FEATURE ARTICLE

Standards of practice for the adult mental health workforce: Meeting the needs of families where a parent has a mental illness

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ABSTRACT: *This article outlines the development of practice standards for the adult mental health workforce for addressing the needs of families where a parent has a mental illness (FaPMI). The practice standards recommended here were formulated using a modified cooperative inquiry process with a group of senior clinical leaders in adult mental health services in Australia, following consultation with the available literature and policy documents. The aim of the project was to generate, align, and operationalize family-inclusive practice standards within the core activities of the adult mental health workforce and integrate into the continuum of care and recovery for service users who are parents of dependent children. As part of a modified Delphi method, the standards were also ranked by the senior clinical leaders to determine what they believe to be essential and recommended practices for the adult mental health workforce they manage. We argue that developing practice standards that provide practical and realistic expectations of the adult mental health service workforce enable services and workers to better adapt practice to respond to FaPMI.*

KEY WORDS: *family-focused practice, mental health service, parenting, practice standards.*

INTRODUCTION

A large number of people living with a mental illness are also parents of dependent children. US data indicate that over half of all people with a diagnosed mental illness are

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parents, and this figure rises to approximately 65% for women (Nicholson *et al.* 2004). A study from the UK showed that up to one in four children aged between 5 and 15 years has a mother with a diagnosed mental illness (Parker *et al.* 2008). Similarly, in Australia, it is estimated that 21–23% of children live with at least one parent who has a mental illness (Maybery *et al.* 2009b).

Children of parents with mental illness are more likely to develop a mental health problem than the general population (Hosman *et al.* 2009). These children are also more likely to experience social, emotional, and developmental problems (Cooklin 2010; Leinonen *et al.* 2003; Maybery *et al.* 2009a; Nicholson *et al.* 2008). These difficulties are related to both biological and environmental factors. Mental illness has been associated with parents being less emotionally available to children. This

can disturb attachment between parents and children, potentially leading to long-term detrimental effects on young people (Reupert & Maybery 2007). On a more everyday level, parents with a mental illness often find it difficult to maintain a consistent and structured approach to family life (Stallard *et al*. 2004; Thomas & Kalucy 2002). For instance, keeping simple routines, such as getting children to school or preparing regular meals, can be challenging for parents who cycle between states of wellness and poor mental health.

Compounding the effects of mental illness for many parents is a range of challenging social and economic factors, including poverty, homelessness, lack of access to education and employment, an increased risk of intimate family violence, and a lack of personal and social supports (Perera *et al*. 2014; Reupert *et al*. 2012). The stigma associated with mental illness might impede parents from seeking support for their parenting, through fear of negative judgment or that their children will be removed by the child-protection authority (Blanch *et al*. 1994; Diaz-Caneja & Johnson 2004).

Despite this, there is evidence that being a parent with a mental illness is associated with improved general functioning and reduced illness severity (Caton *et al*. 1999; Evenson *et al*. 2008; Mowbray *et al*. 2001; White *et al*. 1995). Parenting can give people a positive sense of self-identity and help to develop a sense of meaning and purpose (Montgomery *et al*. 2006). This can be hugely significant for people who might previously have felt defined only by their mental illness (Slade 2009). As such, supporting people in their parenting role might be an important part of mental illness recovery (Nicholson 2010). Furthermore, providing parenting and family-based interventions for parents with a mental illness has been shown to improve outcomes for their children, and reduce the risk that they will develop the same mental health issues by up to 40% (Siegenthaler *et al*. 2012).

Current national and international policy and government direction identify the importance of supporting parents with a mental illness and their dependent children. In the UK, the needs of family carers and children are explicitly addressed in national mental health policy directives (HM Government 2011). The Australian National Practice Standards for the Mental Health Workforce specifically identify the need to recognize and support the importance of carers and children in the recovery of the person with mental illness (Commonwealth of Australia 2010).

The 2011 Protecting Vulnerable Children Inquiry (conducted in Victoria, Australia) found that improving parental capacity among parents with a mental illness can significantly reduce the risk of child neglect or abuse (Cummins *et al*. 2012). The inquiry called on the Department of Health to ensure adult mental health services better interact with patients who are parents, and take into account the needs of vulnerable children when treating adults in these families. The report states that 'specialist adult service providers are not sufficiently attuned and resourced to identify vulnerability in children when they are providing certain services to their parents. These services need to recognize and take action regarding the needs of their clients as parents and respond to the needs of their children' (Cummins *et al*. 2012, p. xxxv). The report has contributed momentum across government departments and services to continue investigating early intervention approaches for vulnerable children and families.

