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

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Abstract

Parents experiencing psychosis can face challenges in addition to those usually associated with being a parent, with their children at increased risk of negative outcomes. Although a strong evidence base has shown that family interventions for psychosis (FIp) can mitigate distress for adult relatives, techniques described in the systemic and parenting literature to facilitate the inclusion of children in family therapy are largely absent from the FIp literature and training. This study used a three- round Delphi survey to investigate what experienced FIp clinicians consider to be best practice regarding the inclusion of children in parental FIp. Findings demonstrated support for including children, with high levels of consensus regarding methods of facilitating their involvement, as well as organisational factors that would support this. The results have important clinical implications given that many FIp practitioners work with families, following brief psychosis specific training, without exposure to the broader literature.

Practitioner points

- Practitioners offering FIp to parents should aim to include the children in at least some elements of the intervention.
- Careful assessment with adult family members should inform decisions about how children can be involved.
- Creative adaptations to the FIp approach can ensure that the intervention is suitably child-friendly.
- Organisations can support a whole family approach by facilitating links between child and adult services and access to training and supervision.

Introduction

Psychosis is a term used to describe a range of mental health experiences, that vary enormously between individuals but which can be distressing and have significant consequences for individuals and families (Cooke et al., 2014). Family interventions for psychosis (FIp) were developed with a clear emphasis on improving outcomes for adults experiencing psychosis, given that high levels of hostile and critical communication between family members, (known as "high expressed emotion") were found to be associated with a higher risk of relapse (Kuipers et al., 2002). Interventions developed to foster mutual understanding and calmer ways of communicating in families were found to be effective at keeping people well for longer (Glynn et al., 2006). Taken together, a range of these interventions, drawing on different theoretical models, have a robust evidence base (Pharoah et al., 2010). FIp is therefore recommended to be offered to everyone experiencing psychosis in the UK (National Institute for Health and Care Excellence [NICE], 2014). NICE guidelines do not specify which model of therapy FIp should be informed by, particularly as over time the different approaches (primarily psycho-educational and systemic) have moved closer together, with the development of common areas of understanding and practice (Burbach, 2018). Key features which should be present include a positive, recovery oriented approach with attention to crisis management, family problem-solving, coping strategies and support (NICE, 2014) as well as psycho-education tailored to the information needs of the family (Onwumere et al., 2016).

Over time, with increasing recognition of the significant levels of distress experienced by those close to the adult experiencing psychosis, there has been more focus on outcomes for carers and relatives in terms of their own well-being (Bucci et al., 2016). The FIp model was developed in the context of adult carers, with the most common demographic being an adult son being seen with an elderly mother (Scazufca & Kuipers, 1997). Consequently there is very little in the FIp literature about the inclusion of children in these interventions and whether the approach can be adapted to be child-friendly. Glynn et al. (2006) noted that FIp approaches had not progressed to take account of different kin relationships - such as families with young children, or couples - and yet revised NICE guidelines (2014) on FIp provision still do not mention children. Similarly, whilst there has been increasing recognition of the role played by young carers, and their considerable support needs (Wardale, 2007) this remains a somewhat separate consideration in the literature. Yet the proportion of adults experiencing psychosis that are becoming parents - and living with dependent children - is increasing, probably due to an increased emphasis on community oriented care (Campbell et al., 2012).

Parenting and psychosis

Research suggests that a significant proportion (up to 50%) of adults experiencing psychosis will be parents, often managing the role without a partner (Campbell et al., 2012; Mueser & Gingerich 2006). Howard et al. (2001) found that in a UK sample, 63% of women experiencing psychosis were parents. Although a clear picture of the demographics is still emerging, the mothers in Howard et al.'s (2001) sample were older overall than other women experiencing psychosis, and had experienced later onset. This is consistent with Craig and Bromet (2004) who found that 28.7% of adults – and almost half of women - experiencing a first admission due to psychosis had already started their families.

