“Being in a group with others who have mental illness makes all the difference”: The views and experiences of parents who attended a mental health parenting program

Abstract

Background: The relationship between parental mental illness and poor outcomes in children is well established. While parents with mental illness could benefit from accessing parenting programs, this population tends to be reluctant to do so. To address this need, we developed an adaptation of the Triple P program specific to people with mental illness, and this paper presents the views and experiences of parents who attended this program. The program is a ten week intervention consisting of a six week group parenting program, followed by four weekly home visits.

Methodology:

This client satisfaction evaluation consists of 18 telephone interviews with program participants as well as feedback from the Triple P Client Satisfaction Questionnaire (CSQ) (N=116). While this evaluation sought to gain participant feedback on the entire program, the focus was on gaining insight into the usefulness of a modified program specifically for this population, and how the unique components of this modified Triple P program are perceived by the participants.

Results: Both the qualitative and quantitative findings indicate high satisfaction with the program, and highlight the value of a parenting program designed specifically for parents with mental illness. In particular, participants stressed that the design of the program was essential to their satisfaction and engagement with the program. Analysis of the interview data identified a number of reasons why participants engaged with this particular parenting program and found it very useful, in particular: *being in a group with others with mental illness; focus on child development and parenting with a mental illness; and the home visits.*

Conclusion: This study adds to the limited evidence base specific to parent programs for parents who experience mental illness, and highlights the importance participants attach to sharing the group experience with other parents who also experience mental illness, and the significance of this in facilitating engagement in parenting programs.

Introduction

Nearly half of Australians will experience mental illness in their lifetime (Australian Bureau of Statistics, 2008), and children of parents with mental illness can be affected in many ways (Reupert, Maybery, & Kowalenko, 2012). In Australia, approximately a quarter of children live in households where at least one parent has a mental health issue (Howe, Batchelor, & Bochynska, 2009; Maybery, Reupert, & Patrick, 2009). An annual audit conducted across the Central Coast Mental Health Service in New South Wales (2008-2011) shows that 25%-28% of active clients are parents of children aged 0-17, of which 60% reside permanently with their parent with a mental illness (Howe et al., 2009; Howe, Batchelor, & Bochynska, 2012).

The relationship between parental mental illness and poor outcomes in children is well established (Reupert, Maybery, et al., 2012). Children of parents with a mental illness are at significant risk of developing emotional and mental health problems and other adverse outcomes at some point in their lives compared to children of healthy parents (Dean, Stevens, & Mortensen, 2010; Hosman, Van Doesum, & Van Santvoort, 2009). The increased risk of adverse outcomes in children of parents with mental illness is mediated by both genetic and environmental factors (Reupert, Maybery, et al., 2012). Mental illness can impact negatively on parenting; in particular on emotional availability, parent-child interaction, consistency with boundary setting and everyday routines (Isobel, Meehan, & Pretty, 2016; Pape & Collins, 2011; Reupert, Maybery, et al., 2012).

To improve outcomes for children of parents with mental illness, it is essential that early intervention programs are developed that enhance parenting capacity (Reupert, Cuff, et al., 2012; Sanders, 2012). In particular, there is evidence that indicates that structured parenting programs based on social learning models, such as the Triple P Positive Parenting Program, enhance parental capacity and impact positively on children's mental health, particularly for targeted population such as children at risk of developing social and emotional problems (Joussemet, Mageau, & Koestner, 2013; Sanders, 2012; Sanders, Kirby, Tellegen, & Day, 2014; Taylor, Eden, Lee, & LaRoche, 2015). Triple P is a well-established behavioural family intervention that demonstrates positive outcomes, particularly in the areas of promoting positive relations with children and behaviour management and encouraging parents to develop realistic expectations of their children and themselves as parents (de Graaf, Speetjens, & Smit, 2008; Sanders, 1999, 2002).

