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Owen Thompson

THE INCLUSION OF CHILDREN IN FAMILY INTERVENTIONS FOR PSYCHOSIS

Section A: How successful have adult mental health services been at meeting the needs of children and families with parental mental health needs? A review of interventions

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Section B: A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children

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APRIL 2018

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Summary of the MRP portfolio

Section A: A systematic review of the interventions designed to benefit families where a parent experiences mental health difficulties in adult mental health settings. It provides an update to a 2006 review. A systematic search found 12 papers. The interventions are described and the findings synthesised. Clinical and research implications are considered.

Section B: An empirical study investigated what experts consider best practice when deciding whether, and how, to include children in their parent's family intervention for psychosis. A three round Delphi survey was used to gather opinions and assess the level of consensus that existed for the group. The findings are presented and the clinical and research implications considered.

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Section A:

How successful have adult mental health services been at meeting the needs of children and families with parental mental health needs? A review of interventions

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Abstract

Parents who experience mental health difficulties contend with additional challenges to those usually faced in parenting. Children raised by these parents are at risk of a range of difficulties. Adult mental health services have been identified as a key point at which interventions can be offered to these families. As investment and research in this area develops, this review provides an update to a 2006 review on what interventions are being offered to families in adult mental health settings. A systematic search of databases found 12 papers. The findings show that interventions have been targeted at a national level, and at staff, families and children. Legislative interventions and those aimed at staff have had mixed results; with an increase in identification of parents using adult mental health services and increases in positive attitudes towards working with families, but with little improvement in the number of interventions being offered. Interventions for families and children have shown positive effects, particularly when delivered flexibly and in a non-stigmatising manner. Questions remain about which aspects of these interventions are most effective and there is a need for sustained investment in research in this area. Clinical and research implications are considered.

1. Introduction

Becoming a parent can be considered as the start of a relationship that affects every aspect of the human condition for the adult and the child (Levy & Orlans, 1998). With it come experiences of great joy and immense challenge. Parents who experience mental health difficulties have an additional set of challenges to manage and their ability to manage these challenges is of crucial importance to the child (van der Ende, van Busschbach, Nicholson, Korevaar, & van Weeghel, 2016). The child's early experiences with their parents are profoundly important and will shape the way that they understand and experience the world (Bowlby, 2005).

It has been estimated that between 10-15% of people who use adult mental health (AMH) services in the United Kingdom (UK) are parents (Falkov, 2011). Studies from elsewhere have suggested that this figure could be up to 50% (Biebel, Nicholson, Williams, & Hinden, 2004).

1.1 Challenges facing families where a parent experiences mental health difficulties

Parents who experience mental health difficulties have reported having to contend with feelings of inadequacy and the fear of transferring their problems to their children as well as the usual challenges of parenting and the distress caused by their difficulties (van der Ende et al., 2016). These parents are often stigmatised. They have reported feeling closely monitored by those around them and that their difficulties parenting are viewed through the lens of their mental health difficulties (Jeffery et al., 2013).

Families can experience a range of physical, emotional and economic difficulties when a parent is diagnosed with a mental illness (MacFarlane, 2011). Growing up with a parent who experiences mental health difficulties has been associated with a range of negative outcomes, with a recent review suggesting that these children have up to a 50% chance of developing mental health difficulties in later life (Leijdesdorff, van Doesum, Popma, Klaassen, & van Amelsvoort, 2017). Research has consistently shown that children of a parent experiencing difficulties have a higher rate of behavioural, emotional and developmental problems than other children. They have been found to be

at risk of attachment problems which can lead to relationship issues (Reupert & Maybery, 2007). They can also experience stigma as a result of their parent's mental health difficulties and may not get as much attention as they need from their parent (Tabak et al., 2016).

Children often don't have much information about their parent's condition, which they are frequently required to manage (Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004); often assuming caring roles for siblings and the parents. A high proportion of children are said to adopt maladaptive coping strategies at times when their parent is experiencing distress, such as withdrawing (Reupert & Maybery, 2007).

With much of the research historically focussing on the risks that parental mental health (PMH) difficulties present to the children it is possible that the strengths and positive narratives that exist in these families are missed. Families have been found to be a great source of strength and can have a positive impact on relapse rates, hospital admissions, medication compliance, risk of mortality, and family burden (MacFarlane, 2011). Jones et al. (2016) conducted a study exploring parents' perspectives. They found that parents felt that they should be given recognition for the times when they felt competent and responsible in their parenting role, and that they had many strengths to offer. Responsive, warm, involved parenting and the presence of another positive, competent parent can mediate some of the risks of being a child of a parent with mental health difficulties (Hosman, van Doesum, & van Santvoort, 2009).

1.2 Working with families where a parent experiences mental health difficulties

There is evidence that families and children where a parent experiences mental health difficulties can benefit from a range of psychological interventions (Fraser, James, Anderson, Lloyd, & Judd, 2006), and over the past 20 years there has been a large increase in investment and research into this area (Falkov et al., 2016). This work has manifested in several initiatives to foster family oriented practice in mental health services, some of which will be described here.

1.2.1 Family-focussed practice

Having previously been used to describe family involvement in paediatric physical health care in the 1950's (Dunst, 2002), the term "family-focussed practice" has come to be used in mental health care in Australia to describe practice that involves a person's system around them, (including close social system as well as family), rather than individually focused practice. Family-focussed practice can be seen on a continuum depending on the availability of the resources of services and the person's need, ranging from basic involvement of the family in the person's care to more formal family therapy or family interventions (Eassom, Giacco, Dirik, & Priebe, 2014).

Foster, O'Brien, and Korhonen (2012) defined family-focussed practice as consisting of 6 key practices:

1. Family care planning and goal setting
2. Liaison between families and services including family advocacy
3. Instrumental, emotional and social support
4. Assessment of family members and family functioning
5. Psycho-education
6. A coordinated system of care between family members and services

Given the increasingly recognised importance of families in a person's recovery, there has been a move to develop more family-focussed practice in AMH services (MacFarlane, 2011; Reupert et al., 2018). In Australia, this has been reflected in the development of the "Children of parents with a mental illness" national initiative to offer support to families and professionals working with them.

1.2.2 Think child, think parent, think family

In 2008 the UK government published a document stating that mental health clinicians should "think family" (Social Care Institute for Excellence, 2012). This document suggested that AMH and CAMHS should work together to meet the needs of families, and that there should be "no wrong door" – meaning that whichever service a family member approached should meet the needs of the entire family. Following this, the "Triangle of care" guideline was developed collaboratively by families and mental health workers in 2010 in recognition of the importance of the involvement of a

person's system in the support that they receive from mental health services (Professionals.carers.org, 2018).

Despite these initiatives there are significant gaps in the implementation of family-focussed work in AMH services (Lakeman, 2008).

1.3 Barriers to implementing family-orientated practice

The slow pace in which family-orientated practice has been implemented and the huge portion of the population eligible for support yet not receiving any worldwide has been described as a global public health issue (McLaughlin et al., 2012). This section will consider what some of the barriers to the implementation of family-orientated practice might be.

1.3.1 Barriers perceived to exist in the family

Research has identified several barriers that have been perceived to exist in the family. Some clinicians have expressed concern that children are too young to be able to have conversations about PMH (Bibou-Nakou, 2003). Others have reported that families are unwilling to discuss PMH (Dean & Macmillan, 2001). This could possibly relate to findings that some families fear that discussing PMH could lead to involvement from child-protection services, and perhaps having their children removed from their care (Nicholson, 2005). Other barriers identified include the client not feeling like they have a mental health problem, feeling that their mental health issues don't affect the child, the child not being able to or not wanting to be involved, and clients being acutely unwell or suffering side effects from medication (Maybery, Goodyear, Reupert, & Grant, 2016).

1.3.2 Barriers located in services

There has been considerable research into what barriers may make it difficult for mental health workers to implement family-orientated practice. These include: the structure of organisations; the limitations of professional roles (Dean & Macmillan, 2001); the ideology of the service (Grünbaum & Gammeltoft, 1993); lack of resources; poor inter-agency communication (Byrne et al., 2000); distance and transport being unavailable for children; fear of disrupting rapport with the adult client; staff not thinking that PMH is a problem for the child; staff not having time to focus on

children's issues; staff feeling it may be harmful for children; staff feeling it is not their role to work with children; lack of knowledge and skills (Maybery et al., 2016). When comparing which factors are particularly pertinent for AMH workers delivering family-orientated practice compared to workers in CAMHS or elsewhere, it has been found that organisational resources, limited knowledge and limited skills are the largest hurdles to overcome.

Staff confidence and skill has been found to be the most important predictor of family-orientated practice being delivered (Maybery et al., 2016). Lauritzen, Reedtz, Van Doesum, and Martinussen (2015) found that despite AMH workers having positive attitudes towards the inclusion of children in their parent's care, this was rarely reflected in their practice. They also found that those who identified themselves as having more knowledge about working with children were more likely to include them. Goodyear et al. (2015) found that staff well-trained in working with families were more likely to deliver family-orientated practice.

1.3.3 Hidden children

Children of parents experiencing mental health difficulties have been said to be "hidden" from AMH services (Fudge, Falkov, Kowalenko, & Robinson, 2004). The dominant medical model of mental health difficulties places the emphasis on working with individuals, often paying little attention to a person's family or social context (Stuart, 2014). This focus is at odds with 'care in the community' which has seen people being treated more at home, with their families being recruited as a support to psychiatric interventions, over the past 30 years (Tunnell, Alpert, Jacobs, & Osiason, 1988).

Mental health care is generally organised according to a person's age; children are seen by child and adolescent mental health services (CAMHS) and adults by AMH services. The threshold to be seen by CAMHS is currently very high (Children's Commissioner, 2016), so children of parents experiencing mental health difficulties who do not meet their criteria are unlikely to receive support.

The boundaries around these separate services can be firm, making it difficult for interagency working (Singer, Tang, & Berelowitz, 2000). A debate exists about who should provide interventions to

support these children; they are often seen as outside of the responsibility of AMH services, and CAMHS staff may not always be aware of mental health difficulties of parents of the children under their care (Cooklin, 2013).

1.4 Interventions for families in adult mental health settings

Given the benefits of family-orientated practice to families where a parent is experiencing mental health difficulties, the difficulties in implementing family-orientated practice, and the fact that AMH services are a crucial point at which these families can be identified, it is important to know what interventions are currently being offered to these families in AMH settings.

A critical review conducted in 2006 (Fraser et al.) identified 26 interventions, in a range of settings and countries, that had been offered to families where a parent had mental health difficulties. They found that there was some evidence of these interventions being successful, no evidence of them being harmful, but concluded that the evidence was at too early a stage to draw any firm conclusions.

All of the studies they reviewed focussed on individual-level issues such as knowledge and skills of parents or children, rather than social or structural contributors to mental distress, despite these being found to have the biggest impact on families' experiences of distress. The interventions offered limited long-term data or analyses of cost effectiveness. The interventions all had different aims, demonstrating the lack of clarity that exists about what the key issues are for this group. Compounding this difficulty is the fact that very few of the programs described the theoretical underpinnings of their components. All but one of the identified studies were conducted in large urban areas, raising questions about the generalizability of their findings to other contexts. Most studies did not have any service user input in their development or evaluation.

1.5 Rationale for review

This review will systematically appraise the literature to examine what interventions have been offered to families where a parent with mental health difficulties has been identified through AMH services.

Despite the compelling evidence base for working with families where a parent has a mental health difficulty AMH has been slow to implement this work. Children in these families are unlikely to be seen by CAMHS and are likely to be unsupported and remain at risk for a host of negative outcomes.

This review will provide a timely update to the review conducted by Fraser et al. (2006) following a period of continued investment in research in the area and the further development of initiatives to support family-orientated practice in AMH settings.

`1.5.1 Review aims

- Describe the interventions that have been designed to benefit children[1] and adults in their parenting roles in the context of AMH services
- How has the efficacy of these interventions been measured?
- How effective have they been?
- What have we learnt about their successful implementation?

2. Method

2.1 Literature search

A systematic search was conducted of three electronic databases in February 2018; Psychinfo, Medline and Web of Science. See Table 1 for search terms.

Table 1

Terms used for systematic search

parent* or child* or famil* or mother* or father* or "family	AND	"adult mental health service*" or AMH or AMHS or "adult	AND	intervention* or therap* or psycholog* or	NOT	transition

[1] In this review children will refer to those under the age of 18 who have a parent who experiences mental health difficulties. This is in distinction to much of the literature on family interventions for psychosis, which often looks at family interventions where a child who experiences psychosis is seen with their parents.

focussed practice" or "family focused practice" or FFP or "child of a parent with mental illness" or COPMI or "family with a parent with mental illness" or FaPMI or "parental mental health" or PMH or "parental mental illness" or PMI	service*" or "adult mental health*" or "adult psychology*" or CMHT or "community mental health team "	counsell* or service*

1660 papers were identified. Google scholar was searched garnering a further nine papers. The papers were reviewed and are presented according to the “Preferred reporting items for systematic reviews and meta-analyses” (PRISMA) (Moher, Liberati, Tetzlaff, Altman, & Group, 2009) in Figure 1.

Identified papers were checked for duplicates and then screened by title. There were 743 papers which remained for abstract review. These were checked against the inclusion and exclusion criteria and 26 papers were brought forward to be reviewed in full. Of these, 12 were included in the systematic review.

Inclusion criteria

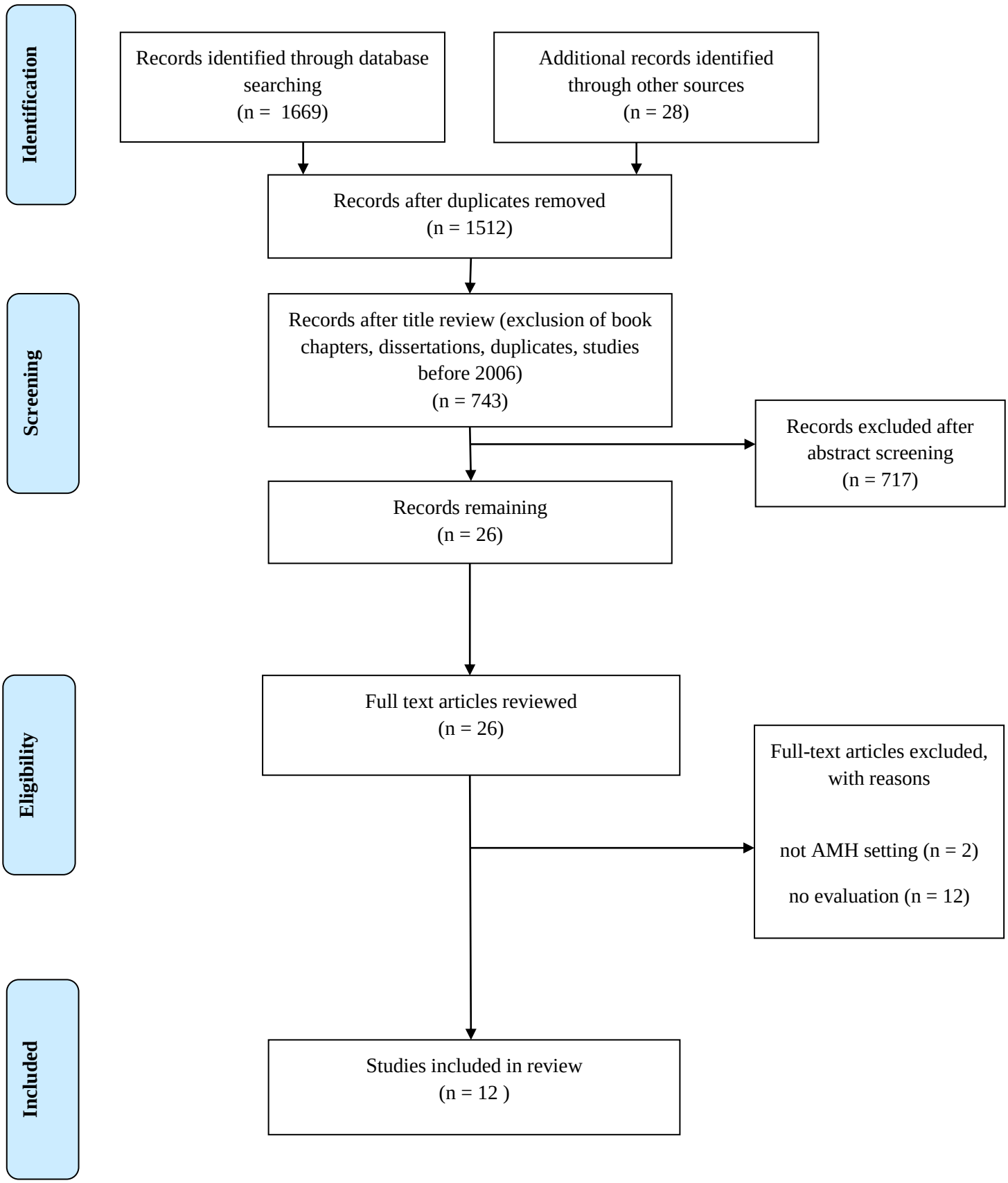
- Describes an intervention designed to provide benefit to families where a parent experiences mental health difficulties
- The target population includes service users drawn from an AMH setting
- Where the target of an intervention comprises multiple groups (e.g. CAMHS, social work and AMH) the percentage of AMH workers must be specified
- The intervention has been evaluated in some form

- Published in peer-reviewed journal

Exclusion criteria:

- Published before 2006
- Focus exclusively on parental substance-misuse

Figure 1. PRISMA flow diagram



2.2 Data extraction, analysis, and quality assurance

A data extraction form based on the Cochrane Handbook for Systematic Reviews of Interventions (Higgins, 2016) was created and used to extract relevant data from the papers (see Appendix A).

The quality of studies was assessed using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (SQAC) (Kmet, Lee, & Cook, 2004) as these allow quantitative and qualitative studies to be compared alongside each other (see Appendix B for scoring). Studies are evaluated on 14 areas for quantitative studies and 10 for qualitative. They are given scores of 2, 1, or 0, indicating meeting criteria, partially meeting criteria, and not meeting criteria respectively. Studies are then given an overall indicator of quality; the highest rank is >75% indicating the highest quality and the lowest is >55% indicating the lowest.

2.3 Structure of the review

The key findings and an assessment of the quality of the papers is presented followed by a description of the interventions that are being evaluated. This is followed by a discussion including themes which emerged and consideration of the clinical and research implications.

3. A systematic review of the interventions

This section will present the key findings of the studies, describe the interventions and consider some of the methodological critiques of the individual papers.

3.1 Key findings

Key information from the papers is presented in table 2. Six out of 12 studies were assessed as having good quality on the SQAC. The quality assessments are presented in table 3 and table 4.