Although the policy context is supportive, and there is a strong body of evidence on the value of family interventions, this has not easily translated into practice (Dixon *et al*. 2001; Kavanagh *et al*. 1993; Lauritzen *et al*. 2014; Magliano *et al*. 2005; McFarlane *et al*. 2003). Adult mental health services are often working within a crisis-response and demand-management framework that focuses on illness and the individual, limiting a strategic prevention and early intervention focus (Korhonen *et al*. 2008; Smith & Velleman 2002). Clinicians do not routinely engage with their clients about parenting, children's needs, or family functioning (Beardslee *et al*. 2007; Fadden 2006; Maybery & Reupert 2006). Further, research has shown that mental health clinicians do not feel they have the necessary skills or knowledge to adopt family-inclusive practice (Biebel *et al*. 2014; Cook & Mueser 2014; Maybery & Reupert 2006; 2009). Research also supports the development of clinical practice guidelines in defining the role for the mental health workforce to meet the needs of parents and children (Houlihan *et al*. 2013; O'Brien *et al*. 2011). Mental health services might also require changes to mandates, policies, and procedures to address the needs of family members (Blanch *et al*. 1994). However, guidelines can provide both the mechanism that drives workers competency by specifying the required skills, and also provide the organization with systems for measuring and guiding practice (Fixsen *et al*. 2009; Metz & Bartley 2012).

Although practice guidelines for family-inclusive practice do exist, practices to support children of parents with a mental illness have not been routinely adopted in clinical settings (Korhonen *et al*. 2010; Krumm *et al*. 2013; Slack & Webber 2008). In part, this is because they are often not easily adapted or transferable into the 'real-life

practice' of adult mental health services (Jones & Scannell 2002). In some cases, the expectations on practitioners are ambiguous or unachievable in the context of existing demands on adult mental health workers. The adaptation of clinical practice guidelines to fixed routines has been associated with greater compliance of health professionals (Foy *et al*. 2002).

This paper reports on a practice-based project which aimed to generate, align, and operationalize family-inclusive practice standards within the core activities of the adult mental health workforce. With a particular focus on the integration of these standards into the continuum of care and recovery for service users who are parents of dependent children, we aimed to address some of the barriers to implementation of new practice mentioned above. The continuum of care, as defined by the Australian Government's Delivery of Care Standards, is the movement through the service system, as experienced by the mental health consumer from the point of entry into the system to eventual exit from the service (Commonwealth of Australia 2010). The study involved senior clinical leaders currently working within the adult mental health sector in Victoria, Australia. Each of these clinicians is employed as a system change agent, tasked with improving service provision for families where a parent has a mental illness (FaPMI). This team of clinicians undertook a process of reviewing existing practice standards and guidelines with respect to current clinical practice and service systems that address the needs of FaPMI, and generated new practice standards specifically for the adult mental health workforce. A benefit of this approach was to operationalize practice standards from an internally-driven and informed perspective in order to create standards that are realistic for the workforce, and therefore, more likely to be taken up by clinical staff and services.

MATERIALS AND METHODS

This project utilized a modified process of cooperative inquiry (Reason 1999), whereby both researchers and clinicians work together as both co-researchers and co-participants through cycles of knowledge development on a particular issue of relevance to the group. In this case, a team of senior clinicians from the adult mental health sector worked collaboratively with a researcher to develop the set of practice standards for FaPMI to address a gap in related practice for FaPMI in adult mental health services. The process involved collaboratively reviewing literature, reflecting on key themes within the literature, drafting and reviewing standards in

response to existing literature, and clinician experience as change agents within adult mental health services. More details of these processes are described later.

