Family-focused practice in mental health care: an integrative review

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ABSTRACT

While mental health services are increasingly encouraged to engage in family-focused practice, it is a nebulous and poorly understood term. The aim of this paper was to examine and synthesize evidence on the concept and scope of family-focused practice in adult and child and youth mental health care settings. An integrative literature review method was used. Medline, Embase, CINAHL, PsycInfo and Proquest electronic databases were systematically searched for abstracts published in English between 1994-2014. Data were extracted and constant comparative analysis conducted with 40 included articles. Family-focused practice was conceptualised variously depending on who was included in the ‘family’, whether the focus was family of origin or family of procreation, and the context of practice. Six core family-focused practices were identified: family care planning and goal-setting; liaison between families and services; instrumental, emotional and social support; assessment; psychoeducation; and a coordinated system of care between families and services. While family is a troubled concept, ‘family’ as defined by its members forms a basis for practice that is oriented to providing a ‘whole of family’ approach to care. In order to strengthen family members’ wellbeing and improve their individual and collective outcomes, key principles and practices of family-focused practice are recommended for clinicians and policy makers across mental health settings.

Keywords: Integrative review; family-focused practice; child and adolescent; adult; mental health services
Highlights

- In mental health services, family-focused practice is poorly defined concept
- An integrative review was conducted to synthesize evidence in this area
- Six interrelated types of family-focused practices were found
- Family as defined by its members provides a basis for ‘whole of family’ care
INTRODUCTION

Mental illness impacts on more than the individual; family members, including children, are all affected by a family member’s mental illness. Increasingly, governments and service providers across countries are investing in a family-centred, collaborative model of practice (Nicholson et al., in press). Family-focused practice (FFP) broadens the unit of care from a narrow focus on the mental health consumer, to the family and caregiving system (Foster, O’Brien & Korhonen, 2012). However, there is little consistency in how FFP is defined, and in particular, a lack of integrated knowledge on FFP in mental health services. The lack of conceptual clarity in FFP is also reflected in the terminology employed, where FFP is used interchangeably with ‘family-oriented’, ‘family-sensitive’ and ‘family-centred’. There is a clear need to examine the concept of FFP across different mental health contexts (adult and child), in order to provide a framework for clinical practices between service providers, mental health consumers and their families and for the purposes of policy and service evaluation.

The term family-focused practice (FFP) originated in the field of paediatrics in the 1950s, where parents campaigned to be included in the planning of their children’s medical care (Jolley & Shields, 2009). Accordingly, much of the work in FFP has been conducted in areas such as disability and chronic illness, where the client or consumer is the child (Hoagwood, 2005). In these healthcare fields, core FFP principles are related to placing the consumer and family at the centre of care decisions, respecting the cultural and linguistic traditions of the family, acknowledging that consumers and their families are experts on their own needs, and keeping the relationship between the professional team, consumer and family collaborative, respectful, open and honest (Dunst, Trivette & Hornby, 2007; Mikkelsen &
Frederiksen, 2010). MacKean et al. (2012) reviewed similar concepts in child and adolescent mental health services but not adult settings. Using the term family-centred care (FCC) they found improved child and family management skill, increased stability of living situations and improved child and family health and wellbeing. However, the same depth of research has not been conducted in relation to FFP across mental health services.

A paradigm shift from a traditional, individual model of mental health care toward FFP has slowly gained traction in mental health services over the past decade, as can be ascertained in policies across the US, Australia, Canada, Ireland, the UK and Norway (Nicholson et al., in press). This has been promoted, at least in part, by repeated research which highlights the benefits of FFP for consumers and their family. In a meta-analysis of 25 studies, Pitschel-Walz, Leucht, Bauml, Kissling and Engel (2004) found that the relapse rate was reduced by 20 percent when relatives of consumers with schizophrenia were involved in their treatment and care, compared to standard mediation treatment. Similarly, Glynn, Cohen, Dixon and Niv (2006) found that FFP was effective in reducing exacerbations in schizophrenia, improving mediation compliance and reducing or eliminating substance abuse. FFP also delivers benefits to the family, with a reduction in subjective burden of care and increased levels of self-care and emotional role functioning (Glynn et al., 2006).

Nevertheless, how FFP within mental health services is conceptualised and subsequently practised is less clear. There are many components of FFP in mental health services documented in the literature but how these relate to each other and promote a consistent set of practice guidelines is currently not available. The main feature of FFP in mental health services that is commonly presented involves psychoeducation, where information is provided to the family about the consumer’s diagnosis, causes, treatment and progress (Lucksted, McFarlane, Downing, Dixon & Adams, 2012). Psychoeducation may also provide an opportunity for family members to manage their stress levels and learn
specific skills in helping their relative (Hoagwood, 2005). Others describe FFP in terms of a family member, typically the parent, working as a ‘co-therapist’ with the professional team, in making treatment and programming decisions for their relative (MacFarlane, 2011). Further elements of FFP include viewing families as a source of information about their relative to supplement assessment and inform treatment options, and acknowledging and responding to the family’s caring role and/or how they cope. More recently, discussions of FFP have acknowledged the parenting role and responsibilities for many consumers and highlighted the needs of consumer’s children (Reupert, Maybery & Kowalenko, 2012).

Notwithstanding the benefits involved in FFP, there are a number of barriers associated with its uptake. Maybery and Reupert (2006) found that the mental health workforce lack the skills and knowledge to engage effectively, and work collaboratively with family members, with clinicians still believing that a consumer’s mental health difficulties originate with family members. Another significant barrier is clarity around how FFP might be conceptualised, practised and evaluated (Foster et al., 2012). Hoagwood (2005, p. 708) summarises this sentiment when she argues that more work is needed on “the content and processes of family involvement” to accelerate progress towards improving the lives of families.

While families are important for those with mental health problems (Reupert et al., 2012), there are very few theoretical or practice frameworks that show how families might be included across different treatment settings. Although there are many ways that ‘family’ can be defined, we align ourselves to Osher and Osher’s (2002) concept of family, where a family and who is included in a family is defined by its members. This definition acknowledges diverse family relationships that may not necessarily resemble a traditional nuclear family. Specifically for this review, we examine families of origin, where the family includes the parents of a mental health consumer (child or adult), as well as families of procreation, where
the family are the children/partner of the consumer, while also noting the inclusion of other family members (such as grandparents, caregivers, and so on).