Table 2

Summary of key information from papers

Paper title	Authors	Quality	Country	Method	Participants	Interventions	Outcome measures	Key findings
Implementing new routines in adult mental health care to identify and support children of mentally ill parents	Lauritzen, Reedtz, Van Doesum, and Martinussen (2014)	50%	NOR	Cohort study	219 AMH workers	Changes to health law	1. Author constructed and evaluated questionnaires 2. Keeping Families and Children in Mind Online Resource – Evaluation	1. Increase in identification of children 2. No increase in interventions offered to children 3. Some negative changes in workers attitudes
Child responsible personnel in adult mental health services	Lauritzen and Reedtz (2016)	59%	NOR	Cohort study	219 AMH workers	Changes to health law	1. Author constructed and evaluated questionnaires 2. Family-focussed mental health questionnaire (FFMHQ)	1. New staff roles had been created 2. There was no difference in the level of family focussed practice assessed between specialised staff and general staff 3. General staffs' family focussed practice increased over three time points
Legislative policy to support children of parents with a mental illness: revolution or evolution?	Tchernegovski, Maybery, and Reupert (2017)	80%	AUS	Qualitative	11 AMH workers	Changes to health law	1. Semi-structured interviews	1. Clinicians largely unaware of changes relating to children 2. Practice unchanged by legislation 3. Clinicians felt unsupported by organisation to make changes
Building capacity for cross-sectorial approaches to the care of families where a parent has a mental illness	Goodyear et al., (2015)	77%	AUS	Mixed methods	55 clinicians (36% AMH)	Staff training	1. FFMHQ 2. Author constructed post training evaluation	1. Significant decrease in FFMHQ scores post training 2. Significant increase in FFMHQ scores at 6 month follow up

"Let's talk about children": A pilot evaluation of an e-learning resource for mental health clinicians	Tchernegovski, Reupert, and Maybery (2015)	85%	AUS	Mixed methods	21 clinicians (24% AMH)	Staff training	1. Family-focussed workforce questionnaire 2. Semi-structured interviews	1. Increase in outcome scores post-training 2. Intervention well received 3. Participants felt they would make changes going forward
A consultation service for Adult Mental Health Service clients who are parents and their families	Jessop and De Bondt (2012)	41%	AUS	Cohort study	An AMH service	A consultation service	1. Referral numbers	1. No impact of consultation service found 2. Confounding factors and barriers identified
An emotional awareness based parenting group for parents with mental illness: A mixed methods feasibility study of community mental health nurse facilitation	Isobel, Meehan, and Pretty (2016)	64%	AUS	Mixed methods	8 AMH clients	Parenting group	1. Parent concerns questionnaire 2. Kessler psychological distress scale 3. Difficulties in emotional regulation scale 4. Parents emotional style questionnaire 5. Qualitative feedback	1. Significant reductions in frequency and impact of difficult behaviours on Parent concerns questionnaire 2. Intervention well received 3. Staff perceive important changes occurring on individual basis for group members
Development of a family-based program to reduce risk and promote resilience among families affected by maternal depression: Theoretical basis and program description	Riley et al. (2008)	57%	USA	Cohort study	10 families	Family intervention	1. Attendance data 2. Satisfaction ratings 3. Behavioural assessment system for children 4. Family times and routine index	1. The program was acceptable and feasible 2. Reductions in children's symptoms 3. Large improvements in family togetherness 4. Several targeted areas did not improve

Safety feasibility and family experiences of preventive interventions for children and families with parental depression	Solantaus, Toikka, Alasuutari, Beardslee, and Paavonen (2009)	92%	FIN	RCT	119 families	Family intervention	1. Beck depression inventory 2. Child depression inventory 3. Author constructed questionnaires on family experience of intervention and perceived benefits of intervention	1. Parents and children reported good experiences of the interventions 2. For parents, both had positive effects on self-understanding, mutual understanding in the family, parenting and future perspectives 3. For parents, FTI was rated significantly higher than the LT-1 for almost all outcomes 4. Over 50% of children reported that FTI had made it easier for them to talk to their parents 5. Participants found the intervention to be safe
Preventive family intervention for children of mentally ill parents a Swedish national survey	Pihkala, Cederström, and Sandlund (2010)	73%	SWE	Cohort study	103 families	Family intervention	1. Author constructed questionnaires on family experience of intervention and perceived benefits of intervention	1. 74% of parents reported a positive impact on their understanding of their children, their feelings of shame and guilt towards their children, their concerns about their children and their own well-being 2. Parents felt FTI gave them skills 3. Younger children benefitted more than older children
Effectiveness of preventive support groups for children of mentally ill or addicted parents: a randomized controlled trial	van Santvoort, Hosman, van Doesum, and Janssens (2014)	96%	NL	RCT	254 families (experimental n=180)	Support group for children	1. Self-perception profile for children 2. Dutch parent child interaction questionnaire 3. Strengths and difficulties questionnaire 4. Brief symptom inventory 5. Author constructed questionnaires on child social support, child cognitions and	1. Support group led to increase in seeking social support and a reduction in negative cognitions 2. Both groups had increase in self-worth and quality of parent-child relationship 3. Further decrease in emotional and behavioural problems in experimental group at 1 year follow up

						parental stress	
"They are the children of our clients they are our responsibility": a phenomenological evaluation of a school holiday program for children of adult clients of a mental health service	Isobel, Pretty, and Meehan (2017)	AUS	Qualitative	12 children, 3 mothers, 8 staff	School holiday programme	1. Semi-structured interviews 2. Focus groups	1. Themes for children included finding connections, having fun and escapism 2. Staff appreciated their different role and felt it helped form rich relationships with children and their parents

Note. NOR = Norway, AUS = Australia, USA = United States of America, FIN = Finland, SWE = Sweden, NL = Netherlands, RCT = randomised control trial

The following two tables present the quality assessment of the studies using the SQAC criteria. See Appendix B for scoring details.

Table 3

SQAC qualitative quality ratings

Criteria	Study	
	Tcherenegovski 2017	Isobel 2017
Question / objective sufficiently described?	2	2
Study design evident and appropriate?	2	2
Context for the study clear?	2	2
Connection to a theoretical framework / wider body of knowledge?	2	2
Sampling strategy described, relevant and justified?	1	1
Data collection methods clearly described and systematic?	2	2
Data analysis clearly described and systematic?	2	2
Use of verification procedure(s) to establish credibility?	1	2
Conclusions supported by the results?	1	2
Reflexivity of the account?	1	2
Total score	80%*	95%*

* Scores >75% cut-point are good quality (Kmet et al., 2004). Scoring: 2=yes, 1=partial, 0=no, N/A=not applicable

Table 4

SQAC quantitative quality ratings

Criteria	Study									
	Lauritzen 2016	Lauritzen 2014	Goodyear 2015	Tcherenegovski 2015	Jessop 2012	Isobel 2016	Riley 2008	Solantaus 2009	Pihkala 2010	Van Santvoort 2011
Question / objective sufficiently described?	1	1	1	2	0	2	1	2	2	2
Subject (and comparison group, if applicable) characteristics sufficiently described?										
Study design evident and appropriate?	1	1	2	2	1	2	1	2	2	2
Method of subject/comparison group selection or source of information/input variables described and appropriate?	1	1	1	1	1	1	1	2	2	1
Subject (and comparison group, if applicable)	1	1	1	2	1	0	1	2	2	2

characteristics sufficiently described?										
If interventional and random allocation was possible, was it described?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A	2
If interventional and blinding of investigators was possible, was it reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
If interventional and blinding of subjects was possible, was it reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outcome and (if applicable) exposure measure(s) well defined and robust to measurement misclassification bias? means of assessment reported?	1	1	2	2	1	2	1	1	1	2
Sample size appropriate?	1	2	2	1	1	1	1	2	1	2
Analytic methods described/justified and appropriate?	2	2	2	1	1	2	2	2	2	2
Some estimate of variance is reported for the main results?	0	0	2	2	0	0	0	2	0	2
Controlled for confounding	1	1	0	0	1	0	0	2	1	2
Results reported in sufficient detail?	2	2	2	2	1	2	2	2	2	2
Conclusions supported by the results?	1	2	2	2	1	2	2	2	1	2
Total score	50%	59%	77%*	85%*	41%	64%	57%	92%*	73%	96%*

* Scores >75% cut-point are good quality (Kmet et al., 2004). Scoring: 2=yes, 1=partial, 0=no, N/A=not applicable

Consideration of the methodological issues specific to each paper will be given as the papers are presented in the following section, and a general methodological critique of the papers as a whole in section 4.4.

3.2 Legislative interventions

Three papers reported on interventions related to changes being implemented at a national or regional level. The papers describe two interventions which will be briefly summarised here.

In Norway, amendments were made to health legislation, specifically to the “Health Personnel Act” and the “Specialized Health Services Act”. The changes to the Health Personnel Act made it mandatory for all health professionals to identify if people using their services had children and to provide information and, if necessary, follow-up for those children. The Specialised Health Services Act made it mandatory for all hospitals to appoint “Child Responsible Personnel” (CRP) in all clinics. The role of CRPs was to address the needs of families being seen by services and to promote family-orientated practice in their teams.

In Australia, the Victorian Mental Health Act (hereafter “the Act”) was produced in 2014. This Act made specific reference to the children of people using AMH services. It stated that “children, young persons and dependents of persons receiving mental health services should have their needs, wellbeing and safety recognized and protected” and that children could be identified as a “nominated person” or as their parent’s carer. Other parts of the Act gave instruction on types of information sharing that should occur between services, but did not make specific reference to children. Flexibility was given over which training strategies organisations could use to apply the Act, and a date was specified by which all aspects of the Act should be complied with.

3.2.1 Norwegian legislation studies

Lauritzen et al.'s (2014) study examined changes in clinical practice following amendments to health legislation in Norway. They recruited 219 clinician participants from the largest hospital in Northern Norway which provided mental health services to 31 municipalities. Participants completed online surveys at two time points; one before the implementation of the legislation, and one three years later. Completion of a form called the ‘family assessment form’ was used to determine how often staff were identifying their clients’ children, and an intervention called ‘family conversations’ was used to gauge the level of involvement clinicians were having with their clients’ children. The ‘Keeping families and children in mind online e-resource’ (Maybery, Goodyear, & Reupert, 2012) was adapted to gather data on participants’ level of knowledge about children and knowledge of the new legislation and guidelines. The authors constructed scales to measure attitudes towards implementing the legislation, and self-assessment of the quality of the service the participants offered.

They found there was a large increase in people using the 'family assessment form' and no significant change in the use of 'family conversations', with 75% of participants still not using them at follow up. They found negative changes in participants' attitudes; there was a statistically significant decrease in participants' beliefs in this type of work having good outcomes, in their general knowledge in working with children, and their assessment of the quality of the service they provided to them. These results were tempered by the finding that there was a small but statistically significant increase in positive attitudes at follow up, and that people who had used 'family conversations' were more hopeful about the benefits of family based work.

Two years later Lauritzen and Reedtz (2016) followed this up with a study focussing on the creation of a specific role in Norwegian services to ensure children's needs were recognised; the 'child responsible personnel' (CRP). Again, 219 participants completed questionnaires, this time at three time points. They were asked if CRP roles had been created in the services they worked in and to evaluate the quality of the service the CRPs provided using the 'family focussed mental health questionnaire' (FFMHQ) (Maybery et al., 2012). Finally, they were asked to rate the level of collaboration with other agencies when working with children.

They found the vast majority of settings had appointed CRP. They found there was no difference in the rating of quality of service provided by CRPs given by CRPs and general staff at time point one and three, though the quality provided by CRPs were rated significantly higher at time point two. A comparison between the levels of knowledge between the CRP and general staff showed the CRPs began with significantly higher knowledge about legislation and had received a higher level of training at time point on which was sustained to time point three. It is also of note that the level of knowledge of general staff increased over the three time points in all domains but this was not statistically analysed, or compared with CRPs.

Both of these studies scored poorly on the SQAC, limiting how much can be generalised from their findings. The research aims were diffuse and didn't always follow on from the introductions. Both lack clarity in their sampling methods and did not control well for confounding variables (e.g. only

collecting basic demographic information). The papers seem to have used the same cohort which had a response rate of 50%. This limits the generalizability of the findings due to participants taking part who are likely to have had an existing interest in the area. The 2016 paper collected some interesting baseline data on job roles which could have usefully been correlated with scores on the FFMHQ or CRP status, but this was not done. It is also difficult to interpret the finding that the majority of participants reporting that CRPs had been appointed without data being presented on how these participants were spread across the study's 31 municipalities. .

3.2.2 Victorian mental health act study

Tchernegovski et al. (2017) conducted semi-structured interviews with 11 AMH clinicians in Australia - following the development of The Victorian Mental Health Act (the Act) - to explore their understanding and experience of using the Act. Interpretive phenomenological analysis (IPA) was used to analyse the data. They found clinicians were largely unaware of the sections of the Act that related to children. None of them reported having seen any specific changes as a result of it. They spoke about clinicians in their workplaces continuing with previous ways of working and suggested not feeling supported by their organisation was a reason for this. They felt the government exerted pressure on AMH services to comply with particular sections of the Act, and supporting the children of their service users was not one of them. They also commented on the practical difficulties of recording information about children on electronic notes systems which hadn't been developed to support the legislative changes.

This study scored highly on the SQAC. However, bias was introduced in its sampling strategy of contacting clinicians known to the researcher, and including senior clinicians who requested to be part of the study. Some triangulation of results was done but was not adequately described. Similarly, the importance of reflexivity is mentioned but not in enough detail to allow the reader to learn exactly how the researcher may have influenced the findings.

3.3 Interventions for clinicians

Two papers reported on interventions which targeted staff who work with families where a parent experiences mental health difficulties. The interventions are summarised in Table 5.

Table 5

Summary of interventions for AMH clinicians

Study author(s)	Intervention(s)	Format and content of intervention
Goodyear et al., (2015)	The "Keeping Families and Children in Mind" educational e-resource developed by the Australian national children of parents with a mental illness initiative	Two full days of face-to-face training Six self-directed online training modules A minimum of a one hour face-to-face cross-sector small group meeting Delivered over a six week period
Tchernegovski et al. (2015)	Let's Talk About Children (LT)	LT is a manualised intervention for professionals to deliver to parents. This training consists of four modules covering the philosophy of LT; an introduction of the first discussion with parents; how to discuss the impact of parental mental health problems; how to develop an implementation strategy

Goodyear et al. (2015) asked clinicians who took part in a multi-disciplinary staff training programme to appraise its efficacy in terms of their family-orientated practice. They used the FFMHQ (Maybery et al., 2012) and an author-constructed post intervention evaluation to gather data on the effectiveness of this training programme. They collected data before the training was delivered (n=151), on the last day of the training (n=55), and six months later (n=20).

Contrary to their hypothesis, they found that directly following the intervention there was a statistically significant decrease in participants' perceptions of organisational support for family-orientated practice. Several items relating to skill and knowledge on the FFMHQ also went down. Respondents perceived more barriers to inter-professional working following the intervention. After six months scores for the 20 participants who took part were significantly better in all domains compared to both time-points one and two. They found increases in participant ratings of cross-sector collaboration paralleled the significant improvements in self-ratings of family-orientated practice.

Goodyear et al. (2015) stated it used a mixed-methods approach; however, the qualitative element was small and lacking in methodological rigour. The use of an opportunity sample was understandable, but the high rate of attrition through the different time-points introduced potential bias into the results, with participants who have interest and enthusiasm for the work more likely to stay engaged in the research. There was no evidence of an attempt to control for confounding variables, such as intra-organisational initiatives supporting family-orientated practice that may have existed for some participants. The use of multiple comparisons increased the risk of a type one error.

Tchernegovski et al. (2015) presented a pilot study looking at how an e-learning resource on using an intervention called "Let's talk about children" (adapted from Solantaus et al. (2009) reviewed in next section) was received. This mixed-methods study used the 'family-focussed workforce questionnaire', (a shorter version of the FFMHQ), to gather data on 21 clinician participants. Eight of these participants agreed to take part in a semi-structured interview. Statistically significant increases were found in the subscales "Family and Parenting Support", "Assessing Impact on the Child"," Connectedness" and "Parenting and Mental Illness". Qualitative data from the interviews was analysed using "thematic content analysis". Participants said the training was well received, and were particularly pleased with the downloadable content available. They described having become more family responsive following the training as a result of their deeper insights into the challenges that families where a parent experiences mental health difficulties face. Finally, participants reported being keen to put their learning into practice, but because the interviews were conducted close in time to the intervention, they had not had the opportunity to do so yet.

Tchernegovski et al.'s (2015) paper scored highly on the SQAC for its quantitative elements. It was considered that there was not enough qualitative material to warrant it being formally assessed. A major limitation of this paper is not having a follow up period, making it impossible to conclude if any changes in practice might have occurred. The sampling strategy was biased, with participants being recruited through the "Children of parents with a mental illness" Australian national initiative website – signalling their existing interest in the subject.

3.4 Interventions for parents and families

Five papers reported on interventions for families where a parent experiences mental health difficulties. The interventions are summarised in Table 6.

Table 6

Summary of interventions for families

Study author(s)	Intervention(s)	Format and content of intervention
Jessop and De Bondt (2012)	A consultation service for AMH service clients who are parents and their families	The consultation service aimed to increase awareness of the needs of families of parents with mental illness within the AMH service, assist in completing a comprehensive family assessment, offer brief family focused interventions and assist in referral to appropriate services
Isobel et al. (2016)	6 session parenting group based on "Tuning into Kids" (TIK) (Havighurst et al., 2013)	A parenting intervention delivered in group format over six consecutive weeks. Two hour sessions delivered by nurses Adaptations to the intervention in this study from TIK: Facilitators ensured some time for discussion of mental health; a mindfulness activity was added; some flexibility in structure, homework and volume of content
Riley et al. (2008)	The Keeping Families Strong Program: A family-based program to promote child and family resilience in the face of maternal depression	A multifamily group format, with the parents from three to five families meeting together and the children (10 years and older) meeting weekly in a group. Parents and children participate in an equal number of concurrent group meetings. A parallel learning process is facilitated between the parent and youth groups so that change can be anticipated and coordinated within the family
Solantaus et al. (2009)	Let's Talk about Children Discussion-One (LT-1)	Designed to meet the minimum requirements of the Child Welfare Act; clinician conducts a child-focused discussion with the parent; one-two sessions; minimum 15 minutes duration; facilitators given three hours training
	Family Talk Intervention (FTI)	Consists of six sessions; two parent sessions covering family history and psycho-education about depression and resilience; child session on same topics; planning session on how to discuss depression and family strategies for dealing with it; family session in which the clinician supports the parents to conduct a meeting with their children; follow-up session to review

		intervention with parents FTI training lasted about two years, including 17 full days a year and supervision of the trainees' cases
Pihkala et al. (2010)	FTI	As in Solantaus et al. (2009)

3.4.1 A consultation service

Jessop and De Bondt (2012) described the development of a consultation service which was designed to promote family-orientated practice in an AMH service and to offer assistance in completing family assessments and interventions. They measured the effectiveness of this by comparing referral numbers to the service across two years of the services operation. They found the number of referrals was low, despite promotion strategies that had been successful in other peer reviewed service development studies. Referral numbers increased following a regional drive to focus on families following a fatality.

