

Finding the Balance:

Family inclusive practice in adult
community mental health

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Abstract

Despite family involvement and participation being strongly recommended in mental health services policies and guidelines, the evidence suggests that this is not always implemented effectively. It is evident from the literature that there are high levels of dissatisfaction among carers regarding their involvement or exclusion within mental health services. It has been increasingly recognised that families, friends and relatives of people with mental health problems have often felt unheard, and overlooked.

The aim of this study was to explore family inclusive practice in Adult Community Mental Health in a District Health Board. The focus for the study was on what adult community mental health nurses and clinical managers consider to be barriers and facilitators to family inclusive practice.

A descriptive qualitative design was used to explore the community mental health nurses and clinical managers' perspectives of family inclusive practice. Participants were sampled from the local adult community mental service and semi-structured interviews were used as the means of data collection. Transcripts were thematically analysed which produced three major themes: 'Great Expectations: getting pulled in all directions', 'Engaging Family: the many layers', and 'Foundations and Pillars: service delivery plus'.

The findings highlighted that navigating competing expectations and demands was an everyday challenge for participants. Among the barriers identified by participants were the lack of a shared understanding of what is expected in regard to family involvement, by society, family, clinicians and mental health services. The lack of time, confidence and skills impacted on effective family inclusive practice, along with a disconnect between the 'ideal' and the 'reality' of embedding organisational policies related to family inclusion. However, this study found strong leadership in particular through the function of the multi-disciplinary team (MDT) and clinicians actively attempting to overcome barriers by being flexible and finding solutions to meet the needs of family to be key facilitators. It also found that participants were philosophically committed to the concept of family inclusive practice, with many considering this was occurring more frequently than the literature suggested.

To address the barriers and enhance the facilitators identified in this study a collaborative model of approach is proposed in order to provide a firm foundation and enable family inclusive practice to be fully embraced and become part of usual practice.

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Definitions and Terminologies

Consumer

There is an ongoing debate about the best term to use when referring to people living with mental illness. The literature uses terms of consumer, service user, psychiatric survivor and client. Participants used consumer and client interchangeably. The researcher adopted consumer.

Family

‘Family’ is defined for the purpose of this research as not limited to relationships based on blood ties. Family can include a person’s extended family, whānau, their partners, friends, advocates, guardians, carer or other representatives. The consumer defines who they identify as ‘family’.

Mental Health Services

Refers to secondary organisations whose primary function is the provision of care, treatment, and support and education for recovery to people with mental illness, or mental health problems.

Family inclusive practice

For the purpose of this study is defined as activities which directly involve members of family as defined by the consumer’s family in their care and treatment.

Family involvement

As a generic term it refers to the entire range of ways in which people in an individual’s family and social network are acknowledged and involved in the consumer’s treatment and care.

Community Mental Health Nurse

This has been substituted regularly by ‘nurse’ or mental health nurse. The term psychiatric nurse is used in the literature.

Clinician

Refers to a qualified health professional. For the purpose of this study clinician is also used to identify both the clinical manager and community mental health nurse.

Pūkenga Atawhai

Pūkenga Atawhai work as members of multidisciplinary clinical teams to provide cultural support to tangata whaiora, their whānau, the clinician and service.

Tangata Whenua

Indigenous people of Aotearoa/New Zealand.

Chapter One:

Introduction

The motivation for this study has come from experiences I have encountered in my various roles as a mental health nurse. I was trained in the era of deinstitutionalisation and worked as a psychiatric district nurse to support consumers moving into community care. Reflecting back this often included supporting family however I wonder now how families would have viewed the maybe, somewhat limited support they had. My career remained in adult community mental health for many years both in New Zealand and Australia until I moved into the area of child, adolescent and family mental health in the late 1990s.

The change from adult to child and adolescent mental health nursing was an interesting awakening in regard to the strong focus on including family, from having come from adult mental health where the focus was very much on the individual. I remember naively saying after my first few weeks that it was not very different from working with adults. This assumption was to be quickly challenged by the complexity of working alongside young people and their families. The importance of involving family was paramount while respecting the young persons need for autonomy. My interest and passion led to my involvement in the development and implementation of national workforce initiatives related to child and adolescent mental health.

I returned to mental health services in the role of Patient Safety Officer which entails leading reviews into serious events. This experience has very much influenced my motivation for this research. I have become curious as to why, despite the policies to be family inclusive, the feedback from family is that this was not always occurring.

1.1 The Study Context

Mental illness is common, but can severely impact on people's lives. In any one year, one in five adult New Zealanders will meet the diagnostic criteria for a mental health and/or addiction condition (Paterson et al., 2018). At present mental health services are expected to

provide access to specialist mental health services for a least 3% of the population for people with moderate to severe mental illness (Ministry of Health, 2016).

Interestingly, the He Ara Oranga Report (Paterson et al., 2018) recommends expanding access to address the needs of those with less severe needs. The report also calls for the strengthening of the consumer and family voice to become actively involved in care and treatment. This supports the need for adult mental health and addiction sector to embed family and whānau-focused practice within all services.

In the context of the above background, this study was conducted in the Canterbury District Health Board [CDHB] Specialist Mental Health Service [SMHS], New Zealand. SMHS provides mental health and addiction services to the whole of the Canterbury region with some specialist services catering to the wider South Island population. Before the Canterbury earthquakes in 2011, four adult community mental health teams were located in geographical boundaries (South, North, West, and East) in metropolitan Christchurch. Following the earthquakes, the teams were collectively relocated on the Hillmorton Hospital site. The teams, however, continue to function and see consumers from the pre-determined geographic area. The participants were recruited from within these four adult community mental health teams which included Crisis Resolution.

1.2 Thesis Structure

1.2.1 Chapter One: Introduction

The introduction to the research study includes background information that relates to the study's conception. Information pertaining to the context in which the study took place is also provided as well an overview of the thesis structure.

1.2.2 Chapter Two: Literature Review

This chapter sets out to explore literature that is relevant to the topic of family inclusive practice. Background information is reviewed including an historical perspective, the evolving role of the mental health nurse, family experience of involvement, international and current New Zealand policy and protocol.

1.2.3 Chapter Three: Methodology

Chapter three offers an overview of the research methodology used in this study. It includes an overview of qualitative research and more specifically the qualitative descriptive design along with the rationale for its use. Theoretical underpinnings relevant to the study are summarised. The research questions are then set out. Specific information pertaining to the chosen methods which include purposive sampling. Consent, confidentiality and the potential risks to participants is included. Data collection, semi-structured interviewing and thematic analysis are then supplied. Ethical considerations are provided, including information pertaining to ethical and local approval. Lastly, the topic of rigour is addressed along with the conclusion.

1.2.4 Chapter Four: Findings

This chapter reports on the findings of the study. This includes three major themes; ‘Great Expectations: getting pulled in all directions’, ‘Engaging Family: the many layers,’ and ‘Foundations and Pillars: service delivery plus’. The themes are supported with narrative from the interviews. Each theme is described by identifying relevant categories as subtitles. A summary is provided concluding each theme.

The first theme, ‘Great Expectations: getting pulled in all directions’ describes three categories of ‘Differing Expectations’, ‘Sharing Information’, and ‘Conflictual relationships’.

The second theme, ‘Engaging Family: the many layers’, describes the categories of ‘Engagement Skills’, ‘Methods of establishing and maintaining engagement’, ‘The next step – involving family’, and the ‘noisy wheel’.

The third and final theme ‘Foundations and Pillars: service delivery plus’, describes categories of the ‘Tick box versus quality’, ‘Service infrastructure’, and ‘Family inclusive approaches’.

1.2.5 Chapter Five: Discussion

This chapter discusses the findings. A synthesis of findings is described including a figure of how the themes interrelate. The findings are then explored in conjunction with relevant

literature. This discussion covers barriers, facilitators, and finding the balance with a recommendation for a collaborative model of approach to family inclusive practice across all of mental health services. The study addresses the limitations and strengths of the research.

1.2.6 Chapter Six: Conclusion

The conclusion restates the aim of the research, summarises the main findings and recommendations.

Chapter Two:

Literature Review

2.1 Introduction

This literature review gives a brief historical overview, of the move from institutional to community-focused care, the role of the mental health nurse in working with family, and families' experiences of involvement in care, including an overview of international and national family inclusive practice.

Many countries, including New Zealand, have developed guidelines and policies promoting family inclusion in mental health practice and service delivery. This has come on the background of the recognition of the positive impact of family inclusive practice in international research (Cohen et al., 2013). In New Zealand, at a national level, it has been recognised that families, friends and relatives of people with mental illness have often felt unheard and excluded from their relative's care (Lumb, 2009; Stanbridge & Burbach, 2007). This is despite the fact that all mental health professionals are required to engage with families and support people as part of mental health care delivery (Ministry of Health, 2008).

2.1.1 Deinstitutionalisation

In Western countries, prior to the 'asylum', in the early 1800s, individuals with a mental health problem were cared for in their homes by their families (Baur, 2013). With the establishment of the asylum, there was a view that a contributing factor in the rise of patient numbers in asylums was due to families' increasing intolerance and unwillingness to look after the 'insane' (Baur, 2013). However, historical studies into family involvement have found little evidence that families were unwilling to look after the mentally ill if they had the resources to do so (Baur, 2013). Interestingly, *The Handbook for Attendants on the Insane* (1908) devotes a section on the attendance of the insane in private homes. With advice that the attendant, must be 'patient but firm with relatives and friends', including advice that it was better for the "doctor to suggest the patient should be left with the attendant without relatives coming in to interfere too much" (Medico-Psychological Association, 1908, p.

347). This suggests families were still willing and wanted to be involved in care if able despite the availability of the asylum.

In New Zealand, in the 1840s, mentally ill people were held in prisons, as there was nowhere else to care for them. The first 'lunatic' asylum was opened in 1854 in Karori, Wellington (Brunton, 2018). From the 1860s larger asylums were built around the country. These asylums were isolated from main centres and provided a basic self-sufficient environment which were directed by staff in the care of the mentally ill with an emphasis on physical and mental hygiene (Killaspy, 2006). The isolation of the asylum and the belief that the patient was a burden and a security risk restricted the amount of contact with family (Brunton, 2018).

The move to community care started to emerge in the 1960s on a background of criticism that long-term hospitalisation was repressive and detrimental to patients, starting the move away from large mental health institutions (Baur, 2013). This came on the background of new developments in treatment such as medication. Alongside this there was a focus on providing community based care which included group homes and day hospitals. In 1967, the Domiciliary Nursing Service in Canterbury, New Zealand was established, following concerns by nursing staff over a lack of adequate follow-up of patients discharged into the community (Biddington, 1993). As part of these changes, family involvement started to evolve in the climate of de-institutionalisation, with the move from institutional to community mental health care in the mid-70s (Prebble, 2007). The move from custodial care to a community focus brought new challenges for both nurses and family. It reinforced the development of the psychiatric nurses' role which was being redefined as 'therapeutic', with new psychological interventions, together with the changing philosophy of care (Prebble, 2007).

On the background of de-institutionalisation, nurses attempted to involve families, and as early as 1968, there is evidence of families being invited to participate in small groups to promote understanding and communication within the family (Williams, n.d.). There was an expectation for family to take on the responsibility to provide ongoing care of their family member on discharge to the community care. However, despite this, family involvement was limited, with family given little information about illness and how to care for the person (Biddington, 1993).

In addition, to the evolving expectation on family there was an environment in which many family members had felt blamed for their family member's mental health problems and illnesses (Whiteside & Steinberg, 2003). In the 1950s through to the 1970s mothers, of those diagnosed with schizophrenia were having to contend with the view of the 'schizophrenogenic mother'. Mothers with a mixture of maternal overprotection and maternal rejection were thought to cause schizophrenia (Johnston, 2013). Mothers' feelings of helplessness, worry and anxiety added to their already developed burden of guilt (Biddington, 1993). It was later established there was no scientific evidence to support this theory of the schizophrenogenic mother (Johnston, 2013). Then the concept of 'expressed emotions' emerged with the theory that a person with schizophrenia who was exposed to families that were highly critical, hostile, and expressed high levels of emotions were more likely to relapse (Bogojevic, Ziravac, & Zigmund, 2015). Expressed emotions was later found to occur in many other psychiatric and non-psychiatric illness and not specific to schizophrenia (Bogojevic et al., 2015). Unfortunately, family continue to be blamed, especially when professionals believe the family are part of the reason for why the consumer is ill and believe they are an obstacle to treatment (Stanbridge & Burbach, 2007; Van de Bovenkamp & Trappenburg, 2012).

From these experiences of 'blame,' strong family-driven advocacy groups emerged. In 1977, New Zealand 'Schizophrenia Fellowship' was founded, now known as 'Supporting Families in Mental Illness' (Biddington, 1993). Internationally in 1982, The World Fellowship for Schizophrenia and Allied Disorders, was established as a global organisation intended to lightening the burden of serious mental illness for suffers and their families. This was in recognition that care frequently falls upon the family, most often the parents, and can last a lifetime.

2.1.2 Evolving role of the mental health nurse

Along with the increasing expectation and role of families in care, the psychiatric nurses' role continued to develop. The term psychiatric nurse has long been recognised, however following the onset of comprehensive nursing training this changed. The psychiatric or mental health nurse is now defined as a registered nurse with a specialisation in mental health nursing and is registered by the Nursing Council of New Zealand to practice in the

speciality of mental health (New Zealand College of Mental Health Nurses Inc., [NZCMHNI] 2012).

The role of the mental health nurse continues to develop with nurses working in a variety of settings. To adapt to the changing needs of consumers, family and community the mental health nurse practice needs “flexibility, adaptability, responsiveness and sensitivity” (NZCMHNI, 2012 p. iii). For mental health nurses there is a strong focus on working with consumers within the context of the individual and in partnership with family and significant others (NZCMHNI, 2012). Therefore the importance of involving and working in partnership with family is embedded and is expected as part of practice and nursing competencies. Working in partnership is underpinned by a treaty of Te Tiriti o Waitangi/The Treaty of Waitangi 1840, the founding document of Aotearoa, New Zealand and for Māori the concept of whanaungatanga (extended family and relations) is critical to health and wellbeing (NZCMHNI, 2012).

Alongside partnership, the therapeutic relationship or therapeutic alliance is fundamental and central to mental health nursing practice. As summarised by Penda (2017) multiple studies have identified communication, empathy, genuineness, empowerment, respect, continuity of care and patient confidentiality as the core components of the nurse-patient relationship. These skills are also required in developing partnerships with family, and the mental health nurse has a key role in overcoming the barriers to effective family inclusion. This finds support with research identifying that attitudes to communication and engagement with family and carers unsurprisingly influence engagement between family, consumers and the service (Rowe, 2012).

Although nurses are identified as a professional group who have an essential role in creating the culture changes necessary for the successful engagement and implementation of family involvement and partnership, their views about consumer and carer participation have not been extensively explored (Goodwin & Happell, 2008). Similarly a literature review by, Martin, Ridley and Gillieatt (2015) identified a gap in existing research, suggesting current studies do not offer explicit detail as to why mental health services have not embraced family inclusion. Martin et al. (2015) suggest that researchers are reluctant to critically examine their own or other professional practices in regards to family inclusion and exclusion.

2.1.3 Family inclusiveness

There are many terms used synonymously to describe family inclusiveness such as family focused, family centred, family sensitive and family orientated approach. All these terms recognise the family's important caring role and broaden care from a narrow focus on the mental health consumer to the family and caregiving system (Foster, O'Brien & Korhonen, 2012). Each approach can, therefore, have a different emphasis on the nature of the family involvement, for example involving family in routine care but not necessarily providing specialised family interventions such as family therapy (Maybery, Goodyear, O'Hanlon, Cuff, & Reupert, 2014).

Traditionally the medical model has underpinned mental health care. Mental health nursing and nursing interventions have been found to be strongly influenced and restrained by the medical model (Carlyle, Crowe, & Deering, 2012). This approach to care takes little account of the family because it has a narrow focus on the individual and their pathology. The disorder is regarded as internal to the individual. Family and consumers have described the dominance of bio-medical language within mental health services as excluding, depersonalising and alienating (Martin et al., 2015). Therefore, it could be suggested the medical model could impede family inclusive practice occurring. Boyd and Siggelkow (2011) suggest a model of care is needed to enhance partnership and collaboration between the consumer, family and mental health professionals, especially when the mental health system does not support the standards and guidelines that exist.

2.1.4 Families' experiences

The potential benefits for consumers involving family are well documented, including relapse prevention and reduced hospital stays (Cohen et al., 2013; Mannion et al., 2012). For family, inclusion is imperative as they are faced with complex roles, from being advocates, seeking help from services, ensuring safety and managing, at times risky behaviour of the unwell person including providing emotional, physical and practical support (Martin et al., 2015). For many families or carers the onset of a severe mental illness can be a particularly difficult time and a steep learning curve with limited support (Gray, Robinson, Seddon, & Roberts, 2009). Family providing support for their family member is often initially accompanied by a sense of crisis, with family struggling with their lack of understanding (O'Riordan & Kelleher, 2016). In addition, some family also continue to

encounter stigma, which can result in distancing friends, neighbours and other family members. Some family have adopted strategies to counter stigma, such as not mentioning a mental health diagnosis (O’Riordan & Kelleher, 2016).

The impact of serious mental illness affects the whole family and family are considered to be disproportionately at risk of carer burden including being at an increased vulnerability to personal mental health difficulties (Bobinac, van Exel, Rutten, & Brouwer, 2010; Bradley & Green, 2018). Wales and Prymachuk (2009, as cited in Rowe 2012) found that family caring for family members with mental health difficulties had different needs to those caring for a relative with physical problems. Clinicians cite reasons for not including families can be due to burden of care concerns such as familial exhaustion, fatigue and carer burden (Lakeman, 2008b; Mannion et al., 2012). Interestingly, families and consumers find the term burden of care to be offensive and disrespectful (Martin et al., 2015).