Although there are rewards in parenting, psychosis can have an impact on a person's experience of the role, as well as on the early experiences of the child (Mueser & Gingerich 2006). Adults experiencing psychosis are often stigmatised in their role as parents; for example being made to feel unfit as a parent, viewed as unsafe or untrustworthy and feeling closely watched and judged by others (Jeffery et al., 2013). These kinds of aversive experiences can be a barrier for these parents to accessing the support they most need (Abrams et al., 2009).

Campbell et al. (2012) found that while most parents in their survey were providing good quality care, around a quarter were experiencing significant difficulty in meeting the demands of the parenting role and had high support needs in this regard. Some children were affected by increased rates of social isolation and poverty, and disrupted parent-child attachment due to high rates of lost custody (Campbell et al., 2012). Up to one quarter of the children in this survey were affected by behavioural or health problems requiring significant treatment. In general children whose parents experience mental health difficulties have been found to be at increased risk of experiencing mental health problems of their own (Ramchandani & Psychogiou, 2009). For children living with parental psychosis, the long-term risks of a developing a similar diagnosis have been estimated to be as high as 1 in 3, with a 50% risk of developing any kind of significant mental health problem (Rasic et al., 2014) though the authors note these are preliminary findings.

These figures provide context for the increasing acknowledgement of the need for a family-focused approach to adult mental health care that will fully attend to the needs of both children and adults (Falkov, 2013). Such approaches appear to show success at improving the experiences of children affected by parental psychosis (e.g. Beardslee et al., 2003).

Parenting interventions for adults with mental health difficulties

There have been a number of parenting initiatives developed to support multi-stressed families, or parents with mental health needs, to care for their children. These have largely, though not exclusively, emerged in the context of improving outcomes for the child (e.g. Beardslee et al., 2003) and most have not been specific to psychosis (Fraser et al., 2006).

Resilience has been identified as a key protective factor in keeping children safe from some of the adverse consequences of parental mental health difficulties (Foster et al., 2012). Beardslee's family intervention (Beardslee et al., 2003) is aimed at increasing childrens' resilience, in order to decrease the risks of them developing mental health problems of their own later in life (Pihkala et al., 2012). Key features of the intervention include promoting open communication about the nature of the mental health issues, positive interactions and a strengthened caretaker role for the parents (Pihkala et al., 2012). Although this approach was developed primarily in the context of affective disorders, Strand and Rudolfsson (2017) recently carried out a qualitative study to see how the approach might translate in the context of psychosis. Their clinician participants reported benefits for both parents and children but also complexities engaging certain families in the work. They also found that the psycho-education component needed adaptations to sensitively address the impact on children of sharing potentially distressing information, when parents appeared to lack awareness. Unlike FIp, mental health outcomes of the parents feature less in these interventions.

Whole family approaches

The need for professionals in child and adult mental health services to work across boundaries and consider the mental health needs of all family members has received growing recognition (Diggins, 2016, Falkov, 2013). The reciprocal influence of parental mental health on the well-being of the child and vice versa is now more fully understood. The Family Model (Falkov, 2013) stresses the need to avoid placing too much emphasis on the needs of any one family member, rather recognizing that a balanced approach takes account of the needs across generations and for all family members, noting the connections between them. This structured approach has some parallels with FIp and could offer some useful adaptations to the traditional FIp approach when children are included. However attempts to develop a whole family approach in AMH services can prove difficult to establish and sustain without focused organisational support (Diggins, 2016, Maybery et al., 2016).

In circumstances specific to psychosis, Power et al. (2015) highlight challenges which arise in treatment when raising questions about the impact of psychosis for each member of the family, given the risk of provoking feelings of shame in the parent. They discuss ways of asking questions that make it more possible to explore the mental health issue and share information with the family where this seems helpful. They also note the value of remaining attuned to the readiness of the family to discuss sensitive topics. This should be borne in mind when considering approaches aimed at developing children's knowledge and understanding of psychosis (e.g. Pihkala et al. 2012; Strand & Rudolfsson, 2017).