How FFP might be conceptualised and subsequently practised may relate to the settings from which it is delivered (for example, child or adult mental health services) and similarly, whether the consumer is a child or an adult. For example, how parents/caregivers are engaged and involved in the treatment of their child may differ from how parents work with services for their adult offspring. The needs of these different family types may differ and this has potential implications for FFP and how it is operationalised. While the underlying principle of FFP in terms of working with and for families, rather than to families, appears to be consistent across child and adult contexts (Hoagwood, 2005; McFarlane, 2011), there is a notable lack of family-focused practice models driven by conceptual frameworks that may be reliably employed in both settings. Greater clarity on the concept of FFP and its practice in mental health settings will inform future measurement, audit and evaluation of FFP, provide guidance on the scope of FFP, and inform professional development in the effective practice and provision of FFP.

AIM

The aim of this paper is to examine and synthesize evidence on the concept and scope of FFP in adult and child and youth mental health care in order to advance understanding and implementation of family-focused practice. The research questions framing this review are:

1. How is family-focused practice conceptualised and defined from a mental health perspective in adult as well as child and youth mental health care?
2. What are the family-focused practices in adult and child and youth mental health care?
METHOD
An integrative review method was employed. This approach uses systematic processes for literature searching and selection, and for data extraction and analysis. An integrative review allows for inclusion of theoretical and empirical literature and is used for a range of review purposes including concept definition (Whittemore & Knafl, 2005).

Data Sources
Medline, Embase, CINAHL, PsycInfo, and Proquest databases were searched for abstracts (see Table 1).

Insert Table 1 about here.

Inclusion and exclusion criteria
To gain an understanding of the development of FFP over time, peer-reviewed literature published between 1994 and 2014, including empirical, theoretical, and/or discussion papers focusing on professional practices for children or adults with mental illness in child and youth, or adult mental health settings, were included. Literature reviews, book chapters, and grey literature were excluded. Papers that examined family therapy alone, or family-focused practice for other health conditions, or in other settings, e.g. schools, were excluded.

Screening
Titles and abstracts of 2123 records were reviewed independently by the first three authors against the inclusion/exclusion criteria. Full texts of retained articles were then read and screened, and consensus discussion resulted in 40 articles included for review (Figure 1).
Analysis

Consistent with the integrative review method (Whittemore & Knafl, 2005), data were initially extracted from the 40 articles into a matrix according to the review questions. Constant comparative analysis was used to categorise and group coded extracts, which were iteratively compared and contrasted within and across articles. Key concepts relevant to each question were collated and emergent patterns and themes identified (Patton, 2002). Key concepts and practices related to family-focused practice were also counted to gain an understanding of the contextual use and emphasis of content in the articles (Hseih & Shannon, 2005). In the final process, data were synthesised into an integrated thematic summary of findings.

FINDINGS

The review included 40 articles; 20 empirical research papers, 22 discussion/opinion papers and four theoretical papers (see Table 2; some papers provided both a discussion of FFP and empirical data). Findings are presented according to the two review questions.

Insert Table 2

Concepts of family-focused practice in adult and child and youth mental healthcare

Twenty-one of the 40 papers described family-focused practice within adult orientated mental health services (hereafter referred to as Adult MH); 19 referred to child or youth orientated mental health services (hereafter referred to as Child MH). The majority of Adult MH publications referred to family of procreation, where a parent had mental illness (n = 16); the remainder (n = 3) focused on family of origin. In contrast, all but one of the Child MH papers (n=17) adopted a family of origin perspective. Two adult orientated papers included
both family of origin and family of procreation (Mottaghipour & Bickerton, 2005; Schmidt & Monaghan, 2012); one youth orientated service included both family types (Miklowitz, Biuckians & Richards, 2006). However, while some Child MH papers mentioned parental mental illnesses (e.g., Miklowitz et al., 2006), the primary focus was on the child at risk of, or diagnosed with, a mental illness or behavioural disorder. The majority of Adult MH papers were from Australia (n = 8/21), USA (n = 4/21) and Finland (n = 3/21) with one paper coming from a non-western country (Samoa; Enoka et al., 2013). The majority of Child MH literature originated in the USA (n= 14/19).

Terms used to describe FFP

There was a plethora of ways to describe FFP, often used interchangeably. While not always clear, some referred to programs (n=7; for example, the family-focused case management program [FFCM; Aubry, Farrell, O'Connor, Kerr, Weston & Elliott, 2000]), approaches (n=2; for example, a family-focused approach; Foster et al., 2012), as an intervention framework for working with clients and their families (n=6, see for example, Beardslee’s intervention for families where a parent has depression), as a service (n=5, e.g. Gross & Goldin, 2008) or as a model for how services might work with families (n=9, for example, Mottaghipour & Bickerton’s 2005, pyramid of family care). Some terms were used synonymously with FFP; family-focused (10/40), family centred (10/40), family sensitive (4/40), family orientated (n=3) and family inclusive (n=2). These terms recognised the family’s pivotal caring role and a concomitant requirement that family be included in services. Nevertheless, there was a lack of clear consensus about the terms and how they were used to describe and define FFP in Adult and Child MH (see Table 2).

Family defined
Integral to the concept of FFP is how ‘family’ is defined. While a range of definitions of ‘family’ appeared in the Adult MH literature, there were significant differences in how this was interpreted; this also differed depending on whether the paper assumed a family of procreation or origin perspective. For example, family of origin included definitions of the family restricted to consumers’ adult family members (individuals 18 years or older) and who were acknowledged as the primary carers (Aubry et al., 2001; Dausch et al., 2012; Enoka et al., 2013; Mullen, Murray & Happell, 2002). Typically other members were excluded from the FFP focus including dependent children though there was an exception; from a Samoan perspective, Enoka et al., (2013), included siblings, partners and extended family members in their description of family.

Conversely, when the focus was on the family of procreation within adult MH services, children were included in discussions of FFP (e.g. Cowling & Garrett, 2009; Devlin & O’Brien, 1999; Foster et al., 2012; Heitmann, Schmuhl, Reinisch & Bauer, 2012; Hinden, Biebel, Nicholson & Mehnert, 2005; Houlihan, Sharek & Higgins, 2013; Jessop & de Bondt, 2012; Korhonen, Vehviläinen-Julkunen & Pietilä, 2008; Maddocks, Johnson, Wright & Stickley, 2010; Maybery, Goodyear, O’Hanlon, Cuff & Reupert, 2014). Some authors who incorporated both family of origin and family of procreation included children and other family members (Mottaghipour & Bickerton, 2005; Schmidt & Monaghan, 2012). Overall, those with a family of procreation perspective referred to varying family configurations and considered the needs of all family members, including children, partners and spouses, grandparents, and significant others. This was irrespective of whether family members were caring for or were being cared by the consumer.