This study scored poorly on the SQAC and is below the level of quality the SQAC advises should be included in a review. It is included here as it contains some relevant material and to give a full picture of the current quality of the literature on this subject. The research aims are not described and are difficult to discern from the paper, as is the design. The outcomes are inadequately described and there is little context given in which to understand the data presented. This is an exploratory study and so it is to be expected that it would not have the same methodological rigour as an experimental study.

3.4.2 A parenting group

Isobel et al. (2016) used a mixed-methods design to explore the benefits of an emotional awareness based group parenting intervention delivered to ten participants. Outcome measures were intended to be collected at three time points (pre, post, and follow up), though difficulties prevented the collection of the follow up data. The measures used rated parental concerns about children, psychological distress, emotional regulation and parental style (see Table 2). Qualitative feedback was collected from participants, and data was triangulated by analysing unstructured field notes from the facilitators on their impressions of the group processes and content.

Quantitative results showed significant reductions in frequency and impact of difficult behaviours in children between the pre and post measures. Other non-significant improvements were found in various domains of psychological distress. Qualitative feedback from the parents suggested they found the group helpful and felt they were managing better as parents. Facilitator field notes suggested change was happening at an individual level throughout the group, and that more change occurred than that which was captured by the quantitative measures.

This study scored moderately on the SQAC. It had a small sample that was not described in detail and may have been recruited in a way which introduced bias. This was counterbalanced by adjusting the statistical analysis and triangulating of the data strengthening the authors' conclusions that the intervention was beneficial for participants.

3.5 Whole family interventions

Riley et al. (2008) presented a review of literature on maternal depression and its relationship to the family, and a detailed summary of an intervention they developed with children and parents in parallel groups. Initial outcome data on 10 mothers and 13 children was presented. This showed the attendance was high (>90%) and satisfaction with the different components of the intervention was high. There were reductions on the Behaviour Assessment Score for Children. The authors described a case study of one mother and child's journey through the intervention. They concluded with considerations of changes to the program based on these preliminary findings.

Riley et al. (2008) presented preliminary data on the efficacy of an intervention. As such it is brief. It scored low on the SQAC as it failed to control for confounding variables, did not report any estimates of variance, and its measures and design lacked methodological rigour.

Solantaus et al. (2009) conducted a randomised control trial (RCT) comparing a family intervention with informal conversations with a clinician. One hundred and nineteen families were randomised to "Family Talk Intervention" (FTI) (n=60) and "Let's Talk about Children Discussion-One" (LT-1) (n=59).

The FTI was based on an evidence based family intervention protocol (Beardslee, Gladstone, Wright, & Cooper, 2003). Standardised measures of depression and author constructed measures on the benefits and experience of the interventions were given pre and post intervention. They found the interventions were well received and deemed safe by participants. Both interventions resulted in positive changes on outcome measures, but the FTI was statistically significantly better than the LT-1 in the vast majority of cases.

Solantaus et al. (2009) scored very highly on the SQAC, potentially increasing the generalizability of its findings. Describing the process of randomisation in more detail, and validating its author constructed measures would have improved it further.

Pihkala et al. (2010) used the same interventions and measures as Solantaus et al. (2009). They asked all clinicians in a region of Sweden who had used FTI to contact the families who had taken part and ask them to rate their experience of the intervention and its benefits. One hundred and three families responded including 89 children. They found parents reported the intervention as having a positive effect, particularly when considering their understanding of their children, their feelings of shame and guilt towards their children, their concerns about their children and their own well-being. Ninety two % felt the FTI had provided them with new tools for parenting. Children also reported having found the intervention positive, with younger children perceiving it as more positive than older children.

Pihkala et al. (2010) used similar components to Solantaus et al. (2009) but scored lower on the SQAC due to its moderate response rate, its lack of a control group, and some lack of clarity around the possible introduction of confounding variables.

3.6 Interventions for children

Two papers reported on interventions for children whose parents experience mental health difficulties. They are summarised in Table 7.

Table 7

Interventions for children

Study author(s)	Intervention	Format and content of intervention
van Santvoort et al. (2014)	Support group	Offered nationwide in NL Delivered by two mental health or prevention experts; eight weekly 90-min sessions and a booster session after 3 months; specific topic in each session
	Control	Three group-based leisure activities which were planned according to a time schedule parallel to the support group
Isobel et al. (2017)	School holiday programme	Two-day program for children run at AMH centre Includes a mixture of fun, psycho-education and strengths-based activities aimed at fostering resilience in children living in families where there is mental illness. Small group activities may focus on understanding illness, the young people's experiences at home, support networks, self-care, talking to friends, coping with stress or other topics determined by the young people

Van Santvoort et al. (2014) reported on the effectiveness of a preventive support group offered to children in the Netherlands. Two hundred and fifty four families were randomised into the experimental group (n=180) or the control (n=74), which consisted of three leisure based activities. They found no statistically significant differences between the groups' demographics at baseline, though the children in the control group were younger, and the parents experienced less stress.

Parents and children completed a range of measures (see Table 2). They found children who had taken part in the support group were more likely to seek social support and had fewer negative cognitions than those taking part in the control group. Children who had taken part in the control group perceived

reduced social acceptance directly after the intervention, though this effect disappeared at follow up where both groups perceived an increase.

Both groups reported improvements in self-worth and quality of parent-child interaction, and reductions in negative cognitions and emotional and behavioural problems. A further decrease in emotional and behavioural problems was reported in the experimental group after one year.

Despite some statistically significant results the intervention did not affect many of the areas it targeted. There was low parental involvement in the interventions, which was suggested to have led to decreased benefits.

Van Santvoort et al. (2014) scored very highly on the SQAC and represents a good quality, large scale RCT. One area it could improve, common to all the papers in this review, is in its sampling. Having participants referred by their therapist introduces some selection bias.

Isobel et al. (2017) reported on a two day group for the children of AMH clients run at the AMH clinic. Semi-structured interviews were held with children, parents and staff, and a focus group held with staff.

All the young people were positive about the program. They looked forward to it and wanted it to last for longer; it was often the only structured activity they had planned for the holidays. They spoke about it allowing them some escapism from everyday worries. They reported being surprised by the connections they formed at the group and of having fun there.

Staff spoke about the program starting informally and evolving into a more structured group, with a balance of psycho-education and fun activities They felt that the non-clinical contact they had with families reduced stigma and utilised their skills in different ways. Supportive management was identified as a key factor in keeping the program going.

Parents were positive about the program; they wanted it to be run more often. They felt comfortable with the mental health content of the program. They didn’t attach any meaning to the fact of the program being delivered by AMH staff.

Isobel et al. (2017) also scored very highly on the SQAC. The methods of data collection and triangulation were robust, and the authors' reflexivity was made clear.

4. Discussion

This review aimed to gather together and critique literature examining the efficacy of interventions offered to families where a parent experiences mental health difficulties in an AMH setting. A discussion of the main themes in the findings is presented alongside a general methodological critique of the studies. This is followed by a consideration of clinical and research implications and conclusions.

4.1 Changes in staff self-ratings of family-orientated practice

Both of the papers which offered intervention to staff found an increase in their measures of family-orientated practice, which was also reflected in the qualitative data from one of those papers (Goodyear et al., 2015; Tchernegovski et al., 2015). An increase in self-rated family-orientated practice was found by Lauritzen and Reedtz (2016). Isobel et al. (2017) noted a positive impact on staff attitudes over the period of their intervention with staff reporting having non-clinical involvement in the lives of their adult service users who were parents led to them developing an increased awareness of the challenges facing these families.

However, as well as some positive changes, Lauritzen et al. (2014) also found negative changes in staff attitudes over the period of their study in terms of their knowledge about working with children, the risk factors for children, and in their hopes for good outcomes in this kind of work. Goodyear et al. (2015) found that attitudes reduced immediately post-intervention before increasing at follow up.

Previous research has found that mental health workers have a tendency to over-estimate the level of service they provide (Walfish, McAlister, O'Donnell, & Lambert, 2012). One plausible explanation for some of the unexpected changes in staff attitudes following the interventions is that they gained a clearer picture of some of the complexities of working with families and an increase in awareness of gaps in their own practice.

4.2 Issues of implementing changes in practice

A common theme in the papers related to issues of implementing changes in practice. Research has pointed out the inadequacy of a "train and hope" strategy whereby a single exposure training intervention is provided with no on-going or organisational support (Lyon, Stirman, Kerns, & Bruns, 2011). This idea was reflected by the participants in Tchernegovski et al. (2017) who commented that changes in practice were dependent on factors within the organisation such as supervision, meeting structures, on-going discussions with co-workers and the existence of practice development staff. Other barriers to implementing change in practice found in these papers included the existing workload of staff, financial cutbacks and a lack of managerial support for the adoption of new practices (Lauritzen & Reedtz, 2016; Lauritzen et al., 2014).

Tchernegovski et al. (2015) participants reported that on-going contact with training providers and consistent national approach to family-orientated practice supported implantation. These ideas are supported by the positive outcomes of Goodyear et al. (2015) whose study took place in the context of a broader workforce initiative resulting in significant organisational support.

4.2.1 Organisational change

Literature on organisational change suggests that there are three levels of implementation; paper, process and performance (Fixsen, Naoom, Blase, & Friedman, 2005). Constructing policies to create change is known as paper implementation and is rarely successful. Process implementation refers to activities related to the topic in question (e.g. talks, workshops) and performance implementation refers to the equipping of the workforce (e.g. training, resources) to be able to implement paper changes. In the case of the two legislative interventions, paper changes had been made and some process changes but little in the way of performance changes, thus limiting the impact of the interventions. Research by Jones and Scannell (2002) looking specifically at the implementation of family work has suggested these kind of centralised policy initiatives risk alienating clinicians, potentially further reducing the impact of these interventions.

4.2.1.1 Revolution

Gersick (1991) presented a model of system change characterised as punctuated equilibrium. This states that changes generally occur in systems in small increments that don't disturb the overall equilibrium of the system, known as evolutionary change. Occasionally there is a revolutionary change that punctuates the equilibrium. Top down legislative changes and re-organisations can be an example of this. In the studies presented here it seems the interventions have failed to punctuate the equilibrium and create any change. In Jessop and De Bondt's (2012) study, the critical incident involving the death of a child could be seen as an example of an event punctuating the equilibrium and leading to a revolutionary change in the way families where a parent experiences mental health difficulties were kept in mind in the team that was under investigation.

Little can be concluded regarding what constitutes successful implementation of legislative changes from the studies in this review aside from policies alone are not enough to foster change.

4.3 Efficacy of interventions for families and children

Six of the seven studies describing an intervention aimed at families where a parent experiences mental health difficulties reported the intervention being well received and being related to positive outcomes (Isobel et al., 2016; Isobel et al., 2017; Pihkala et al., 2010; Riley et al., 2008; Solantaus et al., 2009; van Santvoort et al., 2014). Despite these positive results methodological issues make it difficult to ascertain how much of the positive changes seen were a direct result of the interventions. This is something specifically commented on by two papers (Isobel et al., 2016; Riley et al., 2008). The two studies which had control groups (Solantaus et al., 2009; van Santvoort et al., 2014) reported positive changes in the control groups, making it difficult to conclude anything further than some form of intervention has benefits.

There were several specific aspects of interventions commented on in the papers which will now be briefly summarised.

The timing of the intervention was found to be important. One study found that two thirds of the children taking part in the intervention had clinical or sub-clinical problems, suggesting that for them the intervention was being given too late (van Santvoort et al., 2014). In another, parents gave

feedback that the intervention should be provided either early or late in their involvement with services, not at the acute stage (Solantaus et al., 2009).

The benefit of interventions being delivered flexibly was a theme in several studies (Isobel et al., 2016; Solantaus et al., 2009; van Santvoort et al., 2014) with authors noting these families are not a homogenous group and will have a range in the severity of their difficulties.

Interventions which were non-stigmatising allowed the context of their delivery (AMH services) to be less intrusive, and resulted in participants being able to engage in them without fear (Isobel et al., 2016; Isobel et al., 2017). Participants in these studies did not view the interventions as a component of mental health care despite the links with psycho-education, assessment and intervention.

4.4 Overall methodological considerations

The type and quality of the papers identified for this review demonstrate a body of literature in its early stages. Six out of 12 studies were high quality (see Table 3 & 4). The rest were moderate to low quality, with two studies below the lowest cut off point. Several of the studies were exploratory in nature.

Issues in the methodologies of the studies limit their strength and the generalizability of their findings. All studies used opportunity sampling which potentially limits the extent to which the sample represents the population it is drawn from. Many of the clinician participants volunteered or opted in to the studies, indicating a pre-existing interest in the area. Many sample sizes were small. Few studies provided estimates of variance in their statistics, making it difficult to infer an overall impression of the data. All of the studies used self-report measures which risk being biased due to their subjective nature

4.5 Clinical implications

The papers presented here are aimed at diverse targets; clinical implications will be considered in relation to family interventions, staff interventions, and wider systemic implications.

The papers here suggest that interventions directed at families were received positively, and that some benefit was reported by those who received them. Given the relative low quality and heterogeneous measures of outcome it is difficult to identify any specific clinical implications other than that interventions should be offered. It can be tentatively suggested that these interventions being well-timed, and delivered flexibly, should be taken into consideration by clinicians.

Staff interventions were generally found to have positive effects, and services should consider offering training to increase staff confidence in working in this area. However, some staff interventions showed reduced levels of confidence after training, suggesting that organisations need to also consider how on-going support may be offered to allow staff to take up roles that may feel unfamiliar and burdensome. These could include reducing case-loads for those working with families, and creating regular space in team meetings and supervision for the discussion of service users parenting roles.

The difficulties with implementation of changes in practice noted within the papers suggest the existence of a larger challenge for the wider systems that services are located in. The papers present early evidence that legislative changes can help AMH services identify parents more easily, and the creation of roles specifically to be responsible for offering interventions to service users who have children can have positive outcomes, and these could be considered by services. However, when undertaken in a context of scant resources and low managerial support for changing ways of working they are less effective. It would seem from these papers that for effective interventions to be offered to families seen in AMH services there would need to be a multi-level approach of offering training, supervision, resources, and managerial support. In this way services could attempt evolutionary change (Gerisck, 1991) though it is possible that revolutionary change in the way that services are organised could be needed to address the provision of services to a huge number of people who need them but are not able to access them.

4.6 Research implications

The studies found in this review were few in number and had a diverse array of targets demonstrating a clear need for further research in this field. UK studies could be included to offer an insight into what is being offered by AMH services here. There is some literature describing interventions that are offered to families; the efficacy of these interventions could be evaluated to offer an insight into which aspects of these interventions are most helpful, and for whom.

Little is known about the experience of children who have a parent being seen in AMH services; qualitative studies could be conducted to explore the experiences of these children and what they consider most important to be offered.

Given the relatively few interventions being offered, and the top-down nature of legislative interventions described in the papers, participatory action research involving children, their parents, staff, and policy makers, could be conducted to collaboratively develop acceptable, valid interventions for this group

4.7 Limitations

This review aimed to comment on how successful AMH services have been at meeting the needs of children and families with parental mental health needs; specifically by describing interventions that have had some form of their efficacy measured, and commenting on what can be deduced about the successful implementation of such interventions. The review updated a previous review conducted 12 years ago. Whilst it was anticipated that, given the increasing clinical focus on the subject area in recent years, there would be a large number of papers that would be suitable, only 12 were identified, and they covered a heterogeneous range of intervention targets, participants, methodologies, ways of measuring efficacy, and quality as assessed by the SQAC. Additionally, the identified papers have issues of bias in their sampling and use of outcome measures. This makes it problematic to draw any firm conclusions in relation to this review's question and aims, and their suitability could be questioned.

5. Conclusion

In the 12 years since the review from Fraser et al. (2006) there has been some progress. The present review found 12 studies looking at attempts at systemic changes, interventions for staff, families and for children, the majority of which made clear reference to their theoretical underpinnings. These studies contain a broader range of intervention targets and settings than those found by Fraser et al. (2006).

However, the literature still suffers from many of the shortcomings noted by Fraser et al. There remains very little discernible service user involvement in the development or evaluation of interventions. And despite the aforementioned clarity on theoretical underpinnings, there is a heterogeneity and lack of clarity in what the specific targets of interventions are. This is despite the existence of research specifically looking at what constitutes a good quality of life for children growing up with a parent experiencing mental distress (Bee, Berzins, Calam, Pryjmachuk, & Abel, 2013).

In addition, it is surprising that for a client group that has received considerable funding for research internationally over the past 20 years (Falkov et al., 2016), and for which in the UK specifically there has been government activity to make them a priority (Diggins, 2011), there were only 12 suitable papers, and none from the UK.

Despite the wealth of systemic literature that specifically focuses on how to include children in family based work the searches here did not turn any of these up suggesting that the extent to which it has been incorporated into AMH practice is limited.

6. References

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Section B:

A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children

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Abstract

Parents who experience psychosis experience challenges in addition to those associated with being a parent. Their children are at risk for a range of negative outcome. Family interventions for psychosis have been found to be helpful in mitigating some of these outcomes and have a strong evidence base. Systemic literature has provided a raft of techniques to facilitate the inclusion of children in family therapy, though these are largely absent from the literature on family interventions for psychosis. This study used a three- round Delphi survey to investigate what is considered best practice when deciding whether, and how, to include children in their parents' family intervention for psychosis amongst a group of experts. Findings demonstrated support for including children and suggested methods of facilitating their involvement in assessment, areas that should be attended to in sessions, adaptations that should be made, and organisational factors that support their inclusion. Their responses suggested that adult mental health services were well placed to meet some of the needs of these children. Consideration is given to items which did not have consensus and the clinical and research implications are described.

1. Introduction

1.1 Experiences of psychosis

Psychosis is a term used to describe a range of distressing experiences. These can include hearing voices, seeing, feeling, or tasting things that are not there, holding strong beliefs that others do not share, having difficulties with thinking and concentrating, and feeling withdrawn and indifferent. These experiences often occur at times of stress and are linked to strong emotions such as anxiety, depression, or feeling overwhelmed (Cooke et al., 2014)

Every person's experience of psychosis is different and may include some, or all of the above. Some people will experience psychosis on a single occasion, some people will have experiences of psychosis intermittently, and some will have experiences very often (Gelder, Gath, & Mayou, 1989). People who have these kinds of distressing experiences may be given diagnoses such as schizophrenia, paranoid schizophrenia, schizoaffective disorder, bipolar disorder, and personality disorder.

