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Families with Parental Mental Health Problems: A Systematic Narrative Review of Family-Focused Practice

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The mental health problems of parents can negatively affect their whole family. The organisational and wider context may also influence the outcomes for all involved. The aims of this systematic review were: to develop a working definition of family-focused practice (FFP); identify the types of outcomes that are measured with a focus on service user experiences; and explore how well interventions in the included studies fit with previously established components of FFP. A comprehensive literature search of 16 databases was conducted for peer-reviewed, primary research studies related to FFP published between 1998 and 2016. In total, 3731 articles were identified and screened by four reviewers. Of those, 40 articles met all of the inclusion criteria. The review focused on family outcomes and, consistent with previous reviews, there was a reasonable degree of consistency about the core components of FFP. An additional component, identified by this review, which was part of some interventions, was work to improve access to and engagement with community supports and services. The review concludes that there is a need for: an agreed definition of FFP; clearer links to relevant theories; a more consistent approach to measuring outcomes, including economic perspectives; and an increased strategic promotion of whole family approaches.

KEY PRACTITIONER MESSAGES:

- There is an immediate need for an agreed definition of family-focused practice.
- Relevant theory could further clarify the theories of change and anticipated outcomes.
- There is consistency across studies about the key components of family-focused practice.
- This review suggests the inclusion of an additional component, which is practice that improves access to and engagement with community supports and services.
- Economic evaluations of family-focused practice are needed.

KEY WORDS: parental mental health; parental substance use; safeguarding children; family-focused practice

'There is an immediate need for an agreed definition of family-focused practice'

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Introduction

Internationally, it is estimated that between a fifth and a third of adults receiving treatment from mental health services have children and that between 10 and 23 per cent of children live with at least one parent with mental health problems (Maybery *et al*., 2009; Parker *et al*., 2008). Parents' mental health problems (including problematic substance use) can adversely impact their whole family, including dependent children. While not all children will experience difficulties due to parental mental health problems, a significant number will experience cognitive, emotional, social, physical and behavioural problems on a short- or long-term basis (Mennen *et al*., 2015). For instance, 25 to 50 per cent of children who have a parent with mental health problems experience a psychological disorder during childhood or adolescence, and 10 to 14 per cent of these children will be diagnosed with a psychotic disorder at some point in their lives (Beardslee *et al*., 2012). Additionally, there is an association between parental mental health problems and child maltreatment (e.g. Cleaver *et al*., 2011; Finkelhor *et al*., 2015). While the parenting role can encourage parents' recovery (Siegenthaler *et al*., 2012), it can also be a source of stress and negatively impact parents' mental health (Reupert *et al*., 2017).

Family-Focused Practice

'Family-focused Practice (FFP) is an approach to intervention that emphasises the family as the focus of attention as opposed to any one individual'

Family-focused practice (FFP) is an approach to intervention that emphasises the family as the focus of attention as opposed to any one individual (Foster *et al*., 2013). The concept of FFP in adult mental health services has tended to focus on supporting adult family members to care for the family member with mental health problems (McNeil, 2013). However, increasingly the concept has been broadened to reflect the growing awareness of the need to address service users' roles as parents and to support a range of family members including service users' dependent children (Nicholson, 2015). Emerging evidence of the benefits of FFP has led to calls for both adult mental health and children's services to adopt a whole family approach to address the complexity of the family's needs (Grant *et al*., 2018).

Key Components of Family-Focused Practice

Foster *et al*. (2016) identified six core and overlapping practices within FFP: 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; and 6) a coordinated system of care (e.g. wraparound, family collaboration, partnership) between family members and services. Marston *et al*. (2016) provided a similar analysis of the main components as: psychoeducation; direct treatment and support for mental health and/or substance use; a focus on parenting behaviour; child risk and resilience; family communication; and family support and functioning.

FFP can be provided in a variety of ways and at different levels from mental health promotion to specialist intervention (Smith *et al*., 2020). Information and support to enhance resilience may be provided through peer support

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programmes (e.g. Nilsson *et al*., 2015), online discussion support groups (e.g. Drost *et al.,* 2011), and educational materials (Tussing and Valentine, 2001). In addition, there are family intervention programmes that support both parents and their children (e.g. Beardslee *et al*., 2007). Others, such as Falkov (2012) highlight that health and social care professionals, with additional training, can provide supportive counselling, family case management, and/or intensive child/family interventions, individually or as part of a multidisciplinary team.

Although the above work has been highly influential in furthering our understanding of components of current FFP interventions, there are aspects of FFP which require further exploration. Four recent reviews (Acri and Hoagwood, 2015; Foster *et al*., 2016; Marston *et al*., 2016; Smith *et al*., 2020) have acknowledged the lack of an agreed definition of FFP, explored the way in which the relevant terms are used, and identified key principles and components of FFP. Foster *et al*. (2016) reported that, in the context of adult mental health services, 'there is little consistency in how FFP is defined, and in particular, a lack of integrated knowledge on FFP in mental health services' (pp. 1–2).

The aims of this review were therefore to: develop a working definition of family-focused practice (FFP); identify the types of outcomes that are measured with a focus on service user experiences; and explore how well interventions, in the included studies, fit with the previously established components of FFP.

Methodology

The systematic narrative review focuses on primary research on FFP which we defined as interventions provided by health and social care professionals in adult mental health and children's services for families when a parent or parents have mental health problems (including problematic substance use). The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) Statement (Liberati *et al*., 2009) was used as a guideline for reporting the review findings.

Search Strategy

For practical and resource reasons, the review searches were limited to those reported in English and to studies published between 1998 and 2016. Medical Subject Headings (MeSH) and text words were used to search 16 electronic databases. Grey literature was also searched including unpublished sources and reports via OpenGrey, Google and Google Scholar, and the websites of relevant UK government departments and charities. These sites were searched using a selection and combination of search terms as appropriate. Reference lists of studies that met the inclusion criteria were also checked. Finally, experts in the field were contacted to obtain additional studies.