In the Child MH literature the ‘family’ was described as a ‘system’, or an ‘ecology of the family’ approach (Lee et al., 2009; Malysiak, 1997). ‘Family’ also referred to individual members (Lepage, 2005), including siblings (e.g. Furniss et al., 2013; Gross & Goldin, 2008;
Young & Fristad, 2007), or siblings and parents (Kilmer, Cook & Palamaro Munsell, 2010). ‘Family’ also incorporated ‘non-professionals’ as part of an extended, non-hierarchical collaborative (plus-family) team partnership model that ‘wraps around’ the child identified as needing services (e.g. Handron, Dosser, McCammon & Powell, 1998). This support was considered informal and provided by significant others identified as important to the family and who acted as unpaid caregivers (e.g. friends, neighbours, coaches) (Kilmer et al., 2010). Allen and Petr (1998) argued that family included whomever the family designates as being in the family.

**Family-focused Practice conceptualisations**

The concept of FFP in Child MH literature links definitions of ‘family’ to the mental health care context (e.g. the home or community) and the practice intentions of that environment or anticipated mode of service delivery. For example, Child MH publications from the USA described children considered at risk of ‘out-of-home placement’. ‘Home’ was significant in conceptualizing FFP because ‘home based’ and ‘family-focused’ treatment programs described the least restrictive care setting as optimal; FFP occurred in the community (or home) because it was closest to the family’s natural supports (e.g. Woolston, 2007). The intention was to avoid an ever-increasing continuum of restrictive (and more costly) environments in which children might be hospitalized or placed in residential care (e.g. Bartlett, Herrick & Greninger, 2006; Lee et al., 2009; Woolston, 2007), and services were directed toward ‘preserving’ or keeping the family together (Mosier et al., 2001). A day hospital treatment setting for ‘psychiatrically ill’ infants, toddlers and pre-school children that provided a continuum of flexible care including community and in-patient settings was said to combine the best of both care contexts (Furniss et al., 2013).

An emphasis on family support in the family of origin literature was predicated on the goal of reducing primary caregivers’ negative impact on consumers’ wellbeing, and
promoting their capacity to help consumer recovery (Aubry et al., 2001; Dausch et al., 2012). While family involvement was recognised to reduce family members’ distress, the ultimate aim of family inclusion was to help the consumer (Mottaghipour & Bickerton, 2005; Schmidt & Monagahan, 2012).

There were a number of principles that underpinned the range of terms used to conceptualize FFP and the notion of ‘family’, which are shaped by, and shape, their translation in practice (Table 2). For instance, the Adult MH papers highlighted the importance of familial and community-based care that is individualised, holistic, flexible, transparent, responsive, preventative (e.g., Maybery et al., 2012) and culturally sensitive (Enoka et al., 2013). Thirteen papers explicitly referred to a strengths-based approach that fosters family self-esteem and efficacy as well as resilience (e.g. Foster et al., 2012; Hinden et al., 2005). A number (n = 6) emphasised engaging families in the recovery process (e.g. Mullen et al., 2002), and promoting family resilience through collaborative partnerships (Mottaghipour & Bickerton, 2005). From a family of procreation perspective, some authors proposed that children could be indirectly supported through enhancing parents’ resilience and capacity to cope (Korhonen et al., 2010a); although most argued that children’s needs should be directly addressed by Adult MH services (Cowling & Garrett 2009; Heitmann et al., 2012; Hinden et al., 2005; Maddocks et al. 2010; Nicholson, 2007).

Family-focused practices in adult and child and youth mental healthcare

In addition to a conceptualisation of FFP, the papers were examined for clinicians’ family-focused practices. The six core practices with consumers and their family, across child and adult services, can be summarised as:

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. Psychoeducation;
6. A coordinated system of care (e.g. wraparound, family collaboration, partnership) between family members and services.

See Table 3 for further detail.

It is important to recognise that many of these practices are not mutually exclusive. For instance, there was overlap between liaising with other services, advocating for families and providing a coordinated system of care as might be required in a wraparound service for families. Also indicating an overlap amongst practices, Maddocks et al., (2010) defined support in terms of “being present during clients’ visits to their children, advocating for clients and providing reassurance” (p. 677). Nonetheless, discrete actions can be identified as distinct dimensions of FFP. The most commonly reported practices were providing instrumental, emotional or social support to the family (21/40) and delivering a coordinated system of care (22/40). The remaining four practices were reported almost equally (between 15 and 17 times). Two practices were more commonly reported in Child MH papers; undertake care planning and goal setting with families (ten times compared to four) and provide a coordinated system of care between and within family members and services (13 times compared to 9). There was little/no different amongst other practices between the two settings.

**Family care planning and goal-setting**
The practice of care planning and goal setting with families commonly aimed to mobilise a family’s resources, including support networks (15/40 papers). While this involved planning for future possible crises, it was more commonly employed to identify what is important for the family in the short and long term. Goals for the family were collaboratively established between clinicians and family members and based within a strength based approach. The plans were a means of managing relationships outside of the family including other family members as well as services, thereby meeting the consumer’s treatment goals but also the needs of family members. Nicholson (2007) described the importance of setting basic goals for parents with a mental illness, such as creating a safe environment for their children and getting their children to school with the ultimate long term goal of skills building and recovery. Acknowledging the importance of being able to respond to 24 hour family crises, Hinden et al., (2005) also noted the need to collaboratively establish long term targeted outcomes with families that might, for instance, include improved housing, increased employment and decreased hospitalization.

