Abstract

The shift towards a family-focused approach to practice has been highly endorsed across child and adult mental health services with increasing policy development and a growing evidence base. The aim of this review was to synthesize the qualitative evidence of professionals' perspectives and experiences of implementing family-focused practice across these settings. Electronic databases were searched up to March 2018 of which 9 articles were included. The synthesis produced two overarching challenges relating to the organisational and system issues of family-focused practice, and clinicians' attitudes, knowledge and practice towards addressing the complexity of families' needs. The findings point to a limited evidence of professionals viewing the benefits of family-focused practice and a lack of coherence relating to professionals' investment in family-focused practice. These are discussed within policy and implementation factors.

Keywords: Family-focused practice, mental health professionals, parental mental illness

Introduction

There has been a recent global shift towards a family-focused approach to practice within the healthcare system. Family-focused practice (FFP) acknowledges the family as a unit and identifies the needs of the individual seeking support and the family in order to work collaboratively between services and families (Wong, Wan, & Ng, 2016). Mental health disorders have been one of the main causes of overall disease burden worldwide with the effects of mental illness on the family being widely acknowledged. This is particularly evident within the literature surrounding parental mental illness (PMI) whereby between 12-45% of adults engaging with adult mental health services have dependent children (Maybery & Reupert, 2018). A family-focused approach to working with young people and their parents has been identified as crucial in changing the outcomes of these families wherein focusing on the wider family and system proves essential for making a positive change and further developing family resilience (Foster, Brien, & Korhonen, 2012). Multiple studies have identified that practices of a family-centred approach reduces relapse rates (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001), reduces the burden of care, and increases emotional regulation for the family (Glynn, Cohen, Dixon, & Niv, 2006).

As a result, there has been an increasing investment in a family-centred and collaborative model of practice to address families' needs and improve the quality of care (Nicholson et al., 2015). This has been promoted internationally with a focus on integrating policy, research and practice which has been established across various policies and guidelines in order to move away from the individual model of mental health care. For instance, Australia has developed a policy framework for supporting 'Children of Parents with a Mental Illness' (COPMI) ("Framework for mental health services," 2010-2015). This framework is continuing to be reviewed and has also been included within other national strategies such as the Queensland Mental Health

Strategic Plan (Improving Mental Health and Wellbeing, 2014-2019). The COMPI framework promotes the adoption of FFP within services in which the strengths and vulnerabilities of parents with mental health difficulties, their children and the wider family are identified in order to provide support for all affected. These highlight the important relationships that can impact upon child and parent mental health such as parenting capacity, child development, risk stressors and protective factors. These factors are illustrated within The Family Model (Falkov, 2012) which underpins the family-focused approach to care and is central in supporting current FFP initiatives as a result of the model's support for collaboration between the individual and their family members (Grant et al., 2018). It therefore aims to highlight this vulnerable group as a priority for mental health services to promote a family-focused care assessment of the patient and their family.

Other guidelines include the development of routine practices in Norway with a focus on joint working between child and adult services, as well as increasing professionals understanding of FFP (Lauritzen & Reedtz, 2013). Similarly, across Ireland there has been new policy concerning the roles of practitioners and organisations to fundamentally offer support for the whole family via family-focused interventions (Grant & Reupert, 2016). Within the UK, there has been initiatives such as the "Think child, think parent, think family" initiative (Social Care for Institute (SCIE), 2009), and a continuing focus on improving accessible support for children and parents across child and adolescent services in Scotland (The Scottish Government's Mental Health Strategy, 2017-2027).

The term FFP indicates the significance of the family as at the centre of any practice. A recent integrative review sought to explore this through a review of FFP interventions across adult and child services (Foster et al., 2016). They identified six core practices of FFP with clients

and their families. These included family care planning and goal setting; liason between families and services including family advocacy; instrumental, emotional and social support; assessment of family members and family functioning; psychoeducation; and a collaborative care system between the family and services. This has provided a guiding framework for clinicians to consider the implementation of these core practices. Although this recent framework contributes towards defining what FFP may entail, it also reflects the considerable range of family-focused practices that can be adopted. What has been defined through the literature is that FFP is understood as greater than merely family involvement but rather how professionals directly respond to and engage other family members in support (Foster et al, 2016). In an effort to further define FFP, Leonard, Linden, & Grant (2018) illustrate a continuum of FFP activities in their review which were ranked in accordance with the intensity of practice involving families. For example, similarly to previous FFP continuums (Maybery et al, 2015), low level activities included psychoeducation with the parent to higher level activities such as assessment and intervention with all family members (Leonard et al., 2018).

