the remit of RPN's. Rather, there is an onus on service managers to support RPN's in their endeavours to use evidence in practice. The researcher thereby hopes that she will be invited by DoMHN in general adult mental health services to facilitate workshops with RPN's and other mental health professionals to discuss the findings of this study. It is also anticipated that managers can use the findings of this study to secure and develop the necessary resources, philosophies and standards to enhance RPN's capacity to support mentally ill parents and their children/families. The researcher will also meet with members of the mental health division of the Health Research Board (Ireland's largest health research funding body) with a view to forming a

proposal based on some of the findings from this study. It is intended that such a proposal be collaborative and be formed in association with the supervisors, Dr Darryl Mayberry, and Dr. Andrea Reupert in Australia.

Table 2: Timeline with action plan

Date	Duration	Action Task
1st October 2012		Commence candidature in Monash University
29TH October – 24th November 2012	3 wks.	Quantitative data analysis and apply for ethics approval for second phase from Monash
14th – 30th November 2012	2 wks.	Prepare documents for confirmation and plan qualitative component (including topic guide and selection of interviewees) Undertake trial interview
26th November 2012		Confirmation
December 2012	1 month	Complete quantitative data analysis and write up first phase of study
January 2013	1 month	Pilot topic guide
February – June 2013	5 months	Conduct and analyse semi structured interviews with 12 – 16 RPN
July – September 2013	3 months	Write up findings from second (qualitative) phase
October – December 2013	3 months	Write up Discussion Chapter
December 2013	1 month	Completion presentation
January – July 2014	7 month	Complete final write up of all chapters and submit thesis

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Appendix 1: Family Focused Practice questionnaire

Registered Psychiatric Nurse's practice with mentally ill parents and their children/families within general adult mental health services in Ireland

Anne Grant, School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland

The central aim of this survey is to determine your activities/skills, knowledge, training needs and interests in relation to your practice with service users who are parents and with service user's children/families. The term family focused practice is generally used within this research to describe the process of working with service users around issues related to parenting with a mental illness, which may affect their parenting capacity and/or their mental health. It also entails working with service users' children (those who are younger than 18 years of age) and their families. It may include a number of direct or indirect interventions by RPN's including: interventions to promote the parent's mental health and to develop the parent's capacity to cope with their mental illness, interventions to address parent's socio economic difficulties, including difficulties related to housing, employment, finances and social supports and interventions around parenting to address needs of both the parent and their child(ren)/families.

The survey can be completed even if you have no current or previous experience of caring for service users who are/were parents; it is designed to rate your perspective about statements relating to your knowledge and skill about family issues; your interest in working with children, parents and families; your perception of organisational policy and supports for family focused practice and your level and type of family focused practice undertaken in your work.

What is involved? This survey will take between 10 and 20 minutes to complete. There are no right or wrong answers; we are simply interested in obtaining feedback on the work activities of RPNs and their organisations. We would like to emphasise that your involvement is VOLUNTARY and to maintain your ANONYMITY please don't put any identifying information on the survey.

PART 1: Demographics

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

1.1 What gender are you?
tick one box only

Female [ ]

Male [ ]

1.2 What age are you? _____ (years)

1.3 How long have you been practicing as an RPN?

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

_____(months)

_____ (years)

1.4 What professional/academic qualifications do you hold?
please tick all that apply

RPN	[ ]	Undergraduate Certificate	[ ]
CMHN/CPN	[ ]	BNS/BSc	[ ]
CNS	[ ]	MSc	[ ]
ANP	[ ]	HDip	[ ]
Undergraduate Diploma	[ ]	PhD	[ ]

Other (please specify) _____

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

YES [ ]

NO [ ]

If **yes** please detail type and length of training _____

_____

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

YES [ ]

NO [ ]

If **yes** please detail type and length of training _____

_____

1.7 Which Mental Health Service are you currently working in?

(please specify) _____

1.8 In which mental health setting are you currently employed?
tick one box only

Acute Admission Unit	[ ]	Community Mental Health Nursing Services	[ ]
Day Hospital	[ ]	Homecare Services/Assertive Outreach	[ ]

Other (please specify) _____

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

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

_____ (months)

_____ (years)

1.10 Where is your service located?
tick one box only

Rural Location [ ]

Urban Location [ ]

1.11 On what basis are you currently employed?
tick one box only

Full-time [ ]

Part-time [ ]

Other (indicate hours per week) _____ hrs/wk

1.12 What is the average length of stay of service users in your service?

Please indicate the number of days for the average user _____ (days)

1.13 Which grade are you currently employed at?
tick one box only

Staff Nurse	[ ]	CNM 2	[ ]
CMHN/CPN	[ ]	CNS	[ ]
CNM 1	[ ]		

Other (please specify) _____

1.14 What schedule are you currently working on?
tick one box only

Day duty	[ ]
Night duty	[ ]

Other (please specify) _____

1.15 Are you directly involved in delivering care to service users?
tick one box only

YES	[ ]
NO	[ ]

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

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

YES	[ ]
NO	[ ]

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

PART 2: Family Focused Mental Health Practice Questionnaire

The following scale is designed to rate the extent to which you agree or disagree with statements regarding family focused practice. Please refer to your experience in your current position and provide a response for every item regardless of whether you have current, previous or no experience of caring for mentally ill parents. If you have no experience of caring for mentally ill parents, please tick the not applicable (N/A) option for those items that ask you to comment on your actual activities with mentally ill parents, their children and families.

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

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

1	My workplace provides supervision and/or mentoring to support RPNs undertaking child-related work in regard to service users who are parents (ws1)	**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)(li1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3	There is no time to work with service users' children tw1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4	Government policy regarding family focused practice is very clear(pp1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5	Professional development regarding family focused practice is not encouraged at my work place(pd1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6	I often receive support from co-workers in regard to family focused practice(cs1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7	I regularly have family meetings (not therapy) with service users and their children (fps1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8	I am not confident working with service users about their parenting skills(wc1)	**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(scc1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
10	Many service users do not consider their illness to be a problem for their children(ei1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
11	I am able to determine the developmental progress of service users' children (aic1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
12	I sometimes wish that I was better able to help service users discuss the impact of their mental illness on their children(t1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
13	I am knowledgeable about how parental mental illness impacts on children. (sk1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
14	There are no parent-related programs (e.g. parenting skills) to refer services users to(sa1)	**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

15	I am able to determine the level of importance that service users place on their children maintaining attendance at day to day activities such as school and hobbies (e.g. sport, dance)(c1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
16	I do not refer service users' children to child focused (e.g. peer support) programs (other than child and adolescent mental health)(r1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17	Working with other health professionals enhances my family-focused practice (ic1)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
18	My workplace does not provide supervision and/or mentoring to support RPNs undertaking family focused practices (ws2)	**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(li2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
20	The workload is too high to do family focused work(tw2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
21	At my workplace, policies and procedures for working with service users on family issues are very clear(pp2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
22	My workplace provides little support for further training in family focused practices(pd2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
23	In my workplace other workers encourage family focused practice(cs2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
24	I provide written material (e.g. education, information)about parenting to service users who are parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
25	I am not confident working with families of service user's (wc2)	**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 (scc2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
27	Discussing issues for the service user with others (including family) would breach their confidentiality(ei2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
28	I am able to assess the level of children's involvement in their parent's symptoms or substance abuse(aic2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
29	I should learn more about how to assist service users about their parenting and parenting skills (t2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
30	I do not have the skills to work with service users about how parental mental illness impacts on children and families (sk2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
31	There are no family therapy or family counselling services to refer service users and their children to(sa2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
32	I am able to determine the level of importance that service users place on their children maintaining strong relationships with other family members (e.g. other parent, siblings)(c2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
33	I refer service users to parent-related programs (e.g. parenting skills)(r2)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
34	Children and families ultimately benefit if health professionals work together to solve the family's problems (ic2)	**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

35	There is time to have regular contact with other agencies regarding families or children or service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
36	I regularly provide information (including written materials) about mental health issues to service users' children (fps3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
37	Rarely do I consider if referral to peer support program (or similar) is required by my service users' children (scc3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
38	The children often do not want to engage with me about the service user's mental illness(ei3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
39	I would like to undertake future training to increase my skills and knowledge for working with the children of service users (t3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
40	I am not experienced in working with child issues associated with parental mental illness (sk3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
41	I am not able to determine the level of importance that service users place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)(c3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
42	Team-working skills are essential for all health professionals providing family-focused care (ic3)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
43	I often consider if referral to parent support program (or similar) is required by service users who are parents (fps4)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
44	I would like to undertake training in future to increase my skills and knowledge about helping service users with their parenting(t4)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
45	I am skilled in working with service users in relation to maintaining the wellbeing and resilience of their children(sk4)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
46	I want to have a greater understanding of my profession in a healthcare team approach to working with children and families (ic4)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
47	I provide education sessions for adult family members (e.g. about the illness, treatment) (fps5)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
48	I am not confident working with children of service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
49	I am knowledgeable about the key things that service users could do to maintain the wellbeing (and resilience) of their children(sk5	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
50	I am able to identify how parenthood can precipitate and influence the service user's mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
51	I assess the impact of the service user's parenting role on their mental health	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
52	I suggest practical strategies to facilitate service user's to manage the dual demands of their parenting role and their mental illness	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
53	It is within my remit to address the needs of service user's children directly and/or indirectly	**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

54	I should facilitate service user's to cope with stress related to their parenting role	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
55	RPNs should facilitate service users to realise their potential as parents	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
56	Other members of the multidisciplinary team (i.e. social worker) are better placed, than RPNs, to address issues related to service user's parenting roles	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
57	There is no time to work with service users' children (tw1b)	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
58	I discuss the impact of family functioning, on children's well-being, with the service user's adult family members/carers	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
59	I would classify my interaction with service users' children as planned, purposeful involvement with therapeutic intervention	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
60	Service users generally do not want to engage with me about the impact of their mental illness on their children	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
61	Discussing issues for the children would compromise my rapport with service users	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
62	Insufficient numbers of allied health professionals (i.e. social worker, clinical psychologist) in my service reduces RPN's capacity to address service user's parenting roles	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

There is some evidence to suggest that RPNs who are, or have been, parents of dependent children may feel more comfortable and/or able to address service user's parenting roles. The following questions focus on how comfortable you are regarding parenting and children generally. If you do not have children please indicate N/A to questions 63 & 64

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

PART 3: Experience with service users who are parents

The purpose of this part of the survey is to establish the extent of your exposure to service users who are parents and your experience in caring for mentally ill parents and their children/families. The term 'dependent children' is used to describe children under the age of 18. Please answer all of the following questions irrespective of whether you have experience of caring for service users who are parents.