'The review searches were limited to those reported in English and to studies published between 1998 and 2016'

Search terms were incorporated into the search strategy in order to maximise the inclusion of studies in the review. This included terms which were selected to capture the population (mental disorders, substance-related disorders, family, alcoholics, drug users, child of impaired parents, adult

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children, dual diagnosis (psychiatry), child, parents), the intervention (educate, program, support, intervene/intervention, therapy), the setting (i.e. adult mental health services, child welfare services) and study design (all designs were included and their quality assessed). Searched databases were as follows:

Electronic Searches

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations; Embase (Ovid); CINAHL PsycINFO; Science Citation Index (Web of Science); Social Sciences Citation Index (Web of Science); ERIC (EBSCOhost); Cochrane Central Database of Controlled Trials (CENTRAL); Cochrane Database of Systematic Reviews; Database of Reviews of Effectiveness (DARE); Health Management Information Consortium; Database of Promoting Health Effectiveness Reviews; Trials Register of Promoting Health Interventions; Campbell Library of Systematic Reviews; International Clinical Trials Registry Platform (ICTRP); ClinicalTrials.gov; UK Clinical Research Network Study Portfolio.

Study Eligibility

Types of Included Studies

A variety of study types were incorporated into the current review including controlled studies (randomised controlled trials and quasi-randomised, quasi-experimental and controlled observational studies), cross-sectional and observational studies, qualitative studies that explored the acceptability and impact of intervention, and any study that asked for participant views irrespective of study design or data type. Additionally, any studies that provided quantitative data on attrition and adherence rates were included as part of the effectiveness synthesis. No restrictions were imposed on design for this synthesis as long as the study was about family-focused interventions for parents who have mental illness and/or their children and families.

Participants

Participants in the included studies were parents with mental health problems and/or problematic substance use, their children and adult family members (e.g. adult siblings acting in a caring capacity).

Intervention Type

Studies that reported interventions which involved family-focused practice, in any setting, for parents with mental health problems and/or problematic substance use, their children and adult family members were included. The intervention had to be specifically family-focused (i.e. interventions had to be focused on supporting both the service user/parent and their family). Interventions that involved only the service user/parent were included if they addressed both the needs of the parent and their child/children, so general interventions for mental health problems and substance use were not included unless they had a family-focused aspect to them.

Outcome Measures

Studies were included with the following outcomes:

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- Primary outcome: psychological distress/mental health (depression and anxiety, psychosis, self-harm); social functioning including parenting, attachment and relationships with family and others; substance use; treatment adherence
- Secondary: acceptability; quality of life; child welfare interventions with children to prevent/address concerns about their welfare; hospital admissions.

Exclusion Criteria

Studies were excluded if there was no family-focused component to their intervention, if they were published before 1998 or were not published in the English language. Studies which only addressed family-focused practice for children and/or young people's mental health and/or substance misuse were also excluded. Studies were not included if they were based on interventions that only consulted the family to intervene with the individual (not family-focused/systemic). Studies were also excluded if they only focused on the perspective of practitioners (i.e. no parents included).

Systematic Data Synthesis

Using the search terms as previously described, the initial search for literature yielded more than 3700 articles. All article references were transferred to EPPI Reviewer 4 (web-based management software), and duplicates were removed. Article titles were screened for eligibility using the inclusion and exclusion criteria by reviewer GD with all relevant articles retained for abstract review. Two further reviewers (JDe and JDu) assessed 50 per cent each of the article titles and abstracts retained in EPPI to ensure reliability of initial reviewer assessment, with a further random 10 per cent sample of all articles assessed by reviewer KG to quality assure the screening process. After initial review of relevance and meeting of all reviewers to agree on inclusion, 405 articles were retained for further assessment of titles and abstracts. A further 53 articles were removed based on second observations. When article abstracts provided insufficient information, full text was obtained if possible for further consideration. Full text review was carried out on 352 articles by reviewers GD and SL. Full text articles were assessed for quality appraisal using criteria adopted from the Critical Appraisal Skills Programme (CASP, 2019). The reviewers (GD and SL) met to agree on inclusion of studies based on quality and eligibility criteria. Any disagreements were to be resolved by further independent quality assessment by a third reviewer (which was not needed). After final review of full text articles, 40 studies were included for the review (Figure 1). Data extracted from articles included information relating to the author and publication date, sample population, study setting and design, intervention type and summary of main findings. See Supplementary Table S1 (in the online Supporting Information) for an overview of all included studies.

‘The initial search for literature yielded more than 3700 articles’

‘After final review of full text articles, 40 studies were included for the review’

Results

Marston *et al*. (2016) in their analysis of the components of family interventions provided a useful structure to present the characteristics of the included studies. Current review findings are therefore presented by: characteristics of included studies; for whom and where the intervention was provided; the key components of the intervention (psychoeducation, treatment