Despite an increasing awareness for family-focused approaches, there are a number of identified barriers associated with its uptake. Maybery & Reupert (2009) provide an overview of the barriers that present for the adult mental health workforce to respond to children and families impacted by parental mental illness (PMI). Barriers that were identified to hinder professionals FFP related to issues regarding policy and management; interagency collaboration; and practitioners' attitudes, skills and knowledge. The inconsistency of policy and guidelines was highlighted as a significant barrier in terms of the variations in what should be routinely recorded (e.g. parenting status). Others were in relation to inadequate resources and time for FFP, and demanding workloads (Maybery & Reupert, 2006; Byrne et al., 2000). They also highlight the limitations in skill and knowledge of clinicians to effectively respond

to and ultimately meets the needs of families. This is consistent with research placing more of an emphasis on the experiences of clinicians practice in order to consider how to address these challenges (Tchernegovski, Reupert, & Maybery, 2017). Research is also now exploring the differences across professions and services in implementing FFP (Maybery, Goodyear, O'Hanlon, Cuff, & Reupert, 2014). This is of particular relevance given the variation in which healthcare professionals conceptualize and practice FFP across differing health settings (Foster et al., 2016). Much of the existing research has predominantly explored the challenges of FFP from mental health nurses' perspectives (Maddocks, Johnson, Wright & Stickley, 2010), therefore it would be opportune to explore to what extent other professionals' experiences have been accounted for within the literature.

Aims

As there is an increasing awareness of FFP together with new policy developments, and continuing organisational change across services, the aim of this review was to synthesize the qualitative evidence of mental health professionals' perspectives and experiences of implementing FFP across child and adult settings. This was examined through evidence relating to the barriers and challenges for the mental health workforce in implementing FFP.

Methods

Search Strategy

Six electronic databases were systematically searched up to 23rd March 2018: EBSCO Host – CINAHL, PsycINFO, PsyARTICLES, The Psychology and Behavioural Sciences Collection; Ovid - EMBASE and MEDLINE. Databases were selected based upon their relevance to the research aims and the range of disciplines covered within these databases. Preliminary searches were conducted which helped to generate the final search terms and keywords used. The search

terms were framed within the PICo (Population; Phenomena of Interest; Context) framework. These were categorised into "professionals", "mental health", and "family-focused practice". Search terms from Foster et al. (2016) review served as a guide. Additional hand searching methods were also employed via the reference lists of articles, previous reviews, and citations.

Inclusion and Exclusion Criteria

Criteria for inclusion consisted of peer-reviewed published studies in English with (i) the focus on mental health professionals' perspectives and/or experiences of implementing FFP, (ii) based within adult mental health or child and adolescent mental health settings, and (iii) professionals' qualitative reports with quotations/ excerpts.

Exclusion criteria were (i) any studies relating FFP for physical health conditions, (ii) FFP specific interventions or projects such as family based interventions or any family specific therapies (e.g. behaviour family therapy), (iii) review articles, editorials or discussion papers, and (iv) any studies where the focus was not exclusively on professionals' FFP.

Screening and Selection

Studies were reviewed in accordance with the eligibility criteria and were initially reviewed by title and abstract. Those studies remaining were then assessed for inclusion by reading the full text article, which determined the final number of included articles for review (see Figure 1).

Quality Appraisal

Quality appraisal was conducted on each study to assess methodological quality and rigor. Walsh & Downe's (2006) quality tool provides a comprehensive framework identifying eight key domains: score and purpose; method/design; sampling strategy; analytic approach;

interpretation; researcher reflexivity; ethical dimensions; and relevance and transferability. This was employed to critique the papers due to its applicability for qualitative appraisal which can be applied reflexively to identify studies' strengths and weaknesses (Walsh & Downe, 2006).

Two independent raters each reviewed three purposively selected papers. It was agreed that individual quality ratings of each study would not be reported within this review but rather a focus on the methodological strengths and weaknesses appraised across each of the domains. This would instead provide an initial sense of the relationships and patterns emerging between the individual studies. In addition, the variation of qualitative method and analysis conducted across studies is a key challenge for appraisal (Dixon-Woods, Shaw, Agarwal & Smith, 2004). Thus, it was understood that a descriptive account would better ensure transparency of quality appraisal and to acknowledge the subjective nature of appraising qualitative studies. In this way, scores were not reported as a way of distinguishing those high quality studies from low quality studies, thus reducing the risk of valuable insights being excluded from the synthesis (Dixon-Woods et al., 2007). Additionally, given the limited number of qualitative studies on professionals' FFP it was deemed appropriate to include all those studies identified with an appraisal of their methodologies.

Data Synthesis

The data from studies were synthesized drawing upon the systemic approach of Noblit & Hare's (1998) method for meta-ethnography. The themes from each study were juxtaposed to identify commonalities and differences. This facilitated the 'translating of studies into one another' to further refine the themes and then synthesizing these using interpretation to produce an understanding of each theme.

An audit trail of both the data extraction and synthesis was recorded to enhance reliability (Mays & Pope, 2000) and were reviewed during research supervision. This also facilitated discussions relating to sources of subjectivity and bias such as the selection of papers from many of the same authors and the risk in offering a potentially subjective view of FFP. However, through preliminary searches it became clear that much of the extant literature was predominantly from the same collaborating authors. The development of a clear search strategy and inclusion criteria assisted to reduce ambiguity around study selection.

Results

The PRISMA flow diagram (see Figure 1) illustrates the review process. A total of 9 studies were included in the meta-synthesis. A summary of these studies can be found in Table 1 which illustrates the initial data extraction method.