3.1 Are you a parent?

tick one box only

Yes [ ]

No [ ]

3. 2 Currently are any of your service user's parents of dependent children? (tick one box only)

YES [ ] (please specify number) ____

NO [ ]

Not Sure [ ]

3.3 Have you previous experience, within your current position, of caring for one or more service users who are/were parents?

tick one box only

YES [ ]

NO [ ]

Not Sure [ ]

3.4 Have you experience in previous positions of providing care for service users who were parents?

tick one box only

YES [ ]

NO [ ]

Not Sure [ ]

3.5 In your current position how regularly do you care for service users who are parents of dependent children?
tick one box only

Daily	[ ]	Few times a Year	[ ]
Weekly	[ ]	Never	[ ]
Monthly	[ ]		

3.6 How long is it since you last provided care to service users who are parents of dependent children?
tick one box only

In the last week	[ ]	6 – 12 months	[ ]
Less than a month	[ ]	More than 1 year	[ ]
1 – 3 months	[ ]	Never	[ ]
3 – 6 months	[ ]		

3.7 Did you have face to face contact with a service user who has a dependent child(ren) in the last week?
tick one box only

Yes [ ]

No [ ]

If **yes**, please indicate the number of face to face contacts, in the last week _____

3.8 During the last week did you talk about issues related to parenting with service users?

Yes [ ] → (**Go to 3.9**)

No [ ] → (**Go to 3.11**)

3.9 How many service users did you discuss parenting with during the last week?

Please indicate the number of service users _____

3.10 What was the focus of your interaction(s)?

_____

_____

_____

_____

(**Go to 3.12).**

3.11 What factors and/or circumstances(s) deterred you from discussing parenting?

_____

_____

_____

_____

3.12 In your current position how often do you have face to face contact with a service user's child(ren)?
tick one box only

Daily	[ ]	Few times a Year	[ ]
Weekly	[ ]	Never	[ ]
Monthly	[ ]	Other _____	

3.13 Did you have face to face contact with a service users(s) child(ren) in the last week?
tick one box only

Yes [ ]

No [ ]

If **yes**, please indicate the number of face to face contacts, in the last week _____

3.14 If you have current, or recent, experience (within the last 12 months) of caring for one or more mothers, who are/were mentally ill, would you like to take part in a semi-structured interview in order to discuss your experiences further?
tick one box only

Yes [ ] (please complete the enclosed slip and forward with your questionnaire)

No [ ]

Have you any additional comments that you would like to make?

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

Ms Anne Grant
School of Nursing, Midwifery, & Health Systems
Health Science Complex
University College Dublin
Belfield
Dublin 4
Ireland

Telephone: 01 716 6424 (work)
086 126 7037 (mobile)

Email: anne.grant@ucd.ie

The artwork on the front cover of this questionnaire was provided by the participants of the Vic Champs programme (support group for children whose parents have a mental illness) in Australia.

Appendix 2: Table outlining existing research

Parents' perspectives of their parenting experiences and needs

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Zemencuk and Rogosch (1995)	America	Explored parenting sensitivity and needs, parenting style and parenting function of mothers with EMI	48 women who were hospitalized	Inclusion: at least one child under age of 13, EMI Hospitalized Exclusion: unstable mental state.	Quantitative – mothers were assisted to complete measures by psychology graduate students trained in the administration of the measures.	Children's Reports of Parental Behaviours Inventory (Raskin *et al.,* 1971), Social Support Questionnaire (Bogat *et al.,* 1983) Child Behaviour Checklist (Achenbach *et al.,* 1983). Sensitivity to Children Questionnaire (Stollak *et al.,* 1973).	Quantitative	Mothers have multiple risk factors for parenting difficulties. Most mothers were functioning adequately as parents. Mothers need considerable support to deal with stressors that may put them and their children at risk.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Sands (1995)		Comparison of the experiences of ten single, low-income mothers with mental illness with the experiences of eight single, low income mothers without psychiatric impairment.	Ten single, low-income mothers, with EMI and eight single, low income mothers without psychiatric impairment.		Qualitative	Interview	Qualitative	Mothers who have EMI have a strong desire to develop normal lives for themselves and their children. However when their experiences were compared with mothers without psychiatric impairment mentally ill mothers have greater difficulty disciplining their children and experienced greater stress from role strain. The mothers with EMI also tended to minimize their illness and the impact that their illness had on their children due to fear of custody loss and they did not directly acknowledge the need for guidance or help with parenting.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Nicholson, Sweeny and Geller (1998)	America	Understand the parenting experiences of women with EMI from the perspectives of mothers and their case managers	15 mothers randomly recruited who were receiving community mental health services. 55 Case managers randomly recruited who worked for the depth of mental health	Inclusion: mothers: at least one child under age of 13 EMI, Community care, Case managers: Working with or had worked with female clients with children.	Qualitative	Focus groups	Transcripts were coded and items grouped by themes in qualitative analysis	Many of the issues of mothers with mental illness are generic to all parents; others are specific to the situation of living with mental illness (stigma, managing mental illness and parenting, custody issues). Mothers also found it hard to distinguish between the effects of stress and the effects of illness. Some mothers reported purposely missing their medication doses in order to stay alert and focused on their child. Mothers must play a role in developing standards for clinical care and the research agenda in the area.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Joseph, Shashank, Lewin and Abrams (1999)	America	Estimate prevalence of mothers who have EMI and identify number who retain contact with children. Identify perceived needs.	Purposive sample of 52 women with EMI who were hospitalized	EMI Able to read and write English,	Cross sectional survey	Questionnaire	Descriptive analysis	Almost 50% of the women in the sample were mothers. Hospitalized women were not able to be involved in taking care of their children. Those mothers who had lost contact with their children required help to deal with their sadness about their children

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Basset, Lampe and Lloyd (1999)	Australia	Gain insight into the experiences of mothers who have a mental illness and explore their perceptions of mental health services	Mothers with EMI but no details of sample size not provided	Mothers who had children under the age of 5, Consumers of rehabilitation services	Qualitative – exploratory descriptive	Focus groups and interviews	Verbatim transcription of audiotapes, thematic analysis	Particular themes to emerge included: fear of losing custody, trauma of hospitalization, social isolation, care of the child if the mother becomes ill, accessing community services. Stigma and discrimination, dissatisfaction with mental health services, relationships with their children

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Mowbray, Schwartz, Bybee, Spang, Rueda – Riedle and Oyserman (2000)	Canada	Explore demographic characteristics, stressors and resources of mothers with EMI	Non-random sample of 379 mothers receiving services from community mental health centres.	Female, aged 18 – 55, at least one childcare responsibilities for at least 1 child aged 4 – 16yrs, psychiatric disorder of at least one year duration	Quantitative	Interviews – trained interviewers administered a two-part interview 10 days apart. Structured measures included: The Moms Study Questionnaire, The Diagnostic Interview Schedule, Substance abuse questionnaire		High level of poverty. Concomitant with poverty, respondents experienced adverse living situations (poor standard of housing, crime, and victimization). They also had poor physical/mental health and chronic stress. Whilst respondents experienced stressful lives they did have resources available to them. Mental health services must consider mothers socio economic contexts when providing care.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Dipple, Smith, Andrews and Evans (2002)	England	Explore the experience of motherhood of older mothers who had lost custody of one or more of their children on either a temporary or permanent basis	43 mothers with EMI who had been or who were still in contact with rehabilitation services.	All women who were mothers who had been or were currently clients of rehabilitation services	Quantitative	Case notes, structured interviews, enquiries with key-workers on demographic information	Quantitative data analysis using SPSS	Many women in long-term psychiatric care have experienced multiple losses. 68% of mothers were permanently separated from at least one child and there was a paucity of information in the case notes regarding the respondent's role as mother.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Ackerson (2003)	America	Explore how mothers cope with the dual demands of parenthood and their illness	Purposive sample of 12 mothers and 1 father who had EMI	Inclusion: history of treatment and at least one period of hospitalization with EMI mothers of children up to age of young adults	Qualitative –	Semi structured interviews	Used grounded theory techniques of constant comparison and theoretical sampling in conjunction with narrative history.	Themes that emerged included: problems with diagnosis and treatment, stigma, chaotic interpersonal relationships, strain of single parenthood, custody issues, and relationships with children, social support, and pride in being a parent. Need for early intervention and treatment. Respondents must cope with a disorder that at times challenges their ability to effectively carryout the parenting role.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Caneja and Johnson (2004)	England	Explore participants experiences, views about services and needs for support in parenting	Purposive sample of 22 women with EMI on the case loads of community mental health teams	Inclusion: diagnosis of EMI, at least one child under the age of 16, in contact with specialist community services for at least 6 months, is able to give informed consent and participate in an interview in English. Exclusion: unstable mental state.	Qualitative	Semi structured interviews	Qualitative thematic analysis	Participants described motherhood as rewarding and central to their lives. Demands associated with parenting and at the same time coping with mental illness is considerable. Parenting responsibilities created practical impediments to engaging with mental health services. Services were perceived as offering little continuing support in relation to parenting, intervening only in crises.

Author(s) and Date	Country	Purpose of Study	Sample	Inclusion/exclusion	Research design	Instruments used	Analysis	Main findings
Montgomery, Tompkins, Forchuk and French (2006)	Canada	Explore the experiences of mothers with EMI and how they attempt to manage their mothering circumstances.	Purposive sample of 20 women with EMI who were receiving treatment from mental health services	Inclusion: 20 years of age of older, English speaking, mentally competent receiving psychiatric treatment for EMI for more than 2 years, have at least one child between the ages of 2 and 16 years	Qualitative	Unstructured Interviews and field notes	Glaser's grounded theory approach and purposive and theoretical sampling	Mothers made efforts to have meaningful relationships with their children and to do this they would hide their illness for the sake of protecting their roles and their children.
Davies and Allen (2007)	Wales	Explore the Influence of child – care responsibilities on access to services for mentally ill women	Purposive sample of 11 women under the care of the community mental health team	Inclusion: 1 or more children	Qualitative	Individual, semi structured interviews	Used grounded theory techniques of constant comparison and theoretical sampling	Mentally ill mothers who use mental health services face particular challenges in managing the contradictory aspects of their dual identity. Health professionals can use their disciplinary power in a positive way to help women in this task.