There also exists a significant portion of the population who have unusual experiences that could be thought of as psychosis but do not come to the attention of mental health services (Van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009). The key factor that keeps this group from seeking help seems to be that the meaning that they make of their experiences (Ward et al., 2013) does not cause them to be distressed by their experiences (Beavan, Read, & Cartwright, 2011). These studies point to experiences of psychosis existing on a continuum of unusual experiences.

Because of the broad range of experiences and difficulties in definitions of psychosis, estimating the prevalence of these experiences is problematic. It has been suggested that in the United Kingdom around 10% of people have heard a voice speaking to them when alone (Johns et al., 2014) and around 1% of people receive a diagnosis of schizophrenia at some point in their lifetime (Schizophrenia Commission, 2012). Research has failed to identify one cause of psychosis, through stressful life events (Day et al., 2011) and trauma (Cooke et al., 2014) have been found to play a role.

1.2 Psychosis and parenting

Parenting has been described as a significant social role which forms part of normative adult status, and so is central to a person's sense of self (Mowbray, Oyserman, & Ross, 1995). Following the development of the care in the community approach to adult mental health (AMH) difficulties, and a move away from asylum based treatment, there has been an increase in the number of people who experience psychosis who have children (Fudge, Falkov, Kowalenko, & Robinson, 2004.)

Psychosis can have an impact on a person's experience of parenting, as well as on the early experiences of the child. As well as the distress caused by their psychotic experiences, parents are often stigmatised in their role as parents. This stigma can come in various forms. Being made to feel unfit as a parent, people assuming the parent is unsafe or untrustworthy, feeling closely watched by mental health services and others, and feeling judged by other parents and teachers are some examples reported by parents (Jeffery et al., 2013). These kind of aversive experiences have been identified as a barrier for parents experiencing severe mental health difficulties to accessing support (Abrams, Dornig, & Curran, 2009). Research findings that these parents are often socially isolated, living in poverty, and having difficulties with substance misuse demonstrate some of the costs to these families of not receiving adequate support (Campbell et al., 2012).

Despite the progress in the "access to family life" aspect of human rights legislation that has been afforded by the deinstitutionalisation of people experiencing mental health difficulties (Hendricks, 2007), people experiencing psychosis still report that they have been discouraged from having children. This can take complex forms, such as not being supported to come off medication, or to receive in vitro fertilisation (Jeffery et al., 2013).

Parents experiencing psychosis run a significant risk of having their children removed from their care (Seeman, 2011). This is despite evidence that through intervening early with good quality support, these parents are able to parent effectively (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007).

However, growing up with a parent who experiences psychosis is not without difficulties. The literature has historically focussed on issues of risk for the children (Anthony, 1969), and the recurring themes of abuse, neglect, and being let down by mental health services reflect a potentially grave situation (Dunn, 1993). In addition to having been identified as at high risk of experiencing mental health problems of their own (Ramchandani & Psychogiou, 2009), children whose parents experience mental health difficulties have been described as having emotional problems (John, Mednick, & Schulsinger, 1982), being socially isolated (Rolf, 1972), having relationship and work problems (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997), and having poor self-esteem (Terzian, Andreoli, De Oliveira, de Jesus Mari, & McGrath, 2007).

More recent qualitative research (Foster, 2010) found that children with a parent who experiences severe mental health difficulties described their upbringing as chaotic and living with a lot of uncertainty. They were often not told what was happening to their parent by other family members or mental health services. They found it hard to fit in and were ostracised by their peers. They spoke of a sense of having had to grow up too fast, taking on a lot of responsibility at a young age. This is reflected in data which shows a high number of children in this situation become young carers for their parents (Aldridge & Becker, 2003).

Resilience has been identified as a key protective factor in keeping children safe from some of these adverse consequences of parental mental health difficulties (Foster et al., 2012). This has been described as being able to adjust positively to adverse situations and to find positive meaning in them (Jackson, Firtko, & Edenborough, 2007). Research has suggested that resilience is not an innate strength but something that can be cultivated, and that aspects of resilience such as social connectedness and adjustment, are good targets of psychological interventions for children who have a parent who experiences mental health difficulties (Fraser & Pakenham, 2009).

1.3 Family interventions for psychosis

Family interventions for psychosis (FIp) were developed following the finding that in families where there was a high level of negative and critical communication between members, (known as

"high expressed emotion"), the person experiencing psychosis suffered higher frequencies of distressing symptoms returning (Kuipers, Leff, & Lam, 2002). Based on this, interventions were developed to foster different patterns of communicating and relating within families. FIp has a robust evidence base (Pharoah, Mari, Rathbone, & Wong, 2010) and is recommended to be offered to everyone experiencing psychosis in the UK (National Institute for Clinical Excellence [NICE], 2014). In the UK there are currently three main models of FIp being offered; systemic family therapy, behavioural family therapy (BFT), and cognitive-behaviour therapy based FIp (CBT-FIp). These models share some common elements. All of them take a collaborative approach of working in partnership with families to enrich their coping strategies and reduce distress. They all aim to provide information about psychosis and to improve communication within families (Glynn, Cohen, Dixon, & Niv, 2006). However, there are some key differences between the approaches which will be briefly described here.

Systemic family therapy for people experiencing psychosis is an unstructured, narrative-led approach where a person's experience of psychosis is understood in the context of the family. It was developed following the findings of Bateson, Jackson, Haley, and Weakland (1956) that families where a person experience psychosis often had unusual communication patterns. It seeks to address those unusual communication patterns with a circular rather than linear approach to understanding problems and communication in the family (Burbach, 1996).

BFT and CBT-FIp have much in common. They share recognition of expertise existing in the family and deliver information-sharing about psychosis with them in an individually tailored way. They both have behavioural components such as goal setting and task assignment.

Aspects specific to BFT include: the assessment process including individual meetings with each family member; strongly encouraging the family to prioritise family meetings at home in-between appointments; and using process to address content (i.e. teaching the family communication skills and problem solving strategies, which then allow concerns to be discussed) (Fadden & Heelis, 2011; Falloon et al., 1985).

In contrast, CBT-FIp assesses the whole family together. It includes work on cognitive restructuring, (e.g. work on appraisals made of person with psychosis' behaviour). It has an emphasis on looking at emotions behind actions and interactions in the family, and it uses content to address processes (i.e. using the concerns brought by the family to model communication and problem solving skills) (Kuipers et al., 2002).

Despite the robust evidence base, and NICE guidance stating FIp should be offered to all families, as little as 1.1% of people with psychosis in the UK actually receive it (Haddock et al., 2014). Research has identified organisational issues (e.g. high staff caseloads, competing priorities), staff issues (e.g. lack of access to training and supervision) and individual family factors as some of the barriers to the successful implementation of FIp in practice (Onwumere, Grice, & Kuipers, 2016).

1.4 Inclusion of children in family interventions

One of the central tenets of general systems theory upon which systemic therapy is based is that of "the pattern that connects" (Bateson, 1972). This states that the experience of every family member is determined by the pattern of interactions occurring within the family system i.e. a change in the behaviour of one family member has an effect on all of the others, including any children. Many social-constructionist therapists argue that attempting to exercise change on single parts of the system may result in unintended and destabilising effects on the rest of the system, and that the whole system should be worked with (Carr, 2000).

Systemic literature has long argued the benefits and importance of including children in family interventions, recognising them as important parts of the systems in which people experience their difficulties (Ackerman, 1970; Chasin & White, 1989; Elizur & Minuchin, 1989; Guerney & Guerney Jr, 1987; Zilbach, Gordetsky, & Brown, 1986). Qualitative research has demonstrated that children want to be included in family sessions, even when they are not the main focus of the session (Stith, Rosen, McCollum, Coleman, & Herman, 1996).

Systemic literature has provided a wealth of literature on specific techniques for including children in family therapy. It has suggested the use of art techniques, such as drawing pictures of the family, of

drawing happy and sad times, or drawing genograms (Carr, 1994). Dowling (1993) recommended pictorial representations of emotions being used to facilitate children's involvement in discussions.

Verbal techniques such as using "the empty chair" (Treacher & Carpenter, 1982), the narrative approach (Anderson, 1993) and circular questioning (Benson, Schindler-Zimmerman, & Martin, 1991) have been put forward as techniques that help children engage in sessions as active participants. Concrete visual aids to describe concepts and metaphor (O'Brien & Loudon, 1985) have been used as ways to convey complex, abstract concepts to children.

Drama techniques such as using role play (Blatner, 1994) and the use of puppets and dolls to act out scenarios (Carr, 1994), and the use of experiential techniques such as creating family sculptures (Blatner, 1994) have been found to facilitate engagement.

Non directive techniques such as observing the child play in the room and commenting and interpreting their play (Zilbach et al., 1986) have been used as a way for the child's voice to be present despite their developmental gap in cognitive and verbal abilities compared to the adults.

It has been suggested that these techniques can be used by any theoretical model (Lund, Zimmerman, & Haddock, 2002). However, the extent to which these techniques have been incorporated into FIp is questionable. The issue of whether, and how, to include children is largely absent from the published literature on systemic family therapy for psychosis, BFT, and CBT-FIp. There are mentions in the systemic family therapy for psychosis literature of including children "where appropriate" (Burbach & Stanbridge, 1998). Kuipers et al. (2002) guide to CBT-FIp has a brief section on children in the household, instructing the reader to consider their exposure to the parent's distress and the factors influencing their response to it, though none of the techniques for active involvement outlined above are mentioned.

1.5 Rationale for current study

Parents who experience psychosis experience challenges in addition to those associated with being a parent (Jeffery et al., 2013). Their children are at risk for a range of negative outcomes

(Ramchandani & Psychogiou, 2009). FIp has been found to be helpful in mitigating some of these outcomes and has a strong evidence base (Pharoah, Mari, Rathbone, & Wong, 2010). Systemic literature has provided a raft of techniques to facilitate the inclusion of children in family therapy (Lund et al., 2002), though these are largely absent from the literature on FIP (Burbach & Stanbridge, 1998; Falloon et al., 1985; Kuipers et al., 2002).

Clinicians delivering FIp work with families where there are children and make decisions about whether, and how, to include them without guidance from the three major models. The present study intended to find out what clinicians consider best practice when faced with these decisions with the aim of elaborating current models and intervention protocols for people who experience psychosis being seen with their families.

1.5.1 Research questions

1. What do experienced family clinicians consider to be best practice when considering whether, and how, to include children in their parent's family intervention for psychosis?
2. To what extent is there agreement about which statements are a reflection of best practice?

2. Methodology

2.1 Design

The Delphi methodology is often used to investigate areas where there is little existing literature (Skulmoski, Hartman, & Krahn, 2007). It is used to structure group opinions and to establish what consensus might exist between a group of experts (Hsu & Sandford, 2007).

It uses an iterative process conducted over two or more rounds to gather opinions of a group of experts, and then to establish consensus between them. It uses elements of qualitative and quantitative methodologies (Norcross, Hedges, & Prochaska, 2002).

There is not an overarching protocol for using the Delphi methodology and it has been used in various ways in previous research (Skulmoski et al., 2007). This study will follow the most commonly

described format which has been used to research related fields (Morrison & Barratt, 2010; Powell, 2003; South, Jones, Creith, & Simonds, 2015). This will be briefly outlined below.

In the first round participants were asked open ended questions to generate material relevant to the subject area (R1Q). This material was subject to thematic analysis and a list of statements was drawn up. This list of statements formed the second round questionnaire (R2Q) in which participants rated their level of agreement with each one.

For the third round questionnaire (R3Q) an individual questionnaire was created for each participant. This questionnaire contained the same list of statements as the R2Q, whilst also showing the participant's response, and the percentage of all participants who had selected each response. Participants were asked to review their answer in light of this information and decide whether to keep their response the same or change it.

This methodology was chosen because of the lack of existing literature relating to the inclusion of children in their parent's FIp. Delphi methodology's ability to be administered online meant that experts could be recruited from a broad geographic area resulting in broader scope in terms of maximising diversity of influences. It was intended that the anonymity Delphi methodology affords would allow participants to answer honestly about what can be a controversial topic.

2.2 Participants

Delphi methodology relies on the recruitment of 'experts'. Expertise in this regard has been defined as having knowledge and experience of the subject in question (Adler & Ziglio, 1996). This study used the following inclusion criteria to ensure a sufficient level of expertise to contribute:

- a minimum of five days family intervention for psychosis training (based on current approved FI training standards) (Health Education England, 2018)
- a minimum of two years post training experience working with families

There is little agreement on what constitutes an acceptable sample size for Delphi surveys used in the social sciences. Given that the panellists recruited for this study were a relatively homogenous group, it was decided that 10-50 participants would be recruited (Delbecq, Van de Ven, & Gustafson, 1975).

Fifteen participants completed R1Q, 23 completed R2Q, and 18 completed R3Q. Ten participants completed all three rounds. A table showing participant demographics and completion rates is shown below:

Table 1

Participant demographics and completion rates

Participant demographics		R1Q (n=15) n(%)	R2Q (n=23) n(%)	R3Q (n=17) n(%)
Professional Role	Clinical psychologist	10(67)	13(57)	11(65)
	Mental health nurse	3(20)	6(26)	5(29)
	Occupational therapist	1(7)	2(9)	1(6)
	Counselling psychologist	0(0)	1(4)	1(6)
	Family and systemic psychotherapist	1(7)	1(4)	0(0)
Preferred model	CBT based family intervention	5(34)	5(22)	3(18)
	Systemic	3(20)	4(16)	2(12)
	Behavioural family therapy	6(40)	12(52)	11(65)
	None stated	1(7)	2(9)	2(12)
Current FIp practice	In dedicated FIp post	4	5	4
	Frequent FIp practitioner	7	9	7
	Regular/routine FIp practitioner	3	7	5

	Occasional FIp practitioner	3	3	2
FIp experience	Currently sees families for FIp	14	22	16
	Supervises other practitioners for FIp cases on an individual basis	8	12	10
	Facilitates a supervision group for FIp	8	12	12
	Provides training on FIp to other practitioners	7	12	10
	Leads on FIp developments in their service	6	11	8
	Contributes to research activity relating to FIp	5	9	8
	Is a published author in FIp	1	2	2
Approximate number of families seen overall	1-5	1(7)	1(4)	1(6)
	6-10	4(27)	6(26)	5(29)
	11-15	0(0)	0(0)	0(0)
	16-20	4(27)	5(22)	4(9)
	More than 20	6(40)	10(43)	7(41)
Frequency children seen with a family	Never	1(7)	1(4)	1(6)
	Occasionally	1(7)	2(9)	1(6)
	Sometimes	12(80)	15(65)	11(65)
	Often	1(7)	4(16)	4(24)

2.3 Measures

2.3.1 Round one questionnaire development

Initial questions based on the literature were postulated and reviewed by the research supervisors. These were designed to elicit detailed responses from participants, as far as possible.

Staff were consulted for service user feedback as they were the prospective users of the outcomes of the study. The questions were piloted with five volunteers known to the researcher. They were four AMH clinicians with experience working with psychosis, and one child and adolescent mental health service (CAMHS) clinician with experience delivering family interventions. They completed the questions and gave feedback on their experience of completing them. The four questions were revised based on this.

Qualtrics Research Suite was used to create and distribute surveys. R1Q consisted of demographic information and the four open ended questions described above (see Appendix C). Participants were informed of all four questions before completing them. This may have primed them to respond in a certain way, but served the purpose of helping them organise their responses and not repeat themselves. It was also intended that detailed responses would be more likely if participants knew there would only be four questions.

2.3.2 Round two questionnaire development

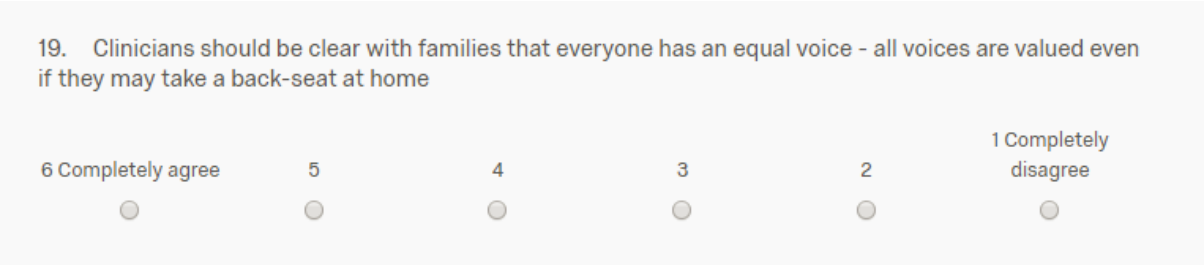
The results from R1Q were analysed using thematic analysis (Braun, Clarke, & Terry, 2014). A detailed description of this analysis can be found in section 3.1. In summary, qualitative data was coded and grouped according to themes. The internal consistency of the themes was corroborated with the research supervisors through meetings to review the analysis.

The R2Q consisted of 65 statements which, as far as possible, followed the wording used by participants in R1Q. These were organised into three very broad themes which formed the sections of the questionnaire. After the first section, “Should children be included”, participants were given the

option of submitting their results without continuing further if they felt it was never appropriate for children to be included in their parent's FIp. No participant took this option.

Participants were asked to rate the strength of their agreement with each statement using a 6 point Likert scale (see Figure 1). Space was given at the end of each section for participants to make additional comments. A copy of R2Q is given in Appendix D.

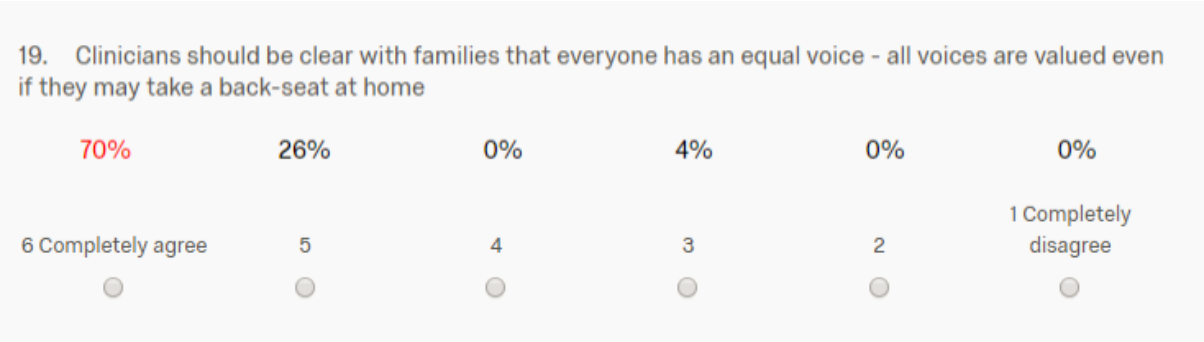
Figure 1. Example of item from R2Q



2.3.3 Round three questionnaire development

The R3Q consisted of the same items as R2Q presented as an individualised questionnaire for each participant. Above the six response options the percentage of participants selecting each response was given, with the participant's own response highlighted in red. An example of an item presented in this manner is given in Figure 2. Participants were given the option to give the same response again, or to change it based on their appraisal of the responses given by the whole sample.

