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Adult mental health practitioner beliefs about psychosis, parenting, and the role of the practitioner: A Q methodological investigation

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Objectives. There is a lack of research into parenting interventions for families which include a parent experiencing psychosis or other serious mental illness (SMI). Preliminary findings highlight the potential benefits of adult mental health practitioners supporting parents experiencing SMI by using self-directed parenting interventions. This study explored beliefs relating to parenting and psychosis held by practitioners working in adult mental health settings, specifically examining their beliefs about the parenting needs of adults experiencing psychosis who have dependent children, as well as their role as adult mental health practitioners.

Design. This study used Q methodology to explore the beliefs of mental health practitioners on psychosis and parenting.

Methods. Twenty-one adult mental health practitioners ranked 58 items according to how much they agreed with the belief statement presented. Participants also provided additional written information and interviews to contextualize the Q methodology data.

Results. Three factors emerged representing three groups of practitioners with similar beliefs around psychosis and parenting. Factors were labelled: 'Parenting interventions are worthwhile, and I'd deliver them', 'Parenting interventions are worthwhile, but I'm not confident to deliver them', and 'Parenting interventions might be worthwhile, but it's not my responsibility'.

Conclusion. Using parenting interventions as part of their clinical work was acceptable to most practitioners; however, some lacked confidence in their ability to work in a family-focused way. Efforts now need to focus on enhancing practitioners' skill, knowledge, and confidence in family-focused approaches to provide increased and improved support to families which include a parent experiencing psychosis or other SMI.

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Practitioner points

- Parenting interventions need to be made more available and accessible to parents experiencing serious mental illness (SMI), such as psychosis.
- Adult mental health practitioners are willing to incorporate parenting interventions into their work with parents accessing their services, but some lack confidence to do this.
- These results highlight the importance of equipping practitioners with the skill, knowledge, and confidence to engage in family-focused approaches.
- Further research needs to involve parents experiencing SMI as well practitioners working in adult mental health services.

Approximately 50–70% of people with serious mental illness (SMI), such as psychosis, are parents of dependent children (Bee *et al.*, 2014; Reupert, Maybery, Nicholson, Gopfert, & Seeman, 2015). Comprehensive reviews highlight an increased risk of adverse outcomes for parents and children in families in which a parent has SMI (Bee *et al.*, 2014; Schrank, Moran, Borghi, & Priebe, 2015). Poor outcomes for parents include relapse leading to rehospitalization, custody loss, and stigmatization (Schrank *et al.*, 2015). For children, risks include poorer mental and physical health and increased emotional, social, and behavioural difficulties which can be compounded in adulthood (Bee *et al.*, 2014). The association between parental SMI and lasting adverse outcomes for children has led public health and political bodies to address the challenges faced by these families (Bee *et al.*, 2014; National Institute for Health and Clinical Excellence (2014); Diggins, 2011).

Parenting interventions can increase overall well-being in families, improve parenting practices, and help to prevent psychological difficulties in children (Barlow, Bennett, Midgley, Larkin, & Wei, 2015; Barlow & Coren, 2017; Kendrick *et al.*, 2008). Parenting interventions are targeted approaches which involve the primary caregiver in structured activities in order to increase positive parenting behaviours such as nurturing, teaching, monitoring, disciplining, management, and language development. They can involve different approaches such as group-format programmes and 1:1 self-directed parenting interventions. Earlier intervention appears more effective in improving long-term outcomes for families (Cicchetti, Rogosch, & Toth, 2006; National Institute for Health & Clinical Excellence, 2012). Research also highlights the influence and importance of involving the family as part of preventing and managing SMI, with family intervention a recommended treatment approach (National Institute for Health & Clinical Excellence, 2014). The importance of parenting as a stressor in its own right is increasingly recognized, as is the need for interventions to reduce this stress; however, there is a lack of research into parenting interventions for families in which a parent has psychosis or other SMI (Bee *et al*, 2014). It is unclear whether improving services for parents with SMI could be achieved by facilitating better access to mainstream services or by adapting interventions to the specific challenges of SMI.

Studies investigating the feasibility and acceptability of parenting interventions in SMI have yielded promising results (Butler, Hare, Walker, Wieck, & Wittkowski, 2014; Butler-Coyne, Hare, Walker, Wieck, & Wittkowski, 2017; Jones *et al.*, 2015). Furthermore, research into the impact of a self-directed parenting intervention involving children and parents with psychosis (Wolfenden *et al*, (unpublished doctoral thesis)) indicated positive effects on parental mental health as well as child behaviour. These findings highlight the possibility of a reciprocal interplay between parenting stressors and mental health, as well as the potential gains of supporting parents experiencing SMI in self-directed parenting interventions. Further research is required to consolidate these findings. However, it is conceivable that such work could improve family functioning and

have a direct and positive impact on the well-being of adults experiencing SMI who face the challenge of managing their mental health alongside the stressors of parenting.