**Liaison between family and services**

Another commonly reported FFP practice was liaising between the family and other services or informal networks (n=17/40). This also occurred within the one agency; Cowling and Garrett (2009) described how one clinician worked with a parent with a mental illness while another clinician from the same agency worked with the child. Le Page (2005) presented a collaborative approach amongst the clinicians within the one service as well as with other services. Foster et al. (2012) urged clinicians to encourage children and parents to engage with others in their community and liaise with other services as required for the families they worked with for example, housing organisations. Lee et al. (2009) argued that effective treatment must include “coordination and collaboration among the diverse organizations.
providing services to the child and the family” (p. 397). Extending this practice, Aubry et al. (2000) suggested that liaison between services involved advocating for appropriate and timely services. Similarly, Devlin and O’Brien (1999) argued that clinicians needed to advocate for parents with a mental illness when dealing with child protective services. Gopalan and colleagues (2014) described the employment of parent advocates who themselves had previously navigated through the CM system and “who could work with families in a different way” (p. 90).

**Instrumental, emotional & social support**

Instrumental support included referring a family member to appropriate services and organising practical support for example, transport or child-care (Reupert & Maybery, 2014). Emotional support involved providing empathy and compassion e.g., Bartlett et al. (2006) asserted that clinicians need to “provide emotional support to family members so that they can nurture each other, survive periods of crisis and flourish” (p. 597). Aubry et al. (2000) indicated that 25 percent of the clinician’s time was spent providing support which involved “assisting with family relationships, especially those involving the member with severe mental illness, discussing and mediating family difficulties, and helping families to cope with stress” (2000, p. 71). Social support involved broadening a family and consumer’s social networks (for example, Foster et al., 2012). Several papers described embedding support within service or treatment (e.g. Gopalan, et al., 2014; Lee et al., 2009; Sin, Moone & Newell, 2007). Sometimes support aimed to empower the consumer or family, for example, the clinician supported parents to solve their own problems, rather than rely on professionals (Lee et al., 2009).

**Assessment of family members and family functioning**
The assessment of family members centred on ‘initial’ and/or ‘ongoing’ assessment practices. The first involved identifying the presence of family (e.g. asking a consumer whether he or she had children at intake, see Foster et al., 2012) as well as assessing the needs of each family member (e.g., Korhonen et al., 2008). Assessment in this instance involved identifying individual and family strengths and/or deficits and the impact the mental illness on family members, especially children (Cowling & Garrett, 2009). Maybery et al. (2014) suggested that that all clinicians who have contact with parents with mental health challenges should have the skills to assess the impact of the illness on children. Other papers referred more generally to assessment practices for example, Dausch et al. (2012) suggested that FFP involved the following assessment domains; the consumer’s diagnosis, the family and consumer’s motivation for services, level of functioning/distress, goals and needs, role of the illness, subjective burden and the presence of practical issues.

Other papers also referred to ‘ongoing’ assessment for determining families’ changing needs over time, rather than a static, ‘one off’ often crisis-driven assessment (see for example Reupert & Maybery, 2014). Mottaghipour and Bickerton (2005) discussed this in terms of a “reassessment of needs” (p. 6). In Child MH, such an approach was consistent with a developmental approach with children. This also acknowledged that parents need to be involved in assessing the child’s problems over time (Bartlett et al., 2006).

**Psychoeducation for family**

Psychoeducation was a commonly mentioned family-focused practice (17/40) and involved a clinician who “teaches the family about adolescent [disorder], encourages the adolescent to chart his or her mood, provides information about risk and protective factors, such as how psychosocial factors can affect the course of the illness” (Young & Fristads, 2007, p.158). Lepage (2008, p 89), noted that “families of psychotic youth have a clear desire for
information on what is happening... and for clinical guidance on how to best care for the psychotic person.” Psychoeducational approaches ranged from awareness raising and general information about the disorder, treatment options and information on services, through to specific manualised approaches for families (such as Beardslee’s, 2007, psychoeducation program for parents with depression and their children). Psychoeducation was found to delay relapse, improve family functioning, child wellbeing, communication, coping, and medication adherence, and assist family members to understand and cope with consumers’ mental health problems (Beardslee et al., 2007; Miklewitz, 2004).

**Coordinated system of care for family**

Many papers (22/40) described a coordinated system of care, usually focused on a multidisciplinary team approach, which incorporated the family as a key entity within the team, who played a key role in assessment and intervention planning and delivery. Initiatives ranged from “Wraparound” programs (Handron et al., 1998) to state-wide implementations of a coordinated system of care (Gopalan et al., 2014). These programs were commonly child-centred approaches with an emphasis on family members being active participants in the care of the child. Others have described “Wraparound” as the ‘Wave of the Future’ (Handron et al., 1998) based on a child-centred team approach that involves parents, the child, teacher, therapist, service co-ordinator, neighbours, friends, extended family doctor or nurse, and potentially social workers and others.

Family members were a key part of this coordinated team approach. This occurred in adult MH services, “relatives are important to, connected with, and involved in the lives of persons with psychiatric illness, and family involvement is a vital aspect of recovery-oriented comprehensive care” (Dausch et al., 2012, p.7) and child MH services for example, Le Page (2005, p. 92) argued that the treatment team consists of “the person with the mental illness, the family and clinicians”. She continued by indicating that the family “provides the
psychiatric team with pertinent information regarding their loved one…[and assists] in assessment, treatment, recovery and relapse prevention” (p. 92).

DISCUSSION

This review sought to identify how family-focused practice (FFP) was conceptualised and practised in adult and child and youth mental health services. While FFP is reasonably developed in healthcare fields such as paediatrics, it has not been rigorously examined across adult and child and youth mental health contexts. As such, the review comprises an essential first step in interrogating family-focused concepts and practices in mental health. Given the growing evidence base for child and adult family interventions across service settings and diagnostic groups (Glynn et al., 2006), as well as treatment recommendations (e.g. by the National Institute for Clinical Excellence in the UK [NICE, 2009]), it is timely to provide a conceptual analysis and description of pragmatic initiatives and practice in mental health settings, as a basis for greater rigor in policy development and practice.

The review found that FFP was conceptualised variously according who the ‘family’ consisted of, and more specifically whether the focus was family of origin or family of procreation, and the context of practice. The problem with lack of conceptual clarity in FFP is that care for families is inconsistent, and family programs and interventions were not founded on comparable principles. ‘Family’ is a key dimension of the FFP concept and its definition is integral to its practice application. The historical review by Allen and Petr (1998), in particular, demonstrated the significance of defining “the family” for conceptualizing FFP and that the concept of ‘family’ is historically, culturally and theoretically contingent.

