

*Making the invisible visible:
Public health nurses role with children who live with a
parent with a mental illness.*

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ABSTRACT

People with a mental illness are some of the most vulnerable people in our community. Children who live with a mentally unwell parent are deemed hidden or invisible with their needs not being recognised. Yet these children are at a greater risk of developing a psychosocial or psychopathological illness themselves, and are at an increased risk of harm and neglect. Public health nurses work with children and families in the community, with mental illness causing greater complexity in their work, yet this aspect of their work is not well recognised and has been described as hidden or invisible. This research used focus group methodology to examine the public health nursing practice with children who live with a mentally ill parent.

Themes were identified from the research data which clarified that mental illness has a burgeoning impact on public health nurses work with their role being identified as assessment and advocacy. Certainly within the research area studied the public health nurses who work with children can identify that those children whose parents have a mental illness can impact on the parent's ability to function as a parent and the consequence for that child is profound. The public health nurses work is increasing in the area of primary mental health and the findings build on the literature on public health nursing practice in primary mental health.

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CHAPTER ONE

Introduction to the research topic

1. 1 Introduction

There has been a shift from institutional care to community care for adults with a mental illness since the 1990s both nationally and internationally, with a subsequent increase in the number of children living with a parent who suffers from mental illness (Cowling, 1999). Research over the last three decades has identified children who live with a mentally unwell parent are at substantially higher risk of developing a psychopathology themselves (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee, Keller, Podorefsky, Staley, Lavori, & Shera, D. 1996; Ferguson & Horwood, 2001; Nicholson & Clayfield, 2004; Smith, 2004), and are at greater risk of abuse or neglect (Beardslee, et al., 2003; Foss, Chantal, & Hendrickson, 2004; Nicholson & Clayfield, 2004).

As an experienced public health nurse (PHN) working with children and families, I noticed a change in the types of referrals that I have received over the last five years or so. When I reflected upon my caseload at the end of 2006¹, I noticed that my caseload was becoming increasingly encumbered with considerably more complex cases. These cases related to issues concerning children whose parents have a mental illness, several of which challenged my professional knowledge. I wanted to know if parental mental illness was also affecting my colleagues' caseload and what the public health approach was for supporting these children. I have been studying towards a Masters of Nursing for several years (part-time) with a focus on public health nursing practice. Through this study I was aware of the lack of literature on public health nursing in New Zealand (NZ) and I wanted to articulate practice from this specialty area of nursing.

The title of this thesis is "*Making the invisible visible: Public health nurses role with children who live with a parent with a mental illness*" and reflects claims that both children of mentally unwell parents and PHNs are invisible (Clendon & McBride, 2001; Cowling, 1999; Robertson-Green, 1993). I examine the role of PHNs in NZ, in particular their role with children whose parents have a mental illness. This research is derived from

¹ I was able to reflect more on the changes in my caseload following the meningococcal immunisation programme (MeNZB) in 2005. That year, I was engaged in the MeNZB programme for almost the whole year, starting at the beginning of January and finishing in late November. At the conclusion of the programme, I managed a minimal client caseload, picking up a normal caseload at the beginning of 2006 and this gave me an opportunity to take a fresh look at my caseload in the end of 2006.

the PHN practice in NZ, with the research question and aims focusing on their practice within the area of mental health.

1.2 Research question

What is the Public Health Nurses' role with children who live with a parent with a mental illness?

1.3 Research aims

There are five aims in this study;

- to identify if there is a trend to PHNs work that sees parental mental illness having an impact on their caseload,
- to identify to what extent this is the case,
- to determine how PHNs identify when a parent has a mental illness,
- to ascertain what the PHNs role is with children who live with a parent with a mental illness and to articulate their practice, and
- to identify potential education needs for PHNs.

1.4 Choice of language and terminology used in this thesis

For clarification purposes, this section explains the usage of common terms referred to in this thesis.

1.4.1 Writing in the first person

I write in the first person throughout this thesis, as it is consistent with reflexive, qualitative research (Webb, 1992) and also because this thesis topic is in the area of nursing practice that I am intrinsically linked to, am grounded in and passionate about.

1.4.2 Parent and family identified

The term parent refers to the main caregiver of children. It does not infer gender or legal connection to children; rather it recognises the essential relationship between adult caregivers and children. Equally the term family refers to the contextual nature of relationships rather than inferring a nuclear family, with the family themselves defining who they are (Hartrick, 1998; Wright & Leahy, 2000).

1.4.3 Children identified

Children are identified in this research project as those aged between five and twelve years. A distinction is made between children and adolescents in this research, because

adolescents are more independent and more able to access health advice themselves. Young children are excluded because PHNs have a minimal involvement with this age group. Therefore I have chosen to identify the PHN practice with children attending primary schools.

1.4.4 Mental illness defined

The term mental illness and unwellness are used throughout this thesis. This research is positioned within well-child primary health care and not in mental health. Hence the term mental illness reflects the importance of the relationship between the illness and its impact on children and not on the pathology itself. I prefer to use the term illness rather than disorder because the latter medicalises illness and as this thesis comes from the discipline of nursing, I use nursing language. However in Chapter Two, I include mental disorders identified in the literature, for instance depression, bi-polar, schizophrenia and psychosis. These terms are taken directly from the research literature relating to the topic and I refer the reader to DSM 1VR (American Psychiatric Association, 2000) for diagnoses of mental disorders.

Services to those with a mental illness are provided at the primary, secondary and tertiary level. Primary mental health refers to health professionals working in primary care including general practitioners, PHNs, Plunket and practice nurses. Secondary mental health involves specialist mental health workers, including child and family mental health (CAFMS) and paediatric services provided on an outpatient basis, and tertiary mental health refers to inpatient and more specialist areas.

1.4.5 Population and personal health defined

The provision of health services internationally can be viewed from the traditional distinction between personal and non-personal or population health care (Ministry of Health, 2002). The former refers to services directed to individuals in society and includes diagnostic, preventative and treatment or therapeutic interventions. The latter focuses on the determinants of health that are directed to communities or groups within populations, for instance Māori and children (Ministry of Health, 2002). Although the role of PHNs varies internationally, both population-focused and individual client-centred models are used simultaneously, that being PHNs take into account the socio-economic determinants of health when working with clients, in particular disadvantaged groups who may be affected by mental illness (Edgecombe, 2001).

1.5 Relevant government documents

Ministerial documents predominantly aim at the non-personal or population health care. The main documents influencing public health nursing practice are;

- The New Zealand Primary Health Care Strategy (Ministry of Health, 2002). This document focuses on the primary health sector. It sets out how this sector should work collaboratively placing an emphasis on health promotion and preventive care along with community involvement. It provides for the coordination of care for individuals through Primary Health Organisations (PHOs). Hansen and Carryer (2007) claim that although this document encourages all primary health nurses to merge with PHOs, a recent survey of PHNs indicated they had a clear preference to remain employed by District Health Boards (DHB) (66% of respondents).
- Achieving Health for all People – Whakatutuki te Oranga Hauora mo ngā Tangata Katoa: A framework for Public Health Action (Ministry of Health, 2002). This document sets out how the public health sector contributes to the NZ Health Strategy and uses the accepted definition of public health as being “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society” (Acheson, 1998, as cited in Ministry of Health 2002, p.18). It explicates the public health approach to tackle inequalities in health.

1.6 Public Health Nursing in New Zealand

Public health nurses in NZ are registered nurses working under the Health Practitioner’s Competence Assurance Act (2003). They work under National Service Specifications (Ministry of Health, 2005a) and are employed by DHB Provider Arms, Primary Health Organisations and Maori Providers (Hansen & Carryer, 2007), however they are mostly situated in the DHB public health services. PHNs make up 8% of the NZ public health workforce (Ministry of Health, 2007). PHNs work in the community,

using knowledge and expertise to support and nurture the health and well-being of individuals, groups and communities throughout NZ...and aim to promote and protect the health of populations, using knowledge from nursing, education, social and public health sciences (Anderson, 2006, p. 1).

Furthermore, PHNs work in schools to promote health and well-being and advocate for children and families (Clendon & McBride, 2001; Lynes, 2003). The NZ Nurses Organisation (NZNO) is one professional body that supports PHN practice in NZ, and the NZNO-PHN Section has attempted to define the scope of practice describing the breadth

of PHN practice in NZ (Appendix 1). This thesis focuses on the personal health service offered to children and families in the community (refer to section 1.1.5). PHN practice internationally is further defined in Chapter Two.

1.6.1 Public Health Nursing caseload

To assist PHNs to monitor their caseload, PHNs use a categorisation² method to ascertain their caseload. This categorisation gives these nurses a meaningful method for collecting statistics and gives a clear means to identify more accurately what their caseload is. Commonly referrals for category 4 clients will involve children with behaviour problems who need input from multiple agencies, child protection cases and families involved with Strengthening Families³ many of which are children who live with a mentally unwell parent.

In 2006, with almost 20 years experience as a PHN, I became alarmed at the increased amount of complex or category 4 clients that I was working with. I noticed a significant number of referrals were for children with behavioural difficulties coming from both schools and parents.

The following exemplar describes a case that I was working with over the last year. I place it into this thesis to provide the reader with an understanding of the PHN role with families.

1.6.2 Placing this thesis into context: Exemplar from practice

I accepted a referral from a local health agency with a request that I make a referral to Health Camp for two children from a family. The referrer explained that the family was in crisis after the father had attempted to commit suicide while the children were in his care (the parents were separated). The children had found their father semi-conscious and called the police who transported him to the emergency psychiatric service. The health agency felt that the children and their mother needed urgent support.

I immediately contacted the children's mother, to discuss this referral and arranged to see her the following day. She told me the incident above was the father's second attempt at suicide in a two week period. My initial assessment included a risk assessment for the safety of the family. I asked her if she thought that her ex-partner might harm her or the children and I was greatly concerned when she replied with considerable uncertainty to this which was also voiced by his own father. Due to the urgent safety concerns for the children and mother, I made several referrals including an immediate notification to Child Youth and

2. Categorisation of clients is on a 1-4 basis; 4 being the most complex and may take months or even years of involvement, whereas category 1 will be for a one-off visit or consultation, for instance for a communicable disease.

³ Strengthening Families is an interagency case management approach to working with families at risk and aims to provide services to families to ensure early intervention and prevention.

Family Service (CYFS) and I encouraged the mother to apply to the Family Court for a Protection Order. The mother was hesitant to do this, so I met with the local police officer who knew the family to raise their awareness of potential harm. My role became one of assessing the risks and needs of the mother and the children individually. This involved discussions with the mother, school staff, and the other agencies working with the individual family members.

The older of the children is a boy of 8 years of age and he has Attention Deficit Hyperactivity Disorder (ADHD) and a borderline intellectual disability. He is under the care of Paediatric Services and on medication. He seemed to have been detrimentally affected by his father's actions, for instance he said that he wanted to "kill himself, just like his dad". His behaviour has changed dramatically causing considerable concern with signs of anxiety, defiance and hitting out at his sibling at home, while at school it was reported that he was swearing at his teachers, and was extremely attention seeking and out of control. I discussed my concerns with the Paediatrician who agreed to see the boy urgently and as a result his ADHD medication was changed. Although the younger child does appear resilient, her father's first attempt at suicide had occurred on her 6th birthday, and I felt she was showing signs of increased stress, which included being very clingy and tearful at home and school. Together, mother and I made referrals for counselling and respite care for both children.

I continued to have regular contact with the mother over the next three months or so, and during this time I noted that the mother was not coping and found her frequently crying, complaining of not sleeping and feeling 'stressed out'. She acknowledged that she had been on anti-depressant medications but because of the cost had stopped taking them. I encouraged her to see her doctor for an assessment of depression, and I spoke to the GP and negotiated there being no the charge for her visit.

I initiated a Strengthening Families process as a way of coordinating the care for the family and to identify any gaps in the services. At the first Strengthening Families meeting both parents attended along with 20 professionals from different agencies who were involved with the family, including, teachers and counsellors from 2 schools, Paediatric services (paediatrician and social worker), Child Youth and Family Service (CYFS), Police, general practitioner, adult mental health services, several NGOs providing respite care for the children and myself.

This exemplar is an example of a complex family that is similar to several other cases that I regularly work with. It is an example of the holistic approach that I and other PHNs take when assessing the needs of, and coordinating the care for children when they live with a parent who has a mental illness.

1.6.3 Public Health Nursing practice

PHNs accept referrals for primary-school aged children (the client) from schools as in the above exemplar, the community and directly from parents. Clients are referred to PHNs when the referrer has a concern for a child's health and increasingly this takes the form of concerns for a child's behaviour (Lynes, 2003) and where the parent requests additional support with managing their children's behaviour (Whittaker & Cowley, 2003). This aspect of their work remains somewhat invisible (Clendon & McBride, 2001; Robertson-Green, 1993). The support I provide to parents will vary from client to client but usually includes listening to them, giving realistic information on parenting skills and assessing the

need for further intervention (Green, Howes, Waters, Maher, & Oberklaid, 2005; Whittaker & Cowley, 2003). The exemplar above demonstrates that interventions include referrals to specialist paediatric and child and family mental health services for assessment of a psychopathology and to other child-focused services for instance; counselling, buddy programme and attending Children's Health Camp.

To enable appropriate support for children and families, PHNs assess their individual needs (Whittaker & Cowley, 2003). The child assessment is holistic in nature and takes into consideration the child's health history, how their child interacts at school and home, and includes relevant aspects of their development, like learning, socialisation and behaviour. This assessment is directly related to the issue that the parent has identified and is child focused and is often focused on injury and illness prevention (Kristjanson & Chalmers, 1991; Reutter & Ford, 1996). Holistic assessment of children includes assessing the needs of the whole family. Parental mental illness presents a complexity for PHNs in identifying the children's needs, and should be addressed as part of their family and child health assessments. However, I believe it may not be routine practice for PHNs to enquire about a parent's mental health. Hence they may not know if parental mental illness is impacting on the child's health and well-being.

Health promoting nursing practice as espoused by Hartrick and colleagues (Hartrick, Lindsey, & Hills, 1994; Hartrick & Lindsey, 1995; McDrury & Lindsey, 2002) is the framework of practice that PHNs apply with all clients, of which active listening is the first component. This is followed by participatory dialogue where the nurse uses critical and circular questions to elicit the parent's perspective. The nurse and parent then identify patterns and themes that influence the family's health experience, for instance the impact of parental mental illness on children, or parenting patterns. The process concludes with the nurse and parent envisaging action and making positive change. This change might include adopting a different parenting pattern (for instance adjusting bedtime routines for the child) or a referral to other services might be made. In this way the nurse supports the client by enabling them to make positive changes for their family. Relational nursing practice builds on the health promoting nursing practice and is defined as "humanly involved process of respectful, compassionate, and authentically interested inquiry into another (and one's own) experience" (Hartrick 2002, p 524.).

1.7 Education for Public Health Nurses in mental health

Ongoing in-service education is provided for PHNs on issues specific to practice including child abuse/protection and population health. Additional educational requirements have traditionally been left to the individual nurse, with much of the relevant learning being learnt on the job (Secker, Pidd & Parham, 1999). I have felt for many years that my personal knowledge of mental illness is not comprehensive. Reading the literature associated with this thesis has provided me with a greater understanding on many of the issues related to mental illness that are pervasive in the community, in particular the impact of mental illness on families. The education requirement of this group of nurses is one of the issues to be investigated in this thesis and is discussed in chapter four.

1.8 Structure of the thesis

This thesis is divided into five chapters. Chapter one introduces the topic, outlining the significance of the issue for me and places the topic within the practice of PHNs in NZ. I provide an exemplar from my practice to ground the reader with additional context of my practice as a PHN.

In chapter two I explore the literature around the impact of parental mental illness on children and the nature of risk to children. This is followed by a discussion on resilience. The literature on the public health nursing role with children who live with a parent with a mental illness is discussed.

Chapter three describes the research design. For this research I used focus group methodology and the uses, definitions and rationale for using focus groups to generate data is discussed. I then discuss the systematic steps used to capture and analyse the data. The chapter concludes with a discussion on how rigour was applied throughout this study. I note at this stage that the second aim of the thesis is to identify the extent to which PHNs work with parents with a mental illness. This aim is clearly a quantitative one and this research is written from a qualitative paradigm, therefore the second aim is not met within the chosen methodology.

Chapter four describes the analysis and interpretation of the data in detail. Themes emerged from the data analysis and these are also discussed.

Finally, Chapter five discusses assessment and advocacy as the key roles of PHNs work in primary mental health. The thesis concludes with recommendations for further research.

1.9 Conclusion

In this chapter I have described the research topic within the context of my role as a PHN. I have clarified terminology used throughout this thesis and the associated Government documents relevant to this area of nursing practice. PHN practice has been defined with subsequent contextual information provided.

The following chapter provides a literature review on the subject of the impact of parental mental illness on children. A further discussion is provided on public health nursing practice and their role.

CHAPTER TWO

Literature review

2.0 Introduction

The incidence of mental illness in society is increasing and the World Health Organisation has identified depression as the leading cause of disability globally (Bayer & Sanson 2003). The promotion of mental health is a priority for the NZ health sector (Ministry of Health, 2001a, 2001b, 2005b) with the objectives being to reduce the incidence and impact of stress and depression, reduce the stigma and discrimination associated with mental illness and to improve the health status of people with mental illness. Mental illness has been linked to the socio-economic determinants of health; with a greater number of people living with a mental illness also being those with financial problems, lower educational achievement and unemployment (Ministry of Health, 2000, 2001a, 2005b). Furthermore, psychosocial problems are the most common chronic condition for paediatric visits, with under-detection and treatment of child mental health problems being well documented (Borowsky, Mozayeny, & Ireland, 2003).

Unequivocal evidence demonstrates a link between parental mental illness and poor psychosocial outcomes for children (Beardslee et al., 1996, Cowling, 1999; Rutter & Quinton 1983). The needs of children living with a parent with a mental illness are often neglected and these children have been labelled as invisible or hidden (Cowling, 1999; Lancaster, 1999) with research generally ignoring the children's perspective (Garley, Gallop, Johnston, & Pipitone, 1997; Mordoch & Hall, 2002). Unless children present with a behavioural or learning problem at school, or parents request support with their children, the needs and voices of children are likely to go unrecognised and unsupported (Ahern, 2003; Mordoch & Hall, 2002). The needs of children who live with a mentally unwell parent is a significant public health issue (Bayer & Sanson, 2003; Fraser, James, Anderson, Lloyd, & Judd, 2006; Maybery, Ling, Szakacs, & Reupert, 2005; Stevens, 2006). It is therefore important and timely to take a fresh look at the needs children who live with an adult with a mental illness.

This chapter is separated into two sections. In section one I explore the literature around the impact of parental mental illness on children. A brief discussion on mental illness in NZ is given in order to provide the context and magnitude of the potential problem and this

is followed by a discussion on the nature of risk to children. Finally the term resilience in children is explained. In section two, the literature on the public health nursing role with children who live with a parent with a mental illness is discussed.