Participants

In 2007, the Victorian State Government of Australia established a policy directive that aimed to improve service provision opportunities for FaPMI (State of Victoria 2007). Under this directive, entitled the 'Families where a Parent has a Mental Illness Strategy', senior clinical leaders (FaPMI coordinators) within the adult mental health sector are employed to facilitate change within the sector to enable the workforce to be more responsive to the needs of clients who are parents and their dependent children. Fifteen of these FaPMI coordinators participated in this project as co-researchers and co-participants. As change agents embedded within the adult mental health sector in specific geographic regions, the FaPMI coordinators have extensive experience negotiating the complexities involved with changing systems and practice to integrating FaPMI practice into the existing continuum of care provided by adult mental health workers. These participants were able to draw on their experience in developing practice and offer a unique 'insider' perspective on the practical barriers and opportunities for a set of practice standards to facilitate change within the adult mental health workforce. Ethics approval was obtained from La Trobe University Human Research Ethics Committee (Melbourne, Victoria, Australia) as part of a broader study aimed at documenting service-development strategies, which were also part of the evaluation of the Victorian FaPMI strategy in mental health services. The documentation of the practice standards development was undertaken as part of this larger study.

Study design

Stage 1: Literature review
A subgroup of three FaPMI coordinators was formed to work alongside the researcher to review existing FaPMI-related practice standards or guidelines related to the development of the standards. Both peer-reviewed publications and grey literature (including reports or guidelines published by government) were included in the review.

Key word searches were undertaken on major databases, including Web of Science, Scopus, PubMed, and Google Scholar. Key words and phrases included 'FAPMI', 'children of parents with a mental illness (COPMI)', 'mental illness', 'parents', 'children' plus 'practice standards', 'standards', 'guidelines', and 'principles'.

Additionally, relevant local, national or international policy documents, and service guidelines or reports were identified by the collaborative team. Snowballing techniques were also utilized from the citation lists of articles and documents to find additional publications of interest. Articles were limited to English-language publications.

Twenty-eight relevant peer-reviewed publications and policy documents were found through the review, of which 19 were used specifically to guide an understanding of existing standards described in the literature. The literature was reviewed using inductive thematic analysis. Two reviewers (MG and BA) independently reviewed the literature and identified standards of FAPMI practice prescribed for mental health clinicians that were common across the literature. The two reviewers then cross-checked their analyses as a way of refining and developing themes. This process involved noting points of difference between each reviewer with respect to their identification of major or important themes, and reaching consensus through discussion and rereading of the literature.

Stage 2: Integration of existing standards and development of FaPMI practice standards
Stage 2 involved a working party of the four FaPMI coordinators and the researcher drafting a set of practice standards based on key themes identified in the literature (see the first section of the Results for the key themes identified as part of stage 1). The working party met on four occasions to discuss and describe key practices adult mental health clinicians should undertake with the parent–consumer to identify and address the needs of the family. Once a consensus was reached amongst the working party, the key practices were then refined to standards of practice that followed the continuum of service engagement. The standards were developed for each of the six stages of the continuum of care of a parent–consumer's engagement with the adult mental health service, from the initial screening and referral process (1), entry and orientation into the service (2), negotiating and developing a care plan (3), implementing treatment (4), monitoring and evaluating care (5), to discharge planning and the transfer of care (6). These stages are aligned with the Delivery of Care Standards of the Australian National Standards for Mental Health Standards (Commonwealth of Australia 2010).

Stage 3: Expert review
As part of the third stage of the cooperative inquiry, a modified Delphi process (Landeta 2006) was undertaken, whereby the entire group of FaPMI coordinators was invited to rank the importance of each of the drafted standards. An online questionnaire, with six sections representing the standards in each of the stages of the continuum of care, was distributed to the wider FaPMI coordinator network ($n = 15$), to which 10 people responded. Respondents were asked to rate each of the draft standards in terms of applicability to their adult mental health services, and whether they viewed them as essential or recommended minimum standards of care through categorizing each of the standards under each section. There was also an open-ended comment box to allow for additional comments about the standards, whether they disagreed with the standard, and whether they wanted to add any standards. For the second round of the Delphi process, the results of the ranking of essential and recommended practice standards were presented to the entire FaPMI group at a face-to-face meeting, whereby feedback was obtained and a consensus was reached. The last stage of the process involved validation of the standards by the state-wide coordinator overseeing the implementation of the Victorian FaPMI strategy.