A systematic literature review underlined international support for incorporating parenting interventions into adult mental health services (Maybery & Reupert, 2009). This review showed that efforts to implement family-focused practice within services were often impeded by barriers at a practitioner and workplace level, highlighting that personal attitudes, beliefs about job role, and perceptions of workplace support were the most influential factors in implementation.

Given the need to better understand the acceptability of incorporating family-focused work by adult mental health practitioners in a UK context, this study sought to explore beliefs relating to parenting and psychosis held by practitioners using Q methodology (Stephenson, 1953). Q methodology offers the opportunity to investigate patterns of shared beliefs by presenting diverse and complex views for participants to consider and rank. This study specifically asked: (1) What were practitioners' beliefs regarding the parenting needs of adults experiencing psychosis who have dependent children? (2) What were their beliefs about their role as adult mental health practitioners in terms of meeting any identified parenting needs?

Method

Design and ethical approval

Q methodology (Stephenson, 1953) was chosen as a means of investigating the subjective perspectives of practitioners. An exploratory tool recognized for its utility in service development (Watts & Stenner, 2005), it enables researchers to quantitatively establish consensus across the sample and supplement these data with richer, qualitative information (Willig & Stainton-Rogers, 2008). Ethical approval was granted by the University Research Ethics Committee.

Participants

To meet inclusion criteria, participants had to be aged 18 or over, currently employed as clinical practitioners working with adults experiencing psychosis, and have prior experience of working clinically with at least one adult with psychosis who was the parent of a dependent child (i.e., aged 0–17 years). Purposive sampling was used to attain a sample that represented the typical composition of adult mental health teams. It also facilitated a way to recruit 'information-rich' individuals (Hennink, Hutter, & Bailey, 2011) to ascertain more nuanced perspectives and expert knowledge of working within the field of adult mental health. Service managers in the north west of England were approached with information about the research. Interested practitioners who met inclusion criteria were offered the option of completing a paper version of the study face-to-face with the researcher, or doing the study online using 'htmlq' – a bespoke questionnaire management system (https://github.com/aproxima/htmlq).

Development of the Q concourse

The Q concourse was developed to present the diversity of views regarding the topic of parenting within the context of parental SMI (Watts & Stenner, 2005). It was derived from existing literature and from transcripts of research interviews with mental health

Table 1. Factor arrays

No.	Item	Factors		
		1	2	3
1	The parenting needs of parents with psychosis are the same as every other parent	−1	−1	−4
2	Parents with psychosis have additional needs compared to parents without mental health difficulties	+2	+4	−3
3	Being a parent is a positive resource for the parents I work with – it acts as a motivator and provides stability	+3	+3	−1
4	Parents with psychosis tend to be open about seeking help for any parenting needs they might have	−4	0	−4
5	For parents with psychosis, any parenting needs are often at the bottom of the agenda	−2	−4	+1
6	Perceived stigma and shame stops parents with psychosis seeking help for their parenting needs	+3	+3	+3
7	By assuming parents with psychosis have additional parenting needs, they are automatically stigmatised	−1	+1	0
8	Parents with psychosis often don't recognise their own parenting needs	−1	0	+4
9	The main need of parents with psychosis is knowing what practical and emotional support is out there	+1	+1	+4
10	The primary parenting need of parents with psychosis is good access to mental health services	+1	0	+5
11	Parents with psychosis need factual information about the basic skills of parenting	+1	−1	−2
12	Parents with psychosis need help in setting up routines, structure and boundaries for their children	0	−1	+1
13	The main parenting need of parents with psychosis is negotiating their own mental health difficulties alongside adjusting to their role of being a parent	+2	+2	+1
14	Building self-esteem and confidence is the main parenting need for parents with psychosis	0	0	+2
15	The biggest need for parents with psychosis is feeling they can speak about parenting needs without fearing their children will be removed	+4	+3	+3
16	The main parenting need of parents with psychosis is being put in touch with other people	−1	−2	−1
17	The parenting needs of parents with psychosis are more closely linked to their social circumstances than their mental health	0	−1	+4
18	The main parenting need of parents with psychosis is about dealing with day-to-day clashes with their children	−3	−1	−2
19	Child wellbeing is outside the remit of adult mental health services	−5	−5	−3
20	Parenting interventions should not be part of routine care in adult mental health services	−3	−2	0
21	Delivering parenting interventions should be the role of other services	−1	0	+1
22	My focus is on getting the parent well because then parenting looks after itself	−2	−3	+5
23	Parenting issues are not significant in the work I do with adults with psychosis who have children	−4	−3	−2
24	My workload is too high to offer parenting interventions	+1	0	0
25	I wouldn't have the time to do parenting intervention training	−2	−2	0