Given the potential adverse impact of parental mental illness on parenting capacity and, in turn, outcomes for children, engaging this population in parenting training is of importance (Isobel et al., 2016; Phelan, Howe, Cashman, & Batchelor, 2012; Phelan, Lee, Howe, & Walter, 2006). Unfortunately, however, parents with mental illness tend to be reluctant to access generic parenting programs (Ackerson, 2003; Isobel et al., 2016; Phelan et al., 2012). The stigma associated with mental illness, combined with the fear that children may be removed from their care, can prevent parents from accessing such services (Ackerson, 2003; Biebel, Nicholson, & Woolsey, 2014; Reupert & Maybery, 2011). To enhance engagement and overcome

these barriers there is a need to develop specific programs for this population (Isobel et al., 2016; Stewart-Brown & Schrader-McMillan, 2011).

In 2005, the public mental health service for children and young people, Children and Young People's Mental Health (CYPMH), on the Central Coast in New South Wales, recognised this gap locally and developed a parenting program that targets parents with mental illness called the 'Mental Health Positive Parenting Program' (MHPPP) (Phelan et al., 2012; Phelan et al., 2006). The MHPPP is an adaptation of the Triple P Program (Sanders, 1999) for this population. In the development of MHPPP, care was taken to ensure that program fidelity was maintained in line with literature that guides adaptation of evidence based programs (Baumann et al., 2015; Kumpfer, Magalhaes, & Xie, 2012; Taylor et al., 2015). Triple P has been successfully adapted to a number of different populations, including for parents of children who are overweight and obese (West, Sanders, Cleghorn, & Davies, 2010), Indigenous families (Turner, Richards, & Sanders, 2007) and working parents (Sanders, Stallman, & McHale, 2011). With a few exceptions (Isobel et al., 2016; Shor, Kalivatz, Amir, Aldor, & Lipot, 2015) there are few evidence based parenting interventions available for parents with mental illness, and MHPPP addresses this gap in service delivery.

Previous quantitative evaluations of this program based on a pre-post design methodology indicate that the MHPPP program is successful at reducing children's behavioural problems as reported by their parents as well as reducing the number of dysfunctional parenting strategies (Phelan et al., 2012; Phelan et al., 2006). While this is positive, it remains unclear which aspects of the program are perceived as

contributing to these positive outcomes from the perspective of the participants. To this extent, the current study sought to gain the perspective of parents who have completed the program through telephone interviews and client satisfaction questionnaires. The current study adds to the previous evaluations, and presents data that was not collected by neither the previous pilot study (N=19) nor full study (N=86).

Method

Program Description

The MHPPP is a ten week intervention consisting of a six week group parenting program, followed by four weekly home visits. The MHPPP program retains four fundamental sessions of Triple P and incorporates two additional sessions to address parenting in the context of mental illness and child development. The two hour sessions were extended to three hours to allow for sufficient breaks to accommodate some of the difficulties with concentration and learning that can be attributed to a mental illness and/or treatment regimes. The MHPPP further varies from the Triple P in that it replaces the four follow-up phone calls with four weekly home visits. This allows the facilitators (the second and third author) to assist parents to apply their learned skills in the home environment, model effective parenting strategies and, where appropriate, create opportunities to talk directly with children about their parent's mental health problem. The facilitators also meet the parents in a pre-program interview to explain the nature of the program and answer

any questions parents may have. No content was dropped from the original Triple P program.

The two additional sessions and home visits were developed as a result of recommendations from clinicians and parents with mental illness who completed the Triple P in an earlier intervention. In early 2005, CYPMH identified that parents with mental illness were interested in a skills based group program to help them learn new parenting strategies. To address this need, a group Triple P pilot program was implemented with nine participants. The program was well attended and parents indicated that the skills they learned were very useful; in particular the skills that helped them connect with their children and those that encouraged positive behaviour management. In addition, an evaluation of this program based on facilitator and participant qualitative feedback indicated that a) parents can benefit from the opportunity to explore the impact of their mental health problem on their parenting; b) parents can benefit from information relating to child development in the context of understanding children's fears, friendships and schooling; and c) parents who received home visits following the course reported being better able to assimilate changes in parenting practices than parents who received follow−up phone calls. (For more information see Howe (2006). This feedback was considered in relation to the literature and the program was expanded to accommodate these findings and the MHPPP was developed and implemented in early 2006.