RESULTS

From stage 1, a review of existing literature and policy documents identified FaPMI practice principles or guidelines for integrating family-centred practice in the adult mental health setting. Even though a limited evidence base for practice standards in the area of FaPMI was noted from the review, there were some clear common areas identified through the thematic analysis of prescribed principles and guidelines stipulated in the literature. These were broadly identified as a requirement for: (i) identification of parenting status and dependent children among adult clients; (ii) a needs and well-being assessment of parents and family members, including children; and (iii) the provision of support to address those needs, including referral to support services (AICAFMHA 2004; Bannerman 2009; Brady 2009; Brockington *et al*. 2011; Evans & Fowler 2008; Foster 2010; Foster *et al*. 2005; 2012; Fudge *et al*. 2004; Heriot 2009; Liangas & Falkov 2014; Maybery & Reupert 2009; Mottaghipour & Bickerton 2005; Mowbray *et al*. 2001; Mullen 2009; Nicholson 2010; Nicholson & Biebel 2002; RCP 2011; Wan *et al*. 2008).

The necessity to integrate family-centred practice across a continuum of care for mental health consumers was highlighted in some literature. For instance, Foster *et al*. (2012) distinguished their recommendations between activities undertaken at intake from other phases of client care. Similarly, Mottaghipour and Bickerton

(2005) developed a hierarchical framework of family involvement for mental health practitioners. They describe a pyramid of engagement consisting of five levels: connection and assessment (level I), general education (level 2), psychoeducation (level 3), consultation (level 4), and family therapy (level 5). Levels I and II are seen as a minimum standard of care, and should be offered to all families in a mental health setting, whereas higher-level interventions (levels III–V) are to be offered on a needs basis. The authors argue that the minimum level of care should fall within the existing skill set of every mental health clinician.

Below is the set of recommended FaPMI practice standards, developed by senior clinical leaders in mental health through the expert review and analysis of the literature. The standards are presented in a series of tables according to each stage of engagement in the continuum of care for adult mental health services.

Practice standards recommendations

Stage 1: Screening and referral

This is the first point of contact a service user, family member, or referring person will have with a clinical mental health service. At this stage of the continuum, it is recognized that there is a need for accurate family information to be collected and recorded, and that this is protective for vulnerable dependants. Collecting accurate information assists in engagement and assessment, as well as other activities of care planning and provision of psychoeducation. This information provides the essential foundation upon which all other service activity will be built (Mottaghipour & Bickerton 2005).

The standards at this stage stipulate that information regarding current supports, parenting status, and pregnancy status are considered at the outset, and set the scene for the parenting role to be included in any ongoing service (Table 1).

Stage 2: Entry into service

Service activity at this stage might include assessment, orientation to the service, psychoeducation, and gaining consent for care planning with other supports. Assessment is a key activity at this stage of the continuum, and ensures that the strengths, vulnerabilities, and needs of service users and their families are identified. Initial orientation to service and care planning from the outset provides further opportunity for connection with service users and their family. Activity at this stage of the continuum also provides a level of general education with regards to service delivery and support, but also allows for targeted psychoeducation to commence. Initial assess-

TABLE 1: *Essential and recommended practice standards for stage 1 (screening and referral) of engagement with adult mental health*

Essential	Recommended
Primary client: • Next of kin identified, and contact details recorded • Legal status is identified and recorded • Current family and other supports are identified and recorded • Pregnancy status is identified and recorded • Parenting status is identified and recorded Dependents: • Dependent children are identified, recorded, and their whereabouts ascertained • Caring responsibilities are identified and recorded (both for dependents and others) • Risks to dependents identified	• Identify who the primary client would like involved in their care (family, carers, children) • Provide client with an orientation to the service regarding family-inclusive practices • Identify clients intent in planning to become pregnant

ment, engagement and education have widely been considered essential elements of providing family responsive services (Bannerman 2009; Foster *et al*. 2005; Liangas & Falkov 2014).

The standards presented in Table 2 specify that the mental health worker consider the strengths, personal resources, vulnerabilities, risks, legal and custodial issues, and identification of family supports.