Figure 2. Example of item from R3Q



2.4 Procedure

The Delphi survey took 13 months to complete. Delphi surveys typically use purposive sampling to ensure experts are targeted. This study recruited participants from the British Psychological Society (BPS) Psychosis and Complex Mental Health (PCMH) Faculty through their discussion list. Snowball sampling was used by asking participants to forward the details of the study on to any colleagues who they felt may be interested and who could usefully contribute. The lead researcher attended a PCMH conference on FIp to publicise the study.

An invitation to participate was sent to the PCMH discussion list and interested parties were asked to contact the lead researcher by email. A participant information sheet was emailed out to all who responded with a link to the R1Q online survey (see Appendix E-J for all study materials). Informed consent was sought at the beginning of each online survey. Participants were given four weeks to complete this, with a reminder email being sent after two weeks. Participants' information was entered into a coding sheet. Email addresses were used to track participants across rounds.

Following analysis (see section 3.1) R2Q was developed and sent out to all participants who had completed R1Q, and all of those who had expressed an interest in the study but not completed R1Q. New participants were also recruited from the PCMH discussion list through the sending out of a second invitation to participate. A follow up email was sent after two weeks to remind participants to complete the survey.

Data from R2Q was analysed using frequencies and R3Q was created. This was then sent out to all participants who had completed R2Q. No new participants were recruited at this stage.

2.4.1 Data analysis

For the purposes of clarity, detailed information on the qualitative and quantitative data analysis will be presented in the results section. In brief, a thematic analysis was conducted on the qualitative data and a Likert scale questionnaire developed to form R2Q. Frequency data was analysed from R2Q to create R3Q. Post-hoc analyses included a Spearman Rho to look for correlations between demographic information and items with low consensus and a Wilcoxon test to examine the extent of change in responses between rounds two and three.

The results of the thematic analysis were corroborated with the research supervisors. Consultation on the statistical analysis was sought from the University's research department.

2.5 Ethics

Ethical approval was granted by the University (see Appendix K) and the study adhered to the BPS code of ethics (beta.bps.org, 2009). Participants had the opportunity to contact the researcher before taking part. On making contact with the researcher participants were given a numerical code which was used to identify them. Participants were informed that their responses would be kept confidential. Data was stored on a password protected computer hard drive. Participants are to be sent a summary of the results on completion of the study.

3. Results

3.1 Research question one: What do experienced family clinicians consider best practice when considering whether, and how, to include children in their parent's family intervention for psychosis?

In R1Q participants were asked four open ended questions. They were:

1. Please describe what you consider to be best practice when working with a family with children who you are seeing for family intervention for psychosis
2. Please describe any ways in which you think it might be helpful to adapt FIp when there are children involved
3. Please describe your views about what might facilitate children's involvement at both service and individual level
4. Please describe your views about what might prevent or inhibit children's involvement as well as any thoughts about whether - and how - these issues could be overcome?

Fifteen participants answered these questions, and their answers were subject to a thematic analysis as described by Braun et al. (2014). When conducting a thematic analysis the researcher needs to be aware of their epistemological position and how they will influence the interpretation of the data

(Braun et al., 2014). This analysis was conducted from a social constructionist perspective, with the acknowledgment of the researcher that themes and categories found in the data would be co-created between the data provided by the participants and pre-existing ideas in the researcher's mind. Data was analysed at the latent level with the aim of organising the data and providing a rich description of it. This decision was taken as participants had taken part via an online survey and so had often responded in a somewhat brief manner, and without the benefit of having follow up questions,

Braun et al. (2014) describe 6 stages to conducting a thematic analysis; familiarisation, generating initial codes, searching for themes, reviewing themes, defining and naming themes, producing a report.

The process of familiarisation consisted of repeated readings of the full data set. This was necessary as the data did not need to be transcribed as it was already in written format. During these thorough readings notes were made of the lead researcher's impressions of what was emerging from the data.

A "data-driven" approach was taken to generating initial codes initially, with codes being tightly related to the data. Nvivo was used to organise the data extracts that formed the initial codes. These codes were organised into initial themes, which were further organised into broader categories, as show in Table 2 below. Research supervisors were consulted to ensure that themes and categories had internal validity.

Table 2

An early organisation of categories and themes

Category	Theme
Should children be included	Reasons to include children
	Age at which children should be included
Best Practice	Additional training
	Supervision
	Adjustments and adaptations

	Adapt language
	Practical adaptations
	Length and frequency of sessions
	Location
	Facilitating influences
	Systemic facilitators
	Using other resources
	Joint working with other professionals
	Guiding principles
	Children should feel they are treated equally
Levels of intervention	Initial assessment
	Discuss benefits of involving children
	Involvement in sessions
	Include in some sessions
	Parenting interventions
	Referral
	Involve children if not present
Areas that should be attended to	Attachment
	Confidentiality
	Impact of parent's mental health on child
	Impact of sessions on child
	Practicalities
	Documentation
	Risk
	Structure of sessions
	Service user experience
	What is shared

This early analysis of the data yielded 256 statements. An iterative process of reviewing, defining and naming themes followed consisting items being checked for overlap and revised, edited and combined to ensure they were succinct, with repeated checks for consistency and face validity with the research supervisors and additional consultation with a member of the University's research team. Some items were added based on material in the literature that had not been presented by participants. There were 65 statements included in R2Q in two broad categories containing seven themes (see Table 3).

Table 3

Final categories and themes forming the basis of R2Q

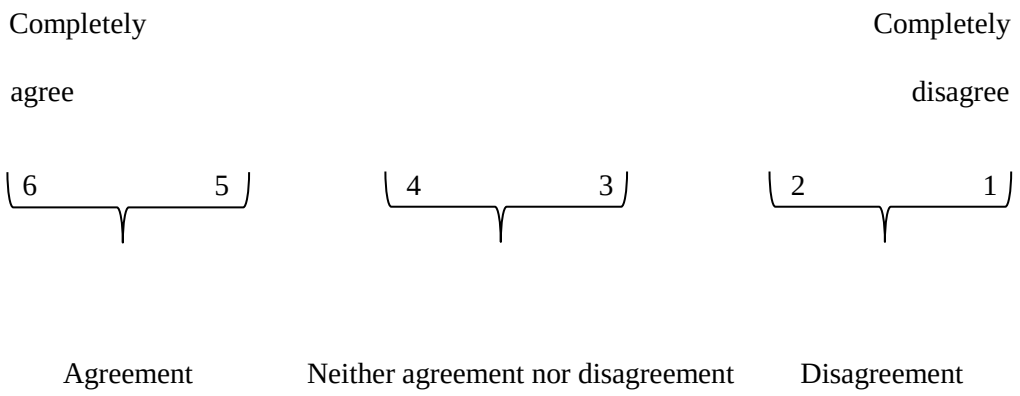
Category	Theme
Should children be included?	Should children should be included
	What factors clinicians may need to consider before deciding whether to include children
	What factors clinicians may need to consider if they are not to be included
How children might be included	What should be considered at the assessment stage
	What areas might be attended to during sessions
	What adaptations could be made
	What organisational factors might facilitate the inclusion of children in their parent's FIp

Due to the rich quality of the data gathered in R1Q some material relating to barriers that exist was not included in R2Q.

3.2 Research question two: To what extent is there agreement about which statements are a reflection of best practice?

There is no standardised measure of consensus in the Delphi literature (Hsu & Sandford, 2007). This study follows a common method of collapsing the six point Likert scale into three (South et al., 2015) as shown in Figure 3.

Figure 3. Calculations of consensus



The percentage of participants agreeing, neither agreeing nor disagreeing, or disagreeing with each statement was calculated. Levels of weak, moderate, and high consensus were based on those described by South et al. (2015) and are shown in Table 4. For participants who responded to R2Q but not R3Q data from R2Q was used in the analysis. From this point, items will be referred to according to the level at which participants had consensus to include or exclude them as being representative of best practice.

Table 4

Levels of consensus

Consensus categories	Percentage of panellists ratings
High consensus	>83.3%
Moderate consensus	66.6%< - <83.3%
Weak consensus	50%< - <66.7%
No consensus	<50%

The following table shows the 38 items which had high consensus to be included as representative of best practice.

Table 5

Statements with high consensus to be included as representative of best practice

Category	Statement	%
Should children should be included	Children should be included because they are acutely aware of what is going on at home but need help to understand it	95.7
	One might include children in some sessions but not others	95.6
	At the very least, clinicians should meet with the children to ascertain what they know, what they have worked out for themselves and what their worries are	91.3
What factors clinicians may need to consider before deciding whether to include children	Clinicians need to bear in mind the vulnerability of the child and how their inclusion might interact with that vulnerability	100
	Thought should be given to which parts of the model may directly help each child's understanding of what is happening, taking account of developmental stage of the child	100
What factors clinicians may need to consider if they are not to be included	If the decision is made not to include children in the actual sessions (or they decline joining), agree with adult family members about how important bits of the sessions will be fed back to children (e.g. write them a letter, hold their own family meeting)	100
	Clinicians should make contact with children, whether it be by writing, or by phone, and signpost to support such as young carers' groups or school counselling	91.3

What should be considered at the assessment stage	If the children do not join the first appointment, then they should be discussed in that appointment	100
	The benefits, and risks, of involving all family members, including children, in the process of family work should be discussed with the family	100
	Clinicians should be clear with families that everyone has an equal voice - all voices are valued even if they may take a back-seat at home	95.6
	Clinicians should have a discussion with the adults in the family around what children may know already and the benefits of them having more information	91.3
	Clinicians should have a clear, early conversation about the limits of confidentiality, both within the family work, but also within the wider service - noting that the child's safety is paramount	91.3
	Clinicians need to establish with parents, as soon as possible, what information can be shared with children	91.3
	Decisions about the inclusion in the first appointment should be made on a case by case basis, based on knowledge of the referral and perhaps a conversation with the adults in the family	86.9
What areas might be attended to during sessions	Clinicians should ask the parent's opinion on how they feel the children are being affected by their experience of psychosis	100
	Clinicians should consider the impact that acute admissions may have had on the family system	100
	Risk should be assessed regularly and normal safeguarding procedures followed in the event of any concerns	100
	Clinicians need to consider how the children are being affected by their parent's experience of psychosis, both inside and outside the sessions	91.3
	Clinicians should speak with service users about their experiences of parenting their children; the rewards and challenges that parenting brings	87

What adaptations could be made	Clinicians need to manage sessions to ensure the children are not exposed to inappropriate experiences in session e.g. excessive parental conflict or anxiety provoking comments	100
	The use of humour can be particularly helpful as a tool to build a relationship with children in sessions	100
	Language has to be adapted to the age and developmental stage of the youngest child involved	95.7
	Clinicians should make sessions active, visual and engaging, rather than didactic or verbally based	95.7
	Clinicians should find out what medium most suits the children for retaining/recording information e.g. using apps, social media, tablets, phones etc. rather than hand-writing notes	95.7
	Ways to check that the child both understands and feels understood, without making them feel stupid for asking questions, need to be agreed at the outset	95.7

	Clinicians need to be imaginative and receptive to expressing emotions using alternative means to language – for example providing toys to assist younger children to express themselves	91.3
	Clinicians should have a transparent discussion with the adults in the family in advance of any sessions planned to include the children, to agree ground rules regarding the expression of conflict or potentially distressing content	91.3
	Clinicians should use the service-user as the expert in information sharing sessions as they can talk about their experiences in language that the child or young person is familiar with	91.3
	Allocating children specific roles, e.g. 'timekeeper' or 'note taker', help to foster a sense of meaningful involvement	91.3
	Role plays are a helpful way to engage children	87
What organisational factors might facilitate the inclusion of children in their parent's FIp	Family intervention for psychosis training should routinely include content on working with children	100
	Supervisors should routinely ask about children in families when cases are presented in supervision	100
	From the start of contact the service should be explained to the service user as a family focused service, where all members of the family are invited to be involved, in order to avoid service users feeling like they are being scrutinised as parents	100
	Co-working with experienced therapists should be encouraged where clinicians do not feel confident working with children	100
	Services should routinely ask children who have been involved in FIp for feedback on how child friendly the experience was and act on any changes suggested by them	100

	Workshops should be provided for people with a special interest in working with children – e.g. workshops on parenting interventions, working with young children, working with teenagers, and involving children in sessions	95.7
	Stories from children who have had a positive experience of FIp may act as a motivator for staff to consider including them and should be fed back to teams	95.7
	Co-working with clinicians from CAMHS should be encouraged; for example services should facilitate supervision groups comprised of staff from mixed specialties e.g. AMH and CAMHS staff	87

The following table shows the 11 items which had moderate consensus to be included as representative of best practice. For an overview of all statements level of consensus, including those with weak or no consensus, see Appendix L.

Table 6

Statements with moderate consensus to be included as representative of best practice

Category	**Statement**	**%**
Should children should be included	Children will receive most benefit if they are directly involved wherever possible	82.6
	Children can usefully participate in all aspects of a family intervention	73.9
What factors clinicians may need to consider before deciding whether to include children	Clinicians need to consider the ability of each child to express and manage emotions	78.3
What factors clinicians may need to consider if they are not to be included	If the decision is made not to include children in the actual sessions (or they decline joining), their thoughts and feedback should be sought in another way e.g. asking them to write a letter/email; draw a picture or write a story	73.9
What should be considered at the assessment stage	Clinicians should assess how the parents are managing with regard to the child's social, emotional and educational development, and what parenting support might be required	78.3

	Clinicians should find out if the children have ever met with any professionals, either in the service you are seeing the family in, or another	78.3
	Clinicians should speak with the children about who they would like to be included in the sessions for example, the people who might look after the child when the parent is in crisis, safe people that the child is connected to (teachers/SENCOs for example)	78.3
	Clinicians should recognise the importance of peer group for adolescents and be willing to include friends if the young person requests this	74
What adaptations could be made	Adding games, play based activities and drawing are helpful ways to encourage children's' participation	82.6
	Concrete techniques such as passing around 'speech ball' will help children understand the 'one person speaking at a time rule'	82.6
	It's important to set individual goals with any children in the family	78.2

3.3 Items with no consensus

A Spearman Rho correlation was carried out to look for correlations between these nine items and two demographic items relating to experience in seeing families with children as experience has been identified as a factor influencing family-orientated practice (Maybery et al., 2016). Only one relationship was statistically significant. However it was not at a level of significance that would have remained after a correction for multiple comparisons and so is not reported here.

3.4 Changes in response between rounds

A Wilcoxon test was run to examine the influence of having received the feedback on other participants' responses in R3Q. No statistically significant difference was found between participants' answers to R2Q and R3Q.

3.5 Understanding which items had consensus

3.5.1 Should children be included?

Participants generally strongly supported the inclusion of children in their parent's FIp, recognising that they lived with their parent's experience of psychosis and needed support to understand it. Items relating to the flexible inclusion of children in some sessions, but possibly not all, were also supported. Items suggesting that children should be seen by CAMHS workers, that they should not be included because they benefit indirectly from work with their parents or because they might be exposed to inappropriate content were rejected.

Items which had no consensus to include or exclude revealed ambivalence about children being included because of the sense of family role they provide for the parent and that they may say things that adults would not. There was also no agreement about whether children under school age should be automatically excluded.

Items relating to things which clinicians need to consider before deciding whether to include children revealed very strong support for tailoring the model to directly help children's understanding of what was happening, and to hold in mind the vulnerability of the child and how being involved in FIp

might affect them. There was also support for considering how able each child is to express and manage emotions.

There was very strong support for involving children in the sessions even if they were not to be present. Suggestions for this included writing letters or contracting with the family what parts of sessions might be fed back to them. There was moderate consensus that children should be asked to contribute with letters or drawings if they were not to attend.

3.5.2 How children might be included

3.5.2.1 The assessment stage

There was high consensus on seven out of the 12 statements relating to things to consider at the assessment stage. Participants agreed that the decision of whether to include children in an assessment session should be made on a case by case basis, and that if they weren't to be involved they should at least be discussed.

Other statements with high consensus related to sharing information and agreeing boundaries, such as letting parents know that children will have an equal voice during sessions, discussing with the adults in the family the risks and benefits of the children being involved, discussing what the children might already know and the benefits of them knowing more, and establishing what could be shared with the children. Participants also agreed that the limits of confidentiality and the paramount nature of the safety of the children should be discussed at this stage.

Four items had moderate consensus. Two of these related to contracting who might be involved in sessions, recognising the importance of the wider social network and peer group for children and adolescents. Moderate consensus also existed for assessing how parents are managing the children's social, emotional and educational development and finding out if the children have had any contact with mental health services.

One item with no agreement to be included or excluded related to clinicians asking children's views before asking adults, and asking the adults to comment on what they heard from the children.

3.5.2.2 Areas to attended to during sessions

Five of the eight items relating to areas that might be attended to during sessions had high consensus. Participants agreed that clinicians should consider how children were impacted by the parent's experience of psychosis, and that the parent's opinion on this should be sought. The impact of acute admissions on the family system was considered an important area, as was the regular assessment of risk. Participants also agreed that it is important to speak with service users about their experiences of parenting their children generally; the rewards and challenges that parenting brings.

There were three items which did not have strong consensus to be included or excluded. They were:

- It is important to explore parents' attachment history, and how their attachment with their children is being expressed
- Sessions can be used to discuss and implement interventions targeting attachment based issues
- If therapists have doubts about the parenting approach, then they should consider offering a parenting intervention as part of the family work

3.5.2.3 Adaptations that could be made

In terms of adaptations that could be made to interventions, there were 11 out of 18 statements with high consensus to be included. These included ways for the sessions to be made more accessible for children such as adapting language, clinicians being imaginative about alternative ways that children might express emotions (e.g. through using toys), using more humour, the use of role plays, and allocating children specific roles to foster a sense of meaningful involvement (e.g. timekeeper). Similarly, the item stating that clinicians should use the service-user as the expert in information sharing sessions as they can talk about their experiences in language that the child or young person is familiar with also had high consensus. Participants endorsed the general idea that clinicians should make sessions active, visual and engaging, rather than didactic or verbally based.

Participants agreed that clinicians should be open to finding out what medium most suits the children for retaining and recording information (e.g. consideration of the use of apps, social media, tablets,

phones etc. rather than hand-writing notes). It was also agreed that ways to check that the child both understands and feels understood, without making them feel stupid for asking questions, need to be agreed at the outset.