Inclusion of children in family therapy

The systemic literature has long argued the benefits of including children in family therapy, recognising them as important parts of the systems in which people experience their difficulties (e.g. Chasin & White, 1989; Zilbach et al., 1986). Qualitative research indicates that children want to be included in family sessions, even when they are not the main focus (Stith et al., 1996). Specific techniques supporting their involvement include the use of drawing, with themes such as pictures of the family, happy and sad times, or drawing genograms (Carr, 1994).

Non directive techniques such as observing and interpreting the child's play (Zilbach et al., 1986) may enable the child's voice to be present despite their developmental gap in cognitive and verbal abilities compared to the adults. Concrete visual aids can convey complex, abstract concepts to children (O'Brien & Loudon, 1985), whilst puppets and dolls can be used to act out scenarios (Carr, 1994). Lowenstein (2010) describes many other creative ideas and games to engage children of all ages in assessment, treatment and the management of endings in family therapy.

Whilst these techniques could be used in any theoretical model, the extent to which they have been incorporated into FIp is questionable. Falloon et al. (2004) note that children should be reassured that sharing concerns about a parent’s mental health will help to keep them well, in order to minimise fears of separation from their parent in the event of an admission or removal to care. Burbach and Stanbridge (1998) suggest including children “where appropriate” whilst Kuipers et al. (2002) briefly guide the reader to consider children’s exposure to the parent’s distress and factors influencing their responses. In a recent development, Burbach et al. (2018) report on a regional FIp training programme that includes content on parental mental health and the needs of children, on one of the 10 days of the programme, but this is otherwise a gap in FIp treatment manuals.

Given the AMH context of FIp, it is also important to note research highlighting a lack of confidence for AMH practitioners when it comes to involving children, and clarifying associated training needs (e.g. Maybery et al., 2016). In addition, current training approaches for FIp tend to be short, ranging from 5 days to 1 year and often manualised (Mairs & Bradshaw, 2005), with the aim of equipping multi-disciplinary professionals - often in care co-ordinator roles - to offer the approach. AMH care co-ordinators trained in FIp struggle to deliver family work for adults (Onwumere et al., 2016), even with supervision, so are likely to require additional guidance and support to confidently include children.

Rationale for the current study

Parents who experience psychosis face challenges in addition to those associated with being a parent (Jeffery et al., 2013), with their children at risk of a range of negative outcomes (Ramchandani & Psychogiou, 2009). Although FIp has been found to be helpful in reducing stress in families and improving outcomes for adult relatives and carers (Pharoah et al., 2010) there is little in the current FIp literature to address the needs of children. Existing literature on the importance of including children in other types of family work (e.g. Beardslee et al., 2003; Carr, 1994) and AMH practice more broadly (e.g. Falkov, 2013), has not translated into research, guidance and training for FIp, making it harder for novice practitioners without other therapy training to make informed decisions about children's involvement, at any age. The present study aimed to find out what experienced FIp practitioners consider to be best practice when faced with these decisions and the extent of the consensus between them. It was hoped that this would contribute towards the elaboration of current approaches for people who experience psychosis being seen with their children.

Methodology

Design

The Delphi methodology is used to structure group opinions and to establish what consensus might exist between a group of experts in areas where there is little existing literature (Hsu & Sandford, 2007). It uses elements of qualitative and quantitative methodologies in an iterative process conducted over two or more rounds; gathering opinions of a group of experts, and then establishing consensus between them (Powell, 2003).

This study followed the most commonly described format used to research related fields (Powell, 2003; South et al., 2015). 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, which formed the second round questionnaire (R2Q) in which participants rated their level of agreement with each statement.

For the third round, an individual questionnaire (R3Q) was created for each participant. This contained the same list of statements as R2Q, but in addition, for every statement participants were reminded of their R2Q response alongside information about other participants' R2Q responses. They were asked to review their answer in light of the information from other respondents.