The six group sessions (each lasting around 3 hours) include:

1. Positive parenting: what is it? Causes of child behaviour problems (Triple P)
2. Developing positive relationships with children (Triple P)

3. Mental health and parenting: impact of mental illness on parenting (additional module developed by CYPMH)
4. Managing misbehaviour (Triple P)
5. Implementing routines and strategies (Triple P)
6. Promoting children's development: children's fears, friendships and schooling (additional module developed by CYPMH)

The MHPPP program is open to parents with a child or children aged two to twelve, of which the parent has custody or at least overnight unsupervised access. All participants self-identify as having a mental illness (primarily depression, anxiety, bipolar affective disorder, schizophrenia and psychosis), however not all are formally diagnosed or do not embrace the diagnosis they have been given. An informal screening process occurs during the pre-program interview to explore the impact of current mental illness on parenting. Entry into the program is voluntary and the program is free. All groups are facilitated by two trained and fully accredited Triple P facilitators from a range of health disciplines. Program fidelity is an important principle of our program and all Triple P program content and order of sessions is adhered to.

Over a 10 year period, from 2006 – 2015, a total of 37 MHPPP groups have been conducted across the Central Coast, for a total of 224 parents. The program is conducted three to four times a year, and there are generally 6−8 participants per program. The vast majority of participants were female (86%) with an average age of 33 years. The majority of participants were referred by mental health teams (29%),

children and family health services (17.4%), self-referrals (21%), and child protection services (13.4%). The remaining (19.2%) were referred by paediatricians and non-government organisations. A small percentage identified as Indigenous (5.4%) or culturally and linguistically diverse (4%).

In terms of self-reported mental illness and in order of prevalence, program participants (N=224) reported depression (35.6%), depression and anxiety (35.6%), bipolar affective disorder (15.7%), schizophrenia and psychosis (6.5%), and post-traumatic stress disorder (4.6%), with 2% missing data. Over 20% of these self-reported using alcohol & other drugs to help manage their stress levels. Over half (56.7%) of participants were either married or de facto; 21.4% were single and 20.1% identified as either divorced or separated, with the remaining 1.8% missing data. The majority of participants were unemployed (80%); while some (26.8%) had a partner who was employed, more than half (50.4%) of families had neither parent employed.

At commencement of the program parents are asked to identify a ‘target child’ to focus the learning on during the sessions. Of the 215 target children that we have data on, 48% were under 5, 40% were 5-8 years and 10% were aged 9-11years. Of the identified children, 58% were male and 38% female, with 4% missing data. 38% of focus children had prior contact with a service for emotional or behavioural issues, and 41% had had involvement of child protection services. Of the parents attending the program, 34% had completed at least one parent program previously. The majority of participants (79%) completed the program (with 100% attendance) including the home visit component.

Procedure

This study is a client satisfaction evaluation of the MHPPP program consisting of telephone interviews as well as well as the Triple P Client Satisfaction Questionnaire (CSQ) (Turner, Markie-Dadds, & Sanders, 1998). While this study sought to gain participant feedback on the entire program, the focus was on gaining insight into the usefulness of a modified program specifically for this population, and how the unique components of this modified Triple P program are perceived by the participants. To this extent both qualitative and quantitative methods were used.

Client Satisfaction Questionnaire (CSQ)

The Client Satisfaction Questionnaire (CSQ) was developed by Turner et al. (1998) as part of the evaluation of Triple P. The CSQ is a 13 item scale that measures the quality of the service provided; how well the program met the parent's and child's needs, increased the parent's skills and decreased the child's problem behaviours, and whether the parent would recommend the program to others (Turner et al., 1998). The measure has a 7-point scale for each item, with varying point descriptors for each item (depending on whether the item is measuring the quality of the intervention, the extent to which it met the participants' needs, the effect it had on their parenting skills and child's behaviour problems). A maximum score of 91 and a minimum score of 13 are possible. To add to the quantitative data, parents are also prompted to make general qualitative comments or suggestions about any aspect of the program.