Historically, it is evident from the literature that there were high levels of dissatisfaction among carers regarding their involvement or exclusion in mental health services (Cree et al., 2015). It has been increasingly recognised that families, friends and relatives of people with mental health problems have often felt unheard, and overlooked during their relative's care (Lee, Crowther, Keating, & Kulkarni, 2013; Martin, Ridley, & Gillieatt, 2017; Stanbridge & Burbach, 2007). Among barriers to engaging and involving family, communication barriers, family conflict and access ability of the service provider to family have been identified (Reed & Harding, 2015; Tambuyzer & Van Audenhove, 2013). Families often express feelings of frustration, anger, bitterness and exhaustion when dealing with mental health services, which leads to feelings of powerlessness (Olasoji, Maude, & McCauley, 2017).

Families have identified poor engagement and communication by professionals as a barrier, while effective engagement with carers and families is seen to foster trust towards clinicians and assists in better therapeutic relationships (Rowe, 2012). According to Boyd and Sigglekow (2011), a primary key focus for family is finding someone they can relate to and trust. Families attributed positive experiences to the ability of individual staff members to communicate with them in a way that is both comfortable and meaningful (Boyd & Sigglekow, 2011). Stanbridge and Burbach (2007) describe how stressed families can quickly be given a label as difficult, which results in mental health staff limiting their contact with them.

Carers have often reported being taken for granted or seen as troublemakers and part of the problem (Gray, Robinson, Seddon, & Roberts, 2008). When carers have had to become assertive due to for example, when trying to share information, they can be subjected to negative attitudes from professionals (Slade et al., 2007). Due to professionals viewing carers as pushy, demanding and prejudged this can lead to a need for families to advocate for their relative, which may mean spending a lot of time trying to access help only to be told their relative was 'not sick enough' to access care (Olasoji et al., 2017; Slade et al., 2007). Carers have identified that their rights need to be acknowledged and respected as a partner in care, with this leading to effective care of their relative (Rowe, 2012). Rapaport, Bellringer, Pinfold, and Huxley (2006) found that good practice includes taking into account the carers' rights and responsibilities, along with recognising the needs of carers.

Families report negative attitudes by clinicians towards their involvement in care planning, with them not being accepted and viewed as the enemy (Cree et al., 2015). Another study found that carers attach more importance in receiving a copy of the consumer's care plan, participating in meetings and being actively involved than mental health care providers (Tambuyzer & Van Audenhove, 2013). Interestingly, families excluded from the treatment planning process are often contacted at times of crisis (Mannion et al., 2012). Bradley and Green (2018) suggest there has been little research conducted to look at the views of family about treatment preferences, their priorities and understandings of recovery, and their support or educational needs.

Sharing information or withholding information has been identified as another barrier with suggestions that confidentiality and privacy considerations provide justification for mental health professionals to raise a 'confidentially smokescreen' (Gray et al., 2008). In a study by Goodwin and Happell (2007) carers describe nurses as 'stubbornly' sheltering behind confidentiality clauses and privacy legislation to avoid communicating with them. Lakeman (2008a) found evidence that information is not always solicited from the family despite no restrictions on the information that family can share. Significantly, Lakeman (2008a) found that in a community mental health centre where 10 per cent of clients had refused to consent to share information, the 36 clinicians surveyed had made contact with only 48 per cent of the family caregivers. The rationale for no contact was that the clinicians did not believe contact would benefit the client.

There are, however, limitations to the information mental health staff can disclose to the family where consent has not been given unless it comes within one of the exceptions in Rule 11 of the Health Information Privacy Code (Privacy Commissioner, 2017). There are clear exceptions however, particularly where there is a serious or imminent threat to public health or safety or the life or health of the consumer or someone else involved in the situation (Privacy Commissioner, 2017). Even when a consumer limits the sharing of personal information, this does not prevent mental health staff from having a working relationship with the family (Royal Australian and New Zealand College of Psychiatrists, 2000). The family is entitled to non-personal information such as education that could enhance their understanding and ability to care for the consumer. The Office of the Health and Disability Commissioner (2018) reports many family and whānau consider that services use privacy as a way of disengaging with them. Slade et al. (2007) however suggest family need to accept they do not need to know everything about their relative.

As well as navigating the sharing of information, carers have described feeling a sense of being lost in the maze of the mental health system (Olasoji et al., 2017). Families can feel unwelcomed due to circumstances such as the physical environment, the acuity of a ward situation, and staff busyness (Boyd & Siggelkow, 2011). Despite this carers hold high expectations of the nurse's ability to respond to their needs recognising nurses workloads were often too high which resulted in not enough time being allocated for collaborative involvement (Goodwin & Happell, 2007). Family have described that the nurse's workload can also impact on the ability to establish a relationship with nurses which would facilitate opportunities for involvement but can also disrupt continuity of care (Goodwin & Happell, 2007).

A lack of continuity of care has been cited by carers as a barrier, conversely having the same team or professionals involved in treatment facilitated carers involvement (Goodwin & Happell, 2007). Yet early involvement is considered critical to engagement, and continuity of care is valued both by family and clinicians (Eassom, Giacco, Dirik & Priebe, 2014; Martin et al., 2015). To address these challenges carers report the need to learn the ropes of the system and make the system work in their favour to get the best care for their relative (Olasoji et al., 2017). This can mean different things such as encouraging one professional to prolong a professional relationship with their family member and accessing respite (O'Riordan & Kelleher, 2016).

Families have identified a need for an orientation to mental health services, along with advice on what to expect, how to approach mental health professionals, and what is expected from them (Boyd & Sigglekow, 2011). Mental health service providers need to involve families in service provision as family do want to be included in treatment and decision making (Rowe, 2012). While systems focus on the needs of the consumer, families can feel unwelcome and excluded in the mental health service (Boyd & Sigglekow, 2011). As a result carers describe having few opportunities within mental health services for genuine partnership in care and treatment (Goodwin & Happell, 2007).

2.1.5 National and International Context

In New Zealand, the founding document Te Tiriti o Waitangi/The Treaty of Waitangi 1840 must be acknowledged and its principles incorporated in all aspects of health services provision for all New Zealanders, and in particular for tangata whenua (Mental Health Commission, 1998). In 1997, the National Mental Health Standards (Ministry of Health, 1997) provided the foundation for national policy development. The standards highlighted the duty of providers to involve families while respecting and ensuring the consumer's autonomy. The principles include partnership, families being entitled to access mental health staff, and obtain information that may assist in care, access to assessment and treatment processes whether the consumer gives consent or not, and recognition that family are a valuable resource in the gathering of relevant patient-related information necessary for effective treatment. The development of the standards were, in part, as a response to a ministerial inquiry into Mental Health Services, known as The Mason Report (Ministry of Health, 1988). In the report, families had expressed the need to be listen to, have access to information that they need and be included in treatment and support planning.

Further to this in 1998, the Blueprint for Mental Health Services in New Zealand was released. The focus was to increase the health status and reduce the impact of mental health disorders on consumers, families, carers and the general community (Mental Health Commission, 1998). This direction was intended to focus on the needs of the whole family and that interventions should include family with regular communication both formal and informal which would achieve a better outcome for all. As early as 2001 the World Health Organisation (WHO), recommended the formation of partnerships between service providers, consumers and their families in order to improve the quality of mental health

services. Partnership and family involvement in mental health services can be reflected or embedded in different forms or expectations. Generally, family involvement may be minimal such as including the provision of general information on the mental health service, to offering family psychoeducation, consultation, and engagement with treatment plans, family interventions and therapies (Eassom et al., 2014). Rowe (2012) suggests a collaborative approach has broad benefits for everyone involved, while a lack of engagement and communication by mental health staff can lead to distress, resentment and frustration on the part of the person with mental illness and their support person.

Since this time, in New Zealand, there have been additional legislation and policy amendments to continue these themes or direction. Guidelines for clinicians that support family inclusive practice have been developed such as *Enabling Effective Family Whānau Participation in CAMH and AOD Services in New Zealand* (Lumb, 2009); *Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (Todd, 2010); *Co-existing problems knowledge and skills framework*. Te Whare o Tiki (2013); *Real Skills Plus CAMHS* (The Werry Centre, 2014).

More recently there are international and national targeted initiatives to address the needs of families where a parent has a mental illness. Thus recognising that parenting and family-based interventions have been shown to improve outcomes for both the parent and their children (Goodyear et al., 2016). In response to this, the Ministry of Health (2015) *Supporting Parents Healthy Children* guidelines have been developed to identify and address the needs of children of parents with mental health and/or addiction issues. These guidelines support services to take a meaningful whole of family and whānau approach which has the potential to enhance the recovery of adult consumers (Ministry of Health, 2015). There is a clear direction for family inclusiveness and family focussed practice to be embedded in all aspects of service delivery (Ministry of Health, 2015).

There is however evidence which suggests New Zealand has been slow to involve family with this being reflected in findings from coroners' investigations of deaths that appeared to be the result of suicide (Manuel, Crowe, Inder, & Henaghan, 2018). Regarding other legislation, the Mental Health (Compulsory Assessment and Treatment) Act [MHA] (1992) provides the legal framework for compulsory mental health care in New Zealand (Ministry of Health, 2012). There is a requirement for clinicians to consult family and whānau at

particular junctures of a person's compulsory assessment and treatment under the MHA. Section 7A of the Act requires a mental health service to consult unless it is deemed not reasonably practicable, or not in the interests of the person. The purpose of family consultation is to strengthen family involvement in the compulsory assessment and treatment process. With the intention to enhance family/whānau contribution to the person's care, and address family concerns about information sharing and treatment options, there is the expectation this will facilitate ongoing family involvement in MHA processes, such as clinical reviews of treatment or Court hearings (Ministry of Health, 2012).

Despite family involvement being a requirement, in 2016, the average percentage of family and whānau consultation in Mental Health Act assessment/treatment events was only 61 per cent nationally (Ministry of Health, 2017). The Health & Disability Commissioner Report (2016) on consumer and family and whānau experience of interacting with mental health and addiction services, has shown 80% are satisfied, which may reflect service improvement. However, it is acknowledged there needs to be more attention to building and maintaining partnerships with consumers and engage with family and whānau (Office of the Health and Disability Commissioner, 2018). Anecdotally, in the New Zealand context, it could be argued that services have been slow or have struggled to embed family inclusive practice routinely into adult mental health service care delivery.

International findings have found that despite the principle of family inclusion being embedded in policy and legislation, there is strong evidence that family inclusiveness has not easily been translated into routine mental health practice (Eassom et al., 2014; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2015). The service providers' attitudes towards family inclusive strategies have been found to be variable with some service providers rejecting the need for a strategy because they perceived themselves to be practising in a family inclusive manner with others believing it would increase workloads (Goodwin & Happell, 2007; Stanbridge & Burbach, 2007).

It can be concluded that having guidelines and policies for 'family inclusion' or 'family inclusive practice' does not guarantee meaningful involvement or participation (Lauritzen et al., 2015). Martin et al. (2015) suggest the need to move away from the development of more policy and standards, with the need for a widespread culture change. Rowe (2012) concluded that barriers to family inclusion are the result of poor engagement and communication by

professionals and carers, and overcoming these barriers lies in quality engagement and effective communication, along with changes in attitude and practices.

2.2 Conclusion

In conclusion, family involvement and participation is strongly recommended in policy and guidelines but the evidence suggests that this is not always implemented effectively. Families continue to express dissatisfaction with their involvement. The literature suggests that there is more that needs to be done but relatively little is known about what would enable this to happen and what acts as a barrier in adult community mental health. This study aims to explore family inclusive practice in Adult Community Mental Health in a District Health Board. The focus for the study is on what adult community mental health nurses and clinical managers consider to be barriers and facilitators to family inclusive practice.

Chapter Three:

Methodology

3.1 Introduction

In this chapter a brief overview is provided on qualitative research and the methodology used to conduct this research study. This includes an overview of the qualitative descriptive design along with the rationale for its use and theoretical underpinnings. Ethical considerations are provided along with specific information about the application of the chosen methods which included purposeful sampling, semi-structured interviewing and thematic analysis.

3.2 Qualitative Research

Qualitative research covers a wide range of approaches that are connected to different beliefs regarding what there is to know about the social world and how to find out about it (Denzin & Lincoln, 2011). Ritchie, Lewis, McNaughton, and Ormston (2014) describe the character and aim of qualitative research as a way to provide an in-depth and interpreted understanding of the social world of research participants. To achieve this the researcher needs to learn about the participant's social and material circumstances, their experiences, perspectives and histories. To enable this, qualitative researcher uses a range of sources from field notes, interviews, conversations, photographs, recordings and memos to self, to understand or interpret phenomena regarding the meanings people bring to them (Denzin & Lincoln, 2011).

The overall goal of most qualitative studies is to provide a rich, contextualised understanding of some aspect of human experience through the intensive study of particular cases or situations (Ingham-Broomfield, 2014; Wu, Thompson, Aroian, Mcquaid, & Deatrck, 2016). Qualitative researchers usually study people, settings, and/or subcultures, hoping to come up with a subjective deeper understanding of how and why individuals understand, reflect, interpret, and interact (Baker & Edwards, 2012). Qualitative research is therefore well suited for "why", "how" and "what" by asking questions that probe into reasons behind human

behaviour, motives, and views including such ideas that can form barriers and facilitators to specific goals (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

A fundamental difference between quantitative and qualitative research is that the basis of quantitative research is to test a hypothesis, as opposed to qualitative designs which do not test a predetermined hypothesis (Ingham-Broomfield, 2014; Leeman & Sandelowski, 2012; Neergaard et al., 2009). Alternatively, the qualitative researcher explores a subjective, holistic pathway which helps to develop a theory (Grove, Burns, & Gray, 2013). It also can contribute knowledge or understanding by describing phenomenon within specific populations or groups of interest, however, does not to provide generalised findings (Wu et al., 2016). Qualitative methods are thereby influenced by the specific questions that need answering (Ritchie et al., 2014).

Qualitative methods are relevant to the study of caring and the development of nursing knowledge as a human science (Ingham-Broomfield, 2014; Leeman & Sandelowski, 2012). The field of nursing research as Ingham-Broomfield (2014) explain, is where there is an observational question to be explored by focusing on patients' and health professionals' experiences. Qualitative inquiry is deemed to have an essential role in incorporating more practice-based evidence into the evidence base for nursing practice (Leeman & Sandelowski, 2012). This finds support from Bradshaw, Atkinson, and Doody (2017) who conclude there is a clear alignment of qualitative description research with the philosophies and principles of nursing, including understanding and supporting the person, their family, and society.

The general goal of mental health research is to maintain or improve the health and well-being of consumers of mental health services. When the initial question arises related to a specific clinical setting, then the likelihood of answering the research question in a meaningful and practical way is therefore increased (Horsfall, Cleary, Walter, & Hunt, 2018; Weaver & Olson, 2006). Cutcliffe and Goward (2000) suggest mental health nurses are drawn to qualitative research as a result of the potential meaningful connection that appears to exist between the practice of mental health nursing and qualitative research. Citing this apparent synchronicity appears to centre around the three themes of “(a) the purposeful use of self; (b) the creation of an interpersonal relationship; and (c) the ability to accept and embrace ambiguity and uncertainty” (Cutcliffe & Goward, 2000 p. 590).

3.3 Qualitative Description

Qualitative description is a term that is widely used to describe qualitative studies of health care and nursing-related phenomena (Kim, Sefcik, & Bradway, 2017). The research method adopted for this study is a qualitative description, as described by Sandelowski (2000, 2010) and is founded in existing knowledge. Qualitative description was deemed by the researcher to be best suited to this research, as it is not wedded to a particular theoretical approach and is based on the philosophical beliefs of naturalist inquiry. It is also an approach which is relevant as qualitative description studies in health care research enables learning from the participants and their descriptions, and secondly, uses this knowledge to influence interventions (Sullivan-Bolyai, Bova, & Harper, 2005).

Sandelowski (2000) describes qualitative descriptive designs as “being typically eclectic but involves a reasonable combination of sampling, data collection, analysis, and re-presentation of techniques” (p. 334). This is an alternative approach in that it may reflect the influences from more than one approach such as ethnography, phenomenology, or grounded theory (Sandelowski, 2000). Neergaard et al. (2009) suggest qualitative description is probably the least theoretical of all the qualitative approaches and therefore is a suitable option when straight descriptions of phenomena are desired. Qualitative descriptive studies may begin with a theory of the target phenomenon or a framework for collecting or analysing data however there is no commitment to stay with this theory of framework (Sandelowski, 2010).

Qualitative description is not about generating new truth but describing and making sense of the truth that already exists within the participants (Sandelowski, 2010). Neergaard et al. (2009) expands on this with the need to make thoughtful links between the work of others and clinical experience of the research group. It allows for the initial questions to be changed depending on responses and probes based on the interviewee’s answers, allowing new questions to emerge (Brown, 2018; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). Thus, based on the research questions, qualitative description can provide findings that are easily translated into practical and useful understandings for strategies for health care providers, consumers and families.

Qualitative description design moves beyond the literal description of the data and attempts to interpret the findings without moving too far from that literal description (Bradshaw et al., 2017). Qualitative content or thematic analyses are the techniques typically used in

qualitative descriptive studies (Sandelowski, 2010). In qualitative description, the researcher must let the participants words and accounts lead the researcher to understandings that would remain hidden without open-minded and probing exploration (Brown, 2018). The qualitative description approach accepts that several interpretations of reality exist, which may be a subjective interpretation reinforced and supported by reference to verbatim quotations from participants (Bradshaw et al., 2017).

The qualitative researcher goes into their exploration with as few assumptions as possible. In qualitative description, the researcher is required to identify what their preconceived views are as a conduit to understanding the influences they have on the collection and interpretation of data. As Lambert and Lambert (2012) suggest, the qualitative descriptive approach does not require the researcher to move as far from the data compared with other qualitative designs although it does result in some interpretation.