Participants

Participants were recruited through the British Psychological Society (BPS) Psychosis and Complex Mental Health (PCMH) Faculty discussion list. Fifteen participants completed R1Q, 23 completed R2Q, and 18 completed R3Q. Ten participants completed all three rounds. Given the total membership of the PCMH faculty discussion list (n = 318) the response rates for R1Q and R2Q were 4.7% and 7.2% respectively, with 74% retained for R3Q. Table 1 shows participant demographics and completion rates. Qualtrics Research Suite was used to create and distribute surveys in all rounds.

Insert Table 1 here

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 criteria based on a history of completing FIp training and at least two years' experience working with families, to ensure a sufficient level of expertise to contribute. Of the final R3Q sample, 78% were supervisors of FIp, 59% were FIp trainers and half the sample was involved in FIp service development in their organisation and FIp research.

Measures

Round one questionnaire

In addition to demographic information, R1Q comprised four initial open questions. Based on the literature, these were generated by the first author, and piloted with five volunteers with relevant experience; working in both AMH and Child and Adolescent Mental

Health Services (CAMHS). The questions covered the following areas: best practice when working with a family with children; helpful adaptations to FIp when there are children involved; factors facilitating children's involvement at service and individual level and factors inhibiting children's involvement and how these might be overcome. Questions were broad in order to include views about children of all ages (any under 18), as well as both mothers and fathers of any age group and duration of psychosis.

Round two questionnaire

The results from R1Q were analysed using thematic analysis (Braun et al., 2014). Initial codes were developed, which were organised into themes, and the themes into categories. The development of themes and categories was led by the first author (a trainee clinical psychologist) and reviewed by project supervisors experienced in qualitative analysis, to support quality assurance and corroborate the themes. The themes generated 65 statements to form the content of R2Q, organised in two main sections: whether and when children should be included and how they should be included. After the first section, 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 selected this option.

Participants were asked to rate the strength of their agreement with each statement using a 6 point Likert scale. Space was given at the end of each section for participants to make additional comments. (R2Q is available from the second author on request.)

Round three questionnaire

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. Participants were given the option to change or keep their original response.

Procedure

Ethical approval was granted by a university research ethics committee and the study adhered to the BPS code of research ethics (BPS, 2014). The three rounds took 13 months to complete. Delphi surveys typically use purposive sampling to ensure experts are targeted so the PCMH discussion list was considered suitable as the primary recruitment source. Participants were also asked to forward the study details to any colleagues who might be interested and meet the inclusion criteria. 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 to all who responded, with a link to the R1Q online survey. Informed consent was sought at the beginning of each online survey. Participants were given four weeks to complete R1Q, with a reminder email being sent after two weeks.

Following analysis, 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 sending out a second invitation to participate. A follow up email was sent after two weeks to remind participants to complete the survey.

Data from R2Q were analysed using frequencies and R3Q was created. This was then sent out to all participants who had completed R2Q. Data from R2Q participants who did not complete R3Q was carried forward and combined with R3Q data for analysis.

Results

Free text answers from Round 1 were subject to a thematic analysis (Braun et al., 2014). Data were analysed at the latent level with the aim of organising the data and providing a rich description of it. After a process of familiarisation with the data set, initial codes were developed, which were organised into themes, and the themes into categories. This yielded 256 statements under 32 themes in 4 categories. Items were checked for overlap, between authors in an iterative process, and then revised, edited and combined to ensure they were succinct. A small number of items were added based on material in the literature that had not been presented by participants. Material focused on barriers to children's involvement was not included in R2Q, unless it concerned suggestions for helpful ways to overcome these. This decision was taken in order to prioritise the development of guidance useful to individual clinicians, rather than describing problems. This overall process led to the inclusion of 65 statements in R2Q subsumed in seven themes, in two broad categories (see Table 2).

