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Parenting in the context of mental health difficulties:

**Parental experiences, support needs and the
engagement of mental health services**

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Submitted in fulfilment for the degree of Doctor of

Philosophy

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Dr Helen Startup

Declaration of originality

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature: A Dunn

Summary

UNIVERSITY OF SUSSEX

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PhD Psychology

Parenting in the context of mental health difficulties: Parental experiences, support needs and the engagement of mental health services

Background

Children of parents with mental health difficulties (MHD) are at increased risk of poorer outcomes, including of developing a psychiatric disorder. Interventions to support the parenting of individuals with MHD are advantageous to both parent and child. When a parent is treated within the mental health system there is an opportunity to identify their support needs in relation to their child.

Methods

Presenting four research studies, this thesis describes the experience and support needs of parents with MHD and the engagement of mental health services with these needs: (1) Qualitative exploration of the experience and support needs of parents (n = 12) with borderline personality disorder and practitioners (n =21) who work with them. (2) National survey of 1105 mental health workers to measure engagement and attitudes towards 'patient as parent'. (3) Systematic review of the experience of psychiatric inpatients who are parents and of parenting-focused interventions. (4) Pilot of a group-based intervention for NHS workers with dependent children.

Results

Parents with MHD describe challenges to parenting and a desire for support in their role as a parent. The limited availability of support was identified by both parents and their clinicians (1). This was mirrored in the survey mental health practitioners which found that 25% of adult mental health practitioners did not routinely ascertain whether patients had dependent children and under 50% engaged with parenting experience or support needs (2). There is no evidence of current UK interventions to support parents who are in receipt of inpatient care despite the clear difficulties they describe (3). Supporting mental health workers who are parents improved their parenting practice (4).

Discussion

Despite the manifest and stated support needs of parents with mental health challenges, there remains a clear lack of provision of this support within UK mental health services.

Acknowledgements

Throughout the programme of study and research presented in this thesis I have been fortunate to receive support and encouragement from a large number of individuals.

First and foremost, I would like to thank my supervisors Sam Cartwright-Hatton and Helen Startup. You have both played a formative role in the development of my thinking and hopefully the work contained in this thesis reflects some of the ideas and excitement that supervision with you offered to me. Sam, I would also like to thank you for the support and opportunities you have given me as I take steps forward in my academic career. I feel fortunate to have such a champion.

Being part of the Department of Psychology has been a pleasure and I would like to acknowledge the friendship and the support of my fellow doctoral students and the wider community of academics and all department members.

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I am fortunate to have carried out much of my research within Sussex Partnership NHS Foundation Trust. I would like to acknowledge the support of the Research and Development Team there who have provided invaluable guidance and assistance.

I wish to thank the patients, carers and staff members who have given their time to my projects. The work contained in this thesis would not exist without your involvement. I would like to give particular thanks to those who agreed to be interviewed. It was a privilege to hear your stories.

I would like to thank my family and friends. Firstly, my parents who probably did not ever imagine (and they had high hopes) that I would be submitting a thesis one day. Thank you for everything. Friends, you make everything easier – I am so grateful to you all.

Finally, I would like to thank my three favourite people: Egg, Rosa and Otto. I love you very much.

Table of Contents

Contribution to co-authored papers.....	13
1. Introduction	14
1.1. Setting the scene: Why the mental health of parents is important.....	14
1.1.1. Parenthood in context	14
1.1.2. Prevalence of parental mental health difficulties.....	15
1.1.3. The impact of parental mental health difficulties.....	17
1.1.4. Risk factors for the intergenerational transmission of poor mental health	19
1.1.5. Interventions to support families where a parent has mental health difficulties.....	22
1.2. Supporting parents within Adult Mental Health Services.....	25
1.2.1. A socio-ecological conception of the family	25
1.2.2. Supporting ‘Patient as Parent’ thinking within Adult Mental Health Services.....	27
1.3. The package of work.....	29
1.3.1. Study 1. Exploration of parenting in the context of borderline personality disorder traits	30
1.3.2. Study 2. Survey of mental health practitioner engagement with ‘patient as parent’ thinking	32
1.3.3. Study 3: Systematic review of the experiences of psychiatric inpatients who are parents, and interventions delivered to them.....	33
1.3.4. Study 4. Pilot intervention for mental health workers who are parents	34
1.4. The Impact of COVID-19	36
2. The parenting experience of those with borderline personality disorder traits: practitioner and parent perspectives. (Study 1.)	37
2.1. Abstract.....	37
2.1.1. Background:	37
2.1.2. Aims:	37

2.1.3. Methods:	37
2.1.3. Results:	38
2.1.4. Conclusion:	38
2.2. Contribution to the field	38
2.3. Background	39
2.4. Methods	43
2.3.1. Ethics	43
2.3.2. Recruitment	43
2.3.3. Participant Characteristics	45
2.3.4. Procedure	46
2.3.5. Analysis	47
2.4. Results	49
2.4.1. Themes related to parenting experience	49
2.4.2. Themes related to support	64
2.5. Discussion	68
2.6. Limitations	71
2.7. Clinical implications	72
3. Adult mental health service engagement with patients who are parents: evidence from 15 English mental health trusts. (Study 2.)	75
3.1. Abstract	75
3.1.1. Objectives:	75
3.1.2. Methods:	75
3.1.3. Results:	75
3.1.4. Conclusions:	76
3.2. Contribution to the field	76
3.3. Background	77

3.3. Methods.....	80
3.3.1. Ethics.....	80
3.3.2. Recruitment.....	80
3.3.3. Participant characteristics.....	80
3.3.4. Materials.....	81
3.3.5. Analysis.....	83
3.4. Results.....	85
3.4.1. ‘Think Patient as Parent’ Practice.....	85
3.4.2. Attitudes towards and beliefs about ‘Think Patient and Parent’ practice.....	87
3.4.3. Interdisciplinary and inter-team differences in ‘Think Patient and Parent’ practice and attitudes.....	88
3.5. Discussion.....	90
3.6. Clinical implications.....	94
3.7. Limitations.....	94
4. Psychiatric inpatients who are parents: what parenting support is given to them and what do they want? A systematic review [and data synthesis] (Study 3).	97
4.1. Abstract.....	97
4.1.1. Objectives.....	97
4.1.2. Methods.....	97
4.1.3. Results.....	98
4.1.4. Conclusions.....	98
4.1.5. Registration:.....	98
4.2. Contribution to the field.....	98
4.3. Introduction.....	100
4.4. Methods.....	103
4.4.1. Protocol registration.....	103

4.4.2. Eligibility.....	103
4.4.3. Information sources.....	104
4.4.4. Search terms.....	104
4.4.5. Study selection.....	105
4.4.6. Data extraction.....	105
4.4.7. Methodological quality.....	107
4.4.8. Intervention data synthesis.....	108
4.4.9. Qualitative data synthesis and analysis.....	108
4.5. Results.....	109
4.5.1. Study characteristics.....	109
4.5.2. Results: Interventions for inpatient parents.....	109
4.5.3. Results: Parents' experiences of psychiatric inpatient care.....	114
4.6. Discussion.....	132
4.6.1. Summary of Results.....	132
4.6.2. Clinical Implications.....	134
5. Workplace support for mental health workers who are parents: a feasibility study. (Study 4.).....	138
5.1. Abstract.....	138
5.1.1. Background:.....	138
5.1.2. Design/methodology:.....	138
5.1.3. Results:.....	138
5.2. Contribution to the field.....	139
5.3. Introduction.....	140
5.4. Methods.....	143
5.4.1. Ethics.....	143
5.4.2. Recruitment.....	143

5.4.3. Participants	144
5.4.4. Materials	146
5.4.5. Design and procedure	149
5.4.6. Analyses	151
5.5. Results.....	151
5.5.1. Recruitment, sign-up and attrition	151
5.5.2. Outcome: parenting practice and experience	152
5.5.3. Outcome: wellbeing, stress, and occupational self-efficacy	152
5.5.4. Outcome: satisfaction	152
5.6. Discussion	154
5.7. Limitations	156
5.8. Next steps	157
6. Participatory Evaluation of a Parenting Programme with Parents with Challenges around Emotional Intensity (Study 5.)	159
6.1. Overview	159
6.2. Abstract.....	160
6.2.1. Background	160
6.2.2. Methods/Design	160
7. Discussion	162
7.1. Overview of findings	162
7.2. Foundational provision to support patients as parents.....	164
7.2.1. Identification of parenthood.....	164
7.2.2. Recognition of the parenting role and identity.....	165
7.2.3. Adapting to the functional needs of parents	167
7.3. Provision of interventions that foster connection	168
7.4. Engaging with the whole family system over time	172

7.4.1. Incorporating the child.....	172
7.4.2. The wider family	174
7.5. Collaboration around the family.....	175
7.5.1. Barriers and facilitators.....	176
7.5.2. Effective interagency working in England.....	178
6.6. Limitations and future opportunities.....	180
6.7 Conclusion.....	182
References	183
Appendixes	210

Tables

Table 2.1. Grid of superordinate [shaded] and subordinate themes (experience).	49
Table 2.2. Grid of superordinate [shaded] and subordinate themes (support).	63
Table 3.1. Participant characteristics.	80
Table 3.2. Means and standard deviations of Practice and Attitudes subscales.	82
Table 4.1. PICO's schema used to inform eligibility criteria.	101
Table 4.2. Participant characteristics of included intervention studies.	109
Table 4.3. Participant characteristics of inpatient parent 'experience' studies.	113
Table 4.4. Description of included intervention papers.	122
Table 4.5. Description of included qualitative papers.	125
Table 5.1. Participant demographic data displayed by group.	142
Table 5.2. Overview of the course content as delivered to participants.	147

Figures

Figure 1.1. The parent-child dyad within a socio-ecological model.	24
Figure 1.2. The relationship between studies included in this thesis.	29
Figure 3.1. Practice subscale items.	84
Figure 3.2. Attitude subscale items.	87
Figure 4.1. Flow diagram of studies included in the results.	98

Declaration of contribution to papers

I declare that I made the primary contribution to the papers (published and unpublished) contained within this thesis. I designed each of the studies, was responsible for gaining, ethical approval, carried out most data collection, conducted all analysis and was lead author on all papers. My supervisors (SCH and HS) provided oversight with regard to study design and implementation, engaged with qualitative data analysis, carried out document screening (SCH) and contributed to manuscript revision. Co-authors were involved in data collection (AT, CD), document screening (HC, ES, CEP, JK), qualitative data analysis (AP) and document revision. My contribution to co-authored works is described in more detail in the table below.

Contribution to co-authored papers

Title	Publication date	Research Q formulation / design	Lit. review	Data collection/ screening	Project management	Data analysis	1 st draft	Draft/ revise	Published version approval
The Parenting Experience of those with Borderline Personality Disorder Traits: Practitioner and Parent Perspectives. (Study 1.)	2020	✓ ✓ ✓	AD	AD	AD	AD	AD	✓ ✓ ✓	AD
Adult mental health service engagement with patients who are parents: Evidence from 15 English Mental Health Trusts. (Study 2.)	2022	✓ ✓ ✓	AD	AD	AD	AD	AD	✓ ✓ ✓	AD
Psychiatric Inpatients who are parents: what parenting support is given to them and what do they want? A systematic review [and data synthesis]. (Study 3.)	---	✓ ✓ ✓	AD	✓ ✓ ✓	AD	AD	AD	✓ ✓ ✓	AD
Workplace support for mental health workers who are parents: a feasibility study. (Study 4.)	2022	✓ ✓ ✓	AD	✓ ✓ ✓	AD	AD	AD	✓ ✓ ✓	AD
Additional publications during period of study									
Examining the Phenomenon of Quarter-Life Crisis Through Artificial Intelligence and the Language of Twitter	2020	---	✓ ✓	---	---	---	✓ ✓	✓ ✓	---
The impact of treating parental anxiety on children's mental health: An empty systematic review.	2022	---	---	---	---	---	✓ ✓	✓ ✓	---
KEY:	AD = Sole contributor		✓ ✓ ✓ = Lead contribution (>80%) with involvement of team (<20%)		✓ ✓ = Large contribution (60-80%)		--- = No contribution		

1. Introduction

1.1. Setting the scene: Why the mental health of parents is important

1.1.1. Parenthood in context

Becoming a parent is one of the most significant points of identity transformation that occurs in adulthood. While being parented is largely universal, the experience of raising a child is dependent on a wide-range of factors, including but not limited to, child health, temperament and needs, parental experiences and emotions, relationships and support within and around the family, and socio-economic and environmental factors (Nelson et al., 2014). Perhaps unsurprisingly, parenthood can be a source of purpose, pleasure and meaning, but it can also lead parents to feel overwhelmed, stressed and unhappy (Nomaguchi & Milkie, 2020; Nyström & Öhring, 2004). These states are liable to fluctuate as the parent passes through the stages of parenthood and their child moves from dependence to independence (Neighbour, 1985).

Given the complexity innate to the role of being a parent, it is useful to operationalise what is meant by the term parenting. In the following work, parenting will be defined as the qualities and activities a parent demonstrates in caring for and supporting the development of their child within a secure and loving environment. Parenting that is associated with positive outcomes for children is typically warm, responsive to developmental needs, encouraging of autonomy, and employs clear but fair discipline. Evaluating parenting involves considering strengths as well as deficits.

When parenting in the context of parental mental health difficulties, the complexities outlined above, can, unfortunately, be exacerbated. The intersection of a child's developmental stage and needs and those of a parent who is struggling with their mental health, can be a source of difficulty and risk. For example, the antenatal and postnatal periods are associated with the onset of specific psychological difficulties for mothers and fathers, with twenty per cent of women developing a mental illness in the post-partum year (Davies, 2014). The impact of parenthood (for example, in terms of sleep and disruption to routine) is challenging to all parents and can be particularly disadvantageous to parents whose mental health is already compromised (Hiscock et al., 2007). This may be exacerbated if existing coping strategies become unavailable. However, early parenthood can also be a point at which mental health difficulties are identified, though there is geographical and socio-economic disparity in the likelihood of identification of this risk (Redshaw & Henderson, 2016). Parenthood can also motivate individuals with mental health difficulties to try and manage their mental health, including in terms of treatment-seeking and adherence (Stiles-Shields et al., 2013). It should be noted, however, that mental health presentations are heterogenous and intensity, duration, re-occurrence, and treatment all play a role in how a parent with mental health difficulties experiences and carries out their parenting role. It must be emphasised that many parents who experience difficulties in their mental health provide nurturing and loving care. Parenting is complex for anyone who undertakes it.

1.1.2. Prevalence of parental mental health difficulties

One in six adults in England had symptoms of a common mental disorder (depression, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, post-traumatic disorder) in 2014, of whom women were more affected than men (19% compared with 12%)(House of Commons Library, 2021). The cause of these

gender differences are not well understood, with a range of factors including hormones, psychosocial risk factors and social inequality implicated (Kuehner, 2017; Oram et al., 2017; Riecher-Rössler, 2017). However, some of the variance could also be an artefact of males not presenting to services (Gonzalez et al., 2011). Prevalence, as determined by receipt of psychiatric treatment, indicates that 1.46 million people were referred for primary care mental health services and 2.8 million were in contact with secondary mental health services in the same period. There is considerable national variation in access, ranging from 8.9% of the adult population in Hull as compared with 2.8% in South Gloucestershire, with socio-economic and demographic factors contributing to some of this variation (Maconick et al., 2021).

Information on the prevalence of mental health difficulties in *parents* is less comprehensive; however, in a review of papers that reported parenthood status in adults who were accessing psychiatric treatment, parenthood rates (of a child aged under 18 years) ranged from 12% to 45% (Maybery & Reupert, 2018). The sole UK study that was included in the review, which drew on a small case note study, reported that 45% of patients (who were asked the question) had dependent children (Gatsou et al., 2016).

Reframing prevalence to consider the number of children who have a parent with mental health difficulties further highlights the magnitude of the those affected.

Public Health England reports that one in three children in the period 2019-2020 lived with a parent who was experiencing emotional distress (GOV.UK, 2022). While these parents may not have a formal diagnosis of a mental health disorder, a high emotional distress score is suggestive of a common mental health problem.

Similarly, in a national cohort study using primary care data, almost a quarter (23.2%) of children were exposed to maternal mental illness, with depression the most common diagnosis. This study also indicates a trend for increasing prevalence over recent years (Abel, Hope, Swift, et al., 2019).

1.1.3. The impact of parental mental health difficulties

Having a parent with mental health problems increases a child's vulnerability to a wide range of impaired psychosocial outcomes and places them at elevated risk of adverse events (Argent, Kalebic, Rice, & Taylor, 2020). Parental mental health challenges are associated with impairments for their children in domains including education, where, for example, they demonstrate poorer levels of school readiness (Ayano et al., 2022; Bell et al., 2019). These children are at greater risk of having an accident or injury and are more likely to have physical health problems, which contribute to greater levels of health care utilisation, at a projected cost of £656 million per annum (Hope et al., 2021; Nevriana et al., 2020; Pierce et al., 2020). To note, while this epidemiologically orientated research is persuasive in its suggestion of the potential risks and costs of parental mental illness, it does not engage with the mechanisms through which these risks are transmitted.

A considerable body of research has sought to quantify the association between parent and child mental health and it is clear that offspring of parents with mental health problems are at increased risk of developing a psychiatric disorder themselves, compared with children of parents without a diagnosis (Offspring Outcomes When a Parent Experiences One or More Major Psychiatric Disorder(s): A Clinical Review, 2020). For example, the child of a parent with serious mental illness (schizophrenia, bipolar disorder, affective disorder and borderline personality disorder (BPD)) has a 32% chance of developing a serious mental health problem themselves; this increases to a 50% chance of developing any mental health disorder (Rasic et al., 2014). While mental health problems clearly run in families, there is less clarity with regard to the specificity of this transmission. Van Santvoort found evidence that depression and bipolar disorder were both associated with a range of child diagnoses, with the strongest relationship being between parent and

child depression (van Santvoort et al., 2015). For anxiety, which is the most common disorder in childhood (Cartwright-Hatton, McNicol, & Doubleday, 2006), there was a clear relationship between parental and child anxiety, and no equivalent relationship between parent anxiety and any other disorder in children (Cartwright-Hatton et al., 2006; van Santvoort et al., 2015). However, all of the parental diagnoses (that were assessed) were associated with an increased risk of the child developing significant problems with anxiety.

Parental mental health is also implicated in sub-threshold child difficulties, including greater levels of emotional dysregulation and behavioural problems (Van Loon et al., 2014). Tragically, having a parent with mental health difficulties also increases a child's vulnerability to abuse and premature mortality (Brandon, 2009). However, while there is an association between parental mental health difficulties and these adverse outcomes, other factors such as social disadvantage, substance abuse, family structure and domestic violence are also implicated (Howard et al., 2010; O'Donnell et al., 2015; Roscoe et al., 2021). Furthermore, when considering outcome metrics that relate to social care involvement, it is worth taking into account the potential bias caused by historic discrimination against parents with mental health challenges (Jeffery et al., 2013).

While parents who experience mental health difficulties frequently characterise the parenting role as an important and rewarding one, they are also more likely to experience lower levels of confidence and self-efficacy in this role (Petfield et al., 2015). This may, in part, be influenced by perceptions of the negative views that others hold of them, with mothers particularly likely to hold a view that they are valued less as a parent by others due to their mental health (Lacey et al., 2015). Parenting is not without difficulty for any parent, and the challenges and stresses of parenthood can lead to onset, relapse, and intensification of psychiatric symptoms

(Gerull et al., 2008). This is likely to be exacerbated when a child has behavioural or emotional difficulties (Berg-Nielsen et al., 2002).

Furthermore, parental mental health problems are associated with lower quality informal and formal support systems, which potentially disadvantage the parent and child further. Such parents are more likely to describe themselves as isolated and to be lacking social support networks (van der Ende et al., 2016). They are also less likely to utilise formal preventative health networks such as health visiting and well-child appointments, which also places their children at risk (Davidsen et al., 2021).

1.1.4. Risk factors for the intergenerational transmission of poor mental health

A series of interconnected mechanisms are responsible for the intergenerational transmission of psychopathology. While genetic heritability plays a role, evidence from twin studies suggests that environmental factors are also important (Eley et al., 2015; Polderman et al., 2015). Furthermore, there is disorder-specific variation in the extent to which genes are implicated in this transmission, with more severe disorders, such as psychosis, showing a greater degree of heritability than more common and typically less severe disorders, such as anxiety (Polderman et al., 2015). Developmental models of psychopathology, such as Goodwin's seminal work on maternal depression (and subsequent adaptation for Schizophrenia), emphasise the interplay of heritability, innate neurodevelopmental factors, environmental stressors (including in utero) and maternal behaviour, affect and cognitions (Goodman & Gotlib, 1999; Wan, Abel, & Green, 2008). Similarly, a review on the development of anxiety disorders in childhood highlights this interplay of inherited and environmental factors through which a child's vulnerability is affected by elements such as adverse life events or anxiogenic modelling of behaviour (Murray et al., 2009). For most children,

parents are likely to be the primary, though not the only contributor, to the environmental influences associated with the transmission of mental disorders.

A wide range of parental behaviours are associated with an increased risk of child mental health disorders. Van Loon and colleagues compared a pan-diagnostic sample of parents with non-disordered control parents and found that parental mental health problems were associated with reduced monitoring behaviours, and that this was, in turn, associated with a higher level of externalising problems in their adolescent children (Van Loon et al., 2014). However, this cross-sectional research does not offer evidence as to direction of flow; for example, it is likely that adolescent externalising behaviour has a reciprocal influence on the family environment. Parental mental health difficulties are also associated with decrements in mind-mindedness, reduced warmth and more punitive behaviours, which in turn are implicated in impaired psychiatric outcomes for their children (Berg-Nielsen et al., 2002). Disorder-specific parenting behaviours have also been implicated in the development of child mental health outcomes. For example, parental threat avoidance, which is most commonly associated with parental anxiety, is implicated in the onset of child anxiety (Ewing et al., 2020). For parents with borderline personality disorder (BPD), impairments in emotional availability and validation, and a pattern of hostile control and aloofness, are specifically associated with the transmission of BPD symptoms (Florange & Herpertz, 2019; Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012). Furthermore, this is a reciprocal relationship, such that child characteristics may elicit maladaptive parenting responses, which then further perpetuate the child's difficulties; for example, a depressed child may elicit more punitive and less affectionate parenting responses from a parent with depression, and an anxious parent may be more overprotective to a child who displays anxious symptoms (Hipwell et al., 2009; Mendes et al., 2012; Murray et al., 2009). There is, furthermore, some evidence that parental mental health difficulties may impede

therapeutic outcomes when a child is in receipt of treatment for their own mental health (Pilowsky et al., 2008). This may be caused by the parent's inability to engage with recommended behavioural parenting approaches (Chronis et al., 2004).

In addition to the transmission of psychiatric vulnerability, parental mental health problems are associated with other impairments, such as in communication and play behaviours, which can contribute to impaired educational outcomes (Sohr-Preston & Scaramella, 2006). Treatment received by parents for their mental health difficulty can also negatively impact on the child and affect their developmental and behavioural outcomes. Psychotropic medication can reduce parental responsiveness, and can limit the ability to actively engage with their child (Thomas & Kalucy, 2003). Inpatient hospitalisation is likely to severely hamper a parent's ability to provide the care they would wish to, and to negatively impact their children (Thomas & Kalucy, 2003).

Parental mental health difficulties can also impede the parent's organisational capacity, willingness and ability to engage with social networks around school and nursery, which can limit the non-formal social activities which benefit children (Dunn, Cartwright-Hatton, Startup, & Papamichail, 2020). The children of parents with mental health difficulties are also more likely to live in an unstable housing situation, experience socio-economic deprivation, and be exposed to parental substance abuse and domestic violence (Howard et al., 2010; Roscoe et al., 2021; Saraceno et al., 2005; Suglia et al., 2011; Trevillion et al., 2012; Weaver et al., 2003). It should also be noted that many parents with mental health problems have themselves experienced impaired formative environments and/or experienced maladaptive parenting, which are implicated in their own mental health difficulties and may have meant they did not have positive models of parenting to draw upon (Bradley et al., 2005).

1.1.5. Interventions to support families where a parent has mental health difficulties

Given that families where a parent has mental health difficulties are vulnerable to impaired outcomes, there is a clear case for support to be provided to minimise this impact. However, while there is a growing body of intervention literature, it reveals considerable variation in how this support is operationalised. For example, preventative interventions may target the parent, the child, the parent-dyad or the wider family (Reupert et al., 2013; Siegenthaler, Munder, & Egger, 2012a). The summary provided here will focus primarily on support which targets the parent or the parent-child dyad. However, this still generates a broad array of interventions with considerable variation in efficacy.

Interventions for parents with mental health difficulties can be broadly organised into three focus areas: improving parental psychopathology, improving child behaviour and improving parent-child interaction (Overbeek, Mathilde et al., 2022).

1.1.5.1. Interventions focused on parental mental health: Interventions which focus on parental psychopathology are associated with positive results for the parent but the effects for the child are less clear. For example, while Cuijpers found that solely treating maternal symptoms had a moderate preventive effect on child depression, Forman found that treatment for depression did not reduce negative appraisals of child behaviour, temperament, and attachment, which are associated with impaired parent-child relations (Cuijpers et al., 2015; Forman et al., 2007).

Furthermore, a recent review by Overbeek and colleagues found that interventions which targeted parental mental health were associated with improvements in that domain but generated limited evidence of the effectiveness of these interventions on child outcomes. (Cuijpers et al., 2015; Overbeek et al., 2022). This variation in outcome may also be influenced by the paucity of research which seeks to determine the

effect of treating parental symptoms on child mental health. This was recently evidenced by a systemic review, which sought to explore the effect of treating parental anxiety on child mental health symptoms, as no studies were identified (Chapman et al., 2022). More broadly there is also a need to develop a more rigorous evidence base regarding intervention effectiveness, in particular using prospective designs, longer follow-up and engagement with critical developmental periods.

1.1.5.2. Parenting-focused interventions: Over the last 50 years there has been increasing provision of interventions which target parents with the aim of improving their children's social, behavioural and emotional functioning, in particular child problem behaviours (for historic overview see Shaffer, Kotchick, Dorsey, & Forehand, 2001). Systematic reviews of manualised parent training programmes have found them to be effective in reducing conduct problems in children under 18, to improve the emotional and behavioural adjustment of young children and to generate short-term improvements in psycho-social functioning in parents (Barlow et al., 2014, 2016; Bennett et al., 2014; Dretzke et al., 2009). Community-based manualised interventions such as Triple P are widely available to parents in higher income countries, often via self-referral (Sanders, 1999).

However, for parents with mental health problems, these interventions may not always be appropriate. Indeed, many community-based interventions were not designed to address or cope with parents with mental health difficulties. For example, parents report that the opportunity to receive support and share information with peers is a common benefit of participation in group-based parenting interventions (Barlow & Stewart-Brown, 2001). The stigma around parental mental health may prevent parents from participating in a group where parents do not have similar experiences (Reupert et al., 2021). More recently, a new wave of interventions has been designed and trialled which do seek to address the specific parenting support needs of parents with mental health problems, generating tentative

evidence that doing so can benefit parent and child (Siegenthaler, Munder, & Egger, 2012b). A more recent review by Thanhäuser and colleagues found a small but significant preventative effect from interventions for parents with mental health problems which target mother-child interaction in infancy or parent/parent-child focused interventions on children and adolescents (Thanhäuser et al., 2017). Promisingly, the effects increased over time for child and adolescent psychopathology as well as internalising and externalising symptoms. However, given that parental mental health can impact across a wide range of domains including educational, social and physical, it is noteworthy that Bee and colleagues were unable to draw meaningful conclusions as to the efficacy of community-based interventions on child quality of life (Bee et al., 2014).

While it is clear there is some way to go in the development of a clear evidence base detailing the most efficacious ingredients of interventions targeting parents with mental health problems, there is evidence that parents want to be offered some form of support (Dunn et al., 2020). Furthermore, where acceptability of interventions has been reported, it generally indicates that parents with mental health problems found specialist parenting interventions to be satisfactory, with adherence rates similar to community-based interventions delivered to parents without mental health problems (Bee et al., 2014).

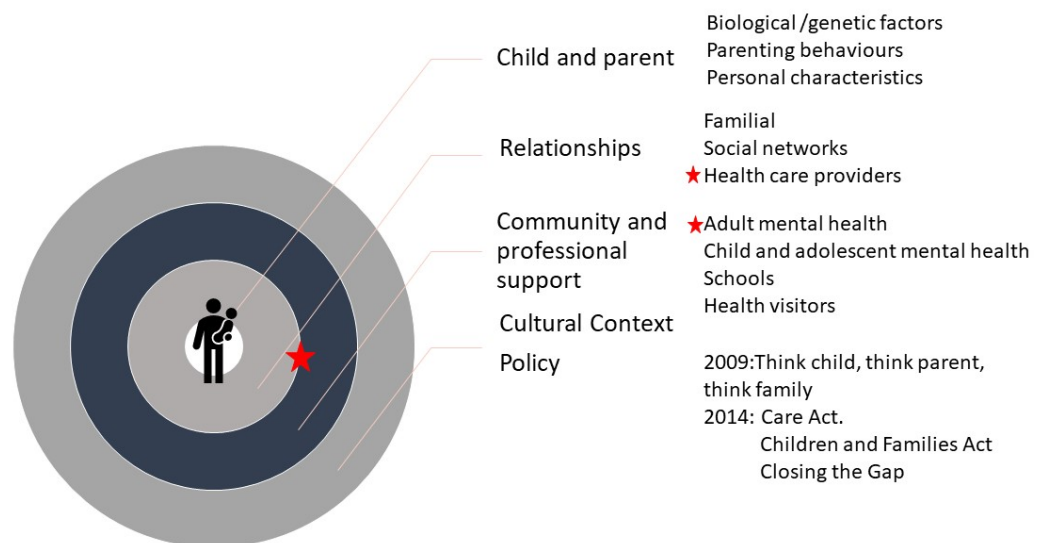
1.2. Supporting parents within Adult Mental Health Services

1.2.1. A socio-ecological conception of the family

Any parent, even the most isolated, exists within a network of personal, cultural and structural influences which shape their experience and that of their child.

Bronfenbrenner's socio-ecological model offers a method of conceptualising the interaction of the individual or family unit with the systems around it (Bronfenbrenner, 1979). Developed in the 1970s, the model was initially used to describe human development and places the individual at the centre of a series of nested circles which describe the influences that act upon them. The first circle contains the strongest influences, for example family relationships, with the degree of direct influence diminishing to encompass community influences, cultural and religious values and finally policy and history (Cross, 2017). The model has subsequently been revised for wide-ranging purposes, including public health and violence prevention (McDaniel & Sayegh, 2020; Townsend & Foster, 2013).

Figure 1.1. The parent-child dyad within a socio-ecological model of the influences with which they interact.



Informed by Bronfenbrenner (1977)

Figure 1.1. presents a revision of this model to describe the system around a family where a parent experiences mental health problems. Each of the levels has the potential to offer protective benefit to parent and child, but many also offer potential for adverse interaction and outcome. For example, schools can offer important protective benefits for the child and provide a mechanism for support to be offered to the parent (Reupert & Maybery, 2010). However, a parent with mental health difficulties may not wish to engage with the school for reasons such as fear of social care involvement (Dunn et al., 2020). Issues around attendance and lateness (which can be influenced by mental health) may also lead to a strained or adversarial relationship (Dunn et al., 2020; Reupert & Maybery, 2010). The outer ring of influences, such as cultural context and policy, have cascading effects on how services engage with these parents; for example, budgetary constraints may hamper provision.

When a parent is accessing mental health care for themselves, they are exposed to potential interactions which could be advantageous to both themselves and their child. In some cases, the mental health service is the only engagement a parent may have. For example, individuals with enduring and acute mental health presentations may become dependent on health services as their sole form of social bond (Buchanan, 1995). In Britain there have been clear recommendations from Charter Organisations and within Government Policy for adult mental health services to support the parenting role of patients and promote the wellbeing of their children. The landmark 'Think Child, Think Parent, Think Family' report commissioned from the Social Care Institute for Excellence (SCIE) by the Department of Health England, offered a guide to improve service planning and delivery in this area for social care and health organisations (Diggins, 2011). Recommendations from the Royal College of Psychiatrists in 2011 and the policy paper Closing the Gap (2014) also explicitly state the need for engagement with patients who are parents to support their needs and those of their children

(Department of Health, 2014; RCPsych, 2011). However, the engagement of adult mental health care providers in supporting patients in their parenting role is dependent on a large and complex set of factors (Reupert & Maybery, 2007).

1.2.2. Supporting ‘Patient as Parent’ thinking within Adult Mental Health Services

The need to provide support to parents with mental health problems is widely accepted. Within adult mental health services this means that practice should take into account the individual as both patient *and* parent and consider their needs with regard to these intersecting identities. However, a growing international focus on implementing family-focused mental health care has been accompanied by variation in how this is conceptualised, including in terms of how the family itself is defined (Foster et al., 2016; Nicholson et al., 2016). Foster and colleagues’ synthesis of these approaches indicates that family-focused practice exists along a continuum, which begins with recognition of parenthood status and progresses through exploration of this, to more extensive levels of involvement which may include interventions that engage all members of the family group (Foster, O’Brien, & Korhonen, 2012). At the minimum, they argue, all mental health workers should have a “basic family skill set”, which would cover identification of parenthood and the ability to engage with a patient’s ability to care for their children (Foster et al., 2012; Maybery et al., 2015).

EASE (Engage, Assess, Support, Educate) is a practice framework underpinned by the concept of relational recovery, which has been devised from this work. This low-intensity intervention focuses on four components: relationship and trust generation (Engage); information gathering with regard to parental role, experience and needs (Assess); identification of needs and provision of support (Support); and providing access to psychoeducation (Educate).

However, despite these policy developments, the delivery of this form of engagement is hampered by individual and organisational barriers. For example, practitioners may not feel skilled or able to engage with patients around their parenting (Slack & Webber, 2007). Operating within multi-stressed service contexts may mean staff do not have the capacity to engage, or that policies and procedures may not be supportive of doing so. Furthermore, staff may anticipate that parents do not want their parental role to be raised, and for some parents that assumption may be correct. Mayberry and Reupert's synthesis of barriers to family-focused practice organises them into three core areas: the organisation's context, including managerial support; workforce attitudes, knowledge and skill; and the engagement of client, child and family (Mayberry & Reupert, 2009). Taking a hopeful stance, it can be argued that the identification of these barriers is a prerequisite of any effort to limit or remove them.