The philosophical underpinnings of qualitative description approach as summarised by (Bradshaw et al., 2017 p. 2):

- An inductive process (describes a picture of the phenomenon that is being studied, and can add to knowledge and develop a conceptual and/or theoretical framework).
- It is subjective (each person has their perspective and each perspective counts) recognising the subjectivity of the experience of not only the participant but also the researcher.
- Designed to develop an understanding and describe the phenomenon (not to provide evidence for existing theoretical construction).
- The researcher is active in the research process (the researcher becomes part of the phenomenon being studied as they talk directly to participants and/or observe their behaviours).
- An emic stance (an insider view which takes the perspectives and words of research participants as its starting point) but is influenced by the researcher not only because of subjectivity but also when a degree of interpretation occurs.
- Conducted in the natural setting (data collected in the natural setting of the participants who experience the phenomenon).

As Sandelowski (2010) notes the researcher will inevitably hold some preconceptions so therefore they cannot be completely open-minded. For this research, the researcher is a mental health nurse who currently leads reviews into serious events, so brings a perspective of hearing from family and clinicians on how well or not so well family inclusiveness has occurred, recognising this is a small narrow sample and may not reflect everyday practice.

The goal of this qualitative descriptive research is to capture the important elements of the experience or situation from the participants and to produce a descriptive summary which will inform inclusive practice in community mental health. Sandelowski (2010) suggests qualitative description data is not to merely be 'reproduced' or 'celebrated' it always requires the researcher to make something of their data. The findings from qualitative description studies can often be of particular relevance to practitioners and policymakers (Sandelowski, 2000). It is envisaged that this research will inform policies and guidelines to embed family inclusiveness into routine practice.

"The value of qualitative description lies not only in the knowledge its use can produce but also as a vehicle for presenting and treating research methods as living entities that resist simple classification" (Sandelowski, 2010, p. 83).

3.4 Method

3.4.1 Aim

The aim of this study was to explore family inclusive practice in Adult Community Mental Health in a District Health Board. The focus for the study is on what adult community mental health nurses and clinical managers consider to be barriers and facilitators to family inclusive practice.

3.4.2 Design

As already stated, a qualitative descriptive approach is a well-considered combination of sampling, data collection and analysis techniques. Sandelowski (2000) provides information concerning appropriate methods to use that fit a qualitative descriptive design including purposeful sampling, semi-structured open-ended interviews and content analysis. The use of these methods in this study will now be discussed.

3.4.3 Sampling

Sandelowski (2000) considers any purposeful sampling techniques as appropriate for qualitative descriptive studies. A purposeful convenience sample of the available local adult community mental health teams was used. There is no guidance on what sample size is required for qualitative research. The sample size is typically smaller than in quantitative studies (Patton, 2014). Ritchie et al. (2014) recognised that a 'reality' captured regarding the social constructs, beliefs and behaviours offers sufficient stable information to inform the development of contemporary social policy and theory. They also support the view that small-scale qualitative studies can be used to draw wider interpretations of the social world (Ritchie et al., 2014). There is no fixed rule to establish the most appropriate sample size in qualitative research, and an adequate sample size sufficiently answers the research question, the goal being to obtain cases deemed rich in information (Bradshaw et al., 2017). It was noted that saturation was reached around the eighth interview when the researcher became aware that information was being repeated in participant's responses and no new responses were being identified. There were a further two interviews.

Purposive sampling is common in qualitative research. Particular individuals are chosen with characteristics relevant to the study who are thought will be most informative. Recruitment for this study was undertaken by purposive sampling, a nonprobability sampling technique. Wu et al. (2016) supports the idea that qualitative sampling should be 'purposeful'. That sampling is based on the study purpose and investigators judgements about which people and settings will provide the richest information for the research questions. Inclusion criteria for participants were registered nurses working in adult community mental health. It required nurses to be registered with the Nursing Council of New Zealand (Te Kaunihera Tapuhi o Aotearoa).

Recruiting methods commenced with research information flyers (see Appendix 1) being placed in key areas to attract the attention of adult community mental health nurses. Four clinical managers for adult community services were sent individual letters, with the Participant Information (see Appendix 2) Sheet asking for them to consider being part of the research. The purpose was to obtain an overview of family inclusion across adult community mental health service.

3.4.4 Informed Consent, Confidentiality and Anonymity

All potential respondents from the initial recruitment stage were sent copies of the Participant Information Sheet and Interview Consent Form. The opportunity to discuss the study in more depth was offered to all potential respondents. All the participants who had indicated their willingness to participate were contacted by email and phone to explain the process. Once the participants had agreed, an interview appointment was arranged.

Before commencing the interview, the participant(s) were again given a full explanation of the research study. The participant was asked to read a copy of the Participant Information Sheet and the Interview Consent Form (see Appendix 3). The voluntary nature of their involvement was emphasised and that they could withdraw fully at any stage up to the point where integration of analysed information had commenced.

Confidentiality and anonymity outlined in the information sheet were reiterated. An explanation of the confidentiality provisions regarding the professional transcriber who had signed a confidentiality contract (see Appendix 4), along with the researcher's academic supervisor was explained. The consent form was signed before the commencement of the interview. All information obtained was confidential and secure. Computer files were stored in the researcher's secure database. The use of code titles anonymised participant's information. These took the form of interviews being coded 001 through to 010. These were randomly assigned. All hard copies, when not in use, were always locked in a secure file with access available only to the researcher.

3.4.5 Potential Risk to Participants

The process protecting participants from risk was required to comply with a mandatory verification process governed by the University of Otago. Given the nature of this study, it was difficult to foresee any potential ethical issues because the interview prompts and the design of the study was unlikely to cause any harm to the participants. All participants were made aware of the pathway they should pursue if they identified any issues, ethical or otherwise that affected their ability to be involved. The Participant Information Sheet explicitly explained the actions they could take to address any concerns. The participants were informed they could withdraw without explanation as previously described.

The researcher did not have a working or supervisory relationship with any potential participants. Although it was considered unlikely, the interviews could have had the potential to evoke emotions and unexpected feelings for participants. The researcher was therefore mindful of possible negative psychological consequences participants may experience.

3.4.6 Data collection

Although qualitative data can come from various sources such as observation, documents and records, for this study individual interviews with community mental health nurses and clinical managers were undertaken. Individual interviews are probably the most widely used methods in qualitative research (Ritchie et al., 2014). The use of open-ended questions allows more detailed information to be elicited (Houser, 2013). Semi-structured interviews are considered the most common form of data collection within a qualitative descriptive design (Sandelowski, 2000).

Data for this study was collected through the use of semi-structured interviews. The interviews took place in a meeting room in a building away from participant's immediate workplace and were conducted during regular work hours of the participants. Approval for release time of participants was obtained in principle in the Specialist Mental Health Service research locality agreement (Appendix 8). Interviews did not take more than one hour each and on average took thirty-five minutes.

All interviews were audio recorded. Audio recording interviews is a preferred method as it provides an accurate record of the interview for analysis along with freeing the researcher from the distraction of constant note taking (Whiting, 2008). Each of the audiotaped interviews was then transcribed by a professional transcriber who had signed a confidentiality agreement.

The interview followed a format which were the processes of introduction, discussing the information sheet and completing consent procedures, and the practical aspects of audio taping.

Examples of questions which provided a guide (see Appendix 5).

- How would you go about engaging with families for the first time?

- What do you see as barriers for involving family?
- What helps or what facilitates family engagement?
- How do you define family inclusive practice?
- How is family involvement monitored and evaluated?

3.4.7 Thematic Analysis

Thematic analysis was chosen for this study, as it fits with the descriptive qualitative methodology and provides a structured process of analysis. Thematic analysis is one of the most common forms of analysis in qualitative research (Javadi & Zarea, 2016). It is a method for identifying, analysing and reporting patterns (themes) within qualitative data. Braun and Clarke (2006) advocate thematic analysis should be seen as a foundation method for qualitative analysis. This method for identifying and analysing patterns in qualitative data fits with questions related to people's experiences, views and perceptions. It enables the researcher to capture and interpret meanings within the data to describe and identify categories and themes (Crowe, Inder & Porter, 2015).

Clarke and Braun (2013) emphasise the theoretical flexibility of thematic analysis and identify it as an analytic method rather than a methodology. It is not tied to a particular theoretical outlook and so can be applied when using a range of theories and epistemological approaches such as qualitative description (Braun & Clarke, 2006; Crowe et al., 2015; Sandelowski 2000, 2010). It is considered to be theoretically independent of a specific methodology (Clarke & Braun, 2013). Given the benefits of thematic analysis in that, it is flexible, is essentially independent of theory but theoretically and methodologically sound. This approach fits with the research aim.

Inductive analysis applies the process of coding data and theme development directed by the content of the data, as opposed to a 'theoretical' thematic analysis which tends to be more explicitly analyst-driven (Braun & Clark, 2006). It is a process of coding data without trying to fit it into a pre-determined coding framework. The themes using inductive analysis are data-driven and may bear little relationship to specific questions asked (Javadi & Zarea, 2016). Clarke and Braun (2013, p. 4) describe six phases of thematic analysis:

- Familiarisation with the data
- Coding

- Searching for themes
- Reviewing themes
- Defining and naming themes
- Writing up

Using Braun and Clark's (2006) approach to thematic analysis, with the first stage involving the reading and re-reading of interview transcripts a number of times, the researcher became familiar with all the aspects of the data. Through the process of re-reading the transcripts it enabled the researcher to reach an overall understanding of the data, listing meaningful, recurrent ideas and key issues. The researcher made notes and jotted down early impressions, all the time considering possible meanings that may provide clues for theme development.

The second step was to generate initial codes. The coding process which was generated manually by examining the data in reference to the research question, focusing on what the participant was saying about what they thought. The researcher organised the data in a meaningful and systematic way. The researcher did this by reflecting on what is happening in the data, considering why and how it addressed specific research questions. Thus provided a context for understanding the participant's experience.

Initially, the researcher used open coding, with no pre-set codes. From there, descriptive codes were developed by writing notes beside the text, including extensive highlighting of keywords, phrases and responses. Each line of the transcripts was numbered to enable the researcher to cross-check data and later to help identify the location of quotes used in the findings. The initial coding process was peer-reviewed with the researcher and the researcher's supervisor independently reviewing and comparing the codes from two interviews.

The entire data were systematically and consistently worked through, giving each set of data full and equal attention. Repeated patterns from the data were identified through setting up a template alongside the data and making notations thus ensuring a consistent approach was used. Coding reduced the amount of raw data to what was relevant to the research question and broke the data down into manageable sections. The coding then was hierarchical and allowed the researcher to analyse the data at varying levels allowing for distinctions to be made within the data.

The third step was the search and analysis for themes. As defined earlier, a theme is a pattern that captures something significant or interesting about the data and/or research question. The search for themes involved clustering the different codes into categories and considering how different categories could be combined to form an overarching theme. The researcher found some categories clearly fitted together as a theme. However, some fitted into one or more themes. The overarching themes were put on a whiteboard, and the categories were reviewed taking into account the relationship between the codes, categories and themes. A theme did not necessarily depend on quantifiable measures but on whether it captured an important aspect in relation to the overall research question (Braun & Clarke, 2006).

Table 1: Example of the coding process

Narrative	Naming it/Code	Category
For me, it is totally about the client I am working with and their permission. It is difficult if people decline us to talk to their families.	The focus of work is with consumer therapeutic alliance	Therapeutic relationship
	Need to check with the consumer for consent	Consent
	Need to respect client wishes Family wanting involvement	Differing expectations

The fourth step included reviewing and refining the themes numerous times which involved re-reading the data to ensure the theme ‘worked’ in relation to the data and to consider if there were any coding misses in earlier coding stages. To make the themes distinct from each other, the researcher considered the following questions: Do the themes make sense and does the data support the themes? Do the themes overlap? The researcher found there were distinct overlaps within the themes which are explained in the findings.

The fifth step was defining and naming the themes. The researcher considered what each theme was saying and the themes were defined, described and named with reference to the transcripts using extracts or quotes to capture understanding and meaning.

The final step provided a more in-depth analysis through the process of writing and re-writing each theme, examining the relationships between the themes from which a descriptive narrative evolved. Each theme was analysed, identifying the ‘story’ that each theme told in relation to the research question and how it fitted into the broader overall story to ensure there was not too much overlap between themes (Braun & Clarke, 2006).

The final phase explored the relationship of each theme and the socio-cultural context within which they emerged, taking into consideration the existing literature available. The researcher interpreted the results and presented the findings, noting the study limitations and possible implications for further research.

3.5 Ethical Considerations

Ethical approval was obtained through the University of Otago Ethics committee. Reference number H17/058 (see Appendix 6).

The researcher’s experience as a mental health nurse has created some assumptions on the topic of interest. The researcher identified three preconceptions held before conducting this study.

- The first, that community mental health nurses are philosophically committed to family inclusion practice.
- The second that the practicalities of working in a family inclusive way are challenging.
- The third was family inclusive practice is not integrated into everyday practice.

3.5.1 The Approval Process

The study was approved through a mandatory process which required scrutiny and approval from the University of Otago Human Ethics Committee (Health). The Participant Information Sheet and Interview Consent Form were approved by the Ethics Committee and the Board of Studies Committee.

While this research study did not specifically target Māori, Māori nurses may have had a presence within the recruitment population. Importantly, the research question was relevant

to Māori as the concept of whanaungatanga (extended family and relations) is critical to health and wellbeing and Te Tiriti o Waitangi is the basis for bicultural relationships and therefore the delivery of culturally responsive care in mental health nursing in New Zealand (NZCMHNI, 2012). The researcher met and consulted with the Kaitohutohu Māori/Māori Research Advisor (see Appendix 7).

The Specialist Mental Health Service (SMHS) Research committee approved the Locality Assessment (see Appendix 8). The approval process aims to ensure that only safe and effective research proposals are authorised.

3.5.2 Rigour

Qualitative researchers are concerned with issues of trustworthiness, which include principles of credibility, dependability, confirmability, and transferability (Bradshaw et al., 2017). Strategies to enhance and demonstrate rigour should be used systematically across each phase of a study with rigour being identified, managed and documented (Wu et al., 2016).

Firstly, credibility addresses the "fit" between respondents' views and the researcher's representation of them (Tobin & Begley, 2004). Strategies and processes used to address credibility in this study included developing a rapport and trusting relationship with the participants to create an environment for a willingness to share information. The researcher has provided the open-ended questions that were used as a guide. The semi-structured interviews were audiotaped and transcribed, the researcher repeatedly listened to the audio tapes and compared these with the transcriptions. Participants were given the option to review the transcribed interview.

To achieve dependability, the researcher has demonstrated the research process to be logical, traceable, and documented (Tobin & Begley, 2004). The study provides background information in the introduction of the study, and the researcher's ethical considerations have been identified in the methodological section. Sufficient information about the methods has also been provided.

Confirmability is concerned with establishing the researcher's interpretations, and findings are clearly derived from the data, requiring the researcher to demonstrate how conclusions and interpretations have been reached (Tobin & Begley, 2004). The researcher has provided an audit trail used to capture the data collection and thematic analysis process. An initial peer review of the initial coding process was completed to ensure quality and accuracy. The findings represent the data gathered and evidenced by the inclusion of direct anonymous quotes from participants.

Transferability refers to the generalisability of inquiry (Tobin & Begley, 2004). There are sufficient study details that would allow recreation of this study to occur. The study used purposeful sampling and has provided rich descriptions in the findings.

3.6 Conclusion

The research methodology chapter has provided an overview of qualitative research and qualitative description including its application to mental health nursing research. Ethical issues have been described including the approval process, information provided to participants and gaining informed consent. The preparation for the research process is described through reference to the recruitment process, the sampling method and a description of the participant group. Confidentiality was ensured with the secure keeping of data. Identifiable data from the transcriptions were removed.

The methods chosen were consistent with the qualitative descriptive design which included purposeful sampling, semi-structured interviews and thematic analysis. The analysis of the data was demonstrated using examples from the narrative. Lastly, the rigour of the study was addressed by explaining the credibility, dependability, confirmability, and transferability. Finally, the practical aspects of data analysis have been explained. The system to track and document the thematic analysis process was outlined, and an explanation of the process of development and interpretation of data was given.

Chapter Four:

Findings

The aim of the study was to explore family inclusive practice in Adult Community Mental Health in a District Health Board by identifying barriers and facilitators to family inclusive practice of community mental health nurses and clinical managers.

The three themes that emerged from the data are presented in this chapter with examples of direct transcription from the interviews to illustrate them. The three themes are ‘Great expectations: getting pulled in all directions’, ‘Engaging family: the many layers’, and ‘Foundations and pillars: service delivery-plus’. On occasions the categories fell into more than one theme therefore they have been situated in the theme that was most suited.

Pseudonyms have been used to provide participant confidentiality, and consumer or other identifying information has been removed or changed. A combination of client and consumer are the words that were most frequently used by the participants, therefore, these are used in this chapter. Interviews were labelled from (001) to (010) which have been used to identify each narrative.

4.1 Demographics

Ten participants were recruited and interviewed. All identified as New Zealand European. All but two participant identified as female. Of the ten, six participants were community mental health nurses. Of these three had over five years’ experience working in adult community mental health and three under five years. Four clinical managers participated in the research. Of the four managers, two were mental health nurses and two social workers. The mean age of participants was 49 years old. The participants had been employed in mental health settings between four and 45 years with the mean being 25 years.

4.2 Theme 1: Great Expectations: getting pulled in all directions.

Family inclusive practice does not occur in a vacuum. There are competing external expectations that are involved when establishing working relationships with family. The nurse is subject to the expectations of society, family, consumer, and the mental health service. In addition, the nurse is professionally obligated to work within the parameters of their professional standards, organisational policy and guidelines including legislation such as the Privacy Act 1993 and Mental Health (Compulsory Assessment and Treatment) Act 1992. Table 2 illustrates an overview of the theme “Great Expectations: getting pulled in all directions”

Table 2: Overview of the theme ‘Great Expectations: getting pulled in all directions’

Great Expectations	
Codes	Categories
Society Media Mental Health Service Mental Health Act Family	Differing expectation
Privacy Act Differing understandings Balancing wishes	Sharing Information
Families’ past experience Impact on clinicians	Conflicting expectations

4.2.1 Differing expectations

This category relates to differing expectations from family that may be driven by both external and internal factors. Several participants described how society’s expectation of mental health services did not reflect the reality of what mental health services can provide. Participants viewed this as being related to the dissatisfaction families express when they perceive the needs of the person in distress are not being met.