A key finding from the review was outdated assumptions which ignore temporal and cultural influences and changes in thinking about ‘family’. This assumption led to descriptions of the practice of family as being about a parent, sometimes a parent-child dyad,
and often, the mother, who was assumed to be the primary caretaker. This finding needs to be considered in light of the family of origin and family of procreation constructs, and raises several questions regarding models and practice contexts. If ‘family’ is viewed through only one lens, then the needs of only some family members are emphasised or addressed in practice. For services using a family of origin model (primarily child and youth services), for example, what could be learned from a family of procreation model (primarily adult services) about envisioning the whole family differently in respect to FFP? This could, for instance, include viewing children as ‘carers’ as well as ‘consumers’ (Gladstone, McKeever, Seeman & Boydell, 2014). The question is whether we can, or should, construct a single concept or framework for FFP in clinical practice, policy and evaluation for both settings.

While family is a troubled concept in the literature, ‘family’ as defined by its members (Osher & Osher, 2002) forms a basis for practice that is oriented to providing a ‘whole of family’ approach to care, including adult family members, children, grandparents, extended family and other significant others, and in so doing helps to prevent transmission of mental illness between family members. The ‘whole of family’ focus can be understood as a means for FFP as a form of preventative intervention, in order to specifically address the impact of intergenerational impact mental illness from parents to children. Aligning ourselves to this concept could go some way to dealing with outdated and restrictive notions of the family. However it needs to be acknowledged that children and young people have differential access to the power and resources to define themselves as family members in medical contexts (Gladstone et al., 2014). Further, this approach raises questions for FFP in terms of how we involve all members of the family and at the same time not subsume individual members, or individual roles within the family, so that members are disenfranchised as ‘family’ in significant ways.
The majority of Adult MH papers in the review were from Australia (8/12 papers) and the USA (4/21), while the majority of Child MH literature originated in the USA (14/19). This result raises contextual issues regarding mental health policy initiatives, funding priorities, and cultural conceptualisations and subsequent practices of FFP in mental health services. Nicholson et al. (in press) noted the absence of national policy setting or initiatives for children of parents with mental illness in the USA. In contrast, Australia has both national policies and initiatives (see www.copmi.net.au) that foster FFP in mental health settings for children living with parental mental illness. In comparison, the family-related policy initiatives in the USA have contributed to expanding FFP wraparound practices and evaluating systems of care to develop less restrictive forms of care and preserve families with the ultimate aim of reducing health and welfare costs (SAMHSA, 2004). Further, in cultural contexts where individualised health care and recovery is less robust, family participation in family members’ recovery may occur more readily as FFP aligns more closely with cultural expectations (Enoka et al., 2013). The ways of thinking about and implementing FFP therefore, can be influenced by cultural considerations, funding priorities, policy settings and guidelines that promote best practice.

In terms of practice implications, the papers illustrated the relevance of FFP throughout the clinical process, from consumer access/identification and engagement, to assessment, support and management, and review. They also illustrate the relevance of service context and the work environment in which FFP can occur, as well as the efforts required to tackle ongoing barriers to FFP. The six family-focused core practices (Table 3) provide a starting point in defining what approaches and practices could be incorporated in services and delivered by clinicians in partnership with consumers and family members. These practices can be understood as existing on a continuum of intensity. FFP is everyone’s responsibility, regardless of whether it is a child, youth or adult service (Foster et al., 2012).
For child and youth mental health clinicians, the defining feature of FFP is the systematic incorporation of parent/carer mental health into a family-focused care plan. Conversely, for adult mental health clinicians, it is an acknowledgement of parenting and child and youth mental health. Importantly, FFP comprises clinicians’ willingness, capacity and capability to see the relationship between the primary/referred person and their ‘key others’.

CONCLUSIONS

As a way forward in developing a consistent and effective care for families in mental health, and strengthening family members’ wellbeing and improving outcomes, the following key principles and practices synthesised in this review are recommended as a beginning point for further work. They can be used as a foundation to inform development of a conceptual framework for FFP applicable across mental health services.

Principles of FFP

Four key principles can be understood to shape FFP including;
1) a belief that consumers’ (child or adult) families play a pivotal role in their recovery;
2) that consumers and their families can be empowered to address and meet their needs;
3) that it is possible to support consumers via their family;
4) that the relationships between clinician and consumer, clinician and family, and between consumer and family members, are key to enabling a ‘whole of family’ approach.

These principles highlight the crucial importance of clinicians using a process of partnership with consumers and families for better outcomes.

Practices of FFP

The six core practices identified in this review (Table 3) form a useful foundation from which to develop further specificity regarding FFP. However, these findings are generated from a review of past practices and are not necessarily best practice. Accordingly, the practices identified here do not necessarily mean that other practices may not be relevant.
The findings of the review have several implications for mental health clinical practice, education, policy and research. Key stakeholders (such as clinicians and their employers and professional organisations) are recommended to take cognisance of the principles of FFP when working towards adopting a ‘whole of family approach’ within mental health services. Mental health services need to be informed by a holistic, family and recovery orientated philosophy. To foster and sustain this type of service delivery, it is essential that mental health services have the necessary resources in place, including workforce education programs, FFP policy, practice guidelines and financial resources. Clinical leadership is also central. This is important, particularly in acute mental health settings, where a biomedical and professional centred approach typically prevails.

The review identified several gaps in knowledge regarding FFP that would benefit from further investigation. Research on ‘age’ as a variable in FFP needs further evidence: for example, day hospital treatment for infants, toddlers and preschoolers (Furniss et al., 2013); and ‘early’ onset diagnoses such as psychosis (Sin et al., 2007) and bipolar disorder (Miklowitz et al., 2006) where families may be encountering mental health clinicians and services for the first time, and when the consumer is a child, youth or transitioning adult. Other areas include family psychoeducational needs in relation to the differences between developmental- and illness-related behaviors; the need for integrated ways of measuring outcomes of FFP; and examining what it means to collaborate with families as decision makers. Qualitative approaches to take account of families’ stories/perspectives that may be based on different assumptions about what is helpful and which may differ from that of professionals, would strengthen investigation. Further research is required to explore whether particular practice settings and professional disciplines should dictate the range of family-focused activities that occur, especially considering the continuum of family-focused
practices that exist and the potential differences in the capacity of different healthcare
disciplines to engage in FFP (see Maybery et al., 2014).