To evaluate the MHPPP program the CSQ was administered post-intervention only. Participants were handed the CSQ at the final home visit, or, in the event that this not occur (eg if the facilitator forgot to hand out the questionnaire or if the final visit was cancelled) the CSQ was posted to the participant upon completion of the program. Participants were asked to put the completed questionnaire in a sealed envelope and were assured that their feedback would not be reviewed directly by the group facilitators but be given to the service researcher for analysis. A total of 116 participants completed the questionnaire, which is just over half of program participants. The majority of these (N=102) were completed during the final home visit, and returned in a sealed envelope to the facilitator at that time. Fourteen completed CSQs were returned by post. As this evaluation was conducted in a clinical setting, we do not have reliable data to report on the total numbers of CSQs that were posted to participants versus handed out at the final visit; however, facilitators report that the vast majority of participants given the questionnaire during the final visit completed the questionnaire at that time. As such, we deduce that the response rate to CSQs posted to program participants was low (approximately 13 % or 16 out of 122). Nonetheless, the sample (N=116) is considered representative of the entire cohort, as there was no key difference between the sample that was posted the questionnaire versus those that received the questionnaire during the home visit. We do not have demographical information specific to this cohort as no identifying information was collected with the CSQs.

The quantitative data was uploaded into SPSS for statistical analysis and the qualitative feedback was analysed for key themes.

Telephone interviews

Feedback from 18 parents who completed the program was obtained through brief telephone interviews conducted by the service researcher who is the first author of this paper. The service researcher is responsible for the ongoing evaluation of programs and services offered by CYPMH. While the service researcher is internal to the organisation, she works separately from the clinical teams and has no line management responsibilities, and is able to report the findings without bias.

An invitation to participate in a telephone interview and a consent form were posted to all parents who completed the MHPPP program between late 2013 and early 2015 (n=33). The demographics of this cohort are consistent with the demographical information of the entire cohort outlined above. Approximately two weeks following the mail out a follow up call was made to ask the MHPPP program participants if they wish to participate, and arrange a time to conduct the interview. Eighteen parents agreed to participate, which represents the majority of those who could be contacted. Two declined to participate and the remainder could not be contacted within three attempts, mostly because their numbers had been disconnected. We do not believe that there is a significant difference between the cohort that participated in the interviews versus those that did not, except that those that could not be contacted may be more transient or have less stable living conditions. There is no significant difference in terms of the demographical information collected.

The telephone interviews, as well as participant consent, were audio-recorded and lasted between 15 and 30 minutes. Pseudonyms have been used. The interview questions pertained to participant experiences of the program, components they found helpful or less so, and the perceived impact of the program on their parenting and family functioning. Care was taken not to lead the participants through the use of open-ended questions. The interviewer is a qualified and experienced counsellor, and the use of open-ended questions is central to counselling practice.

An inductive approach to data collection and thematic analysis was used (Braun & Clarke, 2006; Charmaz, 2006) and effort was made to capture the perspective and experience of the participants. To do so, the interviewer used broad open-ended questions, to elucidate the perspectives of the participants (Braun & Clarke, 2006; Bryant & Charmaz, 2007b; Charmaz, 2006). While some probing was used to focus the interview, the interviewer remained focussed on what naturally emerged in the interview 'conversation' (Charmaz, 2006; Ezzy, 2010). Examples of questions include "*What can you tell me about the MHPPP program?* ", "*Did the MHPPP program help you? How so? If not, how so?*", "*Which aspects of the program did you find helpful, and which less?" and* "*What, in your opinion, are the strengths of this program and which aspects could be improved?"* Member checking was used during the interviews to verify that the intended meaning was accurately understood by the interviewer (Charmaz, 2006).