In terms of the structure of the sessions, participants agreed that clinicians should have a transparent discussion with the adults in the family in advance of any sessions planned to include the children, to agree ground rules regarding the expression of conflict or potentially distressing content. Similarly, they agreed that clinicians need to manage sessions to ensure the children are not exposed to inappropriate experiences in session

There were three items which had moderate consensus to be included. They were:

- It's important to set individual goals with any children in the family
- Concrete techniques such as passing around 'speech ball' will help children understand the 'one person speaking at a time rule'
- Adding games, play based activities and drawing are helpful ways to encourage children's' participation

There were four items which had weak consensus to be included:

- Inviting children to draw a genogram, if this is to be used in the session, is a helpful way to ensure they are actively involved
- Narrative therapy approaches are helpful in informing child-friendly practice in family work
- It's helpful to provide children with a folder for any work done in sessions and to encourage them to make this their own, with doodles and stickers etc.
- In the staying well plan, it's a good idea to include things the child can do with the service user to help them keep well.

3.5.2.4 Organisational factors that might facilitate the inclusion of children

Eight out of the nine statements considering organisational factors that might facilitate the inclusion of children in their parents' FIp had high consensus to be included.

Two items related to the provision of training, with participants agreeing that workshops should be provided for people with a special interest in working with children (e.g. workshops on parenting interventions, working with young children, working with teenagers, and involving children in sessions). Participants also endorsed the suggestion that FIp training should routinely include content on working with children.

Two items related to working collaboratively; participants agreed that co-working with experienced therapists should be encouraged where clinicians do not feel confident working with children and that co-working with clinicians from CAMHS should be encouraged (e.g. services should facilitate supervision groups comprised of staff from mixed specialties).

Participants demonstrated high consensus on three items relating to the organisation of services. They agreed that from the start of contact the service should be explained to the service user as a family focused service, where all members of the family are invited to be involved, in order to avoid service users feeling like they are being scrutinised as parents. They agreed that supervisors should routinely ask about children in families when cases are presented in supervision and that services should routinely ask children who have been involved in FIp for feedback on how child friendly the experience was and act on any changes suggested by them.

Participants also endorsed an item relating to service development. They agreed that stories from children who have had a positive experience of FIp may act as a motivator for staff to consider including them and should be fed back to teams.

There was one item in this section in which participants did not have consensus; “clinicians do not need extra training to include children in FIp but should draw on their existing, transferable skills”.

4. Discussion

This three-round Delphi study intended to describe expert opinion on what constitutes best practice when deciding whether, and how to, include children in their parent’s FIp, and to assess the level of consensus on which factors are the most pertinent. Overall, the experts who participated

provided rich data on factors that constitute best practice and there was a considerable level of consensus found amongst the group. Here, the study's findings will be discussed and the study's limitations, and clinical and research implications considered.

The study's first research aim was to investigate what experienced family clinicians consider to be best practice when considering whether, and how, to include children in their parent's family intervention for psychosis. The qualitative data collected from expert participants was rich and covered a wide area; reflected in the fact that the first draft of R2Q consisted of 256 items. Analysis of the data revealed several themes which have been noted in previous research.

They overwhelmingly supported the inclusion of children in their parent's FIp, reflecting the current prominence of family orientated practice in AMH services in the UK (Social Care Institute for Excellence, 2012). This could also be interpreted as supporting a social-constructionist interpretation of "the pattern that connects", which suggests all parts of the family system should be worked with. There was high consensus that these interventions should be offered flexibly and tailored to the particular needs of the family. This is something that has previously been concluded by studies examining the efficacy of interventions for families where there are children in AMH settings (Isobel, Meehan, and Pretty (2016); Solantaus, Toikka, Alasuutari, Beardslee, and Paavonen (2009); van Santvoort, Hosman, van Doesum, and Janssens (2014)). Participants' responses indicated that they felt that AMH services were well placed to offer interventions to children, which is also something that has been found previously (Fraser et al., 2006).

There was no consensus to include or exclude an item on whether children should be included because of the sense of family role they provide for their parent. This potentially reflects an important ethical dilemma on the reasons as to why children might be included in their parent's FIp. Previous research has noted that feeling successful in the parental role is associated with positive mental well-being (van der Ende, van Busschbach, Nicholson, Korevaar, & van Weeghel, 2016)). However, supporting this role being the primary reason for including a person's children in their FIp could be neglectful of what the needs of the child might be (Fudge & Mason, 2004). This tension between

supporting the parent and protecting the child, which has been described as a “dual role” that family workers in AMH must grapple with (Jessop & De Bondt, 2012), is also demonstrated through high consensus on items relating to being mindful of the vulnerability of the child in the sessions and the need to keep them safe.

A child having mental health needs of their own was not seen as a barrier to their inclusion by participants. This is a welcome finding considering that children of a parent who experiences mental health difficulties offered an intervention in an AMH setting have often been found to have clinical or sub-clinical mental health difficulties themselves by the time they are seen (van Santvoort et al., 2014).

A high level of consensus was found with items relating to collaborative, respectful contracting of information sharing and agreeing boundaries with families. This could demonstrate an awareness of the participants of how stigmatised these parents can feel and the fears that they may have (Jeffery et al., 2013) and a desire to not undermine them in their parenting roles, which research has shown are so important (van der Ende et al., 2016). High consensus to talk with parents about their general experience of parenting can be seen to further support this stance, and is something that has proven successful in previous studies of parents with children being seen in an AMH setting (Isobel et al., 2016).

Almost all items relating to organisational factors were endorsed. This could reflect the awareness of these experienced clinicians of the importance of organisational support for this kind of work to take place (Owen, 2010). The findings here support previous studies looking at family interventions in AMH settings on the benefits of cross-agency collaboration (Goodyear et al., 2015), the importance of on-going organisational support, and of the service being organised as a family orientated service (Maybery et al., 2016).

In addition, there was high consensus for children who have been involved in FIp to be asked for feedback, and ‘success stories’ to be gathered and used in training. This kind of involvement of

children in service development in AMH is something that has not been noted in the existing literature and provides an interesting new direction for future research.

There was high consensus to make a range of adaptations. This suggests that experienced family workers are making use of the techniques found in the systemic literature outlined in the introduction (Lund et al., 2002) and supports the case for them being integrated into the FIp literature.

Several of the items with moderate and weak consensus to be included also include these techniques, some of which can be seen as originating in a particular model (e.g. goal setting, staying well plans in BFT and CBT-FIp and narrative techniques and genograms in systemic therapy). It is possible that practitioners aligned with a particular model may feel less comfortable using techniques from another. This may also be true of the finding that being flexible as to who might be involved in sessions (i.e. important friendships, teachers) had only moderate consensus; it may be more familiar to practitioners more aligned with the systemic approach.

4.1 Strengths and limitations

The use of an online Delphi survey allowed the collection of rich data from a broad geographical area on a complex issue. The Delphi model typically has a high level of attrition though this was not the case in the present study and the sample size is acceptable for achieving consensus. The participants were from a variety of professional backgrounds and had considerable experience in the field. The study also benefitted from the representation of practitioners in all three of the major models.

The study would have been strengthened through recruitment of comparable numbers of participants from each of the three major models to allow a between-group comparison of which items had consensus.

The study did not include any service users in the consultation or data collection stages as this was outside of the scope of the project. The rationale for this was that the users of the results of the study would be professionals. However, consulting with users of FIp at the beginning of the project about

their experiences and opinions on the inclusion of children could have allowed them to have input into the construction of best practice guidance.

4.2 Clinical implications

There were a large number of items with high consensus to be considered as aspects of best practice which may be useful to be adopted by clinicians and their teams. Broadly, these include keeping in mind any children in a service user's family from their first contact with the service and a thoughtful, individualised approach to deciding whether to include them in FIp sessions. There are specific recommendations about ways that clinicians can adapt their approach and materials, and some things which could be discussed with families. From an organisational point of view there are recommendations for FIp training, the organisation of services, and ways of working between services.

The findings of this study have the potential to be developed into resources, such as providing a basis for the development of best practice guidance for clinicians working with some of the dilemmas inherent in this topic. The sample was necessarily skewed to experienced clinicians who were likely to have a high level of interest in and commitment to including children in FIp. However, their experience forms the basis of the results here which could be used to guide less experienced, less confident practitioners in AMH settings to feel able to include children in FIp effectively.

4.3 Research implications

The results of this study demonstrate that some of the systemic literature on how to include children in family therapy is being incorporated into FIp by experienced clinicians who consider it best practice. These findings should be used to elaborate the writings of the three major models.

This study has resulted in a range of clinical and organisational implications for change. However, literature exists demonstrating many barriers to the implementation of such changes (McLaughlin et al., 2012), the most common of these being staff confidence and skill (Maybery et al., 2016), and a lack of resources and poor inter-agency communication (Byrne et al., 2000). These issues were also consistently commented on by participants in R1Q. Future research could examine how best to

improve staff confidence and skill, and to investigate new ways for different agencies such as AMH and CAMHS to work together.

Research into what the priorities of children who have a parent who experiences mental health difficulties are have shown that they want financial, social, and emotional support (Fudge & Mason, 2004). Whilst much current research is thoughtful about how children experience FIp, there is little involvement from them. Participatory action research is one way that AMH services and FIp could be collaboratively developed with clinicians, parents and their children.

5. Conclusion

This study has demonstrated that there is considerable consensus amongst experts in what is considered to be best practice when deciding whether, and how, to include children in their parent's FIp. Many of the items that form this consensus have an overlap with existing literature from systemic therapy, suggesting that those ideas are being integrated into AMH services in their delivery of FIp. The results suggest that this integration should be formalised clinically and in the literature from the three main models of FIp in the UK. Future research should focus on the organisational barriers to the implementation of FIp.

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Section C: Appendices of supporting material

Appendix A: Data extraction form

Source	
Methods	
Participants	
Interventions	
Outcomes	
Results	
Miscellaneous	

Appendix B: SQAC scoring

Quality Scoring of Quantitative Studies

"Total sum = (number of "yes" * 2) + (number of "partials" * 1) Total possible sum = 28 – (number of "N/A" * 2) Summary score: total sum / total possible sum"

(p14; Kmet et al., 2004).

Quality Scoring of Qualitative Studies

"Total sum = (number of "yes" * 2) + (number of "partials" * 1) Total possible sum = 20 Summary score: total sum / total possible sum"

(p20; Kmet et al., 2004).

Appendix C: Round one questionnaire

Delphi survey round one

Consent

Please read the following statements and tick the relevant box.

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions

☐ I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason

☐ I understand that any personal information that I provide to the researcher will be kept strictly confidential

☐ I agree to my taking part in the above study and that doing so will mean that my anonymised responses may be included in a doctoral thesis

☐ I agree to my anonymised responses being used within published research

☐ I can confirm that I have completed a minimum of five days family intervention for psychosis training

☐ I can confirm that I have had two years' experience with families post FI training

☐ I feel that my experience constitutes a sufficient level of expertise to contribute to the study

Please provide your name, or a pseudonym you will remember. This is for matching purposes only. Names will be removed from data and replaced with a unique code.

_____

What is your preferred email address to be contacted on for follow up?

_____

This questionnaire asks for your views of offering family interventions for psychosis (FI) to families which have one or more family member/s under the age of 18. I am interested to know your thoughts about the involvement of children in these interventions. "Involvement" is defined here in the broadest sense so could include a range of activities both directly and indirectly. The terms "child" or "children" will be used from here on to refer to any family member under the age of 18. I am

interested in all forms of a child's involvement in their adult relatives' family work that you may have come across.

Section A

This section will ask you for some demographic information about yourself, and your experiences of family work and working with children.

Age

_____

Profession

_____

Nature of Family Intervention training (any model of family work)

_____

Duration of Family Intervention training - please give your best estimate in days/weeks/months

_____

Approximate dates of FI training

_____

How would you describe your current involvement in FI practice? (please tick one)

☐ Occasional FI practitioner (don't routinely include families in your caseload)

☐ Regular / routine FI practitioner (generally have at least 1 family intervention on your caseload)

☐ Frequent FI practitioner (generally have 2 or more family interventions on your caseload)

☐ In dedicated FI post

☐ Additional comments e.g. how this might have changed or developed over time
_____

Which of the following best describes the extent of your FI experience and knowledge, currently or historically? (please tick all that apply)

☐ Seeing families for FI

☐ Supervising other practitioners for FI cases on an individual basis

☐ Facilitating a supervision group for FI

☐ Providing training on FI to other practitioners (please specify nature of training)
_____

☐ Leading on FI developments in my service

☐ Contributing to research activity relating to FI

☐ I am a published author in FI

☐ Other (please specify) _____

Other sources of knowledge and expertise, either currently or historically (please tick all that apply)

- [ ] Reading FI literature (e.g. research, theory, practice guidance)
- [ ] Active membership of the FI network / PCMH faculty
- [ ] Active membership of a local interest group for FI
- [ ] Regular attendance at group supervision for FI
- [ ] Other (please specify) _____

Approximate number of families seen overall

- [ ] 1-5
- [ ] 6-10
- [ ] 11-15
- [ ] 15-20
- [ ] More than 20
- [ ] Any comments _____

How often do you estimate that these families had family members under the age of 18?

- [ ] Never
- [ ] Occasionally
- [ ] Sometimes
- [ ] Often
- [ ] Always
- [ ] Any comments _____

Which therapy model has the greatest influence on your work with families? *Please select just one even if you are influenced by more than one model*

☐ CBT based family intervention

☐ Systemic

☐ Behavioural family therapy

☐ Any comments _____

Section B

This section asks you to draw on your experience of working with families to inform your views about best practice. Please illustrate with specific examples where this seems helpful.

There will be four questions in this section. You will be asked to describe:

- What you consider to be best practice when working with a family with children who you are seeing for family intervention for psychosis.

- Any ways in which you think it might be helpful to adapt FI when there are children involved.

- Your views about what might facilitate children's involvement at both service and individual level.

- Your views about what might prevent or inhibit children's involvement and how might these issues be overcome.

Please describe what you consider to be best practice when working with a family with children who you are seeing for family intervention for psychosis

_____

_____

_____

_____

_____

Please describe any ways in which you think it might be helpful to adapt FI when there are children involved

_____

_____

_____

_____

_____

Please describe your views about what might facilitate children's involvement at both service and individual level

_____

_____

_____

_____

_____

Please describe your views about what might prevent or inhibit children's involvement, as well as any thoughts about whether - and how - these issues could be overcome?

_____

_____

_____

_____

_____

If you have any other comments to make please enter them here before submitting your answers.

_____

_____

_____

_____

_____

Appendix D: Round two questionnaire

Delphi survey round 2

Consent

Please read the following statements and tick the relevant box.

☐ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions

☐ I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason

☐ I understand that any personal information that I provide to the researcher will be kept strictly confidential

☐ I agree to my taking part in the above study and that doing so will mean that my anonymised responses may be included in a doctoral thesis

☐ I agree to my anonymised responses being used within published research

What is your preferred email address to be contacted on for follow up?

_____

This questionnaire presents a list of 65 statements which have been derived from the qualitative round of data collection which took place in the first stage of this project. There is very little in the current literature about the inclusion of children in FIp, and a wide variety of views are expressed in the following statements. Some of the statements are quite strongly worded – we don't have a view on whether any of them are correct or not. We would really value your opinion on the statements, regardless of the position that you hold.

The initial thematic analysis also revealed several perceived barriers to including children in their parent's FIp. Whilst we recognise that there are many practical difficulties to including children, at this stage the research is focused on what the best practice would be if those difficulties could be overcome. It is likely that our recommendations for future research will include looking at how these barriers could be overcome.

A note on language: child and children are used interchangeably. For simplicity, where the word parent is used to refer to the adult service user, this can also be taken to mean any adult family member who is experiencing psychosis, such as an older sibling.

The questionnaire has been organised into two main sections: (i) should children be included in their parent's FIp? And (ii) how should children be included in their parent's FIp? There is a section for additional comments at the end of each subsection.

Section 1 looks at:

Whether children should be included

What factors clinicians may need to consider before deciding whether to include children

What factors clinicians may need to consider if they are not to be included

Section 2 looks at:

How children might be included

What should be considered at the assessment stage

What areas might be attended to during sessions

What adaptations could be made

What organisational factors might facilitate the inclusion of children in their parent's FIp

Section 1 – Should children be included?

This section contains 18 items relating to the research question of whether children should be included in their parent's FIp.

Please rate the extent to which you agree with each statement as a reflection of best practice

6 Completely agree – 1 Completely disagree

1. Children will receive most benefit if they are directly involved in the family work wherever possible

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

2. It is better not to directly work with children as they will benefit from the work that you do with the adults

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

3. Children should not be included because you cannot know when inappropriate content may come up (such as distressing or unusual ideas which many be traumatic for them to hear), or family conflict

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

4. It should be a CAMHS worker that meets with children, not adult workers

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

5. Children should be included because they provide support and a sense of family role (e.g. parental or sibling role) for the service user (as a parent or sibling)

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

6. Children should be included because they are often less defended so may be willing to say things that adult members won't

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

7. Children should be included because they are acutely aware of what is going on at home but need help to understand it

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

8. Children under school age should not be routinely included in FIp

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

9. One might include children in some sessions but not others

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

10. At the very least, clinicians should meet with the children to ascertain what they know, what they have worked out for themselves and what their worries are

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

11. Children can usefully participate in all aspects of a family intervention

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

12. Children in the family with mental health needs of their own should not be included

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Before deciding to include children clinicians need to consider the following:
Please rate the extent to which you agree with each statement as a reflection of best practice

13. Clinicians need to consider the ability of each child to express and manage emotions

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

14. Clinicians need to bear in mind the vulnerability of the child and how their inclusion might interact with that vulnerability

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

15. Thought should be given to which parts of the model may directly help each child's understanding of what is happening, taking account of developmental stage of the child

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

If they are not to be included:

Please rate the extent to which you agree with each statement as a reflection of best practice

16. If the decision is made not to include children in the actual sessions (or they decline joining), their thoughts and feedback should be sought in another way e.g. asking them to write a letter/email; draw a picture or write a story

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

17. If the decision is made not to include children in the actual sessions (or they decline joining), agree with adult family members about how important bits of the sessions will be fed back to children (e.g. Write them a letter, hold their own family meetings at home with the children, share any written material with children etc.)

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

18. Clinicians should make contact with children, whether it be by writing, or by phone, and signpost to support such as young carers' groups or school counselling

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Do you have any comments related to the above items?

_____

_____

_____

_____

_____

We expect that there will be a range of views on the statements above. If you feel that it is appropriate, or *largely* inappropriate for children to be involved in their parents FIp, please click CONTINUE, and complete the following sections *as if* children were to be included.

If you feel that it is *never* appropriate for children to be included please click WITHDRAW which will allow you to skip the following sections and submit the data you have entered

Section 2 looks at:

How children might be included

What should be considered at the assessment stage

What areas might be attended to during sessions

What adaptations could be made

What organisational factors might facilitate the inclusion of children in their parent's FIp

- ○ CONTINUE
- ○ WITHDRAW

Section 2 – How should children be included?