2.1 Search methods and results

Initially the literature search was computer based using CINAHL, Pubmed and Google Scholar using the terms parental mental illness, parental mental disorder, children living with mentally unwell parents, children of impaired parents – psychosocial factors. I continued searching the literature throughout the writing of this thesis and included individual-based searching of a number of journals that had proved to be helpful. Internet web pages searched included the NZ Mental Health Foundation (NZMHF) and others. Contact was made to various experts including the NZMHF and the Christchurch Health and Development Study (CHDS) who provided me with a number of research articles.

The literature on the impact of parental mental illness on children is predominately based within the biomedical domain, with the research focusing on psychiatry and pathophysiology. The nursing literature on this topic is generally written from mental health nursing perspective with the focus being on adult, child and adolescent specialty areas of nursing practice and is also written from a biomedical perspective. In general this literature focuses on secondary and tertiary mental health services and not on primary mental health.

NZ research includes longitudinal studies from the Dunedin Multidisciplinary study and the CHDS (Fergusson & Horwood, 2001; Fergusson, & Lynskey, 1993; Fergusson, Lynskey, & Horwood, 1993), both of which has produced a significant body of research on the effects of maternal mental illness and infant and child welfare.

I draw attention at this stage of the literature review to the research devoted to attachment theory as espoused by John Bolby and Mary Ainsworth (Bretherton, 1992). I do not address the issue of attachment because the literature focuses almost exclusively on the mother-infant dyad, and this thesis focuses on primary school age children (5-12 years). Furthermore, it is not within the scope of this two-paper thesis to explore the literature on this subject. Suffice to say that as a PHN, I am aware that the relationship between maternal bonding and child health outcomes is significant and thoroughly intertwined.

2.2 Section one - Mental Illness

2.2.1 Mental illness in New Zealand

Oakley Browne and colleagues (Oakley Browne, Wells, & Scott, 2006) identified that 46.6% of the NZ population will meet the criteria for a mental disorder⁴ in their lifetimes, with 20.7% experiencing a disorder in any single year. They identified that socioeconomic disadvantage is prevalent within this group, and although there appears not to be a disparity in access to services, there is however a disparity in prevalence of disorders amongst Māori and Pacific people.

In reference to child mental illness, the CHDS explored the causal pathways for children's mental disorders (Oakley Browne, et al., 2006). This study identified the prevalence of mood disorders, alcohol and substance use disorders and anxiety disorders in NZ children. For instance, in the 12-13 year-old cohort, the CHDS identified a small but significant association between maternal depression with increased risk of depression and behavioural and social adjustment disorders (Fergusson & Lynskey, 1993; Fergusson, et al., 1993).

Finally, whilst undertaking this thesis, a small study of child carers was completed by the Children's Issues Department of the University of Otago in collaboration with Carers NZ (Gaffney, 2007). This study undertook to develop an assessment tool for agencies to identify children who are in significant caring roles (parentification and known as child carers) for parents, siblings and/or themselves in NZ. They identified that parental mental illness is only one reason for children caring for other, with child carers more likely to come from families who are in the lower income bracket and from single parent families and in need of additional support. The role of child carers included domestic, emotional support, caring for themselves and others however there are no structures in place in NZ to identify and support them (Gaffney, 2007). In a comparative study of child carers in the UK (1995, 1997 and 2003), between 25-29% of the children caring for a parent with a mental illness had an average age of 12 years (Dearden & Beaker, 2004; cited by Gaffney, 2007). Gaffney (2007) found that NZ children caring for themselves and others were as young as 7 years with the median age being 11 years.

2.2.2 Parental mental illness

People with a mental illness and their families are among the most vulnerable and unsupported in our community (Maybery, et al., 2005), with children of mentally unwell

⁴ This substantial document refers to the groups of mental disorders with anxiety disorders, mood disorders, substance use disorders and eating disorders (Oakley Browne, Wells, & Scott, 2006)

parents at a far greater risk of developing a psychiatric disorder than children in the general population (Beardslee, et al., 2003; Devlin & O'Brien, 1999; Maybery, et al., 2005; Rishel, Greeno, Marcus & Anderson, 2006; Rutter & Quinton, 1984). Statistics show that the number of adults suffering from a mental illness are parents with children under the age of 16 years (Smith, 2004) and that the number of children who live in a home where a parent is mentally unwell is high (Ahern, 2003; Devlin & O'Brien, 1999; Mordoch & Hall, 2002; Nicholson & Henry, 2003).

With the high rates of adult mental illness there is a corresponding growth in the number of children affected by mental illness (Devlin & O'Brien, 1999), and the demands for child mental health services are predicted not to cope with the demand (Handley, Farrell, Josephs, Hanke, & Hazelton, 2001).

The NZ Mental Health Foundation does not have statistics on parental mental illness, (K. Higginson, personal communication, January 30, 2007), however, Gerard Kenny (G. Kenny, personal communication, October 28, 2007) identified that within the Otago District Health Board, 55% of cases monitored by the Child Protection Department are as a result of parental mental disorder⁵.

2.3 The nature of risk to children living with a parent with a mental illness

The effects on children living with a parent with a mental disorder has been recognised for the past four decades (Beardslee, Bemporad, Keller & Kerman, 1983; Beardslee, et al., 2003; Devlin & O'Brien, 1999; Fraser, et al., 2006; Rutter & Quinton, 1984). Early research internationally focused predominantly on children of parents with schizophrenia, affective disorder and alcohol abuse. This research can be divided into the following;

- Studies conducted during the 1960s and 1970s in the USA of children at risk of developing schizophrenia (Rutter & Quinton, 1984).
- Studies of children whose parents suffered from affective disorder and/or anxiety disorder based in the USA in the 1970s and 1980s (Beardslee, et al., 1983).

However, the literature on mental illness that informed this thesis was divided into two aspects;

- The effect of parental mental disorders, particularly depression on child development and the sequelae in their children developing psychopathology.

⁵ As the Child Protection Advisor for the ODHB, Kenny has taken statistics on child protection cases over the last five years and identified that parental mental disorders is a factor in between 55-65% of all cases. He said that the majority of cases are in women with pre-existing mental disorders and are notified to his Department during pregnancy or in the immediate post-natal period.

- Children who are not affected by their parent's mental disorder and are deemed as resilient.

2.3.1 Parental disorders and risks to children

The specific disorder that the parent suffers from has different implications for children's health outcomes with research heavily weighted towards the impact of maternal depression on children (Ahern, 2003).

The effects of parental depression on children is dominant in the literature, with the outcomes including language developmental delay, social and emotional dysfunction, behaviour problems and depression (Ahern, 2003; Beck, 1999; Fergusson & Lynsky, 1993; Fergusson et al., 1993; Lancaster, 1999; Nicholson & Clayfield, 2004; Smith, 2004; Stevens, 2006). Children of parents with depression are two to five times more likely to develop behavioural problems than other children (Beck, 1999; Fergusson, 1993, Smith, 2004), and are more likely to have accidents at home and suffer from neglect (Beardslee, et al., 1996; Beardslee et al., 2003; Nicholson & Clayfield, 2004). Mothers with depression are more likely to be inconsistent, lax or ineffective in their parenting patterns, especially with discipline where they are more likely to yield to children's demands than be consistent with their parenting strategies (Beck, 1999). Lancaster (1999) explains that it is the way the parent interacts with their children over a period of time that is important, in particular, the lowered affect or episodic emotional withdrawal that leads to inconsistency with parenting.

Parents with anxiety disorder may be over-anxious about the children's welfare with parents conveying that the world is a dangerous place and their children are more likely to develop an anxiety disorder themselves (Lancaster, 1999).

Conversely, disordered thinking and psychotic symptoms in parents with schizophrenia may lead to developmental delay in children. Developmental delay may be a result of lowered parental affect, blurred boundaries, impaired or inappropriate communication and inappropriate responses to the child who may not understand their response to them, for instance the parent may laugh or respond with a blank stare when their child is distressed (Lancaster, 1999). A parent with schizophrenia may also involve their children in their distorted or paranoid thinking which may frighten them. Some children who live with a parent with schizophrenia become child carers, parenting their parent, themselves and their siblings.

Children whose parents are drug or alcohol dependent are more likely to present with behaviour difficulties, attention deficit and conduct disorders, truancy, delinquency and social and school inadequacy. These children may also develop internalizing problems particularly depression and anxiety (Ahern, 2003; Lynskey, Fergusson, & Horwood, 1994).

2.3.2 The impact of socio-environmental factors on child health outcomes

Research prior to 1980 focused on the genetic or familial factors that contributed to the vulnerability of children living in a home with a parent with a mental illness. However, since then the emphasis has been placed on environmental and family factors. The seminal work of Rutter and Quinton (1984) identified family variables as being; severe marital discord, low socio-economic status, overcrowding or large family size, paternal criminality, maternal mental disorder and social agency involvement. This has been supported by recent studies linking parental mental disorders and children's psychopathology with parental marital disharmony (Ahern, 2003; Devlin & O'Brien, 1999; Fraser, et al., 2006; Stevens, 2006), parenting problems and, chronic and severe depression in parents (Beardslee, et al., 2003; Fergusson & Lynskey, 1993; Lancaster, 1999; Rutter & Quinton, 1984; Smith, 2004; Thomas & Kalucy, 2003).

The CHDS has produced consistent evidence associating chronicity of maternal depression with contextual factors of social disadvantage, stress and parental disharmony increasing the risk of adult depression which in turn is linked to childhood disruptive behaviours (Fergusson & Lynskey, 1993). Further, children with one of these contextual or environmental factors alone are at no greater risk of developing a psychopathology than other children. However, where there are two or more factors present the likelihood of developing a mental illness increases fourfold (Ahern, 2003; Stevens, 2006). Atkins (1992) contends that "chronic stresses potentiated each other by producing an effect that was greater than the sum of the stresses" (p. 14). The severity and chronicity of the parental mental illness are better predictors of risk for children developing a psychopathology than the illness itself (Ahern, 2003; Rutter & Quinton, 1984). It is therefore important to identify those children who are at risk, are in need of support and to promote mental health alongside prevention programmes for children.

However, due to the multifaceted nature of the socio-environmental factors, identifying children in need of support is not easy. Gaffney (2007) found that due to the complex nature of families it is hard to judge the impact that the caring role has on child carers. In

the UK (Dearden & Beaker, cited by Gaffney, 2007) child carers were identified through the education system due to educational difficulties or missing school, yet the number of children identified as caring for others was small with the majority of children not being identified. The lack of identification of child carers who need support was attributed to the parent's fear that the child will be removed from their care, yet a third of the children in government agency care makes up one third of all children in care in the UK as a result of the parent needing relief/respite or because of abuse and neglect. Therefore children caring for a parent should be identified as potentially in need of intervention (Gaffney, 2007).

2.3.3 Recognising resilience

Beardslee et al. (1996) claims that 50-70% of children with mentally ill parents are resilient and do not develop significant problems; yet, between 30-50% of these children will develop a psychopathology or a psycho-social problem⁶ including mild behavioural disorders themselves (Mordoch & Hall, 2002). Children who do not develop a psychopathology or psycho-social problem are known as resilient, competent or immune (Atkins, 1992; Rutter & Quinton, 1984; Thomas & Kalucy, 2003). Resilient children are those who have good outcomes despite major environmental risks. Resilience is described as "individual psychological traits as a class of events whereon success persists in the face of barriers" (Mordoch & Hall, 2002, p. 211). Several factors have been identified as being protective for aiding children to develop resilience and the more that is understood about these factors the greater the chance of intervening and the less likelihood that parental mental illness will cause disruption to children.

2.3.4 Protective factors

The protective factors that contribute to resilience in children has been a major focus on later research (Beardslee, et al., 2003; Devlin & O'Brien, 1999; Foster, O'Brien, & McAllister, 2004/5; Nicholson & Clayfield, 2004; Rutter & Quinton, 1984). The factors identified as promoting and enhancing resilience in children are;

- The child themselves – that being, their temperament, including having a sense of humour, good communication skills and high self esteem; the ability to sustain separation from their parent (for example while a parent is hospitalised); being able to separate themselves from their parents symptoms and behaviour, and also being

⁶ Psycho-social problems are considered those that fit within the mild-moderate mental health issues as compared to psychopathology that are diagnosable using the DSM-IVR criteria. Psycho-social problems can include difficulties at school (academic and social), at home (with siblings and parents) and with friendships (loneliness or lack of friendships for instance).

socially and intellectually competent (Beardslee et al., 1996; Nicholson & Clayfield, 2004; Rutter & Quinton, 1984).

- The family – including effective parenting practices, the child having a good relationship with at least one parent, the presence of a supportive ‘non-ill’ parent and a warm, emotionally supportive and intact family (Devlin & O’Brien, 1999; Mordoch & Hall, 2002; Nicholson & Clayfield, 2004).
- Parental illness – this includes when the parent’s symptomatology does not involve the child (for instance paranoid delusions of harm), the child having an awareness of the parents illness and responding appropriately to it, and when the parental illness is mild, brief or transient (Devlin & O’Brien, 1999; Fergusson & Horwood, 2001).
- Social factors – includes relationships with other adult role model (for instance an aunt/uncle, minister or teacher), quality peer relationships, extended support system and compensatory social activity (Devlin & O’Brien, 1999).

Knowledge of these protective factors can be used to enhance resilience in children living with a parent with a mental illness.

2.3.5 Programmes supporting children

The prevalence of children’s mental illness is expected to increase and the demands for child mental health services is predicted to struggle with this demand (Handley, et al., 2001). It is with this in mind that programmes promoting resilience and preventing the onset of mental illness are critical to enhance the well-being of children at risk of developing a psychopathology (Bayer & Sanson, 2003; Green, et al., 2005). Prevention is defined as an intervention before the onset of a psychopathology (Bayer & Sanson, 2003).

Few prevention studies have been evaluated for children beyond the early-childhood years; however the following two studies on primary school-aged children have been appraised. Beardslee et al. (2003) conducted a large-scale efficacy trial of programmes targeted at healthy children aged between eight and fifteen years whose parents had a diagnosed mood disorder. These programmes aimed at promoting resilience and reducing the children’s feelings of guilt and shame by educating them about the effects of their parent’s illness. They found that the preventative programmes do have a long-term effect on children;

By increasing children’s understanding of parental mood disorder, our interventions were found to promote resilience-related qualities in these children at risk. This [research] represents the first and only longitudinal primary prevention study of relatively healthy children at risk of psychopathology attributable to parental mood

disorder and demonstrates a significant reduction in risk factors and increase in protective factors in these families over a long interval - 2 ½ years. Our results provide support for a family-based approach to preventive intervention. (p. 120)

DeSocio and colleagues (DeSocio, Stember, & Schrinky, 2006) designed and evaluated a mental health programme delivered to 10-12 year old children by school nurses. When designing the programme they identified that developmental characteristics of pre-adolescents made them particularly receptive to education about mental health and mental illness, where they recognised the impact of negative thoughts and the became aware of stigma and feelings of loneliness and rejection. Preadolescents are able to recognise the signs of mental illness in themselves and their peers and by reducing their fears and misconceptions about mental illness were more likely to seek help early for themselves, or to act as a resource person/friend to their peers. Their study concluded that “knowledge and skills learned during preadolescence can be carried forward and can exert a protective influence as youth enter adolescence” (p. 83).

Finally, Gaffney (2007) identified that the child carers benefit from having additional support by providing time with an adult on their own. This type of intervention promotes the development of resilience in children and is similar to the Buddy programme which is offered by various social agencies and is one of the interventions that PHNs refer children to.

2.4 Section two ~ Public Health Nursing practice

In this section the literature on the NZ public health nursing (PHN) role with children and families is examined. I critique the literature on PHN from the USA and Canada and health visitors from the UK, as these roles are comparable to the role of the NZ PHNs.

2.4.1 New Zealand literature

In chapter one, I described the role of PHNs in NZ, with an emphasis on the services directed to individual children and families. The literature and research pertaining to PHNs in NZ is limited. There was no literature found directly on their role with children who live with a mentally unwell parent, however several commentaries on advanced public health nursing practice was available.

Gallaher (1999) undertook narrative interviews of PHNs and identified what she explained as “the essence of the phenomenon of expert public health nursing practice” (p.16). This

article was insightful for me, and I draw on Gallaher's work to explore themes from the focus group meetings undertaken for this research in chapter four of this thesis. Gallaher acknowledges the complex nature of the PHN role and that this group of nurses are "often dealing with vulnerable people at vulnerable times in their lives" (p.20). Although Gallaher does not refer specifically to the issue of parental mental illness, I believe this can be inferred in her description of PHNs practice when she refers to;

The reality of the practice world for these nurses was that much of it revolves around the complex, the greys, the blurred boundaries...[and that]...the recognition that it is seldom simple involved a conscious process of peeling back the layers to reveal the many diverse aspects that make up the client's story... (p. 20-21).

Gallaher also identifies the importance that PHNs place on being child-focused and their role in advocating for children as paramount.

Lynes's (2003) thesis on the relationships between PHNs and schools argues that through their work in the school setting, PHNs are in a position where they can help to reduce the effects of socio-environmental factors that impact on children in order to enhance better health outcomes. She claims that the relationship between school staff and PHNs may either hinder or enhance the nurse's ability to meet the needs of children. This relationship is pivotal for the nurse to advocate effectively for children.

Clendon and McBride (2001) undertook a community needs analysis to determine the perceptions of the role and services provided by PHNs in a school. They found that although many participants recognised the more population focused aspect of their role, including health education, they were less likely to identify the nurses' role with families; in particular their role in advocacy and referrals was hidden or invisible and not articulated. However, Robertson-Green (1993) explained that the inability to articulate what PHNs do was in part because of the nurses' desire to maintain client confidentiality for much of their work.

Finally, in Gaffney's (2007) research of child carers, the agencies that referred children to Carer Support NZ for additional support, were from 10% equally PHNs, Child Youth and Family Service (CYFS) and Plunket, whilst the remainder were referred from families themselves for support with their parenting. This suggests that PHNs recognise that children who are responsible for caring for others are a group of children who are in need of extra support. Gaffney (2007) identified that one of the issues around non-identification of children in need of support was attributed to two reasons; firstly the families were

suspicious about professionals and were fearful that their child would be placed into CYFS care and therefore less likely to allow professionals into their lives. The second issue of non-identification of child carers by the professionals was because of their desire to get to know the family as part of the referral and assessment process, asking “when would we have developed a secure enough relationship with the family to be able to ask these questions?” (Gaffney, 2007; p.26). Gallaher refers this to ‘watchful journeying’ where the PHN walks alongside the family aiming to develop a trusting empowering relationship in order to “delve beneath the surface” (p.20). Schon (1983) refers to as the ‘swampy lowlands’ while, Hartrick Doane and Varcoe call this the ‘hard spots’ of family nursing (Hartrick Doane & Varcoe, 2006).

As a PHN with over twenty year’s experience, I concur with Gaffney’s findings that many vulnerable families in particular where the parent has a mental illness, are agency-wary and fearful of their children being removed. I suggest that PHNs have a belief that taking a relational perspective while working with families would assist PHNs to ask the ‘hard questions’ with families and this is consistent with the PHN framework of practice. Furthermore, the literature supports the claim that PHNs play a pivotal role in advocating for children who would otherwise be invisible, and it is through the PHNs relational nursing, that the needs of these children is met.