Meta-Synthesis

Two overarching themes were identified from the synthesis relating to professionals' implementation of FFP: organizational and system issues, and clinicians attitudes, knowledge and practice. There were six subordinate themes identified within organizational and system issues, and three subordinate themes within clinicians attitudes, knowledge and practice. Each were understood as factors through which FFP is implemented and were inferred from both enablers and barriers by professionals. Substantiating excerpts are presented within each theme. It is important to note that participant quotes are italicised while quotes from authors are in plain text. Tables 2 and 3 illustrate the contribution of each study towards the synthesis.

Methodological Review

There was clear documentation of all studies' scope and purpose. For sampling strategy, interpretation, ethics, and relevance and transferability, there was a clear report of how these were conducted and understood. A particularly good example of the analytical coding process was Grant & Reupert (2016):

"Themes were generated from information…around capacity to engage in FFP…Once the basic themes were created, they were categorized according to the underlying story they were telling, these become the organizing themes. The organizing themes were reinterpreted in light of their basic themes…" (p.206).

Design was also well reported across studies however for five of the studies, there wasn't a clear exploration of the rationale for their specific qualitative method or why it was appropriate for their study (Grant & Reupert, 2016; Reupert, Maybery, & Morgan, 2015; Wong et al., 2016; Wong, 2014; Ward, Reupert, McCormick, Waller, & Kidd, 2017). Analysis was generally well discussed such as that described in Baker-Ericzen, Jenkins, & Haine-Schiagel, 2013, and Grant & Reupert, 2016. However, there was a lack of "member checking" in three of the studies (Reupert et al., 2015; Baker-Ericzen et al., 2013; Wong, 2014). The main methodological difference that emerged was the lack of evidence of researcher reflexivity which was not evidenced in four of the studies (Reupert et al., 2015; Wong, 2014; Ward et al., 2017; Reupert, Williamson, & Maybery, 2017). Still, there was some demonstration of the researcher's influence on stages of the research process and evidence of self-awareness and insight by four of the studies (Grant & Reupert, 2016; Wong et al., 2016; Tchernegovski et al., 2017; Baker-Ericzen et al., 2013) with one study discussing the relationship between researcher and

participants, however with no further evidence of the other aspects of reflexivity (Reupert & Maybery, 2014). A particularly good example of demonstrating researcher influence and how potential differences were resolved was Wong et al. (2016): "Writing the reflective memo was useful for flushing the matters out, and regular debriefing was conducted during the research process to address potential bias due to personal and professional orientation, and issues of power and social desirability" (p.451).

Organizational and System Issues

Policy and management

All studies across each country (Australia, Ireland, Hong Kong, and USA) described policy and management issues within professionals' FFP to some degree (Baker-Ericzen et al., 2013; Wong et al., 2016; Wong, 2014; Ward et al., 2017; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2015; Reupert et al., 2017). Participants identified the significant impact service policies had on their capacity to engage in FFP, with a recurring pattern of professionals feeling the pressures of large caseloads and time constraints. This was depicted by social workers in Wong et al. (2016) where work was "oriented towards attainment of output indicators: *"Everybody is trying very hard to achieve impressive statistics…everybody just focuses on numbers…it was impossible to attain the output indicators"* (author and participant quote, p.456). Policy protocols such as documentation and paperwork were also associated with reducing freedom to practice: *"The focus has gotten more off what you're actually doing and [more into] being more accountable…like almost proving you're doing the work that you're doing. I don't like that autonomy is taken away from me…"* (participant quote, p.860, Baker-Ericzen et al., 2013).

There were however positive reports from psychiatric nurses on *"legislation…from Children's First"* having "enabled FFP" (participant and author quote, p.207, Grant & Reupert, 2016). Overall there was a general consensus that "policy needs to acknowledge the relatively higher workloads for practitioners working with families" (author quote, p.649, Reupert & Maybery, 2014) via management support.

Working with services & agencies

Given that an important element of FFP involves collaborative working between services and agencies, this was conveyed across six of the studies (Baker-Ericzen et al., 2013; Wong et al., 2016; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2017) as both a challenge and facilitator in delivering FFP across the countries. For therapists, there were reports of "services in other agencies or related systems as unsupportive in their care of youth and their families" (author quote, p.860, Baker-Ericzen et al., 2013). This was also depicted by social workers reports of "fragmented and uncoordinated" services: *"What if the clients suffer from emotional disturbance because of parenting issues? Can we really divide the issues into two facets?"* (author and participant quote, p.455, Wong et al., 2016). For mental health clinicians there was specific mention of interagency barriers such as "the low level of response: *"...how much intervention they'll do – don't expect much"* with one clinician attributing this to agency differences: *"different systems [that] are working at cross purposes"* (author and participant quote, p.5, Tchernegovski et al., 2017). There were also references from practitioners made to the "multiple players" involved in interagency working which can result in *"conflicting advice for families"* (author and participant quotes, p.646, Reupert & Maybery, 2014).