“In society, mental health services are now having to cater to people like, if you break up with your boyfriend or you get drunk, and you ring up mental health. You know what I mean? Some of society’s issues they’re not necessarily mental illness” (Participant 006).

This was seen as a potential barrier particularly at the first point of contact with family, as participants described having to manage the disappointment and frustration of family due to differing expectations of what both they the participant and the service can provide.

“At times what our role could be or is and maybe the disappointment of what is the reality of what we would be providing. So it might be some expectations that aren’t met that would be disappointing for families. And so at times, we have to agree to disagree that sometimes people don’t need to have mental health services involved” (Participant 008).

Another external influence described by several participants was negative media about the organisation. It was viewed as a barrier for family involvement due to fear being created on what a consumer or family may or may not expect to happen should they have contact with mental health services. In addition, this came on a background in which there has been a high media interest on Mental Health Services for a sustained period.

“The media is a barrier. There’s a lot of media about us at the moment . . . so there’s always that sort of negative stuff” (Participant 002).

In addition, two participants identified stigma as a barrier for family to become involved and this was a factor in establishing family involvement.

“The media at the moment . . . we’ve got people terrified about coming to the site. I’ve had more people recently being fearful of being locked up and what it looks like on the media . . . it’s more the stigma of having a mental illness” (Participant 007).

Alternatively, one participant identified that media is a means for family to be heard *‘people often threaten to go to the media’* (Participant 008). Thus creating another way for family to find pathways to meet expectations or their needs.

Participants identified from their perspectives the challenges when family have unrealistic expectations on what can be offered from the mental health service or done to help the person. They expressed that this is difficult for not only the family but for themselves.

“Families can have unrealistic expectations of us. You know fixing their person, sometimes even the expectation of how much time I have got. So expectations of us are quite tough” (Participant 002).

“Gone are the days where you lock somebody up but I think there’s a perception out in society about what we do” (Participant 006).

To overcome some of these challenges several participants conveyed the need to address the expectations with family of the service and explain realistically what they can expect and what input and treatment may look like.

“Being clear about what the service and what I can and can’t do” (Participant 002).

Participants talked about the often competing wishes of the consumer’s expectations regarding involving family in their care, or not, and the need to respect the consumer’s wishes. Participants identified that this required the need to work with both the consumer and family to reach an understanding.

“Clients that we’re working with need their family to support them, to be involved, whatever, but many don’t. Many don’t want them. They might want them to know that Johnny or Mary’s is distressed but they might not need them to be involved very much at all. So it’s client need that drives that” (Participant 003).

Differing expectations between family and clinicians can result in disagreements. One participant attributed this to a lack of clarity or misunderstanding of information the family have received.

“I think different expectations from both parties, of nurses and family coming from different points of view. It’s less a lack of consultation or communication but more a disagreement. Disagreements will sometimes be seen as a lack of communication but when you tease it apart you’ll find that in fact, the information is all there. The information’s been given but

for the person receiving it, it wasn't the information they wanted"
(Participant 004).

There were also differing views on the interpretation of the Mental Health Act which can create tensions with one participant giving an example where the family disagreed with the person coming off the act.

"His father was always opposed to him coming off the mental health act. Then when we did take him off there was a dispute from his father saying that he didn't agree. My client didn't want to give disclosure to his dad. But I do believe his father's support is imperative so it's been a challenge to maintain contact with the father" (Participant 001).

This highlighted the expectations of professional legal responsibilities and the importance of a family-focused approach by participants.

"We hold very clear professional legal responsibilities as nurses we are thinking more about whether there are children involved. It is about a family approach that is responding to symptoms, to trauma. Rather than a family approach that might be responding to inclusion and sharing and participation as a family approach. They are very, very different models"
(Participant 003).

Some participants concluded that despite working in an inclusive way this might not overcome some of the fundamental differences in perspectives between family and the clinician which may, therefore, inhibit a positive working relationship with family. All participants identified the expectations for family involvement from the service is clear. However, keeping up with these expectations in policy and implementing them was seen as difficult.

"Involving family is part of our framework. Like when you pull up any documents there's always family involvement whether that's comprehensive mental health assessment or even a clinical review. There's family involvement yes/no and the reasons why that may not be"
(Participant 005).

In conclusion, differing expectations can be a potential barrier to establishing a working relationship with family and there is a need to work with family to understand what can be offered. Fundamental differences can be driven from a societal expectation which can be

influenced by how media portray a mental health service and the use of media as an advocate for family. Stigma was also identified as a barrier. Participants identified that although there may be differences in views and disagreements with family this did not prevent attempts to include family. For example there were also differing views on the interpretation of the Mental Health Act which can create tensions between clinicians and family. Participants had clear expectations of the facilitators for family inclusion in service policy, however, one participant identified the challenges of ensuring these are known and accepted.

4.2.2 Sharing information – “it’s very tricky”

This category relates to the clinicians legal and ethical obligation to uphold confidentiality. The Privacy Act 1993 aims to give individuals more control over their personal information and there are rules around consent and disclosure that clinicians must follow. The expectations and rights of the consumers and the need to work with and alongside him or her was seen as both a barrier and facilitator to involving family. There were differences in understanding and expectations of the sharing of information raised by participants.

“There’s a range of opinions that people bring to consent and privacy and confidentiality. At one end of the continuum are people who believe that everybody should talk to everybody about everything and through that process, they may well talk to somebody that the consumer didn’t want to be involved and/or so in which case they are certainly going to damage the relationship. At the other end of the continuum you’ve got people who believe that everything’s held by the individual and it’s sort of a more libertarian view that that information is purely individuals and so they’re loath to communicate with others who are directly involved and in fact could be at risk but you’d hope these days that if there’s any risk involved people are picking up on it” (Participant 004).

It was seen as essential by all participants that families have an informed understanding of the privacy act.

“I explain to people around the privacy processes, privacy levels that we have. I explain to them about disclosure but I also explain to them that I am able to listen and so long as those first two bits around helping them understand privacy and disclosure and boundaries are clear then they love being listened too” (Participant 003).

For some participants, meeting the requirements of the privacy act was also viewed as having a potential negative impact on the relationship with the consumer and family and the consumers continued wellness.

“There was some kind of dispute between the client and his father . . . and he didn’t want to give disclosure to his dad . . . but I do actually believe his father’s support is imperative in terms of his stability. The privacy act, in this example, has impaired the fluency of communication between the client and the family which ultimately impacts on our ability to stabilise and continue his wellness. It impacts in terms of the quality if he unwell then I know that I could contact his father if there were safety concerns. But the quality of their relationship is impacted” (Participant 001).

The expectations of participants to balance risk, while meeting the requirements and expectations of the privacy act, family and the rights of the consumer was raised as a challenge.

“Some people will veer on the side of in my opinion too much caution around what is and isn’t personal information. So I guess the facilitator would be making sure that you worked through all of those things at the beginning of the relationship that this is how we operate, this is who we talk to, this is what we’d expect to do in a default circumstance” (Participant 004).

All participants had a clear understanding of their responsibilities under the Privacy Act when there were safety concerns.

“Well if that’s what the patient, I mean it depends on how high the risk is and what the safety is really. But usually I will be partial as much as I can but I will explain to the patient if it’s to do with risk and we’ve had a case like that yesterday. Where we said we need to tell your partner so we did. Safety overrules” (Participant 009).

However, participants identified the importance of having an understanding of the meaning of full and ‘partial’ consent.

“I think the disclosure is one where it is important to get that clarified around if it’s full disclosure or partial disclosure and what that partial disclosure means” (Participant 008).

“I have to discuss with the patient what partial means to them. I usually say what does partial consent mean to you? Does it mean we say where you are, what’s happened. Can I say a little bit about treatment?” (Participant 009).

The majority of participants identified managing and negotiating consent and disclosure. Participants identified this was not always straightforward due to at times conflicting expectations.

“It’s very tricky, so I try to stick to the letter of what’s written really. But I even think that’s not clear because sometimes people will write full consent but their parents know everything or whatever and you might be aware that a couple of months down the line their views with their parents have changed but it’s still officially full, so I do try and maintain those. Get those signatures on the contacts list so it’s updated as much as possible and I probably follow that. I’m pretty clear like if they don’t want parents to know there’s no disclosure I’m pretty clear that it’s no disclosure unless it’s a very serious matter and even then I try and run it past someone higher up just to check that. So I’ve kept that very simple in my head” (Participant 010).

Consumers themselves were seen as a barrier to family involvement by participants.

“The barrier to me is the patient. Many patients are very selective about what they want people to know. Very selective. So they tell us you can talk about this but you can’t talk about that” (Participant 003).

“But of course we do get people that are adamant and don’t want family involved. The clients that generally say no are guarded around their illness. So there are times that crop up that the safety becomes an issue either for them or for someone else we do liaise with family etc. when that happens but we let them know. So I think we’re trying to be more transparent but also more upfront when somebody comes into the service about the need to consult so that it doesn’t get to be an issue later on, people expect it” (Participant 007).

Several participants suggested the wishes of the consumer can sometimes be in conflict with the family and the organisation’s expectations for family involvement.

“For me, it’s totally about the client I’m working with and their permission in the first instance. Whilst the emphasis in current times is around getting collateral from families. It is more difficult obviously if people decline permission for us to talk to their families. They {organisation} want us to

talk to their families so if the client is telling us bluntly that we can't, then I think we need to respect that” (Participant 003).

One participant talked about differing views around consent and disclosure with another agency. The participant strongly believed a person's mother should be informed of some information while the NGO was insisting on respecting the person's wishes. As seen by this participant;

“I felt stuck in the middle of it all. And it was very difficult, stressful and actually distressing because I strongly believe that the mother has a right to know that her daughter who is 24 is coming home and reasons why she has been stood down. It can be a tightrope involving families and navigating disclosure” (Participant 002).

The importance of working with and explaining to the consumer the benefits of having support were seen as essential and a vital part of the participant's role.

“It's about getting the client on board really and sort of encouraging them and explaining to them the importance of another person that knows them really well, being involved. But if they're really adamant and just refusing that contact, we have to respect that and we do. So sometimes it's the client's choice” (Participant 005).

In conclusion, participants identified the challenges of working within the privacy act and meeting the expectations of family, while respecting the wishes of the consumer. Ensuring that family have an informed understanding of the privacy act was viewed as necessary. However, some participants identified the potential negative impact working within the privacy act requirements could have on the relationship with family and the consumer in particular balancing risk with the need to share information.

4.2.3 Conflicting expectations

This category relates to the conflict or struggles that can occur between family and the mental health service that have arisen from differing expectations which can impact on both the family and clinician's relationship.

Participants identified conflictual relationships with families, which at times can be combative. The possible reasons for this, as described by participants, was the result of the family's past negative experiences with mental health services, including families having unrealistic expectations of what mental health services can do, families experiencing frustration due to feelings of not being heard, misunderstandings regarding the privacy act and at times the attitude clinicians have formed.

“So sometimes families who have been in the system a long time depending on the experience come to see us with a lot of anger. And they just feel like they've been shoved from pillar to post. So they bring their frustration into those meetings which can be quite loaded at times. So being able to sort of communicate well, de-escalate do all those things because it can get a bit hairy at times, intense” (Participant 006).

Another participant said,

“Where family have had a long history with mental health services, you can come in at the end of a long line of disappointment” (Participant 010).

These can be times when family distress can have a significant direct impact on the clinician. One participant talked about two extreme situations where clinicians have been traumatised while trying to work with family, citing protection orders being taken out on the family for threatening behaviour and harassment of the clinician.

“There are sometimes family members we work with where everything ends up very, very broken down. And that can be very difficult for all staff and for obviously for the families as well and actually working through those problems is extremely challenging” (Participant 008).

In conclusion, participants identified the challenges of working within an environment of differing expectations, which can at times result in conflict. Participants were able to recognise reasons for family distress in regard to families' past experiences with mental health services as well as the impact of conflict on clinicians.

4.2.4 Summary

In conclusion, external factors were identified as barriers. Barriers included family expectations generated by society and media, giving family an idealistic expectation on what

is in the parameter of what both the nurse and mental health service can offer. Thus potentially being a barrier to early engagement. However, media was also viewed as a way for family to advocate on the behalf of family and the consumer.

A significant barrier was around information sharing with family and navigating the consent and privacy act, such as balancing the wishes of the consumer and how their wishes may conflict with family. Participants identified the challenges of this and described how this can be distressing for all involved, including themselves. The challenge became considering and understanding family wishes while having to respect the consumer and work within the principles of the privacy act.

Family expectations can result in conflictual relationships developing. Overcoming these differences were viewed as essential to participants. Identifying the need to work alongside the consumer to include the sharing of information with family where appropriate and at other times supporting the consumer's wishes not to involve family while all the time maintaining the therapeutic relationship. All participants were clear about the parameters of sharing information when there are safety concerns. There was an awareness of policy that facilitated family inclusive practice within the organisation.

4.3 Theme Two: Engaging family: the many layers

The importance of therapeutic engagement is core to mental health nursing which extends to engaging with family in a meaningful way which is beneficial to the consumer, family and clinician. Engagement skills, underpinned by attitude and values are essential in the establishment of the therapeutic relationship. Establishing a partnership with the consumer, family and clinician in treatment and care has been shown to be beneficial in recovery. Overall, positive engagement is recognised as being the foundation for enabling family inclusive practice. Table 3 illustrates an overview of the theme 'Engaging family: the many layers'.

Table 3: Overview of the theme ‘Engaging family: the many layers’

Engaging Family: The Many Layers	
Code	Categories
Trust Listening Empathy	Engagement skills
Not confident in working with families Rather family see the doctor Attitude Personality style Length of experience	Confidence and competence
Face to face Technology – text, emails Miscommunication	Methods of establishing and maintaining engagement
Family burden Consumer wishes Judgmental documentation Time	The next step – involving family
Family distress Family need to be assertive Need to be transparent Negative comments in documentation	The ‘noisy wheel’

4.3.1 Engagement skills

This category relates to skills required in the development of the therapeutic relationship and engaging family. Developing trust by listening, being supportive and transparent was seen as important by participants.

“...listening to families concerns, try to be empathetic, sometimes validating how they feel . . . they’re concerned” (Participant 006).

“I try to be realistic. I try to be down to earth. I try not to use jargon. I try to answer questions” (Participant 010).

These core mental health nursing skills, particularly around communication skills and the establishment of trust and engagement with a person, was identified by participants as essential.

Also, the ability to be gentle, encouraging and persevering with the consumer to include family in their care, was seen as necessary. Recognising the consumer has the right to be selective on who they want involved in their care.

“Without those skills and being persistent, part of that but being gentle, persistent and encouraging I don’t know that you could succeed to get their agreement to allow you to contact people if they were saying no in the first instance” (Participant 003).

Other participants identified the importance of the provision of support and educating family about mental illness as a way of involving family and assisting in building a relationship with them.

“Talking with the family about the resources that are around like Supporting Families is important. Maybe some more work with the family or more resourcing as to what that diagnosis is needed. . . being aware of what sort of resources are out there for the family is important too” (Participant 006).

However, participants acknowledged that family might not be wanting to be involved.

“They’re burnt out, and they’re past it” (Participant 010).

In conclusion, participants identified core nursing skills which facilitate family engagement, highlighting that part of their role is to provide education and support, recognising family may not always want to be involved.

4.3.2 Confidence and competence

Confidence relates to the confidence participants have and can be defined as a belief in oneself to carry out a task within a specific situation, while competence refers to the integration of knowledge and skills.

Several participants identified that nurses are not always confident in working with families, with others mentioning the considerable time taken to do family work, differentiating family work from family therapy. One participant identified that they do not engage in family therapy.

“We don’t do a lot of family therapy, but we have referred to certain people for family therapy if there’s a need. It’s just really a resource and the nature of our work really and the workload that we probably don’t really do family therapy” (Participant 005).

One participant preferred to see family with the doctor as *“family have a lot of questions that are best answered by a doctor”* (Participant 010) due to the participant’s feelings of being ‘bewildered or flummoxed’ and not knowing how to respond to questions asked by family.

Alternatively, a more experienced participant reported the involvement with family *“becomes so critical and imperative that you’ve left a huge hole if you don’t”* (Participant 003).

“I’ve always enjoyed working with families, and I’ve always just understood the importance of family” (Participant 002).

“I generally enjoy working with families . . . it feels safer in my practice, and it feels like a more holistic approach” (Participant 010).

Confidence and the ability to engage well with family was linked to the personality style or attitude of the nurse, with this being viewed by several participants as more important than experience.

“I think we are getting more used to doing that. I don’t think it matters . . . I think it’s more around personality rather than the length of experience. Because we have some new staff that are quite comfortable doing that because the scene has been set they’ve done that in their training and whereas sometimes the practitioners that have been around for years don’t like asking around checking into too much into the family it’s seemed as not of our business” (Participant 007).

Confidence was also linked to competence.

“It’s not just about the family work and the family contact it could be just the confidence in their practice. So if you’re competent in your own practice that would extend to contacting family and being confident about dealing with family. You know some families can be really quite tricky or difficult but they’re under pressure, under stress, you know it’s having that understanding” (Participant 005).

This highlighted the ability in the use of self to engage and establish therapeutic relationships which is not necessarily related to the length of experience. Which suggests experience does not necessarily equate to having the skills and confidence in engaging and working with family. Most participants however identified the need for more training in involving and working in partnership with family, in particular around managing or working with family conflict and dynamics.

“Training for working with conflict within families or difficult families would be helpful” (Participant 007).

“Nurses who are interested probably go to courses and maybe the nurses who aren’t interested are probably the ones that need to” (Participant 008).