Children's subjective experiences of living with a mentally ill parent

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Handley, Farrell, Josephs, Hanke and Hazelton 2001	Tasmania	Identify children's needs, Identify how children can be supported to cope Identify current level of support	116 parents 54 children 74 service providers	Mixed methods	Semi structured Interviews and Questionnaires	Descriptive analysis of questionnaires using SPSS Thematic analysis of qualitative data	Difficulty in understanding parents mental illness, Assuming of age inappropriate responsibilities, Impact of parents hospitalization, Unmet needs for support from parents' key workers in mental health services, Feelings of shame, guilt and self blame
Aldridge and Becker (2003)	UK	Experiences and needs of children, Children's caring relationships, Nature of professional intervention	40 Parents 40 Children 40 Service providers	Qualitative	2 phase semi structured interviews	Not discussed	Children undertook a range of domestic and caring responsibilities for parents, Unmet needs for support from parents key workers
Fudge and Mason (2004)	Australia	Children's experiences, Suggestions re family friendly mental health services	33 children aged between 7 – 12 and 25 young people aged between 13 - 25	Qualitative	Focus groups with children focus groups and peer interviews with young people	Thematic analysis	Communication problems with parents' key workers and between families, Additional care giving responsibilities

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Riebschleger (2004)	USA	Children's experiences, Perceptions of psychiatric rehabilitation services	22 children aged between 5 - 17	Secondary analysis of data generated in study by Riebschleger *et al.,* (1993)	9 children had individual interviews and 11 children had focus groups	Thematic analysis	Children expressed concerns about multiple family stressors and bias associated with psychiatric disability
Stallard, Norman, Dickens, Salter and Cribb (2004)	UK	Ascertain prevalence of parents with mental illness, Ascertain the impact of parental mental illness on children	24 adults 26 children	Mixed methods	Semi structured interview and structured questionnaire	Not discussed	Children were concerned about their parents, had little understanding of their parents mental illness and wanted more information. Parents were unaware of the negative impact of the illness upon their children
Maybery, Ling, Szakacs, Reupert (2005)	Australia	Experiences and needs of children, Quantify the impact of various strategies which might be helpful for children when their parent is hospitalized	12 parents 12 children 62 mental health professionals	Mixed methods	Focus groups and questionnaires with children and parents Questionnaires with mental health professionals	Thematic analysis of qualitative data and descriptive analysis of quantitative data	Main themes from children and parents pertained to: parents hospitalization, development of coping mechanisms and importance of sibling support Health care professionals and parents perceived that children should receive professional help to facilitate them to cope whereas children perceived that their friendships with peers would be more helpful.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Somers (2007)	Ireland	Impact of parental schizophrenia on children's lives, Views of services	39 Parents 37 children who were matched with a control group of children whose parents did not have mental illness	Quantitative	Semi structured interviews and questionnaires	Descriptive analysis using SPSS	Children whose parent had mental illness had more psychiatric disturbance, problems associated with school, less contact with relatives, spent more time at home and had little access to services. Parents wanted an educational programme and support for their children and a more co-ordinated approach between child and adult mental health services

Mental Health professionals' perspectives of their practice with mentally ill parents and their children/families

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Byrne, Hearle, Platt, Jenner and Mc Grath (2000)	Australia	Perceptions of: difficulties for parents with EMI, Interventions required to meet their needs, Barriers to effective service delivery	Non random sample of 77 service providers from a range of government and non government agencies	Quantitative	Self report survey	Quantitative analysis using SPSS	30% of sample perceived that parents with EMI cannot adequately care for their children Most service providers perceived that genetic factors can harm children more so than environmental factors Parent based support programmes were the most favoured method of helping parents
Stanley, Penhale, Riordan, Barbour and Holden (2003)	UK	Identify barriers to inter professional collaboration Parents perceptions of their needs and evaluation of service	Non random sample of 500 health and social care professionals 11 mothers who had EMI whose children had been subject to a child protection case conference	Mixed methods	Postal survey of health and social care professionals In depth semi Interviews with 11 mothers	Quantitative analysis using SPSS Thematic analysis	More communication problems existed between child care workers and psychiatrists and child care workers and GP's than between other groups Mothers valued support from professionals whom they felt were 'there for them' and whom they could trust, Child care social workers perceived that they could not fulfil this role, Researchers concluded that a dyad of workers should share the key worker role.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Bibou - Nakou (2003)	Greece	Perceptions of collaboration issues with children and parents, Issues that practitioners would find difficult or easy to address when working with parents and children	Non random sample of 18 practitioners working with different agencies 6 social workers, 3 psychologists, 2 psychiatrists, 3 community psychiatric nurses, 2 police officers, 2 teachers)	Exploratory, descriptive	3 semi structured focus groups	Transcripts of audiotapes and discourse analysis	Service providers expressed anxiety about parenting issues and children's understanding of their parents' mental illness. Perceived that their concerns about parenting were largely unacknowledged. They preferred not to discuss the parents' mental illness with their children. Service providers rarely asked parents about their experiences of parenting.
Gillam, Crofts, Fadden and Corbett (2003)	UK	Examine extent to which mental health system in West Midlands is responding to service users as parents, and working in partnership with other agencies who ensure children's well being	Service providers working in child and adolescent mental health services and adult mental health services across the West Midlands	Mixed methods – primarily qualitative in nature	Surveys Observation for 3 months	Not discussed	A high percentage of service providers are aware that their clients are also parents, Children of service users are not routinely assesses or offered any planned purposeful therapeutic intervention, Over a third of service providers in adult mental health do not feel confident in working with children of service users, When there are concerns about a service users child, clinicians working in adult mental health were most likely to liaise with a child and family social worker,

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Davies (2004)	UK	Explore the experiences of mothers who have EMI and the community psychiatric nurses who support mothers with EMI	13 CPN's working in two CMHT's 5 women receiving services from the CMHT	Qualitative	Focus groups with CPN's Interviews with mothers	Thematic analysis and narrative analysis	CPN's were clear about the parameters of their role, whilst acknowledging practical limitations which prevent them considering mothers parenting role, Mothers highlighted ways in which hospitalization and medication can obstruct the parenting process, Continuity of care, having a crisis plan and input from specialist services was identified as helpful features of support
Thompson and Fudge (2005)	Australia	Gather broad based information about psychiatric nurses' beliefs and practices in relation to assisting adult clients to address parenting roles and family issues, Elicit level of knowledge and practices elated to mandatory notification	307 South Australian registered psychiatric nurses working in patient and community settings	Mixed methods	Questionnaire - 307 completed Focus groups – 28 participated Telephone interviews – 5 completed	Thematic analysis of qualitative data and quantitative analysis of data from questionnaire	Vast majority of nurses perceived that it was part of their role to discuss parenting with their clients and to speak with children of clients if requested, Over a quarter reported barriers to doing so, No systems in place to facilitate nurses to work with other agencies, More than a third of those who suspected child abuse made no formal notification in this regard

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Maybery and Reupert (2006)	Australia	Identify the core barriers that impede clinicians from considering their adult clients parenting role, Rate the importance of these barriers for adult mental health and other workers	Convenience sample of 92 mental health and welfare workers	Mixed methods using two phases	Interviews - 60 participants Questionnaires - 32 participants	Not discussed	All workers reported that it was part of their role to get involved with issues regarding their patients children, Most important barrier was patients not identifying their illness as a problem for their children, In comparison to other workers, adult mental health workers reported time and resource limitation as well as skill and knowledge deficits.
Slack and Webber (2008)	UK	Explore attitudes of mental health professionals regarding support needs of mental health service users children, highlight potential barriers to identifying or meeting children's support needs	Non random sample of 94 health care professionals working within statutory mental health teams in inpatient and community settings within one outer London borough	Cross sectional survey	Self compete questionnaire	Quantitative analysis using SPSS	Practitioners were overwhelmingly in favour of supporting children. Though mental health professionals do not consider it their role to provide this support. Attitudes and practices were significantly associated with profession, setting and whether the respondent was a care co-coordinator.
Korhonen, Julkunen and Pietila (2008)	Finland	Identify factors that hinder nurses from implementing family focused nursing into adult psychiatric services	Non random sample of 223 registered psychiatric nurses and 88 practical mental health nurses	Quantitative study	Questionnaire	Quantitative analysis using SPSS	Family related factors, such as families' fear and lack of time, were considered as 'most hindering'. Nurses who used a family centred approach and had further family education considered most of the factors as 'less hindering' in comparison to other nurses.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Maybery D and Reupert A. 2009	Australia	Paper review the constraining barriers and issues for the psychiatric workforce that impede their capacity to address service user's parenting roles	None	Literature Review	None	None	Psychiatric workers experienced an array of barriers to addressing service user's parenting roles related to: 1. Policy and management, 2. Interagency co operation, 3. Worker attitude, skill and knowledge, 4. The parent consumer and, 5. The consumer's family, including children. Potential solutions are presented and recommendations made, including organizational audits to identify the most pressing barriers that impede family sensitive practice.
Korhonen T, Vehviläinen-Julkunen K and Pietilä AM. 2010	Finland	Identify the extent to which registered and practical mental health nurses address service user's parenting roles.	Non random sample of 223 registered psychiatric nurses and 88 practical mental health nurses	Quantitative study	Questionnaire	Quantitative analysis using SPSS	The majority of respondents perceived that they did endeavor to address service user's parenting roles but the extent to which they did this depended on whether they were parents themselves and the extent of their professional experience and education. Those nurses who were parents and had more experience and education were more likely to address service user's parenting roles.