Continued

Table 1. (*Continued*)

No.	Item	Factors 1	2	3
26	Parenting interventions are not appropriate to my role with parents because I do not have direct contact with children	−5	−5	0
27	In terms of parenting issues, my role should be limited to flagging whether my patients have children and raising safeguarding-type concerns if necessary	−4	−2	0
28	Any assessment should consider the needs of a client's children and identify the support required by the client in assuming his or her parenting role	+5	+5	−1
29	My role should include signposting parents with psychosis to parenting intervention services	+1	+4	+5
30	My role should be about offering practical things to parents rather than addressing parenting needs	−2	−2	−2
31	Having discussions about parenting and giving parenting advice would feel intrusive	−2	−4	−1
32	Adult mental health professionals should be working alongside professionals whose role is specifically about parenting	+2	+4	+1
33	Doing parenting work is pointless if a person's mental health is very unstable	−3	−3	−3
34	I worry that if I mention parenting, the parent won't want to see me again	−3	−4	2
35	I don't know enough about parenting, supporting families or child development to offer a parenting intervention	−1	+1	−1
36	It is easy to just focus on the adult and forget they are a parent with a child	0	+1	+4
37	I would be anxious at the thought of including parenting interventions as part of my role	−3	+2	+1
38	Offering a parenting intervention as part of adult mental health services would make the parent feel worse about their parenting	−5	−3	−1
39	Addressing parenting issues would interfere in the relationship between the service user and me	−4	−3	−1
40	I feel inadequately trained for the task of using parenting interventions with my clients	0	+3	−4
41	The emotional and practical support needs of parents with psychosis are best met through informal resources, like relatives and friends	−2	−1	−3
42	Adult mental health practitioners need to be thinking about the needs of the children of the parents they see	+4	+5	+2
43	My role should be about enhancing parenting confidence to help parents balance the demands of parenting with their own needs	+3	+3	+2
44	Including parenting interventions as part of our service would help parents with psychosis not feel exposed or stigmatized	+4	+1	+2
45	Parenting interventions should be part of the expertise of an adult mental health practitioner	+2	+2	−4
46	Not offering one-to-one parenting interventions to parents in our service is negligent	0	−2	−5
47	I think we over-rely on parenting referrals to other services	0	−1	−5
48	The parent's mental health difficulties can be amplified by the roles and responsibilities of being a parent	+5	+5	+2
49	Parenting interventions should be part of our role because mental illness impacts on parenting and parenting impacts on mental health symptoms	+5	+2	−2

Continued

Table 1. (*Continued*)

No.	Item	Factors 1	2	3
50	I am in a good position to be offering parenting interventions because if a parent is coming to see me I already have one foot in the door	+2	+1	−3
51	I would be in a better position to address the parenting needs of a parent with psychosis than referring them to a parenting group	+1	−4	−5
52	I can spot problems with parenting in the parents that I see but don't know how to help	−1	0	−2
53	Using my current skills, I would feel comfortable doing one-to-one parenting interventions with parents with psychosis	+2	−5	0
54	Parenting interventions should be a part of adult mental health services because practitioners understand where the parent's coming from	+3	+1	+1
55	There should be a special parenting team within our service	0	0	+3
56	If I were to offer a one-to-one parenting intervention, it would be important that it fitted with my existing skills	+1	+2	+3
57	With training I would use parenting interventions as part of my role working with parents with psychosis	+4	+4	0
58	Part of my role should be about discussing parental goals as well as feelings of reluctance and obstacles to accepting help	+3	+2	+3

practitioners about the unmet needs of parents with SMI (unpublished doctoral thesis, Wolfenden). The research team condensed the concourse by extracting key themes which represented the range of beliefs that adult mental health practitioners held about parenting in the context of SMI. This involved ensuring that the items comprising the Q set represented all possible belief statements (insofar as this is possible) and thereby embodied the broad range of opinions on this topic. The final Q sample comprised 58 items: 40 derived from interviews and 18 from the wider literature. Items included belief statements such as 'The parenting needs of parents with psychosis are the same as every other parent' and 'Child wellbeing is outside the remit of adult mental health services' (see Table 1 for all included statements).