Some participants felt that training for involving families was embedded in other training provided. While another participant believes training is ‘ad hoc’ (Participant 005), with one participant suggesting working with families training should be compulsory.

“Working with families should be compulsory training within our District Health Board” (Participant 003).

One participant identified that postgraduate education was particularly useful.

“And I think my post-grad papers really helped . . . They helped particularly around the principals of recovery and partnership” (Participant 002).

While another valued informal training opportunities.

“Just sitting with other nurses’ and watching them interact with families helps, especially being newer, I usually ask what you think I should say”
(Participant 009).

In conclusion, participants identified confidence and the influence of personality style or attitude as both a facilitator and potential barrier. Confidence and competence were not necessarily linked to experience. Training both formal and informal were valued, with a lack of formal training being a barrier in equipping nurses to work with family.

4.3.3 Methods of establishing and maintaining engagement

This category relates to aspects of communication, with the complexities establishing and maintaining family engagement being seen as both critical and challenging. Engagement refers to any process that actively involves family participation, collaboration and partnership in treatment.

Face to face contact with family was deemed to be ‘richer’ and went towards having a working relationship with them. Participants talked about the challenges of enabling this to occur, which is covered later.

“It’s a hell of a lot easier if the family members come in with the person and you see them face to face or you’re visiting them in the home with family members there. You know face to face is so much richer”
(Participant 003).

“From a nursing perspective, I think face to face helps with establishing relationships” (Participant 004).

However, the most common ways of engaging with family is via technology including the phone, texting and emails. One participant identified the barriers to phone contact are that you cannot see any of the environmental and non-verbal cues. Also, it was acknowledged that some people are comfortable with talking on the phone, while others are not.

“You are only getting what is coming down the phone, so it’s about my comfort on the phone and the person’s comfort and their ability to use it”
(Participant 003).

While another participant talked about the difficulties of making contact by phone due to the practical barriers, such as the consumer not having the resources to have credit on their mobile phone.

“They might not have any credit on their phone or do not answer”
(Participant 007).

Participants identified that being able to interview, listen and communicate over the phone were essential skills needed by nurses, as the first initial contact with family is often by telephone.

“And I think that’s another skill set in terms of being able to discuss and interview people on the phone” (Participant 003).

Another skill identified was the ability to terminate a call.

“It was hard to get him off the phone because he wanted to talk . . . he had a lot to talk about. He could have talked for four hours and it would probably have been really good for him to have done it. But someone that’s really experienced maybe, would have managed the call better”
(Participant 010).

Misunderstandings were also seen as a significant barrier which may occur when messages are not being clearly given. Some participants reflected that they do not always paraphrase or reflect back to check if the person on the phone has understood the information.

One participant reflected how it is more challenging for family who are not technologically minded. For others, texting, for example, may be a valuable form of communication.

“I’m quite clear with my consumers and families that texting to me is just things like I’m on my way, I’m running late, script faxed. I try not to get into any clinical discussions on text, but they are quite handy. But emails can be letters basically aren’t they. And so families can email me about concerns and then I can sit down and do a detailed email and it’s reasonably logical coherent words” (Participant 002).

One participant emphasised the importance of phoning family to report when things are going well, not just when there are concerns. Identifying that family appreciate this and this

helps build a rapport. Building rapport with family was seen as aiding positive communication and helping to prevent communication breakdown.

“Building enough rapport with the family that they feel they can ring when they want to give you more information or they need too. Because we get so busy with all the other patients we’re seeing I think if the family feel supported enough that they can call us then that communication breakdown doesn’t happen as much” (Participant 009).

Including an awareness of how it is for family and be enabled to give their perspective.

“The family have got a chance to talk either with or without them present. Arrange that. Facilitate that. A lot of people don’t. Facilitate time for family without the client” (Participant 002).

Overall, participants identified making and maintaining contact was seen as a two-way problem.

“Being contactable making that sure that you’re easily accessed, that they’ve got the correct phone numbers and addresses and know how to follow the process through” (Participant 004).

“Other barriers are like being able to get hold of them because people are working and then I don’t, I’m careful how I leave a message because I don’t want to alarm them” (Participant 006).

Despite the difficulties in the ability to always effectively contact family, all participants identified the notion of family involvement being embedded into practice at the multi-disciplinary team level, whereby there is *“always someone asking about whether family had been contacting, are they engaged, how is this going to happen” (Participant 007).*

“Over the years I can see that we have become more and more family orientated. We’re improving with family inclusive practice from just treating the person in front of you to the family or significant others really” (Participant 005).

However, there was an acknowledgement that an individual centred approach remained a focus for some.

“I think at times people have maybe worked more on an individual approach. I think it has changed over the years and it’s started to change I think we’ve worked on having family champions, and family advisors” (Participant 008).

Others identify the benefits for the consumer to have family involvement.

“There’s great evidence that our consumers do a lot better when they’re not in isolation from that network. Whether it’s family or family in a broader sense or whānau or whatever it is community that they’re involved in you know people do much better when they’re involved in part of the bigger community or family” (Participant 002).

“I think they see the benefit of working with you. If they put that effort in earlier on with the families, even if it’s just to get them on board with an understanding of what an illness is and it avoids a lot of issues, and will call us if you notice these things. Then it saves a lot of we can intervene a lot earlier” (Participant 007).

In conclusion, the range of methods of communication can facilitate communication but can also be potential barriers. Factors of a person’s proficiency and skill in using technology can both promote and be a barrier to effective communication. Participants and family being contactable were identified as a two-way challenge. Using effective communication assisted in building rapport.

4.3.4 The next step, involving family

This aspect related to the transition from engaging with family to involving them in care in a collaborative and inclusive way.

Participants identified that family inclusive practice may not occur due to the challenges and practicalities that family face.

“. . . families are busy. They work, they have other children often, you know the difficulty in getting in contact with them initially if they’re working full time, have other life issues happening . . . they may not have transport to attend meetings” (Participant 005).

Some participants identified time as a factor in them actively involving family.

“I wait for contact from the families. I think that’s a matter of time although it’s not that I’m not aware that I should be working with families” (Participant 010).

Other participants identified the consumer might have good reasons for no family contact, which needs to be respected. Participants stressed the need to be aware of family history and dynamics, often of which are “very” layered.

“Involving families may not be a good idea. If you’ve got a whole lot of substance abuse in the family or there’s a whole lot of history of sexual abuse or abuse in the family it may not be a good idea. So you’ve got to be a bit careful about making that assumption about that family. Especially biological families and some people have moved as they’ve become adult away from their biological families with very good reason. And have developed social networks with good friends that become their family. So I think you have to be a bit careful about what you call family” (Participant 002).

“Well often patients aren’t living with families, they’ve separated, you know many patients we’re working with have burnt bridges, estranged from their families and their families are living elsewhere and so most family contact whilst I even ask for consumers to bring families to certain appointments most 90% plus I would think family contact is on the phone because they live elsewhere” (Participant 003).

A challenge identified by several participants was the nature of a person’s illness which may contribute to the person not wanting family involvement. Participants described the need to respect the person’s wishes and maintain the therapeutic relationship.

“His delusional ideation sits around his family ... it’s a real balance of respecting what he wants” (Participant 006).

“The consumers that generally say no are guarded around their illness” (Participant 007).

When a consumer does not wish to involve family, this can impact on the clinician. One participant talked about feeling torn, with wanting to include and communicate with family but having to respect the wishes of the consumer. Participants described this as being stressful and distressing at times as they want to practice in an inclusive family way.

“It’s difficult because I feel I want to include family ... because they are worried and concerned about him and known him for years. I do feel torn in respecting his wishes” (Participant 006).

Several participants expressed the difficulties of being ‘stuck in the middle’, when there are conflictual relationships between the consumer and family, or when there are differing clinical opinions.

“. . . if there’s a disconnect I guess between what the patient’s been told and what the families been told or not told that’s got to cause friction and I don’t see how that would help to the patient” (Participant 006).

Several participants identified that communication difficulties can occur when there are differing understandings.

“Sometimes it’s easier to work with the family rather than the consumer, to give them the understanding about the illness, educating them and giving them support to deal with their disturbed family member at the time. The consumer may not have insight until they’re down the recovery track a bit further” (Participant 005).

While another participant reported that they preferred not to be proactive in contacting family and would wait for family to make contact.

“Explaining this was ‘more a matter of time, there is always something more important to do, and unless somebody contacts me I don’t think of it unless it comes up in their notes that family want to be involved” (Participant 010).

Meeting with family was part of practice, with time to listen and talk openly was viewed as important.

“It’s always on my agenda to meet family and significant others” (Participant 002).

“Being able to talk quite frankly and openly is really important. And having time to listen to the families concerns that’s a big thing because as you said workload, there’s the next consumer to come in. I don’t, and then I guess sometimes there’s quite a lot of dissatisfaction with us, not always but in our services in how we manage or not manage a patient” (Participant 006).

In conclusion, active family involvement is influenced by the wishes of both the consumer and family in terms of the level of participation or not. For the participant, this presents challenges along with the practicality of ‘time’ required to involve family. Meeting with family was identified as being part of practice however this could be changing when there are communication difficulties due to differing understandings.

4.3.5 The ‘noisy wheel’

This category relates to the skills required when family are dissatisfied with the care the consumer is receiving. Participants discussed the skills required in engaging family, the methods of communication, and the complexities in engaging and working with family. The ‘*annoying family member who keeps ringing the service . . . the noisy wheel scenario*’ (Participant 003) was identified as challenging in terms of how to communicate and manage these situations. In these scenarios, it was recognised by participants that the rights of the family also needed to be considered and skills were required to manage conflict.

One participant identified that making more of an effort to keep family informed helped to prevent increased reactive contact. Another participant talked about how some family have to be a ‘wee bit’ pushy before they are heard. While other family may have an agenda of their own which may not be in the best interest of the consumer.

“Sometimes I find that family can have an agenda of their own which is probably not that healthy. And so if you start to put your finger in that pie it can get a bit mucky” (Participant 010).

Alternatively, there was a view that family needed to be assertive because they had previously been let down by the service and have had bad experiences from mental health services. Two participants saw giving family permission to be assertive as helpful including having constructive meetings for everyone to come together and talk can help.

“I encourage them too if they’re adamant on something . . . it will mean a lot more coming from family. I mean we really care about what family say and I know that we actually do. So I say you need to go and tell the doctor this that that’s your opinion because that’s going to have a lot more merit than me saying it that kind of thing” (Participant 010).

Participants acknowledged that family often know the person best and the importance of having them involved in care.

“I think the family knows the patient best so that’s where the most important information comes from really. And they’re going to be the one overseeing them at home and with them for the rest of their life really” (Participant 009).

Therefore, the importance of being mindful of the broader context that may be driving family distress was viewed as imperative in order to enable a meaningful relationship necessary with family.

“If the family feels supported then the clients more likely going to be supported” (Participant 003).

“Some family can be really quite tricky or difficult but they are under pressure and under stress” (Participant 005).

Strategies to overcome and help facilitate positive family involvement were identified by several participants, and included the need to facilitate opportunities for family to talk with or without the consumer being present.

“The family have got a chance to talk either with or without them present. Arrange that. Facilitate that. A lot of people don’t. Facilitate time for family without the client” (Participant 002).

To enable this, it was acknowledged by participants there was a need to have a transparent, honest conversation with the consumer, about family involvement and this was seen as being part of usual practice. Alternatively, a challenge identified by one participant was the family coming to meetings which can antagonise the consumer, hence the purpose of the meeting cannot be fulfilled. Thus, the need to balance the therapeutic needs of the consumer/person verses family expectations of involvement in care.

Although the primary goal is to involve family, participants identified there are times when there is a need to “exclude family” and a need to develop a cohesive planned approach on how to work with family.

“You worry about how much involvement from unsupportive family or not getting too many people involved and how that might affect the patient. Sort of risk actually makes the risk higher getting such people involved” (Participant 009).

Alternatively, participants identified the need to be aware of not putting pressure on families, while acknowledging families can be very busy and have many other demands they are coping with.

“Families are fearful of what I might be asking of them” (Participant 002).

One participant talked about the influence of reading negative entries in the documentation which can bias clinicians, *‘so you think if they don’t contact me, I won’t contact them’* (Participant 010) thus avoiding contact.

This highlights that attitude and past experience with family can influence how a clinician chooses to engage or not. With one participant reflecting that as a nurse you cannot be judgmental but you sometimes find yourself naturally doing so. Whilst another participant stressed documentation needs to be impartial, noting negative and judgemental attitude is a major barrier.

“We walk out at the end of eight days or eight hours and if they’ve got this and had this a long time it’s very easy for staff to be judgemental about family. And I’ll often say to staff hey you don’t know what their journeys been like. The bipolar person who’s been manic and a handful and for years and years and years don’t judge that family too quickly” (Participant 002).

“Also naturally so you may read negative things in the notes which biases you so you think well if they don’t contact me I won’t contact them, it seems like a bit of trouble. Like avoiding having trouble which I guess for me comes down to time too” (Participant 010).

In conclusion, participants reflected on the challenges for family to be actively involved in care. Strategies to support family and facilitate positive engagement were identified. The impact of judgemental attitudes toward family in clinical records was also highlighted. Also attitude and past experience with family can influence how a clinician chooses to engage or not.

4.3.6 Summary

In summary, the facilitators for engaging family were good communication skills, the ability to listen, be respectful, non-judgemental and be transparent to develop trust and a working relationship. The personality style and the attitude of the clinician were viewed as both a potential barrier and facilitator, this highlighting, the clinician's ability to use self to engage and establish therapeutic relationships is important and not necessarily linked to length of experience.

All participants identified confidence as a facilitator in working and involving family. Confidence is influenced by skill, ability to manage complexities, at times conflicting wishes, and the experiences of the consumer and family. In turn a lack of confidence can become barriers if the clinician does not have these skills. Judgemental documentation about a consumer's family can create a reluctance and motivation for the clinician to actively engage family.

Methods of communication were recognised as both a barrier and facilitator. The effectiveness of all methods be it, telephone, texting and emails are influenced by both the clinicians and families skills in communicating using these mediums. The value of face to face contact was valued the most in the establishment of a working relationship but this is often difficult to achieve due to workload, resources and service delivery barriers. Also, importantly, the demands on family due to their own commitments and situations can be a barrier.

The consumer's wishes that may be influenced by the nature of a person's illness, can be a barrier to engaging and involving family. There was recognition of the importance of working with the consumer to facilitate involving family and especially important when there were conflict and strained relations between family and the service. Working with family to be more assertive or facilitate resolution of concerns, was identified as being important for all involved.

All participants were philosophically committed to working in a family inclusive way however it was identified that this does not always happen due to the barriers identified.

4.4 Theme Three: Foundations and Pillars: service delivery plus

A model of service delivery is a set of principles, standards, policies and procedures used to guide the design, development, deployment and operation of services delivered by a mental health service. There are service delivery aspects such as specific policy, and care delivery systems that are intended to support family engagement and involvement. How these relate to the everyday challenges to practice in an inclusive family way was raised by participants as both barriers and facilitators. Broader influences of service delivery, such as environmental and workforce tensions between the service's ability to be 'family friendly' plus models of care are considered factors that may or may not support family inclusive practice. Table 4 illustrates an overview of the theme 'Foundations and Pillars: service delivery plus'.

Table 4: Overview of the theme 'Foundations and Pillars: service delivery plus'

Foundations and Pillars: service delivery plus	
Code	Categories
Differing views Self protection	Tick box versus quality
Resources Navigating leadership	Service Infrastructure
Models of care Cultural needs	Family inclusive approaches

4.4.1 Tick box versus quality

This category relates to participants concerns of a tick boxing culture which refers to an overemphasis on the bureaucratic process rather than more productive action.

Participant's had differing views on the organisation/service reasons or intent in ensuring family involvement in care. There was a general belief by participants that family involvement has generally become part of intended practice, however, there were also views

that including family has a 'tick box' feel, in particular around 'notifying' family, but not necessarily engaging and involving them.

“Organisationally there’s are clear expectations. Policies exist, but we’re not all familiar with policies and procedures. We know they exist without having read them too much . . . when in consultations with clients we should also always include family considerations. But whether that’s to do with the client or to do with ourselves organisationally, in self-protection that we’ve asked. I hate gatekeeping tick box mentalities, that’s a personal dislike, but I’m not sure that the family involvement is monitored very well organisationally. So while we have a policy I’m not sure what monitoring processes go on for any individual, including myself” (Participant 003).

The content of policies are not known by participants however there was knowledge of their existence. The participants suggest there is a sense the organisation is not looking at the quality of interactions with family but instead ensuring processes are done to 'protect the organisation'. There was the view from other participants of having to tick the 'right boxes' in case the documentation goes to the coroner's court.

“Highlighting or ticking the box does not represent the value of working with family full stop. It’s because if things went bad how’s it going to look if it’s not done. And that’s the very, very clear message” (Participant 010).

Alternatively, another participant held the view that having a 'tick box' was positive.

“I like it that it’s highlighted. That it’s something that I have to do. I like that fact that there is that emphasis that I should be doing it, it’s got a box there. Now I’m sure some people just tick it and you know it’s a tick box exercise but on your clinical reviews that you’ve got to make a statement so it reminds me to check in. But I like that, I find it’s a good reminder and that it’s built into policies and your work that you should be doing that” (Participant 006).

“Like when you pull up any documents, there’s always family involvement whether that’s comprehensive mental health assessment or even a clinical review. There’s family involvement yes/no and the reasons why that may not be” (Participant 005).

Participants suggested the 'tick box' did not necessarily equate to the quality of family engagement and involvement. All participants identified processes that are intended to do this at some level.

“In our assessment format, it’s got collateral from family, who attended, so it’s prompted . . . to talk to family members. Also having them {Family} activity involved in treatment and follow up treatment” (Participant 009).

In terms of monitoring and ensuring family is considered in the person’s treatment there was an overwhelming consensus from participants that the function of the multi-disciplinary team meeting has a significant and pivotal role. The majority of participants talked about the multi-disciplinary team forum as being positive in keeping a focus on family involvement.