Insert Table 2 here

The same statements were presented in R3Q to determine levels of consensus amongst all participants for the most important elements of good practice. There is no standardised measure of consensus in the Delphi literature (Hsu & Sandford, 2007) so this study followed a common method of collapsing the six point Likert response scale into three (South et al., 2015), indicating either agreement, disagreement or neither, with each item. The percentage of participants in each of these three categories was then calculated for each item. Following the approach described by South et al. (2015), for each item these percentages were used to determine whether there was consensus in participants' responses; i.e. whether 50% or more of participants endorsed one of the three categories. As per South et al. (2015), there was deemed to be weak consensus if the percentage endorsement was 50–66.7%, moderate consensus if it was 66.8–83.3%, and high consensus if it exceeded 83.3%.

There were 38 items for which the 'agreement' category was endorsed with a high level of consensus (shown in Table 3) and a further 11 items for which the 'agreement' category was endorsed with a moderate level consensus (see Table 4).

Insert Tables 3 and 4 here

There were three items for which the endorsement of the 'disagreement' category reached consensus, all of which concerned reasons why it might be better not to work with the children (see Table 5).

Insert Table 5 here

Items which lacked consensus

Four items in the category regarding adaptations to the approach showed weak consensus. These related to the inclusion of narrative therapy approaches, a role for the children in a staying well plan, provision of personalised folders for the children's FIp related work and inviting children to draw a genogram.

Eight items lacked consensus as to whether they offered helpful guidance or not. These items concerned the age of child, reasons to include children and how to include them in assessment. Three items concerning attachment and parenting - in the category of "Areas to attend to in sessions" - lacked consensus. Some of the non-consensus stemmed from a range of responses across the Likert scale, but also from a higher proportion of people whose responses fell under the "neither agree nor disagree" category. The spread of responses for these eight items is shown in Table 6.

Insert Table 6 here

Changes in response between rounds

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

Discussion

Consensus on best practice for FIp with children

This three-round Delphi study intended to describe expert opinion on what constitutes best practice when deciding whether, and how, to include children in FIp for parental psychosis, and to assess the level of consensus on the most helpful guidance. Overall, the experts who participated provided rich data and there was a considerable level of consensus found amongst them, with relevance for all children under the age of 18.

The study's first research aim was to investigate what experienced family clinicians consider to be best practice when considering children's inclusion in their parent's FIp. The qualitative data collected in Round 1 covered a wide area; reflected in the fact that the first draft of R2Q comprised 256 items.

Participants overwhelmingly supported the inclusion of children, perhaps reflecting a welcome drive towards whole family oriented practice in AMH services (Falkov, 2013). There was high consensus that these interventions should be offered flexibly and tailored to the particular needs of the family. This is consistent with studies examining the efficacy of other interventions for families with children in AMH settings (e.g. Isobel et al., 2016; van Santvoort et al., 2014). Participants' responses indicated a view that AMH practitioners could work effectively with children, with appropriate training, which is consistent with Maybery et al. (2016).

There was no consensus on whether children should be included because of the sense of family role they provide for their parent. Previous research has noted that feeling successful in the parental role is associated with positive mental well-being (van der Ende et al., 2016). However, if support for this role is the primary reason for including children in parental FIp this risks neglecting the needs of the child (Fudge & Mason, 2004). This tension between supporting the parent and protecting the child - a "dual role" that family workers in AMH must grapple with (Jessop & De Bondt, 2012) - is also demonstrated through high consensus on items related to being mindful of the vulnerability of the child during sessions and the need to keep them safe.

A child having mental health needs of their own was not seen as a barrier to inclusion. This is a welcome finding considering that children of parents seen in an AMH setting have often been found to have clinical or sub-clinical mental health difficulties themselves (van Santvoort et al., 2014) but may have difficulty accessing their own support from CAMHS, given current high referral thresholds (Children's Commissioner, 2016).