1.3. The package of work

The body of work brought together in this thesis represents a multi-faceted account of the experience of parents with mental health difficulties and the support currently provided to them within the context of British mental health services. When a parent is treated within this system, their experience is shaped by the factors described above in Section 2. In an attempt to reflect this interplay of individual and contextual factors, the research presented in this thesis integrates the perspectives of parents and practitioners, as well as the wider mental health system. While each of the four studies included in this thesis is a standalone publication, they are informed by each other and reflect my commitment as a researcher to grappling with the complexity of the interrelations between individuals and services.

The diagram below shows the ways in which individual studies interact: the findings of the first piece of qualitative research on parenting experience in the context of a chronic and enduring mental health problem (borderline personality disorder) informed the national survey of mental health practitioners' engagement with the parenting role of their patients, and the systematic review of the treatment and experience of inpatients who are parents. The fourth study, which describes a pilot intervention for mental health workers who are parents, is informed by recognition that when we ask practitioners to engage with 'patient as parent' we should also recognise that many of them are parents themselves and that there are specific challenges associated with being a parent working in a highly stressful and often emotionally demanding context.

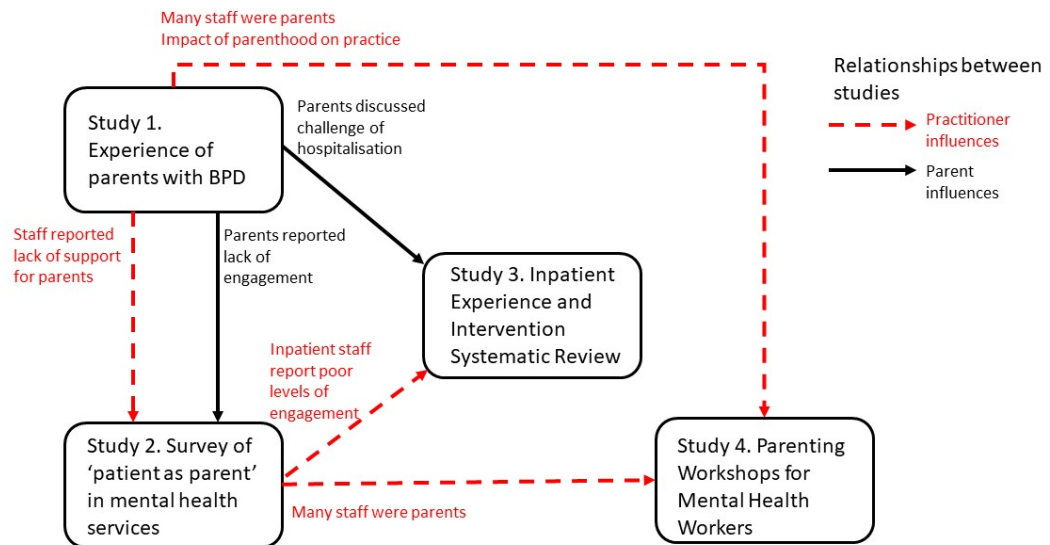


Figure 1.2. The relationship between studies included in this thesis.

1.3.1. Study 1. Exploration of parenting in the context of borderline personality disorder traits

Borderline personality disorder (BPD) is a chronic and enduring condition which is associated with emotional dysregulation and interpersonal challenges. When a parent has BPD, these features can get in the way of them offering appropriately responsive and validating care to their children. Parents with BPD are more likely to be isolated and disconnected from their family compared with other diagnostic groups (Stepp, Pilkonis, Yaggi, Morse, & Feske, 2009). Furthermore, these families are also at risk of other adversities, such as poverty, domestic violence, housing instability and substance abuse, all of which make it harder to parent, and increase the vulnerability of their children (Skodol et al., 2002). Unsurprisingly, parents with BPD report low levels of parenting satisfaction and high levels of stress (Newman et

al., 2007; Ramsauer et al., 2016). Sadly, their children are at elevated risk of abuse and of being removed into care (Adshead, 2015).

While there is a clear need for these parents to be offered support in their parenting, a legacy of poor treatment from health and social care services and the stigma associated with a BPD diagnosis can impact on a parent's willingness to engage (Mental Health in England Personality Disorder: No Longer a Diagnosis of Exclusion, 2003). Similarly, practitioners may avoid talking about parenting to a service user with BPD in case it is distressing, or a parent may choose not to disclose their difficulties in parenting for fear of the involvement of social services. Understanding these barriers is the first step towards dismantling them.

Study 1. explores and integrates the experiences of parents and the practitioners who have been working with them, in order to determine the extent of shared understanding between them, and to inform the future provision of support. While there is a body of empirical research focused on the parenting practices (and deficits) of these parents, the present study was focused on giving voice to this group, which is often described but less often allowed to speak for itself. Data from interviews with twelve parents generated a rich understanding of the parenting experience of individuals with BPD traits (those with subthreshold BPD were purposefully included in the sample), of their self-identified support needs, and their representation of the form and content of appropriate support for their parenting. Interviews and focus groups with 21 multidisciplinary practitioners with experience of working with parents with a diagnosis of BPD (including social workers, psychologists, and family coaches) mirrored parents' experiences and highlighted the paucity of support for these parents and their families. Parents and practitioners alike characterised their experience as being unsupported, of not knowing if help was available and of engagement, when it did occur, typically happening only at the point of crisis.

1.3.2. Study 2. Survey of mental health practitioner engagement with 'patient as parent' thinking

Mental health services are often the only formal point of support for a parent with mental health problems. While the care offered is understandably orientated to the patient's mental health needs, when that patient is a parent, those needs should not be seen in isolation from their parenting role. As described, parenting can be a source of fulfilment, but it can also be a source of stress, which can exacerbate existing mental health struggles. Supporting the patient in their parenting role has the potential to benefit the parent and to limit the potential negative impact of their mental health on their children (Siegenthaler et al., 2012a). However, as described above, family-focused practice exists along a continuum and before any support can be offered to a parent within mental health services, there must first be the identification of their parenthood.

It is a mandatory requirement for mental health services to identify the dependent children of adults in their care. However, a practice report conducted by the Social Care Institute for Excellence (SCIE) in 2011 stated that even this most basic of reporting was not routinely carried out (Diggins, 2011). A subsequent small-scale case note review by Gatsou and colleagues in 2016 indicated that the identification of parental status continued to be inconsistent (Gatsou et al., 2016). Informed by these findings, and by the accounts of participants in Study 1., Study 2. comprises a large national survey of the practice and attitudes of the mental health workforce. This was designed with the objective of identifying the extent to which workers are fulfilling the mandatory requirement to ascertain the parenthood status of their clients and explore their level of engagement beyond that. It also sought to increase our understanding of practitioners' attitudes to supporting their patients as parents, and of potential barriers to doing so. Responses from 1,105 practitioners from 14 British mental health trusts indicated that there is broad understanding of the

interrelationship between adult mental health, parenting and child outcomes, and a majority agreement that supporting the parenting of individuals with mental health problems is important. However, in describing their own practice, a quarter of practitioners reported not routinely identifying the presence of dependent children, and less than half reported engaging with parenting support needs.

1.3.3. Study 3: Systematic review of the experiences of psychiatric inpatients who are parents, and interventions delivered to them

In the process of interviewing parents with BPD traits for Study 1., it became apparent that parents who had experienced psychiatric hospitalisation viewed their treatment experience in negative terms. In most cases, separation from their child/ren was a key concern, as one mother who was treated out-of-area described:

“And I think they specialise with people who have Borderline and it was the hardest year of my life to be travelling there every week and to be travelling home and having the children and then travelling up there for the week. It was incredibly difficult, but I think at the time it was classed as we don’t really have anything else available for me in the way of treatment.” (Mother, Study 1.)

While the very nature of inpatient psychiatric care (usually) involves separating a parent from their child, during this treatment parents want their role as a parent to be engaged with and supported (Diaz-Caneja & Johnson, 2004). The period of hospitalisation offers scope for the delivery of preventative interventions which could mitigate the effect that the parent’s mental health difficulties may have on their children. Parenting-focused support could be embedded in the broader package of support designed to facilitate readiness for discharge. The facilitation of the parent-child relationship during hospitalisation is required within the 1983 Mental Health Act (*Mental Health Act, 1983*). Despite this, however, in Study 2., inpatient staff reported

the lowest level of practice relating to engaging with and supporting the parenting role.

Study 3. systematically reviews the available research on the experience of parents in receipt of psychiatric inpatient care, and of interventions designed for them to support their parenting or their relationship with their child. It extends earlier reviews by employing a more comprehensive search approach and by including German language publications (which was a problematic exclusion in previous reviews). Seventeen studies reported on the experience of parents who had received inpatient care, and the experience was overwhelmingly represented as negative. Being separated from their children was often profoundly distressing for parents, yet services were failing to engage with them as parents and to support them in remaining connected with their children, in particular through the provision of appropriate conditions for children to visit. A small number of intervention studies were identified, of which most described the co-admission of parent and child. Only one paper was from the UK, and the provision described in it is no longer available.

1.3.4. Study 4. Pilot intervention for mental health workers who are parents

The mental health workforce operates within a stressful and overstretched system. In providing care to individuals who are struggling with their mental health, practitioners experience risk in terms of personal safety and emotional load (Johnson et al., 2018). For workers who are parents, this burden can be intensified. As discussed, raising children can be challenging, and the intersection of stressful home and work environments can place these workers at even greater risk of burnout (Netemeyer et al., 1996). In seeking to understand why practitioners may not engage with the patient as parent, there is a possibility that staff do not feel they have the emotional capacity to “open the can of worms” (clinical psychologist

interview, Study 1.)(Maybery & Reupert, 2006). Furthermore, many practitioners report feeling that they do not have the language or skills to engage with parents in this way (Slack & Webber, 2007). Study 4. describes the evaluation of a pilot intervention designed to support mental health workers who are parents in terms of the specific demands of working in mental health, and the intersection of these demands with their parenting. The intervention drew upon an effective programme of work designed for parents with high levels of anxiety and incorporated additional content which was focused on the specific experiences of working within the mental health system (Cartwright-Hatton et al., 2018). It also sought to encourage workers to be curious about the parenthood experience of the patients that they have contact with. While these workshops were well-received, led to improvements in positive parenting approaches, and reduced stress, they were not associated with increased 'patient as parent' thinking. Furthermore, the project was terminated early due to the start of the COVID-19 pandemic, which had an impact on both project delivery and data collection.

1.4. The Impact of COVID-19

The COVID-19 pandemic has affected and continues to affect most people. This is particularly relevant given that the package of work contained in this study describes groups who have been amongst the most affected. The indisputable impact of the pandemic on families of young children is heightened amongst those who already had mental health challenges, as well as those experiencing economic and housing disadvantage (Dawes et al., 2021; Shevlin et al., 2020; Shum et al., 2020). Furthermore, the impact of the pandemic on the mental health workforce continues to be demonstrated in high levels of burnout and attrition, which further stretch an overstretched system.

As was the case for many researchers, lockdown had a deleterious impact on the work developed for this thesis. The pandemic led to the early termination of one study (Study 4.) and entirely prevented the delivery of a further study, which had been fully prepared and was in the process of obtaining ethical approval (briefly described in chapter 6). As a parent of young children, I also have first-hand understanding of the impact of home-schooling and working on the wellbeing of my family. This experience only served to highlight to me the need to focus beyond the parent – to consider their family context as a source of strength and of challenges. We must recognise that every parent is part of a system, and the mental health service has an obligation to see the parent in front of them and consider their needs and that of their family.

2. The parenting experience of those with borderline personality disorder traits: practitioner and parent perspectives. (Study 1.)

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3

2.1. Abstract

2.1.1. Background: Borderline personality disorder (BPD) is associated with challenges around emotional intensity and interpersonal difficulties. The children of parents with BPD are at risk of poorer outcomes in terms of their own mental health, educational outcomes and wellbeing. The challenges of being a parent can also exacerbate the symptoms of those with BPD traits. There is a pressing need to understand the experience of these parents and to determine what support would be appropriate and useful.

2.1.2. Aims: To explore and compare the experiences and support needs of parents with BPD traits with the experiences and understanding of practitioners who work with them.

2.1.3. Methods: Interviews with 12 parents with BPD traits and 21 practitioners with experience of working with individuals with BPD traits. The two strands of interviews were analysed independently using a thematic framework approach, after which the superordinate and subordinate themes were subject to comparison.

2.1.3. Results: Parents with BPD traits represent themselves as experiencing considerable challenges in their role as a parent. These included the impact of emotional intensity, social isolation and lack of a positive parenting models to draw upon. Practitioners demonstrated a strong degree of shared understanding into these difficulties. Both groups highlighted a lack of appropriate support for these parents.

2.1.4. Conclusion: This research highlights the clinical need for parenting-focused support for individuals with BPD traits. Preliminary suggestions for format and content are given.

2.2. Contribution to the field

- The parenting by individuals with borderline personality disorder (BPD) is associated with impaired child outcomes, including the intergenerational transmission of psychopathology.
- Limited attention has been afforded to how these parents experience parenting and what support they would find beneficial.
- This study offers a rich account of the parenting experience, challenges and support needs of this group.
- It also includes accounts of a multi-disciplinary sample of practitioners who work with them.
- The study generates a triangulated understanding of the challenges faced by parents, as well as identifying targets for support.
- There are clear practice implications for the generation of appropriate and accessible interventions.

2.3. Background

Borderline Personality Disorder (BPD) is a chronic and enduring presentation which is characterised by struggles with emotional intensity, fluctuation in moods, challenges in interpersonal relationships, heightened sensitivity to stress, and an increased likelihood of self-harm, substance abuse and suicide (Cheng et al., 1997; Skodol et al., 2002). The community prevalence of BPD is in the region of 0.5% (Coid et al., 2006) but individuals with BPD are disproportionately represented in both outpatient and inpatient care (Beckwith et al., 2014; Zimmerman et al., 2005). The etiology of BPD is complex, and while there is some, though inconclusive, indication of genetic and biological factors, no single cause has been identified (Chanen & Kaess, 2012). However, there are a number of models which propose that BPD arises as the result of environmental risk factors on an underlying vulnerability (Crowell, Beauchaine, & Linehan, 2009; Legrain et al., 2011; Linehan, 1993; J. Paris, 2016). In particular, BPD is associated with parental psychopathology and adverse childhood experiences, including trauma, abuse and neglect (Bradley et al., 2005). As such, when an individual with BPD becomes a parent, they do so in the context of their own frequently negative experiences of being parented and the likely lack of a “good” parenting model. When this is coupled with the challenges of ongoing life stresses, parents with BPD may struggle to know how to get alongside the needs of their children and, furthermore, most do not receive adequate support to do so (Stepp et al., 2012).

A growing body of research into the parenting provided by individuals with BPD indicates patterns of behaviours that can hinder the parent-child relationship and place children at increased risk of negative outcomes (Florange & Herpertz, 2019). Parents with BPD can demonstrate impaired ability to recognise the emotions of their infants (Elliot et al., 2014) and are more likely to respond in an invalidating way

to the 'negative emotions' of young children (Kiel et al., 2017). Parents of older children demonstrate, on average, lower levels of mind-mindedness and greater levels of overprotection and psychological control (Barnow et al., 2006; Schacht et al., 2013; Zalewski et al., 2014). These difficulties are reflected in poorer outcomes for children and adolescents in terms of behaviour, affect, mental health and the parent-child relationship (Eyden, Winsper, Wolke, Broome, & Maccallum, 2016; Petfield et al., 2015). Ultimately, children of parents with BPD are at greater risk of developing psychiatric symptoms, with parenting behaviours likely to be a contributing factor (Eyden et al., 2016; Steele, Townsend, & Grenyer, 2019; Stepp et al., 2012). For parents with BPD, impaired emotional availability and oscillation between hostile control and passive aloofness have been proposed as potential mechanisms for intergenerational transmission of poor mental health (Florange & Herpertz, 2019; Stephanie D. Stepp et al., 2012).

At times, parenting is challenging for everyone, but parents with BPD report particularly high levels of parenting stress and low levels of competency, self-efficacy and reward in the role (Elliot et al., 2014; Newman et al., 2007; Ramsauer et al., 2016). Furthermore, there is a potential bidirectional relationship between family context and symptoms: Children of parents with BPD are more likely than controls to have disruptive behaviour disorders and Attention Deficit Hyperactivity Disorder (ADHD), to have higher rates of BPD symptoms and greater levels of aggression and delinquency than children whose parents did not have a psychiatric disorder (Barnow et al., 2006; Feldman et al., 1995; Huntley et al., 2017; Weiss et al., 1996).

Parenting a child with psychological, emotional and/or behavioural difficulties is stressful and has the potential to worsen a vulnerable parent's own mental health (Berg-Nielsen et al., 2002).

While much of the research on parents with BPD has focused on individuals who meet diagnostic criteria for BPD, there is a case to extend the research parameters to incorporate those with subthreshold symptoms. The evidence suggests that individuals who fall below diagnostic threshold but still demonstrate some of the characteristics of BPD remain at risk of a range of negative psychosocial outcomes (Kaess et al., 2017; Zimmerman et al., 2011). In a series of studies, Zimmerman and colleagues have found that, in comparison with patients who meet none of the DSM-IV BPD criteria, a single BPD criterion is a significant predictor of a range of psychosocial morbidities (Ellison et al., 2015). This is echoed in the domain of parenting where the evidence suggests that parents with sub-threshold diagnoses and their children are likely to be at risk from some, if not all, of the parenting challenges seen in individuals with a full BPD diagnosis (Macfie, 2009). Studies that have included subthreshold BPD as well as full categorical diagnosis have found that maternal BPD symptoms that fall below diagnostic level are associated with psychological control of adolescent offspring (Mahan et al., 2018; Zalewski et al., 2014) and that sub-threshold BPD in parents significantly predicts BPD symptoms in young adults (Barnow et al., 2013). In terms of engaging with parenting needs, it is arguably these traits and behaviours, rather than diagnoses that should be the focus of a comprehensive risk assessment and with service provision (Adshead, 2015). As such, the present study focuses on individuals with both a diagnosis of BPD *and* those with subthreshold presentations. For clarity, this combined group will be referred to as parents with BPD traits.

Although the parenting challenges faced by individuals with BPD traits have been identified using a range of observational and self-report paradigms (Florange & Herpertz, 2019), far less attention has been given to recognising how these parents understand and represent their own experiences, in particular using qualitative methodologies. For example, an extensive review of the qualitative research on

mothers with severe mental health problems identified only one paper that included participants with BPD (Dolman et al., 2013). This gap is of particular relevance given that BPD is one of the most stigmatised mental health disorders: individuals who have BPD traits frequently report an uneasy dynamic with services, where their behaviours can be misinterpreted and misunderstood (Black et al., 2011; Kealy & Ogrodniczuk, 2010). In parenting support settings, this can be reflected with poor levels of engagement and high attrition in people with BPD: understanding their perspective is critical.

Two recent studies have employed a qualitative approach to explore the parenting experience of parents with BPD. Zalewski and Bartsch identified themes relating to low self-efficacy and satisfaction, disruption to empathic and emotionally validating responding, and difficulties in interpersonal boundaries (Bartsch et al., 2016; Zalewski et al., 2015). Both studies highlighted the lack of suitable parenting support for parents, with Zalewski exploring the acceptability of a DBT-focused parenting intervention with parents, and Bartsch generating a speculative set of recommendations from parents.

The current study extends this work by recruiting a broader community sample of parents, as opposed to those who were participating within a specific treatment modality (dialectical behaviour therapy) and, unlike the papers above, does so within the UK.

Every parent exists within an interconnected system, which includes their child, their wider family and social network and any structural support they may receive. The current study seeks to gain qualitative understanding of the experience of parents who have BPD traits. It seeks to achieve this understanding alongside, and informed by, the experience of other factors within this system, namely practitioners who work with individuals with BPD traits.

While there is considerable research into practitioners' general attitudes towards individuals with BPD, (in which historically negative attitudes have shifted somewhat, (Black et al., 2011; Cleary, Siegfried, & Walter, 2002; Day, Hunt, Cortis-jones, & Brin, 2018; Treloar, 2009) only a handful of studies have explored clinician attitudes towards parents with BPD (Bartsch et al., 2016; Wilson, Weaver, Michelson, & Day, 2018). These studies drew upon survey data (Bartsch et al., 2015) or were drawn on small samples and focused solely within Child and Adolescent Mental Health Services (Wilson et al., 2018). The current study benefits from a substantially richer dataset generated through interviews and focus groups with a large sample of practitioners working in a range of settings.

The parent and practitioner datasets addressed the following research question: How do parents with BPD traits experience parenting and how does this compare with the way their experience is conceptualised by practitioners who work with them?

2.4. Methods

2.3.1. Ethics

Ethical approval was obtained from the NRES Committee Brighton and Hove.

2.3.2. Recruitment

Parents: Participants were recruited over a six-month period (August 2018 – January 2019) from Sussex Partnership NHS Foundation Trust (SPFT) through the following mechanisms: self-referral in response to posters and flyers located in SPFT sites across Sussex; following promotion by clinicians; and via referral from

another study seeking participants with some shared characteristics. To be eligible, an individual had to (i) be, or have been, a primary parental caregiver; (ii) be aged 18-89 years; (iii) have presence of traits associated with BPD (identified by a score of 4 or more on the BPD scale of the PDQ-4) a screening instrument for which a score of 5 is associated with a diagnostic level of BPD pathology); (iv) be under the care of SPFT; (v) be proficient in spoken English; and (vi) have capacity to provide informed consent to participate.

In total, 21 parents expressed interest in the study of which three chose not to continue to screening and two did not meet eligibility criteria on the grounds of scoring less than 4 on the PDQ-4-BPD (Hyer, Stephen, 1994). Four eligible and consenting participants did not undertake interviews due to hospitalisation, the effects of a change in treatment or disengagement (indicated by failure to respond to two phone calls and two emails).

Practitioners: Over a six-month period (August 2018 – January 2019) practitioners working in mental health care, social care and the third sector were recruited through the following mechanisms: self-referral in response to promotional materials or following contact from the research team and snowball sampling (participants referring further participants from within their professional network). For a practitioner to be eligible they had to have direct experience of working with parents with traits associated with BPD.

Of 28 practitioners who expressed interest in participating, 21 went on to be interviewed or participate in a focus group. Of those who failed to participate: three were Social Workers within Children's services; two were Child and Adolescent Mental Health Services (CAMHS) practitioners; and two worked within Adult Mental Health. These practitioners either stated they could not give up the time, failed to attend interviews/focus groups and/or disengaged.

2.3.3. Participant Characteristics

Parents: In total, 12 parents aged between 39 and 58 ($M = 47.33$, $SD = 5.78$) were interviewed of which 11 identified as White British and one as White Other. Parents scores on the PDQ-4-BPD ranged from 4 to 8 ($M = 6.42$, $SD = 1.24$). Two parents were male and ten were female. Parents had between one and five children ($M = 2.17$, $SD = 1.11$) and the age of children ranged between one and 34 years ($M = 19.85$ $SD = 9.40$) with seven participants providing care for dependent children (< 18 years). Half of the group were married, in a long-term relationship or co-habiting, and the remaining six characterised themselves as single either following divorce or the death of a partner.

Education and employment varied across the sample with one parent stating they had left school before aged 14, five had attained GCSE or equivalent (school age 16 years), one had attained A-level or equivalent (18 years) and three had completed a first degree. At the time of interview four participants were in employment (part-time or full/time) and eight were unemployed.

Practitioners: Over half of practitioners were adult mental health practitioners ($n = 13$); six were in council-funded roles; one was employed by a charity and one by CAMHS. A range of roles were represented with six Occupational Therapists; five Social Workers; three Clinical Psychologists; three Nursing Professionals; two Family Coaches; one Midwife and one Charity worker. All of the practitioners had been working in their discipline for a minimum of six years, with 38 years the longest reported service duration ($M = 18.89$, $SD = 9.09$). Six participants identified themselves as having managerial responsibility.

2.3.4. Procedure

Following provision of informed consent, participants were either interviewed alone, in a pair, or as part of a focus group. The format was determined by participant choice and scheduling practicalities.

Ten parents were interviewed alone and two were interviewed as a pair. Interviews were conducted in the home ($n = 4$), or on NHS sites. Thirteen practitioners participated in team-based focus groups which ranged in size from three to six participants. Four participants were interviewed in multi-disciplinary pairings (two separate interviews) and four practitioners were interviewed alone. All except one interview took place on an NHS site.

In all cases the participants were interviewed by the lead researcher using a semi-structured topic guide developed in consultation with a clinician with expertise in parent-based work and a clinician with core expertise in supporting individuals with personality disorder [see supplementary materials for topic guides]. The topic guide was used as a framework to determine the overall interview content, but questions were developed dynamically in response to the answers and comments of participants. This approach was used to maximise the development of a relationship between interviewer and participant(s) and has precedence in health and psychological research (Brazier et al., 2014). Within the paired interviews, each question would be repeated to both participants, though space was available for them to comment upon and add to the answers of their co-interviewee. In the focus groups, questions were responded to directly by individual participants and/or formed the basis of a discussion within the group.

The parent topic guide was structured around three research questions: how do individuals with challenges around emotional intensity experience being a parent; what support have they sought and experienced and how effective and appropriate

has it been; and what support would they like to receive/have liked to have received?

The practitioner topic guide was structured around the following research questions: how do practitioners conceptualise the parenting experience of individuals with BPD traits; what mechanisms and opportunities to support these parents are identified by practitioners; how do they experience working with parents with BPD traits?

Given the emotive nature of the subject, the interviewer maintained an empathetic and reflective stance. Interviews took between 45 and 65 minutes and were recorded on an encrypted Dictaphone. After each interview, participants were given the opportunity to raise any concerns or discuss any negative feelings the interview had raised.

Participants (not practitioners) were provided with a £10 voucher to thank them for their contribution.

2.3.5. Analysis

The data were anonymised and transcribed. Both sets of data (parent and practitioner) were then subject to a framework analysis (Ritchie & Lewis, 2003). This form of thematic analysis has been used widely in social sciences research and is become more common in psychologically orientated research. Framework analysis includes a structured and transparent data management and synthesis process. Utilising this approach facilitates analysis across themes and across cases.

The framework approach comprises six stages: 1) familiarisation with the data, 2) review of the dataset to identify recurrent themes or ideas, 3) development of a hierarchical thematic framework, 4) indexing - labelling/tagging the data to the framework, 5) organising the data according to a revised version of the index to create a set of thematic matrixes, 6) summarising the data using appropriate

synthesis, which is applied to the whole dataset. This process is iterative and flexible (Parkinson, Eatough, Holmes, Stapley, & Midgley, 2016).

The lead researcher (AD) and a second researcher (AP) separately reviewed the data at each stage of the process and these perspectives were integrated iteratively into the thematic framework and the index. Additional oversight and comment were provided by the lead researcher's supervisory team: who combined clinical and research experience with parents and personality pathology. The research team operated within a clinical-academic framework and the clinical and academic perspectives and identities of members inevitably shaped the methodology adopted and the interpretation of data. However, the research team adopted a position of epistemological reflexivity in which the team would engage with and question their methodological decisions. The study lead used a reflexive journal and reflexive matters were discussed within the team including direct engagement with assumptions and biases. For example, noting and exploring an occasion when a member responded negatively to a parent's representation

The matrixed dataset (stage 6) was then subject to a thematic analysis whereby the charted data was explored with the aim of identifying patterns which reflected the shared experiences of each group. This set of themes was discussed with the research team and revised. Parents were invited to meet with the research team to discuss the emergent themes. Four participants met as a group with the CI and provided feedback on the themes identified in the data. This took the form of the CI reading descriptions of the themes and example quotes and asking for parent's reflections which were then used to further refine and name the themes. Participants were provided with a £10 gift voucher as acknowledgement of their time.

Once analysis of each of the three data strands was completed, the superordinate and subordinate themes from the parents and practitioner datasets were compared [see Tables 2.1. & 2.2.] The results from these two sets of data have been

integrated in the results.

Due to the sensitive nature of the accounts given, participants are identified only in broad terms: by family role or profession.

2.4. Results

2.4.1. Themes related to parenting experience

Exploring the parenting of individuals with BPD traits from the perspective of the parents themselves and practitioners who work with them revealed considerable shared understanding. Amongst parents, despite situational diversity, there were clear commonalities in the way they made sense of their experience of parenting. These were frequently echoed in the descriptions of practitioners. The main themes identified in both sets of data are orientated to challenges in the parenting role. Comparison of the data revealed four shared superordinate themes with two additional themes present only within the practitioner interviews (see Table 2.1.).

Table 2.1. Grid of superordinate [shaded] and subordinate themes indicating which were shared by parents and practitioners [in bold] and those which are present only in the data from parents or practitioners [not in bold].

	Parents	Practitioners
Themes and sub-themes relating to experience of parenting	i. Impact of mental health difficulties	
	i.a. Emotional intensity	
	i.b. Coping strategy: façade	
		i.c. Coping strategy: control
	ii. Impact of trauma	
	ii.a. Lack of parenting model	
	ii.b. Legacy of abuse	
	iii. Negative view of self as parent	
	iii.a. Failure to live up to expectations	
	iii.b Stigma	
	iv. Unsupported parenting	
	iv.a. Social and family network	
	iv.b. Professional support	
		v. Self in relation to child
	vi. Lack of insight	

i. Impact of mental health difficulties

In the accounts of both parents and practitioners, parents were characterised as struggling to manage the impact of their mental health difficulties on their ability to parent in the way they wished. For both parents and practitioners this was present in the way that parents related emotionally to their children and their children’s emotions. A second subordinate theme was the deployment of a facade as a coping

strategy. For practitioners, an additional coping-related theme was over-planning and control.

i.a. Emotional intensity

For parents, the struggle to experience and contain their own emotions directly related to their ability to respond to their children and their children's emotions, particularly when their children were distressed. Strong and uncontrollable emotional responses, usually anger, despair or emotional withdrawal could be generated by things their children said or did: for example, one mother described her response when her daughter told her that she hated her:

"I would cry and cry and, you know, just think about it constantly for weeks."

Within practitioner accounts, parents' difficulties in managing their emotions and responding to the emotions of their children was depicted as a core characteristic of parenting, as one Midwife stated:

"It's that impulsivity, isn't it? And that quick, that sort of, that quick escalation of their emotional intensity that is usually triggered by maybe something that their child might've done and then the way that they misinterpret it and that causes the anger and frustration and the way that they respond to the child and it may not always be helpful for the child."

This describes the complex interplay of emotional misinterpretation and responsiveness present in the accounts of both parents and practitioners. This was depicted as particularly heightened when parents responded to the emotions of their children; parents described responding with intense anger and distress, and by minimising and/or rejecting their children's emotions. As one mother described: *"I couldn't cope with their emotions and I couldn't cope with mine either."* In disclosing these responses parents frequently expressed dismay:

“Then suddenly I find it makes me really irritable, and angry and then I am getting cross with her and I am making it worse and then it actually feels, oh my god this actually this feels quite abusive, I am shouting and being mean to a child who is here actually having a panic attack.” (Mother)

Practitioners also described this pattern of uncontrolled response followed by regret:

“Because of their emotional intensity, it's almost if they say: ‘Well I can't help myself, I end up shouting at them.’ And you know, then, the guilt again kicks back in.” (Occupational Therapist)

Specific developmental transitions were identified by both parents and practitioners as being associated with emotional dysregulation. While the transition to toddlerhood and school were mentioned, adolescence was most frequently identified as a period in which parents struggled to manage their emotions. This was specifically associated with feelings of rejection caused by their child's need for increased independence. This was reflected in the accounts of practitioners as described by a Family Coach:

“As the kids get older, parents have real difficulties with managing that. You know, there is a potential for flare ups, for big arguments, for all kinds of stuff. For violence, for abusive behaviours. You know, the resumption of alcohol or substance abuse to manage the feelings they are having, how bad the relationship is, the disappointment they can feel.”

i.b. Coping strategy: façade

Parents described putting on a façade to manage the challenging interplay of parenting and mental health. The need to present an alternative or masked version of the self was directly related to their belief that *“there was something wrong”* (Mother) with them, that they were different to other parents who just *“sailed through things”* (Mother). These differences exposed them to stigma or the threat of child

removal. The presentation of a more readily understood and acceptable version of themselves was perceived as protective and necessary in accounts of their engagement with the outside world, as one mother described:

"I would be planning [suicide] and, you know, things I would be doing and on the flip side thinking about who or where I was going to with regards to Rainbows and Pottery Club. You know, it is two different worlds for me."

This parenting façade was depicted as protective but also exhausting and participants were uncertain about its effectiveness in convincing the outside world or their children:

"She [child] would say sometimes, she would say: 'Why can't you be happy like you are when you are at school?'" (Mother)

Practitioners also identified the maintenance of a façade, "a sort of masking", as a common but unsustainable coping strategy developed in response to fear of judgement:

"I felt so much for some of the mothers that I've worked with...when you can see why they're doing it, the child looks impeccable, you know? And you know why, you know, the bow in the hair, you know, the absolute, you know, beautiful clothes and you just think. Gosh, the pressure that they must feel under to do that." (Social Worker)

The use of a façade as a method of managing fear was seen by practitioners as ultimately detrimental as it prevents parents from opening up about their need for support or practitioners recognising a need to offer it. As one Occupational Therapist described, this led them to work as a "detective" to unpick what is "actually going on at home."

i.c. Coping strategy: control

In describing the parenting provided by individuals with BPD traits, practitioners identified control as a coping mechanism. Parents were characterised as deploying strategies such as over-planning to enable them to manage their own heightened responses to a situation – this could relate to the organisation of time and activities and rigidity in daily routines, as a charity worker described:

“They can over plan, over trying to keep safe so they can get completely thrown when that doesn’t happen or something else comes in. So, it is almost like I am OK if I plan out my week or my day but then the crisis.”