The interviews were transcribed verbatim by the interviewer (the service researcher) which is recommended to enhance the accuracy of transcripts (Davidman & Greil, 2007; MacLean, Meyer, & Estable, 2004). The next analytic step involved coding the

transcripts, which was done by one coder, the service researcher. As data was read, reread and coded the service researcher gained insight into what constituted salient information from the perspective of participants and a number of key themes were identified (Braun & Clarke, 2006; Bryant & Charmaz, 2007a; Harper & Thompson, 2011; Kenny & Fourie, 2014).

Ethics approval for this study was received by the Hunter New England Health Human Research Ethics Committee and the Research Manager, Central Coast Local Health District (CCLHD).

Results

Both the qualitative and quantitative findings indicate high satisfaction with the program, and highlight the value of a parenting program designed specifically for parents with mental illness.

As outlined in Table 1, the findings from the CSQ indicate high levels of satisfaction with the program.

Insert Table 1

The high level of satisfaction reported by this study is consistent with high levels of satisfaction reported by other studies that used the CSQ measure to evaluate Triple P group programs (Crisante & Ng, 2003; Fives, Pursell, Heary, Gabhainn, & Canavan, 2014). For the MHPPP program the average total score is 79.42 (out of a maximum score of 91), which is very similar to the average total score reported by Fives et al. (2014) of 80.10 based on feedback from 391 Group Triple P participants in the United Kingdom. The lowest satisfaction rating was on the question "*Do you think your relationship with your partner has been improved by the program?",* and this is also consistent with the findings reported by Fives et al. (2014). This lower score is not surprising given that the item was delivered to all participants regardless of relationship status. Furthermore, the program does not specifically address relationship issues.

These quantitative findings are consistent with the qualitative feedback received through the questionnaire as well as the interviews. Qualitative feedback on the questionnaire highlights that the program is well received and highly beneficial. Comments such as "*the program is wonderful*", "*so beneficial*" and "*I have learned so much*" were common. This is consistent with feedback received during the interviews, which was also overwhelmingly positive. The vast majority of interviewees commented that the program has had a positive influence on their parenting, and in turn their children's behaviour and home environment. Nearly all interviewees made comments such as "*I have nothing but positive for the course. It was eye opening for me….My household runs a lot more comfortably rather than stressed out all the time*" (Sophie); "W*e're doing much better now than twelve months ago thanks to the program*" (Mary) "*I'm much better at managing the*

behaviours now" (Laura) and "*The course helped me be calmer so I can talk to [my son]. The course helped me settle down a bit within myself".* (Tracey)

The vast majority of interviewees stressed that as a result of the program their parenting changed significantly, and that they learned a range of skills and techniques that they continue to utilise. Analysis of interviewee responses indicate that parents had gained skills such as avoiding the escalation trap and staying calm; implementing "fair" (logical) consequences; choosing realistic goals for self and children; monitoring and planning a response to child behaviour; choosing appropriate strategies to manage child behaviour and following through with consequences. They described the skills and techniques as useful, achievable, realistic and having a real and tangible impact. Participants consistently commented that they are now "*fairer",* "*more patient*", "*a better parent*", "*much calmer*", and better able to communicate with their children.

While these participants noted that learning positive parenting skills and strategies was very helpful, they stressed that the design of the MHPPP program was essential to their engagement with the material. While the strategies were identified as important to changing their parenting, analysis identified that for these participants the mental health modification of this program was critical. A number of participants commented that while they had tried more generic parenting programs, they hadn't engaged in the way they did with this program. Analysis of the interview data identified a number of reasons why participants engaged with this parenting program and found it very useful, in particular: *being in a group with others with mental illness; focus on child development and parenting with a mental illness; and the home visits.*

Being in a group with others with mental illness

All interviewees commented on the benefits of attending a group with other parents with mental illness. There was an overwhelming consensus that being in a group with others with shared experience was critical to the success of the program as it *enhances honesty*, *combats a sense of isolation*, *helps gain perspective*, *and offers an opportunity to learn from and support others with similar challenges*.

Participants consistently reported that being in a group with others with similar experiences made it possible for them to discuss and explore their challenges around parenting honestly without the fear of judgement.