This section contains 47 items relating to the research question of how children should be included in their parent's FIp. It is divided into 4 sections; things to consider at the assessment stage, areas to attend to during sessions, adaptations, and organisational factors that facilitate the inclusion of children in FIp.

Please rate the extent to which you agree with each statement as a reflection of best practice

6 Completely agree – 1 Completely disagree

Things to consider at the assessment stage

19. Clinicians should be clear with families that everyone has an equal voice - all voices are valued even if they may take a back-seat at home

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

20. Clinicians should ask for children's views first before asking adults, and ask adults to comment on what they have heard (and vice versa)

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

21. Decisions about the inclusion of children in the first appointment should be made on a case by case basis, based on knowledge of the referral and perhaps a conversation with the adults in the family

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

22. If the children do not join the first appointment, then they should be discussed in that appointment

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

23. The benefits, and risks, of involving all family members, including children, in the process of family work should be discussed with the family

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

24. Clinicians should have a discussion with the adults in the family around what children may know already and the benefits of them having more information

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

25. Clinicians should have a clear, early conversation about the limits of confidentiality, both within the family work, but also with the wider service - noting that the child's safety is paramount

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

26. Clinicians need to establish with parents, as soon as possible, what information can be shared with children

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

27. Clinicians should assess how the parents are managing with regard to the child's social, emotional and educational development, and what parenting support might be required

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

28. Clinicians should find out if the children have ever met with any professionals, either in the service they are being seen for family work in, or another

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

29. Clinicians should speak with the children about who they would like to be included in the sessions for example, the people who might look after the child when the parent is in crisis, safe people that the child is connected to (teachers/SENCOs for example)

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

30. Clinicians should recognise the importance of peer group for adolescents and be willing to include friends if the young person requests this

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Areas to attend to during sessions

Please rate the extent to which you agree with each statement as a reflection of best practice

31. Clinicians should speak with service users about their experiences of parenting their children; the rewards and challenges that parenting brings

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

32. It is important to explore parents' attachment history, and how their attachment with their children is being expressed

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

33. Sessions can be used to discuss and implement interventions targeting attachment based issues

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

34. If therapists have doubts about the parenting approach then they should consider offering a parenting intervention as part of the family work

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

35. Clinicians need to consider how the children are being affected by their parent's experience of psychosis, both inside and outside the sessions

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

36. Clinicians should ask the parent's opinion on how they feel the children are being affected by their experience of psychosis

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

37. Clinicians should consider the impact that acute admissions may have had on the family system

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

38. Risk should be assessed regularly and normal safeguarding procedures followed in the event of any concerns

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Adaptations

Please rate the extent to which you agree with each statement as a reflection of best practice

39. Language has to be adapted to the age and developmental stage of the youngest child involved

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

40. Clinicians need to be imaginative and receptive to expressing emotions using alternative means to language – for example providing toys to assist younger children to express themselves

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

41. Clinicians should make sessions active, visual and engaging, rather than didactic or verbally based

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

42. Clinicians should find out what medium most suits the children for retaining/recording information e.g. using apps, social media, tablets, phones etc. rather than hand-writing notes

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

43. Clinicians should have a transparent discussion with the adults in the family in advance of any sessions planned to include the children, to agree ground rules regarding the expression of conflict or potentially distressing content

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

44. Clinicians need to manage sessions to ensure the children are not exposed to inappropriate experiences in session e.g. excessive parental conflict or anxiety provoking comments

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

45. Clinicians should use the service-user as the expert in information sharing sessions as they can talk about their experiences in language that the child or young person is familiar with

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

46. The use of humour can be particularly helpful as a tool to build a relationship with children in sessions

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

47. Inviting children to draw a genogram, if this is to be used in the session, is a helpful way to ensure they are actively involved

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

48. Ways to check that the child both understands and feels understood, without making them feel stupid for asking questions, need to be agreed at the outset

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

49. Adding games, play based activities and drawing are helpful ways to encourage children's' participation

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

50. Narrative therapy approaches are helpful in informing child-friendly practice in family work.

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

51. Role plays are a helpful way to engage children

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

52. Concrete techniques such as passing around 'speech ball' will help children understand the 'one person speaking at a time rule'

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

53. Allocating children specific roles, e.g. ‘timekeeper’ or ‘note taker’, help to foster a sense of meaningful involvement

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

54. It’s important to set individual goals with any children in the family

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

55. It's helpful to provide children with a folder for any work done in sessions and to encourage them to make this their own, with doodles and stickers etc.

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

56. In the staying well plan, it's a good idea to include things the child can do with the service user to help them keep well.

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Organisational factors that facilitate the inclusion of children in FIp

Please rate the extent to which you agree with each statement as a reflection of best practice

57. Workshops should be provided for people with a special interest in working with children – e.g. workshops on parenting interventions, working with young children, working with teenagers, and involving children in sessions

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

58. Family intervention for psychosis training should routinely include content on working with children

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

59. Clinicians do not need extra training to include children in FIp but should draw on their existing, transferable skills

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

60. Co-working with clinicians from CAMHS should be encouraged; for example services should facilitate supervision groups comprised of staff from mixed specialties e.g. AMH and CAMHS staff

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

61. Supervisors should routinely ask about children in families when cases are presented in supervision

- 6 Completely agree
- 5
- 4
- 3
- 2
- 1 Completely disagree

62. From the start of contact the service should be explained to the service user as a family focused service, where all members of the family are invited to be involved, in order to avoid service users feeling like they are being scrutinised as parents.

- 6 Completely agree
- 5
- 4
- 3
- 2
- 1 Completely disagree

63. Co-working with experienced therapists should be encouraged where clinicians do not feel confident working with children

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

64. Services should routinely ask children who have been involved in FIp for feedback on how child friendly the experience was and act on any changes suggested by them

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

65. Stories from children who have had a positive experience of FIp may act as a motivator for staff to consider including them and should be fed back to teams

- ○ 6 Completely agree
- ○ 5
- ○ 4
- ○ 3
- ○ 2
- ○ 1 Completely disagree

Do you have any comments related to the above items?

_____

_____

_____

_____

_____

If you have any further comments to add please use the space below. Many thanks for completing the survey.

_____

_____

_____

_____

_____

Appendix E: Invitation to participate for round one

Subject line: Inclusion of children in FI – what is your view?

Research Opportunity

My name is Owen Thompson and I am a Trainee Clinical Psychologist at Salomons Centre, Canterbury Christ Church University. I am supervised by Dr Maria Griffiths and Dr Jo Allen.

I am conducting research to explore best practice for practitioners offering family intervention for psychosis to families with children.

I am seeking the opinions of family workers who have completed a minimum of five days family intervention for psychosis training (based on current approved FI training standards) and who have had a minimum of two years' post training experience working with families.

The research will take the form of a Delphi survey. The Delphi survey will aim to find consensus amongst experienced family workers about what constitutes best practice in this area, and to identify areas of commonality and difference between theoretical models. It is hoped that this research will add to what is currently an under researched area and may contribute towards best practice guidelines, regarding the involvement of children.

The Delphi survey consists of three rounds and you would be asked to contribute to each round*. All rounds will be completed online. The first round will consist of a qualitative questionnaire asking for your views on the inclusion of children in their relative's family intervention for psychosis. This is expected to take 20-40 minutes. The second and third rounds will consist of lists of statements which you will be asked to indicate your level of agreement with. These rounds are expected to take around 15-30 minutes. You will be given around four weeks to complete each round online. A reminder email will be sent out one week before the cut off.

If you are interested in participating please email me at o.thompson35@canterbury.ac.uk. You will then be sent a participant information sheet which will also explain how participants will be allocated to the different rounds, and a link to the relevant questionnaire. I am using snowball sampling so please forward this invitation on to anyone with an interest in this area who may like to contribute to this research. If you have any further questions please don't hesitate to ask.

The deadline for registering interest in participating is 27th March 2017.

*Please note that once sufficient numbers have been recruited for round 1, all subsequent participants will be allocated directly to round 2.

Kind regards,

Owen Thompson
Trainee clinical psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road

Tunbridge Wells, Kent TN3 0TF

Supervised by:

Dr Maria Griffiths,
Clinical and Academic Tutor (Wednesday to Friday)
Salomons Centre for Applied Psychology
maria.griffiths@canterbury.ac.uk
Tel: 0333 011 7099

Appendix F: Participant information sheet for round one

Participant information sheet

A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children.

Researcher name and title: Owen Thompson, Trainee Clinical Psychologist
o.thompson35@canterbury.ac.uk

I would like to invite you to take part in this research study looking at best practice for the involvement of children in family interventions for psychosis (FI). Please read the following information, it will help you decide whether you would like to take part in the study or not.

Purpose of the study

There is very little literature on the involvement of children in family interventions for psychosis (FI), and little guidance given in the FI literature on their involvement. Experienced family workers may regularly face the decision of whether, and how, to involve children in these interventions. We are interested in your opinions on how this should be done, with the hope of contributing to the development of some best practice guidelines. A Delphi survey methodology, over 3 questionnaire rounds, is being used with the aim of reaching consensus.

Why have I been chosen?

I am seeking the opinions of family workers who have completed a minimum of five days family intervention for psychosis training (based on current approved FI training standards) and who have had a minimum of two years post training experience working with families.

I'd like you to take part in this study if, having read this information sheet, you feel that your experience constitutes a level of expertise that would allow you to contribute an informed opinion to the study**.**

I would also ask you to pass the details of this study on to anyone you feel may be interested and who may have relevant experience to take part.

If you have any questions before deciding whether you would like to take part please contact me on the details above.

What happens if I take part?

I have emailed you a link to a questionnaire for the first round of this study. This comprises a number of demographic questions and four open ended questions asking for your views on key areas of practice. Once you have consented to take part you can complete and submit the questionnaire online. Once data sufficiency has been reached for Round 1, all subsequent joining participants will be allocated directly to Round 2. This will comprise a list of statements derived from a thematic analysis of responses given in Round 1, requiring participants to rate their level of agreement. This process will then be repeated for Round 3, showing all previous responses, with the aim of reaching

consensus. Consequently I would like to retain your involvement from one round to the next if you are willing.

All data presented in the results will be anonymous. Questionnaires will be sent and collected electronically and results stored on a password protected university file.

If you encounter any problems whilst taking part in this study, please contact me in the first instance. If for some reason we are unable to resolve the issue, complaints can be made to:

Professor Paul Camic
Research Director
Christ Church Canterbury University
Broomhill Road
Tunbridge Wells
TN3 0TF
Telephone: 03330 117 114.

What will happen to the results of the study?

The results of the study will form part of a doctoral research thesis. They may also be published in a journal. There will be no identifiable information in any published material.

What are the potential risks and benefits associated with taking part?

We do not anticipate any risks with your taking part. If you find yourself feeling uncomfortable or distressed at any stage of the study, please do let me know. You may withdraw without giving a reason at any time. This study is using a Delphi Survey to determine its results, and as such there will be repetition in the questions you will be asked in Rounds 2 and 3 which may become tiresome. This is done with the aim of achieving consensus.

A potential benefit of your participation is that you will be contributing to a study which aims to provide much needed guidance on how practitioners approach this issue.

Who has funded and organised the research?

The study is funded and organised by the Canterbury Christ Church University.

Thank you for your interest in this project.

Appendix G: Invitation to participate for round two

Subject line: Inclusion of children in FI – what is your view?

Research Opportunity

My name is Owen Thompson and I am a Trainee Clinical Psychologist at Salomons Centre, Canterbury Christ Church University. I am supervised by Dr Maria Griffiths and Dr Jo Allen.

I am conducting research to explore best practice for practitioners offering family intervention for psychosis to families with children.

This project is using a Delphi survey methodology which collects data over three rounds. I am now conducting rounds two and three of the study. **You do not need to have taken part in the first round to take part in rounds two and three.** These rounds will consist of lists of statements which you will be asked to indicate your level of agreement with. **These rounds are expected to take around 15-30 minutes.** You will be given two weeks to complete each round online. A reminder email will be sent out one week before the cut off. The Delphi methodology relies on the continued involvement of participants from round 2 to round 3so I greatly appreciate peoples' commitment to the different stages of this project.

I am seeking the opinions of family workers who have completed a minimum of five days family intervention for psychosis training (based on current approved FI training standards) and who have had a minimum of two years' post training experience working with families.

The study aims to find consensus amongst experienced family workers about what constitutes best practice in this area, and to identify areas of commonality and difference between theoretical models. It is hoped that this research will add to what is currently an under researched area and contribute towards best practice guidelines, regarding the involvement of children.

I have attached a participant information sheet and encourage you to read this before deciding whether to participate. Many thanks for considering this project.

Here is the link to the relevant questionnaire:

https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_2i3NCJnWv2raNAV

If you have any further questions please don't hesitate to ask.

Kind regards,

Owen Thompson
Trainee clinical psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells, Kent TN3 0TF

Supervised by:

Dr Maria Griffiths,
Clinical and Academic Tutor (Wednesday to Friday)
Salomons Centre for Applied Psychology
maria.griffiths@canterbury.ac.uk
Tel: 0333 011 7099

Appendix H: Invitation to participate for round two for those who completed round one

Subject line: Inclusion of children in FI – what is your view?

Round 2

My name is Owen Thompson and I am a Trainee Clinical Psychologist at Salomons Centre, Canterbury Christ Church University. I am supervised by Dr Maria Griffiths and Dr Jo Allen.

Thank you for your previous involvement in my study exploring best practice for practitioners offering family intervention for psychosis to families with children.

I am now conducting rounds two and three of the study. These rounds will consist of lists of statements which you will be asked to indicate your level of agreement with. **These rounds are expected to take around 15-30 minutes.** You will be given two weeks to complete each round online. A reminder email will be sent out one week before the cut off. The Delphi methodology relies on the continued involvement of participants from one round to the next so I greatly appreciate peoples' commitment to the different stages of this project.

The study aims to find consensus amongst experienced family workers about what constitutes best practice in this area, and to identify areas of commonality and difference between theoretical models. It is hoped that this research will add to what is currently an under researched area and contribute towards best practice guidelines, regarding the involvement of children.

I have attached a participant information sheet and a link to the relevant questionnaire. If you have any further questions please don't hesitate to ask.

Kind regards,

Owen Thompson
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
TN1 2YG

Supervised by:

Dr Maria Griffiths,
Clinical and Academic Tutor (Wednesday to Friday)
Salomons Centre for Applied Psychology
maria.griffiths@canterbury.ac.uk
Tel: 0333 011 7099

Appendix I: Participant information sheet for round two

Participant information sheet

A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children.

Researcher name and title: Owen Thompson, Trainee Clinical Psychologist
o.thompson35@canterbury.ac.uk

I would like to invite you to take part in this research study looking at best practice for the involvement of children in family interventions for psychosis. Please read the following information, which should help you decide whether you would like to take part in the study or not.

Purpose of the study

There is very little literature on the involvement of children in family interventions for psychosis (FI), and little guidance given in the FI literature on attending to the needs of children in the family. Experienced family workers may regularly face the decision of whether, and how, to involve children in these interventions. We are interested in your opinions on how this should be done, with the hope of contributing to the development of some best practice guidelines. A Delphi survey methodology, over 3 questionnaire rounds, is being used with the aim of reaching consensus.

Why have I been chosen?

I am seeking the opinions of family workers who have completed a minimum of five days family intervention for psychosis training (based on current approved FI training standards) and who have had a minimum of two years post training experience working with families.

I'd like you to take part in this study if, having read this information sheet, you feel that your experience constitutes a level of expertise that would allow you to contribute an informed opinion to the study**.**

I would also ask you to pass the details of this study on to anyone you feel may be interested and who may have relevant experience to take part.

If you have any questions before deciding whether you would like to take part please contact me on the details above.

What happens if I take part?

I have emailed you a link to a questionnaire for the second round of this study. This comprises a list of statements which have been derived from a thematic analysis of responses already given in Round 1. You will be asked to rate your level of agreement with the statements. Round 3 will then be sent to all participants from Round 2 and will comprise the same list of statements, along with the ratings given by other participants for these items in Round 2. This is because we are trying to find the consensus amongst a group of experts as to the most important elements of best practice.

All data presented in the results will be anonymous. Questionnaires will be sent and collected electronically and results stored on a password protected university file.

If you encounter any problems whilst taking part in this study, please contact me in the first instance. If for some reason we are unable to resolve the issue, complaints can be made to:

Professor Paul Camic
Research Director
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
TN1 2YG
Telephone: 03330 117 114.

What will happen to the results of the study?

The results of the study will form part of a doctoral research thesis. They may also be published in a journal. There will be no identifiable information in any published material.

What are the potential risks and benefits associated with taking part?

We do not anticipate any risks with your taking part. If you find yourself feeling uncomfortable or distressed at any stage of the study, please do let me know. You may withdraw without giving a reason at any time. This study is using a Delphi Survey to determine its results, and as such there will be repetition in the questions you will be asked in Rounds 2 and 3 which may become tiresome. This is done with the aim of achieving consensus.

A potential benefit of your participation is that you will be contributing to a study which aims to provide much needed guidance on how practitioners approach this issue.

Who has funded and organised the research?

The study is funded and organised by the Canterbury Christ Church University.

Thank you for your interest in this project.

Appendix J: Participant information sheet for round three

Participant information sheet

A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children.

Researcher name and title: Owen Thompson, Trainee Clinical Psychologist
o.thompson35@canterbury.ac.uk

I would like to invite you to take part in the final round of this research study looking at best practice for the involvement of children in family interventions for psychosis. Please read the following information, which should help you decide whether you would like to continue taking part in the study or not.

Purpose of the study

There is very little literature on the involvement of children in family interventions for psychosis (FI), and little guidance given in the FI literature on attending to the needs of children in the family. Experienced family workers may regularly face the decision of whether, and how, to involve children in these interventions. We are interested in your opinions on how this should be done, with the hope of contributing to the development of some best practice guidelines. A Delphi survey methodology, over 3 questionnaire rounds, is being used with the aim of reaching consensus.

Why have I been chosen?

I am seeking the opinions of family workers who have completed a minimum of five days family intervention for psychosis training (based on current approved FI training standards) and who have had a minimum of two years post training experience working with families.

I'd like you to take part in this study if, having read this information sheet, you feel that your experience constitutes a level of expertise that would allow you to contribute an informed opinion to the study**.**

If you have any questions before deciding whether you would like to take part please contact me on the details above.

What happens if I take part?

I have emailed you a link to a questionnaire for the third and final round of this study. This comprises the list of statements presented in Round 2. The percentage of participants selecting each response is presented above each response. The response that you gave is highlighted in red. You are asked to read the statement again, review the responses of other participants, and decide whether you would like to select a new response, or keep the same one. The deadline for completing the questionnaire is 10th January. I will email you one week before this to remind you to complete it if you wish to do so.