2.4.2 International literature

Several terms are used for primary well-child nurses internationally including the terms public health nurse, community health nurse, and health visitor. These terms are often used interchangeable and are at times confusing (Edgecombe, 2001). Regardless of the term used, this group of nurses’ share many similarities; of prime importance is they work in the community with vulnerable populations in their own home (known as home visiting), and environment (including schools). Additionally, their caseload in primary mental health is increasing (Secker et al., 1999) and they recognise that people with a mental illness are at risk of disadvantage and are more vulnerable than others (Scott, 2003).

Edgecombe (2001) completed an international literature review on PHNs for the World Health Organisation and states that “public health nurses have for many years discussed their role in respect to the care of individuals in mental disabilities, but few studies have been undertaken to examine this aspect of their role in any detail” (p. 6). With the rise in emotional and behavioural problems in children, secondary mental health services internationally are at breaking point, and Edgecombe (2001) claims that primary health

services are identifying more mental health issues, with their role extending to caring for parents and children with a mild-moderate mental illness. This includes early identification, support and the prevention of mental illness in both adults⁷ and children⁸ (Foster, et al., 2004/5; Gaffney, 2007; Honeyman, 2007; Lowenhoff, 2004; Nicholson & Clayfield, 2004). Early identification and referral to secondary mental health services can make a positive difference for child health outcomes (Honeyman, 2007). This places primary care nurses including PHNs firmly in the area of primary mental health care. Furthermore, much of the work of PHNs and other primary health nurses is situated in the home where the nurse is in a position to make more accurate assessments of the risk factors for children.

Home visiting places nurses in a critical role of assessing the risk factors⁹ for children and families (Appleton, 1994; Baggaley & Keen, 1999; Honeyman, 2007; Kristjanson & Chalmers, 1991; Long, et al., 2001; Murray, Baker, & Lewin, 2000; Scott, 2003). Home visiting also provides nurses the opportunity to identify and provide support for parents and to work therapeutically to enhance the parent-child relationship, including developing positive parenting skills (Cohen & Reutter, 2007; Devlin & O'Brien, 1999; Long, McCarney, Smyth, Magorrian, & Dillon, 2001; Reutter & Ford, 1996; Secker, et al., 1999; SmithBattle, Diekemper, & Leander, 2004; Whittaker & Cowley, 2003).

Finally, approaches addressing both parental and children's needs have been the focus of mental health services internationally. Family therapeutical approaches are under-evaluated, yet have been identified as helpful for families and children whose parents have a mental illness (Gaffney, 2007; Rishel, et al., 2006), and although PHNs do not have specific training in family therapy, they nevertheless do work therapeutically with families.

In summary, the literature stresses children who live with a parent with a mental illness are at a considerably greater risk in developing a psychopathology themselves. Furthermore, these children are some of the most disadvantaged in our society with the socio-economic

⁷ Assessment of parental depression is discussed in chapter five.

⁸ Early identification of signs of mental illness in children includes inability to cope with problems at home, school or with friends, eating and sleeping disturbances, low self esteem, anxiety, school refusal and social withdrawal and others. PHNs can identify these through accurate assessment taking into perspective the parent's and school teachers' considerations (Honeyman, 2007).

⁹ Risk factors include, 1) Family demographics; age of mother, socio-economic status, education achievement and employment. 2) Parent-child interaction indicators include; a strong link between the parent-child bond and parenting behaviour, knowledge and skill. 3) Family function and social support 4) Health issues including mental illness. 5) Child neglect assessments include assessment of hygiene, nutrition, compliance with health regime and others (Farnshaw, 2003; Murray, Baker, & Lewin, 2000).

determinants of health weighing heavily against them. Yet a significant number of children are resilient and do not develop a mental illness. PHNs work in schools and the community and often have contact with parents with a mental illness. PHNs are in a position where they can assess the risks to children and families and to work therapeutically to enhance resilience, thereby reducing the effects of parental mental illness on children.

2.5 Conclusion

This chapter has identified people with a mental illness are some of the most vulnerable people in our society, and that children living with a parent with a mental illness places them at considerable risk of harm and neglect, developing a psycho-social disorder themselves and caring for others and themselves. There is no doubt that parental mental illness presents a complexity for PHNs in identifying the children's needs. I contend that the PHN role in primary mental health is assessment and referral for children and families, effective advocacy for vulnerable children and families and supporting children to develop resilience.

In this study focus group methodology was used to gather data to support the claim above. Chapter three discusses the research design and implementation of this study.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter describes the research design and methodology. For this research I used focus group methodology, and the uses, definitions and rationale for using focus groups to generate data is discussed. I then discuss the systematic steps used to capture and analyse the data. Finally I describe the rigour that was applied throughout this study.

3.2 Background to the research

This study was generated from my clinical caseload as a public health nurse. I recognised a pattern emerging within my practice, which demonstrated parental mental illness was having an impact on my caseload. I wondered if this was also the same for my PHN colleagues. If this was the case, I wanted to know how they identify if a parent has a mental illness, and what the PHN role is with children affected by parental mental illness.

3.3 Research aims

There are five aims to this research. The first aim is to investigate whether there is a trend in other PHNs' work that sees parental mental illness having an impact on their population caseload. The second aim is to identify to what extent this is the case. The third aim of the study is to determine how public health nurses identify when a parent has a mental illness. The fourth aim is to ascertain what is the PHNs role with children whose parents have a mental illness and to articulate this practice, and the fifth aim is to identify the potential training needs for PHNs to enable them to work more effectively with children and their parents who have a mental illness.

3.4 Research question

The question of this research is; *“What is the public health nurses role with children of mentally ill parents?”*

3.5 Research methodology

3.5.1 Research method – focus groups

Focus group meetings were chosen as the most effective method to generate data for this study, because this method ‘fits’ (Kitzinger, 1995) best with the aims of the research.

Focus groups are exploratory in nature and are able to be used in combination with quantitative and qualitative research (Ivanoff & Hultberg, 2006; Kitzinger & Barbour, 1999; Morgan, 1997). Focus group meetings are useful for discovering how people think and talk about specific issues (Ivanoff & Hultberg, 2006). I chose to use a qualitative methodology for this research as a method to capture the depth of knowledge and the experience of the participants to answer the research question.

3.5.2 Background to focus group methodology

Focus groups were first used in 1941 when Robert Merton and Paul Lazarsfeld tested peoples reactions to wartime radio broadcasts (Kamberelis & Dimitriadis, 2005; Krueger, 1994; Puchta & Potter, 2004). Between 1950 and 1980 focus group methodology was fashionable amongst social scientists for market research (Kitzinger & Barbour, 1999; Krueger, 1994; Puchta & Potter, 2004). In nursing research focus group methodology has been used increasingly since the mid 1990's (Gibson & Bamford, 2001; Happell, 2007; Webb & Kevern, 2001).

3.5.3 Definition of focus groups

Focus group method has been described as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment” (Krueger, 1994, p. 6). Other definitions of focus groups include “a particular form of group interview intended to exploit group dynamics” (Freeman, 2006, p. 491) and Kitzinger (1995) describes them as “a form of group interview that capitalises on communication between research participants to gather data” (Kitzinger, 1995, p. 299).

Focus groups are therefore defined as a group discussion in which the participants discuss aspects of the topic being scrutinised (Curtis & Redmond, 2007; Freeman, 2006; Kitzinger, 1995; Kitzinger & Barbour, 1999; Krueger, 1993, 1994, 1998a; Waldegrave, 2003). In this research I wanted the group participants to converse and explore their views and their experiences about public health nurses role with children who live with a parent with a mental illness.

3.5.4 Advantages of using focus groups

A crucial advantage of focus group methodology is that focus groups are based on the belief that knowledge is generated through the interaction of the participants to generate data required for research (Curtis & Redmond, 2007; Gibson & Bamford, 2001; Morgan, 1997; Patterson & Kelly, 2005; Rabiee, 2004; Webb & Kevern, 2001). This interactive

style of focus group methodology I believed, would meet the aims of this research. A further advantage of focus groups is the ability to efficiently collect a large quantity of rich data that is specific to the topic being examined (Freeman, 2006; Kamberelis & Dimitriadis, 2005; Kitzinger, 1995; Krueger, 1994; Morgan, 1997; Waldegrave, 2003; Webb & Kevern, 2001).

3.5.5 Underlying assumptions of focus groups methodology

The seminal work of Kitzinger (1995) and Kruger (1994; 1998), were used to guide this research methodology. There are four basic assumptions of focus group methodology.

The first assumption of focus group methodology relates to the research arena or environment. The nature of the environment is trusting and non-judgemental and is empowering for participants. The group process creates awareness amongst the participants, allowing new opinions and knowledge to develop. Therefore, the aim of group interaction is to reveal the participants realities.

The second assumption refers to the subjects involved with focus groups, that being the participants and the researcher or moderator/facilitator. The participants share a commonality and are selected for homogeneity and in this study were selected because of their knowledge and experience which is discussed further in section 3.7. The facilitator's role is to raise the participants' awareness and encourage them to share their opinions with each other, thereby allowing the researcher to gather data. As the researcher, I facilitated both focus group meetings. Facilitation is a role in which I am comfortable in and experienced with. I have had previous training in group process and advanced group process and I frequently act as an independent facilitator for Strengthening Families, for which I have received separate training. I was therefore able to use my extensive experience to facilitate these focus group meetings.

Kitzinger and Barbour (1999) say that the facilitator should have prior knowledge of the topic being researched and be familiar with the terminology, the terms and cultural meaning of the group. Further, Curtis and Redmond (2007) claims that it is preferable for the facilitator to come from the same population as the participants. Jamieson and Mosel Williams (2003) agree that the facilitator should have experience and knowledge of the group and be "immersed in the culture of the group" (p.273). As a current member of the PHN group, I am knowledgeable about the terms and cultural meanings expressed by the group and I felt that I understood intuitively what the nurses were saying. I was aware of

having the multiple roles of the researcher and the facilitator and that of a current member of the participant's team. However having a reflexive journal and maintaining a systematic approach to the data collection and interpretation assisted me in keeping these roles distinctive.

The third assumption of focus group methodology relates to the activities in the focus groups. This refers to the method for gaining the maximum information from the participants. This came through a process of carefully guided questions (see Table 1, page 44) which created an evolving conversation (Krueger, 1998b), where the participants' opinions built on previous comments made. The final assumption is that the purpose of focus groups is to collect data for analysis. Data comes from the participants themselves, the questions asked, and the interpretation of the data (Krueger, 1998b) and this is discussed in depth in chapters four and five.

3.5.6 Focus group size

Krueger (1994) states the number of participants in focus groups is determined by the aim of the research, with the optimum number being six to twelve, whereas Kitzinger & Barbour (1999) allow for a minimum of three participants. The design for this research considered that between six and eight participants would be necessary to make this project viable. In deciding on the group size, I took into consideration the following aspects;

- The research topic is complex in nature with the aim of the research being to extract a depth of opinion on the topic (Krueger, 1994). The group process or interaction was integral to ensure quality data was gathered, with the aim being to draw out the participants' beliefs, attitudes, feelings and values.
- The experience that all potential participants have on this subject would be varied. Having six to eight participants would allow for both homogeneity and a diversity of opinion, which focus group methodology seeks (Kitzinger, 1995).
- The size of the group was important to enable sufficient time for each participant to voice their opinion. I believed that more than eight participants could become unruly and would not allow sufficient time for all participants to share their opinion, yet less than six might not allow an in-depth examination of the topic.

3.6 Ethics

3.6.1 Ethical Approval Process

Ethical approval was initially gained from the Otago Polytechnic Ethics Committee, with assurance that I would make minor changes (Appendix 2). The changes required were to

replace the term anonymity with confidentiality from the 'Ground Rules for Focus Group Participants' because the participants would know each other. I was also required to change the wording on the consent form to state that the participants' confidentiality would be preserved in future publications. The third requirement from the Ethics Committee was for my computer memory stick to be password protected. These changes were made immediately and acknowledged via email to the Chairperson of the Otago Polytechnic Ethics Committee.

Initially I considered asking only city-based nurses to join the study, however, following ethical approval I realised that due to PHN staffing changes at my place of work, the number of potential participants who met the inclusion criteria (see section 3.7.2 on page 29 for inclusion criteria) was reduced to three and the aims of the research may not have been met. I therefore considered inviting rural-based nurses to join the study. On further consideration, by including rural-based nurses this study would reflect the region that this group of participants work in which covers both urban and rural geographic areas. Following consultation with my academic supervisor, I contacted the Otago Polytechnic Ethics Committee by email requesting approval to change the conditions of my ethics application and allow me to include rural-based nurses. I explained the change to the process would be more beneficial to my research, yet would not affect the intent of the research and approval for the variation was granted and I could proceed (Appendix 3).

3.6.2 Ethical considerations

The potential participants and I are employees of the same District Health Board (DHB) and as no harm was anticipated, and the participants were not DHB clients, formal ethical approval from the DHB was not required. However while waiting for Otago Polytechnic Ethics Committee approval, I discussed my research proposal with my Primary Care Manager and my Charge Nurse Manager who agreed in principle for this research to proceed. I then informed the Director of Nursing and the Clinical Practice Group Manager of my intentions to undertake this research by letter and was also granted their support. To ensure approval for participants to attend the focus group meetings during work time, I kept the Charge Nurse Manger and the Primary Care Manager informed of times and dates of the focus group meetings.

Informed consent and confidentiality are two essential ethical considerations when using focus groups (Gibson & Bamford, 2001). Agreement to participate in the study, informed consent, confidentiality and the right to withdraw from the study were taken into

consideration when designing the research project. An invitation was sent to all potential participants (Appendix 4) including an information sheet (Appendix 5) which incorporated ethical considerations.

The information sheet (Appendix 5) informed the potential participants that all data will be held on a computer disc and on a password protected dedicated memory stick. The data will be kept in a locked cupboard, along with the consent and demographic forms and will be destroyed five years after completion of the thesis. The dedicated computer memory stick along with my computer and email are password protected in accordance with the Otago Polytechnic Ethics Committee requirements (Appendix 2).

3.6.3 Commitment to the principles of the Treaty of Waitangi

There are three principles of the Treaty of Waitangi and these are partnership, participation and protection. As a researcher (and a nurse) I have a commitment to the Treaty of Waitangi. To meet this commitment, I considered it might be possible that one or more of the potential participants might identify as being Māori. I initially contacted the DHB Koumatua who advised me to read the DHB Tikaka Best Practice guidelines. I did this but felt that the policy did not adequately cover research involving staff, and I therefore contacted the Otago Polytechnic Kaitohutohu by email. In this email I indicated that I would make contact with her if one of the participants identified as Māori. I made further contact with the Otago Polytechnic Kaitohutohu following the focus group meetings with updates on the research progress.

Prior to the first focus group meeting, I invited all potential Māori participants to bring a support person. I asked that they inform me prior to the focus group meeting so I could arrange refreshments for them. No participants indicated that they identified as Māori.

3.7 Focus group participants

In this section I discuss the process of recruitment of participants to this research, including the inclusion and exclusion criteria.

3.7.1 Sampling

It was considered that a total of four and eight participants were required to participate in this research and make the research meaningful (Kitzinger, 1995; Krueger, 1994). To meet the inclusion criteria (discussion follows) all potential participants were required to be currently working as a PHN within the designated DHB.

3.7.2 Inclusion/exclusion of participants

Inclusion to this study was based on the aims of the research using the guidelines recommended by Krueger (1994). Inclusion was limited to those PHNs working under the National Service Specifications (Ministry of Health, 2005a). One of the key aspects of focus group methodology is the capacity to gain an understanding of the participant's knowledge and experience and in order to seek this I felt that nurses with a minimum of a year's experience practising as a PHN was important. Furthermore, I wanted to include rural PHN practice and to obtain this I sought for equal representation from rural and urban-based PHNs practice. The geographic region that the participants and I work in is large, with some rural-based nurses working from regional offices that are between one to three hours travelling distance from the central urban base. To reduce travelling time, I excluded nurses who would be required to travel more than one and a half hours for the focus group meetings. There are four rural-based areas in which PHNS work from in the region being studied and only one area is outside the distance identified making up less than a third of the rural-based nursing service. Therefore I felt the remaining three rural-based areas would be representative of all rural-based participants and I did not believe this would affect the quality of the data.

Other exclusion criteria included nurses working under the PHN employment contract who specialise in communicable diseases and immunisations. They were excluded because their work is based on one-off interventions for a specific issue and were not the focus of this research. The Charge Nurse Manger was also excluded to avoid any superior-inferior relationships amongst the participants (Krueger, 1994). This left four city-based PHNs and seven rural-based nurses who met the inclusion criteria. The group sample therefore was purposively selected and is consistent with the aims of the study (Jamieson & Mosel Williams, 2003; Krueger, 1998b).

3.7.3 Invitation to participate

Once final approval was gained from Otago Polytechnic Ethics Committee (Appendix 3), I approached the Primary Health Manager who agreed to make initial contact to all potential participants with the prepared information on my behalf. The potential participants were sent an invitation to participate (Appendix 4), along with an information sheet (Appendix 5), a consent form (Appendix 6) and the focus group core written ground rules (Appendix 7).

The information sheet stated that participation was voluntary, that there would be no negative consequences for non-participation and that participants could withdraw from the research at any time and also if they withdrew before the data analysis commenced their contribution would be deleted from the transcript. The information sheet also stated that refreshments would be provided and an offer was made to cover the cost of transport and childcare for the participants attending the focus group meetings. The information sheet included my contact details and that of my supervisor and asked potential participants to contact me if they were interested in participating in my research study or if they had any questions they wished to ask me.

3.7.4 Recruitment of participants

Ten potential participants contacted me, and I met with them individually either in person (four city-based nurses) or by phone (six rural-based nurses) and answered any questions they had about participating in the research. I asked them to consider the focus group core written ground rules (Appendix 7) which they needed to agree to before signing the consent form, prior to the first focus group meeting which would provide group safety for all those agreeing to participate. Eight participants agreed to participate and signed the consent forms. The participants who agreed came from city and rural areas equally.

I arranged for the first focus group meeting at a time that was convenient to the majority of the participants and communicated that to them by email. I requested that they complete a Demographic and Professional Profile form (Appendix 8), discussed further in chapter four) and return to me when they confirmed their intention to attend. I explained that the Consent (Appendix 6) and the Demographic and Professional forms would be securely retained along with the data from the focus group meetings and destroyed five years after completion of this thesis in accordance with the Otago Polytechnic Ethics approval.

3.8 The focus group meeting process

The following section describes the planning and process of the focus group meetings. The research method incorporated a single group of participants with two separate focus group meetings held four weeks apart.

3.8.1 The first focus group meeting

Krueger (1994) advises the facilitator should have a support person whose role is to take notes, ensure the equipment is working and to assist the facilitator with the refreshments. I decided to use the person who was going to transcribe the tape-recordings as my support

person. The transcriber was unknown to myself and the participants and was therefore independent from the research study. The transcriber assisted me with setting up the venue and the tape-recording equipment. The table used for the focus group meeting was rectangular and was comfortable for the eight participants and myself. The tape recorder was electrically hooked up and was placed in the centre of the table. A copy of the core written ground rules that had been agreed on by all participants at the time of consenting to participate was placed in front of each participant. We discussed the role the transcriber and they agreed to sign the consent form (Appendix 9) which protected confidentiality for the participants and the data. During the meeting the transcriber sat at a separate table behind the participants and this ensured that they were able to hear the full conversation.