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
Rutherford SJ and Keeley P. 2009	UK	Discussion paper to challenge existing practice in relation to mental health nurses' role in assessing parenting capacity within adult mental health services	None	Literature Review	None	None	Mental health nurses in the UK are involved in the assessment of parenting capacity of mothers with EMI. However, there is little provision for mental health nurses to undertake this role. There are significant tensions for mental health nurses undertaking parenting assessments and there is no specific training for this role.
Reupert A E and Maybery D. 2010	Australia	To identify the topics covered in support programs for children whose parents have mental illness	Purposive sample of 18 COMPI program facilitators across Australia	Qualitative study	Individual Interviews	Qualitative thematic analysis	Participants perceived that it was important to include topics related to education and mental health as they believed knowledge of the parents mental illness and how to look after their own health provides children with a source of power

Author(s) and date	Country	Purpose of Study	Sample	Research design	Instruments used	Analysis	Main findings
O Brien, L Brady P, Anand M and Gillies D (2011)	Australia	The aim of this study was to understand the experiences of children, their parents and carers, and staff when children visit acute in patient units, to better inform service planning.	Nine staff participated (3 nurses, 2 psychiatrists/ registrars, 2 social workers, and 2 occupational therapists).	A qualitative exploratory research framework was used	data were gathered through semi-structured interviews	Qualitative thematic analysis	Findings indicated that staff experienced being in a dilemma about children visiting and there were barriers to implementing family-friendly services. While staff mostly agreed in principle that children's visiting was beneficial, there was a lack of local policy and guidelines, and ad hoc arrangements existed. In addition, staff were unsure of their role with children, felt ill-equipped to talk to children about mental illness; and lacked knowledge of age-appropriate resources. Models of inpatient care need to be developed with a family focus that acknowledges the parental roles of clients and supports children visiting

Appendix 3: Interview topic guide

Semi-Structured Interview Topic Guide

Registered Psychiatric Nurse's Practice with Mentally Ill Parents and their Children/Families within Adult Mental Health Services in Ireland

Preamble

Thank you for agreeing to participate in this interview.

I would like to audiotape this interview – please let me know if this is a problem for you. (If participant/s are fine with audiotaping and consent forms have been received, then switch the tape recorder on).

Good morning, my name is Anne Grant and I am a psychiatric nurse and lecturer in the school of Nursing, Midwifery and Health Systems in University College Dublin.

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

The aim of the study is to explore your views on your practice with mothers who have Enduring Mental Illness and with their child(ren) and family.

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's a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question.

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

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

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

I first need to know:

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

Family Centred Practices:

- Do you ascertain if your service user is a parent? Why or why not?

- What do you do, if anything, when you know a service user is a parent? Can you tell me more about that?

- How, if at all, do you decide to become involved with the children of mothers who have EMI? Can you tell me more about that and what your involvement entails?

- How, if at all, do you decide to become involved with the other family members of mothers who have EMI? Can you tell me more about that and what your involvement entails?

- How do you think a parent's MI impacts on her parenting? How do you think being a parent impacts on a parent's MI? What is your role, if any, in supporting parents in these potentially negative interactions?

Capacity of RPNs to engage in family focused practice?

- Do you think that the care you provide meets the needs of mothers with EMI? The needs of their children? The needs of their families? Can you tell me more about this?
- Are there needs of mothers that are not being met that should be? And how could these needs be met?
- What factors facilitate and/or hinder you in meeting the needs of mothers? The needs of their children? The needs of their families? Can you tell me more about this?
    - Essential skills and knowledge required to engage in FFP?
    - Confidence in addressing service user's parenting role?
    - Impact of service location on engaging in FFP?
    - Impact of being a women/man and engaging in FFP?

How may RPN's capacity to support mothers with EMI, their children and families be further developed?

- What might help you in working with mothers with EMI? Their child(ren)? Other family members?
- On the basis of your experience, describe what competencies and behaviours are essential to enable RPNs to effectively support mothers with EMI, their children and their families?
- What other information, knowledge or skills do you need to work out how to recognise and respond to the needs of mentally ill parents and their children/families?
- How, if at all, may mental health service provision for mothers with EMI and their children/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 and what I think are the main themes. What is the best way to get this back to you? If you think the information we give you is incorrect or might identify you, we would encourage you to change or delete this and ensure we get it back.

Appendix 4: Participant information sheet

Registered Psychiatric Nurses' Practice with Mentally Ill Parents and their Children/Families within General Adult Mental Health Services in Ireland

Introduction

Dear Colleague, this information leaflet outlines a forthcoming study designed to obtain Registered Psychiatric Nurses' perspectives of their practice with service users who are parents. Your help with this study would be greatly appreciated.

Background to study

The number of service users, of general adult mental health services, who are parents, has increased. It is estimated that between 25 and 50% of adults known to mental health services have children (Farrell *et al.*, 1999). Although mentally ill parents value their parenting role and perceive that it promotes their recovery and integration within their communities (Gopfert *et al.*, 2004), the literature also suggests that a substantial number experience varying degrees of difficulty in fulfilling their parenting responsibilities due to their mental illness (Maybery and Reupert 2010, Gopfert *et al.*, 2004). These difficulties in parenting tend to occur at times of relapse and during the acute phase of their mental illness and can adversely affect their own and their children's well being on a temporary and on an ongoing basis (Gopfert *et al.*, 2004).

A parent's mental illness can adversely affect their child(rens') mental, physical and social well being; up to eighty percent of parents with EMI may lose custody, of one or more children, on a temporary or permanent basis, as a consequence (Joseph *et al.*, 1999). Stress associated with parenting may also precipitate a relapse of the parent's mental illness or prevent or prolong their recovery (Gopfert *et al.*, 2004). Parental mental illness may also lead to socio economic disadvantage and family discord and disorganisation (Beardslee *et al.*, 1998); this further compounds difficulties in parenting with resultant adverse effects for the parent and their children/families. Consequently, families affected by parental mental illness are identified as among the most vulnerable in our community (Beardslee *et al.*, 1998).

It is recognized that mentally ill parents and their children/families are potentially an easily identifiable group that would be widely responsive to preventive interventions (Beardslee *et al.*, 2007). Research has clearly and repeatedly demonstrated the benefits of family focused practice to the service user, as well as his or her children and other family members (Maybery and Reupert 2010). As such, mental health professionals have a unique opportunity to alleviate suffering and prevent costly long-term social outcomes if they can identify and support mentally ill parents and their children/families. Consequently, significant work is being undertaken in countries such as, Australia, Canada, Finland and England to facilitate mental health professionals to develop their capacity to support mentally ill parents and their children/families (Lee 2004).

Statutory services, such as adult mental health services, have the potential to support mentally ill parents in their parenting role as these services provide mental health care to parents when they are likely to encounter greatest difficulties in parenting, such as during an acute exacerbation of their mental illness (Gopfert *et al.*, 2004). It is increasingly suggested that for a number of reasons, RPNs in particular, represent a potentially valuable source of support for mentally ill parents and their children/families. However, due to limited research on this subject internationally and an absence of research in Ireland there is inadequate understanding of RPN's practice in this context and the challenges RPN's experience in caring for service users who are parents.

The recent recommendations within Irish mental health policy, *A Vision for Change*, (Department of Health and Children (DoHC) 2006), regarding mentally ill parents and their children/families make it all the more imperative that the gap in knowledge, surrounding RPN's practice with mentally ill parents and their children/families, be addressed.

Information about this study

This study aims to:

- Establish RPN's capacity to engage in family focused practice.
- Identify factors that facilitate and hinder RPN's family focused practice.
- Establish if RPN's practice is consistent with national and international governmental policy objectives and international practice.
- Determine how RPN's capacity to engage in family focused practice may be further developed.
- Develop recommendations addressing the future development of RPN's practice with mentally ill parents and their children/families within the context of education, policy, practice and research.

Definition of family focused practice:

The term family focused practice is generally used within this research to describe the process of working with service users around issues related to parenting with a mental illness, which may affect their parenting capacity and or their mental health. It also entails working with service users' children (those who are younger than 18 years of age) and their families. It may include a number of direct or indirect interventions by RPN's including: interventions to promote the parent's mental health and to develop the parent's capacity to cope with their mental illness, interventions to address parent's socio economic difficulties, including difficulties related to housing, employment, finances and social supports and interventions around parenting to address needs of both the parent and their child(ren)/families.

Methodology:

In the first phase, approximately 300 RPNs practicing in acute admission units and 300 RPNs practicing within adult community mental health services (in day hospitals, day centers, community mental health nursing services and homecare), will be invited to complete a questionnaire on a national basis.
The central aim of the anonymous questionnaire is to determine RPN's activities/skills, knowledge, training needs and interests in relation to their practice with service users who are parents and with service user's children/families. The questionnaire can be completed by both RPNs who have current and/or previous experience of caring for service users who are/were parents and by RPNs who have no such experience.
In the second phase, a subsample of RPNs from the quantitative sample, (n = 20), who have experience of caring for mothers who have Enduring Mental Illness, will be invited to expand upon the findings of the questionnaire.

It is anticipated that data collection will occur between October 2011 and June 2012. The questionnaire will be distributed by me, Anne Grant, with the help of Directors of Mental Health Nursing.

Anticipated outcomes:

This study will develop understanding of RPN's practice with service users who are parents. Increased knowledge of RPN's practice, in this particular context, will benefit both RPNs, mentally ill parents and their children/families. It is anticipated that the findings will result in recommendations which will be used to develop RPN's practice with mentally ill parents and their children/families on a national and international basis. With appropriate supports to enhance their resilience, mentally ill parents can be caring and effective parents. Effectively identifying, supporting and intervening with mentally ill parents and their children/families is also a crucial way that the intergenerational transmission of mental illness can be prevented.
Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC). If you would like further information about this study please contact Anne at:

Tel: (01) 7166424
Email: anne.grant@ucd.ie
URL: http:\\www.parentalmentalillness.info

Appendix 5: Conference Presentation (poster)

REGISTERED PSYCHIATRIC NURSES' PRACTICE WITH SERVICE USERS WHO ARE PARENTS

Anne Grant, School of Nursing, Midwifery and Health Systems, University College Dublin
In collaboration with
Associate Professor Darryl Maybery and Dr Andrea Reupert, Monash University, Australia

Artwork provided by the Participants of the Vic Champs program in Australia

Background

20 – 50% of mental health service users may be parents (Howe *et al.*, 2009).