Stage 3: Negotiating recovery plan

Following from entry into the service, developing a service/recovery plan is an important activity that captures the main focus of service delivery (Table 3). Activity throughout the recovery planning phase of the continuum of care ensures that needs are identified and responded to. With an emphasis on connection and planning service delivery, family members are supported to identify goals and actions, allocate responsibility for agreed tasks, and to explore individual needs. Consideration is given to crisis care planning, and ensuring clinicians and service users are planning for the care of children in times where the severity of the parent's mental illness symptoms might restrict them from doing so. Services can act to minimize the negative impacts for dependent children, such as lack of information, isolation, becoming responsible for the family, and wanting to control situations due to fear (Foster 2010). Family-inclusive care planning provides an opportunity to build upon the protective factors within the family unit. Service providers can utilize the many evidence-based resources to support

TABLE 2: *Essential and recommended practice standards for stage 2 (entry into service) of engagement with adult mental health*

Essential	Recommended
Assessment: • Assessment of family vulnerability to risks (i.e. family violence, child protection issues, victimization, community context) • Legal status of dependants identified, including custodial issues • Current involvement with Child Protection/Child First/Integrated Family Services ascertained and recorded • Genogram, including all dates of birth, full names, identifies living arrangements, 3 generations • Child well-being is assessed Orientation to service: • Copy of service/recovery plan provided and explained, and includes opportunity for a subsequent family meeting. • Service/recovery plans include ongoing opportunity for family meeting at the appropriate time Psychoeducation: • Parenting and mental illness information provided and explained to primary client Consent: • Consent obtained to share information with identified supports • Referral to new supports are identified and presented; referral is facilitated	Assessment • Identifies existing supports for all family members • Strengths of family identified • Family history of mental illness identified • Identification of parenting responsibilities and caring roles of all family members, including children • Identification of impact of trauma • Identify all services involved for each family member Orientation to service • Pathways of care identified • Identify need for case conference with relevant services Psychoeducation: • Family/carer literature provided and explained to all family members

TABLE 3: *Essential and recommended practice standards for stage 3 (negotiating recovery plan) of engagement with adult mental health*

Essential	Recommended
Service/recovery plan: • Provides an opportunity for primary client to identify who is to be included in care planning • Identify individual family members needs • Identifies actions to address each family members needs • Identifies who is responsible for each action • Identifies key contact person for the service and other relevant services • Identifies contact details for service including after-hours contact • Identifies & considers parental status • Crisis strategy is documented	• Family member have opportunity to address concerns for others • Plan articulates any impact of parental mental illness on parenting and impact of parenting on illness • Identifies frequency of planned contact • Provides a family care plan (e.g. alternative child care arrangements, school attendance)

parents in talking to their children about their mental illness in age-appropriate language (e.g. COPMI national initiative, http://www.copmi.net.au/). Family care planning provides an opportunity to tailor service delivery to respond to the needs of all family members. The family care plan process identifies family members' needs, and articulates key resources, supports, and contacts, and determines actions and responsibilities to meet identified needs. Planning to avoid crises or to provide timely responses in crisis events is especially important for parents with dependent children.

Stage 4: Implementing treatment
Implementing treatment with a family where a parent has a mental illness must occur with an appreciation of, and support to, any parenting/caring roles that exists within a family. Psychoeducation, as suggested in the Pyramid of Family Care, needs to be offered on an ongoing basis (Mottaghipour & Bickerton 2005). Beyond this, some service users and families might access specialized consultation and therapy targeted at family needs. Falkov (2012) suggests that timely intervention for families is essential. Consultation and liaison with other family support services is necessary to create a continuum of care (Heriot 2009), and treatment is delivered with regular review of protective factors, risks, and vulnerabilities. To support effective consultation and liaison across agencies and service sectors, and thus, timely acceptance of referrals and assistance to families, it will be necessary to utilize and develop cross-agency and cross-sector relationships (Heriot 2009; Owen 2010; Wan *et al*. 2008).

Service delivery at this point is directed at acknowledging and supporting any parenting and caring roles within a family, including roles undertaken by children

TABLE 4: *Essential and recommended practice standards for stage 4 (implementing treatment) of engagement with adult mental health*

Essential	Recommended
Service delivery (includes inpatient care if relevant):	• Is inclusive of all family members
• Acknowledges caring roles of client (parenting role/responsibilities) and offers support to these roles	• Offers opportunity to meet with all family members
• Offers ongoing psychoeducation to primary client	• Offers ongoing psychoeducation to all family members
• Family aware of how to access crisis supports	• Identifies and offers other supports as required to all family members
• Regular review of risks to children/family members occurs	• Identifies any emerging/ changing in parenting/ caring role for any family member and offers support to this.
• Offers regular liaison and collaboration with existing supports	• Referral to peer support programmes for children and young people is considered
• Offers support to the identified needs of dependent children	• Referral to parenting supports is considered