“The MDT {multidisciplinary team} promotes a strong focus to work with families” (Participant 003).

“I’m hearing about family involvement five days a week every day at two different forums namely the wider MDT and crisis resolution. So that’s all just part of the presentation of clients, you know family involvement, yes or no and to what degree. At the MDTs it’s always spoken about, what about the family, have you spoken to interview collateral? If they haven’t been easy to engage or not” (Participant 005).

Leadership and support were identified by several participants to be a facilitator to family involvement.

“When I sit at the MDT meeting and listen, there’s always {the clinical manager} talking to us about it. Have you involved the family, have you involved the family? Have you talked to the family? I’m always aware of this before I discuss someone, it’s a good prompt that we should always be mindful of the family” (Participant 006).

In addition, administrative supervision has formalised the importance of enquiring about including family.

“We do have in place is admin supervision, and there’s a template” (Participant 005).

Participants identified that these processes have contributed to a sense that in more recent year's family involvement is becoming philosophically embedded.

“Over the years I can see that we're improving with family inclusive practice from just treating the person in front of you” (Participant 003).

However, the majority of participants reported that there is often a focus on when family involvement 'hasn't occurred' and little recognition of the work that is regularly happening within usual practice.

“If serious review, incident review find there's no evidence of including family support people then that's fed back to the team. So in a way it's monitored . . . feeding back the recommendations to the wider MDT” (Participant 008).

“There are complaints from people saying we don't communicate enough” (Participant 004).

Recognising and celebrating work that is occurring was viewed by one participant to be lacking.

“. . . in fact celebrating some good work from time to time because there's no doubt plenty of good work around families and engagement” (Participant 003).

The quote above suggests participants believe there is not an accurate or balanced knowledge or appreciation of the extent of family involvement which is occurring within the organisation.

Participants believe family involvement is routinely occurring but this is not being reflected in the documentation. One participant believes the documentation system is not necessarily set up to capture when family contact and involvement has occurred.

“We haven't got a as good a system as we could have for capturing our information . . . in the subject line all is required in one word 'family, brother, anything like that” (Participant 004).

The perspective that family involvement may not be happening, was viewed by participants to be, in part, due to family involvement not always being visible.

“I find an anomaly that there is a view that it’s not happening. Because every day I sit in clinical discussions and I see it happening time and time again. So family involvement may not be getting caught correctly in the record process. It does happen. We haven’t got as good a system as we could have for capturing the information” (Participant 004).

“Lots of families really appreciate the contact ... sharing the positive feedback from families would help to balance the impression of the involvement as I tend to only hear the negative stories” (Participant 010).

While other participants cited service delivery issues such as time availability and the perceived increase in documentation requirements as a barrier, reporting that often there has been family contact but this is not always reflected in the clinical notes. The need for sufficient time and workload demands was identified by the majority of participants as a barrier to facilitating family involvement.

“A barrier would be a heavy workload because the more people you include the more things you have to do about that, so I guess that would be a barrier to it” (Participant 004).

“When you do family work it takes a considerable amount of time especially if you’re having to go and bring in family . . . to have a family session” (Participant 005).

“Day to day there’s always a phone ringing or something more important to do. I must admit in that way it’s probably not very good because families do slide down the ladder of priority where they shouldn’t” (Participant 010).

However, one participant identified that workload can be used as an excuse for not engaging with family.

“I think we probably do our clients a disservice that we don’t focus enough on families, I speak for myself about that. And I think that we come up with explanations and then there are excuses. We’re too busy, we’ve got other priorities, too many other things to do, we’ve caught up with documentation . . . we don’t go near because there’s another whole bit of work and if we don’t do it how much negative impact will it have” (Participant 003).

In conclusion, participants identified policies and guidelines for family inclusive practice as facilitators. The use of a 'tick' box approach to ensure tasks for family involvement has been completed was viewed as equating to quality. The barriers of time, particularly around documentation and workload was identified and leadership was also seen as a vital facilitator.

4.4.2 Service infrastructure

This category relates to the mental health services' organisational structures, systems and process. The service delivery model was considered not to be 'family friendly' by a number of participants, with participants reporting, on the whole, that usual case management work, occurs between the hours 8am-5pm, Monday-Friday. The ability to work with, and accommodate, family within these times was perceived to be a barrier.

One participant identified the fear some families can experience in approaching the service and the importance of family feeling safe with having a person they can identify with and trust.

“Our service is like a mind field, who do you ring who are you, you're an OT {Occupational Therapist}, what's an OT? But you're a doctor, you look young, you look old you know who are you. What's a registrar, what's a house surgeon you know all this sort of stuff. Who are you, as a case manager you're that lovely first person they go to and they get to know you and they feel safe with you” (Participant 002).

Participants acknowledged the impact on family having to cope with the demands the system puts on them while dealing with their day to day lives.

“Families often have their own often overwhelming commitments in addition to having a family member with a mental illness. You try to have appointments at the end of the day if it's a doctor's reviews. We are not supposed to have people in the building after 5pm. It's very hard to negotiate” (Participant 007).

“So it's reducing obstacles, being flexible, trying to get appointments later in the day if they work, first thing in the day, that's assuming you've got doctors available” (Participant 002).

Several participants identified the challenge for family in navigating or knowing when, how and who to contact within the service.

“They ring, but it goes to the operator, then someone else and they are bounced to someone else. This not only happens to family but for me as well. For family it’s really difficult” (Participant 009).

One participant identified the importance of the nurse knowing the system and using informal connections to facilitate family inclusive practice.

“The nurse might have a quiet off the record chat to someone in the system to get collateral information” (Participant 004).

Participants suggested workforce resources such as a lack of continuity, due to changes in clinicians, impacted on the ability to engage and maintain relationships with family.

“It’s really frustrating to not have access to our doctors . . . we have a shocking doctor situation. For some clients and their families, they’re on their third case manager by the end of 12 months. In two years they’ve had three case managers. It takes a long time sometimes to get to know people really well” (Participant 002).

Another participant described having tell family that a treatment option was not available and the consumer was on a waiting list, which to family can look ‘uncaring’.

“Someone needs psychology input and I’m having to say to family I have put the person’s name down on waiting list and have to apologise for that” (Participant 006).

While another participant believes there is a need for resources that would support family involvement in complex situations.

“I’d love to have family therapists as part of our service because at times we’re working with very complex scenarios. At times the work we could do actually needs a different approach and I don’t think we have that commitment yet in our own service” (Participant 008).

Several participants identified the challenges of meeting family in their own environments due to time availability, resource, and in some cases, the need to travel further because teams are no longer based in the local community.

“It could be a considerable amount of time especially if you’re having to get the family, if you’re not going to the home, you’re bringing them in, transportation then dropping them home and having the family session, that sort of thing that involvement. It could be half a day depending on where people live” (Participant 005).

Time was also a factor when there was a need for family to come into the service where they have limited resources. Participants who identified themselves to be proactive, and ‘make it happen’, build positive relationships by taking the view the benefits far out way the challenges.

“You need to be flexible and find practical ways to support family. You can’t be rigid” (Participant 002).

Alternatively, some participants preferred to see family at the service, reporting there is an expectation that family come to the service.

“I actually prefer to see families at the service because it’s a nicer environment than say the emergency department, it’s more private” (Participant 009).

In conclusion, participants identified barriers related to the provision of care, lack of resourcing which can result in a lack of continuity of care and easy access for family participation. The service delivery model was not viewed as family friendly and the not meeting the demand of family and consumers. Facilitators where the participant’s ability to be flexible and need to ‘make it happen’ by at times using informal methods.

4.4.3 Family inclusive approaches

This category relates to approaches utilised to support family inclusion. Participants generally identified family inclusiveness was driven by factors such as models of care or family focused approaches. These both were identified as barriers and facilitators.

“I think there’s been a culture of practice where for some clinicians they’re very engaging with families and work inclusively with families and then for some people less so. That’s anecdotal. I think at times people have maybe worked more on an individual approach. I think it has changed over the years and it’s started to change I think we’ve worked on having family champions, family advisors” (Participant 008).

Regarding building relationships and working with family, several participants reported overwhelmingly, the benefits of Pūkenga Atawhai (Specialist Māori Mental Health Workers) working alongside them with Māori consumers. The Pūkenga Atawhai provide a whānau approach who work alongside clinicians.

“I guess it’s easier for us as well if the Pūkenga Atawhai is involved. It’s actually much easier to get the whole picture . . . It’s easier to have them involved, than not, generally” (Participant 009).

“I sometimes do wonder if it would be good if there was a family advisor that could be available to come to some family meetings. Because if there’s a conflict there and then they can provide follow up with the family. It would be nice to call upon them as we can with Pūkenga Atawhai, to be able to say look all we need is support with the difficult dynamic that is occurring or where families are needing some extra support” (Participant 006).

Participants identified the strengths of this cultural approach and considered a similar model for non-Māori would support family engagement, involvement and embed family inclusive practice further.

“I think it would be handy because like parents and family have got a lot to talk about and it supports them to navigate the system” (Participant 010).

A participant compared the roles of the Pūkenga Atawhai and Family Advisor.

“A family advisor probably comes once a year at least, sometimes a couple of times a year to talk to the team about how that process works. They’re fully involved, not at an operational level but more at a strategic level” (Participants 004).

In terms, of other ethnicities, one participant identified cultural barriers when other ethnicities are seeking help and then the challenges of involving family.

“Often we lose Samoan families, Korean, Asian families because of the shame and they just only present in crisis, they don’t want us involving the refugee migrant facilitator because they’re worried about people hearing and finding out. So it gets tricky and it’s a shame but we do lose some that way. That they just don’t want to, they’ll engage what they need to at the acute moment but you know it’s going to happen again but we lose them later. And I don’t know how we learn to work with different cultures” (Participant 007).

For some participants, they feel confined to a client centred/individual approach rather than being more holistic and family inclusive. Some participants attributed this to the ‘medical model’ which they saw as ‘alive and well’, identifying there is a need for nurses to work holistically. Suggesting the biomedical model to be limiting.

“I think of some old practices when it was more very medical, now we are constantly saying can you make sure they bring a family member to the review. Many people work in that way, however, some people tend not to, but they are moving in that direction” (Participant 008).

“We use the western framework of diagnosis because that is kind of what we work with isn’t it. The biomedical model full stop is pretty limiting. But I have a very broad interpretation of that and happy to look at other ways of interpreting illness as maybe for that person. I think we’re practicing holistically with clients” (Participant 002).

However, one participant talked about how family sometimes want a more medical approach.

“Basically, the treatment went back to the medical model of the psychiatrist” (Participant 010).

One participant summarised how there is a need to be able to have conversations about how family are included and when indicated excluded from the consumers care.

“We probably need to have a conversation about how our organisational cultural components, aspects of approach, requirements, expectations about family and the health professional. Including myself sometimes we are careless or have a laissez-faire attitude” (Participant 003).

There was a lack of clarity and understanding of what family inclusive practice looks like in everyday practice and how these principles are applied.

“It means that the patient has a choice in terms of how much they want their family to be involved with. Families are updated on current treatment and the potential limitations of the treatment. The family know the structure of how our outpatient service works, they know the formal process in terms of review, how to access after-hours services and what’s available” (Participant 001).

“It’s establishing relationships and looking for the opportunities I think are the two main things. So you’ve got a good relationship with your person you’re dealing with, the consumer then that should translate onto their family whānau supports” (Participant 004).

I think family is actively involved in treatment and care. That they’re notified and aware of what’s going on with the decision making. (Participant 009).

In conclusion, the strengths of having a focused family approach were identified, with the barriers being associated with different models of care that operate in the service. In addition, the challenge of cultural responsiveness was also highlighted. Participants however identified the strengths of this cultural approach and considered a similar model for non-Māori would support family engagement, involvement and embed family inclusive practice further.

4.4.4 Summary

Participants identified facilitators as having policies that guide family inclusive practice but many questioned the motivation or intent of these. Whether this equated to quality engagement, there was the view that family involvement was occurring, however, this was not visible in the documentation due to increased workload and time constraints. Yet, the barriers of time, particularly around documentation and workload was also identified as an excuse that may be used when family has not been engaged. Leadership and the multi-disciplinary team function were seen as vital facilitators in ensuring family inclusiveness is supported and part of practice.

Barriers related to the provision of care, lack of resourcing, lack of continuity of care and easy access to and by family were identified factors. Participants identified informal processes that they use such as the ability to be flexible in accommodating family and utilised their working collegial relationships to help informally overcome barriers.

Participant's cited family from other cultures can be lost to the service due to an inability to engage with them, due to families' cultural beliefs around social and cultural stigma along with a fear of lack of confidentiality. Participants identified a barrier in skills and training to engage in a meaningful way.

The family approach to care was viewed as a strong facilitator. The working alongside the Pūkenga Atawhai was identified as a positive support and facilitator to both the consumer and family. Participants viewed the medical model as being a barrier for working more holistically. In addition, being patient centred did not necessarily equate to being family focused. A family focused approach was viewed as a strong facilitator to family inclusive practice. However, there was a lack of clarity or consistency on how this is applied.

Chapter Five:

Discussion

The focus of this research was to identify barriers and facilitators to family inclusive practice from the perspective of community mental health nurses and clinical managers working in an adult community mental health setting. It was determined that their perspective was lacking in the current literature.

The findings from this study identified three themes; 'Great Expectations: getting pulled in all directions', 'Engagement: the many layers' and 'Foundations and Pillars: service delivery plus'. The discussion chapter will explain the relationships between the three, followed by a discussion about the findings. Lastly, the chapter describes the implications for inclusive family practice within a clinical environment that is driven by differing expectations and imperatives, and recommendations to enhance family inclusive practice within a specialist mental health setting.

5.1 Synthesis of findings

The three themes from the study emerged through the coding of text and the development of descriptive themes. The themes have been interpreted as a whole to generate analytical themes to address the research question and explore the current literature. As a result of further analysis, the barriers have been broadly defined as a lack of shared understanding, lack of skills and confidence, differing expectations and 'time'. While the facilitators have been defined as training and skill development, good intentions and leadership.



Figure 1: Synthesis of findings: Finding the Balance

Figure 1 represents the broader interpretation of the three themes which informs the discussion. Navigating competing expectations and demands which are reflected in the findings were an everyday challenge for participants. The study found that participants are philosophically committed to the concept of family inclusive practice, with many considering that this was occurring more frequently than the literature suggested.

5.2 Barriers

The study found that the understanding of how policy and guidelines are applied to practice can be varied. The practicalities of applying these in everyday practice were fraught and there was, therefore, a disconnect between the intent of policies and these ideals being embedded into the reality of everyday practice. To address this gap, there is an acknowledgement that mental health services need to develop strategies and "champions" to take the concept of family inclusive practice forward (Stanbridge & Burbach, 2007). Without resources to ensure that family and consumer inclusion is implemented as directed in policy, inclusion will remain aspirational, as suggested by Martin et al., (2015). Therefore, as other studies have suggested the translation of policy to practice needs to be supported and promoted through long-term, multi-layered implementation strategies, in all areas of the organisation (Grant, Goodyear, Lauritzen al., 2014; Maybery & Reupert, 2016).

5.2.1 What is family inclusive practice?

The findings identified inconsistencies in the application of models of care or approaches which has resulted in a lack of a shared understanding of family inclusive practice both for the clinician and family. The study found engagement with family occurs in clinical settings, however, there are often barriers to moving this forward to a collaborative and partnership approach. The finding supports the key finding of the Office of the Health and Disability Commissioner (2018) which recommended that services need to pay more attention to building and maintain partnerships with consumers and family.

For the purpose of this study, a family-focused approach referred to practices that seek to involve family in routine care and provide family interventions such as psychoeducation, rather than the provision of specialised family interventions such as family therapy. For a family-focused approach to be embraced, it needs to be integrated into a systems approach based on the values and integration of the whole of mental health service delivery. This study also indicated that the frequency of family involvement is influenced by competing models of care such as the medical model, individual-centred care, and whānau-centred approach. These models of care were not necessarily transparent, understood, or consistently applied and could account for the gap between expectations set out in policy and the reality of practice, including the inconsistencies in approaches and variable family involvement with mental health services.

The findings from this study identified that a family-whānau approach by Pukenga Atawhai was overwhelmingly viewed as a significant facilitator in engaging and supporting whānau for Māori. Given the recognition of the benefits of this approach, it provides the foundations for this or a similar model to be extended to all consumers and their family. However, this study also identified that current models do not fully meet the needs of immigrants or other ethnicities. The finding finds support from the Ministry of Health (2015) who identified a need to ensure that all interactions with families and whānau are undertaken in the context of cultural competence and are aware of the needs of Māori, Pacific peoples and families of other ethnicities is required. Therefore, consideration to models of care or approaches that also demonstrate a multi-cultural approach could be a key facilitator and potentially enhance family participation for these families. The New Zealand Nurses Organisation (2018, p. 10) concludes that models of care are currently “hindered by a lack of nursing input into the design and decision-making, and a conservative culture and a western biomedical approach”.

The challenge for nursing and mental health services is to identify new, and evidence-based models or approaches.

5.2.2 Lack of transparency of family inclusive practice

Although this study suggested that there was evidence of family involvement, there was also a perception that family engagement and participation in care was not occurring in routine practice because its occurrence was not routinely documented. There is a reliance on the quantifiable data by services which could be argued is not a true measure of the frequency and quality of family involvement occurring. A contributing factor for a lack of documentation by clinicians demonstrating family involvement was found to be related to such information not being viewed as a priority by clinicians with busy workloads. Family involvement was consistently recognised as important but was often viewed as 'routine' and part of usual practice, therefore, was not always valued as requiring to be specifically recorded. There was a sense of frustration from participants that family inclusive practice was not acknowledged by management as occurring as part of their usual routine practice.