The findings of this review also highlight a need for further theory development in
FP, so that a shared understanding can be developed around what clinicians currently do,
and should do, when working with families. Such a theory would render FFP tangible and
enable clinicians to be consistent in their FFP approach. At the same time, in synthesising and
unpacking the terms, principles and practices underlying FFP, this review has contributed to
the development of FFP theory for clinicians within adult and child and youth mental health
services. However, a consolidation of theory development is still required, particularly
around models of intervention and an accompanying efficacy base. Developing a
comprehensive construct of FFP has significant implications for
effectiveness of professional practice, adoption of FFP by services,
workforce education, and service evaluation.

References
Orthopsychiatry, 68(1), 4-15. doi: 10.1037/h0080265

Dawn Project: A model for responding to the needs of children with emotional and
behavioral challenges and their families. Community Mental Health Journal, 39
(1), 63-74. doi: 10.1023/a:1021225907821

focused case management: A case study of an innovative demonstration program.
Canandian Journal of Community Mental Health, 19(1), 63-78.

mental health treatment of children and adolescents. The Journal for Nurse
Practitioners, 2(9), 593-598. doi: 10.1016/j.nurpra.2006.06.015

a randomized trial of two public health preventive interventions for parental
depression. Journal of Family Psychology, 21(4), 703-713.


Sin, J., Moone, N., & Newell, J. (2007). Developing services for the carers of young adults with early-onset psychosis - implementing evidence-based practice on psycho-


### Table 1: Search terms

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Subject Headings</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Construct:</strong> Family Focused Practice</td>
<td>Family Focused</td>
<td>“family focused” OR “family centred” OR “family centred” OR “family sensitive” OR “family oriented” OR “family guided” OR “family friendly” OR “family inclusive” OR “family driven”</td>
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<tr>
<td>AND</td>
<td>Family Centred</td>
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<tr>
<td><strong>2. Context:</strong> Professional practice</td>
<td>intervention practitioner</td>
<td>care or practice* OR practitioner OR intervention OR therapy OR treatment OR workforce OR profession* OR &quot;community mental health&quot;</td>
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<tr>
<td>AND</td>
<td>professional workforce</td>
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<td>community mental health</td>
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<tr>
<td><strong>3. Issue:</strong> Mental illness</td>
<td>Mental health</td>
<td>&quot;mental health&quot; OR &quot;mental disorder&quot; OR “mental disorders” OR &quot;mental illness&quot; OR &quot;child of impaired parents&quot; OR &quot;parental mental illness&quot; OR &quot;mentally ill&quot;</td>
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<td>Mental disorders</td>
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<td>Mentally ill</td>
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<td>Child of impaired parents</td>
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</tbody>
</table>
Limit to English language and years 1994-2014.

**Figure 1: Search and Screening**

Records identified through database searching:

- Medline: n = 206
- Embase: n = 395
- CINAHL: n = 353
- PsycINFO: n = 474
- Proquest: n = 695

n = 1977 records excluded (including removal of...)

Preliminary Screening: Article titles and abstracts assessed against in/exclusion criteria

- Medline: n = 3
- Embase: n = 28
- CINAHL: n = 59
- PsycINFO: n = 41
- Proquest: n = 16

Full articles printed and read

Secondary Screening of full text articles using inclusion/exclusion criteria

Final Articles included in review
Table 2: Included papers & conceptualisation of family-focused practice

<table>
<thead>
<tr>
<th>Author, Country &amp; Type of paper</th>
<th>Service orientation</th>
<th>Family type</th>
<th>FFP Description/Terminology</th>
<th>Principles of FFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen &amp; Petr, (1998); USA</td>
<td>Children</td>
<td>Family of origin: children with mental health issues and their families</td>
<td>Family –centred service delivery (FCSD): program</td>
<td>Extend current model of FCSD to include: family as unit of attention; informed family choice; family strengths perspective</td>
</tr>
<tr>
<td>Anderson et al. (2003); USA</td>
<td>Child/ youth: 5-17 years services</td>
<td>Family of origin: parents and their children with mental health issues</td>
<td>Systems of care as a different &amp; non-traditional form of service provision : program</td>
<td>Family centred &amp; culturally competent; involves funding streams of multiple payers [e.g. education, child welfare, mental health]; providers strive to support &amp; strengthen natural supports for families</td>
</tr>
<tr>
<td>Aubry et al. (2001); Canada</td>
<td>Adult</td>
<td>Family of origin: Consumers and their parents</td>
<td>Family focused case management program</td>
<td>Partnership with service users and their families; program developed in collaboration with service users and their families. Autonomy of service user and their families – the family decides if family focused case management is relevant and required.</td>
</tr>
<tr>
<td>Bartlett et al. (2006); USA</td>
<td>Child/youth</td>
<td>Family of origin: parents and their children with mental health issues</td>
<td>Systems of care model</td>
<td>Child &amp; family centre of care Goal to make parent part of child’s treatment team with equal status to professional provider; as experts on their own child. Parent partners with advanced practice registered nurse &amp; ‘others’. Nurse helps family find ‘natural’ supports including family &amp; community resources Children are involved ‘wherever possible’ Holistic, culturally competent, child- and family- centred and community based care; Comprehensive wrap-around services; individualized care in least restrictive setting</td>
</tr>
<tr>
<td>Beardslee et al., (2007); USA</td>
<td>Child/youth</td>
<td>Family of procreation: consumers and their children</td>
<td>Family- centred preventive interventions for parental depression</td>
<td>Family psychoeducation intervention goals to promote long term family functioning</td>
</tr>
<tr>
<td>Cowling &amp; Garrett (2009); Australia</td>
<td>Adult</td>
<td>Family of procreation: consumers and their dependent children</td>
<td>Child and family inclusive practice</td>
<td>Strengthen and build on parents and children’s capacity to manage and to make sense of their experience; Family centred and child inclusive practice is possible within community mental health services; Support provided via child and family inclusive practice program;</td>
</tr>
<tr>
<td>Dauch et al., (2012); USA</td>
<td>Adult</td>
<td>Family of origin: Family defined as relatives, supportive family members of the consumer</td>
<td>Family involvement and services : intervention framework</td>
<td>Family involvement is important for recovery and holistic care Need to provide a variety of services and family choice Empowerment of service user and family to make choices Consumers and family should be given flexibility in service choices Collaboration with consumers and family important to identify and to</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Description</td>
<td>Population</td>
<td>Family Type</td>
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<tr>
<td>Devlin &amp; O'Brien (1999)</td>
<td>Australia</td>
<td>Discussion of a mental health model for mental health nursing advocacy</td>
<td>Adult</td>
<td>Family of procreation: adult consumers and their dependent children</td>
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<td>Enoka et al. (2013)</td>
<td>Samoa</td>
<td>Discussion: developing a culturally appropriate mental health service in Samoa</td>
<td>Adult</td>
<td>Family of origin: including partner, siblings and extended family of adult consumer</td>
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<td>Foster et al., (2012)</td>
<td>Australia</td>
<td>Discussion of family focused approach for mental health nurses</td>
<td>Adult</td>
<td>Family of procreation: adult consumers and their dependent children</td>
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<td>Furniss et al., (2013)</td>
<td>Germany</td>
<td>Discusses a psychiatric day treatment program for infants, toddlers and pre-schoolers and their parents</td>
<td>Child – infant, toddlers &amp; pre-school children &amp; parents/siblings</td>
<td>Family of origin: parents and their children with non-transient mental illness</td>
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<td>Gopolan et al. (2014)</td>
<td>USA</td>
<td>Implementation study of program for children with oppositional defiant disorder or conduct disorder.</td>
<td>Child/youth 7-11 yrs.</td>
<td>Family of origin: parents and their children with behavior disorders</td>
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</table>
Historical overview of wraparound services & political, economic, practice implications and theoretical discussion