TABLE 5: *Essential and recommended practice standards for stage 5 (monitoring and evaluating care) of engagement with adult mental health*

Essential	Recommended
Regular review:	• Family, including children, are included in any review of treatment or service/recovery plan
• Support the primary client to have regular conversations with their children about any concerns children might have	• Any family member in a parenting/caring role is offered the opportunity to provide feedback to the service about their experience of the service
• Status of family members is regularly reviewed and updated (including genogram)	• Family members are informed of changes to service eligibility and the availability of services
• Consent to share information with identified supports is reviewed and updated	• Regular review of strengths and vulnerabilities is articulated

TABLE 6: *Essential and recommended practice standards for stage 6 (transfer of care) of engagement with adult mental health*

Essential	Recommended
Discharge planning:	• All family member's needs are planned for and appropriate referrals have been made as needed
• Ongoing supports are clearly identified and documented.	
• All family members are advised on process for re-entry to service	• Family members are consulted with regards to discharge from service
• Written confirmation of discharge from service provided to primary client and nominated family members	• Nominated services/supports advised of discharge from service with consent

(Table 4). Family members are to be included and educated on how to access support in crisis where necessary. There is also a regular review and monitoring of the risks and liaisons with other supports.

Stage 5: Monitoring and evaluating care

Service delivery might need to be monitored and reviewed regularly to ensure that identified goals are being met and any emerging needs are responded to in ongoing care planning. With a focus on the routine review and evaluation of care, this stage encourages ongoing connection and assessment of service users and their family members' needs. Opportunities are offered to review progress towards agreed-upon goals and re-evaluation of treatment planning. It is essential that children's needs are reviewed and responded to, to ensure that relevant information is provided (Bannerman 2009; Foster *et al*. 2005).

The standards presented in Table 5 reflect the need to regularly ensure family members status and presence is updated, there is regular attention to the needs of children as their developmental needs change, and that goals reflect current parenting status and concerns. The standards also reflect the importance of providing developmentally-appropriate opportunities to capture and value the child's/children's input in planning and review, which is fundamental to family-inclusive practice.

Stage 6: Transfer of care

Discharge planning is an activity that reflects a transition out of one service mode and disconnection from the current clinical care relationship. At this point, however, families might transition into other appropriate supports or continue with their existing supports. Discharge from service is planned, coordinated, and informed wherever possible. Information is shared on procedures for re-entry to services, and families are clear about the availability of ongoing supports. Wan *et al*. (2008) point to the importance of good interagency communication and relationships to ensure families continue to be supported (Wan *et al*. 2008).

The standards presented in Table 6 stipulate that planning at this stage ensures that adequate consideration is given to the ongoing support needs of all family members. Family members (and support services) are also to be advised of the process for re-entry to service.

DISCUSSION

Timely intervention for FaPMI is likely to be effective in reducing the impact of mental illness and providing appropriate responses to support the well-being of all family members (Siegenthaler *et al*. 2012). Children of parents with a mental illness are considered to be 'hidden children' within the mental health and welfare sector, often overlooked by adult-oriented services and not on the radar of child-oriented services, unless presenting with significant emotional or disruptive behavioural issues (Cooklin 2013). Recent policy developments in the areas of FaPMI and COPMI aim to address this oversight, and a number of evidence-based interventions have been developed to better equip the adult mental health service sector to respond to the needs of both children and parents (Solantaus *et al*. 2010). Despite this, family inclusion still remains challenging in the adult mental health sector.

One possible barrier to practice change is that few policy and governmental developments have been able to address or recommend a prescriptive framework for the inclusion of the care of families that has parallels with the existing service-delivery model. In this project, we aimed to overcome this barrier through the development of practice standards for FaPMI for mental health workers. These standards describe a prescription for family-inclusive practice, such as viewing the primary client in the context of their family system; the identification of dependent children, and assessment of their strengths and vulnerabilities; and the provision of support, specific assistance, or interventions for all family members. These standards are designed to be applicable service wide, and describe a framework for family-inclusive work at all points of a service user's engagement with the adult mental health service system. These standards are aligned with a continuum of care that matches the journey of the service user (and the tasks of the mental health worker) as the user moves through a mental health service, as stipulated in the Delivery of Care Standards (Commonwealth of Australia 2010). As the standards are closely matched to the usual flow of the clinician's tasks, it is envisaged that this will assist in uptake and application.