A high level of consensus was found for items relating to collaborative, respectful contracting of information sharing and agreeing boundaries with families. The item concerned with introducing the service in a way that would minimise the risks of parents feeling scrutinised had 100% consensus. This could demonstrate participants' awareness of how stigmatised these parents can feel, the fears they may have (Jeffery et al., 2013) and a desire to avoid undermining them in their parenting roles, which research has shown to be 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). Of note, there was 91.3% level of agreement that the service user should be encouraged to talk to the child themselves about the nature of their difficulties, though Strand

and Rudolfsson (2017) found that their small sample of practitioners observed that some parents were unable to judge what would be appropriate to share, so some support to parents in this process might be necessary.

There was high consensus to make a range of adaptations to session style and content (summarised in Table 3) in order to facilitate children's engagement in a safe and comfortable process. This suggests that experienced family workers are making use of techniques such as those in the systemic literature and supports the case for them being integrated into the FIp literature. High consensus also emerged for children who have been involved in FIp to be asked for feedback, and for 'success stories' to be gathered and used in training, suggesting that participants may recognise a need to encourage their AMH colleagues to feel confident in the value of involving children.

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 family-focused work to take place (Fadden & Heelis, 2011; Maybery, 2016). The findings here support previous studies regarding the benefits of cross-agency collaboration (Goodyear et al., 2015) and the importance of being organised as a family oriented service (Maybery et al., 2016) if the needs of the whole family are to be taken into account.

Some of the items with weak consensus could be seen as originating from particular models, for example staying well plans might be more commonly used in cognitive behavioural FIp or BFT whilst narrative techniques and genograms are more consistent with systemic therapy. The poor consensus might therefore reflect that practitioners aligned with certain models are less inclined to use techniques that are valued by other approaches. The weak consensus for attending to parenting and attachment-based issues may also indicate that there has been insufficient integration of the FIp literature with other whole family approaches that would include attention to parenting, such as the Family Model (Falkov, 2013). Even very experienced FIp practitioners are likely to have training needs where parenting and child-focused interventions are concerned.

Strengths and limitations of the research

The use of an online Delphi survey allowed the collection of rich data from a broad geographical area across the UK on a complex issue. The Delphi model typically has a high level of attrition though this was not the case here and although a larger sample size would have increased confidence in the findings, the final sample of 17 in Round 3 could be considered acceptable for achieving consensus. Akins et al. (2005) note that there is no clear guidance on what constitutes an adequate sample size in Delphi technique but that stable responses can be achieved with small panels. Given that FIp has proved challenging to implement in routine clinical practice over decades (Fadden & Heelis, 2011) regardless of whether children are involved, the potential pool of eligible participants may not have been extensive, even amongst members of the PCMH faculty. The participants were from different professional backgrounds and had considerable experience. The study also benefitted from the representation of practitioners using different therapeutic models, though it would have been helpful to have collected clearer information on the type of FIp training which they had undertaken. Recruitment of comparable numbers of participants from each of the three major models would have allowed a between-group comparison to determine whether different routes into FIp practice had any influence. A major limitation of this research is that it focused only on the views of AMH practitioners, as it was beyond the scope of the current project to include family member participants or CAMHS practitioners, though this would have offered a useful opportunity for triangulation of the data.

Clinical implications

These findings have the potential to be developed into a resource, such as the development of best practice guidance for clinicians working with children in FIp. 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 results which could be used to guide less experienced, less confident practitioners to feel able to include children in FIp effectively. In the event that children are more routinely included in AMH led family work, this should pay dividends for both parents and children. There is emerging evidence from related areas to suggest that children may be more resilient as a result of improved understanding (Beardslee et al., 2003) and less worried (Pihkala et al., 2012). Pihkala et al. (2012) also suggested that, following family intervention, parents felt more confident in their parenting role and supported rather than scrutinised by services, with implications for sustaining engagement.