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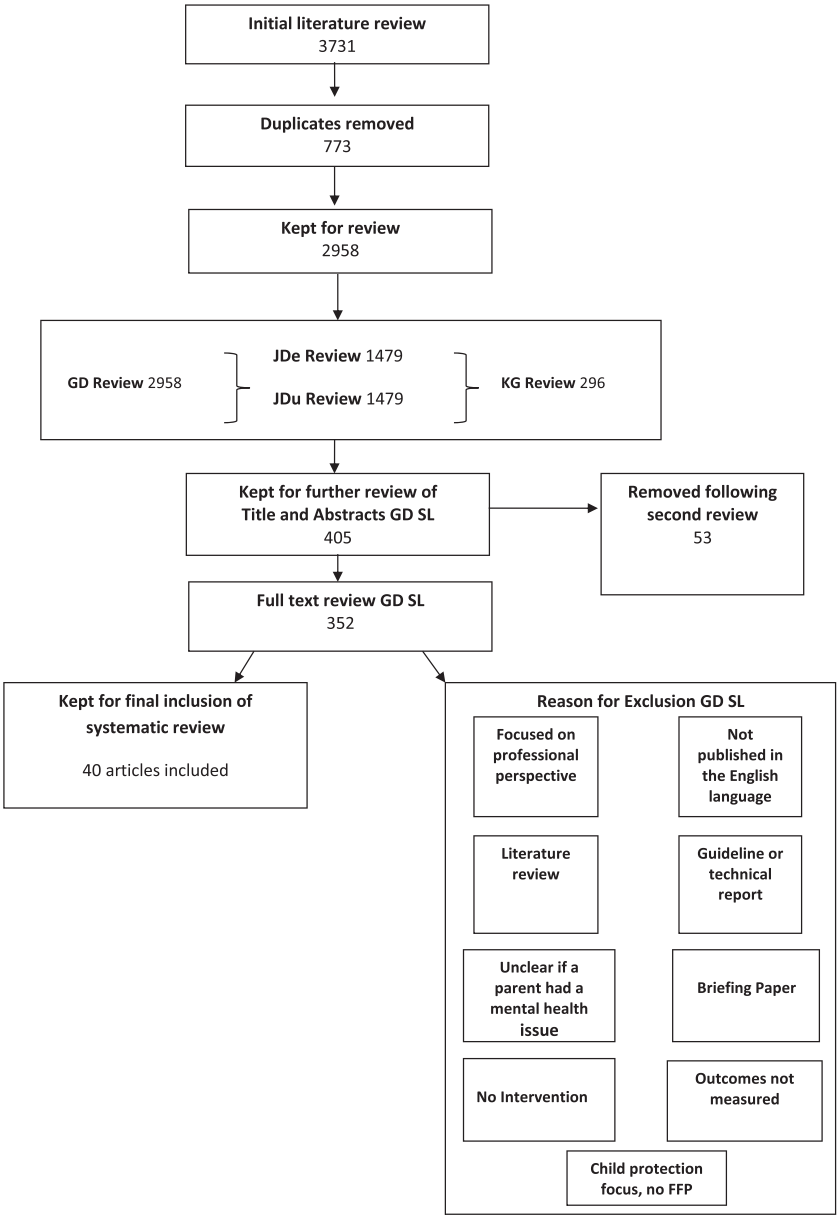

Figure 1. *Overview of Review Process*

and support, parenting behaviour, child risk and resilience, family communication, family support and functioning); the intervention intensity; the measured outcomes; participants' perceptions of the interventions; and recommendations from children, parents, professionals and researchers. There are overlaps across these categories, but the structure is used to organise the main themes from across the studies.

Characteristics of Included Studies

There were 40 studies included in the systematic review (Table 1). The largest proportion were from the USA (15), with the remainder from Australia (9),

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Table 1. Summary of Included Studies in Review

Author and Date	Country	Sample Size	Setting	Design
1. Bassett *et al*. (2001)	Australia	34 parents of children aged under 5 years	Adult mental health services	Mixed methods service evaluation
2. Brook *et al*. (2012)	USA	637 participants	Child welfare services	Longitudinal – matched comparison
3. Brunette *et al*. (2004)	USA	8 families	Community mental health centre	Pilot service evaluation
4. Casselman and Pemberton (2015)	USA	7 fathers who were veterans and were previously diagnosed with PTSD	Adult mental health services	Pre- and post-test evaluation
5. Catalano *et al*. (1999)	USA	144 methadone-treated parents, and their children (n = 178) ranging in age from 3 to 14 years old	Methadone clinics	Randomised controlled trial
6. Cleek *et al*. (2012)	USA	Case study – the Smith family	Institute for Community Living for adults with mental health problems	Case study
7. de Camps *et al*. (2016)	Canada	13 mother–infant dyads	Research Institute	Mixed methods cohort design
8. Diaz-Caneja and Johnson (2004)	England	22 women with schizophrenia, bipolar affective disorder or severe depression with psychotic symptoms	Adult community mental health teams	Qualitative interviews
9. Donohue *et al*. (2010)	USA	Case study – one mother	Child welfare services	Case study
10. Dumaret *et al*. (2009)	France	22 families	Child welfare services	Qualitative service evaluation
11. Einbinder (2010)	USA	21 parents	Substance abuse treatment service	Qualitative interviews
12. Gewirtz *et al*. (2009)	USA	200 children in 127 families	Housing support service	Cross-sectional
13. Grant *et al*. (2008)	UK	10 young people who were caring for their mother who had mental health problems	Child welfare service	Qualitative interviews
14. Grove *et al*. (2015a)	Australia	Children aged 8 to 12 of parents with mental health problems	Child welfare service	Mixed methods – pre- and post-comparison design, and qualitative interviews
15. Grove *et al*. (2015b)	Australia	29 children who had parents with mental health problems.	Child welfare service	Mixed methods – pre- and post-comparison design, and qualitative interviews
16. Gruber *et al*. (2001)	USA	2 case example (families)	Substance treatment service	Case studies
17. Isobel *et al*. (2015)	Australia	20 nurses	Adult mental health services	Mixed methods – service usage analysis, questionnaire and qualitative interviews
18. Isobel *et al*. (2016)	Australia	8 participants	Adult mental health services	Mixed methods – pre- and post-comparison design, and qualitative interviews, questionnaire and facilitator fieldnotes
19. Kern *et al*. (2004)	USA	120 mothers	Substance treatment service	Longitudinal cohort design
20. Khalifeh *et al*. (2009)	UK	18 mothers, and 5 children (from two families)	Child welfare service	Qualitative interviews
21. Killeen and Brady (2000)	USA	35 women and 23 children	Substance treatment service	Longitudinal cohort design
22. Knutsson-Medin *et al*. (2007)	Sweden	36 grown-up children of parents with mental disorders	Inpatient mental health service	Qualitative survey design
23. Maybery *et al*. (2015)	Australia	33 parents and 50 children	Child welfare service	Cohort Study
24. Maybery *et al*. (2013)	Australia	44 parents and 41 children	Child welfare service	Cohort Study
25. McComish *et al*. (2003)	USA	39 mothers and 50 children	Substance treatment service	Cohort study
26. Nielsen (2006)	Denmark	31 families (31 females, 20 males)	Inpatient mental health service	Cohort study
27. Nilsson *et al*. (2015)	Sweden	7 women whose parents have a mental illness	Family support service	Qualitative interviews
28. Noether *et al*. (2007)	USA	253 children	Research institute	Quasi-experimental design
29. O'Brien et al. (2011)	Australia	5 parents, 3 carers of children and 5 children	Inpatient mental health service	Qualitative Interviews
30. Pihkala *et al*. (2010)	Sweden	103 families	Adult mental health services	Cohort study – Questionnaire design