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Study Description</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heitmann et al., (2012); Germany</td>
<td>Adult</td>
<td>Discussion of program development</td>
<td>Family-centred care; Discusses family-centred philosophies [i.e. Systems of Care and practice models [i.e. wraparound] – idea is to support family to help child make gains]; Family system is important for helping child with disorder</td>
</tr>
<tr>
<td>Hinden et al., (2005); USA</td>
<td>Adult</td>
<td>Case study design within a qualitative framework; data obtained from interviews with parents, service providers, and from family file records</td>
<td>Family centred program; Focus on strengths and trust between provider and family; Focus on effective communication, collaboration and partnership between parent and provider; Strengths based approach</td>
</tr>
<tr>
<td>Houlihan et al., (2013); Ireland</td>
<td>Adult</td>
<td>Quantitative survey with mental health nurses</td>
<td>Family focused care; Nurses and services need to be both child and family focused.</td>
</tr>
<tr>
<td>Jessop &amp; de Bondt (2012); Australia</td>
<td>Adult</td>
<td>Discussion of a consultation service by child/youth staff to adult mental health services</td>
<td>Family centred; Family sensitive; Collaboration between services critical; Strengths based approach</td>
</tr>
<tr>
<td>Kilmer et al. (2010); USA</td>
<td>Child/youth</td>
<td>Discussion; identifies discrepancies between conceptualization and practice; of family centred care</td>
<td>Family- focused, family-centred care; System of Care philosophy with wraparound as main practice model; to help families engage their broader communities and connect with informal or natural community supports, not just professionals; Child &amp; Family Team (CFT), composed of family members, professionals from community agencies, and informal supports</td>
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<tr>
<td>Korhonen et al., (2008); Finland</td>
<td>Adult</td>
<td>Quantitative survey of psychiatric nurses</td>
<td>Family centred care; Preventative approach; Collaboration</td>
</tr>
<tr>
<td>Korhonen et al., (2010a); Finland</td>
<td>Adult</td>
<td>Family of procreation: adult consumers and their children</td>
<td>Family centred care; Family orientated approach; Family orientated care methods; Prevention approach; Collaboration; Identifying parenting status and supporting parents to develop parenting</td>
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<td>Study</td>
<td>Study Type</td>
<td>Sample</td>
<td>Setting</td>
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<td>Korhonen (2010b); Finland</td>
<td>Quantitative survey with psychiatric nurses</td>
<td>Adult</td>
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<td>Lee et al., (2009); USA</td>
<td>Reports on a feasibility trial of intervention effectiveness</td>
<td>Child/youth</td>
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<td>Lepage (2005); Canada</td>
<td>Discusses two interventions employed in rural northern communities</td>
<td>Child/youth</td>
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<tr>
<td>Maddocks et al., (2010); UK</td>
<td>Qualitative interview study with mental health nurses</td>
<td>Adult</td>
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<td>Malysiak (1997); USA</td>
<td>Examines theoretical underpinnings of wraparound model</td>
<td>Child/youth</td>
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<tr>
<td>Maybery et al., (2012); Australia</td>
<td>Development and</td>
<td>Adult</td>
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</table>
| | | | | Family sensitive responses can span a broad spectrum of practice from identifying clients who are parents and referring to relevant support.
<table>
<thead>
<tr>
<th>Psychometric testing of instrument to measure FFP</th>
<th>Adult</th>
<th>Family of procreation; consumers and their dependent children</th>
<th>Family focused practices; Family sensitive; Family inclusive; Family centred</th>
<th>Importance of collaboration between professionals and parents and families and between services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maybery et al. (2014); Australia</td>
<td>Quantitative survey research with variety of professional groups</td>
<td>Family focused treatment (FFT) model</td>
<td>The reciprocal influences of a child’s biological and psychological functioning, stage of cognitive, social, and emotional development &amp; the family, cultural, and medical context in which symptoms are expressed. Need for integrated treatment; rely on extra-familial resources Including mental health treatment, extended family, and community supports. A manualized psychosocial intervention consisting of psychoeducation, communication training, and problem-solving skills training</td>
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<tr>
<td>Miklowitz et al., (2006); USA</td>
<td>Discusses a treatment model and presents data from treatment study</td>
<td>Child/youth</td>
<td>Family preservation services (FPS): intervention</td>
<td>The rationale underlying this approach involves having treatment goals driven by parental &amp; child perceptions of what is important; and (a) provide intensive intervention, (b) deal with the family as a unit, (c) provide services primarily in the home, (d) provide services based on need rather than on service categories, and (e) provide intensive services on a short-term basis. FPS similar to wraparound principles</td>
</tr>
<tr>
<td>Mosier et al. (2001); USA</td>
<td>Discussion and quantitative evaluation of an in-home program for 4-17 year olds</td>
<td>Child/youth</td>
<td>Family focused treatment (FFT) model</td>
<td>The reciprocal influences of a child’s biological and psychological functioning, stage of cognitive, social, and emotional development &amp; the family, cultural, and medical context in which symptoms are expressed. Need for integrated treatment; rely on extra-familial resources Including mental health treatment, extended family, and community supports. A manualized psychosocial intervention consisting of psychoeducation, communication training, and problem-solving skills training</td>
</tr>
<tr>
<td>Mottaghipour &amp; Bickerton (2005); Australia</td>
<td>Theoretical discussion of FFP</td>
<td>Adult</td>
<td>Family work; Pyramid of family care; Model of family care</td>
<td>Collaboration with families Partnership with parents – different levels of intervention negotiated over varying timeframes</td>
</tr>
<tr>
<td>Mullen et al., (2002); Australia; Description and evaluation (both qualitative and quantitative) of family intervention</td>
<td>Youth</td>
<td>Family of origin; parents and their children with mental health issues</td>