The first focus group meeting was a face to face meeting with all eight participants attending. The participants who were required to travel for over an hour for the meeting phoned to say that due to poor weather they would arrive approximately thirty minutes late. I decided to delay the start of the meeting and offered the remaining participants refreshments while they exchanged greetings and informal conversation. No discussion relating to the topic was discussed as we waited for the remaining participants. On arrival the participants were offered refreshments and everyone was seated comfortably and the meeting was able to commence.

Once seated, I invited the participants to introduce themselves by name to the transcriber. This introduction acted as a voice check for the transcriber to identify the voices when she transcribed the tape-recording. I noted that two participants were quietly spoken whereas others were able to project their voices well. The seating was adjusted to enable the quieter spoken participants to sit closer to the tape recorder. As the facilitator, I opened the focus group meeting with an explanation of the research aims. I reminded the participants about the focus group core written ground rules and asked if they wanted to include any additional ground rules. No further ground rules were added.

Ninety minutes was allocated for the focus group meeting. Although the rural-based participants were late to arrive, I wanted to keep the full ninety minutes for the meeting. I thought this was important to allow full discussion on the topic. However due to the late start, the transcriber left immediately at the conclusion of the focus group meeting and we agreed to make contact within two days for further discussion and feedback. Several of the participants left at the conclusion with the remaining participants enjoying some camaraderie discussion and refreshments.

3.8.2 The format at the first focus group meeting

Krueger (1994) recommends a maximum of 12 questions are sufficient to generate enough data from focus groups. Using Krueger's (Krueger, 1994, 1998a) guide to asking focus group questions I wrote a plan to guide the first meeting and this plan is discussed in more depth in chapter four.

I purposively facilitated the group discussion by asking questions that were meant to elicit the participant's opinions (Jamieson & Mosel Williams, 2003; Krueger, 1998a; Waldegrave, 2003). The discussion flowed freely with the participants sharing their opinions and experiences, and although in general they agreed with each other, I encouraged them to offer any divergent opinions and experiences as they arose¹⁰.

Occasionally the discussion got off track, and I reiterated the question, or I asked a participant to 'hold their thoughts' when I considered that the participant was broaching on a subject that was intended for discussion later in the meeting. However, minimal intervention or guidance was needed and I took the role of a 'structured eavesdropper' (Kitzinger, 1995).

Krueger (1994; 1998a) counsels that some participants can dominate focus group discussions and I was conscious of this from previous experience of working with groups, both as a facilitator and being a group member. I did not feel that any one participant dominated the discussion however some participants were more vocal than others. I watched and listened for the less vocal participants and encouraged their participation when they indicated that they wanted to contribute. I also gave each participant the opportunity to add further information at the end of the meeting.

3.8.3 The second focus group meeting

All the participants were invited to attend the second focus group meetings. Two rural-based participants were on leave and were unavailable to attend however one gave me feedback via telephone. The feedback this participant offered was about rural-based PHN practice and the stigma of mental illness in rural areas. I wrote this feedback in my electronic journal and included it in the focus group meeting discussion. The remaining two rural-based participants and all city-based participants attended. This left six

¹⁰ An example of divergent opinions was when one participant asked if resilience meant making an intolerable situation tolerable for children, however the other participants did not agree with this.

participants for the second focus group meeting, which fulfilled the number of participants that were required (Krueger, 1994).

This meeting was held via teleconference. Teleconference is a technology that all participants are familiar. This focus group meeting was planned for sixty minutes and was planned to be followed immediately by a service-wide professional meeting, therefore the time was very tight with no allowance for delays.

I did not think I needed a support person for the second focus group meeting, as I planned to tape-record and transcribe it myself. However, I had inadvertently borrowed a transcribing machine, thinking that it functioned as a tape-recorder, nonetheless it did not and I was unable to access another tape-recording machine. This meant that the meeting started approximately ten minutes later than planned which meant that the remaining time was reduced to fifty minutes. I therefore kept the facilitation succinct and on task and did not allow the participants to go off track. Due to the lack of tape-recording equipment I took extensive notes during this meeting. I am unsure if my notes were as full as I anticipated, nevertheless I am confident that I captured the main points. On reflection, I should have invited a support person and I recommend a support person attend all focus group meetings.

The meeting started with a reminder of the focus group ground rules and the aims of the study were reiterated. Rather than using a defined plan as I had in the first focus group meeting, I had sent all the participants a five page analysis of the first focus group meeting and this was the basis of the discussion. I explained to the participants that the aim of the second meeting was to verify this analysis. The participants had a copy of the written analysis with them and we worked systematically through it. I clarified a number of issues that I thought needed expanding; in particular, discussion occurred about the impact of parental mental illness on the PHN workload.

In general all participants agreed that the content of the written analysis represented the first focus group meeting well. In particular the participants affirmed that the themes I had identified were indicative of the information shared in the focus group meeting. Minor changes were made to the script and an additional theme of advocacy was added by the participants. At the end of the meeting I read back some of the points raised and the participants agreed that these represented the conversation.

Unfortunately due to equipment failure the direct quotations provided in chapter four which discusses the analysis and interpretation of the focus group meetings in depth, are from the first focus group meeting only. However, to avoid inaccurate quotations, I have included comments from the second focus group meeting, but have not placed these in full quotation marks.

3.9 Data collection

Krueger (1998b) states that data collection and analysis occurs simultaneously. Analysis of the research data is a continuum, starting at the collection of raw data and finishing at recommendations. Krueger (1998b) provides a guide to analysing focus group data which he calls “The Analysis Continuum” and this is depicted in Table 2 below. There are four components to the “Analysis Continuum” which are; raw data, description, interpretation and recommendations.

<p><i>The Analysis Continuum</i></p> <p><i>Raw data-----Description-----Interpretation-----Recommendation</i></p>

Table 1. The Analysis Continuum (Krueger, 1998b, p. 27)

Each of the four components of ‘the analysis continuum’ is discussed individually throughout the remainder of the thesis. The following section discusses how the ‘raw data’ was captured and managed. Chapter four contains the ‘description’ and ‘interpretation’ of the data and ‘recommendations’ are presented in the fifth chapter.

3.9.1 Collection of the raw data

<p><i>The Analysis Continuum</i></p> <p><i>Raw data-----Description-----Interpretation-----Recommendation</i></p>

The collection of data took a number of mediums. Firstly, from the start of this project I kept an electronic reflexive journal (password protected) on the research process. This journal allowed me to continually critically reflect on the process and on my own knowledge, beliefs and values and how these influenced this research (Koch & Harrington, 1998). Secondly, I took full notes during both focus group meetings. In the first focus group meeting I used a form that allowed a half a page for note taking on each question for myself and for the transcriber to use to reinforce which participant was speaking. The notes and my journal formed the first part of the data analysis. Thirdly, the first focus group was

tape recorded and transcribed verbatim and these along with and journal notes and memory were used to generate the data for this research (Curtis & Redmond, 2007; Kitzinger & Barbour, 1999; Krueger, 1993, 1994). As already stated I was unable to record the second focus group meeting, and I took in-depth notes. These notes and my reflective journal were the only source of data available from the second focus group meeting where verification of the data was achieved.

3.10 Verification

Verification of data allows “another researcher to arrive at similar conclusions using available documents and raw data” (Krueger, 1994, p. 129). Verifiability for this research was maintained by establishing a trail of evidence (Rabiee, 2004) and through a rigorous analysis of the data.

3.10.1 Steps in verification of data

The first step in verifying the data for this research occurred at the end of both focus group meetings when I checked with the participants that all aspects of the topic had been discussed and gave all participants a final opportunity to make a statement confirming their perspective (Tuckett, 2005). The second step in verification arose from in-depth reflective notes written in my electronic diary at the conclusion of the first meeting which was compared with the transcription when analysing the data (Tuckett, 2005). The third step in verification involved a discussion of the impressions with the transcriber by telephone two days after the first focus group meeting. In general these impressions involved comparing notes that we took during the meeting which were similar and had very little difference. Finally an analysis of the first focus group meeting was written that included direct quotations. A covering letter (Appendix 10) was sent to the individual participants requesting that they read the analysis closely to verify the themes and accuracy of the intent of the quotations (Krueger, 1998b). I sent the analysis to the participants one month following the first focus group meeting. This analysis was the focus of the second focus group meeting. Verification was achieved by individual analysis and collectively by the participants at the second focus group meeting.

3.11 Trustworthiness of the research data

Credibility, transferability, dependability and confirmability are used to evaluate rigour in qualitative research (Denzin & Lincoln, 2000; Guba & Lincoln, 1989; Koch, 1994).

3.11.1 Credibility

Credibility refers to how the researcher describes and interprets their experience as a researcher and this requires self-awareness and journaling (Guba & Lincoln, 1989; Koch, 1994; Koch & Harrington, 1998 Tuckett, 2005). I was conscious of my dual role as the facilitator and the researcher in the focus group meetings. Credibility in qualitative research requires the researcher to maintain neutrality, and this was ensured in my role as the facilitator by encouraging the participants to talk openly and naturally; and as a researcher by maintaining my reflexive diary and having a systematic approach to the data collection, handling of the data and the data analysis (Krueger, 1998b) all of which has been described in this chapter.

3.11.2 Transferability

This refers to the research being able to be transferred to another context (Guba & Lincoln, 1989; Koch, 1994). Transferability is the corresponding concept of generalisability in quantitative research, with thick description required to enable other readers to 'fit' the findings into another context, and it is the reader who finds the research meaningful and applicable (Guba & Lincoln, 1989; Krueger, 1998b; Tuckett, 2005). I believe the findings of this research study are transferable to other PHNs practice in areas in N.Z; however this is something that others will ascertain and confirm. In particular these findings represent the personal health aspect of PHN practice and not the public/population aspect.

3.11.3 Dependability

Dependability in this research refers to the audit process (Koch, 1994). Guba and Lincoln (1989) state that this aspect of rigour is gained by having consistent data and that the researcher identifies clearly how the data was analysed. The audit process has been discussed and the data analysis is described in the following chapter.

3.11.4 Confirmability

Confirmability refers in this research to the process of verification and has been discussed above.

3.12 Conclusion

This chapter has discussed focus group methodology as the research method along with ethical approval and considerations. An overview of the design of the research is provided, including an explanation of the participant selection. Data collection and analysis is discussed and the chapter concludes with a discussion on the process of verification and trustworthiness of the data to provide rigour.

Chapter four describes the data in detail in two ways; a description of the first focus group meeting is provided, and this is followed by interpretation of the data which was verified by the participants of this study.

CHAPTER FOUR

Data analysis & Interpretation

4.1 Introduction

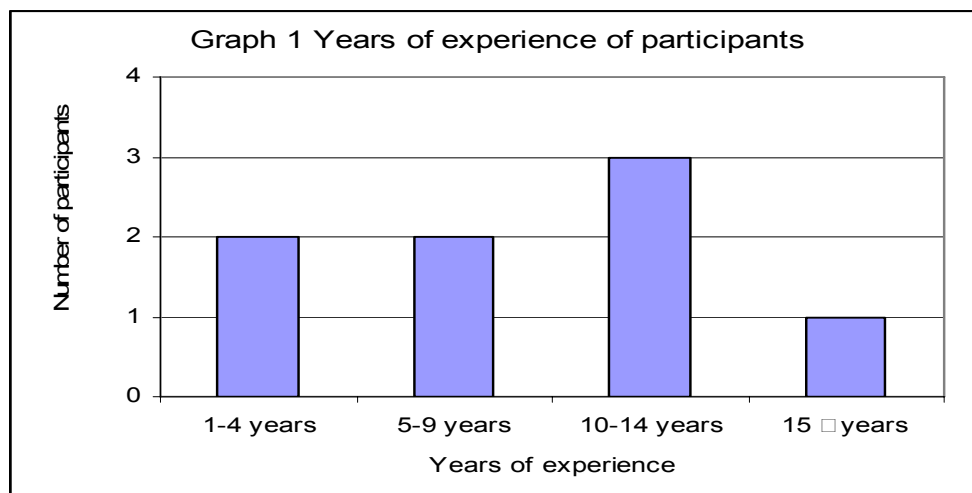
This chapter describes the analysis of the data in detail. Direct quotations from the participants are used. Following on from the description I identify and discuss the themes that emerged from the data analysis of the focus group meetings.

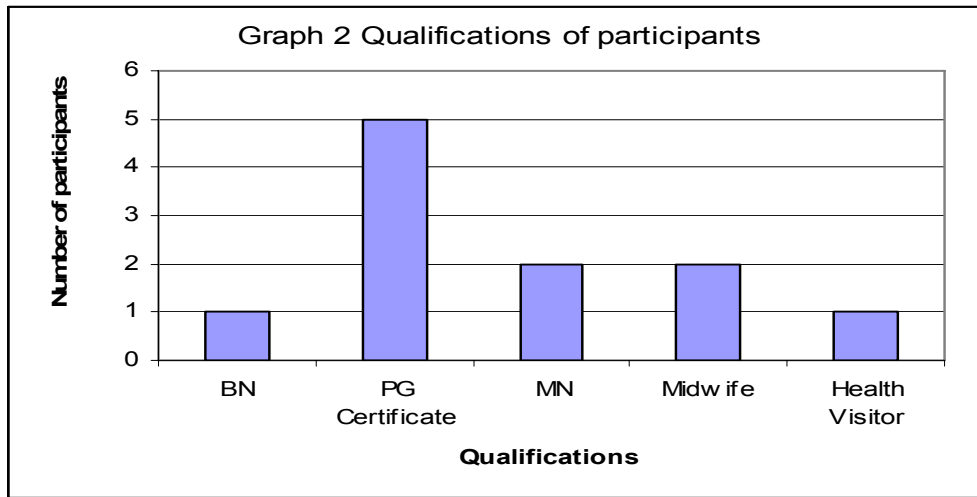
4.2 The participants

4.2.1 Demographic and professional profile of participants

The participants completed a Demographic and Professional Profile form (Appendix 9) when they agreed to participate in the focus group meetings. The purpose of this was twofold; firstly to gather information on the participants' ethnicity (see discussion on Ethical Considerations in chapter three), and secondly to gain information about the qualifications and experience of the participants, which helped to inform my interpretation of the data.

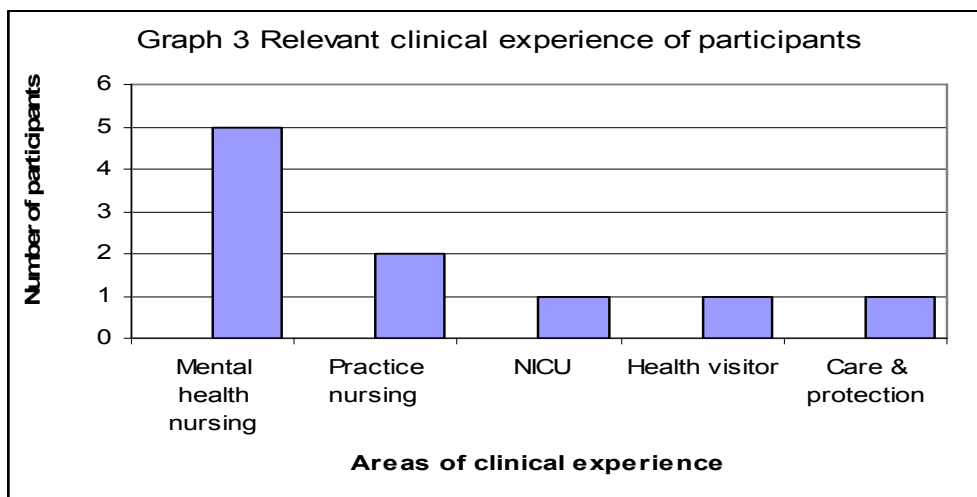
Graph 1 demonstrates that participants experience as PHNs ranged from a minimum of one year to a maximum of twenty years. The average experience of the participants working as a PHN was eight years, which indicates this is an area that nurses continue to work in for several years.





Graph 2 above shows the qualifications held by the participants. Of particular interest is that all participants except one have completed post-graduate education, with two holding Masters of Nursing degrees. Other qualifications include Bachelor of Nursing (1 participant), Registered Midwife (2 participants) and Registered Health Visitor (UK, 1 participant). Two of the participants said they held two qualifications, including; Master of Nursing/Health Visitor and Post Graduate Certificate/Midwife.

Graph 3 below shows relevant clinical experience (to the study topic) indicated by the participants were; mental health nursing, practice nursing, work with mentally ill and drug addicted parents in neonatal intensive care unit, Health Visitor, and participating as a Child Youth and Family Care and Protection resource panel member. The majority of participants identified having previously worked in the area of mental health; however they did not equate their previous experience with the knowledge required to practice as a PHN.



From this profile, it can be analysed that the experience of the participants is vast and varied indicating that PHNs bring a wide knowledge and skill-base to their practice. There is no specific qualification or training for PHN practice in NZ and the table above indicates the high skill level of PHNs in the participant's region. I believe this varied experience allowed the participants to talk from a strong knowledge base at the focus group meetings.

4.3 Description of the data

Using Krueger's (1998b) "The Analysis Continuum", the following section describes the data from the first focus group meeting.

<p><i>The Analysis Continuum</i></p> <p><i>Raw data-----Description-----Interpretation-----Recommendation</i></p>

The first focus group meeting provided me with forty-three pages of data, and as a new researcher I referred to Krueger (1994, 1998b) for guidance in managing the magnitude of the data. Krueger (1994, 1998b) recommends seven criteria as a framework for deciphering and interpreting the data;

- The words – the actual and the meanings of the words, including quotations. Being a member of the professional group the participants work in, I was able to understand and interpret the meanings of the words spoken.
- The context – of the responses that were triggered by the questions asked, or the tone and intensity of the participant's views.
- The internal consistency – I looked for changes of opinion as a result of the interaction of the participants.
- Frequency and extensiveness of the comments made – Some topics were discussed in more depth than others whilst some opinions were made by more than one participant.
- Intensity of comments – I looked for the topics that evoked considerable intensity from the participants rather than topics that did not.
- Specificity of responses – Comments that were drawn from personal experience were given more weight than ones that were not, that means that I gave precedence to practice over theory, and I have included a number of experiences that the participants talked about in the following section.
- Finding the 'big ideas' – this occurred more during the time of reflection and journal writing after the focus groups finished rather than during the meetings

themselves. However, there were some ‘big ideas’ that stood out to me during the meetings, for instance participants talked about ‘looking behind the obvious’.

With the above guide in mind, the data was reduced to a manageable size which allowed me to further deduce themes as they emerged in the systematic analysis (Krueger 1994, 1998b).

The following section describes the data from the first focus group meeting only and includes verbatim quotations. Using Krueger’s guide to focus group methodology (1994) I prepared the following plan (Table2) to guide me in the first focus group meeting. Krueger (1994) suggests that twelve open-ended questions is the ideal to generate the ideas and opinions of the participants. Sequencing of the questions is important to allow for maximum insight with the questions leading the participants into the topic initially giving each participant an opportunity to share their opinion and to listen to the opinion of the other participants (Krueger, 1994).