Monitoring and providing evidence of family involvement, when it occurs, was viewed as a 'tick box' process and was not seen as a function to monitor the quality of the engagement and involvement. Potentially this presents a challenge for organisations on how they monitor the quality of family inclusiveness, as documentation is often used as evidence of family inclusive practice. There is a reluctance for additional 'paperwork' and a need for more practical resources which would support the ability to practice in a family inclusive way.

In the few studies which have evaluated the impact of family inclusive policies, that there is inconsistency in the application of the policies, which is reinforced by this study (Martin et al., 2017). The terms engagement and participation are often used interchangeably in the literature. Family engagement is often defined as to the extent to which families participate or attend appointments, with this being used as a measure for family involvement (Staudt, 2007). However, this does not provide a true reflection of family involvement as participation alone does not provide a true measure of the quality and meaningfulness of these contacts as family can attend appointments without feeling able to take an active role (Steib, 2004 as cited in Ontario Centre of Excellence for Child and Youth Mental Health, 2016). This study also found there was a sense of mistrust or unease about the motivation or

intent of policies, with a suggestion that policies are there to protect the organisation from adverse public criticism and was part of the organisational risk management. These perceptions could be the result of the increasing use of service standards, audits, targets and the care pathways and treatment protocols. As Cohen (2017) concludes, approaches adopted by services can result in unintended consequences such as a reduction in morale and increased workload demands and pressures.

5.2.3 Relationship tensions due to differing expectations

There is an organisational expectation to include family; however, this study suggests this is not always transparent to the family on entering the mental health service. The findings suggest there can be variance between preconceived family beliefs about health care based on society's expectations for caring for the mentally unwell, and what the mental health services can provide. This finding is supported in other emerging evidence that identifies a lack of a shared understanding of what constitutes appropriate family involvement and how to best incorporate it into services (Dirik et al., 2017).

Families require information about what to expect from the mental health service to address some of the tensions that can arise between the family and the professional. Providing families with information about how the mental health service works, the roles and functions of the mental health professionals and what can happen throughout care, assessment and treatment, may help to address the divergent expectations between what the service can and cannot provide. It may also reduce the tensions that can arise between family and the service to achieve a collaborative relationship. As Martin et al. (2017) suggest there needs to be a cultural change to systematically embed meaningful family involvement in the delivery of mental health services, which find support in the direction of the Supporting Parent Healthy Children, Ministry of Health (2015) initiative previously mentioned.

The findings from this study suggest that a shared understanding with family of what they should expect, and an agreement of their role in ongoing care or intervention is required. Acknowledging families may have many reasons of their own for not wanting to be involved, such as concerns about their privacy and conflicts between work and other family commitments (Cree et al., 2015). There is an expectation by the service that families are given written information on contact, but this alone does not translate into family

involvement and could be viewed as a 'tick box' task. There is a need to ensure that a range of information is provided at the right time and in the right way. Boyd and Sigglekow (2011) identified that some people found the amount of information received during a time of crisis was too overwhelming and that they were unable to take it all in. Therefore, services need to be considerate of family needs and capacity to understand the information and identify when it is best to provide additional information and check what has been understood.

The findings from this study also suggests that family may not always be fully informed or understand their rights for information around privacy legislation. A lack of understanding and knowledge was found to be a potential contributing factor resulting in differing understandings between the clinician and family. The findings from this study are supported by the He Ara Oranga Report (Paterson et al., 2018), where families described patient privacy as a barrier used to exclude family from treatment and discharge planning. Paterson et al. (2018) recommend the updating of guidance on sharing information and partnering with families and whānau. There are a large number of studies which have identified the challenges for clinicians regarding sharing information in the context of balancing the consumer rights to confidentiality and privacy with family's need for information (Bradley & Green, 2018; Chan & O'Brien, 2011; Maybery et al., 2016). It is also acknowledged in the literature, that clinicians experiencing complex and ethically challenging situations have a fear of litigation, which has been mostly unfounded (Chan & O'Brien, 2011; Martin et al., 2017).

Overall, this study found that clinicians were often unsure about how much information they could provide and the operationalisation of privacy and disclosure law and policies, and were not sure how well families understood this. Manuel (2017) identified that families reported being 'blocked out' of treatment due to clinician-perceived privacy issues and that mental health clinicians appeared to lack the understanding that family can still be involved when there was a non-disclosure status. That study also concluded that it is essential for nurses to fully understand the privacy and disclosure legislation as it applies to their work with the consumer and to avoid using it as an excuse not to engage and work with family.

This study also found a need for a 'family friendly' service, which was not just focused on to the individual requiring care but as an integrated person-family focused approach. In addition, the 'business hours' of the adult community mental health service have been

identified as a barrier for both the nurse and family for involvement and participation in care. Eassom et al. (2014) endorses the need for the provision of flexible hours which may assist in overcoming some of the barriers families face to be actively involved. As in this study, others studies have identified the 'business hours' of community-based care is a significant barrier, with family experiencing difficulties to attend meetings due to other commitments (Goodwin & Happell, 2008). Along with access to mental health services was identified as a challenge for families by participants, this finds support in the He Ara Oranga Report (Paterson et al., 2018) in which families described the difficulty of accessing advice and supports for their family member. The literature has also identified that family find it particularly difficult to access mental health services, which leads to frustration and distress (Reed & Harding, 2015; Tambuyzer & Van Audenhove, 2013). The Office of the Health and Disability Commissioner (2018) reports that family have described that there are minimal supports available for them and that often services do not know what supports are available.

5.2.4 The barrier of 'time'

Challenges around workload and finding 'time' for families were identified as a significant barrier for the participants in this study. The lack of 'time' as a resource is a barrier to completing documentation and to engaging with family in a meaningful way, with a potential for this impacting the quality of the interactions with family. The study confirmed the findings from other studies that family inclusion is sometimes viewed as too time-consuming in an already busy demanding role, which means for some, avoiding contact as it may generate more work (Martin et al., 2017; Stanbridge & Burbach, 2007). The lack of time experienced was attributed to a lack of resources and the increased time required to following processes and procedures expected by the service. Bee, Brooks, Fraser, and Lovell (2015) also identified the greatest barrier in collaborative care planning was increasing time and workload pressures.

5.2.5 Skills and confidence working with family

A commonly identified barrier to family inclusiveness is mental health clinicians feeling that they do not have the necessary skills, knowledge or confidence to adopt family inclusive practice (Cook & Mueser, 2014). The study had similar findings, with participants identifying a need for the training of clinicians around all aspects of family involvement, to

improve confidence in facilitating family meetings and working collaboratively. A recent study found mental health nurses considered they lacked the skills and knowledge to work with families and were less enthusiastic than other professions to involve the family in treatment (Maybery et al., 2014). Other studies suggest all members of a clinical team should be trained and regularly supervised with a 'whole team approach' in basic family-focused practice, noting nurses make up the largest professional group (Eassom et al., 2014; Maybery et al., 2014).

There was also a strong focus on the importance of the therapeutic relationship in this study. However, it is essential nurses develop or value other skills such as the application of family-focused interventions and expand their 'kete' or tool kit, in the changing environment and expectations of consumers and family. The two are not mutually exclusive. Browne et al. (2012) believes mental health nurses are stuck at engagement in the therapeutic relationship although the 'real' work happens once people are engaged. Nurses may feel comfortable engaging with family, however, do not consider they necessarily have the skills or confidence in taking the next step to involve and work collaboratively with family. A review of acute inpatient settings, supports these study findings, with a key recommendation for intervention-specific training and ongoing training in patient-family collaboration and partnerships for healthcare teams (Mackie, Mitchell, & Marshall, (2018). Improving the skills may lead to an increased willingness to undertake family-focused practice in the adult mental health workforce (Maybery et al, 2016).

This study also found the length of experience of a nurse does not necessarily equate to skill and ability to engage with family, with suggestions that attitude was a barrier. Van den Heever, Poggenpoel and Myburgh, (2015) identified the importance of authenticity or genuineness in therapeutic communication and suggests nurses today are not always caring and genuine with themselves or consumers. In studies that include family perspectives related to professionals, a majority reported experiences of lack of recognition, respect and basic courtesy from professionals as significant barriers (Cree et al., 2015; Landeweer, Molewijk, Hem, & Pedersen, 2017). Cree et al. (2015) considers the facilitators of meaningful relationships between clinicians and family are, effective communication, partnership, working and allowing sufficient time for explanations to be given and understood.

5.3 Facilitators

5.3.1 Leadership

Philosophically, there was a view that policies and procedures are a starting point and guide to including family in care. The study found the role of leadership at a clinical level was a key facilitator in reinforcing family involvement, with multi-disciplinary team meetings also having an important part. Clinical leadership was found to be at every level and policy implementation was not left to one person which is supported by Taylor and Martindale (2013) who suggest that clinical leadership can sit within a range of roles across the team. Other studies also conclude that strong leadership is the most robust facilitator for giving family involvement a priority status within the service (Eassom et al., 2014). The mental health team leader therefore plays a crucial role in facilitating change, including role modelling the organisation values, engaging and supporting the team (Holm & Severinsson, 2010).

5.3.2 Good intentions

Despite the challenges, the study found that family inclusive practice does occur, with nurses making a conscious effort to 'work the system' to the advantage of the consumer and family. Facilitators identified in this study were the use of collegial relationships to access assistance or support for family, and a willingness to be flexible in where and when to meet family, which may require meeting outside usual working hours to accommodate the family. Not all participants viewed time as a barrier, concluding that the value and knowledge family have, can in fact save time in the long term through early intervention. Overall, the findings suggest there is a reliance on the pro-activeness of individual clinicians to find informal solutions and not necessarily on a robust service model of care that enables family involvement. Ness, Borg, Semb and Karlsson (2014) also found practitioners used their system knowledge in order to support service users and families.

Working with disclosure and consent is a regular occurrence and can be challenging. One participant described often 'being stuck in the middle' while respecting the consumer's wishes and recognising the family's wishes to be involved. However, balancing the consumer's wishes and rights to confidentiality and privacy, with the family's need for information is part of everyday practice. The importance of working along-side the consumer

and family was viewed by participants as essential, with clinicians finding strategies to navigate the legislative requirements with consumers and family. The study found that even when a consumer did not want family involvement, family inclusion was still promoted.

5.3.3 Training

Skills training was viewed as a facilitator of family inclusion, which is supported by Kim and Salyers (2008) who found clinicians that had received prior training on working with families provided more services, had more positive attitudes toward family and felt more competent about their knowledge. Relational skills have also been found to be a core facilitator to family involvement (Bee et al., 2015). New practice models such as The Single Session Family Consultation Model which brings structure to family meetings, has been found to help facilitate effectiveness and has increased the confidence of practitioners in working with family (The Bouverie Centre, 2015). Clinical supervision is also a key facilitator in fostering practice change towards the inclusion of families. Nurses and clinicians bring a multitude of thoughts, feelings, beliefs, and attitudes into relationships, some of which may interfere with the establishment of positive relationships with family. Clinical supervision can support the development of positive attitudes and address personal barriers or organisation barriers to family work (Kina Families & Addiction Trust, 2010). The study identified that a positive attitude to working with family was a key factor in an openness to involving family.

5.4 Finding the Balance

For effective family inclusion, mental health services need a collaborative process between consumer, family and services to provide treatment that best meets the needs of people with mental illness. Mental health services should engage consumers and family at the beginning of efforts to implement new practices, which could provide valuable information on how to promote interventions to consumers and family (The Bouverie Centre, 2015).

There is a need to find a balance between the expectations of society, family, consumers and mental health services. A starting point is the development of a shared understanding of what family can expect on entering mental health services, what family inclusive practice is and the model of care or approach that facilitates this. This would create an environment whereby

everyone is potentially on the same page or starting point, with an understanding of potential roles, expectations, and how these principles are enacted in everyday practice. In addition, families want to receive information that is tailored to their specific experience and needs (Bradley & Green, 2017).

This study found there is a need for skill development and ongoing training for nurses and teams is required. Currently, participants described processes for engagement, but there is a need for a supportive foundation to enable genuine collaborative work with family. Collaboration needs to become central to the process of family inclusive practice. To enable this to happen there needs to be a team approach with an accepted and transparent family-focused approach that is adopted by all (Eassom et al., 2014). The findings from this study consider that adult mental health services should fully implement the Supporting Parent Healthy Children guideline for mental health and addiction services (Ministry of Health, 2015). Thus provides processes that would support a change from the traditional individual focus towards embedding family and whānau focused practices within adult mental health services. A facilitator to support this change is the provision of implementation guidelines that identify the specific actions that are required.

There are also a number of international models available which could be adapted for the New Zealand context. For example, the ‘Triangle of Care’ approach which was initially developed by carers and clinicians seeking to improve carer engagement in acute inpatient services but is now intended for all services within a mental health service (Worthington, Rooney, & Hannan, 2013). The ‘Triangle of Care’ approach has been adopted into practice across the United Kingdom.

The development of the Triangle of Care approach came on the background of what was viewed as a disconnected model of involvement that lead to carers being excluded (Worthington et al., 2013). Worthington et al. (2013) defines carers as relatives including parents, children, siblings, partners or friends.



Figure 2: Representing a disconnected model of approach (Worthington et al., 2013)

Worthington et al. (2013) concluded that the above model of approach results in family being excluded causing failures to share information, not being involved in, for example, in risk assessment and care planning. The approach also potentially excludes the recognition of the carer or family’s emotional or health needs.

Alternatively, the 'Triangle of Care' as described by Worthington et al. (2013) is a working collaboration, or ‘therapeutic alliance’ between the service user, professional and carer. The triangle refers to the three way partnership between patient, carer and staff which is different to the ‘traditional’ two-way model of patient and staff.

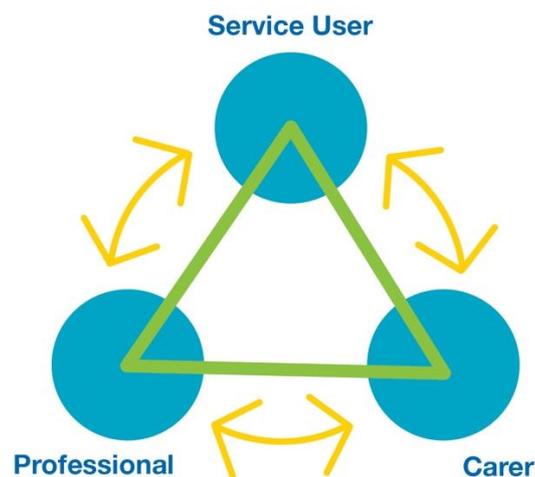


Figure 3: Triangle of Care (Worthington et al., 2013)

The six key standards in achieving a Triangle of Care and best practice examples are described by Worthington et al. (2013, p. 9). For the context of this study ‘carer’ has been substituted with ‘family’.

- Family and the essential role they play are identified at first contact or as soon as possible after that. Family views and knowledge are sought, shared, used and regularly updated as overall care plans and strategies to support treatment and recovery take shape.
- Staff are ‘family aware’ and trained in family engagement strategies.
- Policy and practice protocols regarding confidentiality and sharing information, are in place. Guidelines are available on confidentiality and for sharing information demonstrating a three-way process between service users, family and professionals.
- Defined roles/positions responsible for family are in place, including: Family lead or champion for all wards and teams irrespective of which service. Family links delegated for each shift/team.
- A family introduction to the service and staff is available, with a relevant range of information across the care pathway, including the nature of the service provided and who to contact, including out of hours. Family information packs.
- A range of family support services is available, including: Family support, family needs assessment and family interventions. There also needs to be regular assessing and auditing to ensure the six key standards of family engagement exist and remain in place.

Alongside this the Somerset Partnership NHS Foundation Trust (n.d.) developed a family charter recognising the importance of the role of family. The charter has four principles which includes descriptions of how these will be achieved or demonstrated.

“Our Carers’ Charter” (Somerset Partnership NHS Foundation Trust):

- Principle 1 – We will recognise and respond to your needs as someone who cares for a patient of Somerset Partnership NHS Foundation Trust

- Principle 2 – We will recognise and respect your expertise and knowledge
- Principle 3 - We will welcome your involvement in care
- Principle 4 – We will value your involvement in the development of our services

These are intended to be adhered to by all mental health care services and demonstrate how the service will work in partnership. Therefore, there are clear expectations of what families should expect, alongside families receiving support. The embedding of these principles would potentially address the findings of this study of the absence of a shared understanding of family involvement.

5.5 Summary

This study found that many of the key standards above are already part of New Zealand national policies and guidelines, including mental health service policies. In addition, the findings from this study identify a family-whānau approach was overwhelmingly viewed as a significant facilitator in engaging and supporting whānau for Māori. Given this approach is well established in the service, it therefore provides the foundations for this or a similar model to be expanded and made available for all consumers and family. Policies and guidelines are not enough without a meaningful shared understanding, without leadership, resources, and the commitment of mental health services to promote a strong partnership with family.

A transparent, accepted collaborative approach will provide the foundation to embed family inclusive practice into usual everyday practice and move past the 'tick box' task view. And would therefore promote a shared understanding with clear agreed expectations between clinicians and family and help overcome the barriers found in this study. In addition, to achieve this clinicians and teams are required to have the skills and confidence to work in a family inclusive way.

5.6 Implications for Practice

This study suggested that there was an awareness and intention to inform and involve families however this has not translated into active involvement and shared decision making

with family. One implication from this study may be that for a consistent understanding of family inclusive practice across all of mental health services a collaborative model needs to be adopted. Therefore, there is a need for a consistent approach which enhances partnership and collaboration between the consumer, family and clinician. Community mental health nurses are in an ideal position to advocate and lead family inclusive practice within adult community mental health services. However, nurses need to take professional responsibility and be proactive in ensuring family is meaningfully involved in care. To facilitate this, nurses are required to have the skills and confidence to work with and alongside family, including providing leadership and expertise.

There is also a need for further research of nurse's perception and solutions for embedding family inclusive practice in care and treatment. In addition, any new initiatives and implementation of a collaborative model such as the Triangle of Care approach as suggested in this study would need to be fully researched and evaluated.