<td>Family intervention</td>
<td>Families play a major role in promoting service users’ recovery and preventing relapse Nurses have a central role in providing family interventions Early intervention important</td>
</tr>
<tr>
<td>Nicholson (2007); USA</td>
<td>Discussion of FFP in relation to families where a parent has a mental illness</td>
<td>Adult</td>
<td>Family of procreation; consumers and their dependent children</td>
<td>Family centred; Strengths based approach</td>
</tr>
<tr>
<td>O’Brien et al., (2011); Australia</td>
<td>Qualitative interview study</td>
<td>Adult</td>
<td>Family of procreation; consumers and their dependent children</td>
<td>Family focused services; Family friendly services</td>
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<tr>
<td>Source</td>
<td>Age</td>
<td>Family Type</td>
<td>Service Type</td>
<td>Focus</td>
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<tr>
<td>Pierpont &amp; McCriny, 2004; USA.</td>
<td>Children &amp; youth</td>
<td>Family of origin: children with mental health issues and their families</td>
<td>Family orientated program based on Systems of Care</td>
<td>Child centred, Family focused, Community based, Culturally competent</td>
</tr>
<tr>
<td>Reupert &amp; Maybery (2014); Australia</td>
<td>Adult</td>
<td>Family of procreation; consumers and their children</td>
<td>Family sensitive practice or approach</td>
<td>Strengths based approach, Partnership between parents and practitioners pivotal, Families have complex needs so need for interagency cooperation, Need to balance competing needs of children &amp; parents</td>
</tr>
<tr>
<td>Schmidt &amp; Monaghan (2012); USA</td>
<td>Adult</td>
<td>Family of origin and family of procreation</td>
<td>Intensive family support service</td>
<td>Structures of service driven by individual family choice, Collaborative process based on trust, Focus of intervention is determined by the family’s concerns, Strengths based competence of family recognised, Promotes recovery</td>
</tr>
<tr>
<td>Sin et al. (2007); UK</td>
<td>Child/youth</td>
<td>Family of origin: parents and their youth with early onset psychosis</td>
<td>Early Intervention in Psychosis service</td>
<td>Services developed to address carers’ needs for knowledge, skills and support to cope with their caring roles &amp; situation, from stressful beginnings of a potentially long caring journey</td>
</tr>
<tr>
<td>Woolston, (2007); USA</td>
<td>Child/youth</td>
<td>Family of origin: parents and their children with severe emotional disturbances</td>
<td>The Intensive In-Home Child &amp; Adolescent Psychiatric Service (IICAPS): approach</td>
<td>Combines elements of medicalized treatment with system-of-care principles that place a high value on authentic parent involvement and attention to youth and family strengths; Focus on four critical domains: child, family, school &amp; environment, and other systems, Family members are considered equal partners in all aspects of treatment</td>
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<td>Young &amp; Fristad, (2007); USA</td>
<td>Child/youth</td>
<td>Family of origin: children with bipolar and their families</td>
<td>Four programs presented: Family-focused treatment (FFT); RAINBOW Program; Multi-family psychoeducation program (MFP); Individual family psychoeducation (IFP)</td>
<td>Describes four programs based upon a psychoeducation format &amp; a cognitive-behavioral foundation, Goals to increase adherence to medication &amp; delay recurrence of mood episodes; enhance adolescents’ knowledge of illness; enhance communication and coping skills; &amp; minimize the psychosocial impairment; and incorporate both parents and children as active partners in the management of bipolar disorder</td>
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<td>Core practice</td>
<td>Description</td>
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<tr>
<td>1. Family care planning &amp; goal setting</td>
<td>Clinicians conduct care planning including collaboratively establishing crisis/care plans with families and assisting family members to set goals both in relation to the individual’s recovery and also in relation to improving family members’ mental health and wellbeing.</td>
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<td>2. Liaison between family &amp; services including advocacy</td>
<td>Liaison between families and services. Advocacy involves acting, speaking or encouraging actions with services to achieve better outcomes for families.</td>
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<td>3. Instrumental, emotional &amp; social support</td>
<td>Instrumental support involves the clinician referring a family member to another service, and organising practical support e.g. transport or child-care. Emotional support involves showing empathy and compassion to family members. Social support involves empowering families and encouraging individuals and families to expand social networks and improve their connections with others.</td>
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<td>4. Assessment of family members &amp; family functioning</td>
<td>Assessment ranges from basic questions that aim to ascertain family relationships for example, at psychiatric intake asking, ‘Do you have children?’ through to assessing parenting competency and/or family circumstances, the impact of a family member’s mental illness on other family members, and level of mental health literacy in all family members.</td>
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<td>5. Psychoeducation</td>
<td>Psychoeducation aims to improve family members’ mental health literacy and may focus on education about mental illness, treatment including information about medication, and improving the understanding of mental illness and wellbeing. It ranges from informal discussion through to manualised, evidence-informed family interventions.</td>
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<td>6. Coordinated system of care between family &amp; services</td>
<td>Clinicians provide a coordinated system of care (e.g. family collaboration, family-service partnership) with family members and clinicians and other service providers (e.g. education providers). Commonly this coordinated system of care involves a wraparound that encompassed partnerships between families and service providers in a constructive and synchronised manner.</td>
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ranged from a general approach (coordinating the various services - the ‘system’ - involved with a family) through to specifically defined type of service (e.g. ‘Wraparound’) with clear operating parameters and model of care. Collaborating with family members is a critical component of this.