The effort to control was seen as most effective when children were young; as a Family Coach described, “young child can be fairly easy because you are in a position of power.” As with maintaining a façade, practitioners felt the level of control exerted was largely unsustainable. The failure of control was associated with disengagement and the decision “*not to do any kind of job at all*” (Family Coach).

ii. Impact of trauma

Many of the parents described childhoods lacking nurture and love or characterised by anger and violence. Some experienced abuse in childhood or adolescence, often perpetrated by individuals within their family. For parents, their experience of being a parent was directly related to the maladaptive parenting they had experienced, to traumatic early life experiences, or both. This generated two subordinate themes: lack of an appropriate and nurturing model of parenting to draw on and the aftereffects of abuse. The legacy of these two overlapping themes is viscerally present in the recollection of one mother: “*I didn’t know how to love them but I didn’t want anyone to hurt them.*”

Practitioners also represented parents as shaped by the lack of nurture and/or trauma they had experienced as children. As one described: “*I can say most of my*

patients, most, maybe all of them have had horrific, awful lives. And then they just try and struggle through.” (Community Psychiatric Nurse)

ii.a. Lack of parenting model

Most parents explicitly described the absence of a positive parenting model to draw upon. In some cases, parents tied this to their own inability to parent, for example not being able to play. A number described consciously attempting to provide a better form of parenting to their children, as one mother described:

“Because you always think you are going to, to do better. You kind of think you can always overcome it. Anything. And be the person you want to be for your children and do better than your parents did.”

However, for some parents, trying to do things differently meant doing the opposite of what they had experienced:

“Yeah, I think it's, you know, my mom was one end of the scale and I was at the other end, I think. There should have been some kind of middle.”

(Mother)

Practitioners also described parents who often lacked a positive model of parenting to draw upon and the detrimental effect that had on the care they could provide to their children.

“And what do we do about the fact that our clients themselves have problems being, had poor parenting themselves and, you know, so they're almost sort of like passing on what they know because that's all they've know.” (Occupational Therapist)

However, practitioners also recognised that many parents consciously attempted to do things differently, to offer their children an improvement on their own experience. Though these efforts again could be compromised:

“If somebody's not had good parenting experiences and then in their desperation to try and get it right, they get completely off kilter.” (Senior Occupational Therapist)

At the core of practitioners' accounts of the impact of the lack of a parenting model was the risk to the next generation. As a Midwife described:

“We literally do have mum and daughter [in our service], don't we sometimes? Yeah. And soon, it will be their grandchildren and granny.”

ii.b. Legacy of abuse

The second subordinate theme relates to the impact of abuse. Parents who had experienced abuse represented it as having a central effect on the parenting they provided for their children. The impact of early abuse was depicted as having a complex legacy as parents struggled to manage their own responses to their past. For example, as one mother described, this could be heightened when a child reached the age at which their own abuse started:

“When my daughter turned four, I was, was sexually abused and it started at the age of four, and it messed me up a lot. And I would look and think how could somebody do something like that? And then I lost the plot a bit and I was sectioned.”

In one form or another, each of the parents stated: *“I don't want any other child to experience what I have experienced,”* (Mother) which in some cases led parents to *“overcompensating”* (Father). In particular, this could take the form of overprotective behaviours. *“I didn't trust them going out – even when they were 14,”* (Mother). For two parents, the legacy of abuse was identified in their struggle to provide physical affection:

“When they reached certain age I found it very hard to cuddle them. I think it was about from six to seven up. Yeah, I was very tactile until that point.”

(Mother)

Practitioners also highlighted the burden of past trauma for parents that was related to being stuck at a developmental stage which made it hard to provide appropriate care:

“Obviously it can come out in different ways for different reasons, but that is the most complex when there is something that has perhaps kept them somewhere in their development as a child so they are fighting to be a parent and a child.” (Charity Worker).

More commonly, a legacy of abuse was that parents were *“desperately trying to do differently”* (Social Worker) and prevent repetition of what had happened to them:

“’Cause like you were saying about when trauma started you have, uhm, a mother was raped at 15 and now her daughter is 15, so she's now becoming extremely protective of the child and, you know, and not allowing them to grow up because they're so frightened about what was gonna happen.”

(Occupational Therapist)

Practitioners also described an ongoing process of re-traumatisation in which parents who had adverse experiences in their own childhood continued to experience a pattern of trauma and loss, for example from abusive relationships and, most saliently, in becoming a parent.

“We get parents who the...kind of the process of becoming a parent is traumatic in many ways and so they're dealing with their own trauma whilst also trying to put in the place the skills of containing it...a baby.” (Senior Social Worker)

(Senior Social Worker)

For practitioners the distressing, though not uncommon, conclusion to this pattern was the trauma of child removal.

iii. Negative view of self as parent

Parenting was largely represented by parents as difficult and described in negative terms. This was often allied to a belief that they were not doing/had not done a good job, especially in comparison to others. Even for parents who went on to express some satisfaction in being a parent, their initial description of their experience was frequently negative e.g., “*horrendous*” (Mother) “*a nightmare*” (Mother). When parents expressed pleasure in parenting, or some component of it, it was largely orientated around feelings of competence and teaching, as one mother described:

“There are times when I find it fantastic and I feel like I am doing quite a good job and I am actually doing good by them, you know. Sometimes I might be taken to think I am giving them a better chance than others by helping certain things or helping them understand the world in a certain way, but there are other times when I can’t be the person I wish to be.”

Consistent in this theme was the expression of sentiments relating to their failure to meet their own expectations, not being the “*person I wish to be*”. For many parents this was embedded in a reflective narrative in which their failures had led to negative outcomes for their children:

“Certain things stand out in him now, which I can see I was like – in how I was a mum and how that has affected him really, to me in a bad way.”

(Mother)

This was mirrored in the accounts of practitioners who described parents struggling to cope with knowledge of the negative impact they had on the lives of their children, particularly when children developed mental health difficulties of their own:

“You know, I saw a lady today and she just was like ‘I just want to write letters to everybody in my family.’ Because she has adult children now, but now she’s thinking: ‘Well she’s really struggling and I know that I’m, you know, I ran off, and I took overdoses, and I wasn’t there as a mum, and I did this, and I did that, and now she’s like this’.” (Midwife)

For practitioners, the negative views parents held of themselves had been shaped through their formative experiences and subsequently reinforced. One charity worker described the way a parent’s experience of being passed around mental health teams reinforced her poor self-esteem:

“The ‘end of the pile’ was explicitly used in a conversation I had with someone. Like a dumping ground - like now we are dumped in that pile.”

The intensity of the emotions related to these feelings of failure coupled with the low self-esteem and guilt can for some parents become enmeshed in patterns of self-harm and suicidality.

“Some things...drugs...either prescribed drugs or illicit drugs...alcohol. Self-harm, sometimes, in the moment can be a way of stopping intense emotions...can be a way of validating a sense of their own badness. A punishment, I’m not good enough.” (Clinical Psychologist)

iv. Unsupported parenting

Most participants characterised themselves as isolated and lacking support from a personal network and this was depicted as either of their own choosing, a consequence of their mental health, or both. Most parents described having few if any friends and most had experienced relationship-breakdown. Two parents identified supportive relationships with their co-parent which were informed by the co-parent’s understanding of the participant’s difficulties. One participant derived support from their child who had taken on caring responsibilities from a young age.

However, only one participant was able to recount a positive experience of parenting-focused support, which was via a charitable organisation.

Typically, parents represented mental health services as unengaged with their needs as a parent. If parents did share a need for assistance, it was unavailable. More than one parent described asking for help, to be told that there was not any. Another described a perception amongst health professionals that parenting is something that: *“you just get bloody used to.”* (Mother)

Difficulties in navigating the system, understanding the pathways to support – or even in having knowledge that it existed – was also present across the interviews. For example, one mother stated she *“...didn’t know where you could look for support or if there was any support there for you.”* (Mother). For the male participants, engagement with support was further compromised by their gender, which they characterised as a barrier to access. If support was available, it was not accessible to them as fathers, in particular because they did not have the vocabulary to ask for it:

“Unless you use the right words then help isn’t there, but they don’t tell you what the right word is, you have to wait and find out....if you use the word “I need help”, you’ll get help! But being a man you don’t think you need to use that word you just say “I don’t know what do about this”.” (Father)

In addition, participants expressed ambivalence about support, embodying a tension between desire to engage and fear of accessing support or asking for help. This was often rooted in a fear of child-removal. Two participants had experienced temporary child removal and for eight of the remaining ten parents, the risk and fear of child removal was extremely powerful, as a mother described:

“No. I never got no support. I was anorexic as well when I was pregnant. Errm. I was anorexic when they were growing up in school. But nobody

noticed anything. And I couldn't ask for help. I can't now. Because they might take the kids away."

An additional component of this ambivalent relationship with support related to parental expectation that services or groups would not be appropriate or would not understand them. This was highlighted by practitioners:

"And I know that people feel so self-conscious, that those baby groups and those parenting groups aren't for them. And sometimes they are actually right because they are going to feel very different and isolated if they go into some, you know some lovely group in Hove where it is all organic this and you know." (Family Coach)

Practitioners characterised parents as frequently isolated, lacking familial support and facing difficulties in accessing and of engaging with support. One practitioner described how these elements interact:

"The thing that I have been thinking about is about how actually these guys hold their family systems together and the kind of reality that some of them might be struggling to hold the relationship down or just be single parents. And then that's even harder logistically and to access treatment. Practically, to be able to do any of this stuff." (Clinical Psychologist)

In the accounts of practitioners, parents who do not have a positive network to draw upon are less likely and able to engage with support either for their mental health or their parenting. The absence of support can lead parents to depend on individuals who are harmful, which can take the form of dependence on parents who themselves are abusive, or in terms of romantic partners.

A charity worker also identified a pattern of dependence on mental health crisis support which could have been reduced by supporting parents in managing their

family relationships: *"it is not really a mental health problem, it is a childcare issue which is not being managed."*

v. Self in relation to child

Practitioners described parents as struggling to maintain a stable role in relation to their child. This was manifest in an enmeshment within the parent-child dyads as a Charity Worker stated.

"So, it is a very intense relationship. And so they are trying to support or protect each other and you can see it is not always healthy but it is not an explosive or uhmmm it is just not healthy."

These interpersonal difficulties existed in the form of role reversal. An Occupational Therapist gave this example of a parent demanding care from the child:

"So for me there can be this: 'I'm your parent but you also have to look after me.' So, it is a little bit more expecting a child to be good to them or to be looked after, you know, poor mummy has had a bad time."

For practitioners, role reversal could incorporate the child taking on a carer role. It was also represented as a method of behaviour management and a means of eliciting affection. In some cases, the parent was described as being unable to fulfil their adult role to the child as a result of the legacy of their own maltreatment in childhood.

"She was talking to her child, that she sounded just like a child herself, talking to her child. Like, kind of whiny voice like 'I'm on the phone,' you know, kind of child-like voice and I just thought 'oh, is she talking to her parents?' and then I realize, no, she's actually talking to her daughter, young daughter."

(Occupational Therapist)

vi. Difficulties in self-insight

Practitioners frequently referred to limitations in parents' insight into their behaviour and the effect it may have on their children.

“Externally looking outwards for some kind of, uhm, solution to the problems and find it really difficult to kind of...come back to themselves and identify a part in the chaos or what's happening around them. And it's this kind of desperate seeking often...and being caught up in what everybody else is doing. Sometimes, even the child themselves rather than where their part in it is.” (Social Worker)

For parents who are involved with social care, being unable to understand their role in their family's situation makes it difficult to change and increases the risk of child removal as a Social Worker described:

“I think if we got into that dynamic where we can see really concerning things develop, uhm, it tends to be the situations where the parent's ability to be mindful of that and having insight into that is quite impaired.” (Senior Social Worker).

In the characterisation by practitioners, parents may also lack insight into their child's experience and understanding. Parents were described as sometimes struggling to *“put themselves into their children's shoes”*.

Though insight was generally depicted as compromised in parents, it was highlighted that some parents had the capacity to develop a better understanding of themselves or their situation, in particular following therapeutic intervention. However, this new insight could be compromised by stress and emotional dysregulation.

2.4.2. Themes related to support

Across both datasets, a mismatch is evident between the reported parenting experience and the parenting support available. Both parents and practitioners described a need for specific parenting/family related support, for this group of parents. In describing what would be beneficial and appropriate there was considerable overlap. However, parents and practitioners also identified separate areas where they believed support would be useful.

Table 2.2. Grid of superordinate [shaded] and subordinate themes relating to parenting support needs, indicating those shared by parents and practitioners [in bold] and those which are present only in the data from parents *or* practitioners [not in bold].

	Parents	Practitioners
Themes and sub-themes relating to support for parenting	i. Connection through shared understanding	
	i.a Alongside others with experience	
		i.b Facilitation with understanding of mental health
	ii. Accessible not just available	
	ii.a Logistics	
		ii.b Flexible in response
	iii. Support for children	
		iv. Managing emotions
		v. Normalising parenting

i. Connection through shared understanding

Both parents and practitioners articulated a need for support which was characterised by an understanding of parent experiences and challenges in terms of their mental health. Most parents wanted an opportunity to interact with other parents who had shared experiences of mental health. In some cases, this was related to their positive experience of participating in specialised group-based treatment (e.g. STEPPS-EI; STEPPS).

For others, the focus was on space where they would feel free to be open about the difficulties they faced, as one mother explained: *“If you’re with a group that you did not originally know but who understand, you could open up more.”* The two fathers also presented a desire to connect with other men with shared experience, in part because they had felt excluded in groups that were primarily female.

Practitioners similarly identified a need for parents to be able to share their experiences without fear of judgement:

“Even offering them the space just to be in a, uh, group of parents...That space where they can just be parents and be okay for them to talk openly and honestly.” (Occupational Therapist)

This was associated with ideas with shared learning and supporting parents to build a network: breaking down the perceived isolation of parents through *“a sense of belonging and identification with people.”* (Mental Health Nurse)

A subordinate theme, which was only present in the parent data, was the need for support to be facilitated by practitioners with an understanding of mental health and abuse.

ii. Accessible not just available

For support to be effective it should be designed and implemented with an understanding of barriers to access, which include parents' complex relationships with support as well as logistical concerns.

Parents identified cost, location, timing and availability of childcare as playing an important role in the impeding and facilitating engagement with support:

"The financial aspect even though they were offering things on a financial scale, it was a barrier to be honest. And the fact that location-wise it meant long travel, which sounds really pathetic but when you are in the throes of a really intense lifestyle." (Mother)

Practitioners echoed this, describing the need respond to the specific logistical needs of parents, particularly those who may not have other support around them:

"Then there comes the issue with we want parents to attend group work at our group therapy program but there's never any childcare, or school holidays, or whatever. I mean, that again is a basic." (Social worker)

Alongside these practical considerations, a number of practitioners identified a need for a flexible approach, to take into account the complexity many parents were living with:

"You have a boundary, definitely have a boundary, but have flexibility with the boundaries. It is not that you break it, but be flexible. But once you have got things like a bunch of restrictions, you know, agendas of whatever your service is. That rigidity, people with emotional intensity don't do well with that. They don't get it. They will struggle to understand it." (Mental Health Nurse)

iii. Support for children

Parents identified a need for support to be targeted at their children, to enable the children to cope with their experiences. This included supporting children in their understanding of mental health and providing opportunities to connect with children with shared experiences:

“For the children to be heard and to have other experiences with other children that had difficulties, so they had group support.” (Mother)

Few practitioners identified children as a target of support. More commonly, children were described as at a distance from their work. Where support for children was discussed, it was largely through the prism of the parent, either in terms of support for the parent having a cascading benefit to the wider family, or as a method of engagement:

“I think an incentive is related to the guilt that some parents feel that their children are not meeting other children so giving a way to connect their children. That might be a nice thing.” (Family Coach)

iv. Managing emotions

Practitioners identified a need for support in terms of parents' emotional regulation and in responding to the emotional needs of the children:

“I feel on one hand they would need a way to regulate their emotions, maybe like, uh, mindfulness course. Something that really, like, or skills course that really calms down the nervous system.” (Occupational Therapist)

While parents expressed difficulties in managing and responding to emotion, it was not a strongly identified factor in their desired support.

v. Normalising parenting

Practitioners identified a need to encourage parents' understanding of typical parenting experiences – that parents and practitioners at times pathologize parenting challenges which may be common and shared experiences:

“Just normalise some of these intense reactions. Parents having intense reactions - hold the front page, kind of thing. And so, if some kind of distress is talked about in the context of their parenting it does normalise it a bit. Because every parent can go through it.” (CAMHS, Clinical Psychologist)

2.5. Discussion

This study aimed to generate a deeper understanding of the parenting experiences of individuals with BPD traits, as represented by parents and by practitioners with experience of working with them. Comparison of the experiences and views of these two groups revealed considerable shared understanding. Both parents and practitioners described in stark terms the challenges that parents face in managing their mental health while seeking to provide care to their children. While both groups identified a deficit in and barriers to appropriate support, there were also some clearly identified targets for engagement.

Parents and practitioners described the impact of mental health difficulties on parents' ability to cope with the day-to-day demands and responsibilities of parenting. Within this theme, challenges around emotional intensity were frequently cited as causing a burden on families. The focus on emotional intensity as a primary characteristic of disordered parenting mirrors the views of researchers who implicate emotional dysregulation in the development and maintenance of BPD (Glenn & David

Klonsky, 2009; Linehan, 1993; Stepp et al., 2012). The association between emotional dysregulation and problematic behaviours such as aggression, binge-eating may be reflected in the presence of maladaptive parenting behaviours such as verbal aggression or withdrawing in response to emotionally intense familial situations (Selby & Joiner, 2013). For parents, the recognition that these experiences were not “like other parents” and their awareness of the effect their mental health may have on their children, played into a cycle of guilt and despair. This, in turn, contributed to the negative opinion parents held about themselves, as well as exacerbating mental health difficulties. This pattern may also incorporate models of self-stigma whereby individuals with mental health difficulties internalise the negative labels associated with their disorder (Vogel, Bitman, Hammer, & Wade, 2013).

While the current study sought to represent the experiences of individuals with traits associated with BPD, the accounts of practitioners were largely orientated to those who had a diagnosis, as these parents were more likely to be accessing services. The diagnosis of BPD is still a stigmatising one and may have an impact on both the clinical approach of practitioners in this study and the accounts they gave of the experiences and behaviours of parents. In particular, given the clear association made between experience of trauma and the mental health of the discussed parents, it is noticeable that no mention was made of Complex PTSD (CPTSD) which shares many similar features but is a less stigmatising diagnosis. There is potential that a patient with a diagnosis of CPTSD would be treated differently including through the provision of trauma informed care (Kulkarni, 2017).

A parent is part of a chain which links their past experiences of being parented to the care they provide to their own children. The majority of parents in the study lacked positive experiences of parenting to draw upon and had a history of trauma. Both parents and practitioners described formative experiences of neglect, abuse, lack of nurture or invalidation. These were clearly identified by parents and

practitioners as playing a role in clients' parenting. This absence of a positive parenting role model, and subsequent difficulties with emotional validation and over-protection, were also identified as areas of particular challenge in a review of the empirical literature (Petfield et al., 2015).

Practitioners identified parents as lacking insight in terms of outcomes of their behaviour and in terms of how their children and others may feel and experience this behaviour. This form of reflective capacity is similar to Fonagy's model of mentalisation, impairments in which are common in individuals with BPD (Fonagy & Luyten, 2009). That mentalisation is further impaired by emotional arousal seems to find support within the accounts of parents and practitioners. However, within the interviews some, though not all parents, demonstrated a clear ability to reflect upon the effects their parenting may have had on their children. It is noteworthy that this was primarily the case for parents of older children who were reflecting back, rather than those who were in the more intense stage of active parenting, where arousal would be expected to be greatest. Reflection of this type was also exclusively associated with individuals who had participated in some form of psychological treatment.

Parents represented themselves as frequently lacking a familial and social support network. This related to the ability both to form and maintain relationships. This echoes studies that have found that individuals with BPD tend to have fewer social interactions, tend to describe social interactions more negatively, and are more likely to characterise their family and social network as "very poor" compared to groups with other disorders (Ruud et al., 2019; Stepp et al., 2009). Social network analysis of individuals with BPD identified a trend to "cut off" more people from their network than non-BPD controls. Individuals with BPD were also found to be less discriminant in their selection of individuals for social support (Clifton et al., 2007). Failure to select appropriate targets for support and closeness may lead to disappointment and

rejection (Lis & Bohus, 2013). As one mother described “people came and went”. Cognitive mechanisms that have been implicated in these interpersonal difficulties include negative biases, impairment in interpretation of social behaviour and social problem solving (Lazarus, Cheavens, Festa, & Zachary Rosenthal, 2014). Whatever the cognitive mechanism, the functional impact of struggling to maintain friendships or close and supportive family relationships is the loss of practical and emotional support, including invaluable opportunities to share experiences of parenthood. Within the parent data, this deficit was mirrored by the clearly expressed desire for opportunities to connect with and learn alongside people with a shared understanding. Within the practitioner data it was reflected in the belief that parents needed opportunities to normalise experience, to “check in with other parents” (Clinical Psychologist).

2.6. Limitations

While this study revealed a powerful picture of parenting experience, it was limited in terms of the number of parents involved and by the wide age range and the differing parenting stages of the participants. In particular, the description of parenting experience offered by individuals currently involved in daily childcare may differ from that of parents reflecting on their experiences of childcare, not least due to biases in memory recall. Furthermore, there has been a positive trend in clinical attitudes towards individuals with a diagnosis of BPD over the last 15 years which is likely to have had some differential effect on the experience of parents with this diagnosis or traits associated with it (Day et al., 2018).

A further limitation was the low number of male participants. Exploring the experience of male parents with BPD traits would be of value given the broad lack of

research in male parents and some evidence of differential experiences of parental help seeking in males (Reupert & Maybery, 2009).

While every effort was made to capture a broad multi-disciplinary sample, the lack of representation from Child and Adolescent Mental Health Services and from Child Protection Services obscures part of the picture of the practice and understanding around these families. This is particularly relevant given the high incidence of child protection proceedings for parents with BPD traits (Adshead, 2015).

2.7. Clinical implications

Despite the clear need, parents with BPD traits describe limited, if any, access to targeted family-focused support. The experience of the interviewees in this study are borne out in the wider research literature (Florange & Herpertz, 2019; Stephanie D. Stepp et al., 2012). In Australia, the multi-agency Project Air group has developed a modular package of parenting support designed to be incorporated into routine clinical practice. This has been found to have good clinical acceptability and ongoing use 12 months post the initial roll-out (Gray et al., 2019; McCarthy et al., 2016). In the UK, equivalent interventions are not available and parents (if they receive any service) are caught between standardised community interventions and BPD-focused treatment pathways. This is despite clear societal and economic benefits to supporting parents (Adshead, 2015).

In conducting this study, we sought to illuminate the experience of parents with BPD traits and to determine the extent to which their experience was understood by the practitioners and helpers who work with them. What stood out to us above all was the clear love and good intentions all parents had towards their children. That these

parents frequently lack decent parenting models to draw upon, coupled with the emotional and relational struggles they endure daily, make it essential that targeted parenting support is provided to these parents.

There is a clear clinical and preventative need for support which targets parents earlier and which is shaped by and sensitive to the impaired relational capacity of people who have not had positive formative relationship experience. Supporting parents and families earlier, i.e. intervening before the red flag of risk has been raised, has the potential to increase the acceptability of support and generate protective benefits for children. To enable this, practitioners need an empathic, non-stigmatising narrative with which to talk to individuals with BPD traits about any mismatch between the parenting they offer and their child's needs.

However, in seeking to generate improved support for these parents, there is a corresponding need to engage with and support practitioners to do so. For many mental health practitioners, engaging with the parenting identity of patients is not something they have been trained in and may not feel comfortable to do. That doing so involves holding the parent and child in mind at the same time can be difficult, in particular when navigating matters of risk. For most mental health workers children are not present during formulation or treatment and which further complicates attempts to understand the wider system. In unpublished data collected for this study, this challenge was present in the accounts of many of the adult mental health workers interviewed. Where statutory services were involved with a family, practitioners further described difficulties in developing a shared agreement with social care workers about the needs of parents and the potential risks the parent's behaviours may pose to the child.

The parents interviewed expressed a clear need to feel understood and for opportunities to share experiences and utilise social learning. Practitioners and helpers need to be willing to get alongside these parents, to develop understanding

of their situation and needs, and develop individualised and group-based programmes which reflect their findings and build upon what has been identified in this study. In this way they can appropriately support parents with strategies to develop a model of “good enough” parenting and to strip away some of the keenly felt stigma associated with being a parent with a complex and enduring mental illness.

3. Adult mental health service engagement with patients who are parents: evidence from 15 English mental health trusts. (Study 2.)

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Citations: 1

3.1. Abstract

3.1.1. Objectives: Ascertaining whether mental health service users have children is a clinical requirement in UK health services, and acknowledgement of a patient's parenting role is necessary to enable engagement with their parenting experience and to facilitate support, both of which are associated with improved outcomes for the parent–child dyad. The current study sought to investigate the practice of mental health practitioners working in UK adult mental health services with regard to the following: Ascertaining whether patients have children; engagement with the parenting role of patients; engagement with the construct of 'think patient as parent'.

3.1.2. Methods: Self-report online/paper survey of 1,105 multi-disciplinary adult mental health practitioners working in 15 mental health trusts in England.

3.1.3. Results: A quarter of adult mental health practitioners did not routinely ascertain whether patients had dependent children. Less than half of practitioners engaged with the parenting experience or the potential impact of parental mental health on children.

3.1.4. Conclusions: The parenting role of patients is not routinely captured by large numbers of practitioners working in adult mental health settings. This is despite it being a mandatory requirement and an integral component of the systematic care of the adult, and preventative care for the offspring. Failure to engage with patients who are parents is a missed opportunity with profound downstream public health implications. The practice deficits identified in this study should be viewed in terms of broader structural failures to address the intergenerational transmission of poor mental health.

3.2. Contribution to the field

- This study is the first multi-site survey of adult mental health practitioners' engagement with patients who are parents in a decade.
- It identified that a quarter of adult mental health practitioners are failing to routinely identify parenthood of parents and the presence of dependent children. Over half of practitioners are not engaging with parenting experience or capacity.
- Identification of dependent children is a mandatory component of adult mental health clinical practice and is necessary to understand a parent's support needs.
- This study highlights a major failure of provision and a missed opportunity to engage with the support needs of the parent-child dyad.

3.3. Background

At any given moment an estimated one in six adults in England will meet the criteria for a psychiatric disorder and up to half of these adults will also be parents (Maybery & Reupert, 2018; Mcmanus, Bebbington, Jenkins, & Brugha, 2016) which corresponds to one in four children experiencing maternal mental illness (Abel, Hope, Swift, et al., 2019). While many parents who struggle with their mental health provide excellent, nurturing care, there is also a clear relationship between parental mental health difficulties and impaired child outcomes, across a wide range of domains including educational attainment, social connectedness and physical and mental health (O'Donnell et al., 2015; Pierce et al., 2020; Sidebotham & Heron, 2006). In particular, a parent's mental ill health is associated with increased risk of their child developing a mental disorder (van Santvoort et al., 2015). This intergenerational transmission operates in a non-specific way – parental mental disorder places the child at increased risk of developing all forms of psychiatric disorder. But there is also specific transmission – disorders such as anxiety and depression, as well as complex mental health disorders such as psychosis and borderline personality disorder, run in families (Lawrence et al., 2019; Rasic et al., 2014; van Santvoort et al., 2015). To use depression as an example, in studies carried out by Weissman and colleagues over a 30-year period, children born to a depressed parent were three times as likely to have a major depressive episode and were at greater risk of premature mortality, compared to offspring of non-depressed parents (Weissman et al., 2016).

While heritability plays a role in this intergenerational transmission of psychopathology, environmental factors are also clearly implicated and offer greater opportunity for intervention (Eley et al., 2015). For example, poor parental mental health can be associated with behavioural, emotional and relational deficits which

can be detrimental to the child. A highly anxious parent, for example, may encourage avoidant behaviour in their child (Maybery et al., 2015; Van Loon et al., 2014). There is, additionally, a bi-directional component: while the parenting role can be a positive experience for parents and contribute to their recovery, it can also be a source of stress and be implicated in poorer parental outcomes, particularly when parenting a child with behavioural or emotional difficulties (Dolman et al., 2013; Dunn et al., 2020; Floyd & Gallagher, 1997). However, these challenges can be moderated through the provision of adult mental health support which recognises and engages with the parenting role.

The impact of parental mental health problems can be moderated through the provision of appropriate support which engages with the parenting role. Adult mental health services are commonly the primary source of support for these adults and, as such, provide an arena for preventative approaches that take into account the individual as both patient *and* parent. In practice, for this to be the case, services and clinicians would need to: recognise the parenting and familial role of service users; offer assessment and treatment based on an awareness of the family context and the role the family can play in recovery; and provide care that is sensitive to the challenges and risks experienced by children of parents with mental health difficulties. At a service level, this type of approach would improve outcomes beyond the manifest mental health struggle, to include improvements in the quality of parenting behaviours, as well as prevention of child mental health struggles (Siegenthaler, Munder, & Egger, 2012c). Strikingly, this approach is already recommended by clinical organisations and is present within UK government policy and legislation (Care Act 2014, 2014; Children, Schools and Families Act 2010, 2010; Diggins, 2011; RCPsych, 2011). Despite the clear benefits for parent and child, and the policy and legislative impetus, there is scant evidence of this approach being translated into routine practice (Gatsou et al., 2016; Ofsted, 2013). A survey of five

NHS sites across England in 2009 revealed that the family perspective was largely absent at a strategic level in adult mental health services. At a practice level, assessment and care planning failed to take into account the family context; in fact, adult mental health staff were not routinely asking whether an adult using a given service had children. Perhaps inevitably, there was limited consideration of the impact of adult mental health on parenting and, at a supervisory level, there was a deficit in conceptualising the whole family's needs (Diggins, 2011). These findings were mirrored in a localised case-note review carried out in 2011, where adult mental health services showed minimal engagement with the effects of parental mental health on parenting capacity and child wellbeing (Gatsou et al., 2016).

Reporting in 2013, Ofsted also found that adult mental health services did not clearly record the presence of children and failed to adequately consider the needs of the family in assessment of care (Ofsted, 2013). In the intervening period, the extent to which UK adult mental services identify or engage with a patient's parenting responsibilities has been subject of limited further scrutiny.

This paper reports on a survey of adult mental health practitioner understanding or, engagement with, and attitudes towards the concept of 'think patient as parent'. It was carried out in 15 adult mental health trusts in England and offered to all staff working directly with patients. As such it was designed with the specific aim of rectifying the dearth of research on this important area of practice.

3.3. Methods

3.3.1. Ethics

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by HRA and Health and Care Research Wales [19/HRA/0092]

3.3.2. Recruitment

1178 participants were recruited from 15 Adult Mental Health Trusts in England between June 2018 and March 2019. Participants were recruited within their NHS local trust by email, poster and localised face-to-face campaigns. Participants were invited to complete the survey online or in paper format. *Written informed consent was obtained from all participants.*

The host trust, Sussex Partnership Foundation NHS Trust, recruited for the full period of the study with further trusts joining in three subsequent waves. There was an average of 74 participants per trust ($M = 73.67$, $SD = 38.74$, range 23 -139). Of the 28,385 professionally qualified clinical staff employed across the 15 trusts, 4.15% completed the survey ("NHS Workforce Statistics - March 2019 (Including supplementary analysis on pay by ethnicity) - NHS Digital," n.d.).

3.3.3. Participant characteristics

Participants were eligible if they worked directly with service users and were employed by the given trust. While this broad approach meant that staff working in perinatal and antenatal mental health were eligible, no responses were received from members of these teams. The majority of participants classified themselves as

female 806 (72.9%) and the average age was 41 ($SD = 11.26$, range 19 to 70). Inpatient and Assessment and Treatment teams had the largest number of respondents ($n = 271$ and $n = 249$) and Nursing was the most common role ($n = 423$). Professional characteristics are reported in full in Table 3.1.

3.3.4. Materials

A 31-item questionnaire was developed by the study team to investigate adult mental health practitioners' practice in, and attitudes towards, supporting patients who are parents.

The instrument was developed as follows: An initial set of items was developed, informed by policy recommendations, good practice guidance, and literature on practice, attitudes and barriers. This long-list was iteratively reduced by the study team with a series of rounds of external consultation from an expert panel comprising: a developmental child psychologist; a research design specialist; three clinical psychologists (x2 Adult Mental Health, x1 Child and Adolescent Mental Health); a social worker; a lead parenting practitioner; and a panel of mental health service users who are parents. Feedback was solicited until all parties felt that the scale items had acceptable face validity and captured a sufficiently broad range of behaviours and beliefs/attitudes, while being sensitive to the need to minimise response burden for practitioners. Mental health practitioners tested the final scale for usability and acceptability.

The final 21-item scale comprised three domains: *Routine practice behaviours*; *Attitudes and beliefs about practice*; and *Attitudes and beliefs about barriers to practice*. Items 1-18 took the form of Likert-type questions (example rating: strongly agree to strongly disagree) with three optional free-text questions. Only results from the first two of these three domains are reported in this paper.

Table 3.1. Participant characteristics defined by gender identity, profession, team, parenthood

		N (% of sample)
Gender identity		
	Female	806 (72.9)
	Male	282 (25.5)
	Prefer not to say	14 (1.3)
	Genderfluid	1 (.1)
	Non-binary	1 (.1)
	They	1 (.1)
Team		
	Inpatient	271 (24.9)
	Assessment and Treatment	249 (22.8)
	Recovery and Wellbeing	143 (13.1)
	Early Intervention	126 (11.6)
	Primary Care	104 (9.5)
	Other	67 (6.1)
	Community	86 (7.9)
	Specialist	44 (4.0)
Role		
	Nursing	423 (38.3)
	Support Worker	150 (13.6)
	Social Work	89 (8.1)
	Occupational Therapy	87 (7.9)
	CBT Therapist	84 (7.6)
	Clinical/Counselling	81 (7.3)
	Psychologist	81 (7.3)
	Psychiatrist	73 (6.6)
	Research Assistant	38 (3.4)
	Counsellor/Other	37 (3.4)
	Psychotherapist	37 (3.4)
	Care Co-ordinator	10 (.9)
	Other	32 (2.9)
Parenthood		
	Parent	705 (63.8)
	Not parent	400 (36.2)

3.3.5. Analysis

The data were screened and of 1,178 participants, 73 cases were removed (42 duplicate cases, 10 participants who identified as administrative professionals, which was not an included professional group, and 20 participants who did progress beyond demographic questions). Descriptive characteristics for 1,105 participants were examined and scores for the Practice and Attitudes subscales were calculated for the sample. Subscale items responses for the sample are reported represented in Figure 3.1 and Figure 3.2.