Procedure and Q sort administration

After consenting, participants provided demographic information and detailed their knowledge and/or experience of parenting interventions in their employed role.

The 58 statements were presented in a random sequence for participants to sort into applicable categories on a response grid with 58 spaces (see Figure 1). Participants were informed that the statements were derived from research with practitioners working with parents experiencing SMI. They were prompted to rank the statements according to how much they agreed or disagreed with the belief stated.

Participants were initially asked to divide statements into three groups: (1) statements they tended to agree with, (2) statements they tended to disagree with, and (3) statements they felt neutral or ambivalent about. Participants then selected the three statements they most strongly agreed with and placed them in the furthest right hand of the response grid ('+5'). They then selected the three statements they disagreed with most strongly, placing them in the furthest left-hand column of the grid ('−5'). Participants then chose the four

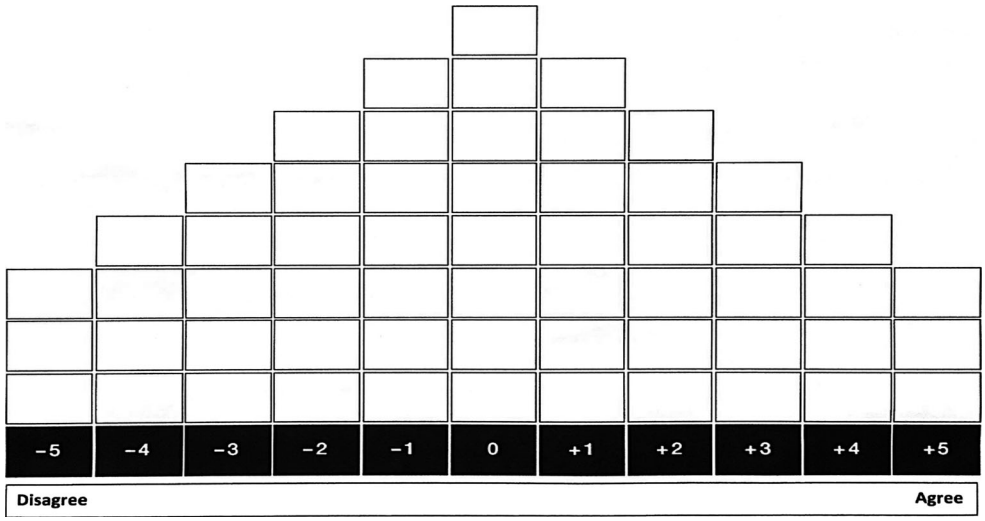

Figure 1. Response grid.

statements from their 'Agree' pile they next most strongly agreed with and placed them in the respective column ('+4'). When all statements in the 'Agree' and 'Disagree' piles had been allocated, the participant was encouraged to rank their 'Neutral' statements accordingly in the middle of the response grid. This process was repeated until all statements were allocated within the response grid, forcing a quasi-normal distribution of the data.

Afterwards, participants were invited to rearrange their Q sort if desired. Finally, they explained why they agreed and disagreed most strongly with the statements they had ranked as '+5' and '−5'.

Data analysis

Each participant's Q sort was analysed using 'by-person' factor analysis (Watts & Stenner, 2005): a process which groups together participants who have ranked statements in similar ways to produce 'factors'. The average sort for each factor is called a 'factor array'. Data were analysed using the Q methodology-specific statistical programme 'PQMethod' (Schmolck, 2014). This programme computes intercorrelations amongst the Q sorts and analyses them using principal component analysis. To maximize the variance explained by the resulting factors, factors were rotated analytically through the Varimax procedure. Each factor was interpreted in terms of how the statements had been ranked ('endorsed') and any additional information provided (e.g., demographic and qualitative data). 'Distinguishing statements' (items which had been ranked in a different way for specific factors at a statistically significant level) and 'consensus statements' (items that were not ranked significantly differently between groups of respondents) were also examined.

Telephone follow-up interviews were conducted with three participants to ensure that factor interpretation fitted with the belief set of practitioners who represented that factor ('factor exemplars') (Watts & Stenner, 2005). Comments from the textual responses and follow-up interviews of participants who represented the identified factors are included below.

Results

Sample characteristics

Sample size in Q methodology is guided by the premise that there are fewer participants than Q sort items and that the breadth, depth, and quality of participant responses are prioritized over the recruitment of large numbers (Watts & Stenner, 2005). Thirty-five practitioners expressed an interest in taking part: 21 completed the Q sort with 19 doing so online. The remaining 14 interested participants reported discontinuing the study due to technical difficulties.