Others such as psychiatric nurses and mental health clinicians were able to draw upon the benefits of interdisciplinary working: *"she [the social worker] was very useful in child protection type issues so we would joint work at times"* (participant quote, p.209, Grant & Reupert, 2016) as well as "share the responsibility of decision making with their work teams" (author quote, p.385, Tchernegovski et al., 2017). Primary care physicians suggested their approach to families could reflect other models that they currently work with such as the *"shared care model – a bit like we do with obstetrics and pregnancy*" to encourage collaborative working (participant quote, p.333, Reupert et al., 2017).

Staffing Issues

Five of the included studies (Baker-Ericzen et al., 2013; Wong, 2014; Ward et al., 2017; Grant & Reupert, 2016; Reupert & Maybery, 2014) across each country contributed to this theme which closely related to the lack of policy and management as impacting professionals implementation of FFP. This was attributed to the demands and expectations placed upon clinicians resulting in loss of staff: *"And we've lost some good clinicians that they, they come in and they just feel like they're so bogged down"* (participant quote, p.860, Baker-Ericzen et al., 2013). Staff inconsistencies was also noted as a factor in "limited teamwork: *"[There is] different staff every day so there's very little consistency and [this] hinders my capacity in working with families"* (author and participant quote, p.210, Grant & Reupert, (2016).

Physical Setting

Although the physical setting of services was only indicated in three studies across Australia and Ireland (Ward et al., 2017; Grant & Reupert, 2016; Reupert et al., 2015), it was nonetheless an important contributing factor in the differences between community and acute inpatient settings. For instance, community settings such as community mental health services and

primary care settings such as medical practices enabled FFP for some practitioners: *"People are much more comfortable to present to their session with their mum, with their dad, with their partner, with their kids"* (participant quote, p.5, Ward et al., 2017). This was also associated with *"less stigma"* (participant quote, p.360, Reupert et al., 2015) and facilitated collaborative working by "situating community mental health services within primary care centres and alongside other professionals" (author quote, p.210, Grant & Reupert, 2016). Acute inpatient settings such as hospitals were found to hinder FFP: *"...you're targeted to four patients…and when they've got family members…[you] actually don't get a lot of time…"* (participant quote, p.5, Ward et al., 2017).

Culture

All but two studies (Reupert & Maybery, 2014; Baker-Ericzen et al., 2013) identified the organizational culture of services as determining the level of support for FFP which was recognised across all countries excluding the USA. This was particularly evident within the culture of a biomedical and problem-focused model within acute inpatient settings (Wong et al., 2016; Wong, 2014; Grant & Reupert, 2016). One professional related this to the "hierarchical relationships between psychiatrists and nurses" as inducing feelings of inferiority: *"It is hard to change the culture…if we want to introduce another intervention approach, the first response we will encounter is "why should I listen to you?"* (author and participant quote, p.216, Wong, 2014). However, this offered an opportunity to instil change: *"the family-centered approach can help build our professional image"* as well as some nurses already seeing shifts in the culture with *"increased dialogue and sharing with colleagues"* (participant quotes, p.216, Wong, 2014).

The theme culture appeared to closely relate to the physical context of services whereby community settings were generally reported to promote a strength-based approach to families. This was indicated by the "structured parenting programmes" for parents (participant quote, p.4, Tchernegovski et al., 2017) and community based professionals valuing home visits which "enabled them to view the family holistically" (author quote, pag.209, Grant & Reupert, 2016). Psychiatric nurses highlighted this advantage of home visiting: *"I think the community perspective is so different to working in an inpatient setting because we see it as it is"* (participant quote, p.210, Grant & Reupert, 2016). Culture also related to how "the patient base was defined" for physicians in Australia in which they are only provided payment for the identified patient and not the family (author quote, p.3, Reupert et al., 2017).

Training needs

Professionals' training needs were indicated internationally across all of the studies as essential to facilitating a family-focused approach. Two of the studies (Wong et al., 2016; Wong, 2014) evaluated family-focused training of various professionals in which they "became more aware of the importance of the family context…[and] developed the ability to conceptualize the case from a systemic perspective" (author quote, p.452, Wong et al., 2016). This was reflected in their teams as encouraging collaborative working: "A colleague and I pair up to see family cases. The process is amazing" (participant quote, p.453, Wong et al., 2016).

It was apparent that a lack of training and continuing need for professional development related to the organizational culture in which "a paradigm shift from individual to family oriented and from pathology focused to strengths based" is required (author quote, p.217, Wong, 2014). There were particular training needs identified with those professionals working with PMI indicating a need for "training on working with complex families" (author quote, p.864, Baker-

Ericzen et al., 2013) and education on "common experiences of parenting with a mental illness" (author quote, p.6, Tchernegovski et al., 2017). Additional skills training to engage children, parents, and families were also implied: *"to switch from group to individual or from adult to adolescent to child"* (participant quote, p.647, Reupert & Maybery, 2014).

Some clinicians indicated the need for training to outline "what the evidence says" for working with parents and families to allow them to *"put them into practice"* (author and participant quotes, p.333, Reupert et al., 2017). Whilst others identified attendance at training only "if there was a requirement to do so" (author quote, p.360, Reupert et al., 2015).