The internal consistency of the Practice and Attitudes subscales was calculated. The Practice scale was found to have good internal consistency (Cronbach's $\alpha = .84$). For the Attitudes subscale, one item - "*many parents do not consider their illness to be a problem for their children*" was removed due to its low item-total correlation and its depressive effect on the alpha score. Upon removal of this single item, the Attitudes subscale had an acceptable level of internal consistency (Cronbach's $\alpha = .74$).

Mean subscale scores, disaggregated by professional characteristics and demographics, are reported in Table 3.2.

Data were analysed in IBM SPSS 25 for Windows with secondary data visualisation in Tableau 2020.2 for Windows.

Table 3.2. Means and standard deviations of (a) Practice and (b) Attitudes subscales. Higher scores are indicative of higher level of routine practice and greater engagement with concept of ‘Think Patient as Parent’. The lowest possible score on each item was 1, and the highest possible score was 6.

	Practice subscale scores		Attitudes subscale scores	
	Mean	Standard Deviation	Mean	Standard Deviation
Total sample	4.18	1.10	4.90	.64
Team				
Inpatient Assessment and Treatment	3.61	1.13	4.82	0.62
Recovery and Wellbeing	4.36	1.00	4.91	0.69
Early Intervention	4.43	0.88	4.92	0.53
Primary Care	4.60	0.94	5.02	0.55
Other	4.14	1.07	4.79	0.66
Community Specialist	3.99	1.29	4.82	0.70
	4.41	0.88	4.95	0.59
	4.65	1.25	5.16	0.82
Role				
Nursing	4.28	1.02	4.91	0.59
Support worker	3.69	1.16	4.74	0.69
Social work	4.71	0.78	5.03	0.60
Occupational therapy	4.00	1.07	4.98	0.69
CBT therapist	4.32	1.03	4.77	0.71
Clinical/counselling psychologist	4.44	0.96	5.05	0.71
Psychiatrist	4.29	0.91	4.99	0.52
Research assistant	3.36	1.07	4.84	0.52
Counsellor / psychotherapist	4.82	0.89	5.03	0.63
Care co-ordinator	4.27	1.14	4.76	0.39
Other	3.12	1.59	4.64	0.83
Gender				
Female	4.24	1.08	4.93	0.63
Male	4.03	1.13	4.84	0.65
Other	3.82	1.16	4.62	0.71
Parental status				
Yes	4.32	1.07	4.96	0.65
No	3.94	1.10	4.78	0.60

3.4. Results

3.4.1. 'Think Patient as Parent' Practice

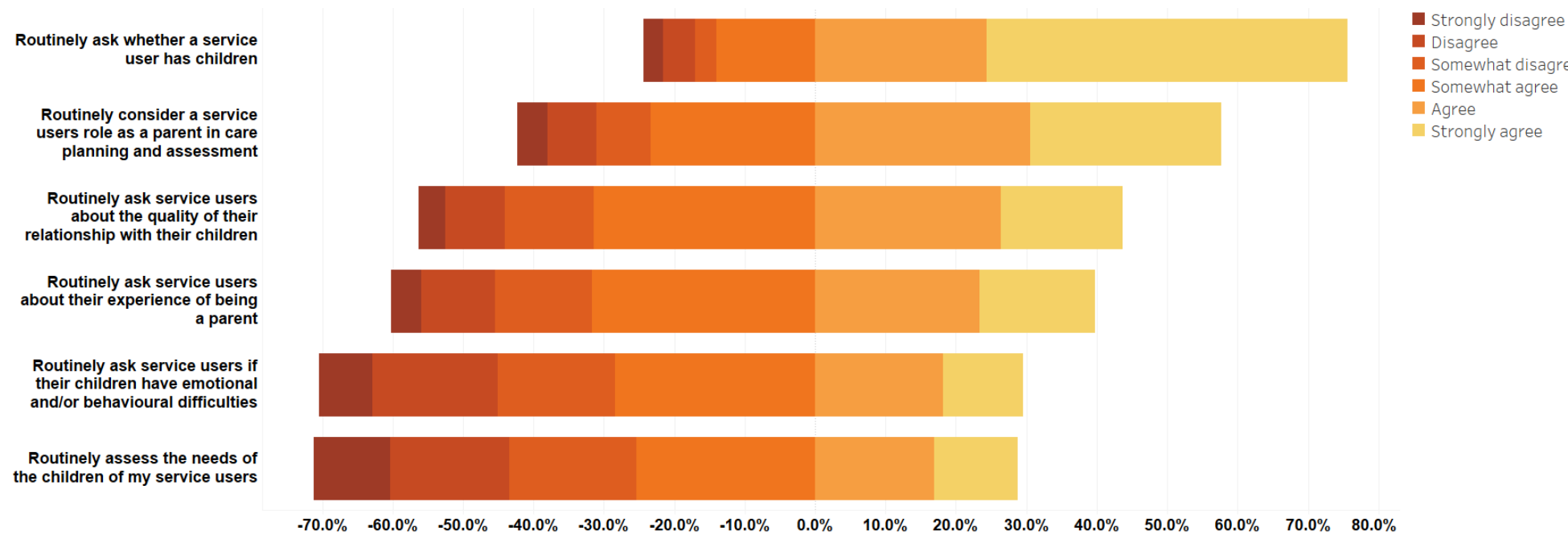
Routine monitoring for presence of children in patients' families.

Three-quarters ($n = 837$, 75.7%) of participants indicated (via either agreement or strong agreement) that they routinely asked whether a service user had children.

Family focused activities

The results from this section of the survey indicated that fewer than half of all respondents routinely (as indicated by agreement or strong agreement) asked service users to tell them about their experience of having children ($n = 438$, 39.6%), or routinely asked service users about the quality of their relationships with their children ($n = 483$, 43.7%), or routinely asked service users if their children have emotional and/or behavioural difficulties ($n = 326$, 29.5%) or routinely assessed the needs of the children of their service users ($n = 317$, 28.7%). For all items "somewhat agree" was the modal response. Slightly over half ($n = 632$, 57.6%) did report routinely considering a service user's role as a parent when making an assessment or care planning (see Fig 3.1.).

Figure 3.1. Practice subscale items. The scale on the x axis refers to the percentage of participants in each response category (see key on righthand side). +% indicates % participants who “strongly agreed/agreed” with the statement, -% indicates % participants who “somewhat agreed – strongly disagreed.”



3.4.2. Attitudes towards and beliefs about ‘Think Patient and Parent’ practice

Attitude towards parental mental health

Of the 1,088 practitioners who responded, the majority agreed or strongly agreed that challenges related to being a parent can affect a service user’s mental health ($n = 991, 91.1\%$) and that a service user’s mental health can affect the way they parent ($n = 988, 89.4\%$). About half of respondents agreed or strongly agreed that talking about parenting can be upsetting for service users ($n = 588, 53.2\%$). Ambivalent categories (somewhat agree/somewhat disagree) were the most common response to the statement “*many parents do not consider their illness to be a problem for their children*” ($n = 615, 56.5\%$).

Attitude towards support for service users who are parents

The majority of participants ($n = 762, 69.0\%$) strongly agreed/agreed with the statement that “*it is important to talk to service users about their parenting*” and that “*assessment and care planning should take into account the role of service user as parent*”.

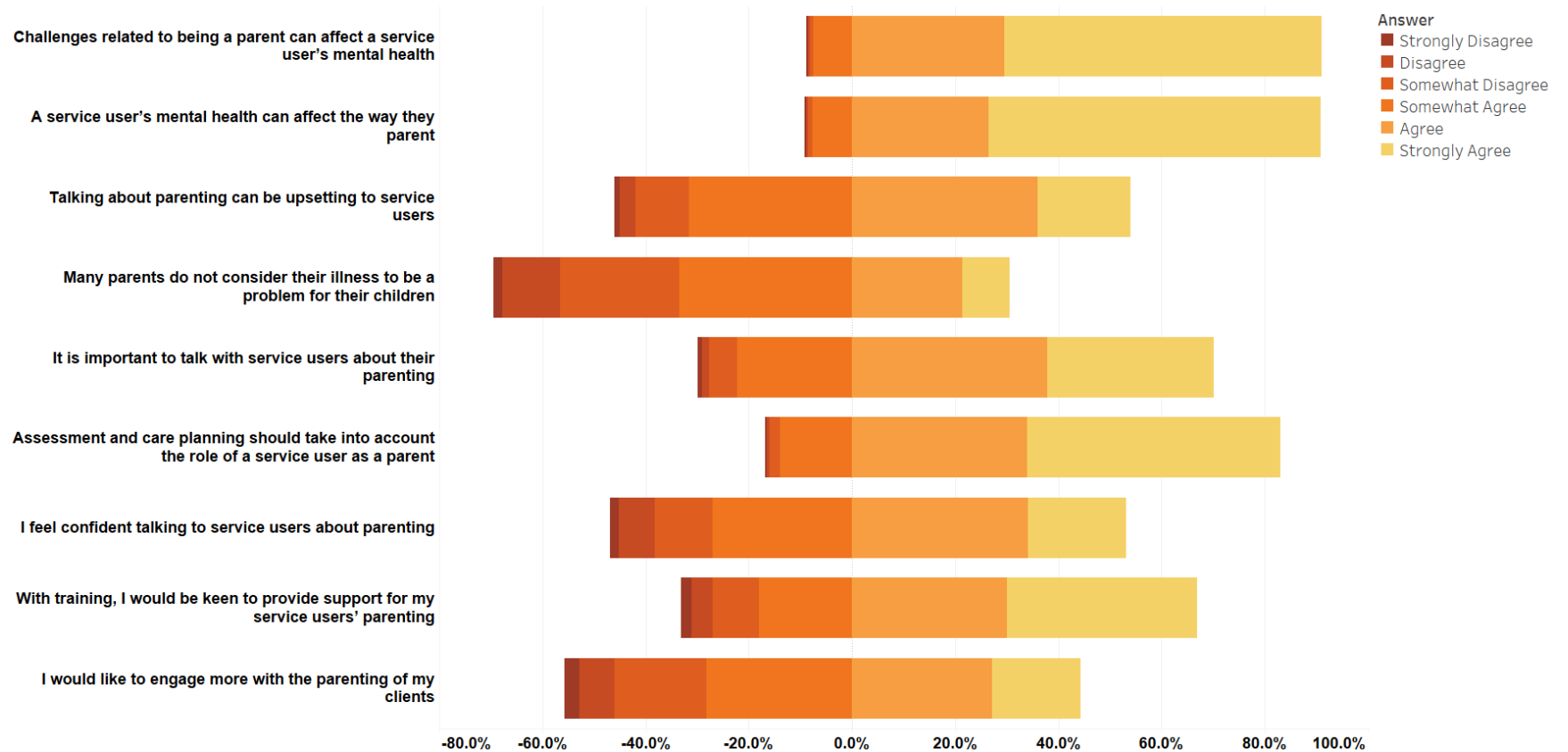
Attitude towards own ‘Think Patient as Parent’ practice

Half of respondents ($n = 578, 53.1\%$) agreed or strongly agreed that they felt confident talking to service users about parenting. Two-thirds ($n = 728, 66.9\%$) of practitioners strongly agreed/agreed that, with training, they would be keen to provide support for their service users’ parenting. Less than half of practitioners ($n = 482, 43.6\%$) agreed with the statement “*I would like to engage more with the parenting of my clients*”.

3.4.3. Interdisciplinary and inter-team differences in 'Think Patient and Parent' practice and attitudes

Mean scores disaggregated by professional team, professional role and parental status indicate lower levels of engagement in 'patient as parent' practice amongst workers in inpatient settings, those working as support workers or research assistants and those without children. Inpatient workers, along with support workers, CBT therapists, care co-ordinators and 'other (team and role categories) were least engaged with the concept (see Table 3.2.) Formal sub-group analyses were not carried out because there was insufficient power for the very large number of comparisons that would be required for this secondary analysis.

Figure 3.2. Attitude subscale items. The scale on the x axis refers to the percentage of participants in each response category (see key on righthand side). +% indicates % participants who “strongly agreed/agreed” with the statement, -% indicates % participants who “somewhat agreed – strongly disagreed.”



3.5. Discussion

This study was designed to investigate the extent to which adult mental health practitioners in England are engaging with their patients as parents. The results allow us to take stock of the support that is currently being offered to parents with mental health difficulties and their children.

The Care Act 2014 gives clear instruction that adult mental health practitioners should routinely record details of the patient's responsibilities in relationship to dependent children as a matter of routine practice but there has been limited investigation into the delivery of this objective (Care Act 2014, 2014). Furthermore, only when a practitioner has obtained this information can they engage with the parenting needs of their patients.

The results of this study provide evidence that within adult mental health services in England, even the most basic level of engagement with 'patient as parent' – asking if a service user has a child – is not routine. By their own account, a quarter of practitioners are failing to do this. When it comes to engaging with parents in terms of their parenting, their relationship with their child, or their child's needs, the picture worsens, with less than half of practitioners routinely undertaking this form of engagement. These findings echo the case 2016 note review conducted by Gastou which found that only two-thirds of patients were asked if they had dependent children (Gatsou et al., 2016). The results also indicate that in the decade since SCIE published its landmark 'Think Child, Think Parent, Think Family' report and practice survey, little has changed (Diggins, 2011).

By not engaging with a patient's parenting role, adult mental health services are failing parents and their children in multiple ways: Patients who are parents are being denied recognition of a significant aspect of their lives; they are being denied the contribution towards recovery that this form of engagement can offer; and they

are being denied support that could enable them to address any impact their mental health may have on their offspring (Swartz et al., 2008). This places their children at heightened risk of wide-ranging and well-documented negative outcomes including the intergenerational transmission of psychopathology (van Santvoort et al., 2015). Abel and colleagues have furthermore drawn attention to the need to increase understanding of the risk and resilience factors of these children and provide co-developed support which meaningfully engages with child-identified outcomes (Abel, Hope, Faulds, et al., 2019). As discussed, these approaches are only possible when children living with parental mental illness are given visibility. Given the numbers of parents who have mental health difficulties, this should be viewed as both a tragedy to the individual and to society. The failure of mental health services to engage in this way has clear public health and economic implications (Mihalopoulos, 2015).

There will need to be a shift in the stance of our mental health organisations to enable parenting to become more of a priority amongst practitioners. Maybery and Reupert's hierarchical framework of barriers to patient-as-parent practice emphasises the need for organisational conditions to be met before the workforce can engage (Maybery & Reupert, 2009). As such, a practitioner's skill, confidence and willingness to engage must be underpinned by structural conditions including policy, guidelines, allocation of resource and managerial support. Within this sample, the majority of practitioners agreed that mental health and parenting are interrelated; that it is important to talk to patients about their parenting; and that a patient's parenting role should be factored into assessment and care planning. Strikingly two-thirds of participants indicated that, with training, they would be keen to provide support for service users who are parents, indicating a clear need for professional capacity building. However, while it is essential that practitioners have the ability and desire to engage with their patients as parents, it is to fail them to expect them to do

this in isolation: for change to come, it must be embedded across the service context.

This is not a pipedream. Integrated approaches to embed 'think patient as parent' have been applied in local and national contexts. For example, Norway and Finland, amongst others, have legally mandated that services treating adults must acknowledge and respond to the needs of their offspring. In Norway, one initiative involved a two-stage clinical process: first, templates were used to ensure child identification at assessment, followed by the offer to parents of 'Child Talks', a short intervention focused on child resilience and information provision (Lauritzen et al., 2014). This was mirrored in Portugal where increased acknowledgement of the children of psychiatric patients following the implementation of practitioner training was coupled with organisational change (van Doesum et al., 2019). It should be noted that transforming service provision is effortful and sustaining innovation generates ongoing challenges (Greenhalgh & Papoutsi, 2019). For example, five-year follow-up at one Norwegian site that had deployed the two-stage approach revealed that practice change was unstable, and engagement declined after the project team withdrew (Lauritzen et al., 2018). While disappointing, these results are a salient reminder that change needs to be embedded within an organisation.

Initial efforts to embed 'family focused practice' (FFP) in Northern Ireland have generated similarly mixed results with high levels of concept recognition across health and social care services but low levels of practice (Grant et al., 2018).

However, considerable inter-role and inter-team variation in practice was identified in the project evaluation for example, lower levels of FFP were present in inpatient teams and greater levels of engagement found amongst social workers, both of which findings were reflected in the current study. This indicates that projects need to be solidly embedded within the organisation but should be responsive to team and role-specific barriers and opportunities for engagement.

An alternative example of a parent being seen and supported within mental health services is the ring-fenced investment in perinatal mental health care in England, which will see £365 million invested in services for women in the antenatal and postnatal period (NHS England, 2014). This is a national initiative developed to increase access to services and reduce regional service variation. It appropriately focusses on the needs of mother and child during a period of vulnerability, but also one in which there is a substantial opportunity for recovery. This programme has already generated benefits for thousands of women, children and their families and demonstrates that change can be achieved. However, support during the perinatal period does not ameliorate the situation for the fathers and mothers of older children whose ranks will realistically be joined by mothers who continue to struggle with their mental health in the post-perinatal period and this number is increasing year on year (Abel, Hope, Swift, et al., 2019). Furthermore, prioritising the perinatal period should not be at the expense of families of children at later developmental stages in which a parent has mental health problems. Explicit identification of support for parents with mental health difficulties has been noticeably absent from key government publications outlining the preventative agenda and on transforming the mental health of young people (Department of Health and Department of Education, 2017; D. Haslam, 2014). Within a financially straitened and understaffed system such as adult mental health services, and in the absence of clear guidance or funding, it is unsurprising that local commissioners, providers and practitioners fail to engage in a meaningful way with patients as parents or indeed to fulfil their basic mandated requirements.

3.6. Clinical implications

Many adult mental health practitioners are failing to identify the parenting responsibilities of their patients and so are not engaging with these parents' experience of parenting or considering the vulnerabilities of their children. This means that a core opportunity to intervene is missed and parents and their children are being failed. The downstream outcome of this is the continued intergenerational transmission of mental health disorder.

The importance of engaging with patients as parents is well-recognised and has long been the recommendation of a broad church of professional bodies as well as a component of government policy. Despite this, over a decade since the publication of 'Think Family', services are not providing the essential ingredients to engender change in practice. While individual practitioners may fail to engage for a range of individual factors such as skill and confidence and also quite simply not having sufficient time because of the pressures of working in underfunded teams, this situation must be seen as a systemic deficiency generated by a failure to incorporate the concept of 'patient as parent' at a structural level. As such there is clear need to unpick the barriers to implementation of this approach in England and develop a coherent and realistic strategy to embed 'think patient as parent' within adult mental health services.

3.7. Limitations

This study was designed with the objective of investigating adult mental health service practice related to the support of the parenting role of a patient with offspring. The findings should be interpreted as a 'snapshot' of the practice and

attitudes of a self-selecting sample of clinicians. As such, care must be taken with regard to the representativeness of the data. Whilst the overall sample size is reasonable given the scope of the study, the low response rate relative to the number of clinical staff working in the participating trusts is a clear limitation. The diffuse recruitment approach, which was pragmatically motivated, did not generate data on how many clinicians were invited compared with the number who took part. However, it is likely that clinicians who were willing to respond to this survey were more engaged with the approach, which may have skewed the results in the direction of a higher reported level of engagement with parents than is typical. To note, practitioners working in perinatal mental health services situated within participating trusts were eligible for inclusion within the study but no survey responses were received from them. While the inclusion of data from practitioners in these settings would likely have offered very different trends in engagement with 'patient as parent' it would have offered useful comparison.

An additional limitation of this study is the potentially differing levels of engagement that practitioners may have with male and female patients in terms of their parenting role. We have used the term parent to refer to any gender, but it is possible that practitioners are more focused on mothers in this context. Should this be the case it would reflect trends in both engagement and research into parenting, which is more orientated to mothers (Panter-Brick et al., 2014). However, fathers with mental health challenges may have specific support needs. The relationship between parent gender and mental health practitioner engagement is one which would benefit from further research (Fisher, 2016).

Future research in this area would also benefit from engagement with the impact of child age on practitioner engagement – the experiences and needs of parents and children at different developmental stages vary considerably. However, it is possible

that parents of older are less likely to be engaged with and offered support, despite the fact that parenting an older child can be a source of specific challenges.

4. Psychiatric inpatients who are parents: what parenting support is given to them and what do they want? A systematic review [and data synthesis] (Study 3).

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4.1. Abstract

4.1.1. Objectives

Little is known about the experiences of parents who are in receipt of inpatient care or about what interventions are employed to support them in their parenting role.

The objective of the current study is to review two complementary areas of research:

1) Research examining interventions developed to support the parent-child relationship within these settings. 2) Research focused on the experience of parents in inpatient settings.

4.1.2. Methods

For studies reporting on parents' experience, qualitative accounts of past or present psychiatric in-patients (child aged 1-18) were included. For intervention studies, the intervention had to focus on supporting the parenting role and/or the parent/child dyad of parents (child 1 to 18 years) in current receipt of inpatient care.

Four bibliographic databases (Pubmed, SCOPOS, Web of Science, PsychINFO) were searched for relevant published and unpublished literature from 01/01/1980 to 04/12/2021.

Intervention studies were appraised using the Mixed Methods Appraisal Tool. Qualitative papers were assessed using the Critical Appraisal Skills Programme tool. Data were extracted using tools designed for the study. Qualitative data were synthesised using thematic analysis.

4.1.3. Results

Twenty-four papers (eight intervention studies and 16 examining parent experience) were included in the eventual review. Inpatient parents commonly reported hospitalisation as having negative impacts on their parenting. Very few robust reports of interventions designed to support parents in receipt of psychiatric inpatient care were found.

4.1.4. Conclusions

Despite the identified need for support by parents who are receiving inpatient care there are currently no intervention of this nature running in the UK health service.

4.1.5. Registration:

The protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) reference CRD42022309065.

4.2. Contribution to the field

- Parents comprise up to a quarter of psychiatric inpatients and hospitalisation involves separating parent and child with high potential for distress to both.

- There has been limited research which synthesises the experience of parents in psychiatric inpatient care. This review sought to generate a clearer understanding of the experience of psychiatric inpatients who are parent and of interventions which have been delivered to them,
- Lack of provision, including appropriate facilities for child visitation, exacerbates the negative experiences of parents.
- Parents do want support in their parenting role including, at a minimum, greater engagement with their parenting identity and function, and improved provision for child visits.
- Research into appropriate support is, however, in its infancy.

4.3. Introduction

Of the approximately 16,500 psychiatric inpatients in the UK at any time, around one quarter are parents of dependent children, with similar figures reported internationally (Benders-Hadi et al., 2013; Ostman & Eidevall, 2005). Parents who are in receipt of inpatient care are not a homogenous group. However, for the majority, hospitalisation requires separation from their children. In many cases this follows a period of acute mental illness, and sometimes a difficult or non-voluntary admission process, which is distressing to both parent and child.

For most adults with children, parenthood is an integral part of their identity, and one that brings both rewards and challenges. The centrality of the parenting identity is no different for parents with serious mental health problems (Hine et al., 2019). However, this parenting role is rarely acknowledged by clinical services (Lauritzen et al., 2015). Adults experiencing serious mental illness can provide nurturing parenting and derive satisfaction from the role (Campbell et al., 2018; Diaz-Caneja & Johnson, 2004). However, the challenges of parenting are understandably greater for those with severe mental illness. The ability to provide appropriate care may be compromised by both symptoms and treatment, behavioural and relational challenges, financial hardship, and isolation from the informal networks that parents call upon (Strand et al., 2020). Furthermore, mental health difficulties are often associated with specific parenting attributes, such as challenges in containing children's emotions, boundary setting and discipline, and overprotection (Stephanie D. Stepp et al., 2012; Wan et al., 2008). Consequently, while not specific to those who have received inpatient care, having a parent with severe mental illness is associated with impaired psychosocial outcomes for children (Argent, et al., 2020).

For parents who have experienced psychiatric *inpatient* care, these risk factors and vulnerabilities are even greater. Whilst there is limited research that focuses on

outcomes for the children of hospitalised parents, there is evidence that such children are at risk of adverse outcomes, including being re-housed, (e.g. into foster care), poor school readiness, and of abuse (Bell et al., 2019; Konishi & Yoshimura, 2015). Parents who have received inpatient care also report higher levels of psychological and behavioural problems in their children compared with parents from the general population (Markwort et al., 2016).

Parents who have received inpatient care largely characterise their experience as negative: hospitalisation is seen as having a significant, detrimental impact on the parenting role (Scholes et al., 2021). For some, this rupture may continue beyond discharge, due to child removal or because the relationship is perceived to be irretrievably damaged. Such parents also report low confidence in their parenting and considerable parenting challenges (Dolman et al., 2013). Children of parents with severe mental illness also report profound disruption on their lives, including negative experiences when visiting their hospitalised parents (Källquist & Salzmann-Erikson, 2019).

However, it should be emphasised that negative outcomes are not inevitable, with many parents providing excellent care to their children as they manage their mental health, and some children reporting positive aspects to parental mental ill health (Drost et al., 2016).

The provision of parenting support to parents with mental health difficulties (regardless of whether inpatients) is rare but is likely to have cascading benefits for the parent-child dyad, including reducing the intergenerational transmission of mental health difficulties. A growing body of research suggests that effective interventions can be delivered to parents who experience a wide range of diagnoses at varying degrees of severity (Cartwright-Hatton et al., 2018; Day, Michelson, & Thomson, 2012; Loechner et al., 2018; Siegenthaler et al., 2012a; Thanhäuser et al., 2017).

Furthermore, the literature suggests that parents overwhelmingly want to be supported in their parenting role, that they want this support to occur preventatively rather than as a response to mental health crisis, and for it to exist beyond the perinatal period (Dunn et al., 2020).

Despite the challenges faced by parents in inpatient psychiatric care and the corollary risks to their children, there have been limited efforts to develop an evidence-base of interventions designed to support parents through this vulnerable period. In a 2015 systematic review of interventions to support parents with severe mental illness, only two of 18 studies were delivered to parents during inpatient/residential treatment, with one delivered post-discharge (Schrank et al., 2015). Of inpatient studies, one comprised a case-note review of co-admitted parents and children, with no reported change statistics (Rothenburg et al., 2005). The second focused on mothers with comorbid substance abuse and mental illness, with limited information about the intervention or outcomes (Anonymous, 2002). The third, delivered as post-discharge home-visits for mothers with psychosis, focussed on minimising re-admission. However, the approach did not specifically engage with parenting (Cohler & Grunebaum, 1983). Furthermore, a subsequent scoping review of interventions supporting mothers with mental illness actively excluded interventions delivered in institutional settings (Suarez et al., 2016).

There is a similar lack of research attempting to understand the *experience* of being admitted to psychiatric care as a parent: a recent review of the experiences of inpatient service users included no mention of parents or parenthood. An earlier review, focussed on the support needs of families when a parent is hospitalised, comprised just six papers (of 18) that focused on the specific experience of parents (Foster, Hills, & Foster, 2018).

The current study aims to extend the evidence base on support for parents using psychiatric inpatient care by reviewing two complementary areas of research:

- 1) Research examining interventions developed to support the parent-child relationship within these settings.
- 2) Research focused on the *experience* of parents in inpatients settings.

4.4. Methods

This research is reported in line with PRISMA guidelines (Page et al., 2021).

4.4.1. Protocol registration

The protocol was registered with PROSPERO: CRD42022309065.

4.4.2. Eligibility

To maximise sensitivity, broad inclusion criteria were applied (Table 4.1.). Papers were considered if they included primary research published in any country between Jan 1980 and Dec 2021. All designs were eligible.

For studies reporting on parents' experience of being psychiatric inpatients, past *or* present psychiatric in-patients with a child aged 12 months to 18 years at the time of treatment were included. Where both inpatients and community patients were included, data were extracted only on inpatients.

For intervention studies, interventions had to be focused on supporting the parenting role and or the parent/child dyad, where the child was aged 12 months to 18 years, and the parent was in current psychiatric inpatient care.

Papers were excluded if they had no English-language abstract and/or the full paper was unavailable in English or German.

Table 4.1. PICO's schema used to inform eligibility criteria.

4.4.3. Information sources

Intervention Studies		Qualitative studies	
P atient, Pop, Prob	Parent accessing inpatient care for mental health treatment with child aged 12months - 18years	P atient, Pop, Prob	Parent accessing/accessed inpatient care for mental health treatment with child aged 12months - 18years
I ntervention	Parenting intervention targeting parent/parent-child dyad	I nterest	Experience, views, opinions
C omparison	None	C Ontext	Mental health inpatient care
O utcome	Any outcome for parent OR child (other than compliance with the intervention)		
S etting	Inpatient psychiatric care	S etting	

After scoping searches, and in consultation with an information specialist, Pubmed, SCOPOS, Web of Science, and PsychINFO were searched for published and unpublished literature from 01/01/1980 to 4/12/2021.

4.4.4. Search terms

To maximise inclusivity, no disorder-specific or methodological keywords were used. Reference lists of prior reviews and of the final included papers were searched. Relevant academics were asked to identify papers not identified in the database search and/or unpublished materials. The following search terms were used

Parent*OR mother*OR father*AND inpatient*OR "mental health unit*"OR"psychiatric unit*"OR "psychiatric ward*"OR"psychiatric hospital*"OR"mental health rehabilitation unit"OR"mental health residen*"OR"mental health hospital**"

The review was conducted within online data reference manager EPPI-Reviewer 4.0 (EPPI)(J. Thomas et al., 2010).

4.4.5. Study selection

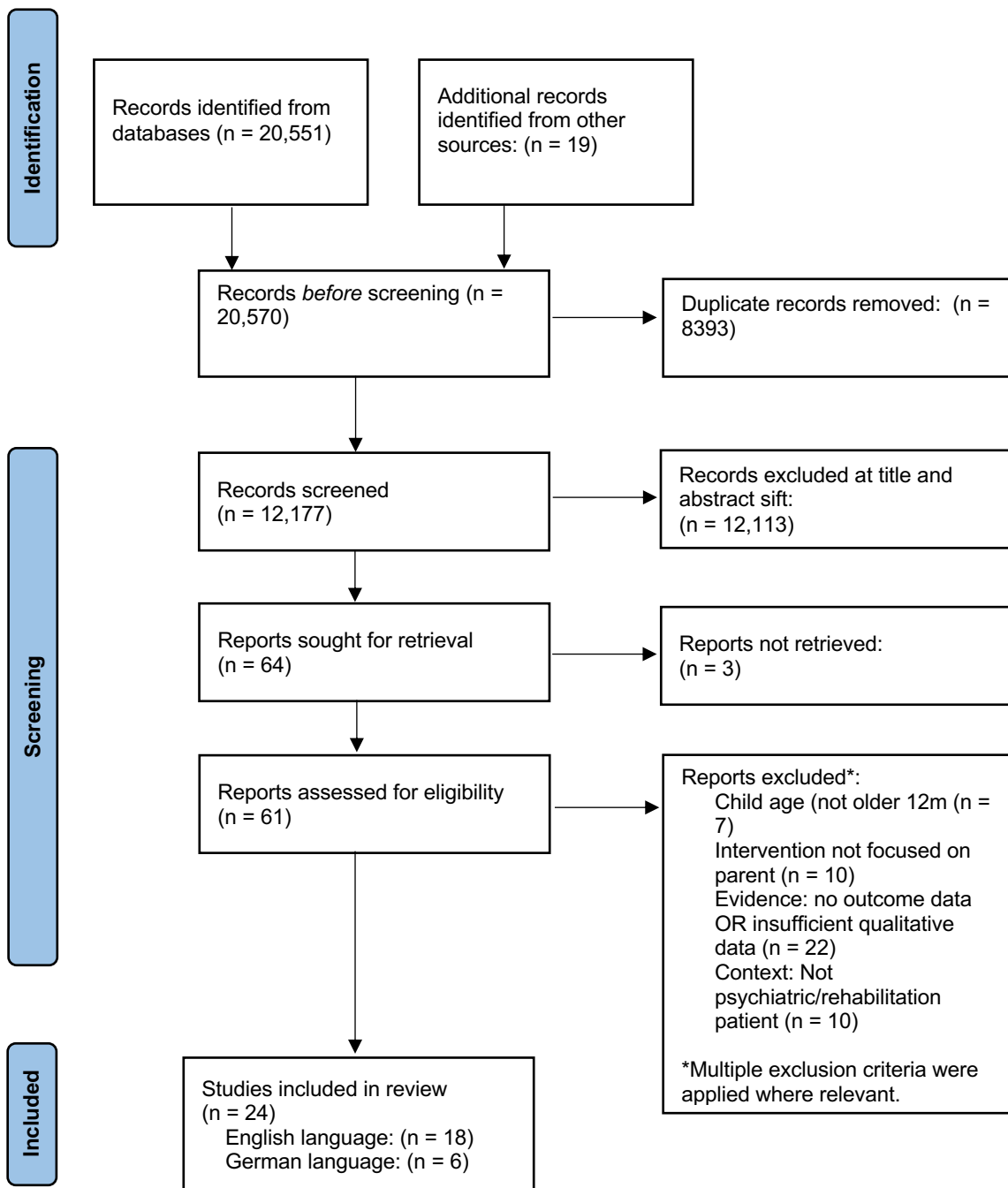
Following deduplication, two reviewers (AD, ES), from a pool of six, independently screened 20% of titles/abstracts against the inclusion criteria. Disagreement at this stage was below 1% (17/2811 randomly selected, double-coded references) and was resolved via discussion. The remaining titles/abstracts were screened by a single reviewer (AD). See Figure 1.

Where possible, full text papers for were obtained for all studies that were retained following title/abstract screening. All full text papers were independently screened by two reviewers from a pool of three (AD, SCH, ES) with discrepancies resolved in consultation with a fourth. German language papers were doubled-coded by two fluent German speakers (HC, JK), with additional discussion with the first author (AD) to reach consensus. Of 61 full text papers, there was concordance rate of 95%. Three papers were resolved by discussion.

4.4.6. Data extraction

Data were extracted using either a qualitatively- or quantitatively-orientated data extraction form (Appendix 3.), both generated by the study team. All members of the team were trained in using the tool and the process informed by ongoing discussion. All papers were extracted twice (by two members of a pool of six) with discrepancies resolved collaboratively. All data that were compatible with each outcome domain in each study were sought.