> *It was good to have other people with mental health problems in the group because that meant we could all be honest about our experiences. We could talk about things without being embarrassed or feeling judged*. (Laura)

> *I think it was easier to talk knowing that the other people in the group have issues as well. You weren't treated as a lonesome basically. There was more understanding and less judgement. I wasn't stigmatised. You could be honest. I felt comfortable.* (Suzanne)

One participant reported that knowing everyone had some experience of mental illness allowed her to feel less anxious and helped her to concentrate on the session material. She also reported that she had attended a previous generic group, but that

she was so concerned the other parents would find out about her diagnosis that she went blank and could not absorb any information.

Participants commented that they felt less alone, and that being in a group with others with mental illness helped overcome their sense of isolation.

> *I have suffered from anxiety a lot and having other parents with similar issues was good. I felt less alone. I didn't feel like the oddball in the class. It's good to have people you can relate to there.* (Kira)

> *Sometimes when you have mental health problems you feel quite alone and isolated, and it was good to see that there's people out there with the same challenges. I know there's research that says that you shouldn't stick people in the same group because they have the same stuff going on, but actually it helps because it stops you feeling alone and isolated*. (Debbie)

Participants also commented that being in this group helped gain perspective.

> *It was good to gain perspective as well, to see that I'm not alone and others go through even harder stuff.* (Kira)

> *The program helped me see that I'm not the only one going off my head, and that other people also lose control.* (Suzanne)

> *You looked around the room and you didn't know these people also had mental health problems, you wouldn't know. It showed me that anyone can suffer from mental health problems*. (Michelle)

The group also offered an opportunity to learn from and support others with similar challenges.

> *The other members of the group who were also learning had similar experiences so when we were discussing things we could understand each other a bit better….Given we all have mental health problems we were able to support each other as well instead of just learning from experts. We could learn from each other…The experience of other mothers was valuable, in mothers group no one else has mental health issues so their general every day experiences are different.* (Mary)

Focus on child development and parenting with a mental illness

While participants commented that they learned a range of skills and strategies that are useful, they highlight that learning about child development and the impact of mental illness on parenting was particularly helpful. In particular, participants found the parenting training within the context of mental illness valuable.

> *I liked how it went over the parenting stuff with mental health issues in mind, like what it might be like given my anxiety.* (Mary)

Participants explained that they were encouraged to reflect on the way in which their mental health issues impacted on their parenting, and identify ways in which to better manage this impact. They explained that they are now better able to identify their own triggers and manage their response to stressful parenting situations better. They report that they are now kinder to themselves and in turn less anxious in their parenting style.

> *I am now much kinder to myself and much less anxious … It assured me that I'm doing ok. I'm easier on myself and much more aware. I'm much better at reflecting and identifying my triggers whereas before I would have yelled my head off.* (Debbie).

> *I feel less stressed about parenting because I can look past my triggers to the actual situation in front of me. I'm more in control.* (Isabel).

> *It has taught me to handle things in a different way so that I don't get anxious. I don't get so upset when I'm dealing with her behaviour. I feel more in control and confident, less anxious and stressed.* (Vivienne).

While nearly all participants were satisfied with the extent to which the program addressed parenting with a mental illness, a couple of participants commented that they would have liked to explore this in more detail.

> *I think we could have talked more around the difficulties of parenting with mental health problems. The techniques are hard to apply given that my home*

> *life isn't that consistent and I can't always stick with it…There could be more emphasis in the course on the reality of living with a mental illness as a parent, or with a partner with a mental illness, and the disruption that causes.* (Ana)

A number of participants also highlighted that they gained a better understanding of what their child may be experiencing and as a result they are better able to respond appropriately and are less anxious in their response.

> *I understand why* [my daughter] *does certain things now much better and I can go around it instead of getting angry and stressed*. (Kira)

Participants explained that with a better understanding of what is age appropriate behaviour and what isn't, and what life may be like for their child, they are much more patient.