Discussion of the complex interactions between mentally ill parents and their children/families is entering mainstream clinical practice (Gopfert *et al.*, 2004).

In *A Vision for Change*, the Government of Ireland (2006), recommended that mental health services should support service users to realize their full potential as parents and address the needs of service users' children.

Mentally ill parents commonly describe parenthood as a rewarding experience (Gopfert *et al.*, 2004).

However, a parent's mental illness may adversely affect their parenting capacity and stress from the parenting role can jeopardise their mental health. Difficulties in parenting tend to occur at times of relapse and during the acute phase of the parent's mental illness and can adversely affect both the parent and their children/families' well being on a temporary and on an ongoing basis (Maybery and Reupert 2009a, Gopfert *et al.*, 2004)

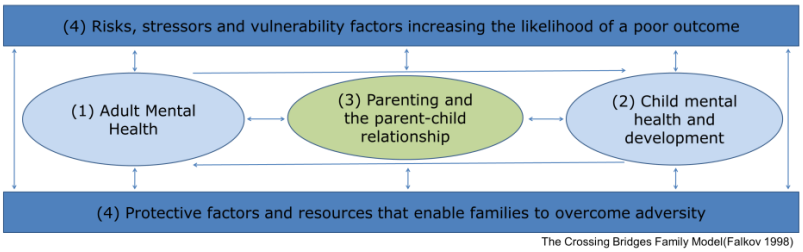
The ability of mental health professionals, including RPNs, to respond to children and family issues, when the service user is a parent, is an important point of intervention for such families (Maybery and Reupert 2008).

Research demonstrates the benefits of family focused practice to the service user, as well as his or her children and other family members (Maybery and Reupert 2009b).

However there is limited knowledge about RPN's practice with mentally ill parents and their children/families.

Within the family system it can be seen that

Parental mental illness affects children (1-2)	Parental mental illness can affect parenting and the parent-child relationship (1-3)	Parenthood can precipitate and influence parental mental illness (3-1)	Children's mental health and development needs impact on parental mental health (2-1)



The Crossing Bridges Family Model(Falkov 1998)

Aims

- This study aims to:
  - Establish RPN's capacity to engage in family focused practice.
  - Identify factors that facilitate and hinder RPN's family focused practice.
  - Establish if RPN's practice is consistent with national and international governmental policy objectives and international practice.
  - Determine how RPN's capacity to engage in family focused practice may be further developed.
  - Develop recommendations addressing the future development of RPN's practice with mentally ill parents and their children/families within the context of education, policy, practice and research.

Participants and methods

- In the first phase, approximately 300 RPNs practicing in acute admission units and 300 RPNs practicing within adult community mental health services (in day hospitals, day centres, community mental health nursing services and homecare/assertive outreach services), will be invited to complete a questionnaire on a national basis.
- In the second phase, a subsample of RPNs from the quantitative sample, (n = 20), who have experience of caring for mothers who have Enduring Mental Illness, will be invited to expand upon the findings of the questionnaire.

Outcomes

- The study will develop understanding of RPN's practice with service users who are parents; the findings may be used as a starting point for future research in both the national and international context; with an ultimate aim of developing RPN's capacity to meet the needs of mentally ill parents and their children/families. With appropriate supports to enhance their resilience, mentally ill parents can be caring and effective parents. Effectively identifying, supporting and intervening with mentally ill parents and their children/families is also a crucial way that the intergenerational transmission of mental illness can be prevented.

Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC).
If you would like further information about this study, you may contact Anne at (01) 7166424, email: anne.grant@ucd.ie
or http:\\www.parentalmentalillness.info

Appendix 6: Cover letter to DoMHN

UCD School of Nursing, Midwifery and Health Systems

UCD Health Sciences Centre,
University College Dublin,
Belfield, Dublin 4, Ireland
www.ucd.ie/nmhs

T +353 1 716 6424

Scoil na hAltrachta, an Chnáimhseachais agus na gCóras Sláinte UCD

Ionad Eolaíocht Sláinte UCD
An Coláiste Ollscoile, Baile Átha Cliath,
Belfield, Baile Átha Cliath 4, Eire

Nursing.midwifery@ucd.ie
www.ucd.ie/nmhs

1st May 2012

Dear (Director of Mental Health Nursing – Acute Admission Unit),

I wish to thank you for taking my recent telephone call. I found our conversation very helpful. This letter and other information is a follow up from that call. As I stated in our telephone conversation I am a lecturer in the School of Nursing, Midwifery and Health Systems, University College Dublin, and I am undertaking a study to examine Registered Psychiatric Nurse's (RPN) practice with mentally ill parents and their children/families within general adult mental health services in Ireland. In undertaking this study I am collaborating with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC).

As part of my data collection method I wish to recruit RPNs practicing within acute admission units throughout Ireland. I would like to obtain your permission to distribute a questionnaire and supporting documentation to RPNs practicing within your area. Hopefully upon reading the information in this envelope you will grant me such permission.

In order to invite RPNs, practicing within acute admission units, to participate in this study, I would be grateful if you could distribute a pre notice letter and information sheet to those colleagues who are working in the grade of Staff Nurse, Clinical Nurse Specialist and Clinical Nurse Manager 1 & 2 within your service. I enclose for your attention; a letter confirming that I have obtained full ethical approval from UCD, a letter of support from my primary supervisor, Associate Professor Darryl Mayberry, the pre notice letter, information leaflet, participant information sheet and questionnaire.

Could you please distribute the pre notice letter and information sheet a week in advance of my visit to your mental health service to distribute the questionnaire? I will distribute the questionnaire to all those RPNs who I meet during my visit to your mental health service and would appreciate it if you could distribute questionnaires to the remaining RPNs who I do not meet in the week following my visit. Respondents will not have to place their name on the questionnaire, nor will they have to divulge confidential client/service user information. Included with the questionnaire will be an interview volunteer form asking

RPNs if they would like to participate in a semi-structured interview which would be arranged at a later date. Again, persons who participate in interviews will remain anonymous, as will their employers. Respondents are free to refuse to take part at any given time, without giving a reason. I may wish to use data gathered in questionnaires and interviews in further publications. Neither respondents nor their employer will be identified in these.

There are no known risks to respondents from taking part in this research. It is anticipated that the research will provide a baseline level of skill, knowledge and activity regarding RPN's family focused practice with mentally ill parents and their children/families on a national basis. This will be used as a starting point for future research in this area. Ultimately, it is hoped that this research will benefit the psychiatric nursing profession and mental health professionals in general to develop their capacity to engage in family focused practice and to support mentally ill parents and their children/families. If you have any queries regarding the study please do not hesitate to contact me at 01 7166424 or anne.grant@ucd.ie Otherwise I may contact you in two weeks time. May I thank you for your time and in anticipation of your help.

Yours sincerely,

Anne Grant

UCD School of Nursing, Midwifery and Health Systems

UCD Health Sciences Centre,
University College Dublin,
Belfield, Dublin 4, Ireland
www.ucd.ie/nmhs

T +353 1 716 6424

Scoil na hAltrachta, an Chnáimhseachais agus na gCóras Sláinte UCD

Ionad Eolaíocht Sláinte UCD
An Coláiste Ollscoile, Baile Átha Cliath,
Belfield, Baile Átha Cliath 4, Eire

Nursing.midwifery@ucd.ie
www.ucd.ie/nmhs

1st May 2012

Dear (Director of Mental Health Nursing –Community Mental Health Services),

I wish to thank you for taking my recent telephone call. I found our conversation very helpful. This letter and other information is a follow up from that call. As I stated in our telephone conversation I am a lecturer in the School of Nursing, Midwifery and Health Systems, University College Dublin, and I am undertaking a study to examine Registered Psychiatric Nurse's (RPN) practice with mentally ill parents and their children/families within general adult mental health services in Ireland. In undertaking this study I am collaborating with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC). As part of my data collection method I wish to recruit RPNs practicing within acute admission units throughout Ireland. I would like to obtain your permission to distribute a questionnaire and supporting documentation to RPNs practicing within your area. Hopefully upon reading the information in this envelope you will grant me such permission.

In order to invite RPNs, practicing within community mental health services, to participate in this study, I would be grateful if you could distribute a pre notice letter and information sheet to those colleagues who are working in the grade of Staff Nurse, Clinical Nurse Specialist, Community mental Health Nurse/Community Psychiatric Nurse and Clinical Nurse Manager 1 & 2 within four areas of your service including: community mental health nursing, homecare, day centre and day hospital. I enclose for your attention; a letter confirming that I have obtained full ethical approval from UCD, a letter of support from my primary supervisor, Associate Professor Darryl Mayberry, the pre notice letter, information leaflet, participant information sheet and questionnaire. Could you please distribute the pre notice letter and information sheet a week in advance of my visit to your mental health service to distribute the questionnaire? I will distribute the questionnaire to all those RPNs who I meet during my visit to your mental health service and would appreciate it if you could distribute questionnaires to the remaining RPNs who I do not meet in the week following my visit. Respondents will not have to place their name on the questionnaire, nor will they have to divulge confidential client/service user information. Included with the questionnaire will be an interview volunteer form asking RPNs if they would like to participate in a semi-structured interview which would be arranged at a later date. Again, persons who participate

in interviews will remain anonymous, as will their employers. Respondents are free to refuse to take part at any given time, without giving a reason. I may wish to use data gathered in questionnaires and interviews in further publications. Neither respondents nor their employer will be identified in these.

There are no known risks to respondents from taking part in this research. It is anticipated that the research will provide a baseline level of skill, knowledge and activity regarding RPN's family focused practice with mentally ill parents and their children/families on a national basis. This will be used as a starting point for future research in this area. Ultimately, it is hoped that this research will benefit the psychiatric nursing profession and mental health professionals in general to develop their capacity to engage in family focused practice and to support mentally ill parents and their children/families. If you have any queries regarding the study please do not hesitate to contact me at 01 7166424 or anne.grant@ucd.ie Otherwise I may contact you in two weeks time. May I thank you for your time and in anticipation of your help.