Current training programmes for FIp should consider including content on child-friendly approaches and FIp practitioners should have access to supervision and consultation with CAMHS colleagues or others experienced in the involvement of children, in order to support the development of these skills in an AMH context.

Research implications

There is an emerging literature regarding children’s experiences in parental family interventions (e.g. Pihkala et al., 2012) but more could be done to involve them in shaping service developments according to their needs. In particular little is known about the experiences of either child or parent in the specific context of FIp.

The development of standardised outcome measures for children in families affected by parental experience of psychosis would be a helpful contribution and could pave the way for larger trials aimed at demonstrating outcomes for families seen for child-inclusive FIp.

Conclusions

Considerable consensus was found amongst experts regarding best practice when deciding whether, and how, to include children in their parent’s FIp. Many items with high consensus are consistent with existing literature from systemic therapy, suggesting that these ideas are being integrated by experienced AMH practitioners in their delivery of FIp. There was less clear support for the inclusion of adaptations related to parenting tasks. Given that these might be helpful in some situations this finding might indicate a training need.

These findings could help to inform elaborations of established FIp models to encourage an appropriately child-focused approach. Translation of best practice ideals into routine practice will require organisational support including training, supervision and consultation as well as a more integrated approach with colleagues in child services.

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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(27)	5(15)	4(24)
	Frequent FIp practitioner	7(47)	9(39)	7(41)
	Regular/routine FIp practitioner	3(20)	7(30)	5(29)
	Occasional FIp practitioner	3(20)	3(13)	2(12)
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)

TABLE 2*: Final categories and themes forming the basis of R2Q and R3Q*

Category	Theme
Whether and when children should be included	Whether children should be included at all
	What factors clinicians may need to consider before deciding whether and when to include children
	What factors clinicians may need to consider if they are not to be included
How children might be included	Issues to be considered at the assessment stage
	Areas to attend to during sessions
	Adaptations that could be made
	Organisational factors which might facilitate the inclusion of children in their parent's FIp

TABLE 3: *Statements with high consensus (> 83.3% agreement) to be included as representative of best practice (n = 38)*

Category	**Statement**	**%**
Should children 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 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

TABLE 4: *Statements with moderate consensus (66.8% - 83.3% agreement) to be included as representative of best practice (n = 11)*

Category	**Statement**	**%**
Should children 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 sessions (or they decline joining), their thoughts and feedback should be sought in another way e.g. asking them to write a letter; 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 they 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

TABLE 5: *Statements with moderate or high consensus (>66.8% disagreement) to be excluded from descriptions of best practice (n = 4)*

Category	**Statement**	**%**
Should children be included	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	91.3
	Children in the family with mental health needs of their own should not be included	91.3
	It is better not to directly work with children as they will benefit from the work that you do with the adults	82.6
	It should be a CAMHS worker that meets with children, not adult workers	78.3

TABLE 6: *Statements without consensus, defined as <50% agreement or >50% endorsing the "neither agree nor disagree" category (n = 8)*

Category	**Statement**	**% Agreeing**	**% Neither agree nor disagree**	**% Disagree**
Should children be included	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)	26.1	73.9	0
	Children should be included because they are often less defended so may be willing to say things that adult members won't	4.3	60.9	34.8
	Children under school age should not be routinely included in FIp	30.4	52.2	17.4
What should be considered at assessment stage	Clinicians should ask for children's views first before asking adults, and ask adults to comment on what they have heard (and vice versa)	17.4	69.6	13
What areas might be attended to during sessions	It is important to explore parents' attachment history, and how their attachment with their children is being expressed	39.4	52.1	8.7
	Sessions can be used to discuss and implement interventions targeting attachment based issues	26.1	65.2	8.7
	If therapists have doubts about the parenting approach then they should consider offering a parenting intervention as part of the family work	34.7	56.5	8.7
What organisational factors might facilitate children's inclusion	Clinicians do not need extra training to include children in FIp but should draw on their existing, transferable skills	17.3	73.9	8.7