Practitioners reported working with mothers and fathers from the most commonly represented ethnic groups in the United Kingdom. Parents ranged in age from 18 to over 65 and had children aged 0–17. See Table 2 for further information on participants' demographic data.

Q sort analysis and interpretation

Principal component analysis provided a three-factor solution explaining 63% of the variance, onto which all 21 Q sorts loaded. Twelve participants loaded onto Factor 1 (explaining 50% of the variance), eight participants loaded onto Factor 2 (7%), and one participant loaded onto Factor 3 (6%). The accounts encompassed by the three factors were labelled: 'Parenting interventions are worthwhile, and I'd deliver them', 'Parenting interventions are worthwhile, but I'm not confident to deliver them', and 'Parenting interventions might be worthwhile, but it's not my responsibility'. Ten of the 21 participants had work-related experience of parenting intervention services; seven loaded onto Factor 1 and three onto Factor 2. No notable differences between factors were observed in terms of participants' demographic data, including professional group, as professions were generally evenly distributed between factors. See Table 1 for factors arrays.

Factor 1: Parenting interventions are worthwhile, and I'd deliver them

This factor was made up of 12 people who saw the interplay between parenting stressors and mental health difficulties as a 'vicious cycle' (P14). As one Factor 1 exemplar described: 'Having psychosis and being a parent both inform and have an impact on an individual's wellbeing. To incorporate both aspects of a person's life can have a positive impact on the work that is being completed' (P20). This group described themselves as reasonably confident, capable, and willing to support parents using parenting intervention approaches if this kind of work was supported in adult mental health services.

People loading onto Factor 1 endorsed beliefs such as parenting interventions should be part of their role due to the impact of mental illness on parenting and the impact of parenting on mental health symptoms (+5). They also endorsed that adult mental health assessments should routinely incorporate potential parenting and child needs (+5) and rejected the idea that parenting issues were insignificant in adult mental health work (−4). They agreed that mental health difficulties could be amplified by a client's parenting responsibilities (+5) and believed that including parenting interventions as part of their service might reduce the extent to which parents with psychosis felt exposed or stigmatized (+4). They endorsed parenting interventions being part of adult mental health services because practitioners 'understand where the parent's coming from' (+3).

Importantly, they indicated that they would use parenting interventions given training (+4) and were confident about their ability to do so, denying that they felt anxious about using parenting intervention approaches (−3). They were not concerned that parenting issues would interfere in their relationship with clients (−4) or make it less likely their clients would want to see them again (−3). Additionally, they did not believe that offering parenting interventions might make the parent feel worse (−5). With their current skill set, they felt somewhat comfortable doing one-to-one parenting interventions (+2) and better positioned to address such needs than referring the person to a parenting group (+1). This analysis was validated in a follow-up interview with a Factor 1 exemplar who, when describing their experience working with a parent who had psychosis, explained:

> I seem to have been the only person that she's trusted. . . to be able to safeguard really her and the children's needs. It's that trust part in mental health that is absolutely vital. . . children's services are great, but they know very little about mental health, and it's another person coming into their lives, another person that they have to trust. . . I would think. . . we would have the holistic skills to be able to manage that. (P18)

Factor 2: Parenting interventions are worthwhile, but I'm not confident to deliver them

As with Factor 1, there was consensus amongst people loading onto Factor 2 that the needs of parents experiencing psychosis and their children should be considered as part of the clinical remit of adult mental services. However, in contrast to the first group, these participants expressed limited confidence and competence in their ability to meet these needs. One Factor 2 exemplar said: 'My work is about wellbeing and if [a] parenting intervention is what is needed. . . I would be anxious personally, as currently this is outside my expertise' (P19).

Participants in this group also agreed that a parent's mental health difficulties could be amplified by the roles and responsibilities of being a parent (+5) and that adult mental health assessments should include ascertaining support for the parenting role (+5). They strongly believed that practitioners should consider the needs of their client's children (+5), believing that parents with psychosis had additional needs compared to those without mental health difficulties (+4). Whilst believing their job should involve working alongside professionals whose role was specifically around parenting (+4), they also endorsed using parenting interventions if training was provided (+4).