Clinicians attitudes, knowledge and practice

Attitudes, roles, and identity

The development of this theme was contributed to by all of the included studies whereby there was a pattern of professionals' attitudes towards families as largely impacting upon their engagement in FFP. For instance, "therapists expressed a desire to conduct family-focused therapy but felt constrained by parents' lack of involvement: *"You have the resistance of parents…you can only do so much work without the family involved"* (author and participant quote, p.859, Baker-Ericzen et al., 2013). This was also echoed by social workers' attitudes as *"seeing the family is extra work"* (participant quote, p.455, Wong et al., 2016) and primary care clinicians' whose attitudes presented a "barrier to meeting children: *"Unless they've a good reason for children to be involved…why would you involve children?"* (author and participant quote, p.359, Reupert et al., 2015). These issues were in contrast to primary care physicians who "recognised that their role was working with families" (author quote, p.332, Reupert et al., 2017).

Professionals' roles also appeared to influence the extent to which they were able to adopt a family-focused approach such as some psychiatric nurses who reported "we were it [performing role of social worker]" (participant quote, p.210, Grant & Reupert, 2016) due to a particular lack of social workers in their team. This indicated the often ambiguous roles of professionals' which leads to the disparity of views on whose role it is to conduct family work: *"is that my job?"* with some identifying their concern of *"doing more damage than anything"* (participant quotes, p.359, Reupert et al., 2015). As such, Tchernegovski et al. (2017) noted the need for "the provision of clear guidelines and role descriptions in regard to family-focused tasks" (author quote, p.7). For psychiatric nurses in particular, their professional identity was viewed as a traditional one where *"therapies should be referred to the clinical psychologists and those with the title of 'therapists…if we do this [family nursing], at least senior management will not agree with us"* (author quote, p.215, Wong, 2014). It is evident that much of these attitudes are influenced by the organizational issues and training needs as mentioned.

Addressing Parenting Status and Concerns

Six of the studies across Hong Kong, Ireland and Australia (Wong et al., 2016; Grant & Reupert, 2016; Tchernegovski et al., 2017; Reupert & Maybery, 2014; Reupert et al., 2015; Reupert et al., 2017) made reference to the challenges in identifying parenting status and concerns when engaging in family work. Psychiatric nurses noted "the lack of a formal mandate to identify service users' parenting status" as a barrier: *"there isn't anything compulsory or formal in how we reach out to families"* (author and participant quote, p.208, Grant & Reupert, 2015). This was reflected in clinicians' variation in addressing parenting status in which it was viewed as a standard procedure for some, whilst others "would 'wait' for patients to bring up their parenting role, or the child's needs" (author quote, p.359, Reupert et al., 2015).

Regarding parenting concerns there was a general sense of uncertainty and sensitivity around how to approach this. For example, clinicians acknowledged the absence of the child in their assessment of the family as a barrier: *"you've got to rely on what [the parent is] saying"* (participant quote, p.5, Tchernegovski et al., 2017). Four of these studies however conveyed approaches that facilitated their engagement with parents and families such as a strength-based approach (Reupert & Maybery, 2014; Reupert et al., 2015), home visits (Grant & Reupert, 2016), and empathy (Tchernegovski et al., 2017).

Knowledge – Practice Issues

All studies contributed to this theme with a large emphasis on clinicians' "feeling overwhelmed" in their response to families' needs (author quote, p.859, Baker-Ericzen et al., 2013). This was related to the competing needs of families with reports of it being *"tricky"* and *"stressful"* (participant quotes, p.647, Reupert & Maybery, 2014). Psychiatric nurses reported having an increased knowledge on family-focused work following training, however there were questions remaining as to the extent this would "actually be translated into clinical practice", with their contact with families being limited to advice and information: *"I phoned the families to share information about the client's diagnosis and treatment plans"* (author and participant quotes, p.215, Wong, 2014). There was particular attention drawn to the importance of developing FFP theory in order *"to identify first what it is we do"* and a need for *"sharing and articulation of information regarding FFP within and between mental health services"* (participant quotes, p.212, Grant & Reupert, 2016). Essentially the issues emerging within this theme drew closely upon the need for continuing training.

Discussion

This review presents the synthesized qualitative findings of mental health professionals' experiences and perspectives of implementing FFP. Many of the themes drew upon the challenges that professionals' identified in their workplace. The results showed a significant overlap between challenges of FFP that present within the organization as well as those challenges relating to clinicians attitudes, knowledge and skills required to address the complexity of family work. Each of these were strongly found to impact the other and were closely aligned to training needs. As such, there was a strong association between themes of organization, clinician attitudes and competency, and training which are proposed as essential components to enable the implementation of FFP.

The themes identified draw close comparisons to Maybery & Reupert's (2009) review in which they conceptualized the barriers to working with families as a hierarchy at which change can be affected at specific points. They acknowledge the foundation of any family-focused service to lie within the organizational and managerial support. This was certainly consistent with the findings of the current review where issues with policy and the level of management support directly influenced professionals' capacity to implement FFP. Sub-themes within the organizational context such as interagency working, and staffing were also found to overlap, with each being influenced by the other. This was particularly evidenced from Grant & Reupert's (2016) study in which many of the organizational barriers simultaneously acted as facilitators of FFP. This suggests the close relatedness of these issues and highlights the importance of services to consider these in turn to promote an organisation that is family-focused. These organizational factors have also been documented in earlier studies (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014).