(Continues)

Table 1. *(Continued)*

Author and Date	Country	Sample Size	Setting	Design
31. Pihkala *et al*. (2011)	Sweden	14 children, 9 parents, 5 non-identified-patient (NIP) parents	Adult mental health services	Cohort study – Qualitative Interviews
32. Punamäki *et al*. (2013)	Finland	109 families (including 145 children)	Adult mental health services	Randomised controlled trial
33. Schaeffer *et al*. (2013)	USA	43 mother–youth dyads	Child welfare service	Quasi-experimental pre- and post-comparison design
34. Suchman *et al*. (2011)	USA	47 mothers	Substance treatment service	Randomised controlled trial
35. Templeton and Sipler (2012)	UK	13 practitioners and 23 young people	Child welfare service	Qualitative interviews
36. van Doesum *et al*. (2008)	Netherlands	71 participants	Child welfare service	Randomised controlled trial
37. van der Ham *et al*. (2013)	Australia	21 women	Adult mental health services	Cohort pre- and post-comparison design
38. van der Zanden *et al*. (2010)	Netherlands	48 parents with mental illness	Research institute	Cohort pre- and post-comparison design
39. Wansink *et al*. (2015)	Netherlands	99 parents with mental health problems	Community mental health centre	Randomised controlled trial
40. Wolpert *et al*. (2015)	UK	5 parents, 6 young people, 9 previous service users	Family support service	Qualitative interviews

UK (5), Sweden (4), Netherlands (3) and one each from Canada, Denmark, Finland and France.

Although it was sometimes difficult to establish if the setting was mainly adult or child focused, it appeared that 22 were in adult mental health settings, including seven with a specific focus on problematic substance use. Fourteen of the studies were undertaken in services focused primarily on support to children and families. There was a range of research designs used, from case studies to randomised controlled trials. It is also worth noting that of all included articles, only six (Bassett *et al*., 2001; Isobel *et al*., 2015; McComish *et al*., 2003; Nilsson *et al*., 2015; O'Brien *et al*., 2011; Wansink *et al*., 2015) mentioned terminology relating to FFP or family-centred practice, with no articles providing a definition of FFP even though interventions focused on the 'family' (parent and child needs). Although we aimed to include economic evaluations of interventions, none of the 40 studies reported economic data.

For Whom and Where the Intervention Was Provided

'The majority of the studies (30/40) considered interventions that were provided to both parents and children'

The majority of the studies (30/40) considered interventions that were provided to both parents and children although one of these included a direct comparison with a parent-only intervention (Punamäki *et al*., 2013). Within these, some were specifically focused on the mother–baby relationship (de Camps *et al*., 2016; Kern *et al*., 2004; van der Ham *et al*., 2013; van Doesum *et al*., 2008). Some interventions were only provided to parents. There were six interventions only provided to children. These included the children of a parent/s who had mental illness (Grant *et al*., 2008; Grove *et al*., 2015a; Noether *et al*., 2007), children of a parent/s with problematic substance use (Templeton and Sipler, 2012), and grown up children whose parent/s had a mental illness (Knutsson-Medin *et al*., 2007; Nilsson *et al*., 2015). Most seemed to be provided in service or clinical settings, including residential (Killeen and Brady, 2000; McComish *et al*., 2003) and inpatient care (Isobel *et al*., 2015; O'Brien *et al*., 2011), but some were specifically provided in the family's home setting (Brunette *et al*., 2004; Gewirtz *et al*., 2009; Gruber *et al*., 2001; Maybery

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et al., 2015; van Doesum *et al*., 2008) and two were provided via DVD and/or the internet (Grove *et al*., 2015b; van der Zanden *et al*., 2010).

Key Components of the Intervention

All interventions provided more than one component of the range of elements of family-focused interventions that Marston *et al*. (2016) identified. It was difficult, at times, to identify which category or categories the interventions would best fit with. As summarised in Table 2, 25/40 of the included studies included some clear component of psychoeducation (including increasing knowledge around either mental health problems or substance misuse). Of these, just under half (n = 11 provided psychoeducation to children (Grove *et al*., 2015a; Grove *et al*., 2015b; Killeen and Brady, 1999; Maybery *et al*., 2015; Maybery *et al*., 2013; Noether *et al*., 2007; Pihkala *et al*., 2010; Pihkala *et al*., 2011; Punamäki *et al*., 2013; Templeton and Sipler, 2012;

'25/40 of the included studies included some clear component of psychoeducation'