Figure 4.1. Flow diagram of studies included in the results.



4.4.7. Methodological quality

Methodological quality assessment was carried out on all included papers following data extraction, to evaluate risk of bias. None were removed as a result of this process. All papers were assessed by two coders from a pool of four. For the four

(of 26) papers where ratings were not in perfect agreement, ratings were resolved via discussion.

Intervention studies were appraised by two reviewers from a pool of four (AD, ES, HC, JK) using the Mixed Methods Appraisal Tool (MMAT, 2018) which comprises two screening questions and five criteria focused on the paper type (i.e., randomised controlled trial or descriptive study) using three response categories (Yes = 2, No = 0, Can't Tell = 0).

Qualitative papers (all exploring experiences of parents) were assessed for methodological quality using the Critical Appraisal Skills Programme tool for qualitative research (CASP, 2018) by AD and ES. The checklist comprises 10 items, which are rated using three response categories (No = 0, Can't Tell = 0, Yes = 2). To increase sensitivity, an additional response category (Somewhat = 1) was included for papers when the authors had made an attempt at fulfilling a given domain (Long et al., 2020). See Tables 4.2. and 4.3.

4.4.8. Intervention data synthesis

Due to the small number of quantitative studies, heterogeneous outcomes measures and lack of reported effect sizes, a meta-analysis is appropriate. Descriptive results are presented below.

4.4.9. Qualitative data synthesis and analysis

Qualitative data were subject to a thematic synthesis employing Thomas and Harden's three step approach (Thomas & Harden, 2008).

Stages one and two: Extracted data were line-by-line coded by two team members (AD, ES). Codes were created iteratively and inductively, and then revised to generate a hierarchical code-set. The order by which papers were coded was shaped by the results of the quality assessment, so high quality papers were used to

develop codes (those scoring >17 on CASP) and lower quality papers were then incorporated (Long et al., 2020). The text contained under each code was then examined to check consistency.

The third stage, carried out by the AD in discussion with the team, generated analytic themes, informed by the research question, using an iterative process of refinement.

Data collection forms, extracted data, and data used for analyses can be obtained from AD.

4.5. Results

4.5.1. Study characteristics

In total, 20,551 titles were identified in database searches, with a further 18 from citation-chain searching. Following deduplication, 12,176 abstracts were screened, of which 63 were selected for full-text assessment. In total 24 papers met the inclusion criteria and were retained for data extraction. Of these, 16 were focused on the experiences of parents, and eight were intervention studies. Eighteen studies were English-language and six were German-language (all intervention studies). See Figure 4.1. Results are reported independently for the two parts of the study.

4.5.2. Results: Interventions for inpatient parents

Eight intervention papers met criteria for inclusion (Besier et al., 2011; Fritz et al., 2017, 2018; Healy & Kennedy, 1993; Lenz & Lenz, 2004; Tritt et al., 2004; Verbeek et al., 2004; Volkert et al., 2019). Seven were published in Germany, of which six were German-

language and one English-language. One was published in the UK in English. Four included an all-female sample and the remaining four included mothers and fathers. The methodological quality of papers varied widely with four papers achieving 80% or more of MMAT quality criteria and two meeting only 20% (see Tables 4.4 and 4.5).

4.5.2.1. Study design and outcomes

Two papers reported randomised controlled trials (Lenz & Lenz, 2004; Tritt et al., 2004). In both, the intervention group was co-admission of mother and child, and the control group was parents admitted without children (Lenz & Lenz, 2004; Tritt et al., 2004). Four studies employed a within group pre-post or pre-post-post design (Besier et al., 2011; Fritz et al., 2017; Volkert et al., 2019). Two included two intervention arms: co-admission *and* co-admission plus a six-module group-based psychoeducational intervention, (SEEK)(Fritz et al., 2017, 2018). One was a comparative analysis (Healy & Kennedy, 1993), and one a case series (Verbeek et al., 2004).

Parent mental health symptoms were an outcome in five papers (Besier et al., 2011; Fritz et al., 2017, 2018; Tritt et al., 2004; Verbeek et al., 2004), parental stress in four (Fritz et al., 2017, 2018; Verbeek et al., 2004; Volkert et al., 2019), parental self-efficacy in one (Volkert et al., 2019) and quality-of-life in one (Besier et al., 2011). Four reported child outcomes, including internalising or externalising behaviours, with one deploying both parent and child-report versions of the Strength and Difficulties Questionnaire/SDQ (Besier et al., 2011; Fritz et al., 2017, 2018; Verbeek et al., 2004). Family function was assessed in two (Healy & Kennedy, 1993; Verbeek et al., 2004).

4.5.2.2. Participants

Aggregating data from the eight intervention papers generated a sample of 428 participants. Demographic information was variable across papers. Table 4.2 reports the available data.

Table 4.2. Participant characteristics of included intervention studies. Includes data on participants in intervention group and intervention group and control group where control is parent-child admission.

	Number of papers (total n)	N	%
Gender	7 (381)		
Female		361	94.68
Male		20	5.32
Diagnosis	6 (374*)		
Neurasthenia		202	54.01
Affective disorders		138	36.90
Schizophrenic and psychotic disorders		9	2.41
Bipolar disorder		3	0.82
Disorder non-specified		1	0.27
Anxiety disorders		16	4.28
Personality disorders		2	0.53
Substance abuse disorders		3	0.80
Delusional disorders			
Is patient primary carer?	6 (408)		
Yes		393	96.32
No		15	3.68
Unknown			
Marital status	5 (365*)		
Single/Divorced/Widowed		253	69.32
Married/Co-habiting		112	30.68

**Includes only data on participants included in follow-up assessment in Fritz 2018.*

4.5.2.3. Summary of interventions

All intervention studies involved the co-admission of parent and child. We found no studies where the active intervention involved parents being admitted alone. In two studies, the presence of the child during the parent's admission was the sole described intervention (Lenz & Lenz, 2004; Tritt et al., 2004), and it was the treatment-as-usual condition in two further studies (Fritz et al., 2017, 2018). Admission for these studies ranged from one to 12 weeks.

Six studies included an intervention which comprised co-admission of parent and child to a psychiatric ward or a designated parent-child institution, supplemented with work on parenting or the parent-child relationship (Besier et al., 2011; Fritz et al., 2017, 2018; Healy & Kennedy, 1993; Verbeek et al., 2004; Volkert et al., 2019). In one paper, this took the form of activities to promote parent-child interaction (e.g. massage)(Besier et al., 2011). In the single UK-based paper, co-admission of parent and child was supplemented by provision of a family nurse who supported parenting and liaison with external agencies (Healy & Kennedy, 1993). The Leuchtturm-Elternprogramms comprised a four-week mentalization-orientated course, which included individual and group sessions designed to explore the parent's attachment experience, to foster positive attachment with their child, including through relationship-repair and management of difficult situations (Verbeek et al., 2004).

Two papers evaluated the same intervention: SEEK (Fritz et al., 2017, 2018). This five-week group-based programme comprised: stress and symptom reduction; psychoeducation focused on children's needs, mental health reciprocity, and increasing sensitivity to the impact of parental mental health on the child. In these papers, treatment-as-usual comprised parent-child co-admission. In two papers, children also received psychological treatment, though this was not a focus of the current review (Healy & Kennedy, 1993; Verbeek et al., 2004). See Table 4.4.

4.5.2.4. Intervention effectiveness

Co-admission

Parent outcomes: In two studies, parent-child co-admission was associated with significant improvement in parental distress and mental health symptoms compared to baseline, with results stable at six-months (Fritz et al., 2017, 2018). Parents in one study reported significantly higher levels of satisfaction with treatment following co-admission compared with parents admitted alone (Lenz & Lenz, 2004). However, one paper reported no significant differences in symptom severity compared with a control group comprising sole admission (Tritt et al., 2004).

Child outcomes: In two studies, there was a significant post-intervention improvement in a child behaviour (hyperactivity, distractibility, adaptability)(Fritz et al., 2017, 2018). The studies reported no significant improvement in behavioural and emotional problems (CBCL) compared to baseline.

Co-admission plus further intervention

Parent outcomes: One intervention was associated with significant pre-post improvements in parent symptoms and quality- of-life (Besier et al., 2011). The intervention reported by Verbeek was associated with improvement in maternal depression in a case-series (Verbeek et al., 2004). The two SEEK trials were associated with significant main effects in a pre-post design, though no within-group effects were reported. In the first trial there was a significant reduction in parental strain and overall mental health symptoms and the in depression and anxiety (Klein et al., 2017). These main effects were replicated in the second trial with a significant improvement in parental strain and overall mental health symptoms at 6-month follow-up. The Lighthouse Parenting Program was associated with significant

improvement in parental stress compared to baseline (Volkert et al., 2019). In Healy and colleagues' study, intervention was associated with a descriptive account of improvement in family functioning, but no statistical analysis were reported (Healy & Kennedy, 1993).

Child outcomes: There were significant improvements in children's behavioural and emotional symptoms (SDQ) and quality of life associated with Besier and colleagues' intervention compared to baseline (Besier et al., 2011). SEEK was associated with a significant reduction in child internalising and externalising symptoms, and in behavioural and emotional problems compared to baseline (Fritz et al., 2017). The effects were maintained at six months for behavioural and emotional symptoms, but not for the internalising and externalising subscales (Fritz et al., 2018). In the case series study, co-admission was associated with clinician reports of improved child sleep, social interaction, separation anxiety, and reduced temper tantrums and impulsivity, compared to children who were not co-admitted with parents (Verbeek et al., 2004).

4.5.3. Results: Parents' experiences of psychiatric inpatient care

Sixteen papers were included, all of which all were published in English (Bassett, Lampe, & Lloyd, 1999; Benders-Hadi et al., 2013; Blegen, Eriksson, & Bondas, 2016; Castleberry, 1988; Cunningham, Oyeboode, & Vostanis, 2000; Diaz-Caneja & Johnson, 2004; Evenson, Rhodes, Feigenbaum, & Solly, 2009; Hawes & Cottrell, 1999; Johnson et al., 2009; Montgomery, Tompkins, Forchuk, & French, 2006; Mowbray, Oyserman, Bybee, Macfarlane, & Rueda-Riedle, 2001; O'Brien, Brady, Anand, & Gillies, 2011; Rampou, Havenga, & Madumo, 2015; Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003; Wang & Goldschmidt, 1994; Wang & Goldschmidt, 1996). Papers were published in UK (5), USA (3), Denmark (2) Canada (1), South Africa (1), Australia (2), Greece (1), Norway (1).

Fourteen studies recruited participants from inpatient settings or inpatient settings plus community settings, and two recruited exclusively from community mental health services (Diaz-Caneja & Johnson, 2004; Evenson et al., 2009). Eleven papers focused exclusively on mothers, one only on fathers, and four had a mixed gender sample. One study used focus groups and the remainder used individual interviews. Where stated, the analysis was descriptive (5), thematic (4), discourse (1), IPA (1), Grounded Theory (1) Hermeneutics (1). Seven papers were identified as of low quality according to the CASP checklist. See Table 4.1.

4.5.3.1. Participants

Participant data from 14 papers were aggregated, (one failed to report sample size (Bassett et al., 1999) and one was excluded from because it employed a sample that was reported elsewhere and already included in the count (Wang & Goldschmidt, 1996) to generate a combined sample of 629 participants. Gender, diagnoses, care-giving responsibilities and marital status of participants is reported in Table 4.3.

Table 4.3. Participant characteristics of inpatient parent 'experience' studies

	Number of papers reporting (total n)	N	%
Gender	11 (604)		
Female		577	95.53
Male		27	4.47
Diagnosis	12 (615)		
Affective disorders		224	36.42
Schizophrenic and psychotic disorders		158	25.69
Bipolar disorder		121	19.67
Disorder non-specified		78	12.68
Anxiety disorders		13	2.11
Personality disorders		10	1.63
Substance abuse disorders		10	1.63
Delusional disorders		1	.16
Is patient child's primary carer?	9 (209)		
Yes		151	72.25
No		51	24.40
Unknown		7	3.35
Marital status	10 (590)		
Single/Divorced/Widowed		333	56.44
Married/Co-habiting		256	43.39
Unknown		1	.17

4.5.3.2. Key themes

The experiences of parents were categorised into six themes: who is looking after my child?; maintaining connection from hospital; impact on self as a parent; discharge is not the end; perceived child experience; what needs to change.

Together, these represent the impact of hospitalisation in terms of the parent's physical separation from their children as well as its effect on the parenting role, on the child, and on parent's self-concept. The final theme integrates views on improvements that could be made to better support parents.

Who is looking after my child?

This theme, present in seven studies, is focused on the care arrangements put in place for children while their parent is hospitalised. Many parents expressed worry, confusion or anger about these arrangements, as described by one mother: *“On the ward, there were women who were very distressed by the fact that their children were in care somewhere and they couldn’t see them, and I just think that it is so damaging.”* (Diaz-Caneja & Johnson, 2004)

Parents identified difficulties in arranging care, or having no-one to care for their children during their hospitalisation, and in cases where children were under the care of social services, not knowing who was looking after their child was a source of distress (Diaz-Caneja & Johnson, 2004; Rampou et al., 2015):

“When I was admitted at the hospital I was thinking of my children, where are they? Who is taking care of them? Who is bathing and making food for them?”(Rampou et al., 2015)

Even when co-parents or family members were looking after children, it was still a source of worry or in some cases ambivalence (Montgomery et al., 2006). The exception was in one paper where four parents said they felt their children were looked after well (Cunningham et al., 2000).

A number of parents associated hospitalisation with a risk of permanent removal of children (Bassett et al., 1999; Blegen et al., 2016; Diaz-Caneja & Johnson, 2004; Montgomery et al., 2006; Rampou et al., 2015; Savvidou et al., 2003). The threat of child-removal was a source of extreme distress in all accounts. Some parents reported worrying that the alternative care arrangements during their hospitalisation made the subsequent removal of their child more likely, whether into the care of a co-parent as in the example below, or the care of the state (Bassett et al., 1999; Montgomery et al., 2006; Rampou et al., 2015).

"I'm the one who fears that he [father] might take them from me saying that I'm an unfit mother." Another stated the following: "I was scared when I was admitted at the hospital that they would take my children from me. I don't want them to stay with somebody or be taken away from me..."(Rampou et al., 2015)

Parents who had experienced the loss of a child in this way characterised it as highly distressing and as detrimental to their recovery (Diaz-Caneja & Johnson, 2004; Rampou et al., 2015; Savvidou et al., 2003).

Maintaining connection from hospital

Ten studies featured parental accounts that discussed maintaining connection. For most parents, hospitalisation involved a physical separation from their children, which was accompanied by a desire to maintain some form of connection, for example, through regular telephone contact (Bassett et al., 1999; Castleberry, 1988; Diaz-Caneja & Johnson, 2004; Evenson et al., 2009; Hawes & Cottrell, 1999; O'Brien, Anand, et al., 2011).

Child visitation was discussed by parents in several studies (Castleberry, 1988; Diaz-Caneja & Johnson, 2004; Evenson et al., 2009; Hawes & Cottrell, 1999; Johnson et al., 2009; O'Brien, Brady, et al., 2011). However, these visits were ambivalently represented. In two papers, children were described as making regular visits to parents including eating meals with them (Castleberry, 1988; Hawes & Cottrell, 1999). However, for many parents, the desire to see their children conflicted with concern that their children should not visit (Castleberry, 1988; Diaz-Caneja & Johnson, 2004; Evenson et al., 2009; Hawes & Cottrell, 1999; O'Brien, Anand, et al., 2011). Concerns included the suitability of the ward environment, due to the lack of appropriate visiting facilities, and worry about exposure to other unwell patients, as described below (Diaz-Caneja & Johnson,

2004; Evenson et al., 2009; Hawes & Cottrell, 1999; Johnson et al., 2009; O'Brien, Anand, et al., 2011).

"I'm a little cautious about having them in to see me, the ward, cause . . . some people are quite disturbed and it can be quite upsetting for them." (Evenson et al., 2009)

Some parents did not want their child to see them while they were unwell (Castleberry, 1988; Evenson et al., 2009; O'Brien, Anand, et al., 2011). One father described having been admitted to hospital annually for periods in excess of a month, but refusing visits from his child for this reason (Evenson et al., 2009).

For some, the distance afforded by admission was felt to be useful, in that it offered a break from the stresses of parenting/family life, after which the parent was able to *"return to bond with their children as a 'new mom.'"* (Johnson et al., 2009; Montgomery et al., 2006)

Impact on self as parent

Nine studies explored the impact of hospitalisation on parenting identity. The experience of hospitalisation and the poor mental health preceding it appeared to diminish parents' belief in their value as a parent (Castleberry, 1988; Cunningham et al., 2000; Evenson et al., 2009; Rampou et al., 2015; Wang & Goldschmidt, 1994).

Hospitalisation was described as preventing parents from fulfilling their parental responsibilities (Castleberry, 1988; Evenson et al., 2009; Rampou et al., 2015). It meant parents were *"not available"* (Rampou et al., 2015), as one father described:

"I haven't been there for them sometimes because I've been in hospital . . . I miss out, and my son misses out on my contact." (Evenson et al., 2009)

Some parents viewed their parenting negatively because of harms they may have caused to their children through exposure to their behaviour, their symptoms or

during hospitalisation (Castleberry, 1988; Cunningham et al., 2000; Montgomery et al., 2006; Wang & Goldschmidt, 1994) . For example, Montgomery and colleagues report that unwell mothers felt they struggled to meet their “*primary responsibility*” which was to protect their children from their illness(Montgomery et al., 2006). This was accompanied by the fear that they may have “*inadvertently hurt*” their children. Rampou and colleagues describe parental concern about children being cast into a parental role by their parent’s illness, in particular where a child took on caring responsibilities (Rampou et al., 2015).

Parents also described the corrosive effect of the stigma associated with hospitalisation on their experience of being a parent (Bassett et al., 1999; Benders-Hadi et al., 2013; Blegen et al., 2016; Castleberry, 1988; Cunningham et al., 2000; Evenson et al., 2009; Rampou et al., 2015; Savvidou et al., 2003). For some, this was related to shame they had about being unwell and hospitalised; this self-stigma was related to their view of their own illness or of the hospital environment, as described by Savvidou and colleagues “*inpatients in psychiatric units are mad and dangerous*” (Savvidou et al., 2003). Others felt that hospitalisation impacted on the way they were perceived and treated by others, including on the access they were given to their children (Bassett et al., 1999; Benders-Hadi et al., 2013; Evenson et al., 2009; Johnson et al., 2009) as described by one mother:

“And then it was treated like it was something to be ashamed of and I think that’s why society’s attitude that mental illness is something that it’s sort of like having ‘crazy bitch’ stamped across my forehead and everybody treats you differently because you have been a patient in a psychiatric unit.”

(Bassett et al., 1999)

For some, this stigma, rather than illness or hospitalisation, was represented as the thing which had most affected them as parents (Benders-Hadi et al., 2013), as one

mother expressed: *“I’m probably afraid of being labelled a lunatic and then they will take my children away.”* (Blegen et al., 2016)

Discharge not the end

In six studies, parents described challenges after hospitalisation. While returning to their parental role motivated engagement with treatment for several parents (Benders-Hadi et al., 2013; Diaz-Caneja & Johnson, 2004; Savvidou et al., 2003), discharge was not represented as straightforwardly positive (Bassett et al., 1999; Benders-Hadi et al., 2013; Cunningham et al., 2000; Diaz-Caneja & Johnson, 2004; Johnson et al., 2009).

While no paper explicitly discussed the threshold at which parents had been discharged, there were clear indications that many parents continued to be unwell, and that this contributed to their concern about their ability to cope with the practicalities of parenting (Cunningham et al., 2000; Evenson et al., 2009; Johnson et al., 2009; Rampou et al., 2015). In one example, a father found the intensity of family life too great and returned to hospital.

“Four young children . . . all under 5 and that, and they’re flying about, large as life all the time. You know, as soon as I got home, after coming out of a quiet hospital, you know it was too much for me. I had to go back in.”

(Evenson et al., 2009)

The failure of inpatient settings to engage with the parenting role was represented as contributing to these difficulties (Blegen et al., 2016; Montgomery et al., 2006). By focusing on symptoms and failing to give space to the complexity of the parental role, and the specific needs of parents, treatment failed to support them in the resumption of that role:

“Since I’ve been in treatment I’m not anxious, I’m thinking better, I’m sleeping, I can focus but what about when I leave to go home? I will keep

seeing [the psychiatrist] but it is the other stuff that worries me...when I have to get up at night, when I have to play with them but I'm tired."

An additional complication of discharge, described by some parents, related to difficulties in re-establishing their relationship with their children (Benders-Hadi et al., 2013; Cunningham et al., 2000; Diaz-Caneja & Johnson, 2004; Johnson et al., 2009). One aspect focused on the child's understanding of the parent's separation and their feelings of rejection (Diaz-Caneja & Johnson, 2004). Other parents highlighted their inability to communicate their experiences of hospitalisation or illness or to explain their absence (Benders-Hadi et al., 2013; Castleberry, 1988; Diaz-Caneja & Johnson, 2004). One mother pulled these strands together when describing aspects of parenting that she felt she would have to re-learn:

"It's like I have to learn how to be around my kids again...how to get along with them, how to tell them I love them, and how to explain that I wasn't there because I'm sick." (Benders-Hadi et al., 2013)

A further component was the potential of readmission. For some parents, preventing future hospitalisation motivated treatment adherence (Mowbray et al., 2001), whereas in other accounts, help-seeking was avoided due to the risk of re-hospitalisation and the accompanying separation from children (Diaz-Caneja & Johnson, 2004; Wang & Goldschmidt, 1996). Just as some parents experienced hospitalisation as a "hostile" act (Montgomery et al., 2006; Savidou et al., 2003), in an account by Bassett and colleagues, a mother expressed fear that the father of her children would use hospitalisation as an aggressive act towards her: *"I'm scared. I'm scared. I'm so scared."* (Bassett et al., 1999)

Perceived child experience

Parents' consideration of their children's experiences was reported by eight studies, though in limited form (Castleberry, 1988; Cunningham et al., 2000; Evenson et al., 2009; Rampou et al., 2015; Savvidou et al., 2003). In some cases, hospitalisation of the parent was described as having a negative impact on the child's affect or behaviour, as in the account below (Castleberry, 1988; Cunningham et al., 2000; Rampou et al., 2015; Savvidou et al., 2003):

"It looks like he's holding something, a worry inside. When he came to the hospital the next day to see me, he was so quiet and bashful. I could hardly get him to talk."

However, in the same paper, other parents described their children as adapting to their parent's situation, and elsewhere parents described their children as having 'an understanding' of the situation (Castleberry, 1988; Cunningham et al., 2000).

As discussed in earlier themes, where parents discussed the impact of their hospitalisation or health on their children, it was frequently associated with feelings of shame and the focus of discussions often oriented towards self-blame rather than on the experience of the child.

What needs to change?

Nine studies highlighted a need for improved provision for parents in order to better enable them to maintain their parenting role while undergoing inpatient treatment. The clearest target for improvement was the development of appropriate facilities for children to visit parents during treatment (Cunningham et al., 2000; Diaz-Caneja & Johnson, 2004; O'Brien, Anand, et al., 2011; Rampou et al., 2015). This included 'family rooms' or private spaces away from the main ward (Cunningham et al., 2000; Diaz-Caneja & Johnson, 2004): "*somewhere quieter*" (Johnson et al., 2009) and "*away from other patients*" (Diaz-Caneja & Johnson, 2004). In some studies, there was a call from

parents? for co-admission of child and parent (Diaz-Caneja & Johnson, 2004; Rampou et al., 2015).

The second key suggestion was that parental identity should be engaged with and supported (Blegen et al., 2016; Mowbray et al., 2001; Rampou et al., 2015; Wang & Goldschmidt, 1996). It was suggested that staff should engage with openness, persistence and empathy, and in the words of one parent “*to show more love*” (A. R. Wang & Goldschmidt, 1996). Or as described by one parent, therapists need to enable parents to share what they hold as important:

“I feel I have much at heart, but when I arrive he asks me about how I have been since the last time, and continues with that, including techniques and exercises, and I have no opportunity to say what I was going to say.”(Blegen et al., 2016)

Parents also proposed that greater effort should be made to identify that a patient is a parent (Cunningham et al., 2000) and that support should aim to strengthen parental functioning, promote parenting skills and ease the transition home (Mowbray et al., 2001; Rampou et al., 2015; Wang & Goldschmidt, 1994; Wang & Goldschmidt, 1996).

Table 4.4. Description of included intervention papers.

Reference	Intervention details: elements focused on support for parenting/parent-child dyad. (Duration)	Study type	Population	N (control)	Follow-up	Outcomes	Intervention effects	Quality Assessment (MMAT)
Besier (2011)	Co-admission + parent-child interaction interventions (e.g., massage). (3 weeks with 1 week extension)	Pre-pre-post-post	Parents admitted for inpatient treatment. Diagnoses: neurasthenia and depression. Child ages: 0-2 years = 48; 1-6 years = 141; 7-11 years = 168; 12-17 years = 39.	256	4 weeks before admission, pre-admission, post admission, 3 months post discharge.	Parent: Psychiatric symptoms, quality of life. Child: Behavioural screen, quality of life.	Significant improvement in parental mental health and quality of life with both maintained at follow up. Significant improvement in child behaviour which was maintained at follow up.	4
Fritz (2017)	Int: Co-admission + SEEK: 6 module group programme: 3 modules from the parent perspective - psychoeducation around mental illness and coping strategies, dealing with stress and warning signs; 3 from child perspective - psychoeducation on mental health reciprocity, child basic needs and mental health. (5 weeks) Control: Co-admission.	Pre-post	Parent and children both with mental health diagnosis. Parental diagnoses: schizophrenia/schizoaffective and depressive disorder. Child ages: 0-6 years.	25 (26)		Parent: Psychiatric symptoms, parental stress. Child behaviour.	Int: Significant reduction in parental strain and symptoms. Control: Significant reduction in parental stress and symptoms.	4
Fritz (2018)	<i>See above</i>	Pre-post-post	Parent and child both with mental health diagnosis.	28 (26)	Six months	<i>See above</i>	Int: Significant reduction in overall	4

			<p>Parental diagnoses: schizophrenia/schizoaffective, affective disorder, depressive disorder, bipolar.</p> <p>Child ages: 0-6 years.</p>		post discharge.		<p>psychiatric symptoms, depression and anxiety. Significant reduction in parental stress. All effects maintained at follow-up</p> <p>Control: Significant reduction in overall psychiatric symptoms and in depression. Significant reduction in parental stress. Reduction in depression and stress maintained at follow-up.</p>	
Lenz (2004)	<p>Intervention: Co-admission to mother-child ward. (1-12 weeks).</p> <p>Control: Admission without child.</p>	RCT	<p>Mothers with children aged under four. Diagnoses: depression, psychosis, personality disorder, substance abuse, OCD, mania.</p> <p>Child ages: Mean 2.33 (SD = 2.26). 25/44 children aged under 2 years; 19/44 aged over 2 years.</p>	22 (22)	Six months to two years after discharge.	Satisfaction with treatment experience.	Intervention group significantly higher level of treatment satisfaction.	2
Healy (1993)	<p>Co-admission + Nurse support around parenting. Liaison with outside agencies. (5 – 40 weeks)</p>	Comparative	<p>Parents admitted to the Cassell Hospital with their children. Diagnoses included personality disorder, affective disorder.</p> <p>Child ages: Under 5 years = 30/44.</p>	28		Change in family functioning.	Beneficial change was identified in 14 of the families reported descriptively.	3
Tritt (2004)	Intervention: Co-admission. (6 weeks)	RCT	<p>Mothers with generalised anxiety disorder aged 20-13.</p> <p>Child ages: 5-12 years.</p>	16 (17)		Parent psychiatric symptoms, changes in	No significant differences.	5

	Control: Admission without child.					experience and behaviour.		
Verbeek (2004)	Co-admission + Psychoeducation on children's behaviour, feedback on parenting behaviour and interaction (using video); role play. (3.5 weeks)	Case series	Depressed mother with child aged 2.	1	6 months and 1 year.	Parent: depression, psychosocial stress. Child: behaviour, development. Parent-child interaction and relationship.	Improvement in maternal depression, improvement in child sleep behaviour, social interaction and reduced temper tantrums, separation anxiety, impulsivity, disobedience.	1
Volkert (2019)	Co-admission + Manualised 8 session programme: 3 individual sessions including exploration of attachment experiences and parent-child interaction; 4 weekly mentalisation-focused parenting group sessions including relationship repair and how to handle difficult situations; one session on provision of social support. (4 weeks)	Pre-post	Mothers with a child aged between 0-14.	5		Parental stress, parental self-efficacy, participant satisfaction.	Significant reduction in stress and increase in self-efficacy.	1

Table 4.5. Description of included qualitative papers.

Author (year)	Country	Participants	Methodology and data collection	Analysis	Key findings related to parenthood and care.	Quality assessment (MMAT total score)
Bassett (1999)	Australia	Mothers with children under 5. Sample size not reported.	Qualitative using semi-structured interviews	Thematic	1) Fear of losing residence. 2) Trauma of hospitalisation. 3) Social isolation. 4) Care of the child if mother becomes ill. 5) Accessing community resources. 6) Stigma of mental illness. 7) Dissatisfaction with mental health services. 8) Importance of relationship with children.	14
Benders-Hadi (2013)	USA	24 mothers. Diagnoses: schizoaffective disorder, schizophrenia, affective disorder.	Mixed methods including focus groups with semi-structured interviews.	Not reported	1) Importance of parenting role. 2) Stigma. 3) Difficulty of prolonged hospitalisation.	12
Blegen (2016)	Norway	10 mothers with a child aged under 18. Diagnoses: depression, anxiety, bipolar disorder; ADHD	Semi-structured interview with philosophical hermeneutics.	Hermeneutical dialectics	1) Dare I say it? The anxiety mother's experience with regard to disclosing their inner world. 2) Living between the silent mask and the beating heart. The struggle between responsibly inherent in being a parent and the fear of condemnation.	17
Castleberry (1988)	USA	20 patients with children aged up to 12 admitted to inpatient hospital. Diagnoses: affective disorder, thought disorder, substance abuse disorder.	Qualitative methodology incorporating whole-family perspective interviews	None reported	1) Family life in the period coming up to hospitalisation. 2) Children's reactions to the separation, with particular focus on sleep. 3) How parents explained illness/hospitalisation to children. 4) Hospital visits. 5) Partner-child relationship during hospitalisation. 6) How family-life adapted during hospitalisation.	12
Cunningham (2000)	UK	29 mothers with children aged 2-11. Diagnoses: depressive disorder, bipolar disorder, schizophrenia and other psychotic disorders, anxiety disorder,	Longitudinal design incorporating semi-structured interviews	None reported	1) Children's knowledge of parental mental health. 2) Feelings towards children. 3) Experiences/issues since discharge. 4) Support since discharge. 5) Concerns for their health and their children. 6) Service improvements. 7) Attitude to visitation.	12

		substance abuse disorder.				
Diaz-Caneja (2004)	UK	22 mothers with a child aged under 16. Diagnoses: Schizophrenia, bipolar affective disorder: severe depression with psychotic symptoms.	Qualitative semi-structured interview	Thematic analysis using coding framework methodology	1) Positive aspects of motherhood. 2) Difficulties associated with motherhood. 3) Effect of mental illness on children. 4) Stigma. 5) Views about services, which included a) custody loss b) adult mental health services c) other agencies. 6) Arrangements when mothers were unable to look after their children. 7) Service needs.	17
Evenson (2009)	UK	10 fathers. Diagnoses: psychosis, schizophrenia, schizoaffective or other psychotic disorders.	Interpretative Phenomenological Analysis (IPA). Semi-structured interviews	IPA	1) Psychosis undermines the father-child relationship and the work of parenting: a) Emotional disengagement from one's children; b) Hospital as a family disruption; c) Medication as a straitjacket; d) A negative impact on one's memory. 2) The impact of parenting on the fathers themselves: a) Pride in the father role; b) Sense of purpose and meaning; c) Support and understanding from children; d) Motivation to make positive changes to one's life; e) Fatherhood can exacerbate one's psychosis.	17
Hawes (1999)	UK	26 women with a child under 16. Diagnoses: psychosis or unstated.	Descriptive and qualitative. Short semi-structured interviews	Descriptive report.	Contact with children.	12
Johnson (2009)	UK	50 mothers. Diagnoses: psychosis or unstated.	Qualitative comparative	Thematic	1) Safety and fear of other service users. 2) Benefits of the company of other service users. 3) Effects of the crisis house and hospital environments. 4) The stigma of admission. 5) Contact with staff and opportunities to talk. 6) Involvement in care. 7) Women with children. 8) Other treatments and activities. 9) Management of medication. 10) Assessment and admission 11) The position of Drayton Park in the spectrum of local services.	15
Montgomery (2006)	Canada	20 mothers with a child aged between 2 and 16.	Qualitative: Grounded theory method.	Grounded theory	1) Appearing normal. 2) Creating security. 3) Being responsible. 4) Keeping Close: a)	16

		Diagnoses: schizophrenia, bipolar disorder, major depression.	Unstructured interviews with informal follow-up conversations.		Masking; b) Censoring speech; c) Doing motherwork; e) Seeking help.	
Mowbray (2001)	USA	379 mothers with responsibility for at least one child aged 4 -16. Diagnoses: schizophrenia, schizoaffective disorder, major depressive disorders, bipolar disorders.	Questionnaire-based survey with exploratory open-ended questions	Descriptive	Changes brought by motherhood.	14
O'Brien (2011)	Australia	5 parents with a child aged under 18.	Qualitative, interpretive framework.	Thematic	1) Making the decision about children visiting. 2) Being responsible for the children while on the unit. 3) Being a child visiting. 4) Looking for help. 5) Being family friendly.	18
Rampou (2015)	South Africa	10 mothers. Diagnoses: schizophrenia, bipolar disorder, depressive disorder.	In-depth interview Explorative, descriptive and qualitative research design.	Descriptive	1) Challenges for mothers with regard to caring for their children: a) Insufficient financial resources; b) Psychiatric symptomatology; c) Effects of medication; d) Lack of alternative childcare when accessing health services; e) Fear and distress about separation; f) Stigmatisation. 2) Family support needs: a) Enhanced understanding of mental illness and treatment by mothers and their children; b) Enhanced parenting skills; c) Parent-friendly arrangements for mothers who are hospitalised.	17
Savidou (2003)	Greece	20 mothers with a child under 18. Disorders: schizophrenia, delusional disorder, bipolar disorder, major depression, borderline personality disorder.	Qualitative interview based.	Content analysis and discourse analysis	1) The discourse of "parenthood". 2) The discourse of "mental illness" and "mentally ill parent".	13
Wang (1994)	Denmark	50 parents or stepparents of children	Cross-sectional, descriptive, and based	Data categorised	1) Concern over child development and health. 2) Relationship with children. 3) View	13

		aged 0-10. Diagnoses: mental and behavioural disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorder, neurotic, stress-related and somatoform disorders, disorders of adult personality and behaviour.	on semi structured interview.	and reported descriptively	of own mental health. 4) Cooperation with professionals.	
Wang (1996)	Denmark	50 parents or stepparents of children aged 0-10. Diagnoses: mental and behavioural disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorder, neurotic, stress-related and somatoform disorders, disorders of adult personality and behaviour.	Cross-sectional, descriptive, and based on semi structured interview.	Data categorised and reported descriptively	1) Professional help relating to children. 2) Additional needs of help. 3) Establishing contact with professionals. 4) Children's extrafamilial contacts. 5) Children at time of hospitalisation. 6) Advice from parents to professionals.	13

4.6. Discussion

This systematic review was designed to synthesise research on the experience and support needs of parents in receipt of psychiatric inpatient care, and to evaluate the interventions currently available to them. It was anticipated that this review would generate evidence to inform the design and delivery of future interventions, to the benefit of these parents and their children.