The organizational culture and physical setting of services also appeared to be closely linked whereby community settings advocated a more family-sensitive approach than acute inpatient units. The benefits depicted by professionals within community services is consistent with a recent review exploring health visitors' FFP in which they convey the importance of home visiting as facilitating a whole family approach (Leonard et al., 2018). Importantly, their review emphasized the links between limited resources and poorly specialized training as hindering FFP. These findings were reflected within the current meta-synthesis whereby professionals' capacity to engage in FFP related to a need for continuing training and professional development skills. This was viewed as particularly influential in promoting collaborative and interagency working, and changing the organizational culture towards FFP, as well as a shift towards holistic and strengths based approaches.

Training needs were also associated with clinicians feeling the complexity of families' needs. There were a range of issues that emerged in responding to the multiple layers of need within family systems that can arise. Much of this pertained to clinicians ambiguity around their professional role and its influence upon their attitudes, skill and knowledge when working with families. These issues are crucial to highlight with referrals particularly to child and adolescent mental health services on the rise together with an expanding workforce ("Better Mental Health in Scotland", The Scottish Government, 2018). It is therefore becoming an increasing challenge for services to maintain standards of care whilst meeting families needs. This is also consistent with much of the literature on parental mental illness and the challenges that professionals' feel in adequately responding to both parent and child needs (Reupert & Maybery, 2016). In this way, the findings stress a continuing need for FFP to be further embedded within policy and systems in order to inform clearer guidelines and role descriptions together with training that

is closely matched to the need of the professional group. This is also in keeping with Maybery & Reupert's (2009) hierarchy of needs.

Issues around addressing parenting concerns were also understood within the context of a lack of policy (e.g. no routine identification of parenting status) and clarity on how to respond to families' needs alongside the practical skills required to match the need. The knowledge-practice gap that was evident from the synthesis further supports the literature on the need for formalised FFP specific practice guidelines (Foster et al., 2016). Thus with initiatives focusing on the importance of a family approach (Grant et al., 2018), these findings further support the need to consider the enactments and benefits of FFP for professionals and families, and reflects a wider implication upon government policy to act upon this.

Strengths and Weaknesses

The included studies were based within four different countries where variation is likely to occur in the practices adopted within mental health services as well as in the interpretation of FFP, mental health, and contextual issues such as the organizational settings. However, the fundamental aim of this review was to explore different professions' implementation of FFP. Thus given that there has been an international emphasis on promoting FFP and the majority of themes being evidenced across each of the countries., it was relevant to include those studies. Nonetheless, it was deemed a strength of the synthesis that FFP was understood similarly across the studies. This review's clear and transparent systematic design and methodology was also viewed as a particular strength which is intended to contribute to the growing literature on FFP.

The inclusion criteria facilitated the systematic selection of studies enabling clear theoretical generalisations to be produced in keeping with the aims of meta-ethnography (Pope, Mays, &

Popay, 2007). Arguably the inclusion and exclusion criteria acted as a false dichotomy given the challenge of distinguishing between FFP interventions versus implementation of professionals FFP. However as Foster et al. (2016) review already explored the range of FFP interventions, we sought to focus on FFP implementation at a broader level. Similarly, differences between profession groups proved difficult to separate with many of the studies using various health and non-health professionals with quotations from participants not always being directly linked to the profession type.

The reviewer was also aware of interpretations being naturally influenced by an existing knowledge and familiarity of FFP, however supervision ensured the synthesis process was as transparent and reflective as possible through reflective discussions and note taking. Similarly, this encouraged an awareness of the variety of epistemologies and qualitative methods employed across the studies and their contribution to the interpretation.

Implications and Conclusion

The findings highlight that in order to tackle the barriers outlined, there must be a response to identify to what extent the needs within each of the connecting themes can be realistically met. Maybery & Reupert's (2009) hierarchy on addressing low level factors in the first instance, such as organizational support building up to addressing workforce attitudes, knowledge and skill, is an essential framework that should be utilised across mental health services. However, the findings from the current synthesis seek to place an equal emphasis on each of these factors when considering professionals' enactment of FFP. Furthermore, future research should seek to develop these models by differentiating between various mental health professions as has been initiated by Maybery et al. (2014). Future research should also continue to seek input from service users and their families to incorporate their views and experiences of family-focused input across a range of FFP activities as highlighted (Leonard et al., 2018). Regarding policy,

it is intended that the current review draws attention to the lack of policy advocating FFP across the UK in particular which naturally has implications for the wider implementation of FFP internationally.