Table 2. Key Components of the Intervention Being Studied

Study	Psychoeducation	Direct support and treatment for mental health and/or problematic substance use	Parenting behaviour	Child risk and resilience	Family communication	Family support and functioning	Access to community supports and services
1. Bassett *et al*. (2001)	X	X	X		X	X	X
2. Brook *et al*. (2012)				X	X	X	
3. Brunette *et al*. (2004)	X	X	X				X
4. Casselman and Pemberton (2015)	X	X	X				
5. Catalano *et al*. (1999)	X	X	X	X	X		
6. Cleek *et al*. (2012)	X	X	X	X	X	X	X
7. de Camps *et al*. (2016)	X	X	X		X		
8. Diaz-Caneja and Johnson (2004)		X	X	X		X	
9. Donohue *et al*. (2010)	X	X	X	X	X	X	
10. Dumaret *et al*. (2009)	X	X	X	X	X	X	X
11. Einbinder (2010)	X	X	X			X	X
12. Gewirtz *et al*. (2009)				X		X	X
13. Grant *et al*. (2008)	X			X	X	X	
14. Grove *et al*. (2015a)	X			X		X	X
15. Grove *et al*. (2015b)	X			X	X	X	
16. Gruber *et al*. (2001)	X	X				X	
17. Isobel *et al*. (2015)		X				X	
18. Isobel *et al*. (2016)	X	X	X		X	X	
19. Kern *et al*. (2004)	X	X	X		X	X	
20. Khalifeh *et al*. (2009)		X					
21. Killeen and Brady (2000)	X	X	X	X	X	X	
22. Knutsson-Medin *et al*. (2007)							
23. Maybery *et al*. (2015)	X	X			X	X	
24. Maybery *et al*. (2013)	X						
25. McComish *et al*. (2003)		X	X	X			
26. Nielsen (2006)				X	X	X	
27. Nilsson *et al*. (2015)						X	
28. Noether *et al*. (2007)	X			X			
29. O'Brien *et al*. (2011)		X					
30. Pihkala *et al*. (2010)	X		X	X	X	X	
31. Pihkala *et al*. (2011)	X		X	X	X	X	
32. Punamäki *et al*. (2013)	X		X	X	X	X	
33. Schaeffer *et al*. (2013)		X	X	X		X	X
34. Suchman *et al*. (2011)			X		X	X	
35. Templeton and Sipler (2012)				X		X	
36. van Doesum *et al*. (2008)	X	X	X		X	X	
37. van der Ham *et al*. (2013)	X	X	X		X	X	
38. van der Zanden *et al*. (2010)			X	X	X	X	
39. Wansink *et al*. (2015)		X	X				X
40. Wolpert *et al*. (2015)	X		X	X	X	X	

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Wolpert *et al*., 2015). Psychoeducation for children primarily centred around understanding parental mental illness and promoting children's psychological wellbeing. In 23/40 of the studies, direct treatment and support for mental health and/or substance misuse was provided. In 24/40 there was a focus on parenting behaviour. The authors explicitly addressed child risk and resilience in 21/40 studies. In 22/40 studies, there was an element of family communication. The most common component, although possibly the most general, was family support and functioning, which was clearly addressed in 29/40 interventions. Attempts to improve access to community supports and services was identified as a component in 9/40 of the studies.

Intervention Engagement

Articles were also reviewed in relation to the co-design of the intervention components through the involvement of the target population (i.e. families experiencing parental mental health problems) or participation and engagement by parents, their children and other family members in their own self-care as part of an intervention. Eleven studies indicated some form of involvement in this way (Table 3). Grove *et al*. (2015b) note that their DVD intervention was developed in consultation with consumers, carers and leading practitioners from around Australia, although no further detail was provided on what this entailed. For the remaining studies, a number of common themes were noted in relation to participation and engagement. Notably, three studies reported on partnership approaches with families regarding needs assessment and identification of support as part of the co-construction of a service plan (Cleek *et al*., 2012; Dumaret *et al*., 2009; Grant *et al*., 2008). Additionally, remaining studies describe the facilitation of communication between parents and their children (Pihkala *et al*., 2010; Pihkala *et al*., 2012; Punamäki *et al*., 2013) during family sessions planned with parents and children's questions and experiences as a basis. Collaboration and goal setting during interventions were also notable forms of engagement with families (Maybery *et al*., 2013; Maybery *et al*., 2015), parents (McComish *et al*., 2003) and children (Templeton and Sipler, 2012) as part of ongoing care and recovery planning.

Intervention Intensity

There was an extremely wide range of lengths and intensities of intervention from a 64-minute DVD (Grove *et al*., 2015b), to 50 visits a year (Brunette *et al*., 2004), an 18-month programme (Einbinder, 2010), to weekly family support for seven years (Dumaret *et al*., 2009). However, most interventions involved between two and 18 sessions often delivered weekly.

‘The most common measures of outcome tended to involve aspects of parental mental health and/or substance misuse and family functioning’

Measured Outcomes

The most common measures of outcome tended to involve aspects of parental mental health and/or substance misuse and family functioning (Table 3). Twenty-nine studies addressed increases in family function, with positive improvements on the parent–child relationship assessed by ten studies. Changes in parenting skills were assessed in nine of the included studies. Twelve studies sought to measure parental stress and coping, and family communication regarding mental illness and/or problematic substance use

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Table 3. Adult Outcomes Measured in the Studies