The Delivery of Care Standard's first directive reflects the movement towards recovery-oriented practice in the international and national stage, and places the person living with a mental illness in the driver's seat of their own recovery (Stickley & Wright 2011a,b). Recent advances, such as Australia's first National Framework for Recovery-Oriented Mental Health Services (Commonwealth of Australia 2013), herald a new policy and practice direction in Australia. Craig (2008) identified that it is the way services are provided, rather than the techniques they employ, which are beneficial for a person's recovery journey (Craig 2008). The practice standards outlined in the present study reflect the concepts of recovery through their strengths-based focus that provides a framework for the mental health worker to collaborate with the client to support and enhance significant roles and relationships in their lives.

Recovery does not occur in isolation, but in the context of the person's relationships and community. Social inclusion and being able to take on meaningful and satisfying social roles is important for recovery (Shepherd *et al*. 2008). The parenting role is one of the most significant components of a service user's life, having the potential to connect the parent with their community through interactions with other parents in areas, such as schools and sporting clubs. As a result, family and other supporters are often crucial to recovery, and should be included as partners wherever possible (Shepherd *et al*. 2008). The practice standards presented here describe how workers can implement family-inclusive practice within their everyday role, and enable services to work in partnership with the parent as a service user to re-establish the life roles that give them meaning and purpose (Nicholson 2010; Shepherd *et al*. 2008). Furthermore, the focus of these practice standards on identifying and addressing the different needs of all family members moves towards a perspective that the family as a whole is on a recovery journey (Muhlbauer 2002), rather than maintaining a recovery focus that sees families, children, and carers as providers of support for the individual adult client's recovery. Family-centred recovery is especially important where families have a parent with mental illness, as all family members are potentially service users, as well as service providers (Trowse *et al*. 2013).

RECOMMENDATIONS FOR PRACTICE

These practice standards represent the first distillation of the literature pertaining to FaPMI practice in adult clinical mental health services. They might also require future research into their applicability across other adult mental health systems nationally and internationally, as well as measured adaptation to be employed across the broader mental health and welfare sectors. However, the standards are designed to be an important reference point for all service sectors working with parents with a mental illness. Presented within the framework of the client's continuity of care, the standards are readily applicable to current service-delivery models, and create benchmarks

of essential and recommended activities for the development of FaPMI practice within services, thus giving greater definition to those articulated in the National Practice Standards for the mental health workforce (Commonwealth of Australia 2010). It is recommended that the standards be utilized in conjunction with an implementation guide for services to assist integration into practice. Such a guide would be complemented by the development of an audit tool based on the standards, to give services clear and measurable targets to measure performance against the practice standards. Furthermore, the standards also provide a framework for exploring barriers and enablers of workforce capacity around working with FaPMI.

Supportive organizational policies and procedures are essential, as well as favourable attitudes, knowledge, and skills of the clinician to work with FaPMI families (Maybery & Reupert 2009). Although the standards presented as part of the continuum of care might address some barriers, other possible barriers might still impose a challenge. These include individual practitioner barriers, such as perceived or actual increased workload (Byrne *et al*. 2000), negotiating permission and catering for confidentiality (Chen 2008), or practitioner apprehension about simultaneously holding the multiple or potential conflicting needs or wishes of both clients and family members (Fleck-Henderson 2000). These considerations might need to be given some attention in any implementation guides accompanying the standards.

CONCLUSION

The practice standards outlined in the present study constitute an important tool for the adult mental health clinician to enhance their work with parents who have a mental illness and their families, including children. The development of standards, such as these, is part of a mix of strategies that is necessary to shift focus and competence among the mental health workforce towards family-centred practice to support FaPMI. It is hoped that the internally-driven and informed perspective from which these standards are derived will generate realistic and achievable expectations of the workforce, and therefore will be more likely to lead to long-lasting practice change that better responds to the needs of FaPMI.

FaPMI-centred practice can help maintain and strengthen important family relationships, and identify and enhance the strengths of a parent with a mental illness, all contributing to the recovery of the person with the mental illness. In addition, the extensive evidence base for timely and effective early intervention and prevention approaches for COPMI highlights the importance of the unique position of the adult mental health worker to 'ask the right questions'. These standards stipulate how the mental health workforce can open their practice to incorporate FaPMI-centred practice as part of their role in supporting recovery for people with mental illness.

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