There was also limited evidence of professionals viewing the benefits of FFP which was not reflected across professionals' attitudes. Many of the professions expressed their concerns around whose responsibility family work is. These views allude to professionals lacking a sense of shared expectations and outcomes and perhaps raises the question as to why professionals should invest in FFP. It is evident that the ongoing challenges to implement family-focused care have been widely acknowledged with a need for greater empirical evidence, policy and legislative support, leadership, and capacity (Falkov et al., 2016). This integrated approach is therefore likely to better inform stakeholders of the value of investing in the implementation of FFP. Exploring stakeholders' involvement through implementation models should also be a direction for future research. Research has also begun to identify and make this integrated approach explicit through the development of a comprehensive logic model (Grant et al., 2018) which recognises the need for a focus on expected outcomes for meeting families' needs. It is therefore hopeful that the development of FFP specific models will assist to establish standards of practice across mental health services.

To the authors' knowledge, this is the first qualitative review looking specifically at mental health professionals' experiences of FFP across adult and child mental health settings. From the synthesis, there was a clear association between the organization, the complexity for clinicians in meeting families' needs, and professionals' training needs, all of which combine to facilitate FFP. There exists a significant challenge in FFP becoming embedded within services but it is intended that the growing literature on the benefits of FFP together with the

development of FFP guidelines and identifiable short and longer-term outcomes will assist the implementation process.

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Table 1. Characteristics of included studies

ID/ Author	Year	Country	Professional group (n)	Mental health disorder	Mental health setting	Qualitative method and Analysis	FFP definition
1. Baker-Ericzen et al.	2013	USA	Therapists (n=26) [b]	Disruptive behaviour problems (DBPs)	Community child mental health	Focus groups; Thematic content analysis	"Parent and child engagement"
2. Wong et al.	2016	Hong Kong	Social workers (n=7)	Mood; anxiety; and psychotic disorders	Adult community mental health	Semi-structured interviews; Constructivist grounded theory analysis	"The family as the unit of care…clients and families as collaborators"
3. Wong [a]	2014	Hong Kong	Psychiatric nurses (n=34)	General mental health	Community psychiatry; psychogeriatric; young people with psychosis; and child development service	Open-ended questions, Focus group and semi-structured interviews; Thematic analysis	"Patient and family as the experts on themselves and involves families as collaborative partners…"
4. Ward et al.	2017	Australia	Mental health practitioners (n=11): (mental health nurses (5), social work (2), social/community welfare workers (2), psychology (1), and occupational therapy (1).	Severe, persistent mental illness and complex needs	Acute inpatient, community services, and private practice	Interviews; Thematic analysis	"acknowledges and addresses the needs of people with mental healthcare needs and their family"

(continued)

Table 1. (continued)

ID/ Author	Year	Country	Professional group (n)	Mental health disorder	Mental health setting	Qualitative method and Analysis	FFP definition
5. Grant & Reupert [a]	2016	Ireland	Psychiatric nurses (n=14)	Parents with mental illness	Acute inpatient and community mental health	Semi-structured interviews Thematic analysis	"The family as the unit of attention as opposed to working with an individual alone"
6. Tchernegovski et al.	2017	Australia	Mental health clinicians (n=11): Psychologists (4), mental health nurses (2), social workers (3), psychiatrist (1), and occupational therapist (1).	Parents with mental illness	Inpatient; outpatient; and community	Semi-structured interviews; IPA	"extends the focus of care beyond the consumer…"
7. Reupert & Maybery	2014	Australia	Practitioners (n=10): Welfare workers, social workers, and mental health nurses.	Parents with mental illness and/ or substance abuse disorder	Child protection agencies and child mental health	Semi-structured interviews and focus groups Discovery-oriented approach – inductive analysis	"care that is mindful and responsive to the needs of families…"
8. Reupert et al. [a]	2015	Australia	Primary care clinicians (n=21): Mental health nurses (6), psychologists (7), social workers (6), occupational therapists (1), and GP (1).	Parents with mental illness	Primary care	Focus groups; Thematic analysis	"recognises the family of the client"
9. Reupert et al.[a]	2017	Australia	Primary care physicians (n=9)	Parents with mental illness	Primary care	Thematic content analysis	"family orientation"

