

TITLE: Family-focused practice with EASE: A practice framework for strengthening recovery when mental health consumers are parents.

ABSTRACT

This paper provides a framework for essential family-focused practices (EASE: Engage, Assess, Support, Educate) for clinicians to support parents with mental illness in the context of their family. The framework is underpinned by relational recovery as the parent/consumer's recovery is considered within the context of their relationships, including the relationship between clinician and parent/consumer. The central aim is to strengthen nurses' and other clinicians' capacity to address key psychosocial needs of parents and to strengthen relational recovery in families where parents have mental illness. The EASE framework is a theory and evidence-informed family practice approach to relational recovery within healthcare provision. The EASE practice components are defined and illustrated with practice exemplars that operationalize the framework within adult service settings. Potential applications and outcomes of using EASE are also described. The framework is intended as a practical guide for working with parents and families in inpatient and community mental health settings, and may also be relevant for clinicians in a range of contexts including child welfare and primary health care.

KEYWORDS

Recovery, parenting, family, mental illness, family-focused practice, children

INTRODUCTION AND AIM

Family and significant others provide essential psychosocial support to mental health consumers. Many consumers are, or will become, parents. Yet individualistic approaches to practice continue to dominate mental health service provision. There is a need for more inclusive approaches that address family relationships and needs. Nurses and other clinicians play key roles in supporting the recovery of parents with mental illness and it is well-established that family-focused practice is necessary; however there are significant system and organizational barriers to making it happen. There is a critical need for practice frameworks that provide guidance on clinician-initiated family-focused interactions. The central aim of the paper is to describe the EASE practice framework for family-focused practises to strengthen clinicians' capacity to address key psychosocial needs of parents and to strengthen relational recovery in families where parents have mental illness. EASE builds on the existing therapeutic relationship between clinician and parent/consumer and draws on clinicians' knowledge about consumers' family contexts.

BACKGROUND

Working with families in mental health

Family members and significant others are important relational connections in peoples' lives. The presence or absence of supportive relationships is known to influence mental, emotional, social, and physical health and wellbeing (Umberson & Montez 2010). In the context of mental health, family members and carers provide essential physical and psychosocial support to people with mental ill-health, many of whom are or will become parents (Naughton et al. 2017). While much of the literature on parents with mental illness has focused on meeting their needs, it is

important to recognize that parents are in mutually dependent relationships with their family. Thus, family and other close relationships are multi-directional (Reupert et al. 2015). These relationships have an impact on the person with mental illness. The individual and his or her mental illness has a reciprocal impact on children and other family members in a ‘give and take’ process (Reupert et al. 2015; Ward et al. 2017). ‘Family’ has been variously defined in the literature, but includes individuals with mental illness and their partners, children, extended family members such as grandparents, and close personal relationships. Following Osher and Osher (2002), in this paper ‘family’ is understood to be defined by its members and is not limited to a heteronormative nuclear family structure.

In Australia and elsewhere the individualistic medical model has impeded a deeper understanding of the psychosocial family context within which people with mental illness live, with missed opportunities for enhancing individual and family or relational recovery (Nicholson et al. 2015; Price-Robertson et al. 2016; Reupert et al. 2015). Due to this, there are mounting calls for more inclusive approaches that consider adults in the context of their family life, and recognize child, parent, and family relationships and the needs of parents (Foster & Isobel 2017; Foster et al. 2012; Goodyear et al. 2015; Price-Robertson et al. 2016; Weimand 2013a).

Relational recovery is an emergent approach in mental healthcare that views people as inter-dependent relational beings, and relationships as being multi-directional and both positive and negative. From a relational standpoint recovery from mental illness is understood to occur in the context of relationships as a social process where relationships affect all aspects of recovery (Price-Robertson et al. 2016). From this perspective, family and family relationships are the context for recovery for people with mental illness who are parents.