5.7 Study Limitations and Strengths

Recruitment bias was possible given the site in which the study was advertised and was limited to four adult community mental health teams within one specialist mental health service, at a district health board. Purposive sampling enabled the selection of participants whose qualities or experiences were required for the study. Also, interviews and analysis were conducted by one researcher which may have also lead to bias, this also provided consistency. The sample size was relatively small at ten participants however saturation was reached, and small sample sizes are considered more appropriate in qualitative research. Despite these limitations, the study has strengths. The methodology was applied rigorously. The findings could have only been generated by using a qualitative approach and the qualitative descriptive design allowed for the findings to be described in a form close to the raw data which was essential given the specific topic. The main strength of the study is that it has explored a topic from the perspective of community mental health nurses and clinical managers who are working in the area to learn from the participant's descriptions, knowledge and expertise.

Chapter Six:

Conclusion

The focus of this study was on what adult community mental health nurses and clinical managers consider to be barriers and facilitators to family inclusive practice. The findings highlighted that navigating competing expectations and demands is an everyday challenge for participants. Among the barriers identified by participants were the lack of a shared understanding of what is expected in regards to family involvement, by society, family, clinicians and mental health services. The lack of time, confidence and skills impacted on effective family inclusive practice, along with a disconnect between the 'ideal' and the 'reality' of embedding organisational policies related to family inclusion. However, this study found facilitators to be strong leadership, the promotion of family involvement through the multi-disciplinary team and clinicians actively attempting to overcome service delivery challenges by being flexible and finding solutions to meet the needs of family.

There is a need for a shared, informed understanding of the expectations and the application of a family inclusive approach within community adult mental health services. Clinicians are philosophically in favour of family inclusive practice and find ways to achieve this in individual practice. However, the key to overcoming the barriers to effective family inclusion lies in the quality of engagement, involvement, shared understandings and a collaborative approach to developing and maintaining relationships between clinicians and family. This requires changes in professional attitudes and practices, including a clear consistent understanding of family inclusive practice. An agreed model of care or approached also requires the support of the mental health service, family and consumers.

The recommendation from this study is to address the barriers identified by adopting a collaborative model of approach. The study has offered an example of the 'Triangle of Care' which could be adopted within the New Zealand context. The 'Triangle of Care' approach complements policies and current mental health initiatives such as Supporting Parents Healthy Children, Ministry of Health (2015) which gives a clear direction for family inclusiveness and family focussed practice to be embedded in all aspects of mental health service delivery. In addition, more research is required into the influences and effectiveness

of family inclusive practices in specialist adult mental health services within the New Zealand context.

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APPENDICES

Appendix 1: Research Information Flyer

University of Otago Human Ethics Committee (Health)



Family inclusive practice in Adult Community Mental Health in a District Health Board.

This research aims to identify what the adult community mental health nurses consider as barriers and facilitators to family inclusive practice.

Recognising factors that facilitate and hinders family inclusive practice will provide a basis for developing clinical practice to best meet the needs of patients and their families.

We are seeking eight participants who are nurses and work in adult community mental health, Canterbury District Health Board to join us in this research.

The commitment time required would be no more than one hour interview within work time to take part in this research.

There is no monetary incentive.

This project is being undertaken by Karen Moke as part of the requirements for Masters of Health Science (Nursing-Clinical).

For more information, contact: Karen Moke | 021 331 235 | mokka774@student.otago.ac.nz

(Principal Investigator: Professor Marie Crowe)

This project has been reviewed and approved by the University of Otago Human Ethics Committee, (Health). Reference: H17/058.

Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235	Family inclusive practice in Adult Community Mental Health in a District Health Board Karen Moke 021 331 235
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Appendix 2: Participant Information Sheet



Participant Information Sheet

Study title:	Family inclusive practice in Adult Community Mental Health in a District Health Board.	
Principal investigator:	Marie Crowe Department of Psychological Medicine, Christchurch Professor	Contact phone number: 03 3720 400

Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with colleagues or friends, before deciding whether or not to participate.

This project is being undertaken by Karen Moke as part of the requirements for Masters of Health Science (Nursing-Clinical).

If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the aim of this research project?

The aim of the research is to identify what adult community mental health nurses consider to be barriers and facilitators to family inclusive practice.

Identifying the factors that facilitate and hinder family inclusive practice provides a basis for developing clinical practice that best meets needs of consumers and families.

Who is funding this project?

There is no funding attached to this project

Who are we seeking to participate in the project?

Registered nurses and clinical managers working in adult community mental health within Canterbury District Health Board.

If you participate, what will you be asked to do?

Should you agree to take part in this project you will be asked to be involved in an interview. The interview will be semi-structured guided by questions.

The interview will take no more than one hour in length and will be carried out in work time. The interview will be recorded on tape and later transcribed. If there are any areas that needs clarifying the researcher will contact you. The interviews will be held away from the immediate work environment but on the premises to maintain your anonymity in terms of your participation.

Is there any risk of discomfort or harm from participation?

It is not anticipated that any harm will occur as a result of participation in this study.

What information will be collected, and how will they be used?

No identifying information will be stored. Data will be stored using a research identifier and any material that may identify you will be removed.

What about anonymity and confidentiality?

The interviews will be digitally recorded and stored electronically in password protected files. You will be asked to read and sign a consent form should you wish to participate. Transcription of the interviews will be completed by an experienced audio typist who will be required to sign a confidentiality form

if you agree to participate, can you withdraw later?

You may withdraw from participation in the project at any time prior to the de-identified information having already been integrated into the study and without any disadvantage to yourself.

Any questions?

If you have any questions now or in the future, please feel free to contact either:

<p>Name Marie Crowe Position Professor Department of Psychological Medicine, Christchurch</p>	<p>Contact phone number: 03 3720 400</p>
<p>Name Karen Moke Position Student Investigator Department: Centre for Postgraduate Nursing</p>	<p>Contact phone number: 021 331 235</p>

This study has been approved by the University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix 3: Participant Consent Form



Family inclusive practice in Adult Community Mental Health in a District Health Board.

Principal Investigator, Professor Marie Crowe (marie.crowe@otago.ac.nz and 03 372 0400)

CONSENT FORM FOR PARTICIPANTS

Following signature and return to the research team this form will be stored in a secure place for ten years.

Name of participant:.....

1. I have read the Information Sheet concerning this study and understand the aims of this research project.
2. I have had sufficient time to talk with other people of my choice about participating in the study.
3. I confirm that I meet the criteria for participation which are explained in the Information Sheet.
4. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
5. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage.
6. I know that as a participant I will be expected to take part in an interview that may take up to one hour.
7. I know the interview will explore family inclusive practice in adult community mental health and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) , and /or may withdraw from the project without disadvantage of any kind.
8. I understand that the results of the project may be published and be available in the University of Otago Library.
9. I know that there is no remuneration offered for this study.

10. I know that when the project is completed any personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.

Signature of participant:

Date:

Name of person taking consent

Date:

Appendix 4: Transcriber Confidentiality Agreement



Transcriber Confidentiality Agreement

Project Title:

Family inclusive practice in Adult Community Mental Health in a District Health Board.

Principal Investigator:

Professor Marie Crowe, Psychological Medicine, University of Otago, Christchurch.

Contact Person: Karen Moke (Researcher)

Address: Quality & Patient Safety Team, Hillmorton Hospital, Specialists: Mental Health Services, Canterbury District Health Board, Christchurch.

Phone Number: 021 331 285

Email: karen.moke@cdhb.health.nz

I, Brigitte Caldwell, agree to transcribe *ad verbatim* research data from subjects/patients from the above named research project. I agree to maintain complete confidentiality in regard to anything I may hear or read in connection with this research.

All tapes, digital files, and paper copy of this information will be password protected and kept in a secure place while in my possession for the purposes of transcription. All the aforementioned material will be returned to the Researcher on completion of each transcription and any information on the computer hard drive will be erased.

I understand this confidentiality agreement is binding both now and in the future.

Signed Brigitte Caldwell (Transcriber)

Date 12-6-17

Signed Karen Moke (Researcher)

Date 14-6-17

Appendix 5: Base Interview Question Guide

Base Interview Question Guide

1. Can you tell me about your nursing or professional background?
2. What is your current role?
3. What age (range) are you? Ethnicity?
4. How would you go about engaging with families for the first time?
5. What do you see as barriers to involving family?
6. What helps or what facilitates family engagement?
7. How do you define family inclusive practice?
8. How is family involvement monitored and evaluated?

Appendix 6: Final Ethics Approval



H17/058

Academic Services
Manager, Academic Committees, Mr Gary Witte

6 June 2017

Professor M Crowe
Department of Psychological Medicine (ChCh)
Terrace House, 4 Oxford Terrace
University of Otago, Christchurch
University of Otago Medical School

Dear Professor Crowe,

I am again writing to you concerning your proposal entitled "Family inclusive practice in Adult Community Mental Health in a District Health Board", Ethics Committee reference number H17/058.

Thank you for your letter of 31st May 2017 addressing the issues raised by the Committee.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:

Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

<http://www.otago.ac.nz/healthandsafety/index.html>

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

gary.witte@otago.ac.nz

jo.farronediaz@otago.ac.nz

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee (Health) asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page <http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html>

Yours sincerely,



Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor R Porter Head Department of Psychological Medicine (ChC)

Appendix 7: Maori Consultation Letter

26 May 2017



CHRISTCHURCH

Professor Marie Crowe
Centre for Postgraduate Nursing Studies
University of Otago, Christchurch

Mā te rangahau Hauora e tauroko te whakapiki ako to Hauora Māori.
All health research in Aotearoa New Zealand benefits the Hauora (health and wellbeing) of tangata whenua.

Tona kōwhiri Marie.

Thank you for taking the time to meet with me at my office at the University of Otago, Christchurch on the 22nd May 2017, to discuss your research study titled:

Family Inclusive Practice in Adult Community Mental Health in a District Health Board

I note that you are the Principal Investigator for this study and that Ms Karen Moke, a student completing the research requirements for a Master's degree in Health Sciences (Clinical Nursing) from your department, will also be involved. I understand that the Ms Moke has received partial funding to support this study from Te Pou.

Commentary on Proposed Research Project

Identifying factors that facilitate and hinder family inclusive practice provides a basis for developing clinical practice that best meets the needs of consumers and families. It is recognised both internationally and nationally that family inclusive practice in mental health service provision has economic, social and clinical benefits. However, according to current research embedding family inclusive practice into everyday practice is proving to be a challenge. The aim of this research is to identify what adult community mental health nurses consider to be the barriers and facilitators to family inclusive practice. This research is a qualitative study that proposes to recruit a total of 8-9 community mental health nurses, half with more than 5 years' experience and half with less than 5 years' experience working in adult community mental health settings. The research criteria includes registered comprehensive nurses working in adult community mental health services at Canterbury District Health Board, Christchurch. In addition, four clinical managers for the Adult Community Mental Health Service will be sent a letter and information sheet inviting them to consider participation in the study. It is proposed to recruit a minimum of two clinical managers.

Ethnicity

Whilst this research project does not specifically target Māori, you have indicated Māori nurses may have a presence within the recruitment population. A major strength of the using the interviewing method is that it provides an opportunity for researchers to access the lived experiences of participants who are able to describe their world in their own words. In this way, Māori nurses working with the Adult Community Mental Health Service will be able to provide a voice regarding their experience and perceptions identifying barriers and facilitators to family/whānau inclusive practice in mental health. In terms of identifying Māori nursing staff eligible to participate in the study, you inform that you will be discussing this further with Ms Cassandra Stamps (Māori Nurse, Mental Health Services). It is recommended that ethnicity data is collected from each participant in accordance with the New Zealand Ministry of Health guidelines, which involves the use of the Census 2013 question.

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Māori Health Gain

It is expected outcomes from the research will provide information to enhance and promote family inclusive practice within adult community mental health, Specialist Mental Health Service, Canterbury District Health Board. It is also envisaged the research will inform policies and guidelines to embed family inclusiveness into routine practice. Improved delivery of family-inclusive practice may be of benefit to Māori service users and their families. This would complement whānau inclusive practice offered by Te Korowai (Māori Mental Health Service), Specialist Mental Health Service, Canterbury District Health Board. This provides the appropriate context to the importance of this research to Māori and to improving Māori health outcomes.

Consent

Issues regarding informed consent for participants who are recruited to the study were discussed. With this in mind, you must ensure that study participants are aware that consent will be for this single study only. Should any study participant wish to opt out of the study, you must provide information as to who they should make direct contact with to arrange this.

Potential Further Support Resources

Further resources that you might want to access to strengthen your responsiveness to Māori with your research are: 1. HRC's Ngā Pōu Rangahau Hauora Kia Whakapiki Ake Te Hauora Māori 2004-2008, 2. The Health Research Strategy to Improve Māori Health and Well Being 2004-2008. For regional data relating to Māori in each District Health Board (DHB) region, the District Health Board (DHB) Māori Health Profiles (2015) published by the Ministry of Health New Zealand will help to create a picture of the health status of a DHB's population at a given time. The other reference that is available is 3. Hauora Māori Standards of Health IV: A Study of the Years 2000-2015 by Bridget Robson and Riccol Harris, Māori Health Research Unit, Wellington School of Medicine, University of Otago, Wellington. All provide Māori specific information on a range of health issues. The recent publication Tātau Kahukura: Māori Health Chart Book 2015, Ministry of Health, 2016 (3rd edition) is an update relating to the socio-economic determinants of health, health status and service utilisation of the Māori population. Further references are available from the HRC's Guidelines for Researchers on Health Research Involving Māori.

Dissemination of Results

The HRC's Guidelines for Researchers on Health Research Involving Māori, is important in terms of how your research results may contribute to Māori health gain. Therefore, it is important that appropriate Māori organisations and/or researchers are aware of your findings. This should occur not only in an academic forum, but also within the community from where study data is drawn. I understand that a summary of findings from your study will be made available to study participants as well as Hauora Māori staff from Te Korowai Atawhai. You will also share your findings with the Specialist Mental Health Services Research Group and the Mental Health Quality Service Team. In addition, you have also offered to present your findings in person with colleagues at the Canterbury District Health Board Specialist Mental Health Nurses Day. I have also suggested that you discuss and identify other avenues for dissemination with Mr Dean Rangituna (Māori Consumer Advisor, Specialist Mental Health Services, Canterbury District Health Board), as he may be able to help direct you to an appropriate hui where the results can be shared with the community. As such, these avenues may allow opportunity for the consideration of Māori feedback into any discussion going forward.

Ka nui tonu ngā mihi,



Karen Keelan
Kaitiaki Māori/Māori Research Advisor

Appendix 8: Research Locality Assessment

<p style="text-align: center;">Canterbury District Health Board <small>Te Pori Hauora o Waitaha</small></p>	<p>Specialist Mental Health Service Research Locality Assessment</p>																
<p>Step one: Researcher to complete this section</p> <p>Researchers name: Karen Moke Proposed timeframes Research title: Family inclusive practice in Adult Community Mental Health in a District Health Board. Start: May 2017 Completion: Dec 2018</p> <p>Research location: Adult Community Mental Health Service, SMHS Please attach proposal.</p> <p>Have you sought funding? No If so, from where? Are there any resource implications for SMHS (staffing or other costs)? If so, what?</p> <p>It is proposed to interview 6-12 participants. Each participant will be required to be interviewed for no more than one hour within their work time.</p> <p>Is it your intention to publish any part of this research or findings? No. Thesis will go into the Otago University Library and Hillmorton Library SMHS</p> <p>Is ethics approval required? • If no, briefly state why? • If yes, has application been made for ethics approval? Attach copy of application. • If ethics approval has been given, attach copy of approval.</p> <p>The researcher accepts accountability for ensuring that all ethical and/or regulatory obligations are met and that appropriate consultation is undertaken.</p> <p>Researcher's signature: <i>[Signature]</i> Designation: Nurse Consultant Date: 5 May 2017</p>																	
<p>Step two: Service Leadership Team member to complete this section</p> <p>SLT approves the research being undertaken and will monitor progress of the research. The proposal is recommended for approval.</p> <p>Chair's signature: <i>[Signature]</i> Name: A Lockington Designation: Service Manager Date: 2-6-17</p> <p>If SLT is not appropriate for the monitoring function, the SMHS Research Committee will appoint an appropriate monitor.</p> <p>A scanned copy of this form and proposal is to be emailed to SMHS Research Committee now SMHSResearch@cdhb.health.nz</p>																	
<p>Step three: SMHS Research Committee to complete this section</p> <p>Prior to approval, the SMHS Research Committee will consider the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 2px;">Vulnerable populations' rights are protected</td> <td style="width: 20%; text-align: center; padding: 2px;">Yes/no</td> </tr> <tr> <td style="padding: 2px;">Privacy issues are identified and mitigated</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">Health Information Privacy Code 1994 is adhered to</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">Benefits and risks (including mitigations) are transparent and acceptable</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">Resource implications for SMHS (staffing and other costs) are transparent and acceptable</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">The proposed study meets generally accepted ethical standards</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">The locality is suitable</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> <tr> <td style="padding: 2px;">Local researcher has the ability to undertake the study</td> <td style="text-align: center; padding: 2px;">Y</td> </tr> </table> <p>SMHS Research Committee approves the proposal and recommends the General Manager approve.</p> <p>Chair of Research Committee signature: <i>[Signature]</i> Name: <i>[Signature]</i> Designation: GM Date: <i>[Signature]</i></p>		Vulnerable populations' rights are protected	Yes/no	Privacy issues are identified and mitigated	Y	Health Information Privacy Code 1994 is adhered to	Y	Benefits and risks (including mitigations) are transparent and acceptable	Y	Resource implications for SMHS (staffing and other costs) are transparent and acceptable	Y	The proposed study meets generally accepted ethical standards	Y	The locality is suitable	Y	Local researcher has the ability to undertake the study	Y
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The locality is suitable	Y																
Local researcher has the ability to undertake the study	Y																

6.6.17

Step four: General Manager approves the research to commence.
Name: B Wilson Signature: [Signature] Date: 6.6.17
Acting GM. PP T. Gutschlag