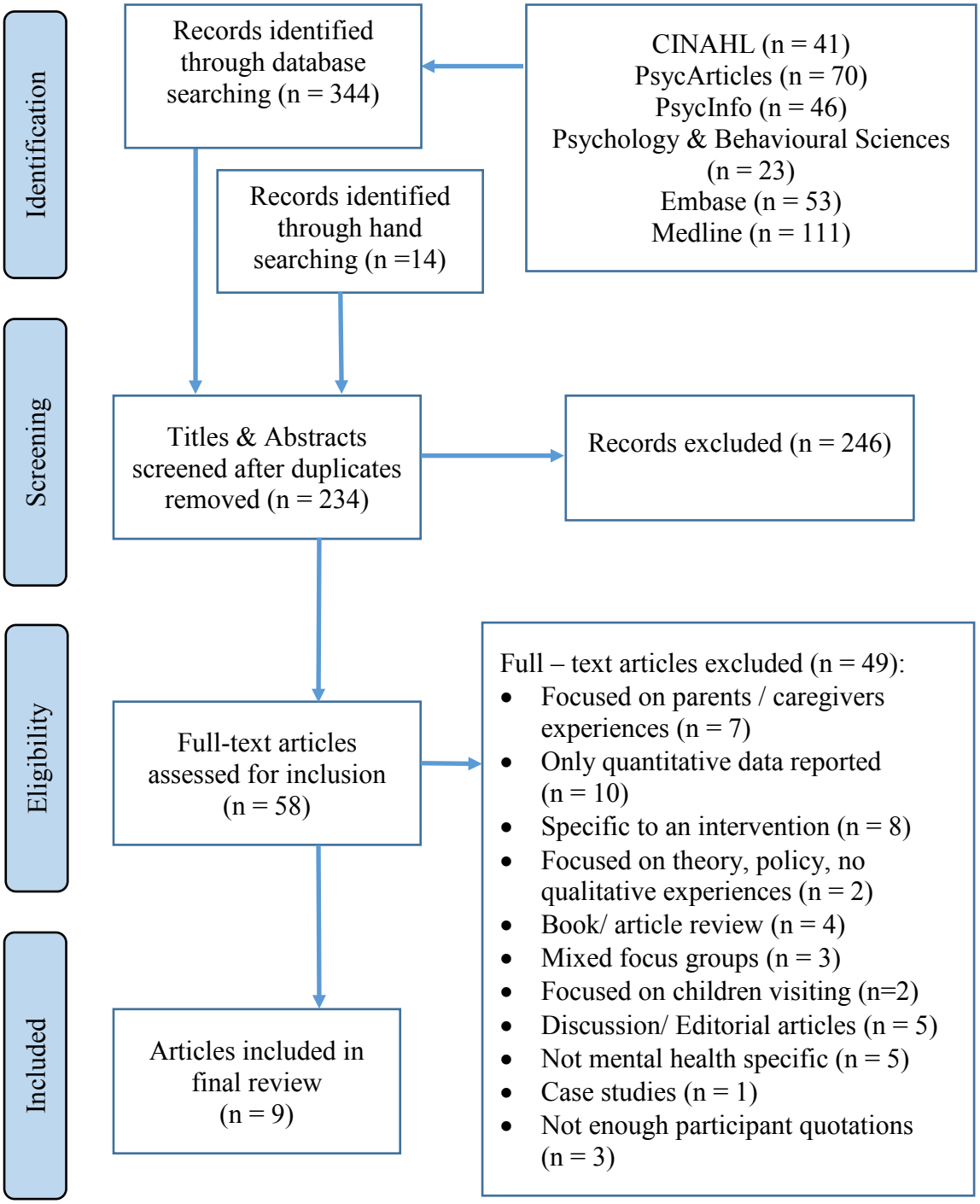
[a] Mixed method study
[b] Study also included families' perspectives but are not reported

Table 2. Studies contribution to themes relating to Organizational and System Issues

Studies	**Sub-Themes**					
	Policy & management	Working with services	Staffing issues	Physical setting	Culture	Training needs
Baker-Ericzen et al. (2013)	X	X	X			X
Wong et al. (2016)	X	X			X	X
Wong (2014)	X		X		X	X
Ward et al. (2017)	X		X	X	X	X
Grant & Reupert (2016)	X	X	X	X	X	X
Tchernegovski et al. (2017)	X	X			X	X
Reupert & Maybery (2014)	X	X	X			X
Reupert et al. (2015)	X			X	X	X
Reupert et al. (2017)	X	X			X	X

Table 3. Studies contribution to themes relating to clinicians attitudes, knowledge and practice.

Studies	**Sub-Themes**		
	Attitudes, roles & identity	Addressing parenting status & concerns	Knowledge–Practice Issues
Baker-Ericzen et al. (2013)	X		X
Wong et al. (2016)	X	X	X
Wong (2014)	X		X
Ward et al. (2017)	X		X
Grant & Reupert (2016)	X	X	X
Tchernegovski et al. (2017)	X	X	X
Reupert & Maybery (2014)	X	X	X
Reupert et al. (2015)	X	X	X
Reupert et al. (2017)	X	X	X


Identification
Screening
Eligibility
Included
Records identified through database searching (n = 344)
CINAHL (n = 41)
PsycArticles (n = 70)
PsycInfo (n = 46)
Psychology & Behavioural Sciences (n = 23)
Embase (n = 53)
Medline (n = 111)
Records identified through hand searching (n =14)
Titles & Abstracts screened after duplicates removed (n = 234)
Records excluded (n = 246)
Full-text articles assessed for inclusion (n = 58)
Full – text articles excluded (n = 49):
Focused on parents / caregivers experiences (n = 7)
Only quantitative data reported (n = 10)
Specific to an intervention (n = 8)
Focused on theory, policy, no qualitative experiences (n = 2)
Book/ article review (n = 4)
Mixed focus groups (n = 3)
Focused on children visiting (n=2)
Discussion/ Editorial articles (n = 5)
Not mental health specific (n = 5)
Case studies (n = 1)
Not enough participant quotations (n = 3)
Articles included in final review (n = 9)