Family-focused practice and recovery in mental health

Nurses and other clinicians play key roles in supporting the recovery of parents with mental illness through family-focused practice (Foster et al. 2012; Foster et al. 2016; Grant & Reupert 2016; Korhonen et al. 2010; Reupert et al. 2015). Family-focused practice (FFP) is the provision of psychosocial support to the family as a unit. This may be through working directly with the person with mental illness, and/or with their child/ren, partner or other family members (Foster et al. 2012). This approach acknowledges the strengths as well as vulnerabilities of individual family members and the family as a whole, and aims to support family choices and collaboration in treatment (Foster et al. 2016). Timely provision of FFP can help reduce subjective and objective burden for family members, improve mental health literacy, support family relationships, children's wellbeing, and family recovery, and be preventative for intergenerational mental illness (Foster et al. 2012).

Six core elements of FFP derived from systematic review of the literature are: assessment, provision of psychoeducation, social, emotional, and practical support, family care planning and goal setting, liaison between families and services, and a coordinated system of care (Foster et al. 2016). For families where parents have mental illness, elements of particular relevance include psychoeducation for parents, children and key family members, appropriate mental health intervention for the parent, and parenting support (Marsten et al. 2016). Traditionally, clinicians have often worked with consumers in a clinician/consumer dyadic conversation. However, triadic conversations, where a family member such as a child or partner is also present (Dalton 2013), can include family members' knowledge, attitudes and expectations and help the parent/consumer and family member identify and address their particular needs. As relevant for

each family, it may be important to include triadic as well as dyadic conversations that explore each family member's needs.

Clinicians can find it challenging, however, to support parents in the context of their family due to a range of barriers including lack of relevant practice models and training (Goodyear et al. 2017; Maybery et al. 2016; Weimand 2013b). Evidence indicates there are service-related, clinician-related, and family-related barriers to provision of mental health family-focused care. There is a substantial body of evidence that while nurses and other clinicians recognize the importance of addressing consumers' needs as a parent and family member, they can struggle with a lack of confidence, lack of role clarity, and lack of clinical skills and knowledge to engage readily with parent/consumers and their children about mental illness (Foster & Isobel 2017; Goodyear et al. 2015; Maybery et al. 2014). Inadequate time, lack of structure and resources are further barriers to working in a family-focused way (Grant et al. 2016), as are staff shortages, high workloads, and high staff turnover; particularly in acute inpatient settings (Grant et al. 2018). Barriers also stem from clinicians' attitudes, knowledge, and skill set on child and family support needs (Foster & Isobel 2017; Grant et al. 2016), and from parents, children and adult family members who may be reluctant or not available to discuss family issues (Grant & Reupert 2016; Maybery et al. 2015).

DESIGN AND METHOD – EASE PRACTICE FRAMEWORK

As defined by Connolly (2007), practice frameworks are conceptual maps for clinical practice with specific client groups which are presented in an accessible format. As a conceptual map, the framework "links the foundational philosophical and theoretical underpinnings with the practice

interventions used to support desired outcomes” (Connolly, 2007, p. 827). Such a framework provides the means by which theory, practice and research are integrated (Connolly 2007) to support better outcomes for parents and families where parents have mental illness. The EASE framework is evidence- and practice-informed and underpinned by the conceptual framework of relational recovery (Price-Robertson et al. 2016), and by principles of implementation science (Fixsen et al. 2009). The framework is intended as a tool to provide clinicians with theoretically-informed practice logic (Connolly 2007) including a set of initial questions and actions to support foundation family-focused practices.

In respect to evidence, the EASE framework is informed by substantial international literature in the field of families where parents have mental illness, and family-focused practice, and by the authors’ expert experience in the field. The elements of EASE are based on systematic review of international evidence on FFP (Foster et al., 2016), and prior review and guidelines on the continuum of FFP (Foster et al. 2012; Goodyear et al. 2015), which have identified key components of FFP. However, these reviews and guidelines have yet to be operationalized into a brief descriptive framework for essential practices for parents with mental illness receiving mental health services.