> *One of the really good things I learned is not to expect too much of my kids. He's only eight and he's still learning so I shouldn't expect unrealistic things. It's ok if it's not perfect or up to my standards….It made us more aware that they are only little, and sometimes we get caught up with our adult things and expect so much that we forget that they're still a child and still learning. I'm now so much more patient.* (Debbie)

The home visits

Another key component of the program that participants mentioned consistently as important in terms of their level of satisfaction were the home visits. Participants explained that the home visits allowed for the facilitators to help them implement and embed the positive parenting strategies at home, by both observing and providing feedback on the children's behaviours as well as the parenting.

> *The home visits were really good too. I have a ten month old and a 2.5 and 5 year old so home visits were really helpful so they could see the kids in their own element…. I was showing the lady who came out to me what I was doing and she could see it rather than me just describing it verbally and she could say "maybe we try this a different way" or "that's working well, we'll stick with that". For me that was really good.* (Kira)

> *It was good to have them watch* [my son] *in his environment, and tell me what I could work on… to get their opinion and feedback, to get their reflections from what they see from a different point of view.* (Debbie)

> *And having them come to your house was fantastic because they could see the way I was doing things. It really made the program. They met the kids and gave suggestions of how to apply some of the things we learned.* (Laura)

> *It was important for me to carry through, sometimes it was hard for me not to give in and stick to what I needed to do, and the home visits were good to*

give me some ideas and help me carry through. I liked the one on one. (Kristy)

Discussion

The findings provide support for the design of the MHPPP program and indicate that the program modification effectively addresses the needs of participants. Without being prompted by the researcher, participants highlighted the program enhancement as essential to their strong engagement and satisfaction. In addition to the benefits of being in a group with others with mental illness, the findings indicate that the program components that address parenting with a mental illness, child development and the home visits are valuable.

Being in a group with others with mental illness

The finding that parents benefit from sharing their experiences with other parents who experience mental illness is consistent with the literature (Isobel et al., 2016; Reupert & Maybery, 2011; Shor et al., 2015). It is increasingly recognised that opportunities for parents to learn *from* and *with* other parents is an important aspect of programs for parents with a mental illness (Reupert & Maybery, 2011; Shor et al., 2015). A study by Isobel et al. (2016) found that the group format for parents with a mental illness is particularly suitable as it allows for parents who are initially reluctant

to actively engage and observe others sharing openly and share when they are ready, as the group progresses. Furthermore, being in a group with others who have a mental illness is important to engagement as it helps overcome the stigma many parents with mental illness experience accessing generic parenting programs (Ackerson, 2003; Biebel et al., 2014; Reupert & Maybery, 2011).a

Focus on child development and parenting with a mental illness

The finding that parents found the focus on parenting with a mental illness particularly beneficial is consistent with the recovery-focussed literature that highlights the importance of considering the parenting role, family relations (with a particular focus on supporting the parent-child relationship) in recovery for all family members (Price-Robertson, Obradovic, & Morgan, 2016).

The session called ‘the impact of mental illness on parenting’ encourages parents to explore the impact of their mental health issues on their parenting, reflect on their parenting in the context of their mental illness and plan for times when they are less well. While the facilitators consistently observe that participants find this session confronting, and that many parents are initially reluctant to engage in this session as they experience guilt and shame around the impact of their illness on their children, the findings indicate that this session has a positive impact on their parenting. This session provides an opportunity for parents to express their anxiety and concern around the impact of their mental illness on their parenting, and, as the findings suggest, this process appears to alleviate some of the anxiety and stress around this, allowing parents to be kinder to themselves, and in turn, to their children.

Participants also highlighted the session focussed on child development as important in helping them better understand their children's experiences. The session titled *'*children's fears, friendships and schooling', identifies appropriate expectations of children across different ages in regards to their fears, friendships and schooling, and aims to challenge unrealistic parental expectations. Evidence indicates that parental knowledge of child development impacts positively on parenting styles, and is associated with parental sensitivity and less harsh responses to their children (Sanders & Morawska, 2014; Zand et al., 2015).