Type of question	Questions asked
Opening questions (seeks factual and not attitudinal information)	What do you mean by the terms mental health and mental illness? Do you think that the parental mental illness is impacting on your caseload?
Introductory questions (generates conversation only & aims to allow the participants to reflect on their experiences)	Do PHNs have a role in supporting children whose parents have a mental illness?
Transition questions (helps participants to envision the topic)	Have you had any experience with this?
Key questions (drives the research)	How do you identify when children are in need of extra support? What is the nature of this support? Do you think it is important to assess parent’s mental health? How do you do this?

<p>Concluding questions (brings closure and enables participants to reflect on topic)</p>	<p>Do you still hold that PHNs have a role in supporting children whose parents have a mental illness?</p> <p>Is there anything else you want to add?</p> <p>Can you think of any areas of education that might help your practice?</p> <p>Do you think that you can incorporate an assessment tool into your practice?</p>
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Table 2. Question plan for the first focus group meeting

4.3.1 Opening questions:

Opening questions are ‘round robin’ questions that introduce the topic and to open up discussion with the participants. They are often factual or yes/no questions and do not seek in-depth opinions. Once the preliminaries (introductions, ground rules and aims of the research) were completed, I asked the participants what the terms mental illness and mental health meant to them. The participant’s responses varied, starting with diagnosis (medical language) and then moving on to how mental illness affects parents (nursing language). The following quotations represent the conversation;

“I think about different levels of mental illness, ranging from mild depression that may be transient or not, and brought on by some event or events, and then ranging through to the sort of psychoses and other thing. Certainly a lot of clients, a proportion of the people who have psychosis, have other issues like drug abuse, alcohol abuse...other set of behaviours.”

“Mental health and mental illness is a continuum, with the signs and symptoms of mental illness seen as an extension of normal behaviour.”

“Mental illness is that most of the symptoms and signs are extensions of normal behaviour so, I think that would be a hard job for a lay person to decide when their friends are sad and when they, I don’t want to use the other word, depressed.”

“At some stage function comes into it doesn’t it. You get people that are sad, others that are depressed, or some that are grieving and you’ve got someone with clinical depression, and I think that somewhere we have to do an assessment of how it’s affecting function, whether they’re able to go to work or are they able to get up in the mornings, whether they’re able to feed the kids?”

Following this, a consensus was found by the participants that parental mental illness means to them as the ability to function as a parent, and a lack of functioning can be what alerts PHNs to a parent’s mental illness. One participant summed up this question with...

“When we become involved with a family, there is generally some level of dysfunction either with the child or with the parent.”

Once agreement was found on what mental illness meant to the participants, I asked the participants if they thought parental mental illness was having an impact on their workload. They all agreed saying that parental mental illness makes their work more complicated and is all-encompassing in their caseloads. The discussion was animated with all participants agreeing that parental mental illness has a significant impact on their caseload and is unpredictable compared to other aspects of their work for instance school visiting. In general PHNs work with the parents rather than with the children (primary school aged) and the discussion included meeting the parent's needs to ensure the needs of the children are met. The following quotations are examples of where the participants identified when they work with the parent's needs;

"Its quite pervasive in our work isn't it, and you realise that in fact until we get something happening for the parent, we're not going to get anywhere for the children at all."

"Because not only are we working around the issues for the child, we're working around the needs of the parent in order to meet the needs of the child."

"The issue I have with parents is with them actually acknowledging they've got issues themselves."

4.3.2 Introductory question:

Krueger (1994) explains that introductory questions should generate a conversation that aims to encourage the participants to reflect on their experiences. I asked the participants if they thought PHNs have a role in supporting children whose parents have a mental illness. Introductory questions are not critical to the analysis and on reflection this question should have been included in the key question section as the discussion on the PHN role persisted throughout the focus group meeting. Issues that were discussed included identifying children whose parents are mentally unwell and working with the parent's problems (rather than working directly with the child), and these are identified throughout the interpretation of the data.

4.3.3 Transition question:

Transition questions (Krueger, 1994) help participants to envision the topic and moves the conversation from broad aspects to more narrow focused aspects of the topic being researched. I asked the participants about their own experiences with working with a parent with a mental illness. Again, when I reflected on this question, I think it was a poorly phrased question as all participants had already stated they have been involved with clients whose parents have a mental illness. However, the participants described their experience

in recognising that children whose parents have a mental illness present with common issues like poor behaviour, and these become a conduit for PHN involvement. An example was given by one participant...

“...a child was a victim of a bullying incident at school, and I was asked to visit them. I went to visit thinking that I don’t know what to expect here. I got there and Mum was still in her dressing gown – it was close to lunch time. So we talked about what was going on, and it turns out that they had shifted here in the last year, and Mum had a known mental health problem with anxiety and depression, but when they had shifted here, she hadn’t been transferred into the [mental health] system, so there had been no support or follow up for her condition apart from her GP’s care; and it had been missed completely and the outcome was that this child had been the victim of an incident completely separate from his mother’s, but he was also exhibiting signs, by arriving to school hungry and not doing homework, and so that [parental mental illness] actually did impact on him in the way he was at school, and consequently there’s quite a lot of work going with this family to get supports in place and things to happen. And nobody knew, even the school had no idea that this was happening.”

4.3.4 Key questions:

Key questions are the driving force of the focus group meetings with Krueger (1994) recommending between two and five questions being asked in this section. The first key question I asked the participants was how they identify when children are in need of extra support from the PHN. All participants identified that working with schools was a pivotal role for PHNs, because schools are the main venue for accessing the majority of client referrals (Lynes, 2003). One participant said...

“And you hear what’s happening with the children at school, and you realise there is an issue [at home].”

As noted in the literature review, children living with a parent with a mental illness may come to the attention of the PHN when the school notices a change in the child’s behaviour, or there may be other causes of concerns, for instance poor or late attendance, truancy and wearing inappropriate clothing to school (Couzins, 1999). Additionally, teachers may discuss unexplained concerns about a child with the PHN. In these instances the PHN becomes a ‘sounding board’ for school staff where the PHN may offer advice on what the most appropriate action is. This role is commonly called ‘advice and consultancy’. An example of this is when a participant said...

“Our role as about advice and consultancy, about where to next or whether it’s about coming involved and helping [the client] access the right help...it’s really about advocating for the needs of the child”

PHNs work in geographic regions covering several schools (it can be as many as fifteen schools for a full time equivalent), and this allows the PHN to monitor children who attend several schools over a course of several years, for instance one participant said...

“They’re [the children] consistently late or absent. Now, I happen to know from my contact at another school that there are mental health issues going on with these children’s mother, and clearly it has an impact because they’re not being schooled. They are dressed inappropriately for the weather – midriff bearing on frosty morning...there’s that element of denial, but I’m surmising that these children are caring for themselves largely.”

Earlier the participants described parental mental illness in terms of the ability to function as a parent and a parent’s lack of functioning may be reflected in a child’s behaviour which the PHN might consider as an indicator of parental mental illness.

“Noticing the obvious or noticing what presents, and talking to that, and I don’t know that you have to have mental health background to assess where the children’s needs are being met, and or, parents functioning, you know, are they able to get up in the morning, are they able to understand what’s being told to them, are they, able to get to work, those kind of basic things that... that may be symptoms of underlying mental health stuff.”

Another participant identified that what appears on the initial presentation as a minor issue may result in the PHN taking a management and coordination role for the child’s needs, and described the following situation ...

“It was not until that child had a relatively minor incident in school that I had a chance to talk to the mother and suddenly became aware of the need to co-ordinate all of this child’s care; that was huge. And it [involved] co-ordinating multiple disciplines of health, education, welfare and childcare.”

When PHNs work in schools, they are constantly making observations of those around them, and this observatory role allows them to see children’s responses which might be a catalyst for nurses to become involved. One participant described an occasion when she observed an interaction between a teacher and a child...

“The child was at the window with the teacher. The teacher said to that child, ‘Oh, there’s your dad’. The child was all smiles and grins and then she said ‘Oh, he’s got your mum with him and the child’s face went totally mask-like. I was able to say to them, ‘It might be a good idea to go and see the family.’ The impact on that child seeing her mother because she had been away for quite a long time, she’d been in hospital ..., so that I thought, that told me everything really about what it is like living in that house at times.”

Another participant described the following scenario when they observed a child.

“They were what [another participant] described before as ‘closed face.’ When we had the vaccination campaign (MeNZB) I went to get the oldest girl from the class and I said ‘mum’s here’ and her face just ‘shut off,’ she was horrified because she didn’t know what state her mother would be in.”

The participants then talked about the value in home visiting. Working in homes can give the PHN information about a child that the school may not know and can allow the PHNs to facilitate support for children at school (Cohen & Reutter, 2007). One participant reflected on an occasion when they home visited for what seemed like a reasonably straight forward school concern and recognised that the parent had a mental illness.

“The child who is not achieving, and the teacher say’s ‘I’m sure this child could be doing better than they are’, and you go home and find there’s all this going on at home...”

Furthermore, PHNs have a liaison role that allows them to move freely between family, home, and school and the health system (Lynes, 2003). One participant gave the following quotation which I thought captured the impact that home visiting has for PHNs.

“Our role includes supporting teachers, to support families. They don’t recognise that the difficulties that the children may have at home. I heard a discussion in a staffroom one day about a child who was going to be forbidden to go on a school trip because she hadn’t behaved well enough. Now I happen to know that in that family she hadn’t had a bed for the last three weeks because her drunk sister had been home causing havoc, and pinching her bed, and she just slept wherever she could, and it was important that she go on this trip.”

The conversation above was animated with all participants engaged and expressing their opinion, however I realised that to complete the focus group plan I needed to keep the conversation moving. I then asked what the nature of the support was that PHNs offered to children. On reflection, this question was also poorly phrased, with participants’ description of their support being included throughout the focus group meeting. However, the participants identified the following list of interventions as inclusive of their role; advice and consultancy for schools, engaging with clients for other agencies, empowering parents to make own appointments, providing scaffolding so people can go from strength to strength, referral to other services for respite care and to help develop resilience for instance Children’s Health Camp. The following quotations are examples of these interventions;

“I often feel that almost that we are engaging for other agencies. We’re doing the engagement for them, you know, doing the process, because they [the parent] actually haven’t got time, or the knowledge or desire, or whatever. They [the mental health services] want people to meet their criteria at the door, be there for the

appointment, but sometimes there's a whole lot of work done by a public health nurse or somebody else to make sure that appointment happens."

"I'll make an appointment with somebody...I'll phone someone, but I also follow up with visits to say, you know, "Now you know it's [appointments] on Thursday" "Have you got a car?" "Do you need me to take you" "Are you sure you don't want me to take you?", and "No, No, I can manage". And that's fine, and they nearly always go."

"Health Camp as an intervention, sometimes, referrals I make provide for that child to have respite from the family."

"Well we have the children who are ADHD, who are all over the place, they've got no boundaries, no rules at home, you've got a mother who simply cannot get out of her own way to do anything with the children at all because she's feeling so low and so tired, or not motivated anyway, and I [refer to] health camps for some of these children, and those four week they have at the health camp [allow the] children [to] blossom and you almost see them like little balloons become deflated when they go home again because things have not changed."

After identifying the interventions I then asked the participants if they thought it was important to assess parent's mental health. All participants agreed that assessing parental mental health is an important aspect of holistic nursing care for children. The focus of the PHN intervention becomes the parent rather than the child; and the nurse's role involves assessing the needs as a parent and their ability to function as a parent. A participant considered that to make an assessment of a parent's mental health requires the PHN to have very good communication skills. The PHN engages with the parent developing a relationship of trust in order to make an accurate assessment of the parent's mental health (Gallaher, 1999) however another participant noted that sometimes this is difficult...

"I could possibly pick up on obvious mental health [problems], but if the parent didn't come out with the not so obvious, I don't think I have the skills sometimes to pick that up".

Other factors in the nurse's assessment includes parental intellectual capacity/disability, family and intimate partner violence and drug and alcohol addiction, with several participants saying they include addiction as a mental illness. One participant described...

"...mainly drugs and alcohol with the parents, particularly with 'P' which also creates tremendous mental health issues, but just with the... effect on the children ... if they do turn up to school, they're very much having to fend for themselves; lucky if they get any breakfast, dressed inappropriately for the school day, if they are turning up at all. Unfortunately, having parental role models of actually seeing parents drink alcohol, staying in bed till past lunch time, having to cook all the meals, because, I mean, they were fending for themselves, and also, almost having a caring role for the parents because they were in charge of the house and the parents incapacitated

either by the alcohol, the drugs or the actual effects of the drugs that was having on their mental health”.

Another participant reflected on the needs of the parent...

“I asked a parent ‘who looks after you?’, and her answer was ‘nobody’. And I said, ‘well what do you like to do ... what did you used to do?’ and she said ‘I used to go for walks with my daughter’. I said, ‘have you thought about trying that again’. And I went to visit her three weeks later and she said, ‘look, I got onto that – I’ve been going for walks and its great’ and her mood had just lightened. So something that I thought was pretty simple had such a big impact on her, so that in fact helps support her son as well.”

I then asked the participants how they assess parent’s mental health, in particular if they used a particular screening process or a mood assessment tool, an example is using a scale of 1-10 to gauge their client’s mood. Some participants use questions that help to quantify or gauge the depth, severity and longevity of the parent’s illness and this assists them to be objective in their nursing assessment and also allows them to hear the parents perspective. The responses include participants asking clients...

“I then said to her, ‘and how’s your health, and do you have any health issues’? I actually asked her; ‘have you ever been depressed?’ And she looked at me and smiled, and said ‘I’ve been in bed for two months’.”

“You seem a bit down. How are you?”

“What’s the best thing that’s happened to you in the last few days, what’s the worst thing that’s happened?”

4.3.5 Concluding questions:

Concluding questions (Krueger, 1994) bring the discussion to a closure and enables the participants to reflect on their previous comments. They ask participants to make a final statement and are usually in a round robin manner. I asked the participants if they still hold that PHNs have a role in supporting children whose parents have a mental illness and all participants strongly affirmed this. One participant said...

“We’re the first person that may have listened to that student or person [in self referral clinics with adolescents]...so I think actually for children, that’s a big deal to be listened to, because often their parents are busy, or they just don’t think they can talk to their parents because it’s, something they’re not comfortable with. That’s I think a huge asset to our role.”

I was aware of the time restrictions for the participants who were required to travel and I drew the focus group meeting to a close by asking the participants if there was anything

else they wanted to add. This question gave the individual participants an opportunity to add and verify any opinions they had. I sought eye contact with all participants encouraging individual comments. Some participants reiterated that this area of their work was difficult, and that nursing interventions can be more long-term than others with health gains being small.

Finally, there was a further question on the focus group meeting plan regarding further education needs specific to this area of nursing practice, but with time drawing to a close I decided to leave this question for the second focus group meeting. The meeting closed on time and on a positive note with participants saying that they felt this aspect of their work is important and they valued the opportunity to express their thoughts and opinions.

At the conclusion of the first focus group meeting I wrote my interpretations of the meeting immediately in my reflexive journal and this formed the initial part of the interpretation of the data analysis. The transcriber returned the forty-three page transcription to me on compact disc within a week of the first focus group meeting and the analysis and interpretation of the transcriptions began.

4.4 Process of analysing the data

Krueger (1994) states that interpretation of data starts immediately at the end of the focus group meeting and is the most complex aspect of the Analysis Continuum. It builds on the descriptive statements made in the focus group meetings and provides a clearer understanding to the intent of the participants.

<i>The Analysis Continuum</i>			
<i>Raw data</i>	<i>-----Description</i>	<i>-----Interpretation</i>	<i>-----Recommendation</i>

The following section discusses the systematic approach I took to interpret the data. I identify the themes, how I communicated this with the participants and verification of the themes at the second focus group meeting.

4.4.1 Systematic Analysis approach

A systematic analysis approach was used to interpret the data (Krueger, 1998b). I listened to the tape-recording initially separately and then simultaneously while reading the transcript. This process of reading and listening to the transcripts simultaneously occurred several times and allowed me to become immersed in the data (Fereday & Muir-Cochrane, 2006; Jamieson & Mosel Williams, 2003).

I made several electronic copies of the transcript with the first copy being kept unchanged as the original (Rabiee, 2004). On the second copy I organised the transcript into two halves longitudinally. On one side of the page, I wrote a one-two word code on a line-by-line basis. At the end of the line-by-line analysis I was able to identify several themes that emerged from the data (Krueger, 1994). On the third electronic copy I highlighted important quotations that represented the identified themes (Fereday & Muir-Cochrane, 2006). In the final systematic stage, I colour coded the themes and cut and pasted them electronically onto a fourth copy which allowed me to compare and contrast the data. Krueger (1998) refers to this type of coding as axial coding where the data is fractured and reassembled in a new way. The themes that emerged from the first focus group are as follows;

- Assessment
- Advocacy
- Walking the line between education and health
- Models of practice
- Barriers to practice
- Rural/urban practice differences

Following the axial coding I wrote a five-page analysis of my interpretation of the first focus group meeting including the identified themes. The analysis was sent to all participants both electronically and in a hard-copy form. A covering letter (Appendix 10) requested the participants read the analysis and consider if it captured the meaning of the conversation and asked them to consider if they agreed to retain any quotations that they recognised as their own. The analysis included a position statement that reflected what I considered was apparent from the data. That is, in general PHNs do not work directly with children in a therapeutic manner in schools, rather the contact PHNs have with children is either through their education role¹¹ in schools, in an observatory role, or when contact is made in a casual and non-purposive manner when the PHN is in the school environment. Subsequently in the written summary I made an opening statement which read;

It is important to start this analysis with a clear statement that PHNs practice does not normally include working directly with children; rather they work with and alongside parents; and it is their practice when working with parents as guardians of children that nurses have a role in supporting children. An exception to this practice is in self-referral clinics, where nurses work directly with young people, and as part of making

¹¹ PHNs provide education to children in schools on subjects included in the school health curriculum, for instance, immunisation, hygiene, pubertal changes and others. This is one of the public/population health roles for PHNs (refer to Section 1.5.5).

an assessment of that young person, are more likely to assess the child or young person's mental health, rather than assessing their parent's health. However the HEADSS assessment does give the opportunity for nurses to ask about the home life of young people.

HEADSS is an accepted tool for assessing adolescents and is an acronym for home, education, alcohol and drugs, sexuality and safety including suicide (Goldenring & Cohen 1988). This statement was affirmed by the participants, with a slight change to the wording to infer that PHNs work with **families** rather than specifically with parents or children, yet the focus remains on the children. This confirmation is consistent with the literature and provides additional verification and credibility in the research project (Section 3.12 & 3.13). After verification of this statement, the themes identified in the analysis were discussed.

The following discussion of the themes includes full double quotations from the first focus group meeting, and also single quotation marks for the second focus group meeting. The second focus group meeting uses single parenthesis (and italicised) only because it was not tape-recorded and although I took full notes which included quotations from the participants the quotations may not be completely accurate. However I believe that these do represent the meaning of the participants.

4.5 Themes arising from the data analysis

Through immersion of the data I identified that the two primary roles for PHNs while supporting children who live with a parent with a mental illness are assessment and advocacy which will be discussed separately and in more depth in Chapter five. The remaining four themes that were derived from the data are intertwined with the roles of assessment and advocacy.