4.6.1. Summary of Results

The studies that explored inpatient parents' experiences indicated that parents largely experience psychiatric inpatient care in negative terms and find that it impacts on their ability to function in their parenting role. This impact arises as a consequence of several factors. Chief amongst these is the physical separation of parents and children, but the impact of stigma (both self and external) was also clear (Dobener et al., 2022). Parental concern about their ability to provide care once discharged and worry about the potential loss of their children also featured widely.

Where parents described what improvements should be made to the provision of care, the inappropriateness of facilities for child visits was emphasized. It is noteworthy that poor provision of visiting facilities was highlighted in the oldest included paper and continued to be flagged as a concern by parents 25 years later. This echoes a review by Scholes and colleagues, where women identified a similar tension between the negative impact of separation and belief that hospital was unsafe for child visits (Scholes et al., 2021). The lack of appropriate provision for children's visits has also been identified as a concern by psychiatric nurses and by children themselves (Houlihan et al., 2013; O'Brien, Brady, et al., 2011).

However, although there has been a reasonable amount of research interest in the experiences of parents who are inpatients, there has been comparatively little work that attempts to develop or evaluate interventions for this group. Even with purposefully broad search criteria, the results of this part of our review include just a handful of interventions. Moreover, all of these studies examined an intervention that was centred on co-admission of parent and child, and all-but-one reported interventions that were delivered in the German health service. Co-admission was largely associated with positive outcomes for both parents and children, and with positive ratings of treatment satisfaction. In Germany, co-admission exists within the broader health system through a network of “Mutter-Kind-Einrichtungen” at which parents receive care alongside their child. These centres are not equivalent to psychiatric wards, rather they provide rehabilitative and preventative holistic treatment to parents who experience psychological and/or physical “exhaustion” and are associated with benefits to health status of parents and improvements in child behaviour (Arnhold-Kerri et al., 2003). These settings reflect a wider, systemic engagement with the parent *and* child in addressing parental difficulties. In contrast, from elsewhere in the world (UK), only one intervention study was identified. This involved co-admission of parent and child, but was delivered at a hospital which has ceased to offer this provision (Healy & Kennedy, 1993).

Within the included studies, the integral element of co-admission is subject to minimal critical engagement, yet the admission of parent and child together has the potential to impact the parent, child and wider family system. For example, is there an assumption that co-admission of the child is more beneficial to the child than the care which could be offered to the child in the community? Where the parent’s gender is stated, the hospitalised parent is exclusively female, which reflects a bias towards mothers as the primary source of care, even when unwell. This stance puts considerable pressure on the mother and may disadvantage the child, as well as

excluding the potential for paternal care. It is feasible that the co-admission interventions which took place in Germany were delivered in setting which treat patients with lower levels of acuity than in the UK. In the UK psychiatric health system, where admission thresholds have increased and the majority of patients are admitted under section, it would be inconceivable for children to be co-admitted (Degli Esposti et al., 2022).

Studies that offered parent-oriented interventions in addition to co-admission provided tentative evidence of effectiveness. These interventions, ranging from supporting parent-child interaction to structured multi-session psychoeducational interventions, were associated with improvement in outcomes for parent, child, parenting or a combination of the three. This reflects findings from earlier reviews of interventions for parents with mental health diagnoses, which indicate that there is benefit in supporting the parent-child dyad (Radley et al., 2022; Schrank et al., 2015).

4.6.2. Clinical Implications

The results of this review suggest three areas where improvements could have substantial impacts on inpatient parents and their children.

Family-friendly visiting rooms

In the UK, the Mental Health Act (1983) states that every effort should be made to support inpatient parents to maintain contact with relatives and to continue to support their children. It is clear that, in order to facilitate this, family-friendly spaces should be available in all psychiatric inpatient settings and these, if managed well (ensuring privacy and safety), would be widely welcomed by parents. Unfortunately, a recent review by the Scottish Executive highlighted 'patchy' provision of child-friendly visiting spaces (Mental Welfare Commission for Scotland, 2013) in Scottish inpatient psychiatric settings, and the situation is likely to be similar across the UK. In Australia, implementation of family-friendly rooms has been associated with

cascading benefits, from supporting visitation through which the parent-child relationship is maintained, to promotion of parental recovery. Staff have also suggested that these spaces may be associated with a reduction in stigma experienced by parents (Isobel et al., 2015). In creating an appropriate environment for children, family-friendly spaces could also address the negative attitudes and experiences children associate with their parent's mental health services (Källquist & Salzman-Erikson, 2019).

'Patient as Parent' thinking

It is clear that inpatient units could engage better with their patients' identities as parents. Such 'patient as parent' thinking could include improved recognition of the parenting role in general ward care (e.g. asking about patients' families and encouraging them to talk about their children and their concerns for them) as well as incorporation into ward-based therapies. In particular, it is likely that interventions targeted at supporting parenting skills and, in particular, the parent-child relationship, would have benefits both for the parent and their children upon return home. Within current provision, such engagement is ad hoc and uncommon: a recent survey of British mental health workers found that inpatient staff were the least likely of any clinical group to engage with patients in terms of their parenting role (Dunn et al., 2020). The willingness of staff to engage in this way is influenced by a range of factors including confidence and training (Dunn et al., 2020). However, given that both staff and parents recognise the importance of validating a patient's parenting role, there is a need for services to do so (Bartsch et al., 2015; Dunn et al., 2020). Furthermore, tentative evidence suggests that when staff do engage with their clients' parenting role, there is potential for cascading benefit for the parent-child dyad (Afzelius et al., 2017).

Parent and child co-admission

Parent-child co-admission was identified, in several studies, as a suitable method for support the parent-child relationship during hospitalization. It was regarded positively by most parents who experienced it, although a small number described it as a potential impediment to treatment effectiveness. However, this approach is likely to be considerably more expensive than sole admission of the parent, and major changes to service infrastructure would be required.

4.6.3. Strengths and Limitations

This review was purposely broad in its inclusion criteria, yet it still only found a small number of reports of interventions delivered to parents accessing inpatient care. As such, it may not represent the full range of experiences. Furthermore, the search strategy did not include grey literature, which may have reported evidence of small-scale interventions.

Strengths of this review included thorough and inclusive search terms, and accessing of papers written in two languages, namely German and English, which, between them, are likely to capture the large majority of the published literature. However, it is possible that including studies in additional languages would increase the scope of the results, with the potential for analytical synthesis: as it was, high levels of heterogeneity in the data rendered a meta-analysis impossible.

Given the limited data, the variation in extent and form of engagement, and the reliance of within-groups analysis, (including when a control group was present) the results of the current review should be interpreted cautiously. However, while disappointing, this evidence gap demonstrates the need for future research in which interventions are scrutinised. Furthermore, in designing future studies, researchers should incorporate standard outcomes relating to parent and child wellbeing, as well as the specific behavioural or functional targets of the program.

4.6.4. Conclusion

Bringing together the evidence on the parental experience of inpatient care and the provision offered to them makes it clear that there is an unmet need within services. The hospitalisation of a parent typically reflects a situation in which their mental health precludes them from providing care for their child. This may exist alongside other adversity such as socio-economic disadvantage, lack of social and familial networks, housing instability and interparental conflict or abuse (Saraceno et al., 2005; Suglia et al., 2011; Trevillion et al., 2012). While the provision of inpatient care cannot address the multiple vulnerabilities faced by some parents, it should not contribute to them by hindering the relationship between parent and child. While this review is unable to provide recommendations on the form and content of future interventions, it can conclude that at the very least inpatient provision should identify and engage with the parenting identity of parents and offer appropriate facilities for their children to visit.

5. Workplace support for mental health workers who are parents: a feasibility study. (Study 4.)

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5.1. Abstract

5.1.1. Background: Mental health workers are subject to high levels of occupational stress which is associated with poorer health and wellbeing and impaired patient outcomes. For individuals operating in high stress environments, reducing challenge at home, in particular around parenting, has been found to generalise into improvements in the professional domain. The present study sought to investigate the effectiveness and feasibility of brief targeted workplace intervention to support workers in terms of their parental role.

5.1.2. Design/methodology: An uncontrolled evaluation of a series of three-session parenting-focused courses delivered to employees of a large Mental Health Trust. A pre-post-follow-up design was used to investigate effects on outcomes including parenting practice and experience, wellbeing, stress, and occupational self-efficacy. Intervention feasibility and acceptability was also evaluated.

5.1.3. Results: Data from 15 participants who completed measures pre-post indicates the courses were associated with improved parenting practice and experience at a $p < .005$ level. Improvements were reported at 6-month follow up.

Participant satisfaction and course acceptability was highly rated by 100% of participants.

5.2. Contribution to the field

- Mental health workers, many of whom are parents, exist under extremely high levels of stress.
- Parenting can be challenging, and stress from the home and professional domains can interact and lead to greater impairments in either/both.
- This study describes the first known intervention designed to engage with mental health workers who are parents, with the aim of supporting their parenting and broader mental health.
- Participation was associated with improved mental health, wellbeing, and parenting practice with high levels of participant satisfaction and course acceptability.
- This indicates there is scope for the wider implementation of acceptable and effective workplace support for parents in the mental health workforce.

5.3. Introduction

Mental health workers are amongst the most vulnerable to burnout of any health care professionals (Johnson et al., 2018). Rates of workplace stress amongst the mental health workforce have increased by 10% in a decade, with 41.2% of workers stating that stress led them to feel unwell in 2019. A 2018 meta-analysis identified a similar proportion of mental health workers to be operating at the level of emotional exhaustion, which is the core component of burnout (O'Connor et al., 2018).

Unsurprisingly, mental health staff have higher levels of sickness-related absence than other medical sectors (Johnson et al., 2018). These figures represent the pre-COVID mental health workforce, with the most recent NHS Staff Survey indicating an 8% increase in workers experiencing elevated stress, and this is likely to be a conservative representation of the impact of the pandemic (NHS England, 2021).

The challenges faced by individuals working in the mental health sector are complex, encompassing organisational stressors such as staffing shortages and workload, as well those which relate to the emotional burden carried by workers. This latter category includes violence towards staff, as well as the experience of involuntary detentions, suicidality and self-harm in patients (Johnson et al., 2018).

While these experiences are not universal to all members of the mental health workforce, the majority are engaged directly or indirectly with individuals in distress and do so within an underfunded and oversubscribed service context. This has an impact in terms of staff wellbeing, the care they offer and leads to depletion of the workforce via absence and turnover, which in turn further contributes to fragility of an understaffed and overloaded system (Johnson et al., 2012; O'Connor et al., 2018; M. Paris & Hoge, 2010).

For individuals who experience high levels of work-related stress, an additional risk factor relates to the intersection of their professional and family life. Parenting can

be both rewarding and challenging and childcare responsibilities generate logistical and financial burdens. Work-family conflict (WFC) describes the tension when a professional's work and domestic roles are in conflict, which leads to impaired ability to perform in one of both domains (Greenhaus & Beutell, 1985). WFC comprises two bidirectional components, work interference with family life and family interference with work (Netemeyer et al., 1996). For example, the spill-over of employment-related stress can lead to impaired parental communication and engagement which may contribute to an escalation in child behavioural difficulties. This, in turn, increases stress at home, which can then lead to poorer engagement and function in the professional domain. WFC has also been found to mediate between job demands and psychological outcomes such as depression and burnout. In a study of Greek physicians, WFC was found to explain the relationship between work-related burden and emotional exhaustion. This was replicated in a survey of Japanese mental health nurses, where WFC was found to have a mediating effect on the relationship between job-related stress and burnout. Given the role WFC plays in burnout, this suggests workers within the mental health workforce are multiply vulnerable: operating in a stressed and stressful system which is likely to contribute to elevated levels of WFC, which in turn leads to elevated risk of burnout. It is unsurprising that mental health workers aged under 45 are most vulnerable to emotional strain, a core component of burnout (Johnson et al., 2012), given that these are the workforce members most likely to be parents of school-age children and as such more likely to experience conflict between their home and work domains.

In this representation of a multi-stressed workforce, it is important to recognise that while relatively common, burnout and chronic stress are not universal. Furthermore, just as the emotional burden of work can be exacerbated by the challenges of home, sources of resilience in one domain can operate as protective in another. Similarly, a reduction in stress within one domain can result in a reduction in the other. Many of

the role and sector-based stressors experienced by the mental health workforce are unlikely to change in the foreseeable future; indeed the burden may intensify as the full impact of the pandemic is revealed (Byrne et al., 2021). Given the bidirectional transmission of stress from work to home, one method to improve the experience of the workforce is by targeting the domestic domain, in particular parenting role and experience.

The administration of health and wellbeing interventions in the workplace has risen as employers seek to prevent costs associated with sickness and absenteeism (Proper & Van Oostrom, 2019). While initiatives have been deployed to engage with varied outcomes including obesity, smoking cessation and mental health, interventions focused on the specific challenges faced by working parents are less common. Those that actively target parents fall into two broad categories: the first address WFC by engaging with the parent with regard to their working role, for example supporting workers to manage time better and reduce 'presenteeism' (McHale et al., 2016). The second form of intervention is orientated to the parenting role of the worker. For example, delivering a tailored version of a widely-used behaviourally based parenting course to Australian teachers who were parents led to improved outcomes including in parental self-efficacy, parenting satisfaction, and a reduction in dysfunctional parenting and reduced workplace stress (Haslam, Sanders, & Sofronoff, 2013). The acceptability of interventions designed to help parents manage the competing demands of work and home is high, with 80% of working parents stating they would attend a workplace parenting intervention (Sanders et al., 2011). A separate survey of working mothers identified a specific wish for brief interventions which incorporated tools and techniques orientated to parenting challenges such as behaviour management (Haslam, Patrick, & Kirby, 2015).

Within mental health services, there is scope to engage with workers in terms of their parental role with the potential for positive effects in terms of stress within the

professional domain. Despite the opportunities afforded by this form of engagement, there is no evidence of a workplace intervention designed to do so in the UK mental health service context. The current study reports on the feasibility of a brief targeted intervention to support parents working in one UK mental health service. This was motivated by recognition at a leadership level that the intersection of the stress of working in the mental health system, and the demands of parenthood, could be a specific source of difficulty to workers who are parents. The intervention took the form of a series three session courses run across a large mental health trust in the South of England designed to achieve the following outcomes: improvement in the parenting practice and experience of participants, improvements in wellbeing, stress, and occupational self-efficacy. Intervention feasibility and acceptability was also evaluated.

5.4. Methods

5.4.1. Ethics

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by HRA and Health and Care Research Wales.

5.4.2. Recruitment

Sussex Partnership NHS Foundation Trust (SPFT) is a large Mental Health Trust operating across more than 100 sites in East Sussex, West Sussex, Brighton and Hove and Hampshire. It employs more than 4,500 staff organised into 430 teams.

The CEO of the Trust was instrumental in the initiation of the programme and had authorised staff to take part in the sessions during their core working hours. The recruitment process was designed to encourage staff members who were parents to feel able to take time out from work to participate. Recruitment strategies included visiting leadership meetings to promote the project and gain buy-in with team leads, communication to staff direct from the CEO of the Trust and inclusion in the weekly wellbeing newsletter sent to all staff by the HR Service. These activities were accompanied by localised promotional posters and advertisements on the Trust intranet.

Potential participants were able to sign-up directly for a course using an online ticketing system or could email the project team. Participants could apply to join any course and if their chosen course was full, they were invited to join a waiting list.

5.4.3. Participants

A broad inclusion criterion was used to maximise engagement. Participants were eligible if they were a current employee of the Trust and were a parent or carer to a child aged between 2 and 11 who resided with them for at least part of the week. A parent had to have agreement from their manager that they could take time away from their usual work in order to participate.

The course (comprising three sessions) was scheduled to run with four separate groups of participants. The final two courses were terminated prematurely in response to the COVID-19 epidemic. Only demographic data from the two courses which ran to completion is reported.

Of the two completed courses, a total of 17 participants attended the first session (Group 1 = 8, Group 2 = 9). Most participants classified themselves as female ($n = 76.5\%$) with an average age of 40 years ($SD = 7.2$, range 30 to 57 years). Most

participants had more than one child (range 1 to 4) with ages ranging from 1 to 12 years.

Most participants identified as being from a clinically focussed team (n = 12, 70.6%) and holding a clinical role (n = 11, 64.7%). The average duration of service at the Trust was 7 years and 10 months (SD = 73.0, range 2 months to 19 years).

Demographic and professional characteristics disaggregated by group are reported in full in Table 5.1.

Table 5.1. Participant demographic data displayed by group.

		Group 1	Group 2	Total
Participants		8	9	17
		N (%)	N (%)	N (% of sample)
Gender identity				
	Female	5 (62.5)	8 (88.8)	13 (76.5)
	Male	3 (37.5)	1 (11.1)	4 (23.5)
Ethnicity				
	White British	8 (100)	8 (88.9)	16 (94.1)
	White Other	-	1 (11.1)	1 (5.9)
Disability				
	No	8 (100)	8 (88.9)	16 (94.1)
	Yes – a little	-	1 (11.1)	1 (5.9)
Team				
	CAMHS	2 (25.0)	2 (22.2)	4 (23.5)
	Administration	1 (12.5)	1 (11.1)	2 (11.8)
	Assessment and Treatment		3 (33.3)	3 (17.6)
	Community	3 (37.5)	-	3 (17.6)
	Early Intervention	-	1 (11.1)	1 (5.9)
	Estates and Facilities	1 (12.5)	-	1 (5.9)
	Inpatient	-	1 (11.1)	1 (5.9)
	Leadership	1 (12.5)	-	1 (5.9)
	Primary Care	-	1 (11.1)	1 (5.9)
Role				
	Nursing	2 (25.0)	2 (22.2)	4 (23.5)
	Occupational Therapist	3 (37.5)	-	3 (17.6)
	Administrative	1 (12.5)	1 (11.1)	2 (11.8)
	Clinical/ Counselling Psy.	-	2 (22.2)	2 (11.8)
	Psychiatrist	1 (12.5)	1 (11.1)	2 (11.8)
	Facilities Manager	1 (12.5)	-	1 (5.9)
	Pharmacist	-	1 (11.1)	1 (5.9)

Support Worker	-	1 (11.1)	1 (5.9)
Voluntary Services Manager	-	1 (11.1)	1 (5.9)

5.4.4. Materials

All measures were self-completed and administered prior to the start of the first session of the course and at the end of the final session, unless stated otherwise. Six-month follow-up data was collected online with participants invited by email to complete measures via the Qualtrics survey platform.

Parenting-related outcomes

Parental self-efficacy was assessed using TOPSE a 48-item scale developed to measure change in parenting self-efficacy across six domains: emotion and affection, play and enjoyment, empathy and understanding, control, discipline and boundary setting, pressures of parenting, self-acceptance, learning and knowledge (Kendall & Bloomfield, 2005). The scale is widely used to evaluate a range of parenting studies, has good reliability (Cronbach's alpha = .94).

Parenting behaviour was assessed using the 9-item Alabama Parenting Questionnaire-Short Form (APQ-SF) which assesses parenting practice in three domains: positive parenting, inconsistent discipline and poor supervision (Elgar et al., 2007). It has good internal consistency (Cronbach's alpha = 0.68), test-retest reliability (.84-.90) and its sub-scales scales are sensitive to change.

The Strengths and Difficulties (SDQ) was administered as a child behavioural screen (R. Goodman, Ford, Simmons, Gatward, & Meltzer, 2003). This 25-item screening tool measures parent reports of child behaviour across five subscales: emotional problems, conduct problems, hyperactivity, peer relationship problems, prosocial behaviour. It has been found to have good psychometric properties with a

Cronbach's alpha (.84), and good test-retest reliability (.62). It is sensitive to change and is widely used as screen for child psychopathology in community and clinical samples.

Ideographic goal: parents were asked to set a personal goal in attending the course. Parents provided a score of between one and 10 to describe their attainment towards the goal at the start and the end of the course.

Parent mental health and wellbeing outcomes

Stress was measured using the stress sub-scale of the 21-item Depression, Anxiety and Stress Scale (DASS-21)(Lovibond & Lovibond, 1995). The seven item sub-scale has been used to measure stress in large populations and has been found to represent a distinct construct as well as a general dimension of negative affect (Henry & Crawford, 2005). The subscale possesses excellent internal consistency (Cronbach's alpha = .90 (95% CI=.89-.91)

The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS was) administered to assess wellbeing with regard to feeling and functional domains (Tennant et al., 2007). The WEMWBS is widely used in population-level and interventional research, has good sensitivity to change and excellent and widely tested psychometric properties including Cronbach's alpha score of .91, high test-retest reliability (.83) and significant high correlation with measures of affect and life satisfaction (e.g., PANAS-PA $r = .71, p < .01$; SWLS $r = .73, p < .01$) (Stewart-Brown et al., 2009).

Occupational self-efficacy

The 6-item Short-form Occupational Self-efficacy (OSE-SF) scale was administered to assess participants' ability to manage the challenges of work and achieve their occupational goals (Rigotti et al., 2008). The scale has good convergent validity with significant partial correlations (controlled for age) with measures of job satisfaction

(.17-.46, $p < .05$) and high levels of internal consistency (Cronbach's alpha = .9)(Rigotti et al., 2008).

Patient-as-parent practice

A secondary goal of the study was to explore whether the staff who took part increased in their use of parent-focused practice at work – i.e., thought about the parenting role of their clients. Parent-focused practice was measured using a 26-item scale developed by the research team for administration in a previous research project (Dunn, Startup, & Cartwright-Hatton, 2021). It comprised six items assessing the extent to which practitioners engage with the parenting role of patients in the service; nine items assessing practitioners' attitudes and beliefs related to supporting 'patient as parent' and 11 items assessing barriers to practice. These data will be reported elsewhere.

Feasibility and acceptability

Participant satisfaction and course acceptability was assessed using a nine-item scale administered at the end of the third course session. It comprised a series of brief questions (e.g. How enjoyable was the training? [very enjoyable/somewhat enjoyable/somewhat enjoyable/not enjoyable]) with an option to add further comment.

Acceptability of the course to participants' managers was assessed using a brief online questionnaire comprising four yes/no questions relating to positive and negative effects of the course and an optional free text comment. This was administered to managers/team leads by email with the consent of participants. Two questions related to impact on 'patient as parent practice' and are not reported here.

Project feasibility was evaluated using recruitment, sign-up and attrition data.

5.4.5. Design and procedure

The project was designed as a series of four parenting courses to be held at sites across East and West Sussex and Brighton and Hove. As discussed, two courses ended prematurely upon the introduction of COVID-19 restrictions. Of the two completed courses one took place in a community location, and one took place on a clinical site. The courses comprised three 2.5-hour sessions run over a four-week period, which included a one-week break for school holidays. Each course was led by two members of the study team: Group 1 was led by a clinical psychologist seconded to the trial from the from Child and Adolescent Mental Health Services (CD) and a research psychologist with expertise in the delivery of parenting interventions (AD); Group 2 was led by CD and a research and clinical psychologist with expertise in the design and delivery of specialist intervention for parents with anxiety (SCH). All facilitators have experience of working within the NHS and a good understanding of the Trust the intervention was located within.

Participants who had signed up for a course were contacted by the study team by email to remind of the location and duration of the workshop and were invited to identify a goal in attending. The courses took place during paid work hours and participants were granted time out of their routine work to take part, and travel expenses were paid by the Trust. At the start of the first session consent was taken and baseline measures were administered.

The content of the course was developed by the research team with an awareness that each group could include participants holding a variety of roles and responsibilities and with varied levels of seniority. It was designed to offer participants an opportunity to share their experiences of parenting while working in a stressful mental health environment, and to foster skills and understanding around positive parenting and behavioural approaches. It incorporated content from a well-established intervention designed to promote positive parenting amongst parents

who experience anxiety (Sam Cartwright-Hatton et al., 2018) with additional material focused on work-life conflict in relation to operating in an emotionally and operationally demanding professional setting.

Further information about the course content is detailed in Table 5.2.

Table 5.2. Overview of the course content as delivered to participants. The shading delineates the three course sessions.

Module	Module content
Introduction and ground rules	Including confidentiality. It was made clear that information divulged during sessions would not be relayed to managers.
Parenting identity	Rewards and challenges of being a parent
7 Confident thoughts	Core beliefs to promote child confidence
Parenting hotspots	Parenting behaviours which can undermine a child's confidence
Attachment	Overview of core principles of attachment
Emotional coaching	Noticing and engaging with child's emotions with empathy and active listening
Basic needs	Sleep, exercise, caffeine, diet
Play	Importance of play and specific methods of confidence-promoting play
Noticing, rewards and praise	Noticing child's positive behaviour and efforts with strategies for praise and rewards
Boundaries and limit setting	Importance of boundaries and 'top tips' for using commands
Managing difficult behaviours	Emotion coaching approach to discipline

5.4.6. Analyses

Descriptive characteristics for 17 participants were examined and outcomes scores were calculated. To maximise comparisons, data was analysed using pairwise deletion.

Data were checked for normality of distribution using Kolmogorov-Smirnov tests with significance set at 0.05. Occupational self-efficacy (OSE-SF) and positive parenting (APQ-PP) data were non-normally distributed. Short-term intervention effects were calculated using pairwise t-tests with significance set at the 0.05 level. For variables which failed to meet the assumption of normality, Wilcoxon signed ranks were used. No comparisons were made using 6-month follow-up data due to the limited number of cases.

Data were analysed in IBM SPSS 25 for Windows.

5.5. Results

5.5.1. Recruitment, sign-up and attrition

Each of the four scheduled courses could accommodate 12 participants. Groups 1, 2 and 3 were fully booked (n = 36) with a combined waiting list of 33 participants. Ten participants signed up for Group 4.

Of the 46 participants who signed up to one of the four scheduled courses, 13 (28.26%) failed to attend the first session. Where a reason was provided, workload and illness were most commonly cited. Of the 17 parents who attended the first session of Group 1 (n = 8) or Group 2 (n = 9), 15 (88.24%) were present at the final

session to complete post-intervention measures and six (35.29%) completed measures online at six-month follow-up.

5.5.2. Outcome: parenting practice and experience

On completion of the intervention, participants reported significantly higher levels of parental self-efficacy ($M = 365.08$, $SD = 31.89$) compared with baseline ($M = 306.08$, $SD = 43.59$), $t(12) = 6.91$, $p < .05$. The intervention was also associated with a significant reduction in use of inconsistent disciplinary strategies ($M = 7.61$, $SD = 2.36$ v $M = 5.92$, $SD = 1.50$), $t(12) = 3.69$, $p < .005$ and in child behavioural difficulties ($M = 12.92$, $SD = 5.26$ v $M = 9.58$, $SD = 4.61$), $t(11) = 2.85$, $p < .005$. At six-month follow-up, improvements in self-efficacy and reduction in inconsistent discipline remained elevated in comparison to baseline, however due to the small number of cases, no formal statistical analysis was carried out. Participation was not associated with improvements in parental supervision or positive parenting activities.

5.5.3. Outcome: wellbeing, stress, and occupational self-efficacy

Participants reported a significant decrease in stress on completion of the intervention ($M = 21.67$, $SD = 11.30$ v $M = 14.08$, $SD = 7.38$), $t(11) = 3.04$, $p < .05$ with a smaller reduction maintained at 6-month follow up.

The courses were associated with an increase in wellbeing and occupational self-efficacy which remained above baseline at six-month follow up. These effects failed to reach significance at the $p < .005$ level.

5.5.4. Outcome: satisfaction

Of the seventeen participants who set a goal in attending the course, fifteen rated their progress towards it at the end of the final session. Participant goals related to engagement with their children (e.g. "to be more present"); managing behaviour (e.g. "establishing consistent boundaries"); their child's anxiety (e.g. "new ways to

support my child's anxiety"); and to their own emotional state (e.g. "be less agitated"). There was a significant increase in participants' reports of progress towards their goal after the course ($M = 4.33$, $SD = 1.23$ and $M = 6.27$, $SD = 2.05$), $t(14) = 4.61$, $p < .005$.

Thirteen participants completed course evaluation measures and all reported high levels of acceptability. In response to the following questions all participants selected the most positive response category: Would you recommend to colleagues? (yes = 100% ($n = 13$)); How enjoyable was the training? (very enjoyable = 100% ($n = 13$)); Did you find the format and timings of the courses acceptable? (yes = 100% ($n = 13$)); Did you feel your manager supported your attendance? (yes = 100% ($n = 12$)).

Participants were given the option to add free text comments in relation to the statements above or to add further comment. Sixteen comments were received and have been organised into the following domains: 1) Satisfaction, eight participants commented positively on the facilitation, the benefit of sharing experiences with other or the utility of the content. E.g. "Kind supportive facilitators. Helpful amount of supporting material. Helped my wife and I think about parenting styles differences. Used resources with children." No critical comments were received. 2) Scheduling, four participants expressed satisfaction with the format and duration of the course with two explicitly stating that it had been beneficial to participate during work hours. One recommended an earlier finish. 3) Managerial support, two participants stated they had not been supported to attend, with one choosing to attend on their day off and the second stating they were asked to miss a session but refused.

Managers/team leads reported that the courses had benefitted the wider team (yes = 71.4% ($n = 5$), no = 28.6% ($n = 2$) and did not report any negative impact (no = 100% ($n = 5$)). Four comments were received from managers which all stated the relevant participant had benefitted from attending, with two reporting that participants

had shared strategies with other team members who were parents. No negative comments were received from managers.

5.6. Discussion

The current project was designed to test the preliminary effectiveness of a workplace parenting intervention to deliver positive change for mental health workers, in terms of their parenting experience and practice, their mental health and wellbeing, and their self-efficacy in work. Given the pressures faced by the workforce in terms of capacity and resourcing, there was also a question of the feasibility of delivering this form of intervention and its acceptability to both participants and their managers. The study provides preliminary evidence that this approach is both effective and acceptable.

Staff who participated in the three-session courses reported increased parental self-efficacy and consistency in discipline. They also reported improvement in child psychological adjustment. The relationship between parental self-efficacy and positive parent and child outcomes is well-established (Albanese et al., 2019). Within the current context, it is arguable that the positive change reported for children was the result of parents developing skills to manage difficult behaviours and their increased confidence in their ability to perform their parenting role. Though there was reduction in the effects over time, after six months they remained elevated compared to baseline, indicating some longitudinal benefit of the training.

The courses were associated with a significant reduction in self-reported stress in participants, which declined from 'moderate' to 'normal' levels as categorised by the DASS. This is noteworthy given the programme did not contain specific stress-management techniques, as was the case with Haslam's work with the teaching workforce (Haslam et al., 2013). What is clear is that by ameliorating some of the

challenges faced by parents of young children, the courses contributed to a reduction in the parents' overall stress levels. This may relate specifically to improvements in the domestic sphere, for example a reduction in stress in response to reduced child behavioural difficulties. It could also be conceptualised as a positive 'spill-over' as presented within the model of work-family conflict where improvements in either the home or work domain can have a protective effect in the other. The improvements in occupational self-efficacy may also reflect this inter-relationship, so that a greater belief in ability to function in the parenting role maps across to the professional domain

The project also showed clear signs of feasibility and acceptability. The recruitment, participation and evaluation data all suggest that that delivery of this form of intervention is both practicable and desirable. Demand for places was high, with over-subscription at close to 100% and the attrition level was consistent with the mean rate identified in a meta-analysis of behavioural parent training programmes (Chacko et al., 2016). The evaluation data suggests that the programme met the needs of participants, which was further reinforced by the positive trend in response to participants' ideographic goals.

The high levels of engagement with the programme indicate there is a demand within the workforce for on-site support around parenting. However, any attempt to replicate the project must take into account some of the specific situational factors which may have contributed to its success. The Department of Health's comprehensive review of workplace health interventions found that financial commitment from the organisation, ease with which it can be taken up, intervention accessibility, and structures available to support participation are key to the success of an initiative (Brunton et al., 2016). The project under review contained four of these factors: it was funded by the Trust, participants were invited to participate during paid work time, with a range of course times and locations, and they were able to

sign-up directly. Furthermore, the clear communication from the CEO of the Trust that the courses were developed with her support and a strategy of gaining buy-in from team leads further pulled the project in line with Bruton's findings. In seeking to engage with staff who are parents, mental health trusts would be advised to replicate these approaches.

This was an exploratory project, designed to determine whether a brief parenting-focused course would be desirable and beneficial to staff working in the mental health sector. Even when taking into account the small sample, the results indicate the courses were of utility to participants, generating short-term effects in line with group-based parenting courses delivered in the community (Barlow & Coren, 2018). While the evidence of longer-term effects should be interpreted cautiously given the low response rate, the positive trends are nonetheless noteworthy given that data was collected during the midst of a global pandemic. In reducing the stress levels of participants, the courses could offer a low-cost approach to scaffolding the health of the mental health workforce. This is particularly salient given the burden placed upon these workers as a result of the pandemic (Byrne et al., 2021). Now more than ever there is an imperative to deliver support which is acceptable and effective in promoting the mental health of the workers who have responsibility for looking after the mental health of the nation.