Yours sincerely,

Anne Grant

Appendix 7: UCD Human Research Ethics Committee approval

21st April 2011

Ms Anne Grant
UCD School of Nursing, Midwifery and Health Systems
Health Science Centre
Belfield
Dublin 4

Re: LS-11-54-Grant-Maybery: *Registered Psychiatric Nurses' practice with mentally ill parents and their children/families within adult mental health services in Ireland*

Dear Ms Grant

Thank you for your response to the Human Research Ethics Committee – Sciences (13/04/11). **The Decision of the Committee is to grant approval for this application which is subject to the conditions set out below.**

Please note, if not already done, that a signed hard copy of the HREC Application Form is required by the Research Ethics Office. Please ensure that the signed form includes all approved revisions – your approval status will be registered upon receipt of this document.

Please also note that approval is for the work and the time period specified in the above protocol and is subject to the following:

- If applicable - all permissions to access participants, whether internal (heads of Schools/Registrar) or external are obtained before recruitment of participants is commenced;
- Any amendments or requests to extend the original approved study will need to be approved by the Committee. Therefore you will need to submit by email the *Request to Amend/Extend Form* (HREC Doc 10);
- The Committee should also be notified of any unexpected adverse events that occur during the conduct of your research by submitting an *Unexpected Adverse Events Report* (HREC Doc 11);
- You are required to provide an *End of Study Report Form* (HREC Doc 12) to the Committee upon the completion of your study;
- This approval is granted on condition that you ensure that, in compliance with the Data Protection Acts 1988 and 2003, all data will be destroyed in accordance with your application and that you will confirm this in your *End of Study Report* (HREC Doc 12), or indicate when this will occur and how this will be communicated to the Human Research Ethics Committee;

…/.

- You may require copies of submitted documentation relating to this approved application and therefore we advise that you retain copies for your own records;

- It must be understood that any ethical approval granted is premised on the assumption that the research will be carried out within the limits of the law.
- Please note that approved submissions are subject to a random audit.

The Committee wishes you well with your research and look forward to receiving your report. All forms are available on the website www.ucd.ie/researchethics please ensure that you submit the latest version of the relevant form. If you have any queries regarding the above please contact the Office of Research Ethics.

Yours sincerely

_____

Professor William Watson
Chairman, Human Research Ethics Committee - Sciences

Appendix 8: Interview volunteer form

Registered Psychiatric Nurse's Practice with Mentally Ill Parents and their Children/Families within Adult Mental Health Services in Ireland

Interview Volunteer Form

If you have current or previous (within the last 12 months) experience of providing services to one or more mothers with enduring mental illness, and would be willing to take part in a semi-structured interview, please complete the Interview Volunteer Form below and forward it to me along with your questionnaire in the stamped self-addressed envelope. If you complete this form and agree to participate in a follow up interview you will not remain anonymous but your confidentiality will be maintained.

The semi-structured interview will provide an opportunity for you to talk about your practice in more detail; it will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the tape recorder to be turned off. All of the information that you provide will be confidential including your name, place of employment and responses. Your response will be combined with those of other registered psychiatric nurses practicing in various adult mental health services within Ireland.

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

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

My name is: _____

I work in the following type of care setting (please tick one)

(a) Acute Admission Unit

(b) Community Mental Health Nursing Services

(c) Homecare services

(d) Day Hospital

(e) Day Centre

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

Telephone number: _____

E-mail address: _____

Appendix 9: Interview informed consent form

Title: Registered Psychiatric Nurses' practice with mentally ill parents and their children/families within adult mental health services in Ireland

Dear (name of participant)

Thank you for agreeing to participant in a semi-structured interview. The purpose of the semi-structured interview is to follow up on findings from the questionnaire which examined RPN's practice with mentally ill parents and their children/families. The semi-structured interview will focus on your practice with mothers who have enduring mental illness and on your practice with their children and families; It will provide an opportunity for you to talk about your practice in more detail; it will last no longer than one hour and will be held in a location which is convenient for you. If you choose to take part in an interview, with your permission, the interview will be audio recorded to facilitate transcription and subsequent analysis. However, at any time, you can ask for the tape recorder to be turned off.

The research knowledge might lead to publications in a theses, journals, books and/or evaluation reports for the future benefit of others. It may also be used for comparison purposes with other countries such as Australia and Canada. However, all of the information that you provide will be confidential including your name, place of employment and responses. Your information will also be combined with information provided by other RPNs throughout Ireland and findings will be reported in a collective way as opposed to identifying one particular mental health service or location. You will be able to withdraw from the study at any time, up until the point when I commence writing up my research.

All information from the semi-structured interviews will be filed under a number and not your name. Note that the confidential information you provide in the interview will be stored for two years on a password protected computer in my office at UCD. After this time it will be shredded. Audiotapes will be destroyed once they have been verified for accuracy of transcription.

I am aware of the constraints on your time and appreciate the effort required to participate. Please take time to consider whether you want to take part in this research. It would be a privilege to have you participate and hopefully your involvement will help to develop mental health service provision for mentally ill parents, their children and their families. If you have any questions please do call me at 7166424 or contact me by email at anne.grant@ucd.ie

Thank you

Anne Grant

Consent Form

If you are willing to participate in the semi-structured interview outlined above please complete the following Informed Consent Form:

I (name of participant) have spoken to the researcher and have had the study explained to me and I agree to the following:

1. I have read the information provided in the Interview Consent Form and have had time to consider whether to take part.
2. I understand the purpose of the study.
3. I understand what will be personally entailed should I agree to participate in the study.
4. Details of procedures and any risks have been explained to my satisfaction.
5. I agree to take part in this research.
6. I agree that my information and participation can be recorded on audio tape and subsequently transcribed.
7. I understand that I am free to withdraw from the interview at any time without disadvantage.
8. I am aware that I should retain a copy of the Interview Consent Form for future reference.
9. I agree that the data can be used in publications.
10. I agree that the data can be shared with other international groups, including researchers in Australia and Canada
11. I understand that:
    - I may not directly benefit from taking part in this research.
    - My participation is voluntary (it is my choice).
    - I am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified in any way and individual information will remain confidential.

Name of Participant (in block letters): _____

Participant's Signature _____ Date _____

I certify that I have explained the study to the participant and consider that he/she understands what is involved and freely consents to participation.

Researcher's Signature _____ Date _____

Appendix 10: Pre notice letter

PRENOTICE LETTER

6th June 2012

Dear Colleague, I am writing to ask for your help with an important study being conducted by myself - Anne Grant, Registered Psychiatric Nurse (RPN) and lecturer in Nursing, at University College Dublin (UCD), in collaboration with Associate Professor Darryl Maybery and Dr Andrea Reupert at Monash University, Australia. In the next few days you will receive a request to participate in this study by completing a questionnaire, designed to obtain your perspectives of your practice with service users who are parents.

Increasing numbers of adult mental health service users are parents. Whilst a parent's mental illness may adversely affect their parenting capacity, stress from the parenting role can jeopardise their mental health. Difficulties in parenting tend to occur at times of relapse and during the acute phase of the parent's mental illness and can adversely affect both the parent and their children/families' well-being on a temporary and on an on-going basis. There is increasing evidence to suggest that RPNs represent a potentially valuable source of support for mentally ill parents and their children/families. However there is only limited understanding of RPN's practice in this context and the challenges they experience in caring for service users who are parents. This questionnaire is important; by completing it you will help to increase understanding of RPN's practice with mentally ill parents and their children/families and assist the psychiatric nursing profession and allied health professionals to comprehend the issues and challenges encountered by RPNs in this respect. This understanding can then be used to develop mental health service provision for mentally ill parents and their children/families in the Irish context; in line with developments in countries such as Australia, Canada and the United Kingdom.

Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC). The Director of Mental Health Nursing, in your area, has also endorsed this study and has agreed to facilitate you to participate, if you so wish. You can obtain additional information about this research study at http://www.parentalmentalillness.info or directly from me at the address and/or phone number above.

We would like to do everything that we can to make it easy and enjoyable for you to participate in the study. I am writing to you in advance because I am aware of the constraints on your time and because many people like to know ahead of time that they will be asked to fill out a questionnaire. This research can only be successful with the generous help of people like you. I hope that you are able and willing to take 20 - 25 minutes of your time to help us. Most of all, I hope that you enjoy the questionnaire and the opportunity to voice your thoughts and opinions about RPN's practice with service users who are parents.

Yours Sincerely,

Anne Grant

Appendix 11: Information booklet

Registered Psychiatric Nurses' Practice with Mentally Ill Parents and their Children/Families within General Adult Mental Health Services in Ireland

Introduction

Dear Colleague, this information leaflet outlines a forthcoming study designed to obtain Registered Psychiatric Nurses' perspectives of their practice with service users who are parents. Your help with this study would be greatly appreciated.

Background to study

The number of service users, of general adult mental health services, who are parents, has increased. It is estimated that between 25 and 50% of adults known to mental health services have children (Farrell *et al.*, 1999). Although mentally ill parents value their parenting role and perceive that it promotes their recovery and integration within their communities (Gopfert *et al.*, 2004), the literature also suggests that a substantial number experience varying degrees of difficulty in fulfilling their parenting responsibilities due to their mental illness (Maybery and Reupert 2010, Gopfert *et al.*, 2004). These difficulties in parenting tend to occur at times of relapse and during the acute phase of their mental illness and can adversely affect their own and their children's well-being on a temporary and on an ongoing basis (Gopfert *et al.*, 2004).

A parent's mental illness can adversely affect their child(rens') mental, physical and social well-being; up to eighty percent of parents with EMI may lose custody, of one or more children, on a temporary or permanent basis, as a consequence (Joseph *et al.*, 1999). Stress associated with parenting may also precipitate a relapse of the parent's mental illness or prevent or prolong their recovery (Gopfert *et al.*, 2004). Parental mental illness may also lead to socio economic disadvantage and family discord and disorganisation (Beardslee *et al.*, 1998); this further compounds difficulties in parenting with resultant adverse effects for the parent and their children/families. Consequently, families affected by parental mental illness are identified as among the most vulnerable in our community (Beardslee *et al.*, 1998).