Study	Intervention engagement	Family functioning outcomes	Positive improvements on the parent–child relationship	Parenting skills	Parental stress and coping	Family communication	Improvements in parental mental health and/or problematic substance use	Improvement in parental knowledge	Improvement in child behavioural and emotional functioning
1. Bassett *et al.* (2001)		X	X	X	X			X	
2. Brook *et al.* (2012)		X		X	X				
3. Brunette *et al.* (2004)		X		X					
4. Casselman and Pemberton (2015)					X		X		
5. Catalano *et al.* (1999)				X	X		X	X	
6. Cleek *et al.* (2012)	X	X					X		
7. de Camps *et al.* (2016)		X	X		X		X	X	
8. Diaz-Caneja and Johnson (2004)		X							
9. Donohue *et al.* (2010)		X	X	X			X	X	
10. Dumaret *et al.* (2009)	X	X						X	
11. Einbinder (2010)		X						X	
12. Gewirtz *et al.* (2009)		X	X		X				X
13. Grant *et al.* (2008)	X	X							
14. Grove *et al.* (2015a)		X						X	
15. Grove *et al.* (2015b)	X	X						X	
16. Gruber *et al.* (2001)		X	X						
17. Isobel *et al.* (2015)		X							
18. Isobel *et al.* (2016)		X	X					X	
19. Kern *et al.* (2004)		X			X		X		
20. Khalifeh *et al.* (2009)									
21. Killeen and Brady (2000)		X			X		X		
22. Knutsson-Medin *et al.* (2007)									
23. Maybery *et al.* (2015)	X	X			X				
24. Maybery *et al.* (2013)	X							X	
25. McComish *et al.* (2003)	X						X		
26. Nielsen (2006)					X				
27. Nilsson *et al.* (2015)		X							
28. Noether *et al.* (2007)									X
29. O'Brien *et al.* (2011)									
30. Pihkala *et al.* (2010)	X	X	X			X		X	X
31. Pihkala *et al.* (2011)	X	X			X	X			
32. Punamäki *et al.* (2013)	X								X
33. Schaeffer *et al.* (2013)		X					X		
34. Suchman *et al.* (2011)		X	X	X					X
35. Templeton and Sipler (2012)	X	X							X
36. van Doesum *et al.* (2008)		X	X						
37. van der Ham *et al.* (2013)		X	X	X			X		
38. van der Zanden *et al.* (2010)		X		X		X		X	
39. Wansink *et al.* (2015)				X	X				
40. Wolpert *et al.* (2015)		X				X		X	

was assessed in four studies. Of those ten studies reporting on direct improvements in parental mental health and/or problematic substance use, findings note a reduction in mental health symptoms or cessation of substance misuse among parents taking part in an intervention.

Furthermore, most interventions reported some positive impacts on parents' knowledge or awareness of issues associated with mental illness and substance misuse and increased knowledge of the needs of children. Interventions involving children also report that children improved in areas such as behaviour and emotional functioning, stress reduction, and better understanding of parental issues (Table 4). Improvements in these measured outcomes should also promote child safety, although that did not tend to be an explicit outcome measure.

Parents' and Children's Perceptions of Effective Interventions

Overall, interventions which incorporated a multi-disciplinary approach and included access to more than one service or area of support were identified as

Table 4. Child outcomes measured in the studies

Study	Improvement in child behavioural and emotional functioning	Reduction in children's stress	Better understanding of parental issues
1. Bassett *et al*. (2001)			
2. Brook *et al*. (2012)			
3. Brunette *et al*. (2004)			
4. Casselman and Pemberton (2015)			
5. Catalano *et al*. (1999)			
6. Cleek *et al*. (2012)			
7. de Camps *et al*. (2016)			
8. Diaz-Caneja and Johnson (2004)			
9. Donohue *et al*. (2010)			
10. Dumaret *et al*. (2009)			
11. Einbinder (2010)			
12. Gewirtz *et al*. (2009)	X	X	
13. Grant *et al*. (2008)		X	
14. Grove *et al*. (2015a)		X	X
15. Grove *et al*. (2015b)			
16. Gruber *et al*. (2001)			
17. Isobel *et al*. (2015)			
18. Isobel *et al*. (2016)			
19. Kern *et al*. (2004)			
20. Khalifeh *et al*. (2009)			
21. Killeen and Brady (2000)			
22. Knutsson-Medin *et al*. (2007)		X	
23. Maybery *et al*. (2015)			X
24. Maybery *et al*. (2013)			X
25. McComish *et al*. (2003)			
26. Nielsen (2006)			
27. Nilsson *et al*. (2015)			
28. Noether *et al*. (2007)	X		
29. O'Brien *et al*. (2011)			
30. Pihkala *et al*. (2010)	X	X	X
31. Pihkala *et al*. (2011)		X	X
32. Punamäki *et al*. (2013)	X		
33. Schaeffer *et al*. (2013)			
34. Suchman *et al*. (2011)	X		
35. Templeton and Sipler (2012)	X	X	X
36. van Doesum *et al*. (2008)			
37. van der Ham *et al*. (2013)			
38. van der Zanden *et al*. (2010)			
39. Wansink *et al*. (2015)			
40. Wolpert *et al*. (2015)			X

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helpful by families (Brunette *et al*., 2004; Cleek *et al*., 2012; Dumaret *et al*., 2009; Einbinder, 2010; Gewirtz *et al*., 2009; Grove *et al*., 2015a; Pihkala *et al*., 2012; Schaeffer *et al*., 2013; van Doesum *et al*., 2008; Wansink *et al*., 2015). Furthermore, opportunities to understand mental health/substance misuse issues and how these impact on the parent and child were also valued (Bassett *et al*., 2001; Catalano *et al*., 1999; de Camps *et al*., 2016; Donohue *et al*., 2010; Dumaret *et al*., 2009; Gewirtz *et al*., 2009; Grove *et al*., 2015a; Grove *et al*., 2015b; Isobel *et al*., 2016; Maybery *et al*., 2013; Maybery *et al*., 2015; Pihkala *et al*., 2010; Pihkala *et al*., 2011; Templeton and Sipler, 2012; Wolpert *et al*., 2015). Community-based interventions, particularly those which would ordinarily be clinically-based, were also reported as favourable among parents, particularly those associated with addiction issues (Catalano *et al*., 1999; Cleek *et al*., 2012; Diaz-Caneja and Johnson, 2004; Gruber *et al*., 2001; Khalifeh *et al*., 2009), as this allowed for better opportunities for family inclusion as well as more practical support (i.e. providing a stable environment for children). However, a preference for home-based treatment was not always shared among children who reported that hospitalisation of a parent with mental health problems sometimes provided an opportunity for respite for them and reduced their stress and worry surrounding their parent (Grove *et al*., 2015a; Khalifeh *et al*., 2009; Knutsson-Medin *et al*., 2007). Additionally, studies which recorded the subjective perceptions of parents in receipt of an intervention (i.e. Diaz-Caneja and Johnson, 2004; Einbinder, 2010; Khalifeh *et al*., 2009; O'Brien *et al*., 2011; Pihkala *et al*., 2011; Wolpert *et al*., 2015) noted that not all individuals feel that they are receiving the best service. For example, from the perspective of adult mental health services, Diaz-Caneja and Johnson (2004) highlight that mothers reported that there was:

> '…inconsistency of care, lack of any practical or emotional support in parenting and a tendency for any practical help provided to be withdrawn as soon as an immediate crisis had resolved, even though continuing support would have been valued.' (p. 478)

Interventions which addressed the wider needs of the family, including improvements in family relationships, and which moved beyond the mental health/substance use issue were also reported as helpful:

> 'The counselors are wonderful. They really take the time to deal with your issues and try to help you whatever your needs are, whether it's food, clothes, legal matters, mental issues, whatever. That's a plus for me. They are not just trying to work with the drug program.' (Einbinder, 2010, p. 38, Mother)

Recommendations Regarding Interventions

A theme across the included studies in this review was the relative consensus among professionals and researchers about appropriate and effective interventions. This included providing interventions aimed at addressing the needs of parents and children in environments that best suited their needs (Bassett *et al*., 2001; Brunette *et al*., 2004; Casselman and Pemberton, 2015; Diaz-Caneja and Johnson, 2004; Gewirtz *et al*., 2009; Gruber *et al*., 2001; Killeen and Brady, 2000; Maybery *et al*., 2015; McComish *et al*., 2003; van

'A theme across the included studies… was the relative consensus among professionals and researchers about appropriate and effective interventions'

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Doesum *et al*., 2008) and which incorporated a multidisciplinary approach aimed at increasing resilience through knowledge, understanding and effective coping (40/40). As Gruber *et al*. (2001) concluded:

> 'Extending support beyond the "program walls" into clients' homes and their families will ensure that more substance-affected parents will be involved with their children's development and provide a safe, stable, and healthy environment for their children to thrive.' (p. 276)

Discussion

The systematic narrative review examined the existing research evidence for the components of family-focused interventions for parents who have mental health problems, their children and families. There is a fine balance to be achieved in seeking to see family members as part of a group, while also recognising their individual needs and perspectives. The main themes from the findings include: the lack of an agreed definition of FFP; the identification of the key components of effective interventions; the parallels between what families and professionals need in terms of information, education and support; the need for more economic evaluations of these interventions; and the need to consider FFP in its wider systemic context. The aims of current review were to develop a working definition of family-focused practice (FFP); identify the types of outcomes that are measured with a focus on service user experiences; and explore how well interventions, in the included studies, fit with the previously established components of FFP. Each of these aims will now be considered in more depth following from the review findings.

Working Definition of FFP

'None of the included studies provided a definition of FFP, although six studies did use that specific phrase'

None of the included studies provided a definition of FFP although six studies did use that specific phrase. The lack of an agreed definition has been repeatedly identified and discussed throughout the literature (Foster *et al*., 2016). Although previous reviews do helpfully identify the key characteristics and components of FFP, they do so from a specific perspective: adult mental health (Foster *et al*., 2016; Marston *et al*., 2016) or child welfare (Acri and Hoagwood, 2015). It could therefore be helpful to develop a definition of FFP that could be used across adult and children's services and applied regardless of the combination of issues that the family may be experiencing, including parental mental health problems and/or problematic substance use, but also domestic violence and the wide range of other issues that may be relevant. Arguably the theory base for FFP, especially from ecological, life course and systemic perspectives, is already well-developed but perhaps needs to be more clearly and explicitly applied to FFP across settings. A possible concern is that without an agreed definition, and one which can be applied across areas, there is increased risk of some of the difficulties identified with siloed services.

Despite the complex nature of FFP, based on the existing evidence reviewed, we suggest that FFP can be defined as an approach to delivery of services whereby professionals engage the service user within the context of their

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immediate connected family relationships and endeavour to meet the needs of both service users and family members. For instance, professionals in adult mental health services may directly engage service users' children around issues related to parental mental health problems and promote their capacity to understand and cope with it. Professionals may also indirectly support children by keeping them in mind while caring for service users, and by referral to other specialist support services as required. Activities can be classified as more or less family-focused on a continuum, with direct support of service users' children (i.e. psychoeducation) more family-focused than provision of more indirect support, such as referral to other agencies. The types and intensity of activities and processes that professionals use to engage in FFP are partly determined by the service type they work in and by their beliefs about the need for and importance of FFP; capacity to engage in it and how they think it should be operationalised. Central to this is a need to be explicit about how the needs of the family are seen as both collective and individualised – especially in the context whereby a parent's mental health may be impacting a child to such a significant extent that the focus must shift from supporting the parent to protecting the child. This study adds to the limited discussion of this complex issue by seeking to focus on the outcomes that professionals seek to achieve when working with families.

Types of Outcomes – Including the Service User Experiences

There are a number of key issues raised by the types of outcomes that the included studies focused on and what appears to be relatively neglected. In general, the studies focused on symptoms, deficits, family functioning, relationships and understanding of mental health issues. They did not tend to explore, in as much depth or at all, families' qualitative priorities or experiences. None of the included studies had an economic evaluation as part of their design. The most common measures of outcome were of parental mental health and/or substance misuse and family functioning, but even within these areas of outcome there was a variety of approaches and measures used. The findings suggest that there should be a greater focus on identifying what outcomes are important to families, and on measuring outcomes in a more consistent way that would facilitate comparison across studies and interventions, and open the possibility for more explicit and supported discussions with parents, and children, about their needs and professional responsibilities. In doing so, consideration must be given to the power imbalances that arise within families, as a result of age (for children) or disability (for parents with mental health problems), and the role of different professionals in supporting and advocating for individual family members, while retaining a family focus.