5.7. Limitations

This was a feasibility study in which the Coronavirus pandemic led to a reduction in an already small sample. While the results are promising, they would need to be replicated with a larger sample before effectiveness can be determined with any certainty. Furthermore, while the design and delivery of the project was supported

by Trust leadership and was motivated by a desire to support the wellbeing of staff, as an intervention it also fails to engage with the profoundly difficult situation experienced by many of the mental health workforce. It offers a short-term intervention where there is arguable need for structural improvement.

Given the self-selecting nature of the sample, it is likely that participants were highly motivated which may have biased the results. In a larger trial, taking into account the challenges of the workforce, the effects may be smaller. However, outside of mandated parenting interventions, self-referral is a common mechanism in research and delivery of parenting interventions.

A further limitation of the study relates the demographic composition of sample. While research into parenting interventions largely involves female participants, the generalisability of the present study would benefit from reflecting the demographic make-up in terms of both gender and ethnicity of the Trust in which it is situated. Given the known high levels of stress in the mental health workforce there would additionally be benefit in capturing baseline mental health and disability data to enable disaggregated results.

5.8. Next steps

This study is a tentative first step towards the delivery of workplace-based parenting support for the mental health workforce and it would be valuably extended with a controlled trial with a sample large enough to unpick potential mediators. For example, does this form of intervention differentially benefit staff according to domains e.g., clinical and non-clinical? Sussex Partnership NHS Foundation Trust is one of the largest mental health trusts in the country and while it has reported above average levels of stress in its workforce, workers also report it to be more engaged

in supporting their wellbeing compared with the national average (NHS England, 2021). Given the variation in stress, work conditions, perceptions of managerial and organisational support at a trust level, there would be value in replicating the project in variety of trusts to better evaluate demand and acceptability.

The reduction in stress associated with participation indicates there is also utility in exploring whether the course has additional benefits in the professional domain, e.g., workplace-related stress or reduced absenteeism. Correspondingly, an economic evaluation is essential to determine value for money, particularly given the funding challenges faced by the sector.

A realistic attempt to take the intervention forward would also need to consider more flexible methods of delivery so that facilitation could be carried out by extant members of the workforce. One potentially cost-effective method would be using peer facilitation, which has been effective in community-based parenting interventions (Day, Michelson, & Thomson, 2012).

6. Participatory Evaluation of a Parenting Programme with Parents with Challenges around Emotional Intensity (Study 5.)

6.1. Overview

In 2019 I designed a study which would take a participatory approach to evaluate and revise an existing community-delivered parenting intervention with parents who have a borderline personality disorder diagnosis and subthreshold borderline personality disorder (BPD/BPDs). The project would have been carried out with the support of the Brighton and Hove Council Parenting Service, who would have provided two experienced facilitators to deliver a version of the Triple P parenting course. The research team would then have run a series of collaborative sessions with parents using a range of participatory methods to develop an understanding of the following:

- How do parents with challenges with BPD/BPDs experience a standard parenting programme?
- How do facilitators experience delivering the programme to this group?
- Which content components of a standardised parenting programme are found to be acceptable and useful by parents with challenges around BPD/BPDs?
- What revisions and additions would participants (parents and facilitators) make to the parenting programme to increase utility and acceptability

Unfortunately, the COVID-19 epidemic meant that this study was delayed and then eventually cancelled. The risk of face-to-face working and the challenges

experienced by the parenting service made it impossible to deliver. However, I have applied the principles of participatory working which informed this study to a subsequent research project for which I have received an NIHR ARC Individual Development Award. This award has funded an intervention design and feasibility study for psychiatric inpatients who are parents.

6.2. Abstract

6.2.1. Background

Parents who have struggles around emotional intensity can find it difficult to provide consistent and nurturing care for their children. They experience higher levels of parenting stress and lower satisfaction and may experience difficulties in their relationships with support services. Providing appropriate support in the parenting role could improve outcomes for these parents and their children. Standard community group-based parent-training interventions are widely available. However, these may be less effective for such parents, because of factors including feelings of stigma and past experiences of trauma. A detailed understanding of what aspects of these groups are effective and appropriate and which are not has the potential to improve service provision and outcomes.

6.2.2. Methods/Design

A participatory evaluation of a standard parent-training programme. For seven weeks participants will take part in a standard weekly parenting workshop run by highly skilled parent-work practitioners. Participants will then be supported to evaluate the workshop using a range of approaches including self-generated indicators, and feedback on video footage from the group. In addition, measures of

depression and anxiety and parental satisfaction will be carried out at the beginning and end of the programme. *The study protocol can be found in Appendix 4.*

7. Discussion

7.1. Overview of findings

The four studies presented in this thesis describe the parenting experiences of adult mental health patients who are parents, explore the quality of engagement that adult mental health services have with parents in terms of their parenting role and needs, and outline the attitudes and needs of mental health practitioners in regard the parenting role of their patients. There is an inherent difficulty to this endeavour: mental health services are vast and multifaceted; they are organised into discrete child and adult services with separate infrastructure and funding; and they are under extraordinary pressures. Furthermore, every parent that engages with them exists within a unique and complex family system. Given this, the research described here represents a fraction of this complexity, yet it nonetheless offers a contribution to factors that may be important in the future provision of care.

Fundamentally, the studies reported in this thesis show that adult mental health services are not engaging with their patients as parents. Parents and practitioners in Study 1. described a manifest lack of support offered in terms of the parenting role or support needs. This was reinforced in the self-described practice of 1,105 mental health practitioners (Study 2), of whom a quarter were failing to carry out even their mandated responsibility to identify dependent children. The lack of mental health services' engagement with parenthood is accompanied by a clearly expressed need and desire for support from parents, as demonstrated in primary data collected for this thesis (Study 1.) and in a systematic review of the experiences of patients in receipt of psychiatric inpatient care (Study 3.) In the former, parents describe not

knowing whether there was support available, of being certain there was not support, and, in two cases, asking for help, only to be told there was nothing available. In the systematic review (Study 3.), the aggregated experience of parents was that their parenting needs were unmet during their hospitalisation. This was reinforced by the results of the second part of the review, which sought to synthesise interventions for hospitalised parents and located only a handful. In 1996, parents identified a need of preventative support "before everything is in a mess" (Wang & Goldschmidt, 1996) and the same request continued to be made in the data collected for this thesis, 25 years later.

However, alongside the clear deficits and frank omissions in care offered to patients who are parents, the research in this thesis generates an opportunity to consider how families where a parent has mental health difficulties could be better supported. There is some hopefulness embedded in the findings, in particular the empathic engagement of practitioners with the complex experiences of the parents in their care (Study 1.), the positive attitudes expressed by practitioners towards engaging and supporting parents (Study 2.), and in the participation of so many mental health practitioners in the research studies.

The findings from the research contained in this thesis are wide-ranging and offer a nuanced engagement with individual-level and service level factors relating to the experience of parents with mental health challenges. In synthesising the research, four core focus areas were identified. These comprise tangible recommendations for service development and generate clear targets for future research activity. The first, foundational provision to support patients as parents, discusses the basic building blocks of adult mental health service provision which would benefit families. The second, provision of interventions that foster connection, describes the need for interventions which support connection for parents. The third, engaging with the whole family system over time, widens the gaze from the needs of the parent to

consider the family system around them. The fourth, collaboration around the family, engages with the relationships between agencies that a family may come into contact with. These four focus areas are explored in detail below.

7.2. Foundational provision to support patients as parents

As identified by Foster, and discussed in the Introduction to this thesis, engagement with patients as parents exists on a continuum (Foster et al., 2012). While there is evidence of need for, and benefit from, interventions for families, there is a pressing need to first embed some foundational aspects of care. Within the findings of the included studies, the following three features were emphasised as a minimum requirement: that care should identify when a patient is a parent; that care should engage with that parenting identity; and that care should accommodate the functional needs specific to parents.

7.2.1. Identification of parenthood

That a quarter of adult mental health practitioners who responded to a national survey did not routinely ask if a patient had children is alarming, especially given that those responding to this survey were likely to be biased towards a higher level of interest in parenting. It is also noteworthy that parents themselves have identified a need for clinicians to capture this core information (Cunningham et al., 2000). These findings reflect a stable trend of inconsistent capture of data related to parenthood within the British mental health context (Gatsou et al., 2016). The failure to capture rudimentary and essential information at a practitioner-level reflects a systemic lack of engagement. For example, the national Improving Access to Psychological Therapies (IAPT) dataset, the monthly-updated report of service use, does not

contain any data on parenthood/dependents (NHS Digital, 2022). That this most data-driven of adult mental health streams fails to report this information is emblematic of a lack of structural commitment to recognising parenthood. This failure to identify parenthood at a practice and service level within adult mental health services, contributes to the lack of overall clarity regarding prevalence of parents using mental health services (Maybery, Nicholson, & Reupert, 2015). Neither the impact of parental mental health nor the potential benefits of intervention can be calculated effectively without a knowledge of how many families are affected.

7.2.2. Recognition of the parenting role and identity

When a parent accesses mental health services, engaging with their role as parent and its associated responsibilities may increase their motivation to engage and may contribute to the success of their treatment (Ackerson, 2003; Reupert & Maybery, 2007). Clinical support that strengthens a parent's confidence in their parenting, has been linked to recovery (Hine et al., 2019). A desire to be recognised as a parent by their clinicians was present in the accounts of parents in Study 1. and Study 3. and has also been identified in other mental health settings, including fathers in forensic treatment (Parrott et al., 2015). Furthermore, in wanting their parenting role to be identified, these parents are reflecting an understandable and common desire: for those with children, parenthood is typically a core aspect of their self-concept, and it is gratifying when it is recognised as such. To draw a parallel, mental health workers who participated in the staff parenting workshops (Study 4.) expressed satisfaction that their employer had made a demonstrable commitment to supporting them in their parenting role.

The expressed desire from parents accessing mental health services to have their parenting role engaged with, can co-exist with a protective desire to hide that

identity, frequently motivated by fear of the involvement of child protection services.

This is captured in the account of a mother in Study 1.

“No. I never got no support. I was anorexic as well when I was pregnant. Errm. I was anorexic when they were growing up in school. But nobody noticed anything. And I didn't know that. I can't ask for help. I can't now. Because they might take the kids away.” (Mother, Study 1.)

This fear of child removal and its impact was manifest in the accounts of parents and of practitioners in Study 1. and in the experiences of parents in Study 3. When engaging with the parenting identity of individuals with mental health challenges, it is essential to acknowledge this fear as an understandable and widely held narrative (Busch & Redlich, 2007). The impact of child removal is traumatic and enduring, and may contribute to further adversity (Broadhurst & Mason, 2019). The loss of a child to the state does not end parenthood, and parents report being distressed by being engaged with as ‘non-parents’ (Broadhurst & Mason, 2019). Given that parents who have their children taken away are likely to have further children, as was described by practitioners in Study 1., it is even more important that their prior experiences and the complexity of their parenting identity is engaged with and taken into account.

This understandable tension between wanting to be seen as a parent and to hide that identity is not insurmountable. For example, Maybery and colleagues argue that, when services demonstrate a family-focused culture, this parental reluctance will be reduced (Maybery et al., 2015). Furthermore, the belief that parents may feel uncertain about discussing their experience should not prevent practitioners from asking. During recruitment for Study 1., clinicians expressed considerable reluctance to refer potential participants, due to their concern that doing so might negatively affect their relationship with the patient or cause them distress. While well-intentioned, this gatekeeping may not reflect the wishes of parents. In fact, the

process of being interviewed was described as positive by parents who took part, and a number of parents made spontaneous contact after the interview to say they were grateful for the opportunity to talk about their experiences as a parent.

7.2.3. Adapting to the functional needs of parents

The data generated for this thesis presents a clear picture that adult mental health services are failing to make necessary adaptations for the needs of parents. This was overwhelmingly the case within Study 3, which focused on the experiences of inpatients, where the lack of appropriate visiting spaces prevented parents from seeing their children. The impression of inpatient wards as being unwelcoming, unsuitable or unsafe for child visits is also present in the extant research that has explored the views and experiences of children of hospitalised parents, of family members and carers, and of ward staff themselves (Källquist & Salzmänn-Erikson, 2019; O'Brien, Brady, et al., 2011). In a 2007 review of 60 British mental health services, only five were found to make 'good' provision for children and 21 were 'adequate' (which was awarded if the setting had clean and accessible space but without any sustained effort to make it family-friendly (Scott & Robinson, 2007)). There has been no recent review of provision, which reinforces the hidden nature of this problem. Within UK Government policy there is an ostensible prioritisation of child welfare and a commitment to supporting the family relationships of hospitalised adults (HMG/DH, 2011). Without appropriate space within inpatient settings, neither of these provisions are met which seriously raises ethical concerns. Furthermore, it is noticeable that the 2021 'Reforming the Mental Health Act' white paper's outline of reforms to the ward environment, it failed to mention provision for family friendly visitation (*Reforming the Mental Health Act - GOV.UK, n.d.*).

Community-delivered care has a similar blind spot when it comes to the practical needs of parents and their children. At the most basic level, the demands and

logistics of childcare can make it hard to access treatment, for example, parents may not feel comfortable taking their children to appointments (Osborn et al., 2019). When a parent lacks social support and/or is in a difficultly or estranged relationship with their co-parent, accessing treatment for themselves can be even more difficulty (Study 1.). However, as was described by an occupational therapist interviewed for Study 1., small changes can make a considerable difference to engagement.

“So, we changed the timing just by 15 minutes because they were like “I can’t, I can’t” (make it to school collection in time). Just changed it so it finishes 15 minutes earlier so they can get to their school.”

These are not novel suggestions; the necessity for adult mental health services to engage in these ways has featured in a number of recommendations (RCPsych, 2011; Scie, 2011). The first two approaches described above are also in the recent core recommendation of the Prato Research Collaborative for change in parent and child mental health recent principles and recommendations for service change (Reupert et al., 2022). The salutatory fact is that these relatively simple approaches still need to be highlighted within this thesis and elsewhere, because they are not being embedded in practice.

7.3. Provision of interventions that foster connection

While there is a clear argument for adult mental health services to put in the place the service changes described above, parents also described a need for targeted interventions that support their experience of parenting. This is in addition to any mental health-specific treatment they may be in receipt of. As described, there is a growing body of psychoeducational interventions for parents living with mental

health difficulties, and some parents within Study 1. and 3. expressed a desire for this form of provision to be made available to them. In unpublished data on barriers to engagement with 'patient as parent' practice (collected as part of Study 2.), almost a third of mental health practitioners (30.6%) reported not having a knowledge of or access to parenting interventions, which indicates that provision of this form of intervention could increase practitioners' engagement with the idea of thinking 'patient as parent'.

However, a core feature of the support that was wanted by parents in Study 1 and Study 3. was the opportunity for connection. Parents described wanting to be part of a group with shared understanding, which would enable them to express themselves; to "mix with others like me" (Cunningham et al., 2000). As one mother described, "*being in a group with people with the same diagnosis or experience of the same diagnosis really is helpful for me. I think it gives other people; it gives you, a chance to hear other people's views on things.*" (Study 1.) For parents and practitioners, there was an identified need for opportunities to foster connection, to reduce the isolation inherent in being a parent with mental health difficulties, to enable shared learning, and to normalise parenting experiences. The desire to be in a group with mutual understanding is a common theme in parenthood and was also reflected in the feedback from the participants in the parenting programme for mental health workers (Study 4.). Four of nine feedback comments explicitly focused on the benefit of sharing experiences, of have a "*safe space*" to "*swap stories and share tips.*"

The centrality of shared experience is borne out in evaluations of parenting programs designed for parents with mental health problems, such as an adapted version of the widely delivered Triple P programme, where parents identified being in a group with others with shared experience as critical to its overall effectiveness (Coates et al., 2017). In Shor's group-based intervention for parents with a mental

health diagnosis, parents were actively encouraged to provide help to each other including information, encouragement, validation and empathy. The approach was associated with improved parent-child relationships (Shor et al., 2015). The importance of connection is further reinforced by the relationship between loneliness and mental health presentations, where loneliness is associated with higher risk of diagnosis, more acute presentations and greater hospital usage (Cacioppo et al., 2006; Mgutshini, 2010; Mushtaq et al., 2014).

Given the role of mutual understanding and shared experience and connection, peer support approaches could be particularly advantageous in supporting parents with mental health difficulties. Peer support is a strengths-based approach which prioritises connection with others with lived experience, including drawing upon the helping capacity of individuals who have experienced mental health challenges themselves (Basset et al., 2010). This support can take a variety of forms and while informal peer support has been present for time immemorial, there has been a recent push towards professionalisation, and a focus on using peer workers to support the delivery of mental health services (NHS England, 2017).

The engagement of individuals with lived experience in the delivery of care to mental health services users has been found to largely advantageous (Repper & Carter, 2011). The approach has been effectively translated to supporting children where a parent has mental health problems, where peer support is operationalised both in terms of fostering connection and understanding with peers and facilitation by individuals with lived experience (Goodyear et al., 2014). As a preventive approach, peer-based support has positive effects for children in terms of self-esteem, coping and social support (Foster, Lewis, & Mccloughen, 2014; Goodyear et al., 2014).

In addition to fostering connection through shared understanding, peer-led programs may also increase the acceptability of interventions amongst parents who are wary

of professional support. In the UK, a peer-led parenting course designed to address child disruptive behaviour was found to generate benefits in domains including parenting practice and child problem behaviours (Day, Michelson, Thomson, Penney, & Draper, 2012). It also successfully engaged black and ethnic minority, and socio-economically disadvantaged parents, and had higher retention rate than was found in professional-led parenting programmes focused on child disruptive behaviour. Despite these promising indicators, there is currently limited evidence of peer-led interventions for parents with mental health difficulties. One Australian programme, which extended its provision from peer support for children of parents with mental health difficulties to include the parent, has generated promising initial qualitative evidence. Parents in the revised CHAMPS (Children And Mentally ill ParentS) programme, described benefits including reducing feels of isolation, and fostering a shared language to talk about mental health (von Doussa et al., 2022). The programme was also viewed as safe space in which parents were able to allow themselves to be open.

7.4. Engaging with the whole family system over time

To develop appropriate support for families where a parent has mental health problems, there is a need to engage with the complexity of the family's systems and, more broadly, to recognise the heterogenous array of strengths, needs, risk-factors, and opportunities that each one presents. Families are not static: composition, financial security, employment, and housing status all have the potential to change. Within the literature it is noticeable that family features which have the potential to dramatically affect the experience of parents and children (e.g., 'blended' families, families where a child has special needs and/or physical health difficulties, cultural background) are rarely taken into account. As children grow up, the associated developmental shifts can ameliorate or heighten family difficulties, including parental mental health. For example, certain developmental stages or ages can cause difficulty due to their association with traumatic events in the parent's life (as discussed in Study 1.). Furthermore, parental mental health is not fixed and patterns of recovery or relapse, changes in medication and other treatment, can all have an impact. Given the potential for each family member to have shifting needs over time, support for families where a parent experiences poor mental health should be ongoing. One fixed-point assessment of needs (and strengths) fails to reflect the reality of need.

The two sub-sections below explore the need to embed the perspective, needs and strengths of the child and of the wider family in formulating support for the parent. In particular, the need for understanding rather than assumption and with engagement with familial reciprocity in terms of risk and of resilience.

7.4.1. Incorporating the child

The absence of the child's perspective is a limitation of the work contained in this thesis. While the experience of children is present in Studies 1. and 3., it is through

the perspective of others. In the original design for Study 1., young adult offspring of parents with BPD traits were interviewed. However, only a small number could be recruited, and because of this, and their relationship to the parent participants, publication of these data (even in this thesis) could have compromised anonymity. However, the data were analysed, and the identified superordinate and subordinate themes represented the children as feeling: that their needs were unmet; that they and their family were different to “normal families”; and that they were confused by, and unheard by, their parents and the professionals they encountered. These themes are reflected in two recent systematic review of children’s experience of parental mental illness in which children represented themselves as having limited understanding of their parent’s health and of being excluded and disrespected by the care teams around their parent (Källquist & Salzmänn-Erikson, 2019; Yamamoto & Keogh, 2018). According to these reviews, when children were provided with appropriate information, they were more able to manage their anxiety about their parent and their own future and had increased capacity to cope with their parent’s symptoms and behaviour. This emphasises the need for care to look beyond the parent and, at the minimum, to provide children with information which can empower them. While all children can benefit from mental health literacy, there are specific components, such as helping children communicate about their parent’s mental illness, which could be particularly advantageous to affected children (Riebschleger, Grové, Cavanaugh, & Costello, 2017).

By reframing parental mental health to incorporate the perspective and needs of the child there is also scope to identify strengths and opportunities which may be beneficial to both parent and child. While the risks to children of parental mental health difficulties are widely stated, the same focus is not given to understanding and promoting resilience. Incorporating a bottom-up approach to consider the protective factors around the child has potential for cascading benefits (Cooklin,

2013). The focus of this research has been on the actions of parents and practitioners, there is opportunity for the child to receive protective engagement from other domains. Fostering connectedness through alternative and supplementary relationships with their other parent, with siblings, within the educational setting, with health workers and with friends, can all mitigate the negative impact of poor parental mental health (Fudge & Mason, 2004; Gladstone et al., 2011; Källquist & Salzmänn-Erikson, 2019; Yamamoto & Keogh, 2018). In doing so, there is potential to reduce the extent to which the child's wellbeing is the responsibility of the unwell parent.

7.4.2. The wider family

When a parent has mental health problems, the family around them can be a source of positive support but can also be a source of difficulty. In most cases, family relationships will incorporate some combination of these features. In seeking to engage with parents, their relationships with the family around them (or lack of), should be considered. For example, one of the identified causes of distress for parents in receipt of inpatient care were the arrangements put in place for their children, in particular when they did not have available family support and their children were put into the care of the state (Study 3.). Where children are cared for by family members, the experience of parents and children is typically more positive (Yamamoto & Keogh, 2018). However, for some parents the placement of children with an estranged co-parent is perceived in entirely negative terms, which can relate to feelings of being excluded or that their relationship with their children is in jeopardy (Study 1. & Study 3.)

Furthermore, the relationship between family members is multi-directional. Where family members contribute to the care of the parent or child, they are taking on an emotional and practical load. There is a broad literature base on the impact of caring responsibilities, which highlights the impact on the mental and physical health of

those who carry out this role (Shah et al., 2010). Carers of adults with mental health needs often describe themselves as existing under an obligation to provide effective care, yet doing so within a system which fails to give them support, recognition or rights (McAuliffe et al., 2009; Rowe, 2012). These difficulties may be heightened when the carer has responsibility for the unwell parent *and* their child. Furthermore, the damaging impact of caring on the mental health of a co-parent or other family member may place the child at further potential risk (Reupert & Maybery, 2016).

It should also be recognised that some parents with mental health challenges will not have a family to draw upon. Parental mental illness is associated with elevated levels of family discord and domestic violence, as was found in Study 1. in which only two of twelve parents reported supportive co-parent relationships (Hosman, Doesum, & Santvoort, 2014). Parents and practitioners also described parents whose current experience was informed by experiences of abuse and trauma, frequently within their own family background, and a lack of a functional parenting models to draw upon. Efforts to support parents with mental health difficulties and to minimise the burden of parental metal health on the child would beneficially engage with the family context of that parent, recognising sources of strengths and capacity for support for parent and child, whilst also engaging with the potential challenges embedded within the parent's family network. At its core, this approach involves engaging, without assumption, to understand the strengths and vulnerabilities within the specific family system.

7.5. Collaboration around the family

The work contained in this thesis is primarily orientated toward adult mental health services, however it would be an oversight to fail to engage with the wider spectrum

of agencies that can exist around the family when a parent has a mental health difficulties. At its broadest, interagency working describes planned and formal joint work between two agencies, which may also be supported by informal relationships and working (Warmington et al., 2004). When supporting parents with mental health problems and their families, a broad network of organisations and services, including social care/child protection services, schools, child and adolescent mental health organisations, charities and community organisations can be involved. Given the variety of potential interactions between services, it unsurprising that interagency work in the context of parental mental health is inconsistently delivered (Foster et al., 2016). However, the importance of effective interagency collaboration to support families has been repeatedly stated in policy outputs and is recognised by workers and parents (Diggins, 2011; RCPsych, 2011). Below I will consider the barriers and facilitators to this form of work and outline some positive practice examples.

7.5.1. Barriers and facilitators

In the interviews with practitioners carried out for Study 1., currently unpublished data explored how practitioners represented their experience of working with parents with traits of borderline personality disorder. Of the four themes that related to the challenges they experienced, two described the tension of working with other agencies. In the theme 'the difficulty of balancing risk', adult and child mental health practitioners described a lack of coherence and understanding between how risk to the child was conceptualised by themselves and by social services. For example, one occupational therapist reported that they "*don't know what the threshold is for when social services do or don't get involved in the case.*" Within a second theme, 'working with other services' each of the 21 practitioners interviewed identified interagency working as being a core challenge when working with parents with complex psychiatric needs. Criticism was levelled at all other services, most commonly regarding their failure to engage, as one clinical psychologist described:

“My experience in working, working in a clinical role for CAMHS for about 15 years, I have called Adult Mental Health hundreds of times in that period. I have never received a call from adult mental health about a child, including when I have left messages and asked people to call me back. Never.”

(Clinical Psychologist, Child and Adolescent Mental Health Services).

With regard to engagement of the range of professionals who come into contact with parents, it was noticeable that while the study was effortfully multi-disciplinary, no participants were recruited from social care, despite repeated and insistent attempts to include members of the service. Other factors identified as creating difficulty in interagency work were: a lack of understanding of the mental health needs of the specific patient group, which was present in the accounts of both adult and child mental health practitioners; and unrealistic expectations of what could be delivered (Study 1.). These themes mesh with an analysis of the barriers to engagement between child protection and mental health services, conducted by Darlington and colleagues, which identified inadequate resources, confidentiality, process gaps, unrealistic expectations and professional knowledge, domains and boundaries (Darlington et al., 2005).

What then supports effective working between agencies around a family? A shared passion for supporting parents, along with capacity to work together, were identified as a key factor in the success of an interagency project designed to support the parents and families through the US legal system which is biased towards child removal (Nemens & Foster, 2015). The Clubhouse Family Legal Support Project involves partnerships between professionals focused on supporting the mental health and recovery of parents with mental illness, and legal professionals. By developing a shared understanding of the parent’s mental illness, including specific symptoms and treatment, legal representation is specifically focused on the parent’s ability to deliver care to their child and on negotiating for realistic markers of

progress through which a parent can increase contact and/or enable the return of this child. Facilitators to joint working can be presented as organisational, team and individual-level factors. A recent review of reviews identified these factors as follows: at an organisational level, engagement with interagency work should be embedded in the culture, mission, values of an organisation and reflected in the structuring of support. Within an interagency team, work is supported through clarity in role and protocols, effective leadership, and professional conflict management. At an individual level, this working is facilitated when practitioners have clarity in their role, feel valued, trusted and operate within mutual respect (Wei et al., 2022). As identified by the Clubhouse Project, personal characteristics such as compassion, competence and commitment also contribute (Nemens & Foster, 2015; Wei et al., 2022).

7.5.2. Effective interagency working in England

For two decades, Liverpool, England, has been the site of a concerted programme to 'Think Family', of which a central component was a dynamic and purposeful approach to collaboration between agencies. In seeking to take a family-focused approach, children's and adult social care services, adult mental health services, the children's physical health trust, the local mental consortium and the charity Barnardo's, have worked together with the core principle that "*meeting the needs of families effectively does not lie within the power of a single organisation or service.*" (Wardale, 2020) In reviewing the program, its co-ordinator stressed that collaboration is effortful and dynamic and requires sustained energy and commitment from stakeholders at all levels, but essentially from those at a commissioning level. In bringing together agencies and the workers within them, there must also be recognition that the process is complex, can be fraught, and is liable to deviate from the good practice models that appear in the literature (Warmington et al., 2004).

Furthermore, the benefits of interagency working may not present themselves in terms of clinical outcomes but in other domains, such as service usage and the experience of parents and practitioners (Cooper et al., 2016). Despite these challenges, collaboration around the family has the potential to benefit parents, children, family members and practitioners who work with them. While the data collected for Study 1. was clear in the difficulties interagency working generated, it also described a clear need for it to happen.

6.6. Limitations and future opportunities

While the research reported in this thesis was designed to reflect the complexity of the interaction between parents and mental health services, a core limitation is that it does not take an adequately intersectional perspective. In particular, the representation of parenthood employed by this thesis would benefit from nuanced consideration of race and culture, socio-economics and gender, and how these attributes relate to the inequalities experienced by individuals with mental health problems (Cole, 2009).

The thesis engages with parents and parenting, yet the data it presents is largely focused on mothers. In Study 1. and Study 3. women comprise the majority of participants. This is echoed in the pilot parenting intervention for adult mental health workers described in Study 4., in which only a quarter of participants were male. While this latter figure reflects the demographic make-up of the mental health service as a whole, it is also reflects the historically poor level of involvement of men in research and interventions engaged with parenting (Panter-Brick et al., 2014; van Santvoort et al., 2015). In Study 1. the experience of the two participating fathers was of being excluded, and a recent study indicates this is a systemic failing of health services in the ante and post-natal period (Burgess & Goldman, 2022). Given that fathers may have the capacity to play specific beneficial roles in the development of their children, and also that their mental health may impact differentially on child outcomes, it is essential that future research engages specifically with the father's experience, attributes and engagement with services (Ramchandani & Psychogiou, 2009). For example, a future practice survey which extends the work of Study 2., could disaggregate attitude and practice by parent gender.

Ethnicity and cross-cultural factors should also be more clearly embedded in future research in this domain. In the studies reported in this thesis, there has been

insufficient consideration of the impact of ethnicity on parent and practitioner behaviours. Racial inequalities continue to be present in the provision of and access to mental services as well as in the experiences and outcomes of adults and children (Bignall et al., 2019). Efforts to engage with families where a parent has mental health problems must reflect differences in help-seeking behaviour and stigma which may be related to culturally- and faith-based attitudes (Mantovani et al., 2017). In the argument proposed by this thesis, that engagement with the parents must understand the complexity, strengths and opportunities present in their ecosystems, ethnicity must be embedded within this.

Finally, there is a necessity for future research to integrate a more involved engagement with socio-economic factors. Poverty, housing instability and homelessness are risk factors for individuals with mental health difficulties and are implicated in the onset and maintenance of poor mental health and independently generate risk for dependent children (Luciano et al., 2014; Najman et al., 2010; Ridley et al., 2020). The interaction of these difficulties may impact on families in numerous ways, not least heightened stress (Hooper et al., 2007). Families which experience multiple difficulties including parental health problems and poverty are more vulnerable to child abuse and neglect (Bywaters et al., 2016). In terms of service provision, in seeking to develop available and accessible support for parents' economic factors should be taken into consideration, for example the cost of travelling to appointments can prohibit engagement.

6.7 Conclusion

In engaging with parents with mental health difficulties, this research calls for urgent improvement in the provision for the individuals and their families. The studies reported in this thesis highlight key deficits in current provision and provide supporting evidence in favour of doing more and doing it soon. The broad sweep of epidemiological research makes it abundantly clear that the need to support such families is a matter of public health (see work by Abel's group). It is both unethical and uneconomic to ignore the impact of parental mental health on the outcomes of children *and* on the parent. However, the research here also indicates that this engagement needs to be informed by the specific needs of families. Every family deserves to be engaged with in a way which recognises their strengths and their limitations without assumptions about lack or availability of support, presence of absence of risk factors, and with understanding of the specific needs and wants of the parent, children, and other family members. This may not make for easy engagement or solutions, but it is work that is well worth the effort.

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Appendixes

Appendix 1. Topic guides used for interviews in Study 1.

Parent Topic Guide

The parenting experiences, help seeking, and support provided to parents who struggle with emotional intensity and changeable moods (EICM)

Objectives:

- To gain an understanding of parenting experiences of parents with emotional intensity struggles and changeable moods
- To gain an understanding of the core parenting struggles when parenting in the context of emotional intensity struggles and changeable moods.
- To gain an understanding of the aspects of parenting that those with EICM would like support with
- To identify strengths and weaknesses of any parenting support undertaken
- To identify targets for support and requirements of support

Parenting experience:

This section is focused on the parenting experience of participants and how it relates to their mental health problems

- Positives in relationship with child/being a parent/their child
- Challenges in relationship with child/being a parent
- Ways of being which get in the way of parenting
- Logistics – appointments etc

- Communicating with child and co-parent
- What changes in relationship and/or parenting?

Help seeking:

This section focuses on the drivers for seeking support in parenting, what was offered and whether it was taken up

- When and why and what would be a point to seek help?
- Crisis
- Own / child behaviour
- Barriers to help seeking
- Barriers to participation in support offered

Help received:

For parents who participated in some form of support programme for parenting, this section is focused on understanding what worked, what didn't and why

- Types of support
- Challenges
- Positives
- Group-based interventions
 - Facilitation
 - Materials
 - Strengths / weaknesses
- Adherence

Design:

This section is focused on the elaboration of what parents would like to experience in parenting support

- Aims
- Structure
- Feeling safe
- Managing difficulties
- Contact
- Characteristics of the facilitators considered important
- Size
- Measurement of success

Example questions (from transcripts)

- How would you describe your experience of parenting?
- It sounds like parenting was challenging please can you tell me a little more about that?
- What would be helpful to you and your family in terms of supporting you with the challenges you have described?

NHS Mental Health Services Practitioner Topic Guide

The parenting experiences, help seeking, and support provided to parents who struggle with emotional intensity and changeable moods (EICM)

Objectives:

- To explore the way these practitioners conceptualise individuals struggling with EICM?
- To understand the extent to which practitioners engage with the parenthood and parenting of these individuals
- To explore the ways practitioners characterise working with parents struggling with EICM?
- To find out what parenting support parents are offered - strengths and weaknesses of existing support
- To explore mechanisms and opportunities to support these parents?

Parenting while struggling with EICM:

This section is focused on gaining an understanding of what these practitioners understand about these parents and the strengths and deficits in their parenting.