This group of practitioners did not believe that child well-being was outside the remit of adult mental health services (−5) nor agree that parenting interventions are inappropriate due to lack of direct contact with clients' children in adult mental health (−5). Strikingly, however, this group strongly did not feel comfortable doing one-to-one parenting interventions using their existing skills (−5) or that they were better positioned than external services to address the needs of parents with psychosis (−4). These concerns were not related to fears about parents' reactions – they disagreed that advisory parenting discussions would feel intrusive (−4), or that by mentioning parenting, the client was unlikely to want to see them again (−4). Thus, this group's ambivalence appears to stem from a lack of confidence in their ability to incorporate parenting approaches into their clinical work, rather than from a belief that parenting issues are insignificant in adult mental health or that parents might not be receptive to parenting intervention.

Notably, compared to Factor 1, Factor 2 participants felt less well trained to use parenting interventions with clients (+3 compared to 0) and reported more anxiety about

incorporating parenting interventions within their role (+2). With regard to parenting issues, they more strongly agreed that their role should include signposting (+4) and less strongly rejected the idea that their role only required identifying clients' children and raising any safeguarding-type concerns (+2). A follow-up interview with one factor exemplar indicated this collective standpoint fitted with their own belief set, explaining:

> I'm not trained in it, I don't have personal experience either, and erm, I wouldn't feel that I could teach a parent anything, really. . . as long as there was training in place, I could try and take it on board. . . [I'd need] quite a lot, I still, I still wouldn't feel that confident. (P19)

Factor 3: Parenting interventions might be worthwhile, but it's not my responsibility

Only one participant loaded significantly onto Factor 3, but this sort highlighted an important view. Mental health difficulties and parenting stressors were seen as interrelated, but parenting intervention work for clients with dependent children was believed to be the remit of other services. This participant explained: 'Parenting groups are evidence-based parenting interventions, don't they have the best outcomes with parents with psychosis? If a service is designed and commissioned to receive referrals of this nature – refer away!' (P21).

This participant strongly endorsed 'getting the parent well because then parenting looks after itself' (+5). As such, parents with psychosis needed good access to mental health services (+5) which made the adult mental health practitioner's role about increasing parents' knowledge of practical and emotional support (+4) and signposting parents to parenting intervention services when appropriate (+5). This person also reported that it was easy to focus only on the adult, forgetting they were a parent (+4).

This participant strongly disagreed that not offering one-to-one parenting interventions to parents in their service was negligent (−5) or that they were better positioned to address parenting needs than a parenting group (−5). Whilst they did not feel inadequately trained for the task of using parenting interventions with clients (−4), they also did not believe that parenting interventions should be part of the expertise of an adult mental health practitioner (−4). By strongly refuting the claim that they over-relied on external parenting referrals (−5), this person communicated that parenting needs of parents with psychosis could be better met by other services.

Factor 3 highlighted views in stark contrast to Factors 1 and 2. Rather than seeing parenthood as motivating and stabilizing, being a parent was not necessarily seen as a positive resource for the clients accessing mental health services in Factor 3 (−1). Factor 3 also advocated more strongly for a special parenting team within their service compared to participants in Factors 1 and 2. When interviewed, this participant explained:

> I just don't feel like that's the role in adult mental health, because someone's got to advocate for the parent. . . Let's try and stabilise the person and put things in place for them. . . the fact that there is very limited, if not ever, enough kind of communication between adult and child services; that is a problem. That's the problem, I think, about this.

Distinguishing statements

The distinction between all three factors was illustrated in the following statistically distinguishing statement (significant at $p < .01$): 'Parenting interventions should be part

Table 2. Participant demographic information

Sample characteristics	Participants (n = 21)
Age (years)	Age range: 29–59 (30)Mean: 42.7 (*SD*: 9.1)
Sex	15 female (71%)6 male (29%)
Ethnicity	19 White British (90%)1 White Irish (5%)1 Caribbean (5%)
Employment role	8 Clinical Psychologists – 2 in training (38%)3 Social Workers (14.5%)3 Care Coordinators (14.5%)2 Psychiatric Nurses (9.5%)2 Support Workers – 1 in training (9.5%)2 Team Managers (9.5%)1 Therapist (4.5%)
Work setting	17 from Community Mental Health Teams (CMHTs) (81%)2 from EIs (9.5%)2 from Perinatal CMHT (9.5%)
Experience working with parenting adults experiencing psychosis (years)	Length of experience: 0.5–28 (27.5)Mean: 11.5 (*SD*: 8.6)

Note. *SD* = standard deviation.

of our role because mental illness impacts on parenting and parenting impacts on mental health symptoms'. Factor 1 participants strongly agreed with this item (+5), seemingly endorsing both aspects of this statement about the bidirectional impact of parenting and mental health and the clinician's role in addressing such challenges. Factor 2 rated it as +2 (seemingly believing it to be important but feeling hesitant about their role), and Factor 3 rated it as −2 (seeing this as important work for *other* services).