It is recognized that mentally ill parents and their children/families are potentially an easily identifiable group that would be widely responsive to preventive interventions (Beardslee *et al.*, 2007). Research has clearly and repeatedly demonstrated the benefits of family focused practice to the service user, as well as his or her children and other family members (Maybery and Reupert 2010). As such, mental health professionals have a unique opportunity to alleviate suffering and prevent costly long-term social outcomes if they can identify and support mentally ill parents and their children/families. Consequently, significant work is being undertaken in countries such as, Australia, Canada, Finland and England to facilitate mental health professionals to develop their capacity to support mentally ill parents and their children/families (Lee 2004).

Statutory services, such as adult mental health services, have the potential to support mentally ill parents in their parenting role as these services provide mental health care to parents when they are likely to encounter greatest difficulties in parenting, such as during an acute exacerbation of their mental illness (Gopfert *et al.*, 2004). It is increasingly suggested that for a number of reasons, RPNs in particular, represent a potentially valuable source of support for mentally ill parents and their children/families. However, due to limited research on this subject internationally and an absence of research in Ireland there is inadequate understanding of RPN's practice in this context and the challenges RPN's experience in caring for service users who are parents.

The recent recommendations within Irish mental health policy, *A Vision for Change*, (Department of Health and Children (DoHC) 2006), regarding mentally ill parents and their children/families make it all the more imperative that the gap in knowledge, surrounding RPN's practice with mentally ill parents and their children/families, be addressed.

Information about this study

This study aims to:

- Establish RPN's capacity to engage in family focused practice.
- Identify factors that facilitate and hinder RPN's family focused practice.
- Establish if RPN's practice is consistent with national and international governmental policy objectives and international practice.
- Determine how RPN's capacity to engage in family focused practice may be further developed.
- Develop recommendations addressing the future development of RPN's practice with mentally ill parents and their children/families within the context of education, policy, practice and research.

Definition of family focused practice:

The term family focused practice is generally used within this research to describe the process of working with service users around issues related to parenting with a mental illness, which may affect their parenting capacity and or their mental health. It also entails working with service users' children (those who are younger than 18 years of age) and their families. It may include a number of direct or indirect interventions by RPN's including: interventions to promote the parent's mental health and to develop the parent's capacity to cope with their mental illness, interventions to address parent's socio economic difficulties, including difficulties related to housing, employment, finances and social supports and interventions around parenting to address needs of both the parent and their child(ren)/families.

Methodology:

In the first phase, approximately 300 RPNs practicing in acute admission units and 300 RPNs practicing within adult community mental health services (in day hospitals, day centers, community mental health nursing services and homecare), will be invited to complete a questionnaire on a national basis.

The central aim of the anonymous questionnaire is to determine RPN's activities/skills, knowledge, training needs and interests in relation to their practice with service users who are parents and with service user's children/families. The questionnaire can be completed by both RPNs who have current and/or previous experience of caring for service users who are/were parents and by RPNs who have no such experience.

In the second phase, a subsample of RPNs from the quantitative sample, (n = 20), who have experience of caring for mothers who have Enduring Mental Illness, will be invited to expand upon the findings of the questionnaire.

It is anticipated that data collection will occur between October 2011 and June 2012. The questionnaire will be distributed by me, Anne Grant, with the help of Directors of Mental Health Nursing.

Anticipated outcomes:

This study will develop understanding of RPN's practice with service users who are parents. Increased knowledge of RPN's practice, in this particular context, will benefit both RPNs, mentally ill parents and their children/families. It is anticipated that the findings will result in recommendations which will be used to develop RPN's practice with mentally ill parents and their children/families on a national and international basis. With appropriate supports to enhance their resilience, mentally ill parents can be caring and effective parents. Effectively identifying, supporting and intervening with mentally ill parents and their children/families is also a crucial way that the intergenerational transmission of mental illness can be prevented. Full ethical approval for this study has been obtained from the UCD Human Research Ethics Committee (HREC). If you would like further information about this study please contact Anne at:

Tel: (01) 7166424
Email: anne.grant@ucd.ie URL: http:\\www.parentalmentalillness.info

Appendix 12: Monash Ethics application

Do not staple

MONASH University

Monash University Human Research Ethics Committee (MUHREC)

Application for
Multi-centre research project where another Human Research Ethics Committee has approved the research as the primary ethics committee

Form MC (V1/2011)

INFORMATION FOR APPLICANTS

1. Ensure that you are using the most current version of the form.
2. MUHREC does not accept hand written applications.
3. **PLEASE NOTE**

Research with certain Victorian Health Service Providers
Monash University has entered into special arrangements with Southern Health, Peninsula Health, Alfred Health and Cabrini Health to expedite ethics approval for human research conducted at their hospitals. If research is conducted at one of those hospitals, that research will be reviewed by the hospital's Human Research Ethics Committee. Researchers will **not** be required to complete a multicentre form for MUHREC but will be required to submit copy documentation to MUHREC. See http://www.monash.edu.au/researchoffice/human/form-mc.html

Research with the Department of Justice (Vic)
Monash University has entered into an arrangement with the Department of Justice (DOJ) to expedite ethics approval for human research involving both Monash and DOJ. Where multi-centre research involves both Monash and DOJ, then unless Monash and DOJ otherwise agree in writing, DOJ's Human Research Ethics Committee (HREC) shall be the primary HREC for that project. Researchers will **not** be required to complete a multicentre form for MUHREC but will be required to submit copy documentation to MUHREC. See http://www.monash.edu.au/researchoffice/human/form-mc.html

Submission requirements for Form MC:

Researchers can submit Form MC at any time. Most applications are considered within 2 weeks of receipt.

Researchers should provide ONE hard copy and an electronic copy of the following:

- completed Form MC;
- the final version of the application form to the primary HREC;
- the Certificate of Approval from the primary HREC; and
- other relevant documentation from the other HREC.

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Send Hard Copy to Human Ethics Office

First Floor, Building 3E, Room 111
Monash University VIC 3800
Tel +61 3 9905 5490; Fax +61 3 9905 3831

Send electronic copy to muhrec@monash.edu

Note: All researchers listed in the multicentre application must already be approved by the primary HREC.

PRIVACY INFORMATION: The information you provide on this form is collected for the primary purpose of assessing your human ethics application. This information will also be entered on to a database to assist with administration, correspondence and statistical analyses. These records are accessed by staff in the Research Office and possibly other administrative staff at Monash University (e.g. Occupational Health, Safety and Environment, Archives and Records Services) and are kept in a manner to ensure confidentiality and secure storage for 7 years after the expiry of the term of approval. Although this information is not usually disclosed to other individuals, there may be some circumstances, which require the information to be disclosed (eg FOI Act). If you chose not to complete all the questions on this form it may not be possible for MUHREC to assess your application. To access your personal information, please contact the Human Ethics Officer on +61-3-9905 2052. For privacy related concerns please contact the Monash University Privacy Officer on +61-3-9905 6011.

Important – Using the form

- It is best to view this form in TEXT WIDTH or PAGE WIDTH.
- This form is set up as a series of tables and check boxes ☐. The table will enlarge to the size you require when you type and by pressing the Enter key.
- Double click on the left mouse button ☒ and a "check box form fields" box will appear. Choose CHECKED and OK.
- If you want to uncheck it, double click on the left mouse button ☐ and a check box form fields box will appear. Choose NOT CHECKED and then click on OK.

Abbreviations

HREC	Human Research Ethics Committee
MUHREC	Monash University Human Research Ethics Committee

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MONASH University

Application for

Multi-centre research project where another Human Research Ethics Committee has approved the research as the primary human research ethics committee

	DATE RECEIVED		APPLICATION NUMBER
Office use only		*Office use only*	

1	Title of project
Max 10 words	Registered Psychiatric Nurse's practice with mentally ill parents and their children/families

2	Researchers involved in the conduct of the project		
Chief Investigator / Primary Supervisor *(must be a Monash University staff member)*			
☐	Please check box if an **Honorary staff member** and provide the name of the organisation of your primary affiliation:		
Title: Associate Professor	**Name:** Darryl Maybery	**Staff ID:** 1064437	**Current qualifications** *(please include all)*: BA, BSc (Hons), Phd.
Department: Department of Rural and indigenous Health			**Campus**: Moe, Victoria
Full postal address (if external address including international campuses): Associated Professor of Rural Mental Health Monash University Department of Rural and Indigenous Health PO Box 973 Moe, Victoria 3825 Australia			
Phone 1:		**Phone 2:**	**Fax:**
Email *(MUST be Monash staff email address)*:			

Please choose one

☐	**Co-investigator**		
☒	**Student researcher**		
☐	**Other, please specify**		
Title: Ms	**Name**: Anne Grant	**Staff ID:**	**Current qualifications** *(please include all)*: RGN,RPN & Masters in Education
Affiliated Institutions ***(if not affiliated with Monash University)***: University College Dublin Ireland			
Department: Faculty of Medicine and Nursing			**Campus**: Clayton

Full postal address (if external address including international campuses): School of Nursing, Midwifery and Health Systems, Health Science Complex, University College Dublin, Belfield, Dublin 4, Ireland		
Phone 1: [redacted] Dublin 7166424	**Phone 2**: [redacted] Clayton 95447869	**Fax:** [redacted]
Email: *(If Monash staff or student, you MUST provide a Monash staff or student email address)*: anne.grant@monash.edu		
If student researcher - Student ID number: [redacted] 23445432		

☒	**Co-investigator**		
☐	**Student researcher**		
☐	**Other, please specify** [redacted]		
Title: Dr	**Name**: Andrea Reupert	**Staff ID:** 1064452	**Current qualifications** *(please include all)*: BA, DipEd, Grad.Dip.Couns.Psych, PhD
Affiliated Institutions ***(if not affiliated with Monash University)*:**			
			Campus: Clayton
Full postal address (if external address including international campuses): Faculty of Education, Monash University, Clayton.			
Phone 1: 9902 4587	**Phone 2**:		**Fax:**
Email: *(If Monash staff or student, you MUST provide a Monash staff or student email address)*: andrea.reupert@monash.edu			
If student researcher - Student ID number:			

☒	**Co-investigator**		
☐	**Student researcher**		
☐	**Other, please specify** [redacted]		
Title: Ms	**Name**: Melinda Goodyear	**Staff ID:** 10644954	**Current qualifications** *(please include all)*: BBSc (Hons), MBSc
Affiliated Institutions ***(if not affiliated with Monash University)*:** [redacted]			
Department: Monash University Department of Rural and Indigenous Health			**Campus**: Moe
Full postal address (if external address including international campuses): [redacted] 3 Ollerton Avenue (PO Box 973) Moe, Vic, 3840.			
Phone 1: 5128 1021	**Phone 2**: 0412 880 598		**Fax:** 5128 1000
Email: *(If Monash staff or student, you MUST provide a Monash staff or student email address)*: [redacted] melinda.goodyear@monash.edu			
If student researcher - Student ID number: [redacted]			

Please copy, paste and complete table for additional researchers.