The following section includes full quotations from the first focus group meeting that are indicative of these roles, and single quotation marks from the second focus group meeting that verified the themes.

4.5.1 Assessment

Interpretation of the data identified that the PHN role in supporting children who live with a mentally unwell parent is firmly based in holism and health promoting practice, both of which will be discussed further in section 4.5.4. Holism in this case refers to where the needs of the individual and the family as a whole are assessed and health promoting

practice is the main process of making this assessment. Furthermore, in order to make appropriate assessments a participant in the second focus group meeting said that; *'PHNs need good communication skills to develop trust so they can engage with clients'* or as Gallaher (1999) suggests, "the assessment process emerged as one requiring a high level of sensitivity, because the nurses were often dealing with vulnerable people at vulnerable times in their lives" (p.20). An example of this sensitivity was provided by a participant when they said that they were fully aware of their own perceptions and the importance of not allowing them to pervade their assessment...

"I think we are people that leave our origins and our prejudices and things behind. We know what they are, we know ourselves really well, we'll go in there and make an unbiased assessment and part of that of course, is about a mental health issue, or is it just a kid with head lice or is it just..."

This same participant continued by talking about being objective with their assessment and asks themselves ...

"Who has the problem? Whether it's everyone else's problem or whether it's theirs for example – where you have a parent with a mental illness, and everything is the kid's fault. Identifying it [insight] can be just noting its absence"

The assessment of parental mental illness varies as discussed earlier in this chapter (see Section 4.3.4). An example of this is when a participant said they look for personal attributes in clients as part of their assessment and describes their ability to engage with their client;

"People's ability to laugh at their situation. Have you ever noticed how some people say they've had the most terrible day, everything has gone wrong, and then you'll laugh together about it, and somehow it helps, you know somehow that helps, and people have an individual capacity for that. And I found to me, it's a common feature, and I guess its based on my own experience and observations over the years, but people that lack that ability to be able to laugh at themselves and to laugh at their issues, it's usually a battle for them, you know. I think it's something you can work on with them."

Another participant suggested...

"If it's an indication, like if they've said that they feel flattened and low, I'll ask, 'When was the last time you felt differently, and if you had to kind of sum up how you're feeling at this point in time', and I actually do find that scale [1-10] really useful because it helps them quantify...and then it gives you something to measure against."

This same participant acknowledged that some issues that the PHN faces can not always be taken as what is initially presented and they need to ...

“...look behind the obvious. Like the child that you become aware of because of their bullying... looking at what’s actually behind that, and not taking it at face value that this is a naughty child...if the root cause is about mental health in the parental role, then my instinct is to try and work with that ... because in turn, that flows onto the kids.”

Another participant picked up on this phrase ‘look behind the obvious’ saying...

“You said, look beyond the obvious... and that’s how we sometimes find out that a child who’s behaviour is problematic for people, is when we start to look behind the front [and that is when] we find parents’ mental health is affecting the children, and we can, [then] start to identify the strengths of the children or perhaps when we identify that that child has got particular needs in terms of his parental care that we then start to look at the resilience.”

Gallaher (1999) describes this aspect of the PHNs work with families as “watchful vigilance” (p. 21) where nurses form and build relationships with their clients over time.

An example of this is when one participant said...

“I actually had a young lad who was showing behaviour issues and problems at school, and when I did a home visit, his mother had been in bed for two months. So you can guess where I spent the next two months just quietly calling in there and talking about parenting.”

Hartrick Doane and Varcoe (2006) maintain the importance identifying the ‘hard spots’ with families and suggests that having a commitment to relational nursing practice will enable the family to make and maintain change. Specific to the study topic, relational nursing practice means being honest, authentic and relational rather than blaming and disempowering when recognising parental mental illness as an issue that affects children (Hartrick Doane, 2002; Hartrick Doane & Varcoe, 2006). A participant said...

“One of the things mind that comes into this is, about empowering these parents to try to make their own appointments, like getting them to go to the facility and describe how they are, and talk about their history with them so that they can get the appointment themselves, because we do find they are more likely to keep to their appointments than if we try to facilitate it, and anyway, it’s about the practice too, isn’t it?”

4.5.2 Advocacy

I identified from the data from the first focus group meeting that advocacy was a further primary role for PHNs, and as the researcher I made the following comment to the participants at the second focus group meeting;

‘The impact on the child can be the indicator for nurses to ask ‘what is going on here?’, and this can lead to an advocacy role that nurses willingly accept.’

The participants all agreed that advocacy was a ‘*big part of the job*’. One participant identified that ‘*advocacy was an aspect of supporting children*’ who live with a parent with a mental illness, and another participant said that ‘*maintaining paramountcy of the child is the key to this*’. In this context, advocacy means acting as an advocate or pleading for the rights of children who live with a parent with a mental illness and can be at the individual personal level and/or at the political level.

The PHN role in personal advocacy encompasses their advice and consultancy role with schools (discussed on page 46). The participants identified this as an essential aspect of advocating for the needs of the children. Advocacy for children within the school context includes ensuring that the school is aware of the wider situation affecting the child (with parental consent and within the limits of privacy), and that appropriate support is in place. One participant gave an example of when the PHN identified that advocacy for a child was required;

“I can think of more than one instance, where the children were quiet, but not obviously damaged or exhibiting terrible behaviours, but there was some suspicion about mum and the day that she arrived to go on a school trip completely drunk, that was the trigger for the school to actually finally do something about it; but they weren’t willing to do that themselves. And you know my role really was supporting them to take action, and initially we did it together. That was actually a real affirmation for them, and my role was supporting the family, but also supporting the school.”

4.5.3 Walking the line between health and education

PHNs work with schools and school communities and hence travel through the mire of the complexity of the education system. PHNs are not members of the school staff and are considered a visitor and a support person to the school (Lynes, 2005). For PHNs to be effective in the school system they need to have an understanding of how schools operate and at the same time maintain a health focus. Hence PHNs need to simultaneously ‘talk the education talk’ and ‘talk the health talk’ (Lynes, 2003).

“Or they sometimes say ‘that’s health, and I’m education and you’re health’ but ... we don’t actually separate them. I think a good point about supporting [schools] is providing that supervisory role. And they often think in a holistic way too, but they’re in an institution like a school that think in education, but they bounce things off you as ‘phew, here’s someone who you know has that social like mind and that’s part of it too.’”

Ultimately however, it is through their role in schools that PHNs are able to advocate for children who live with a mentally ill parent. An example of the PHNs role in advocating for children was provided when a participant reflected on an incident around a child who was reported to have been bullied at school.

“I think we would follow that through the school processes you know? What are the school processes around that... I think we have the capacity to go to the school and work within their systems, and say “Look, can we support you, did you know this was happening...or help the students to quote the school policy to their teacher, whether that works, or gets them anywhere, I don’t know.”

The PHN role in schools can include providing an advisory role to teachers as one participant described the teachers not understanding the full implications of the environmental factors for a child who was living with a mentally unwell parent and described...

“Early on in my role as a PHN, I became aware that we end up filling a supervisory role, clinical supervisory role for teachers, because they have no similar kind of process, and it’s about looking at the bigger picture and helping teachers to see outside of the classroom.”

4.5.4 Models of practice

The participants identified several theoretical models that guided their practice and these are as follows.

4.5.4(i) Holism

All participants agreed that PHNs look at the family as a whole. Holism as a model was referred to several times by participants with the child seen as one person in a family and the not just as a child with a problem. This meant that they were often dealing with a parent’s mental illness and the effects the illness has on the child. The following quotations are examples of how the participants work holistically;

“I think it goes back to, that the child is not a unit, isolated from the family, and you look at the whānau¹² concept, you’ve got to look at the family as a whole and their extended family.”

“If you can take a more holistic approach to a family as in treating them as a unit, in the whole, and not just a piecemeal bit of ‘I’m here for bedwetting’; or ‘I’m here for fears’, or you know, whatever, that that is far more effective and useful. Treating a family as a whole unit and not just diving into a bit of it.”

¹² Whanāu is the Māori term for family. Māori do not restrict family to those members living in the home, rather it refers more to the whakapapa or ancestral links (Adair & Dixon, 1998)

4.5.4(ii) Health promoting nursing practice

As explained in chapter one, health promoting nursing practice is a four-step model and is the accepted framework for PHNs (Hartrick et al., 1994, Hartrick & Lindsey, 1995; McDrury & Lindsey, 2002). The first three steps of listening, participatory dialogue, critical questions involves the identification of risk factors and the assessment of the child, parent and family. The fourth step of envisaging action and making positive change includes advocacy (at an individual and political level) for the child and family. The participants acknowledged that health promoting practice ensures the nursing assessment is objective with one participant saying...

“I think an important part of health promoting practice is to allow people [clients] to make their own judgements and own view of their issues. It puts you in an interpretive role, but you listen very much to what the people are telling you, and that includes the teacher, and parents, kids..., what they’re telling you. We keep your own stuff out of it as much as you can. Of course you’re entitled and allowed to have an opinion, but there’s a subjective-objective assessment in planning. I mean at the end of it, your summing up needs to be objective, and... not disempowering, or disenfranchising of the people, so that if a self referral is best, you know for their sakes, you’ve got better control of the problems. And if they have the good ideas, then you’re probably working in the right way.”

The following quotation describes how a participant applies the health promoting model to their practice;

“Health promoting practice framework...valuing that they are the experts in their experience, and, adding to that our expert experience and our own specialty knowledge, and combining that to come up with a common goal. Acknowledging that, their reality is valid.”

Being accurate in making an assessment of children and their family’s needs is important, with identifying appropriate intervention/s as being a vital aspect of the assessment process. With health promoting practice, identifying the interventions is the fourth step or envisaging action for change (Hartrick, et al., 1994; Hartrick & Lindsey, 1995). One participant said...

“We are often the first ones to be called; we like to try to get it right because a part of the engagement is to do your referral well, make sure you get them into the right place straight off so that they get to re-engage quite quickly with the right person.”

4.5.4(iii) Resilience

The participants were very familiar with the theory of resilience (see Section 2.3.2 and 2.3.3). They understood this theory to mean that their role is to help the child to make positive choices so they can cope with the stressors in their life. Participants said...

“What I mean is that you are building the child’s self esteem so that they’re able to make some choices for themselves that are good for them...so that they can be, can resist getting knocks at school.”

“You are building the child’s self esteem so that they’re able to perhaps make some choices for themselves that are good for them”.

“So that they can cope in what may be a less than ideal world.”

“[Health Camp] can try and get some provision for that child to be stronger....to build resilience and advocate for them. And while they’re there, they can attend the Four Seasons programme, they can attend self esteem programmes and you can try and get some provision for that child to respond.”

“I think that, I see two children or families, and they both have had similar situations and one of them of them has gained, you know sort of grown from it if you like, and the other has not... it’s affected them differently.”

One participant mused that resilience is a way of finding the child’s strengths,

“I think if you rephrase it for these young people; if they could have another perception and actually, yes I [the child] am very tolerant and protective, and it makes me more accepting of other people, and ...it’s that big global stuff again, you know, it’s about helping that young person to say that you have an important position in society...”

However another participant responded with an alternative theory which the other participants disagreed with...

“Although I struggle with that, because, I, had the words of one of our colleagues from child protection ring in my ears saying, you know, is resiliency about making an intolerable situation tolerable for a child. Is this about making a child cope with an intolerable situation? And I struggle with that sometimes.”

4.5.5 Barriers to practice

Participants identified a number of barriers to their practice. The first barrier identified was organisational. The participants referred to documentation, particularly statistic collection not reflecting the PHNs role in primary mental health. Currently the national PHN service contract (Ministry of Health, 2005) is for the delivery of services to children and young people under eighteen years of age; however this research has clearly identified that PHNs work with children and families, and the information systems do not include this aspect of

their work. This is problematic internationally with a lack of systematic information collection tools that accurately reflects this aspect of the scope of PHN practice being available (Grumbach, Miller, Mertz & Finocchio, 2004). This is captured by the participants in the following comments;

“I think our statistics don’t reflect our role in mental health. No way. I mean how often we put mental health in our stats? It’s not a number, it’s not needed.... We don’t have a code for it.”

“I’m thinking of one case in particular where the child’s issue, is actually just not an issue but, I’ve got a separate lot of notes on the mother, because I have to record what it is that I’m doing, and it goes down in our statistics as parenting or management and co-ordination.”

“I actually find that a difficulty with our work is that we are too strongly structured. I mean, I sometimes see a child and the issues are with the parents, but one can’t put that down [on statistic reporting] in the sense that really the parent is your client, but you have to have the child as our client because that is what our contract says.”

The second barrier that was identified by the participants was regarding the criteria for referrals to the mental health services. With the increase in mental health needs in children, Child and Adolescent Mental Health Services (CAMHS) have redefined their service criteria to moderate to severe mental health. This has resulted in primary health services, like PHNs having a greater role in primary mental health with children and families with mild-moderate mental health problems (Lowenhoff, 2004; MacDonald et al., 2004, Secker et al., 1999). I believe this is an area for further research. One participant talked about the increase of mental illness in the community;

“I think we’re gate-keeping a lot more...I do believe now there’s more crises situations where there’s other agencies pulling their boundaries back... they [families where mental illness is evident] go into the too hard basket, so you [the PHN] hold onto the family. That is impacting a lot.”

An adjunct to this barrier is the poor communication between primary and secondary mental health services, with communication being seen as ‘one way’. One participant explained...

“Something that is also an issue for me, [is] when I refer people to the mental health team, ... I don’t ever get any feedback from that, I don’t get anything from mental health, saying, ‘I saw Mrs Jones, and at this stage, you know I feel she is coping’, or ‘I saw her for three months and I’ve discharged her now.’ Because the assumption is that you hand over to them and your problem has gone, but sometimes it hasn’t gone. Or you can leave it with them for a period that you send them, but then someone needs to go back down the track as [another participant] was saying and just touch base and make sure that things are still okay”.

A further comment was made, which all participants agreed with;

“I think also, the state of the support agencies that we sometimes refer to - you say to a parent ‘ there’s a long waiting list’, that just automatically deflates them and I think, I don’t know how you can change that but, that also has an effect on mental health as well I think, mental illness”.

With the increase of mental illness in the community, alongside the tightening of the referral criteria to CAMHS, the participants said they felt they were working with more mental health issues now than they were in the past. Yet PHNs are not recognised for this, because, as one participant identified they are not mental health workers, saying; *“others ask, what’s mental health got to do with public health nursing?”* Yet the literature claims primary health nurses have an increasing role with adults and children with mild-moderate mental health issues (Cohen & Reutter, 2007; Devlin & O’Brien, 1999; Foster et al., 2004/5; Honeyman, 2007; Lowenhoff, 2004, MacDonald et al., 2004; Nicholson & Clayfield, 2004; Secker et al., 1999).

The UK has a four tier system¹³ for CAMHS with Tier 1 being primary health care professionals including PHNs, practice nurses, GPs and social workers. The role of Tier 1 professionals is health promotion and to identify and manage less severe problems in children and young people and to refer on to professionals in Tier 2 and 3 for further intervention (Honeyman, 2007; MacDonald et al., 2004). Throughout this process several agencies or professionals may be working with a child or family at any one time. However, Devlin and O’Brien (1999) suggest that agencies working with the same families are often working in isolation and they call for better case co-ordination and interagency communication. Case co-ordination would enable effective advocacy for all members of the family and would be enhanced through respectful working partnerships. However working with other agencies isn’t always smooth sailing with one participant saying...

“I’ve had calls from one of the mental health agencies in town saying, “Why is this patient not here?” Well I’ve done as much as I can short of physically picking them up, but I want them [the client] to take some responsibility”.

A further barrier to effective PHN practice identified by the participants was a perceived gap in services, in particular the lack of a systematic communication process between general practitioners, adult mental health services and PHNs. This is highlighted when

¹³ Tier 1 is as stated in the text, Tier 2 is specialists working in general practice, including mental health workers and psychologists; Tier 3 includes a multidisciplinary team with psychiatrists, psychologists, therapists and others, whereas Tier 4 is specialist and inpatient services (Honeyman, 2007; MacDonald, et al., 2004).

families are transient and PHNs identify there are mental health concerns in the family.

One participant who has worked in the UK noted that,

“It appears to me that there is a wee gap somewhere in the network that [the PHN] is alerted by teachers who are concerned about the way that children are turning up at school or actually missing school, or people moving into the area; that there isn’t a network with GPs, or having to alert us that there are families moving in...That under the U.K. system [the health visitors] would be notified by the GP that this family have now arrived, and you could make contact and see whether they’re attending school, rather than having to wait for the school to notify us...and perhaps the school are not even aware that there are mental health issues within the family. That still to me, sort of seems an area where we’re not getting the right communication.”

4.5.6 Rural/urban practice differences

The focus group discussions identified a perceived difference between rural and urban PHN practice. A rural-based participant said that rural communities are unsure how to handle mental illness, so the PHN role becomes one of coordination and referral for the parent rather than the child.

“We don’t have many services in our community,[so] that I will get a referral that’s really nothing to do with me from some member of the community, because they see me as an ‘expert health person’ for want of a better term, and they’ll ring me up and tell me about some person who’s either psychotic, or having some sort of problems in the community, and a lot of community people can’t deal with that. If it’s a broken leg, or you know, Mary’s hurt her shoulder, they know what to do; but when people have mental health problems they don’t, and so I am the first point of call occasionally, and my role is to actually co-ordinate, refer on to the most appropriate person; and I presume that doesn’t happen in bigger places...”

Ross (1999) claims that rural nurses practice at an advanced level, because they fill in the gaps where there is a lack of service provision in rural areas, and that “rural nurses work well beyond the limits of what is conventionally thought to be the scope of professional nursing practice” (p. 254). In the first focus group meeting one participant considered that the difference between rural and urban practice was the lack of mental health services in rural areas and that distance from urban areas provided a limitation for mental health workers.

“I see a considerable number of people who have mental health difficulties for want of a better word, that don’t meet the criteria for mental health services...and who’s going to deal with that – Me? We get our mental health services from a centre that’s an hour away. They will not come over to see cases that don’t fit their criteria, and so there isn’t anybody else. And you’re left dealing with things like that...that certainly impacts on your work, not only that but, who am I to be doing it? And yet, if you don’t deal with it when it’s mild, they’re going to see these people down the track because it’s going to get worse.”

However urban-based participants in this study identified that limited child and adolescent mental health services were an issue across the region. A city-based participant said...

“I wonder if it’s not just a rural thing, because we still face the same issues around meeting criteria... and outside of that there are counselling services, but they’re pretty stretched.”

In a recent edition of PHN In Touch¹⁴ Connell and Robinson (2007) said that their role is no different from urban PHNs, however because rural-based PHNs live and work in their own communities they are more visible and are the “most consistent, reliable, and professional mobile health service within the limited services available to our community” (p. 4). The perceived difference between urban and rural PHN practice was a topic of discussion at the second focus group meeting. One of the participants who was unable to attend the second meeting had feedback to me that they thought that there is considerable stigma attached to people with mental illness in rural areas. In the second focus group meeting I raised this with the participants and they agree with this. One of the rural-based participants said that ‘the stigma attached to mental illness was more significant in rural communities than in urban areas, because the perception is that everyone knows everyone else’s business and there is a lack of confidentiality or the fear of the same’.