It is striking that beliefs about being 'inadequately trained' in parenting matters were also a distinguishing statement. The Factor 3 participant strongly disagreed that they were inadequately trained to use parenting interventions with clients (−4), but Factor 2 participants did believe this (+3) whilst Factor 1 participants were ambivalent (0). Thus, it seems attitudes towards incorporating parenting approaches in adult mental health work can be influenced by clinicians' beliefs about their own competence and confidence, and what they feel able, or willing, to do.

Consensus statements

All participants agreed that perceived stigma and shame stops parents with psychosis seeking help for their parenting needs. They reported that the biggest need for parents with psychosis was feeling able to speak about parenting needs without fearing their children would be removed as a consequence. The belief that 'assuming parents with psychosis have additional needs is automatically stigmatizing' was not strongly endorsed by any factor, and all groups disagreed that parenting work was 'pointless' if a person's mental health was very unstable. Notably, practitioners did not endorse the belief that parents with psychosis needed help in setting up routines, structure, and boundaries for their children, or that practitioners' workload was too high to offer parenting interventions.

Discussion

This study is the first to explore the acceptability of incorporating parenting interventions into the work of practitioners in UK adult mental health services. Q methodology allowed

for the exploration of how practitioners clustered in their views about incorporating family-focused work in adult mental health, specifically with regard to psychosis and parenting. Although the third factor comprised just one individual and cannot be assumed to represent a shared narrative, these findings illustrate the beliefs that may be held by practitioners about the parenting needs of adults experiencing psychosis who have dependent children, as well as their own professional role in meeting any identified parenting needs. By exploring these three accounts within the context of the wider literature, the overall acceptability of incorporating parenting interventions within UK adult mental health services can be better gauged and have implications for similar work internationally.

Beliefs about the parenting needs of parents experiencing psychosis

Participants believed that the impact of parenting stressors on mental health challenges was two-directional and cyclical – a finding that is supported in the wider research literature (Goodyear *et al.*, 2015; Tchernegovski, Hine, Reupert, & Maybery, 2018; Ward, Reupert, McCormick, Waller, & Kidd, 2017). Participants consistently endorsed the need for parents to feel able to speak about parenting needs without fearing the removal of their children. Perceived stigma towards parents experiencing mental health difficulties is highlighted throughout the research literature. A review published in 2013 exploring the experience of motherhood within the context of SMI underscored the stigma perceived by both mothers and health care professionals (Dolman, Jones, & Howard, 2013). Whilst the participants in the current study reported that perceived stigma and shame stopped parents with psychosis seeking help for their parenting needs, they disagreed that assuming parents with psychosis have additional needs was automatically stigmatizing. Studies in the Dolman *et al.* (2013) review largely focused on staff in inpatient psychiatric settings, whilst the current study recruited from community mental health teams. This disparity might be attributable to the different settings, but the need to find ways to address preconceptions around parental mental illness and better facilitate support for these parents is once more reasserted.

Most practitioners did not believe that parents experiencing psychosis had any specific parenting needs in terms of practical, emotional, or social support. At the same time, the parenting needs of parents with psychosis were believed to be different to parents *not* experiencing psychosis. This apparent contradiction might reflect a perceived role of practitioners to normalize and advocate within adult mental health, whilst simultaneously witnessing the challenges faced by the individuals accessing their service. These incongruous findings add more weight to calls for further research so that evidence-based parenting interventions can be developed for and offered to parents experiencing SMI (Bee *et al.*, 2014; Schrank *et al.*, 2015).

Beliefs about practitioners' roles in meeting parenting needs

Perhaps recognizing the interplay between parenting and mental health stressors, all participants refuted the claim that there was no merit in parenting work if a person's mental health was unstable. In contrast to previous research (Lauritzen & Reedtz, 2013; Ward *et al.*, 2017), this study found that issues concerning high workload were not perceived as a barrier to offering parenting interventions – results that are more akin to findings by Maybery *et al.*(2016). Together, these findings lend weight towards considering introducing parenting interventions into adult mental health services.

Despite the consensus that parenting impacts on mental health and vice versa, practitioners differed in their beliefs about their role with respect to this. This is an important finding, as recent research reports that beliefs about job role were crucial to the successful implementation of family-focused approaches in adult mental health services (Tchernegovski, *et al.*, 2018). Most participants showed willingness to incorporate parenting interventions into their work, but there was stark contrast between practitioners' level of confidence in doing so.