‘There should be a greater focus on identifying what outcomes are important to families’

How Well Do Interventions, in the Included Studies, Fit with the Previously Established Components of FFP?

There seemed to be a reasonable degree of consistency about the core components of effective interventions across reviewed studies. These fitted well with the elements Marston *et al*. (2016) had identified: psychoeducation; direct treatment and support for mental health and/or

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substance use; a focus on parenting behaviour; child risk and resilience; family communication; and family support and functioning. The current review also identified an additional component relating to working to improve service user access to or engagement with community supports and services. In general, the theme of facilitating engagement with other resources and services is a more prominent feature of the professional-focused literature. For example, the need for training and education to develop professionals' ability to form collaborative partnerships with parents and adult family members (Coyne *et al*., 2013) parallels the need to support families to navigate services. The availability of other support services and the importance of being able to refer to and access a range of supports when the relevant professional cannot meet the identified need is also an important facilitator of FFP according to the professional-focused research (Nicholson, 2015). Although some of the included studies do address how families were supported to access services, this perhaps could have been a more developed aspect of other family-focused interventions.

Psychoeducation for children can help them cope more effectively with parental mental illness (Siegenthaler *et al*., 2012). While the core component of the majority of interventions for children is psychoeducation (Marston *et al*., 2016), the present review found that only 11 of the 40 studies reviewed provided psychoeducation for children. Therefore, more emphasis could be placed upon delivering psychoeducation to children and examining what content, format and duration is most useful.

'More emphasis could be placed upon delivering psychoeducation to children and examining what content, format and duration is most useful'

Interdisciplinary and organisational teamwork and interprofessional practice is also repeatedly identified as important (Grant *et al*., 2018), along with a commitment of all team members to adopt a whole family approach (Korhonen *et al*., 2010).

With regards to intervention and intensity, findings suggest that there is no agreed style or pace of intensity across the FFP interventions identified, rather commonalities can be noted within the principles adopted. Principles of FFP which have been identified throughout the wider family-focused literature highlight the importance of caring for parents in the contexts of their families and communities, and working with families in an individualised, holistic, flexible, transparent, responsive, preventative, recovery, strengths-based and culturally sensitive manner (Grant *et al*., 2018). Critical to FFP is the need for health and social care professionals to form partnerships with each other and with parents and their families, and to help parents set and achieve appropriate and realistic goals (Grant and Reupert, 2016). However, across the studies there was also a wide range of outcomes measured using a variety of tools which made any direct comparison difficult.

An aspect of the professional-focused interventions, which can also be paralleled with the family-focused interventions, is the importance of context and place. For example, for professionals, environmental design that allows close physical proximity of the various disciplines with each other has been identified as facilitating interagency co-operation and thereby family-focused practice (Coyne *et al*., 2013; Grant *et al*., 2018). The importance of context and place is also very relevant to families, including the proximity and accessibility of services, such as the provision of family rooms within mental health inpatient facilities. The professional-focused literature also suggests that

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caring for families in community settings is thought to enable family-focused practice, as it provides mental health professionals with opportunities to care for parents within their home environments and to observe normal family life (Grant *et al*., 2018; Grant and Reupert, 2016). For families, this may also be easier to engage with in contrast to arranging to attend various appointments in a range of clinical settings.

There are two other comparisons which may also be relevant and contribute to the discussion of FFP. Interventions are attempting to meet the needs of both parents and children. While there are areas of overlap, and the majority of the included interventions were provided to parents and children together, it was also identified that it can be useful to include some aspects of interventions specifically designed for parents and some for children. Finally, the comparison between interventions that were mainly focused on parental mental health problems with those more focused on problematic substance use also reinforced that there are broad areas which are common across issues, such as: the need for awareness and understanding of the nature of the issues; the need to consider different perspectives; and the need to identify appropriate supports. There are also aspects of specific content which need to be tailored for the specific issues and/or the specific family.

‘Interventions are attempting to meet the needs of both parents and children’

Limitations

This review is limited by the lack of an agreed definition of FFP as the definition used for this review may have excluded some relevant research. The broad approach meant that it was not possible to carry out any meta-analysis (due to inclusion of a variety of research designs) and limited the detail with which the content of each paper could be captured. Similarly, secondary thematic content analysis of qualitative studies was not applied as these were outside the paper's scope but could provide useful future review findings on this topic. Another limitation is the exclusion of additional and mental health/substance use associated factors, such as domestic violence. Furthermore, interventions included in the study were largely developed within Western industrialised countries, making generalisations to other settings difficult. Exploration of cross-cultural differences would be a useful endeavour in future research. The studies included in this review also used various lengths of intervention intensity and delivery methods making definitive conclusions about key components of effective family-focused interventions difficult. Finally, for resource reasons, the search strategy was limited to studies reported in English and published between 1998 and 2016. These limits may have resulted in exclusion of additional material and would therefore be a recommended focus of future work.

Conclusion and Implications

Poor parental mental health has been identified as having the potential to impact negatively on children and, for some children, may result in maltreatment. This review explored interventions to support families with parental mental health and substance misuse problems across both child

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'None of the included studies involved an economic evaluation and this presents a clear and urgent need for future research'

welfare and adult mental health services. The review identified the need for an agreed definition of family-focused practice that can be used across services and countries. It also suggests that links to the relevant theory base should be more explicit to clarify the theories of change and anticipated outcomes of interventions. It is very positive that there is relative consistency about what are identified as the effective components of family-focused practice, and this review suggests the inclusion of an additional component, which is interventions that improve access to and/or engagement with community supports and services. None of the included studies involved an economic evaluation and this presents a clear and urgent need for future research. In this complex area of practice and research, it is difficult to capture all the relevant perspectives on what is working well for the parents and children involved. It would help to further develop the evidence base if there was a more standardised and consistent approach to outcomes and the measures used. Finally, FFP needs to be considered in its wider systemic context and more randomised controlled trials of family-focused interventions would help to further clarify the critical components of these complex interventions.

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