- Description in practitioners' own language
- Diagnosis
 - To what extent does it feature in approach, decision making
- Traits and behaviours associated with these parents
- Parenting behaviours specific to or strongly associated with this group
- Crisis and risk

- Strengths and opportunities – targets for support

Working with and supporting these parents:

This section relates to the experience practitioners have working with parents who struggle with EUIM. Primarily this is focused on working with regard to their parenting but it can be opened up.

- Challenges and opportunities
 - Engagement
 - Emotional
 - Logistical
- Communication around parenting
 - Language
 - Fear of stigma
 - Triggering
- Managing parent's fear/anxieties
- Strategies employed by practitioners in supporting parents (this may include avoidance and other maladaptive strategies – encourage honesty) and managing their own responses

Specific parenting support/initiatives:

This section is focussed more granularly on the types of support provided to parents struggling with EUIM. Want to gauge when, how and what is offered, how parents respond to it, how suitable and successful practitioners have found different types of support to be.

- Has it been offered?

- Help sought/referred into/compulsion
- Types of support
- Suitability – practitioner/parent view
- What could be different/better?

Example Questions (from transcripts)

- How would you describe in your own language the experience of individuals with BPD traits?
- How would you characterise or describe the parenting of individuals with BPD traits?
- Can you identify aspects of their parenting which are specific to these parents?

Social Care Practitioner Topic Guide

The parenting experiences, help seeking, and support provided to parents who struggle with emotional intensity and changeable moods (EICM)

Objectives:

- To explore the way these practitioners conceptualise individuals struggling with EICM?
- What strengths and challenges do practitioners they identify in their parenting
- To explore the ways practitioners characterise working with parents struggling with EICM?
- To find out and evaluate extant parenting support
- To explore practitioners' views on possible targets and forms of support

Parenting while struggling with EICM

This section is focused on gaining an understanding of what these practitioners understand about the challenges and experiences of parents struggling with EICM as well as strengths and deficits in their parenting.

- Description in practitioners' own language
- Diagnosis
 - To what extent does it feature in approach, decision making
- Traits and behaviours associated with these parents
- Parenting behaviours specific to or strongly associated with this group
- Crisis and risk

- Strengths and opportunities – targets for support

Working with and supporting these parents

This section relates to the experience practitioners have working with parents who struggle with EUM. Primarily this is focused on working with regard to their parenting but it can be opened up.

- Challenges and opportunities
 - Engagement
 - Emotional fallout
 - Logistical
- Communication around parenting
 - Language
 - Fear of stigma
 - Triggering
- Managing parent's fear/anxieties about Social Care
- Strategies employed by practitioners in supporting parents (this may include avoidance other maladaptive strategies – encourage honesty) and managing their own responses

Specific parenting support/initiatives

This section is focussed more granularly on the types of support provided to parents struggling with EUM. Want to gauge when, how and what is offered, how parents respond to it, how suitable and successful practitioners have found different types of support to be.

- When would it be offered?

- Help sought/referred into/compulsion
- Types of support
- Suitability – practitioner/parent view
- What could be different/better?

Example Questions (from transcripts)

- How would you describe in your own language the experience of individuals with BPD traits?
- How would you characterise or describe the parenting of individuals with BPD traits?
- Can you identify aspects of their parenting which are specific to these parents?

Parenting Practitioner Topic Guide:

The parenting experiences, help seeking and support provided to parents who struggle with emotional intensity and changeable moods (EICM)

Objectives:

- How do these practitioners conceptualise the parents?
- What strengths and challenges do practitioners they identify in their parenting
- How do practitioners find working with these parents?
- What parenting support are these parents offered – strengths and weaknesses of existing support
- What would the practitioners want to see developed to support these parents?

Parenting while struggling with EICM

This section is focused on gaining an understanding of what these practitioners understand about the challenges and experiences of parents struggling with EICM as well as strengths and deficits in their parenting.

- Description in practitioners' own language
- Diagnosis
 - To what extent does it feature in knowledge, approach, decision making
- Traits and behaviours associated with these parents
- Parenting behaviours specific to or strongly associated with this group
- Crisis and risk

- Strengths and opportunities – targets for support

Working with and supporting these parents

This section relates to the experience practitioners have working with parents who struggle with EUIM. Primarily this is focused on working with regard to their parenting but it can be opened up.

- Challenges and opportunities
 - Engagement
 - Emotional fallout
 - Logistical
- Communication around parenting
 - Language
 - Fear of stigma
 - Triggering
- Managing parent's fear/anxieties about Social Care
- Strategies employed by practitioners in supporting parents (this may include avoidance other maladaptive strategies – encourage honesty) and managing their own responses

Specific parenting support/initiatives

This section is focussed more granularly on the types of support provided to parents struggling with EUIM. Want to gauge when, how and what is offered, how parents respond to it, how suitable and successful practitioners have found different types of support to be.

- When would it be offered?

- Help sought/referred into/compulsion
- Types of support
- Suitability – practitioner/parent view
- What could be different/better?

Example Questions (from transcripts)

- How would you describe in your own language the experience of individuals with BPD traits?
- How would you characterise or describe the parenting of individuals with BPD traits?
- Can you identify aspects of their parenting which are specific to these parents?

Appendix 2. Patient as parent questionnaire (Study 2.)

Adult Mental Health Staff Survey: Service Users as Parents

Thank you for your interest in this study. The purpose of the study is to gain a greater understanding of the extent to which adult mental health practitioners engage with their service users as parents. We are also interested in the barriers which may get in the way of this.

When we talk about parenting, we are referring to the qualities and activities a parent demonstrates in caring for and supporting the development of their child. Parenting which is associated with positive outcomes for children is typically warm, responsive to developmental needs, encouraging of autonomy, and presenting firm but fair discipline. Evaluating parenting involves considering strengths as well as deficits

The questionnaire is being sent out to adult mental health practitioners across the Trust.

It should take no longer than 10 minutes to complete.

This section is about your usual practice – select the answer that best fits your practice over the last 6 months.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

A	I routinely ask whether a service user has a child/children	1	2	3	4	5	6
B	I routinely ask service users about their experience of being a parent	1	2	3	4	5	6
C	I routinely ask service users about the quality of their relationship with their children	1	2	3	4	5	6
D	I routinely ask service users if their children have emotional and/or behavioural difficulties	1	2	3	4	5	6
E	I routinely assess the needs of the children of my service users	1	2	3	4	5	6
F	I routinely consider a service user's role as a parent when making an assessment and/or care planning	1	2	3	4	5	6

This section is about your beliefs and attitudes. For each statement select the answer which best reflects your opinion.

1	2	3	4	6	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

A	Challenges related to being a parent can affect a service user's mental health	1	2	3	4	5	6
B	A service user's mental health can affect the way they parent	1	2	3	4	5	6
C	Many parents do not consider their illness to be a problem for their children	1	2	3	4	5	6
D	I feel confident talking to service users about parenting	1	2	3	4	5	6
E	It is important to talk with service users about their parenting	1	2	3	4	5	6
F	With training, I would be keen to provide support for my service users' parenting	1	2	3	4	5	6
G	Talking about parenting can be upsetting to service users	1	2	3	4	5	6
H	Assessment and care planning should take into account the role of a service user as a parent	1	2	3	4	5	6
I	I would like to engage more with the parenting of my clients	1	2	3	4	5	6

This section is about potential barriers to engaging with service users as parents – e.g. activities such as discussing the family context with parents, evaluating their parenting practice and assessing the needs of the child(ren).

For each statement select the answer that best reflects your opinion

1	2	3	4	6	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

A	My workload is too great/there is insufficient time to talk about parenting with service users	1	2	3	4	5	6
B	I am unclear what the Trust policy is with regard to engaging with the parenting of service users	1	2	3	4	5	6
C	Trust policy prevents my engagement with the parenting of service users	1	2	3	4	5	6
D	My manager does not support conversations about parenting with service users	1	2	3	4	5	6
E	I do not have the space in my practice to engage with more than what is directly presented by the client	1	2	3	4	5	6
F	It is not my role to engage with the parenting of service users	1	2	3	4	5	6
G	I do not have sufficient knowledge and skills to support parenting	1	2	3	4	5	6
H	I do not know of parenting interventions to refer parents to and/or I am not sure how to make a referral	1	2	3	4	5	6
I	Discussing parenting with service users will put the therapeutic relationship at risk	1	2	3	4	5	6
J	The subject of parenting risks upsetting the client	1	2	3	4	5	6
K	Talking about parenting can create safeguarding issues	1	2	3	4	5	6

Please note down any additional barriers and rate their importance to your practice

A		1	2	3	4	5	6
B		1	2	3	4	5	6
C		1	2	3	4	5	6

For each of the factors below please state whether they make you more likely, less likely or make no difference to how likely you are to engage with a service user's parenting:

Factors	Less likely	No difference	More likely
Service user presentations:			
Anxiety			
Autism Spectrum Conditions			
Bipolar Disorder			
Depression			
Eating Disorder			
OCD			
Personality Disorder			
Phobias			
Psychosis			
PTSD			
Service user behaviours:			
Service user raises the subject			
Substance abuse			
Self-harm			
Suicidal ideation			
Aggression			
Family situation:			
Social care involvement			
Domestic violence			
Removed child			
Family network			

This section provides space for you to elaborate on your answers to the questionnaire. Your comments will help us to provide context to the questionnaire data and gain a greater understanding of adult mental health practice and the service context.

To what extent do you incorporate parenting and the family context into your practice? *(Optional)*

What are the biggest barriers to working with service users as parents? *(Optional)*

What would assist you in engaging with service users as parents? *(Optional)*

Appendix 3. Data extraction form (Study 3.)

Bibliographic details Author(s) Date Linked studies	
Intervention studies	Qualitative studies
<ul style="list-style-type: none"> • Study aim and objectives • Research question • Design • Setting • Recruitment methods • Consent • Inclusion/exclusion • Number of participants • Participant characteristics (as appropriate: age, gender, ethnicity, diagnostic information, service characteristics) • Intervention(s) characteristics (including description, frequency, delivery) • Comparator (if appropriate) • Study outcomes (primary and other) • Number of participants included in analysis • Follow-up • Reported intervention effects • Funding and sponsorship 	<ul style="list-style-type: none"> • Study aim and objectives • Research question • Theoretical/epistemological perspective • Design • Setting • Recruitment • Consent • Inclusion/exclusion • Number of participants • Participant characteristics (as appropriate: age, gender, ethnicity, diagnostic information, service characteristics) • Data collection • Analysis • Reflexivity • Outcomes • Findings: Themes • Conclusion • Funding and sponsorship

Appendix 4. Protocol: (study 5.)

Study Title:	Participatory Evaluation of a Parenting Programme with Parents with borderline personality disorder/subthreshold borderline personality disorder (BPD/BPDs)	
Study Acronym:	(PEPPY)	
Principal Investigator:	Abigail Dunn	ad560@sussex.ac.uk
Research Team:	Professor Sam Cartwright-Hatton	s.cartwright-hatton@sussex.ac.uk
	Dr Helen Startup	helenst@sussex.ac.uk

Key points

- Parents with challenges around borderline personality disorder/subthreshold borderline personality disorder (BPD/BPDs) are often referred into standard parenting programmes. Tentative data suggests they may struggle with some aspects of these programmes.
- Drawing on the principles and methods of participatory evaluation will enable deeper understanding of the experience of participants with (BPD/BPDS) who go through such programmes and of facilitators running such programmes.
- The project will result in a provisional list of tailored revisions that may be applied to a standardised parenting programme, in order to better meet the needs of this group of parents.

Background

Parent management training programmes can be effective in changing parenting behaviour, increasing confidence and self-efficacy amongst parents and supporting the emotional and behavioural adjustment of children (Bennett, et al, 2013; Day, Michelson, & Thomson, 2013). However, when delivered to parents who are experiencing mental health challenges, there is evidence that standard, unmodified parenting programmes such as these, may be less effective (Reyno, 2006). Unfortunately, we know very little about the utility of such standard parenting programmes for parents with (BPD/BPDs), but there is good reason to suspect that they may be sub-optimal.

Borderline personality disorder is characterised by very intense emotional responses that occur for long durations. This presentation is very often linked to having had early childhood experiences of poor care, lack of nurture or trauma. In this study, however, we will also include individuals who would not meet full diagnostic criteria for BPD/EUPD but who share many traits with individuals who do meet diagnosis and are at risk of similar negative outcomes (Zimmerman, 2012; Kaess, Fischer-Waldschmidt, Resch, & Koenig, 2017).

Parents with difficulties around emotion regulation are often signposted to or referred onto standardised community-run parenting courses despite the absence of understanding of their suitability. Standardised parenting programmes may be less appropriate or effective for this group, for a number of reasons. In focus groups with parents, run by this team, the following issues were identified: feelings of stigma and isolation when asked to talk about their own early childhood experiences, which were very different to the positive experiences related by other members of the group; feeling that their own emotion regulation symptoms were poorly understood by the group leader. However, other than this early research, there has been limited investigation of the suitability of these common interventions for this group.

The current study seeks to explore, in depth, the ways in which a standardised parenting programme may and may not fulfil the needs of parents with (BPD/BPDs). The intervention will comprise a standard Triple P parenting training course (Markie-Dadds, Turner & Sanders, 1997) run by facilitator(s) who deliver these in the community for Brighton and Hove City Council's Parenting Service. The course will be an unmodified version of the programme that is usually run by the Parenting Service, but will comprise only parents with shared challenges around emotional intensity.

As a result of this study, we hope to be able to offer a list of preliminary refinements to standard parenting courses, which can be used to increase satisfaction with and outcomes of such courses for parents with struggles around emotional intensity.

Participatory research approaches (Guijt, 2014) are used in a wide range of fields including international development and healthcare improvement. Participatory evaluation invites service users to play a greater role in the process of evaluation of a programme. The active involvement of service users in the design and evaluation

of Mental Health services was first prioritised by the Government in a 2010 White Paper (DH, 2010) and has been cascaded down to local implementation within NHS Trusts (for review see NSUN, 2014).

For the current study, the active involvement of participants in the process of evaluation has two key purposes: 1) It will enable more accurate understanding of how, where and when the programme satisfies and fails to satisfy the needs of the group. 2) It shifts the power balance within the study so that the participants are partners in the process. This has value in hard-to-reach groups or those who are typically placed in a role as passive recipient of services.

This is particularly relevant to individuals with (BPD/BPDs) who have often had negative experiences with services and who may carry considerable concern about discussing and engaging with parenting-focused support due to fears around child removal. Service user feedback on this methodological approach during PPI consultation on the project was extremely positive and emphasised its potential to empower.

This study is part of a larger package of doctoral research which is focused on parenting in the context of challenges around emotional intensity.

Research question

The study aims to develop an understanding of the extent to which a standardised parenting programme meets the support needs of parents with (BPD/BPDs). It is broadly organised around the following research questions:

- How do parents with (BPD/BPDs) a standard parenting programme?
- How do facilitators experience delivering the programme to this group?
- Which content components of a standardised parenting programme are found to be acceptable and useful by parents with (BPD/BPDs)?
- What revisions and additions would participants (parents and facilitators) make to the parenting programme to increase utility and acceptability?

Patient and Public Involvement (PPI)

Past PPI

Patient and public involvement in the design of the study, the recruitment materials and the participant information sheet was conducted via the Personality, Emergency Care and Complex Needs (PECC) research group run by Sussex Partnership Foundation Trust. Four members with lived experience reviewed a brief protocol, poster and Participant Information Sheet (PIS). In the meeting they were then provided with an overview of the study aims and design by the CI as well as being given time to re-read all the materials.

Feedback on the design of the study was positive: Participants expressed a clear desire for more support for parents with (BPD/BPDs), given their own experience of lack of support in parenting; There was unanimous support for the design of the study, in particular, the decision to include only parents with similar experiences and

traits of (BPD/BPDs). The latter was described as being important in terms of group learning and empathy as well as in relation to the isolation, which participants highlighted, as playing a major role in their own experience. The evaluation approach was also felt to offer participants an empowering experience.

The poster was liked and thought to be an effective recruitment tool. Changes have been made to some of the language including a reduction in reference to (BPD/BPDs). It was also suggested that the poster should make it clear that lunch would be provided as a mechanism of increasing potential engagement.

The PIS was described as clear and answering the majority of questions participants may have about the study. Additional clarification about the type of practitioners running the course have been made, in response to comments from the group.

Future PPI

The evaluation tools (e.g. evaluation wheel) will be trialled with the PECC group prior to study commencing. The group will also be informed of ongoing developments with the study which will occur via the PECC group.

7.4.5. Methods/Design

Type of study

Qualitative evaluation

Participants

8-12 parents with challenges around emotional intensity

Inclusion/exclusion criteria

Inclusion Criteria:

- Parent has one or more children aged between 2-9 years.
- Parent is identified as having challenges round emotional intensity, or subthreshold BPD/EUPD or a diagnosis of BPD/EUPD: Screening: 4+ on [PDQ-4-BPD]
- Parent should be in weekly contact with the child

Exclusion:

- Parent cannot commit to the time requirements
- Due to resource limitations it is not possible to offer to support individuals with insufficient English language or cognitive capacity to participate fully in the focus group.

Recruitment and consent methods

Participants will be recruited in the community and will self-refer into the study. Recruitment will take place using the following mechanisms:

- Promotional materials displayed at targeted sites across Brighton and Hove (e.g., charities, nurseries and schools, children's centres).

- Advertising on social media platforms such as Facebook
- Through the research team's network

Consent will be requested after the PI has had a conversation with the participant and provided them with the participant information sheet (PIS, contained in appendixes). A minimum of 24 hours will elapse between a service user receiving the PIS and the request to provide written consent (ICF).

Potential participants will then be screened verbally using the PDQ-4-BPD. The screening process will also involve an open discussion about the time commitment and subject matter.

Participants who do not meet criteria at screening will be informed they will not be able to take part in the study. They will be provided with information about the courses offered by Brighton and Hove Parenting Service.

Eligible participants will then self-refer to the Parenting Service via Front Door for Families. This will be done with the support of the research team member using an iPad.

Assessment process

Assessment	Carried out by	What the assessment is for	How is the assessment carried out	At what stage is the assessment carried out	Copy of assessment is in Appendix Y/N
Screening	Research team & participant	Establish participant suitability	Face-to-face	Following consent	Y
Demographic questionnaire	Participant	Data for analysis	Paper questionnaire	Session 1	Y
Outcome measures (pre)	Participant	Data for analysis	Paper questionnaire	Session 1	Y
Course evaluation measures	Participant	To evaluate effectiveness of parent-training programme	In an evaluation workshop with the research team	weekly	Y
Outcome measures (post)	Participant	Data for analysis	Paper questionnaire	Session 8	Y

Procedure

Participants will be involved in the study for a total of 8 weeks. This will comprise:

- A one-hour introductory session
- 5 weekly sessions at the University of Sussex where they will participate in a group-based parenting programme (90mins) and then 60mins with the research team to evaluate that session.
- A one-to-one follow up phone call (in week 6)
- Two one-hour evaluation sessions.

The parenting programme sessions will be led by a skilled practitioner(s) from Brighton and Hove Council's Parenting Service, the evaluation will be led by the research team.

Week 1

Introductory meeting (60min):

- Parents meet other group members and group leader(s) and receive an overview of course and evaluation work.
- Completion of questionnaire booklet (see appendix x)
- Parent to set individualised indicator related to parenting (see appendix x).
- Participants will identify and agree on learning and experience factors which are important to them and which will be used to evaluate the group by (e.g. feeling heard).

Should a parent be unable to make this session a member of the research team will meet with them to complete these tasks and ensure they feel prepared for the course.

Weeks 2-5 & 7

Weeks 2-5 and 7 will comprise the following. (Week 6 detailed below).

1) Clinical session (90-120min)

Weekly parenting programme run by parenting facilitator covering content as follows:

Week 2: Positive parenting

Week 3: Helping children develop

Week 4: Managing misbehaviour

Week 5: Planning ahead

Week 6: Using positive parenting strategies (home-based work with follow-up call)

Week 7: Programme close.

These sessions will take place at the University of Sussex Baby Lab and will be observed, through a two-way mirror, by members of the team with experience in EI and parenting work. The session will also be video recorded. The observers will:

- a. Identify points of engagement, disengagement, conflict
- b. Mark video timings for evaluation session.

2) Break for lunch (60min)

3) Post-clinical evaluation session (60min)

Led by the research team, participants will discuss their experience of the clinical session. This will be group-format and will include:

- a. Playback of excerpted video recordings to parents, to enable deeper understanding of how they felt and experienced the sessions.
- b. Evaluation of content of course
- c. Evaluation of session against factors identified by group in introductory session
- d. Completion of ideographic indicator (set at introductory session)
- e. Check in with participants and signposting to external support

4) Independent/home work

Parenting programme homework: Participants will be encouraged to complete the home tasks associated with the weekly content of the parenting programme.

Complete a photo diary. Parents asked to take a photo each week, which captures their experience of employing skill learnt on the course with their family.

Optional parenting self-reflection diary. Parents given the option of capturing their experience of parenting to share with the research team. This may take the form of paper diary, self-recording, or emailing to secure NHS address.

Week 6

This week will not include a face-to-face clinical session. Instead, as is standard in this course, parents will spend one week utilising the positive parenting strategies they have learned during weeks 2-5. In addition, they will:

1. Receive a one-to-one follow-up from the call from the parenting course facilitator during this period. This call will be recorded.
2. Attend university for a group-based evaluation session as detailed above.

Week 8 Final workshop (60-90min)

There will be no clinical session this week. Instead, parents will evaluate the full course and explore their experience.

- a. Use of photo voice /storytelling to explore participants' experience of the course (participants use the photos they have taken through the course to create a story of their experience)
- b. Review course materials and delivery
- c. Consider experience and impact of course
- d. Revisit personal indicators
- e. Complete outcome measures

Parenting Group Leader(s) will undertake mirrored evaluation process during weeks 2-7

- 1) Parenting Group Leaders will be invited to participate in an evaluation session each week (1hr) – this will be scheduled at a time convenient to them and will include:
 - a. Playback of excerpted video recordings, to enable deeper understanding of how they felt and experienced the sessions.
 - b. Evaluation of content of course
 - c. Evaluation of session against factors identified by group in introductory session

Intervention schedule weeks 2-5 & 7

Time	Activity	Led by	Notes
9.30-10am	Set up	Research team (AD, SCH, HS)	
10am-12pm	Parenting workshop	Parenting service facilitator(s)	Research team observe
12-12.45pm	Lunch	Research team	Research team prepare room for workshop
1-2pm	Evaluation workshop (parent)	Research team	
1-2pm	Evaluation workshop (facilitator)	Research team	This may be scheduled for another day, as best suits facilitators

Primary & Secondary Outcome Measures

The primary aim of this study is to identify, through a participatory approach, which components of a parenting intervention participants deem effective and appropriate

and which fall short of this standard. As such the primary data will be a rich qualitative dataset and clearly identified revisions to the standard parenting intervention. This will be supplemented by changes to an ideographic measure of parenting goals and changes to group-defined measures of criteria determined to be important in the acceptability and effectiveness of the parenting programme.

Secondary outcome measures are:

- depression and anxiety (as measures by the DASS)
- child behaviour (measured by SDQ)
- parental discipline behaviours (measured by Parenting Scale)
- parenting self-efficacy (measured by Being a Parent Scale)
- parental functioning (measured by Parent Problem Checklist).

All measures can be found in Appendix.

Data Management & Analysis

Summary of the Types of Data

Qualitative data will be generated via the evaluation sessions. These will be recorded on an encrypted Dictaphone and transcribed for analysis. Additional note taking from these sessions will be stored in a locked filing cabinet and may be transcribed onto a University of Sussex computer and password protected.

Quantitative data will be generated through the completion of pre/post measures. These will be paper-based and entered into SPSS. Qualitative data will be generated by participants in the focus groups. This will also be paper based and will be entered into SPSS. All electronic data will be stored on a secure University of Sussex database.

Research Variables Form (RVF)

Type of data	Variable name	Outcomes/units	Source/Any Instructions	Shared with BHCC
Inclusion	Child aged 2-9	Yes/no	Pre screen qnre	NO
Inclusion	Score > 4 on PDQ-4-BPD	Number Yes/no	Pre screen qnre	NO
Exclusion	Unable to commit to time commitment	Yes/no	Pre screen qnre	NO

Exclusion	Insufficient language/cognitive capacity	Yes/no	Pre screen qnre	NO
Consent	Has the participant given consent freely	Yes/no	Pre screen qnre	NO
Demographics	Name	Text		YES
Demographics	DOB	DD/MM/YYYY	Baseline qnre	YES
Demographics	Gender	M/F/other	Baseline qnre	YES
Demographics	Current Marital Status	Single parent / married / separated/divorced / civil partnerships / living together /widow/er	Baseline qnre	YES
Demographics	Sexual orientation	Heterosexual / Homosexual / Other / Prefer not to state	Baseline qnre	YES
Demographics	Disability or severe chronic illness	Yes /no	Baseline qnre	YES
Demographics	Ethnicity	White British /White Irish /White Other / Black and Black British Caribbean / Black and Black British African /Mixed White and Black Caribbean / Mixed White and Black African / Mixed White and Asian / Mixed Any other Mixed background	Baseline qnre	YES

		/ Chinese / Asian or Asian British Indian / Asian or Asian British Pakistani / Asian or Asian British Bangladeshi/ Any other Asian background / Any other		
Demographics	Recipient of benefits other than child benefit?	Yes/no	Baseline qnre	YES
Demographics	Services working with	List of services e.g. CAMHS	Baseline qnre	YES
Child Demographics	Date of Birth	DD/MM/YYYY	Baseline qnre	YES
Child Demographics	Ethnicity	Select from list above	Baseline qnre	YES
Child Demographics	School attended	Text	Baseline qnre	YES
Child Demographics	Participant relationship to child	Mother/father/step parent/foster carer /other	Baseline qnre	YES
Child Demographics	Child living with participant	Yes/no	Baseline qnre	YES
Strengths and Difficulties (SDQ)	Emotional	Pre and range	Baseline qnre	YES

SDQ	Pro-social	Pre and range	Baseline qnre	YES
SDQ	Conduct	Pre and range	Baseline qnre	YES
SDQ	Impact	Pre and range	Baseline qnre	YES
SDQ	Peer	Pre and range	Baseline qnre	YES
SDQ	Hyperactivity	Pre and range	Baseline qnre	YES
SDQ	Pre-total	Pre and range	Baseline qnre	YES
Parenting scale	Laxness	Pre and range	Baseline qnre	YES
Parenting scale	Overreacting	Pre and range	Baseline qnre	YES
Parenting scale	Verbosity	Pre and range	Baseline qnre	YES
Parenting scale	Pre-total	Pre and range	Baseline qnre	YES
Being a parent	Self-efficacy	Pre and range	Baseline qnre	YES
Being a parent	Self-satisfaction	Pre and range	Baseline qnre	YES
Conflict	Pre	Pre and range	Baseline qnre	YES
Parent- problem checklist	Pre	Pre and range	Baseline qnre	YES
Depression, Anxiety, Stress Scales (DASS 21)	Depression	Pre and range	Baseline qnre	YES
(DASS 21)	Anxiety	Pre and range	Baseline qnre	YES
DASS 21	Stress	Pre and range	Baseline qnre	YES

DASS 21	Final	Pre and range	Baseline qnre	YES
Individual indicator	Participant indication of parenting change	Scale 1-10	Evaluation measures	NO
Learning and experience evaluation factors	Course evaluation factors identified by parents	Scale 1-10	Evaluation measures	NO
Strengths and Difficulties (SDQ)	Emotional	Pre and range	Post qnre	YES
SDQ	Pro-social	Pre and range	Post qnre	YES
SDQ	Conduct	Pre and range	Post qnre	YES
SDQ	Impact	Pre and range	Post qnre	YES
SDQ	Peer	Pre and range	Post qnre	YES
SDQ	Hyperactivity	Pre and range	Post qnre	YES
SDQ	Pre-total	Pre and range	Post qnre	YES
Parenting scale	Laxness	Pre and range	Post qnre	YES
Parenting scale	Overreacting	Pre and range	Post qnre	YES
Parenting scale	Verbosity	Pre and range	Post qnre	YES
Parenting scale	Pre-total	Pre and range	Post qnre	YES
Being a parent	Self-efficacy	Pre and range	Post qnre	YES
Being a parent	Self-satisfaction	Pre and range	Post qnre	YES
Conflict	Pre	Pre and range	Post qnre	YES
Parent-problem checklist	Pre	Pre and range	Post qnre	YES
Depression, Anxiety,	Depression	Pre and range	Post qnre	YES

Stress Scales (DASS 21)				
(DASS 21)	Anxiety	Pre and range	Post qnre	YES
DASS 21	Stress	Pre and range	Post qnre	YES
DASS 21	Final	Pre and range	Post qnre	YES

Sample size

The sample size of 8-12 is defined by the number of parents typically involved in a behavioural parenting programme (e.g. Day, et al, 2012; Wilson, et al., 2012) and the recommendations of Brighton and Hove Parenting Service.

Planned data analysis

- Descriptive thematic analysis of parents' feedback on content, delivery and experience of the parenting programme.
- Descriptive thematic analysis of facilitator(s') feedback on content, delivery and experience of the parenting programme.
- Descriptive statistical analysis reporting trends in scores on ideographic parenting-related indicators set by each parent.
- Descriptive statistical analysis reporting trends in parental and facilitator weekly scores against experiential and learning factors.
- Descriptive statistical analysis reporting pre-post trends in pre-post outcome measures.

Data collection, entering, coding and checking process

The CI, Abby Dunn, will be data manager with oversight from her academic supervisory team. Outcome data in the form of paper questionnaire booklets will be taken before the first parent training workshop and after the final parent training workshop. This data will be collected by the CI and entered by a member of the research team. Ongoing evaluative data will be collected and recorded by the CI.

Potential bias

The evaluation is collaborative and the research team will be vigilant to monitor their own influence on the discussions. Separating the facilitation of the parenting programme, which is being carried out by individuals who are not members of the research team, from the evaluation workshops will lessen moderator bias.

Selection bias will be reduced by recruiting participants from a range of community settings.

The CI will adopt a reflective stance throughout the process of analysis and will bring the ongoing analytical work back to the wider doctoral supervisory team.

Data custodian and data ownership

Name of data custodian: University of Sussex.

Data quality and Standards

The research team adhere to the good practice and standards principles which are set out in

the University of Sussex Data Protection Policy 2018 this reflects the General Data Protection Regulation (2018).

All research will be carried out under the above standards and will be reviewed by the University of Sussex Ethics Committee.

Data management will be a standard item on the agenda for both research team.

Data security

All data will be collected by the research team. All electronic data will be password protected and stored on the University of Sussex server until analysis has been completed. All paper data will be stored in a locked filing cabinet on the University of Sussex site. Consent forms and anonymised questionnaires will be scanned and subject to long term storage as identified below. Paper documentation will then be securely destroyed.

Videographic data will be destroyed at the close of each weekly session.

Following the completion of analysis all data will be anonymised and stored on ReShare repository of the UK Data Service [<http://reshare.ukdataservice.ac.uk/>] for an indefinite period. This will enable the data to be used for learning and research in the future.

Data sharing

Non-anonymised participant data will be shared with Brighton and Hove City Council Parenting Service.

Participants will be asked to consent for personal data to be shared with Brighton and Hove City Council (the Parenting Service) (variables to be shared are identified in 7.2 Research Variables Form). This data is usually collected by the parenting service to inform the facilitation of the course.

Ethical considerations

The research has been designed and will be conducted in accordance with the British Psychological Society Ethical Principles for Conducting Research with Human Participants. As such the study will demonstrate respect for the autonomy and dignity of persons, scientific value, social responsibility and will maximise benefit while minimising harm.

The safety and wellbeing of participants in the study is paramount and the parent-training sessions and the evaluation workshops will be run with this in mind. Parenting is an emotionally loaded subject, and this is particularly the case for parents with complex personal and interpersonal challenges for whom emotional states and interpersonal relationships can be volatile. However, the potential for harm to participants will be minimised by the activities detailed below.

- 1) Parents are participating in a parenting intervention of a sort commonly provided to parents with challenges around emotional intensity – as such their involvement reflects care they would receive in the community.
- 2) The facilitators are highly skilled and experienced and have additionally been provided with training on the specific needs of parents with these challenges.
- 3) Parents will have had an open discussion with the CI about the suitability of the intervention.
- 4) The group will agree to abide by a clearly stated and mutually agreed 'group agreement' which will help to foster a safe environment where participants feel able to speak openly and will be free from harassment, judgement, or blame.
- 5) The parenting programme facilitators will be mindful of the potentially triggering nature of the subject matter. However, experience has shown that in a safe environment, a discussion of parenting can actually provide a useful opportunity for parents with to feel heard and to contribute to the development of services.
- 6) At the end of each weekly session participants will be invited to share any concerns or worries with the research team and time will be available for them to be supported to regulate their emotions.
- 7) Should a crisis arise as a consequence of participation in a research the participant will be supported to seek the necessary help.

All participants will have provided informed consent and will be aware that they can subsequently withdraw or alter their consent, and to ask for the withdrawal and/or destruction of any or all of their data. All participants will be made aware of and

agree to the confidentiality policy. The study will adhere to the 'Caldicott Principles' and confidentiality will be broken only when issues relating to safeguarding arise. At the beginning of the programme participants will be informed that conversations will be confidential. Confidentiality will be breached only if the facilitators are concerned that a child or vulnerable adult is at risk of serious harm in which case they will contact Front Door for Families, Brighton and Hove Social Services Multi-Agency Safeguarding Hub or the Safeguarding Adults Board. They would attempt to speak to the parent before a referral is made.

Risks to the researchers are minimal as the group will be facilitated by experienced practitioners and researchers, working together, in a community setting.

Projected outputs and dissemination

A set of recommendations for maximising the efficacy of standard behavioural parent-training interventions with parents who experience emotional intensity.

The results of this study will be published in the form of a journal article and presented at relevant conferences. A report will also be made to the relevant PPI group of Sussex Partnership Foundation Trust and to the Parenting Service. The study will also be incorporated into a doctoral thesis.

Plans for Translation

The research will inform the eventual development of a modified parenting programme, specifically tailored to parents with challenges around emotional intensity. This will incorporate the revisions made to the standardised parenting programme as well as any core content identified as missing from the standardised programme.