Twelve participants felt ambivalent about their training in this area, eight felt inadequately trained, and one felt sufficiently trained. As is emerging in the wider literature (Goodyear *et al.*, 2017; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2015; Maybery *et al.*, 2016; Tungpunkom, Maybery, Reupert, Kowalenko, & Foster, 2017), self-assessed skill and knowledge, as well as a perceived need for further training, may be influential in adult mental health practitioners adopting family-focused approaches. The current findings suggest most practitioners are amenable to incorporating parenting interventions into their work, but this may be dependent on training and management support to encourage and maintain confidence.

Overall acceptability of parenting interventions within adult mental health

Findings showed that using parenting interventions as part of their clinical work in adult mental health services was acceptable to most practitioners. All participants reported that parenting issues were significant to an extent in mental health work. This finding is important because it suggests that recent policy drivers seeking to address the challenges faced by families experiencing parental SMI are considered by those on the frontline (Bee *et al.*, 2014; Department of Health, 2011; Social Care Institute for Excellence, 2011). Indeed, whilst most expressed willingness for a greater family-focus within their role remit, improved communication between adult and child services was another approach emphatically proposed. This observation fits with findings across the literature that adult mental health practitioners are largely receptive to the support of their client's children, but currently face significant challenges regarding professional and workplace barriers including cross-service collaboration (Maybery & Reupert, 2009).

Strengths and limitations

This study contributes to the emerging literature examining mental health practitioners' attitudes towards identifying and meeting the support needs of parents experiencing mental health difficulties. The use of online Q methodology minimized the potential impact of social desirability bias and the inclusion of diverse viewpoints allowed us to discover subjective perspectives on a topic that could be socially contested.

A limitation of this study lays in possible sampling bias. Purposive sampling helped to ensure each discipline within a typical mental health team was represented, but attempts to recruit from psychiatry were unsuccessful. It is also conceivable that the practitioners who were most focused on research and service development were disproportionately represented. As such, the views of the participant who loaded onto Factor 3 might have highlighted beliefs shared more widely throughout adult mental health teams, and hence the reported willingness of practitioners to incorporate parenting interventions could be overstated. As with all

Q studies, whilst efforts were made to include the diversity of views on this topic, some beliefs may have been unintentionally omitted.

Clinical implications

Practitioners largely agreed that including parenting interventions as part of their service might reduce the extent to which parents with psychosis felt exposed or stigmatized. On balance, practitioners did not feel this would be poorly received and negatively impact the therapeutic relationship, despite this concern being raised in other literature (Maddocks *et al.*, 2010; Tchernegovski, Reupert, & Maybery, 2017). Finding ways in which to have transparent and supportive conversations about parenting needs is therefore likely to benefit the client and family. Such conversations can be fostered by boosting workplace support via supervision, multi-disciplinary team discussions, and by both informal and formal debrief sessions (Grant & Reupert, 2016; Slack & Webber, 2008; Tchernegovski *et al.*, 2018). This might be best led by practitioners whose role requires broad training in service delivery and provision of supervision across varied mental health issues and client groups, such as that of clinical psychologists whose training spans the breadth of mental health clinical work alongside professional leadership and service development.

There was also support for the increased identification of children as part of assessment with adults accessing services. As Laurtizen et al. (2015) highlight, this is the first step towards facilitating a family-focused approach to bridge gaps between child and adult services. Such a 'blanket approach' across services might also contribute to reducing the stigma recognized by both service users and mental health practitioners. Efforts to ensure teams have good knowledge and links to local parenting service provision would encourage signposting to support parents and likely have positive, more immediate implications for families.

Research implications

This study provides some early support for the acceptability of parenting interventions in adult mental health services. Future research should explore what parenting interventions would be most suited to an adult mental health service context and how these might best be implemented. Such research should be conducted in line with the MRC framework to ensure the development, evaluation, and implementation of such interventions are of high quality (Craig *et al.*, 2006). Since most practitioners agreed that they would use parenting interventions given training, research drawing on the expert knowledge of parents and practitioners working in adult mental health would help address the current evidence gap regarding interventions that specifically address the needs of parents with SMI.

Conclusion

This study reflects a willingness of most practitioners to engage in more family-focused approaches. By situating the three factors identified in the context of the wider literature, this study contributes towards research exploring the acceptability of incorporating parenting interventions into practitioners' work with parents accessing mental health services. In doing so, it highlights the need to enhance practitioner skill, knowledge, and confidence to work in a family-focused way and thereby help provide increased and better

support to parents, children, and families living with the challenges of parental mental illness.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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