4.6 Educational requirements for PHNs

The educational requirement for PHNs was one of the aims of the research and was one of the concluding questions (Table 2). Due to the time restraints at the first focus group meeting, I delayed asking this question until the second focus group meeting. At that meeting, I therefore asked the participants if they thought that further education on mental health might help their practice. The participants did not feel they needed further training in mental health. This may have been because five of the eight participants had experience in mental health, but not all did, yet the participants who did not have experience in mental health did not identify they needed formal training in this area. However the participants did identify motivational interviewing, de-escalation techniques and conflict resolution would be beneficial. These training programmes are available to mental health nurses but not routinely in primary health and given that PHNs work considerably with clients with a mental illness, the participants thought these training programmes could be useful for them.

¹⁴ PHN In Touch is a national newsletter for PHNs in NZ. It is produced by the NZNO-PHN Section 3-4 times annually.

4.7 Conclusion

This chapter has focused on the description of the data at the focus group meetings and the interpretation arising from the data. I used Krueger's (1994) Analysis Continuum as a model to assist with the data. From this several themes were identified and these have been discussed.

The roles that PHNs have while working with children who live with a parent with a mental illness were identified through the data analysis as advocacy and assessment. These roles will be discussed in depth in chapter five briefly placing these roles within the domains of competency for nurses.

CHAPTER FIVE

Discussion and Conclusion

5.1 Introduction

The literature identified that children living with a parent with a mental illness are at greater risk of developing a psychosocial¹⁵ or psychopathological disorder and are at an increased risk of being abused and neglected (Beardslee et al., 1983; Beardslee et al., 2003; Devlin & O'Brien, 1999; Fraser et al., 2006; Rutter & Quinton, 1984). The socio-environmental factors alongside the chronicity and severity of the parent's illness, significantly increases the risks for children (Ahern, 2003; Rutter & Quinton, 1984). However, there are a number of protective factors that promote children's resilience, and prevent the development of psycho-social or psychopathological disorders (Beardslee, et al., 2003; Devlin & O'Brien, 1999; Foster, et al., 2004/5, Nicholson & Clayfield, 2004; Rutter & Quinton, 1984) and these were discussed.

The research question is "*What is the public health nurses role with children who live with a parent with a mental illness?*" The literature on the PHNs role in mental health was scarce, however it was descriptive in nature and through this I identified that the PHN role is in primary mental health. Their role is twofold; firstly the identification of children at risk through accurate assessment and referral on to appropriate agencies (henceforth known as assessment), and secondly advocacy (Foster et al., 2004/5; Honeyman, 2007; Lowenhoff, 2004; Nicholson & Clayfield, 2004; Secker et al., 1999).

Focus group methodology was used for this research because it is an ideal method to discover how people think about a specific topic (Ivanoff & Hultberg, 2006; Kitzinger, 1994; Krueger, 1994) and I wanted to capture the depth of knowledge and experience of the participants. From the analysis of the data from the first focus group meeting, I established that assessment and advocacy as identified in the literature, was the role of PHNs and this was verified by the participants in the second focus group meeting.

In this chapter I provide a detailed discussion of the assessment and advocacy roles of PHNs. I place these within the domains for nursing competency (Nursing Council of New Zealand, 2007; hereon referred to as NCNZ). I briefly discuss the importance that clinical

¹⁵ Psycho-social problems are the most common chronic condition for paediatric visits (Borowsky et al., 2003)

experience plays in identifying risk factors for children when PHNs work with parents with a mental illness. This is followed by a reflection on the aims of the research. Finally I present recommendations that arose from the research and conclusion to the thesis.

5.2 Assessment

The first aspect of the PHN role evolving from the literature was that they have a distinctive role in primary mental health. The participants in the study were very clear in their affirmation that PHNs have a burgeoning role in mental health for children and families and this was described in their assessment and referral process (discussion follows). The participants recognised that identification of potential risks for children hinges on the PHNs (and other primary mental health professionals) ability to make accurate assessments of children and families (Foster, et al., 2004/5; Lowenhoff, 2004; Nicholson & Clayfield, 2004). Furthermore, the literature establishes that home visiting places nurses in a critical role of assessing the risk and protective factors (Appleton, 1994; Baggaley & Keen, 1999; Honeyman, 2007; Kristjanson & Chalmers, 1991; Long et al., 2001; Murray et al., 2000; Scott, 2003). In the focus group meetings the participants shared their experiences affirming the importance they place on home visiting and their assessment process.

Assessment fits within the NCNZ (2007) second and third domains that relate to management of nursing care and interpersonal relationships. In the focus group meetings the participants articulated a high level of assessment skills (Domain two, NCNZ, 2007) with various models referred to, including HEADSS (see page 51), and the health promoting nursing practice. The health promoting nursing practice (Hartrick, et. al., 1994; Hartrick & Lindsey, 2005) is a generalised framework of practice based on holistic nursing where nurses assess the individual members and the family as a whole as described in chapter one. When the PHN identifies through their assessment that the family as a whole requires further intervention, then the family becomes the client rather than the child or parent. There are standardised complex tools for assessing families that primary care nurses use internationally, for instance the family systems nursing approach based on the Calgary model (Wright & Leahy, 2000). The Calgary model uses ecomaps to identify environmental aspects that impact on the family including, mental illness, employment, social supports and others (Wright & Leahy, 2000). However the complexity of the standardised assessment tool has drawn criticism. Mitchenson and Cowley (2003) found that when using a complex standardised tool the UK Health Visitors' practice becomes routine and mechanistic addressing only what was required by the assessment tool and

ignores the client's concerns. Furthermore the assessment tools do not allow for professional judgment and were noted to be a barrier to the client's empowerment and participation;

There is clear research evidence....that a trusting practitioner/client relationship combined with a skilled open communication style can provide a very successful basis from which to elicit health needs. This study therefore adds to the growing body of literature that is critical of the use of structured guidelines and needs assessment tools. Accordingly it is recommended that health visitors should use the open style of needs assessment that has shown to be effective and acceptable, rather than an approach based on a structured instrument (Mitchenson & Cowley, 2003. p. 423-424).

This supports the need for nurses to maintain relational practice with clients and the use of a simple tool rather than complex assessment tool. Although the participants in the focus group meetings did not refer to the term 'relational nursing practice' I believe they described it. Relational nursing practice is described by Hartrick (2002) as 'respectful, compassionate, and authentically interested inquiry into another (and one's own) experience' (p 524.). It is a way that nurses form a caring therapeutic relationship with their clients (Domain three, NCNZ), and is required for nurses to make accurate family assessments (Hartrick, 1997, 2002; Hartrick Doane & Varcoe, 2006).

With immersion of the data I noted that the participants recognised the importance of identifying the needs of the whole family and to advocate for them; in other words, holistic practice. Specific to this thesis, holism is when PHNs identify the needs and strengths of each individual member of the family and also of the family as a whole, which means they work with both individuals and families (Anderson, 2006, Clendon & McBride, 2001; Gallaher, 1999). Hartrick and Lindsey (1995) describe this as recognising the polyphonic voices of the family, which means listening to individual voices, stories and experiences of each family member. With primary mental health in mind, the nurse is aware of the risk and protective factors for children and families and addresses the mental health issues for individual family members and makes referrals to the appropriate agencies.

The literature identifies depression as a major health problem globally (Bayer & Sanson, 2003). Parental depression is linked with language delay and behavioural and emotional problems in children (Ahern, 2003; Beck, 1999; Fergusson, 1993; Smith, 2004). The participants described the importance of identifying when a parent is "*functioning as a*

parent". They said that a parent's dysfunction caused by depression and other mental illnesses becomes apparent when there are noticeable risk factors with the child for instance poor behaviour and inappropriate clothing or through their child and family assessments when home visiting (Cohen & Reutter, 2007; Lynes, 2003; SmithBattle et al., 2004; Whittaker & Cowley, 2003). The use of a brief screening tool for parental depression is recommended as part of routine family assessments (Beck, 1999; Nicholson & Clayfield, 2004; Olson, Dietrich, Prazer & Hurley, 2006). I believe the assessment tool that follows (Nicholson & Clayfield, 2004) could be incorporated into routine assessments when a parent indicates their child has behavioural, developmental or emotional problems;

"Over the last two weeks, have you felt down, depressed, or hopeless?"

Over the last two weeks, have you felt little interest or pleasure in doing things?"

(Nicholson & Clayfield, 2004; p. 138)

Nicholson and Clayfield (2004) also recommend the following alternative screening questions. *"How's your mood been lately? Or, what have you enjoyed doing lately?"* (p. 138). These questions will help the PHN to determine the impact of a parent's mood on their day-today functioning and their interactions with their children.

In the above discussion I have concentrated on the PHNs assessment of the family as a whole, in particular the parent's ability to function as a parent. However, it is important to acknowledge the necessity of recognising or having knowledge of children's psychopathology long with the determinants of health, in order to make an accurate assessment of the child and family (Beardslee et al., 1996; Cowling, 1999; Rutter & Quinton, 1984). Finally, I believe that PHNs orientation on child and family assessments should include the risk and protective factors for children and families (Beardslee et al., 2003), understanding that parental mental illness affects children's health outcomes (Beardslee et al., 1984; Rutter & Quinton, 1984; and others) and include a simple screening tool for parental depression as above.

5.3 Advocacy

The second role of PHNs with children who live with a parent with a mental illness is that of advocacy. Advocacy fits within the NCNZ (2007) first and fourth domains of nursing competency, that being professional responsibility, and interprofessional health care and quality improvement. The first competency refers to the professional, legal and ethical responsibilities and cultural safety of registered nurses. The fourth competency relates to

nurses evaluating care collaboratively with the health care team. In the following section, I discuss the PHN's role in advocating for children and families.

The participants agreed that advocacy is a key role for PHNs, with one participant saying "*it's really about advocating for the needs of the child*". Advocacy can be either at the individual or the political or collective level and is closely intertwined with the assessment and referral process and hence they are difficult to separate. Advocacy at the political level includes working with policies to address the socio-economic determinants of health and encouraging schools to include education on developing resilience in children including information on mental health issues like bullying and stigma. It also involves ensuring that adult mental health services are aware of the whole family's needs (Cohen & Reutter, 2007; Couzins, 1999; Zahner & Gredif, 2005).

Advocacy at the individual level focuses on the individual needs of the child and aims to enhance resilience in children. This aspect of the PHN role includes identifying and assessing children who are in need of advocacy and referring on to appropriate child health agencies (Gaffney, 2007; Lowenhoff, 2004). Hartrick (2002) refers to the 'hard spots' of family nursing and in respect to this topic means that the PHN identifies and addresses the issues of parental mental illness, in a relational way. Very good communication skills and clinical experience are required for nurses to work relationally with the parent (Gallaher, 1999, Hartrick, 2002; SmithBattle, Diekemper & Leander, 2004). The ability to make accurate assessments and to be an effective advocate comes with clinical experience (SmithBattle & Diekemper, 2001) which I believe cannot be under-appreciated.

5.4 Clinical experience

Clinical experience provides the nurse with a "repertoire of exemplary themes from which, in the subsequent cases of his practice, he may compose new variations" (Schon, 1983, p. 140). SmithBattle and Diekemper (2001) demonstrated that clinical and relational knowing comes from practice experience that can not be ascribed to the use of protocols, guidelines and taxonomies. They refer to Benner's (1984) work on expert practitioners to describe how expert PHN practice encompasses a "holistic and finely tuned grasp of clinical situations" (p.401), with skilful judgement and practical reasoning, and that "clinical reasoning and experience are indispensable" (p.402). In a later study by the same authors (SmithBattle, Diekemper & Leander, 2004) their research on skill development of PHNs, found that relational skills improved with experience with more-experienced nurses "addressing the personhood of the parent" (p.9) rather than attaching blame for the chaotic

nature of the family circumstances. In this study, the participants said that an awareness of the limitations in their practice and knowing their professional boundaries comes from experience. One participant in the focus group meetings said it was important to be aware of their own perceptions of mental illness and said it is important that mental illness does not become an excuse for poor parenting.

With immersion of the data I came to understand that the experienced participants articulated their practice more clearly than the lesser experienced participants. This intrigued me and I asked the participants at the second focus group meeting if the experienced participants had articulated expert nursing practice. One of the lesser experienced participants (four years experience as a PHN) disagreed, saying that working with parents with a mental illness ‘has a comfort level that comes from experience’, and a participant with five years experience as a PHN said ‘they felt they were on the cusp of expert practice and that they were coming to understand mental illness more with experience’. This is supported by Secker et al. (1999) who found that primary health nurses knowledge of mental health issues was learnt on the job. Another participant (two years experience as a PHN) thought that experience ‘helps in how the nurse works with a parent with a mental illness’, yet all PHNS come to the job with different knowledge and clinical experience.

5.5 Reflections on the aims of the research

There were five aims in this study and I will reflect on each aim individually. I will provide further discussion on some of the aims where applicable.

1) To investigate whether there is a trend in other PHNs’ work that sees parental mental illness having an impact on our caseload: All participants agreed that parental mental illness was impacting on their work with one participant saying that it “*was quite pervasive.*”

2) To identify to what extent this is the case: I reflected on this aim throughout the analysis continuum and considered that this question could not be answered effectively in a study using purely qualitative methodology, however participants did answer with scenarios from their practice, for instance one participant described meeting a mother who had spent three months in bed as a result of depression. While others talked about their role in advocating for children who live with a parent with a mental illness. A limitation of this

study is that there is no quantitative data to support the claims made that are qualitative in nature.

Additionally, in chapter four I identified barriers to PHN practice, that being organisational, the restrictions of mental health services and the lack of a systematic communication system between primary and secondary mental health services. I believe investigating these is an important step to addressing the barriers. By addressing these barriers, the PHNs role in primary mental health will be acknowledged and the nurses supported in their role. Furthermore, improving communication between primary and secondary mental health services could result in better advocacy for child who lives with a mentally unwell parent.

3) To determine how PHNs identify when a parent has a mental illness: This was a specific question asked at the first focus group meeting. Participants were very articulate in describing how they identify when mental illness is an issue with parents. Identifying mental illness is not normally part of the orientation to PHN practice and this knowledge came from the individual participants' experience and practice. The participants identified that they assess a parent's mental health by quantifying the state of illness, for instance "*how long have you felt like this?*" Furthermore the literature supports routine screening of parents for depression and this has been discussed above.

4) To ascertain the PHN role with children who live with a parent with a mental illness and to articulate this practice: Initially I anticipated that the role of PHNs would be to support children whose parents had a mental illness, but after searching the literature and being immersed in the data, it became apparent that PHNs role is not a supportive one. I felt that the term support was not specific enough. Furthermore, the literature identified that it is the socio-environmental factors of a parent's illness that primarily impacts on the child rather than the parent's illness itself. Additionally, many children do not live with their mentally unwell parent and I wanted to distinguish that actually living with the parent, alongside the socio-environmental factors that increases the risk for children. I therefore reconsidered the title and the aims of the study. These should reflect the public health nurses' role with children who live with a parent with a mental illness, rather than their support for children who live with a mentally ill parent. I could not change the title on the appendices so the initial title of the study is retained there only.

Furthermore, it was clearly identified that the PHN role is that of assessment and advocacy and not of support. I have discussed these concepts individually however they are entwined with their assessment of the risk factors for children and families and the referral process. The participants talked about their role in primary mental health and verified that assessment and advocacy were the PHNs role when working in schools and families. This research therefore builds on the literature regarding public health nurses and their role in primary mental health.

5) Finally, the fifth aim of this research study was to identify potential education needs for PHNs: The participants stated their knowledge comes from experience. This may be reflected in that several of the participants had previous experience in mental health, yet it is not a criterion or expectation of entry to PHN practice and therefore it can not be assumed that all PHNs have experience in mental health. However the participants did identify that further development on the skills of motivational interviewing, de-escalation techniques and conflict resolution would meet the educational needs of PHNs.

5.6 Recommendations

The following recommendations conclude the analysis continuum (Krueger, 1994).

The Analysis Continuum

Raw data-----Description-----Interpretation-----Recommendation

- Education for PHNs should include family assessment that acknowledges adult mental illness as an issue that affects children's health outcomes.
- Education for PHNs in the use of a simple tool to screen for adult depression.
- Further research identifying the role of the rural PHN, in particular where there is a lack of resources for supporting parents with a mental illness.
- That PHNs role in primary mental health services for children and families is acknowledged through their own organisational processes through accurate statistic collection.
- Further training in motivational interviewing, de-escalation techniques and conflict resolution is provided for PHNs.

- Finally that routine PHN practice should include communication with other services thereby providing greater advocacy for children and their families.

5.7 Conclusion

The literature review highlights that children whose parents have a mental illness are at greater risk of developing a psychopathology and are at greater risk of being abused and neglected. To that end, recent research has dwelt on the protective factors for children in order for them to become resilient and to produce better health outcomes for them. In this thesis I have described the PHNs role in working with children who live with a parent with a mental illness.

To identify the role of the PHN, combined focus group meetings were held with participants from both an urban and a rural geographic region in NZ and from these meetings data was gained that described the practice of PHNs. Although the results of this study can not be generalised to PHNs internationally, the findings have shown insight into how this particular group of nurses perceive their work in primary mental health. They described in detail their praxis and this I believe is generalisable to primary care nurses who work with clients in a therapeutic relational manner.

The research question asked ‘What is the public health nurses role with children who live with a parent with a mental illness?’ The answer is relatively simple, yet is reliant on highly skilled and experienced nursing practice which involves assessment and advocacy. Children who live with a parent with a mental illness are some of the most vulnerable people, living in the most vulnerable situations and it is the public health nurses role to identify the risks associated with parental mental illness and address those appropriately through effective assessment and advocacy.

Finally, the findings of this research build on the literature on public health nursing in New Zealand, in particular their practice in primary mental health.

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APPENDIX ONE

Public health nurses area of practice in Aotearoa/New Zealand – February 2006

Permission for reprinting was gained from NZNO-PHN Section

The Public Health Nurses Area of Practice is underpinned by the Te Tiriti o Waitangi Ottawa Charter and the Bangkok Charter

Individual Expertise

- National Representation Policy/Professional Development
- Enhancing Public/Population Health strategies/programmes

Regional Specific

- Interdisciplinary networking
- Public Health Units/DHB divisions
- Involved in Regional Networks with allied health and community public health professionals
- Rural Health Nursing Specialists
- Tamariki Ora 0-5yrs, Well Child 5-22yrs

Areas of Specialisation

- Strengthening families facilitation
- Legislation e.g. Contraception and Sterilisation Act
- Emerging issues of Public health

- Lobbying social determinants
- Communicable disease
- **Year 7** immunisations
- **BCG** Gazetted
- Child, Youth and Family **Service** - panelists

- Youth Health
- Community Networking
- Refuge & Migrant Support
- Parenting
- Health Promotion
- Ear Nurse Specialists
- Maori and Pacific Health

Generic PHN Service

- Legislation e.g. section 125 of Health Act
- Child, Youth and Family Child Protection
- Advocacy
- Facilitate self care

- Facilitate the access to primary & secondary health services
- Allied health and education Liaison/Networking
- Mental Health

- Holistic practice; School/Early Childhood Health Centres
- Targeted Health Promotion in School Settings: e.g. Fruit in Schools
- School based immunisation campaign

NB: Additional "Areas of Specialisation" may be offered depending on the regional context and the community need.