The home visits

The findings highlight that parents appreciate the home visits, which is consistent with the literature that highlights the benefits of meeting with families in their natural environment (Mills et al., 2012; Rautio, 2012; Taylor et al., 2015). More specifically, evidence presented by UCD Geary Institute for Public Policy (2016) in Ireland shows the many positive outcomes of incorporating Triple P principles into home visiting programs, including improvements in children's cognitive development, attention control, motor skills and social skills.

Home visiting provides an opportunity for the facilitators to coach parents in problem solving, to model strategies directly with children and to provide parents with feedback. Role modelling and coaching is an effective way to facilitate social and parenting skill development (Mills et al., 2012). Home visiting builds on and helps to

embed the learning that parents have gained from the group program. Home visits also provide parents an opportunity to further explore how to talk to their children about their mental illness at an age appropriate level and how to allay any fears their children may have. Children may feel that they are responsible for their parent's mental illness and may feel a burden to 'fix it', or they may feel worried or alone. Supportive conversations with children of parents with mental illness, either led by the parent themselves or a facilitator, have been shown to be very valuable in reducing children's sense of isolation and worry (Drost, van der Krieke, Sytema, & Schippers, 2016; Grove, Reupert, & Maybery, 2013).

The home visits also provide opportunities to engage with the other parent/caregiver who had not attended the group program, although this did not happen frequently. The groups as well as the home visits are delivered during the day, which make them less accessible to working parents, and this is a limitation of the program. From the perspective of the facilitators, the home visits are helpful in modelling some of the techniques to the parent who did not attend the group to help ensure that both parents "*are on the same page*". Parental conflict is an unintended consequence of some parenting programs, as one parent tries to makes changes without the other parent's commitment to the change, and as such engaging both parents is important (Mockford & Barlow, 2004; Rautio, 2012). Facilitators find that partners/caregivers are generally interested and supportive once they understand the principles behind the program.

All parents in our program are offered home visits and most receive these visits. Barriers to home visits include parents not living in independent housing (e.g. living

with a relative) or parents living out of area by the time of the home visits. Parental anxiety or fear of judgement are also potential barriers to the home visits, however the relationship formed during the course of our group appears to help parents overcome this.

Conclusion

There are few evidence based parenting programs that have been specifically developed for parents with a mental illness and this study helps address this omission. The findings highlight those components of the MHPPP program that are most valued from the participants' perspective, in particular the importance participants attach to sharing the group experience with other parents who also experience mental illness. The findings suggest that being in a group with others who also have a history of mental illness is important to help overcome a common barrier to engagement in parenting programs for this population, namely stigma.

The majority of participants (around 80% of the entire cohort) completed all aspects of the program including the home visit component, indicating high levels of engagement. This challenges evidence that indicates that a ten week program is too long for high need families (Joussemet et al., 2013); however, it is possible that the high levels of engagement in MHPPP can be attributed to the combination of group work and home visiting.

In terms of limitations of this study, specific to the qualitative interviews, it is important to recognise that 18 participants is a small sample size. However, this is common in qualitative research and saturation was achieved as no new themes emerged during the last couple of interviews (Charmaz, 2006). The interviews shared significant commonalities and the same key themes emerged across the majority of interviews. Furthermore, the key themes that emerged in the telephone interviews are consistent with those captured on the CSQ by a larger sample size. In addition, the interviews were all conducted over the phone, so body language could not be interpreted.

While our findings provide some insight into the components of the program that are important in terms of consumer satisfaction, this study is limited in scope and does not claim to be representative of the population of people with mental illness. In particular, participation in the MHPPP program and, as such, this study is limited to people with mental illness who are available during the day, as the program is delivered between nine and five. The current study should be read in conjunction with our quantitative evaluation of the program as outlined by Phelan et al. (2012) as together these studies present a more complete evaluation. The participants in the qualitative component of the overall evaluation (as reported here) are unique to this study. Approximately half of the participants who completed the CSQs also participated in the study by Phelan et al. (2012) (from feedback received between 2006 and 2011).

Given the strong association between parental mental illness and adverse child outcomes, the MHPPP is a promising avenue for early intervention in this population.

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