3	**Clearly state the aims and/or hypotheses of the research project**

250 words max

1. Benchmark RPN family sensitive practices with mentally ill parents and their children/families from the perspective of RPN's working within acute admission units and in community mental health nursing services in Ireland.

2. Establish RPN's capacity to engage in family sensitive practice and compare the extent to which RPNs working within acute admission units and within community mental health nursing services engage in family sensitive practice.

3. Compare and contrast the survey findings with those in Australia and Canada.

4. Develop recommendations addressing the future development of RPN's practice with mentally ill parents and their children/families within the context of education, policy, practice and research.

3.1	**Give details of procedures involving participants:**

In the first phase 600 RPNs in 12 mental health services were invited to complete an annonymous national survey within a cross sectional design. The measure which was developed by Maybery *et al.*, 2010, has been developed to determine RPNs' training needs, interests and behaviour regarding family focused mental health practices (please see attachment 2 in supporting documents). The survey was adapted for use in the Irish context. Items measured RPN's attitude, interest, knowledge, skill and activity as well as factors that facilitate and hinder them in addressing service users' parenting roles (e.g. policy). The questionnaire was distributed to RPNs by Directors of Mental Health Nursing and respondents returned the questionnaire to the researcher in sealed addressed envelopes provided. Return of the completed questionnaire by RPNs implied their consent. The information sheet (please see attachment 4 in supporting documents) provided the researcher with an opportunity to provide RPNs with the necessary information regarding the use and purpose of the questionnaire.

In the second phase, commencing January 2013, a subsample of RPNs from the quantitative sample (approx n =15), who have tangible experience of caring for mothers who have EMI, will be invited to expand upon the findings of the questionnaire. In the final section of the questionnaire RPNs with previous or current experience were invited to participate in a follow up interview (please see attachment 3 in supporting documents). RPNs who wished to participate were asked to provide their name and contact details on a separate slip which was included with but separate to the questionnaire. The interview will take no longer than one hour and will be held at a location that is most convenient to the RPN. Written consent will be obtained for the semi-structured interviews in the second phase of the study. Participants will consent to participate in interviews by completing and returning an interview volunteer form (please see attachment 6) which will be included with (but separate) to their questionnaire. Prior to commencing the interview the participants will be asked to complete an informed consent form (please see attachment 5).

The qualitative component will explore the process of RPN's practice with mothers who have Enduring Mental Illness. In particular, the qualitative component will build upon the quantitative findings of Korhonen et al., (2008), Maybery and Reupert (2006), Thompson and Fudge (2005) and Gillam et al., (2004) by exploring how RPNs engage in family sensitive/focused practice and how and why factors facilitate and hinder them in the process. The qualitative component will also elicit RPN's perspectives as to how they can best support mentally ill parents and their children/families.

Although face to face interviews are not anonymous the confidentiality of the information provided will be assured through not disclosing the individual or organisational names in reporting the

	findings and through appropriate storage of data. The process of audio taping interviews will be clearly outlined in the information letter and participant's permission to tape their interview will be obtained at the start and checked throughout the interview. Participants will be given the option to not have their interview taped and assured that they can terminate their interview at any given time without giving a reason. Participants will also be invited to verify the summary of their interview with an invitation to delete and/or change any part of this (please see attachments 5 & 6 in supporting documents).
	If in the unlikely event that an RPN may get upset during the interview the PI will stop the interview and recommence it only when and if the RPN is ready to continue. Interviewees will also be contacted two weeks after the interview to check if there is anything further related to the interview that they would like to discuss. No potential or actual harm is thought to be imposed on participants (from interviews) consequently, there is no need to offer or make provision for counselling.
	In reporting findings the names and locations of organisations or RPN's will not be reported. Consequently, if there are service gaps, not one organisation will be highlighted but will instead be reported as a general issue.

4	**Please identify which human research ethics committee accepts primary responsibility for the scientific and technical assessment of the project and its ethical review.** ***Please attach the Letter of Approval from the primary HREC.***
	University College Dublin Human Research Ethics Sub Committee has accepted primary responsibility
4.1	**Please confirm that all researchers named in this form have been approved by the primary HREC:**
☒	**YES**
☐	**NO** – If no, please apply to the primary HREC for an amendment to include these researchers before submitting this Multicentre application to MUHREC. The amendment approval from the primary HREC will need to be submitted with your MUHREC multicentre application.

5	**If the project has been approved at multiple sites, list other HRECs where you have submitted a human ethics application.** PLEASE NOTE (If your research involves **Southern Health, Peninsula Health, Alfred Health, Cabrini Health** or the Department of Justice (Vic) stop completing this form and see our website for the appropriate expedited process.http://www.monash.edu.au/researchoffice/human/form-mc.html)

	Name of HREC	Is approval granted and letter attached? *Place x in appropriate box*		
		Yes	No	Pending
1	University College Dublin HRESC	☒	☐	☐
2		☐	☐	☐
3		☐	☐	☐
4		☐	☐	☐

6	**Please identify if you are using potentially vulnerable participants as listed below.**

Please place an x as appropriate

YES	**Please identify which group**	
☐	Women who are pregnant and the human foetus	
☐	Children or young people under the age of 18	
☐	Children or young people aged 16 or 17 whose circumstances indicate that they are capable of giving informed consent, e.g. University students aged 17.	
☐	Persons with an intellectual disability or mental impairment of any kind, includes • intellectual or mental impairment; • mental disorder; • brain injury; • dementia.	
☐	Persons considered to be (a) a forensic patient; or (b) an involuntary patient; or (c) a security patient;	You may have additional responsibilities under the Mental Health Act.
☐	Persons with impaired capacity for communication	
☐	Prisoners or people on parole	You may also need to obtain approval from the Department of Justice HREC.
☐	Children who are Wards of the State	
☐	Persons highly dependent on medical care including a person who is unconscious	
☐	Military personnel	
☐	Persons who would not usually be considered vulnerable but would be considered vulnerable in the context of this research project	
☐	Persons in dependent or unequal relationships relevant to the research	
☐	Collectivities / Communities	
☐	Aboriginal and / or Torres Strait Islander peoples	
☐	Deception of participants, concealment or covert observation	

☐	Examining potentially sensitive or contentious issues	
☐	Seeking disclosure of information which may be prejudicial to participants	
☐	Study of or participation in illegal activities	
☐	Other. Please specify	

7	**Will the data be collected in a location other than Australia?**

Place x in box

☐	**NO**
☒	**YES,** please specify the location and, if relevant, please explain whether there are any cultural issues related to the conduct of the research which would assist the committee with the review of your research project? The data will be collected in Ireland – there are no cultural issues related to the conduct of the research.

8	**Funding of your research project – please complete the table**		
	Name of organisation / funding agency	Award (e.g. NHMRC, project grant)	Name of Institution administering the funds
1			
2			

9	**What is the role of Monash University and Monash University staff in this research project?**
	Dr Darryl Maybery and Dr Andrea Reupert and Melinda Goodyear are supervising this research which is being completed for the award of Doctor of Philosophy within the Faculty of Medicine and Nursing at Monash University.

10	**Will Monash University staff be directly in contact with participants in this study?**
No	

11	**Please describe the participants involved in your research project**		
	How many people	Group of people involved	Age range
Group 1	600 RPNs were sampled and 346 responded.	Registered Psychiatric Nurses	18 - 60
Group 2			
Group 3			
Group 4			

If you need more rows please click on a row, go to TABLE on the menu bar and then to INSERT on the drop down menu. Click on ROWS BELOW.

12	**Will Monash University staff be involved in the recruitment of participants in this study? If Yes, please provide a step-by-step description of how this will happen and how potential participants will be invited to take part in the study?** ***(i.e. via advertisement? through email?)***

In the first phase approximately 300 RPNs practicing in acute admission units and approximately 300 RPNs practicing within community mental health nursing services, across all 4 Health Service Executive (HSE) regions, were invited to complete a national survey. As there is no register of RPNs practicing in either of these areas in Ireland, a claustered random sampling approach was used to select 12 mental health services for inclusion in the study. Within these services, Directors of Mental Health Nursing (DoMHN), with the help of the researcher, identified RPNs who met the study inclusion criteria and DoMHN distributed information leaflets, pre notice letters and questionnaires to potential participants on behalf of the Principle Researcher.

13	**Will you be offering any reimbursement to participants?**
☒	**NO**
☐	**YES – how much and what form will the reimbursement take?**

14	**Will any dependent or unequal relationship exist between anyone involved in the recruitment and the participants?**
☒	**NO**
☐	**YES** – *describe the nature of the relationship, and explain what special precautions will preserve the rights of such people to decline to participate or to withdraw from participation once the research has begun.*

15	**Is a consent form attached?**
☐	No
☒	Yes – *(please attach the consent form to this application)*

16	**Does the project involve the collection, use or disclosure of health information, personal information or sensitive information?**
☒	**NO**
☐	**YES** – *If Victorian privacy legislation was not considered in the original application to the primary HREC, you will need to complete Form P (Privacy Issues) which is available on the Human Ethics website.*

17	**What arrangements are in place if participants experience distress or there is an emergency (i.e. free counselling services? A nurse on hand? etc)?**

If in the unlikely event that an RPN may get upset during the interview the PI will stop the interview and recommence it only when and if the RPN is ready to continue. Interviewees will also be contacted two weeks after the interview to check if there is anything further related to the interview that they would like to discuss. No potential or actual harm is thought to be imposed on participants (from interviews) consequently, there is no need to offer or make provision for counselling.

Signature of Chief Investigator/or Supervisor	
Name DARRYL MAYBERY	Date 3/Nov/2012
Signature	