APPENDIX 2**Letter issuing provisional ethical approval**

Appendix 4: Parental Evaluation Developmental Status (PEDS) Questionnaire

PEDS RESPONSE FORM

Child's Name _____ Part:nes Name _____
 Child's Birthday _____ Child's Age _____ Today's Date _____

1. Plcosc_list iycc iiab s kamlng dc icipnaen Land.,,bch.

Do you have any concerns about your child's ability to walk, run, or climb?
 Circle on No Y COMMENTS:1

2. Do you have any concerns about your child's ability to use their hands and fingers to do things?
 Circle on: No Yes A little COMMENTS

3. Do you have any concerns about your child's ability to use their arms and legs to do things?
 Circle on: No Yes A little COMMENT:SI

4. Do you have any concerns about your child's ability to use their arms and legs to do things?
 Circle on: No Yes A little COMMENTS:

5. Do you have any concerns about your child's behavior?
 Circle on: No Yes A little conimwrs,

6. Do you have any concerns about your child's ability to use their hands and fingers to do things?
 Circle on: No Yes A little OMME141-51

7. Do you have any concerns about your child's ability to use their hands and fingers to do things?
 Circle on: No Yes A little COMMENTS:

8. Do you have any concerns about your child's ability to use their hands and fingers to do things?
 Circle on: No Yes A little COMMENTS:

any other cot*eras

PEDS SCORE FORM - AUTHORIZED AUSTRALIAN VERSION

Child's Name: _____ Date of Birth: _____ Date of Assessment: _____

Instructions: This form is used to assess a child's development. It consists of 10 domains. For each domain, you will observe the child and mark the appropriate box. The boxes are numbered 1 to 10. If the number shown in the box is 0, count the number of links in the small shaded boxes and place the number in the large unshaded box below.

Category	0-3 mos	4-5 ma	6-11 r	12-14 21106	15-17 raps	11123 mm	5647 mos	45-53 mos	54-fl vb.	72-85 mos	84-SiSeries
Global/Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptive Language	<input type="checkbox"/>	7	7	7	7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressive Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross Motor	<input type="checkbox"/>	1-1	<input type="checkbox"/>	<input type="checkbox"/>	n	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1: Gpini-it the oft... in .thesit2) 1sh aci - box xP444aiRi7a

If the number shown in the large unshaded box is 0, count the number of links in the small shaded boxes and place the number in the large unshaded box below.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

If the number shown in the large unshaded box is 0, count the number of links in the small shaded boxes and place the number in the large unshaded box below.

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Appendix 6: Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

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For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name

Male/Female

Date of birth

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in any of the following areas:
emotions, concentration, behavior or being able to get along with other people?

	No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	A little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	A little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
		<input type="checkbox"/>	<input type="checkbox"/>

Signature Date

Mother / Father / Other (please specify:)

Thank you very much for your help

0 kb., Goettma. 2000

Scoring the Informant-Rated Strengths and Difficulties Questionnaire

The 25 items in the SW comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. Somewhat True is always scored as 1 but the scoring of Not True and Certainly True varies with the Item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if 0-5 items were completed. Scale score can be prorated if at least 3 items were completed.

<u>Emotional Symptoms Scale</u>	Not True	Somewhat True	Certainly True
Often complains of headaches, stomach aches ...	0	1	2
Many worries, often seems worried	0	1	2
Often unhappy, downhearted or tearful	0	1	2
Nervous or clingy in new situations ...	0	1	2
Many fears, easily scared	0	1	2
<u>Conduct Problems Scale</u>	Not True	Somewhat True	Certainly True
Often has temper tantrums or hot tempers	0	1	2
Generally obedient, usually does what ...	2	1	0
Often fights with other children or bullies them	0	1	2
Often lies or cheats	0	1	2
Steals from home, school or elsewhere	0	1	2
<u>Inattention Scale</u>	Not True	Somewhat True	Certainly True
Restless, overactive, cannot stay still for long	0	1	2
Constantly fidgeting or squirming	0	1	2
Easily distracted. concentration %ganttlets	0	1	2
Thinks things out before acting	2	1	0
Sees tasks through to the end, good attention span	2	1	0
<u>Peer Problems Scale</u>	Not True	Somewhat True	Certainly True
Rather solitary, tends to play alone	0	1	2
Has at least one good friend	2	1	0
Generally liked by other children	2	1	0
Picked on or bullied by other children	0	1	2
Gets on better with adults than with other children	0	1	2
<u>Prosocial Scale</u>	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	0	1	2
Shares readily with other children	0	1	2
Helpful if someone is hurt, upset or feeling ill	0	1	2
Kind to younger children	0	1	2
Often volunteers to help others	0	1	2

The Total Difficulties Score:

is generated by summing the scores from all the scales except the prosocial scale. The resultant score can range from 0 to 40 (and is counted as missing if one of the component scores is missing).

Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on one or both of the total difficulties scores can be used to identify likely "cases" with mental health disorders. This is clearly only a rough and ready method for detecting disorders — combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10% of a community sample will fall in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender — normative SOD data are available from the web site. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

	Normal	Borderline	Abnormal
Parent Completed			
Total Difficulties Score	0 - 13	14 - 16	17 - 40
Emotional Symptoms Score	0 - 3	4	5 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 2	3	4 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4
Teacher Completed			
Total Difficulties Score	0 - 11	12 - 15	16 - 40
Emotional Symptoms Score	0 - 4	3	6 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 3	4	5 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

Generating and Interpreting Impact Scores

When using a version of the SDQ that includes an Impact Supplement, the items on overall distress and social impairment, can be summed to generate an impact score that ranges from 0 to 10 for the parent-completed version and from 0-6 for the teacher-completed version.

	Not at all	Only a little	Quite a lot	A great deal
Parent report				
Difficulties upset or distress child	0	0		2
Interfere with HOME LIFE	0	0		2
Interfere with FRIENDSHIPS		0		2
Interfere with CLASSROOM LEARNING	0	0		2
Interfere with LEISURE ACTIVITIES	0	0		2
Teacher report				
Difficulties upset or distress child		0	1	2
Interfere with PEER RELATIONSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered "no" to the first question on the Impact supplement (i.e. when they do not perceive the child as having any emotional or behavioural problems) they are not asked to complete the questions on resultant distress or impairment: the impact score is automatically scored zero in those circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to clarify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.

APPENDIX 3**Letter confirming full ethical approval**

APPENDIX 4

Letter of invitation to participate in research study

Letter to participants.

Dear Colleague,

I am undertaking my Masters of Nursing thesis this year with a research project.

This letter is inviting you to participate in this research relating to the PHN practice of supporting children/tamariki whose parents have a mental illness.

An information sheet is attached; please take time to read this.

If you are interested in participating, please contact me to arrange a time to discuss this project further. My contact details are on the information sheet.

Thank you for considering this.

Sincerely,

Laurie Mahoney
Public Health Nurse.

APPENDIX 5

Information sheet

Information sheet for participants

The Public Health Nurses practice of supporting children/tamariki whose parents have a mental illness.

You are invited to participate in a research study to explore the PHN role with children whose parents have a mental illness. This topic became a focus for my study when, at the end of last year, I became aware that my workload had been heavily laden with increasingly more complex clients, many of whom were children whose parents had a mental illness and I started to wonder if parental mental illness was also impacting on other PHNs workload. This research will explore your perceptions of this.

Hence, the **aims of the research project** are;

- To investigate whether there is a trend in other public health nurses' work that sees parental mental illness having an impact on their caseload.
- To identify how public health nurses identify if a parent has a mental illness.
- To examine the best approach for nurses to support children/tamariki whose parents have a mental illness
- To ascertain potential training needs for public health nurses.

The international literature identifies that children/tamariki living with a parent with a mental illness is considerably at greater risk of developing a psychopathology themselves, and are also more at risk of neglect and abuse. Parental mental illness presents a complexity for PHNs in identifying the children/tamariki's needs.

By participating in the project you will contribute to the awareness of parental mental illness on children/tamariki from a well-child nursing perspective. New understandings that may emerge could enhance PHN practice at an individual and a Service level. To enable this to occur, I will encourage all participants to come with an open mind and to contribute to the conversation as much as they feel comfortable doing. I would value your contribution to this research project.

Research process

The research will be based around two focus group meetings. The first meeting will last for 90 minutes and will be held at a convenient time for all participants. It is likely to be at the end of April, with the second approximately four weeks later. The second meeting will last for 60 minutes, with the total time that you will be required to volunteer, at a maximum of 2.5 hours.

A maximum of 8 participants will be included in the focus group meetings. The first 8 nurses to agree to participate by signing a consent form (attached) will be included; others will be excluded however they will receive a copy of the final report if they request it.

Should you agree to participate, you are asked to attend both meetings. I am attaching the core ground rules for your consideration. These core ground rules will ensure a safe environment for participants to contribute openly. I will facilitate these meetings. The meetings will be audiotaped and transcribed. An experienced, independent transcriber will be present at the first focus group meeting and she will also take detailed notes of the meeting. I anticipate that the transcribing will be completed within two weeks after which I will begin the thematic analysis of the data.

Sharing of information

At the completion of the thematic analysis, I will send you a copy of the themes that were discussed for your verification. I will send a report of my findings to the participants on completion of my thesis. A soft-bound copy of my thesis will be lodged in the Public Health South library, and a copy will also be available to you on request. I anticipate presenting the findings at a PHN/PHC conference and I also hope to submit an article in a New Zealand nursing journal.

Refusal and withdrawal

You can refuse to participate without prejudice or consequence. You can withdraw from the project at any point until the analysis of the data commences. Should you choose to withdraw from the project between the period when the focus group meetings are held and the thematic analysis commences (approximately two weeks), the details of your contribution to the conversation will be deleted from the transcript without prejudice or consequence to yourself.

Confidentiality

Your participation will be anonymous to other colleagues, until the time of the first focus group. Confidentiality is an important ethical consideration in research and I encourage you not to discuss this project outside of the focus group arena.

Your confidentiality will be maintained at all times with your name and identifying features (for instance gender and ethnicity) being excluded in the final report. I anticipate that others reading the report may recognise that Otago is the area pertinent to this project and as such, I will make this explicit, however I will maintain your confidentiality by ensuring any identifying features are excluded from the final report including your names, ethnicity and your length of experience as a PHN or prior relevant experience.

It will also be important to maintain client confidentiality in the focus group meetings. I acknowledge that the nature of how PHNs work may see that some of the cases that you might bring to the discussion will be known to some of the participants, and in this case, I will ensure that no identifying characteristics are added into the final report and hereby maintain the confidentiality of you as participants and also your clients. However please withhold client names and identifying details. As a facilitator I will remind you of that during the meeting if needed.

The transcriber will sign a confidentiality agreement. The data held on the transcriber's computer will be deleted once I have received and confirmed the transcripts through my Polytechnic email address at home. My home computer is password protected. I will securely store the data on a computer disc in a locked space at home. No data will be kept on my work computer and on completion of my thesis will be deleted from my

home computer. Only my supervisor and I will have access to the data. At the end of the project the transcripts will be retained in secure storage for a period of five years, after which it will be destroyed.

Refreshments will be provided at both focus group meetings. I will reimburse childcare and transport costs should they arise.

If you are interested in participating in this project I would like to meet with you individually at a time that suits you to discuss any further questions you might have. When we meet, we will discuss the group ground rules which are attached for your consideration, and I will ask you to sign a consent form to participate.

Please contact me or my supervisor for further information on this project.

Researcher

Laurie Mahoney, PHN
6 Harden Street,
Leith Valley, Dunedin
467 9233; 027 444 1649
mahonlf1@tekotago.ac.nz

Supervisor

Jean Ross, Principal lecturer
School of Nursing, Otago Polytechnic
Forth Street, Private bag, Dunedin
479 6107
jeanr@tekotago.ac.nz

Thank you for considering this request,

Sincerely,

Laurie Mahoney

APPENDIX 6

Consent form

Consent Form

The PHNs practice of supporting children whose parents have a mental illness.

I have read and understood the information sheet concerning this project.

I have had the opportunity to discuss this study with the researcher and my questions have been answered to my satisfaction.

I understand that I am free to request further information at any stage.

I understand and agree that:

- My participation is entirely voluntary.
- My participation will be confidential and that no material which could identify me will be included in any reports on this study. However I agree that Otago will be identified as the region of interest in the final report
- I commit to attending two focus group meetings.
- I am free to withdraw at any time with no disadvantage to myself.
- If I withdraw in the period between the focus group meeting and the commencement of the thematic analysis my contribution to the discussion will be withheld from the analysis. However if the thematic analysis has begun, my contribution will remain as part of the research data.
- The focus group meetings will be audiotaped and transcribed.
- Following the thematic analysis of the first focus group, I will receive a copy of the themes for verification.
- At the conclusion of the project the researcher will keep the data in secure storage for five years, after which it will be destroyed.
- The data will not be used for any purpose other than this research project.

- The results of the project may be published in a New Zealand nursing journal or used in a presentation at a Public Health Nursing or Primary Health Care conference, however my confidentiality will be preserved.

- a) I agree to the group ground rules and will adhere to them Yes No
b) I consent to the focus group discussion to be audiotaped Yes No
c) I would like a summary of the results of this research. Yes No

If you have circled c) above, please provide your address below.

I agree to take part in this project under the conditions set out in the Information sheet.

Full name of participant _____

Signature of participant _____

Full name of researcher: **Laurie Frances Mahoney**

Signature of researcher _____

Date _____

Researcher
Laurie Mahoney, PHN
6 Harden Street,
Leith Valley, Dunedin
467 9233
027 444 1649
mahonlf1@tekotago.ac.nz

Supervisor
Jean Ross
Principal lecturer
School of Nursing, Otago Polytechnic
Forth Street, Private bag, Dunedin
479 6107
jeanr@tekotago.ac.nz

This project has gained ethical approval from the Otago Polytechnic Ethics Committee

APPENDIX 7

Focus group core written ground rules

Core ground rules for focus group meetings

Re: Participating in a Research study to identify PHN practice in supporting children whose parents have a mental illness.

It is necessary for all participants to agree to these ground rules before participation in focus group meetings.

Additional ground rules can be added if all participants agree

- All participants will attend two meetings
- All participants contribution is valid
- The purpose of the focus group meeting is to gain as many opinions as possible therefore there are no right or wrong answers
- All participants are encouraged to contribute to the discussion
- Only one person will speak at a time
- All participants are encouraged to not mention client names or identifying characteristics.
- Confidentiality of focus group members and dialogue not to be discussed with any third party, all discussion to remain in the room
- Meeting to start and finish on time

APPENDIX 8

Demographic and Professional Profile form

Demographic and Professional Profile

Public Health Nurse's practice of supporting children of parents with a mental illness.

Personal Characteristics

1. Name _____
2. What is your gender? Female Male
3. Which ethnic group or groups do you belong to?
Other European; NZ European; Maori; Samoan; Cook Is Maori;
Tongan; Niuean; Chinese; Indian; Other.
4. Are you of Maori descent (that is, did you have a Maori birth parent, grandparent or great grand parent etc.)? Yes No Don't know
5. Do you know the names of your iwi (tribe or tribes)? If yes print the name and home area, rohe or region of your iwi below:
(Adapted from NZ Census) _____

Professional Characteristics

6. Please indicate the **current qualifications/title** that you hold:
For nurses, as per Practising certificate e.g. Registered Nurse;
Nurse Practitioner. (A registered nurse is defined as a nurse whose name appears on the Register of Nurses maintained by the NCNZ).
7. **Year of registration:** _____
8. **Other qualifications:** please circle
BA, BN, Post graduate Certificate (e.g. child & family), MA, MN, other
(please specify). _____
9. **Years of experience as a PHN:** _____
10. Please list **other experience relevant** to the topic e.g. worked in mental health. _____

Appendix 9

Transcriber consent form

Confidentially Agreement for transcribing Audio-tapes

I _____ agree to maintain confidentiality of participants' audio-taped interviews in the research conducted by Laurie Mahoney.

I agree to:

- Maintain security of the audiotapes and computer discs during the period which I am transcribing the tapes. This includes having a password protected computer.
- Not to discuss details of the focus group meetings with anyone other than the researcher.
- Return all material to the researcher on completion of transcribing the audiotapes.
- To delete from my computer all transcribed material from my computer when the researcher confirms that this should occur.

Signed: _____ (Transcriber)

Signed: _____ (Researcher)

Date: _____

Appendix 10

Covering letter of written analysis for participants

*Public Health Nurse's practice of supporting children of parents
with a mental illness.*

Dear Colleague,

Thank you all so much for making the time to attend the first focus group. I was amazed at the depth of knowledge amongst you all and it confirms my belief and respect for public health nurses as a group of highly professional and caring nurses. I hope that my thesis will represent the thoughts, views and a degree of the knowledge that guides and makes up the extraordinary praxis of public health nursing.

The transcript of the focus group was 43 pages long and in order to analyse this material into useable data, I read and reread the transcript; and listened and re-listened to the tape recording. I highlighted what I thought were themes especially those that had general agreement.

I have written the report in a similar format to that taken from the meeting. The identified themes are bulleted in the end and the final report will take that format. In the report, I have attempted to capture the depth of the conversation. The quotations (in italics) that I have used are an example of the meanings that came from the meeting. My final thesis is likely to include these quotations, however it will include others, but to keep this report to a reasonable size for you to read, I have tried to keep these to a minimum. I think these quotes capture your opinions and views, but not your practice, and so longer quotes giving examples of praxis will also be included in the final document.

The next stage of your involvement is for you to verify my findings, and this requires careful reading of this report. Please take your time in reading this and consider if I have captured the meaning of the conversation in the meeting.

A second aspect of verification is, if you recognise something that you have said, to reflect on whether I have captured what you were meaning. Some of the quotations are not written in full and are not necessarily in the order that they were discussed, but I hope I have caught the core of the quotation. Further, if you do recognise a quote as something you have said, please let me know if you would prefer for that **not** to be included in the final thesis. This is particularly important if there is a possibility that you might be recognised, either because of your area of practice, either current or in the past. Please get back to me for further discussion if this is the case.

Finally, I have yet to secure time for a second focus group meeting, and my thoughts at the moment are that there has been a lot of 'staff training' during these school holidays; and while this is not 'staff training' it does require your time away from your clinical practice. Therefore, if you feel that the report captures most of your comments then maybe we only need to meet briefly. I am aware that we haven't discussed the training needs for PHNs and that is one topic that I would like your opinions on and could be the focus of the next meeting.

Please get back to me with your thoughts on the report.

Thank you again,

Regards
Laurie

Contact details

Researcher

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Leith Valley, Dunedin
467 9233
027 444 1649
mahonlf1@tekotago.ac.nz

Supervisor

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Principal lecturer
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Appendix 11

PEDS Assessment tool

Accessed from unpublished Well/Child Tamariki Ora Framework review: Background Paper