All data presented in the results will be anonymous. Questionnaires will be sent and collected electronically and results stored on a password protected university file.

If you encounter any problems whilst taking part in this study, please contact me in the first instance. If for some reason we are unable to resolve the issue, complaints can be made to:

Professor Paul Camic
Research Director
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
TN1 2YG
Telephone: 03330 117 114.

What will happen to the results of the study?

The results of the study will form part of a doctoral research thesis. They may also be published in a journal. There will be no identifiable information in any published material.

What are the potential risks and benefits associated with taking part?

We do not anticipate any risks with your taking part. If you find yourself feeling uncomfortable or distressed at any stage of the study, please do let me know. You may withdraw without giving a reason at any time. This study is using a Delphi Survey to determine its results, and as such there will be repetition in the questions you will be asked in Rounds 2 and 3 which may become tiresome. This is done with the aim of achieving consensus.

A potential benefit of your participation is that you will be contributing to a study which aims to provide much needed guidance on how practitioners approach this issue.

Who has funded and organised the research?

The study is funded and organised by the Canterbury Christ Church University.

Thank you for your interest in this project.

Appendix K: Ethical approval

This text has been removed from the electronic copy

Appendix L: Levels of consensus for all statements

	Strong agreement to include	Strong agreement to exclude	Moderate agreement to include	Moderate agreement to exclude	Weak agreement to include	No agreement to include or exclude
Should children should be included	Children should be included because they are acutely aware of what is going on at home but need help to understand it	Children should not be included because you cannot know when inappropriate content may come up (such as distressing or unusual ideas which many be traumatic for them to hear), or family conflict	Children will receive most benefit if they are directly involved wherever possible	It is better not to directly work with children as they will benefit from the work that you do with the adults		Children should be included because they provide support and a sense of family role (e.g. parental or sibling role) for the service user (as a parent or sibling)
	One might include children in some sessions but not others			It should be a CAMHS worker that meets with children, not adult workers		Children should be included because they are often less defended so may be willing to say things that adult members won't
	At the very least, clinicians should meet with the children to ascertain what they know, what they have worked out for themselves and what their worries are					Children under school age should not be routinely included in FIp
Factors before deciding to	Clinicians need to bear in mind the vulnerability of		Clinicians need to consider the ability of each child to			

include	the child and how their inclusion might interact with that vulnerability Thought should be given to which parts of the model may directly help each child's understanding of what is happening, taking account of developmental stage of the child	express and manage emotions
If they are not to be included	If the decision is made not to include children in the actual sessions (or they decline joining), agree with adult family members about how important bits of the sessions will be fed back to children (e.g. Write them a letter, hold their own family meeting) Clinicians should make contact with children, whether it be by writing, or by phone, and signpost to support such as young carers' groups or school counselling	If the decision is made not to include children in the actual sessions (or they decline joining), their thoughts and feedback should be sought in another way e.g. asking them to write a letter/email; draw a picture or write a story

The assessment stage	If the children do not join the first appointment, then they should be discussed in that appointment	Clinicians should assess how the parents are managing with regard to the child's social, emotional and educational development, and what parenting support might be required	Clinicians should ask for children's views first before asking adults, and ask adults to comment on what they have heard (and vice versa)
	The benefits, and risks, of involving all family members, including children, in the process of family work should be discussed with the family	Clinicians should find out if the children have ever met with any professionals, either in the service you are seeing the family in, or another	
	Clinicians should be clear with families that everyone has an equal voice - all voices are valued even if they may take a back-seat at home	Clinicians should speak with the children about who they would like to be included in the sessions for example, the people who might look after the child when the parent is in crisis, safe people that the child is connected to (teachers/SENCOs for example)	
	Clinicians should have a discussion with the adults in the family around what children may know already and the benefits of them	Clinicians should recognise the importance of peer group for adolescents and be willing to include friends if the young person requests this	

	having more information		
	Clinicians should have a clear, early conversation about the limits of confidentiality, both within the family work, but also with the wider service - noting that the child's safety is paramount	Clinicians should assess how the parents are managing with regard to the child's social, emotional and educational development, and what parenting support might be required	
	Clinicians need to establish with parents, as soon as possible, what information can be shared with children		
	Decisions about the inclusion in the first appointment should be made on a case by case basis, based on knowledge of the referral and perhaps a conversation with the adults in the family		
Areas to attended to during sessions	Clinicians should ask the parent's opinion on how they feel the children are being affected by their experience of psychosis		Sessions can be used to discuss and implement interventions targeting attachment based issues

	Clinicians should consider the impact that acute admissions may have had on the family system			If therapists have doubts about the parenting approach then they should consider offering a parenting intervention as part of the family work
	Risk should be assessed regularly and normal safeguarding procedures followed in the event of any concerns			It is important to explore parents' attachment history, and how their attachment with their children is being expressed
	Clinicians need to consider how the children are being affected by their parent's experience of psychosis, both inside and outside the sessions			
	Clinicians should speak with service users about their experiences of parenting their children; the rewards and challenges that parenting brings			
What	Clinicians need to be	Adding games, play based	Narrative	

adaptations could be made	imaginative and receptive to expressing emotions using alternative means to language – for example providing toys to assist younger children to express themselves	activities and drawing are helpful ways to encourage children's' participation	therapy approaches are helpful in informing child-friendly practice in family work
	Clinicians should have a transparent discussion with the adults in the family in advance of any sessions planned to include the children, to agree ground rules regarding the expression of conflict or potentially distressing content	Concrete techniques such as passing around 'speech ball' will help children understand the 'one person speaking at a time rule'	In the staying well plan, it's a good idea to include things the child can do with the service user to help them keep well.
	Clinicians should use the service-user as the expert in information sharing sessions as they can talk about their experiences in language that the child or young person is familiar with	It's important to set individual goals with any children in the family	It's helpful to provide children with a folder for any work done in sessions and to encourage them to make this their own, with doodles and stickers etc.
	Allocating children specific roles, e.g. 'timekeeper' or 'note taker', help to foster a		Inviting children to draw a genogram, if this is to be used in

	sense of meaningful involvement Role plays are a helpful way to engage children		the session, is a helpful way to ensure they are actively involved	
Organisational factors	Family intervention for psychosis training should routinely include content on working with children Supervisors should routinely ask about children in families when cases are presented in supervision From the start of contact the service should be explained to the service user as a family focused service, where all members of the family are invited to be involved, in order to avoid service users feeling like they are being scrutinised as parents. Co-working with			Clinicians do not need extra training to include children in FIp but should draw on their existing, transferable skills

experienced therapists should be encouraged where clinicians do not feel confident working with children

Services should routinely ask children who have been involved in FIp for feedback on how child friendly the experience was and act on any changes suggested by them

Workshops should be provided for people with a special interest in working with children – e.g. workshops on parenting interventions, working with young children, working with teenagers, and involving children in sessions

Stories from children who have had a positive experience of FIp may act as a motivator for staff to consider including them and should be fed back to teams

	Co-working with clinicians from CAMHS should be encouraged; for example services should facilitate supervision groups comprised of staff from mixed specialties e.g. AMH and CAMHS staff

Appendix M

Author Guidelines for publication: Journal of Family Therapy

Manuscript submission

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication, a paper cannot be published elsewhere in any language without the consent of both Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world.

Manuscripts should be submitted to the following website: https://mc.manuscriptcentral.com/jft. Full submission instructions can be found on this website.

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Covering Letter

A cover letter should be submitted with your manuscript and must include a statement that the data has not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript. The cover letter should include a statement outlining what is new, impact making and original about the paper and why it should be considered for publication.

Please also include a paragraph detailing the Authorship contribution detailing the Author(s) responsible each of the following:

- designing the work
- acquiring the data
- interpreting the data
- drafting the work/ revising the work critically for intellectual content

A statement from the authors agreeing to be held accountable for all aspects of the work and any questions relating to the accuracy or integrity of the work should also be included.

Manuscript Format

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must not** contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:

- Title Page: to contain the title of the paper, word count, suggested running head (short title for your paper), key words, author names, affiliations and contact details for the corresponding author.
- Abstract: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present. *For tips on optimizing your abstract for search engines please click here.*

- Practitioner Points: two to six bullet points of no more than 180 characters each (including spaces), up to a total of 480 characters.
- Organisation of the text: see copy of Journal for the format currently in use.
- Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.
- References (in text): These should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh et al. (2010)'. Quotations should include page numbers. Websites should also be cited in this way, with a full reference appearing in the References section (see below). Please check all websites are live and the links are correct at time of submission.
- References: Should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details following the APA style of referencing.
    - **Articles**: Altschuler, J. (2015). Whose illness is it anyway? On facing illness as a couple. Journal of Family Therapy, 37(1), 119-133.
    - **Chapters**: Burnham, J. (2012). Developments in the Social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In I.B. Krause (Ed.), Culture and Reflexivity in Systemic Psychotherapy. Mutual Perspectives (pp 139-163). London: Karnac.
    - **Books**: Burck, C., & Daneil, G. (2010). Mirrors and Reflections. Process of Systemic Supervision. London: Karnac.
    - **Web pages** (no author or date identified): Counting the cost: caring for people with dementia on hospital wards. (n.d.) Retrieved from http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=1199. [Cite in text as ("Counting the costs", n.d.)]

For further details, please see the APA Style website: (http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx)

3. The word limit, excluding abstract and practitioner points will vary depending on the type of paper you are submitting. Please refer to the 'Advice to Authors' section below.

4. Style: Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Your manuscript will be returned to you if you fail to conform to these requirements.

Case material and Confidentiality

Journal of Family Therapy readers particularly welcome papers which link theory and practice, and such papers are often enhanced by case material.

The Author takes responsibility for anonymising material in order to protect client confidentiality. All possible identifying information must be altered. Another way of protecting confidentiality is by presenting composite case material, made up of different aspects from a number of similar cases.

Do not identify any participants without consent or write about them in any way that identifies them to the public or other participants without consent.

Every paper that contains case material must be accompanied by:-

- A statement in the letter to the Editor from the Author(s) specifying whether the material presented is disguised/generic/composite; or
- A statement in the letter to the Editor that the Author has gained signed consent from patients/clients or teachers/students authorizing publication of the material. Please note that upon signing the Author Agreement the Author becomes liable for any third party information collated

and takes complete responsibility for preparing the work and gaining the relevant permissions and consent.

Pre-submission English-language editing

It is often helpful to Authors for whom English is a second language to choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found here.

All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Evaluation of Manuscripts

The Editorial office will acknowledge receipt of manuscripts. The Editor will arrange for evaluation by at least two assessors. Following receipt of the assessors comments the Editor will advise the authors about the decision concerning the manuscript. This will be done as rapidly as possible with the aim being 12 weeks for a first decision. Revised manuscripts may take longer to reach a final decision).

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors of the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

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To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services and visit this website.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) or the Austrian Science Fund (FWF) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funder requirements. For more information on this policy and the Journal's compliant self-archiving policy please click here.

All papers published in the *Journal of Family Therapy* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Copy Editing

Following acceptance for publication an article is copy edited for conformity to the style of publication, clarity of presentation, punctuation, standard usage of terms, etc.

Proofs

Corresponding authors will receive proofs for correction which must be returned within 48 hours of receipt. The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from this website. Further instructions will be sent with the proof.

Early View

The *Journal of Family Therapy* is part of the Wiley Online Library Early View service. Articles accepted for publication (excluding book reviews) can be accessed on a regular basis online in advance of their appearance in a print issue.

These articles are fully peer reviewed, edited and complete and are considered fully published from the date they first appear online. This date is shown with the article in the online table of contents. The articles are available as full text HTML or PDF and can be cited as references by using their Digital Object Identifier (DOI) numbers. All of the articles currently available can be viewed here. On print publication, the article will be removed from the Early View area and will appear instead in the relevant online issue, complete with page numbers and volume/issue details. No other changes will be made.

ADVICE TO AUTHORS

Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors and The *Journal of Family Therapy*wants to hear from you.

These are the types of papers that are regularly submitted to the *Journal of Family Therapy*:
(The word count for all these papers does not include tables and figures.)

Research Presentation (3,000-6,000 words)

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study
- Previous work
- Description of methodology including participants
- Results/Findings
- Discussion of results, including implications for future research and practice

Systematic reviews (up to 6000 words).

Systematic reviews are welcomed. For systematic reviews and meta-analyses please ensure that you have used the PRISMA checklist and include a flowchart as part of your submission. Please complete and supply AMSTAR for systematic reviews which are narrative reviews not meta-analyses.

Suggested headings for systematic reviews are:

- background or context;
- objective;
- search strategy;
- inclusion criteria;
- data extraction and synthesis;
- main results; discussion and conclusions.

Please ensure that you include the standard points for practice.

You should provide the PROSPERO number in the methods section of the paper, or explain in your covering letter if you have not registered your review with PROSPERO.

Case Study (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

The *Journal of Family Therapy* welcomes case studies. A case study paper should include the following:

- Theoretical/Research Basis
- Introduction of the case including presenting issues
- Relevant background information
- Systemic case conceptualisation
- Self-reflexivity
- Description of intervention/ treatment
- Outcomes and follow up
- Implications/contributions to the field

For anonymised case studies informed consent to publish must be obtained from all participants in the treatment and/or all family members before submission.

CONSENT TO PUBLISH MUST ALWAYS BE OBTAINED FROM CLIENTS/FAMILIES BEFORE SUBMISSION

Theoretical Discussions or Controversial Theoretical Papers (4,000-6,000 words)

We welcome the submission of articles of this nature. A paper of this type would include:

- A brief general introduction
- A review of previous statements of the issues
- A definition of problems and solutions
- A development of an argument (Research based work which was undertaken for a thesis may be referenced)
- Relation of theory to practice
- Issues to be resolved

Often we will ask one of the reviewers to write a commentary on the paper to stimulate debate through the Journal pages.

Literature Review (3,000–5,000 words)

These are much sought after by the readership. Such a paper would have:

- A brief general introduction
- A description of the way in which the themes in the literature are organised by the author for review. This may include conceptual and definition problems.
- The review
- An overview of the review process including gaps in existing knowledge
- Future directions

Teaching and Learning (up to 2,000 words*)

*Longer papers may be considered at the discretion of the Editor if it is felt the manuscript fulfils the role of a full paper.

These should include:

- Practitioners Points – key ideas for trainers from paper
- Description of context – situation in which teaching event occurred, experience and constitution of participants and trainers, pre and post learning required for this session
- Aims of teaching event – aims and learning outcomes
- Theoretical Description which includes systemic theory / practice and education / learning/ pedagogical theory
- Description of event – pre reading, structure of session, length, didactic, experiential
- Feedback from participants – formal and informal
- Learning as a result of experience – trainers own evaluation, any suggested changes as a result of feedback or experience, suggestions for application in other settings

Additional Notes to Authors:

- JFT has an international readership, so spell out details that might be unfamiliar to the non UK field.
- JFT welcomes the linking of previous literature in a substantive, explanatory sense and therefore advises authors to reference other papers where possible.

PAPERS EXCEEDING THE SPECIFIED WORD LIMITS (including references) WILL BE RETURNED TO THE AUTHOR

Appendix N

Feedback to ethics committee

This report outlines in brief my recently completed study, "A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children".

Parents who experience psychosis experience challenges in addition to those associated with being a parent. Their children are at risk for a range of negative outcomes. Family interventions for psychosis have been found to be helpful in mitigating some of these outcomes and have a strong evidence base. Systemic literature has provided a raft of techniques to facilitate the inclusion of children in family therapy, though these are largely absent from the literature on family interventions for psychosis. Clinicians delivering FIp work with families where there are children and make decisions about whether, and how, to include them without guidance from the three major models (systemic family therapy, behavioural family therapy, CBT-FIp). The present study intended to find out what clinicians consider best practice when faced with these decisions with the aim of elaborating current models and intervention protocols for people who experience psychosis being seen with their families.

This study used a three- round Delphi survey to investigate what is considered best practice when deciding whether, and how, to include children in their parents' family intervention for psychosis amongst a group of experts. Fifteen participants completed R1Q, 23 completed R2Q, and 18 completed R3Q. Ten participants completed all three rounds. A table showing participant demographics and completion rates is shown below:

Table 1

Participant demographics and completion rates

Participant demographics		R1Q (n=15) n(%)	R2Q (n=23) n(%)	R3Q (n=17) n(%)
Professional Role	Clinical psychologist	10(67)	13(57)	11(65)
	Mental health nurse	3(20)	6(26)	5(29)
	Occupational therapist	1(7)	2(9)	1(6)
	Counselling psychologist	0(0)	1(4)	1(6)
	Family and systemic psychotherapist	1(7)	1(4)	0(0)
Preferred model	CBT based family intervention	5(34)	5(22)	3(18)
	Systemic	3(20)	4(16)	2(12)
	Behavioural family therapy	6(40)	12(52)	11(65)
	None stated	1(7)	2(9)	2(12)
Current FIp practice	In dedicated FIp post	4	5	4
	Frequent FIp practitioner	7	9	7
	Regular/routine FIp practitioner	3	7	5
	Occasional FIp practitioner	3	3	2

FIp experience	Currently sees families for FIp	14	22	16
	Supervises other practitioners for FIp cases on an individual basis	8	12	10
	Facilitates a supervision group for FIp	8	12	12
	Provides training on FIp to other practitioners	7	12	10
	Leads on FIp developments in their service	6	11	8
	Contributes to research activity relating to FIp	5	9	8
	Is a published author in FIp	1	2	2
Approximate number of families seen overall	1-5	1(7)	1(4)	1(6)
	6-10	4(27)	6(26)	5(29)
	11-15	0(0)	0(0)	0(0)
	16-20	4(27)	5(22)	4(9)
	More than 20	6(40)	10(43)	7(41)
Frequency children seen with a family	Never	1(7)	1(4)	1(6)
	Occasionally	1(7)	2(9)	1(6)
	Sometimes	12(80)	15(65)	11(65)
	Often	1(7)	4(16)	4(24)

R1Q consisted of four open ended questions. Responses were subject to a thematic analysis and a list of 65 statements was created from this to form R2Q. Participants indicated their level of agreement with each statement as being representative of best practice. R3Q presented the same statements with the percentage of respondents indicating each level of agreement and participants either kept their response the same of changed it after reviewing the responses of others. Statistical analysis was conducted and the level of consensus for each statement to be considered representative of best practice was calculated. There were 38 statements considered to have high consensus and 11 to have moderate consensus. The findings demonstrated support for including children and suggested methods of facilitating their involvement in assessment, areas that should be attended to in sessions, adaptations that should be made, and organisational factors that support their inclusion. The responses suggested that adult mental health services were well placed to meet some of the needs of these children. Consideration was given to items which did not have consensus and the clinical and research implications were described.