From an implementation science perspective, a structured practice framework can act as an important driver to enhance worker skill and competency, and to provide organisational leadership with standards to guide performance development and practice monitoring. These are significant structural supports required to underpin the translation of new practice into routine service delivery (Fixsen et al. 2009; Michie et al. 2009). The benefits of distilling theory and

evidence into a concise practice framework to guide family-focused work in various settings and sectors can assist with translation to practice issues (Goodyear et al., 2015). The known barriers to family-focused practice (e.g. Landeweer et al. 2017) can be addressed through clear operational definitions and practice specifications, and careful and considered development of workforce training foci and strategies (Biebel et al. 2014; Fixsen et al. 2005).

EASE PRACTICE FRAMEWORK

Family-focused practices exist on a continuum of intensity ranging from essential or foundation practices such as identification of parent status and checking child/ren's status, through to higher intensity practices such as family case management and family therapy (Foster et al. 2012). The EASE practice framework sits at the essential end of the FFP continuum (Foster et al. 2012). EASE is a brief, low intensity intervention of foundation family-focused practices upon which more intensive practices can build and extend. Towards the lower end of intensity this would be, for example, a brief 2-3 session approach like Let's Talk (Solantaus et al. 2009), through to higher intensity approaches such as the Family Model approach (Falkov 2015), and Family Options (Nicholson et al. 2016). The EASE framework stands for: Engage, Assess, Support, Educate. This concise family-focused practice framework can be used to obtain meaningful information about parent/consumers and their families and to meet immediate needs.

The EASE framework has a set of underlying practice principles and specific core components to guide clinicians. These can be integrated into a conversation or sequence of conversations the clinician has with the parent over the course of their relationship. Whether the relationship is short-term or ongoing, the premise of EASE is that a conversation of any length about parenting

and family can promote an impactful clinician/parent relationship and open the door to further support for the family including more intensive family-focused interventions. While EASE is focused on parents with mental illness, as relevant for each family situation the practices also include consumers' partners and children.

Principles of EASE

Key underlying principles of EASE reflect aspects of an approach to practice that shape the clinician's 'stance' with the parent (Emerging Minds 2016). These include: addressing stigma and hesitancy; taking a parenting focus with an eye towards the person's roles, responsibilities and priorities as a parent; promoting resilience and recovery; understanding families' unique experiences; and reflecting on practice experiences that may remind or be similar to the clinician's own life experiences. Further, EASE is informed by practice underpinnings that promote an approach that is family-centered, strengths-based, recovery-focused, and trauma-informed (Nicholson et al. 2016; Nicholson et al. 2014). Family-focused practice standard recommendations that are relevant to EASE include obtaining essential information about consumers' status as a parent and that of their children; considering parents' strengths, resources and vulnerabilities; supporting the parenting role; and considering, as relevant, the support needs of key family members such as partners and children (Goodyear et al. 2015).

The key principles that underpin EASE practice framework are therefore: (1) take a parent focus, that is, consider the person's status, roles, responsibilities and desires as a parent; (2) recognize a parent's strengths and resources as well as vulnerabilities; (3) acknowledge the contribution of family life experiences and relationships to a parent's recovery and the mutuality in family

relationships; and (4) understand that, while many life experiences may be similar or shared, each parent and family is unique, with goals specific to their family, cultural context, and past and present circumstances. These principles are focused on identifying and building strengths, enhancing recovery, and strengthening family relationships (Goodyear et al. 2015; Reupert & Maybery 2014; Van der Ende et al. 2016).

Components of EASE

The key components are essential family-focused intervention processes (Foster et al. 2016) that can promote positive outcomes for consumers who are parents, and as relevant, their child/ren and partner. These components do not necessarily need be addressed in a linear fashion and have feedback loops that integrate and strengthen the approach. Practices may overlap and/or occur at the same time, for example engagement and assessment. Nevertheless, each component has distinct actions and purposes as described below. The components and practice guidelines and examples are outlined in Table 1, and are demonstrated in practice examples for inpatient and community settings.

Engage

Engagement is the process of building a relationship with a parent (and family members as relevant), and building rapport and a sense of trust and collaboration in the work to follow. A positive therapeutic alliance is a core feature of effective clinical relationships in mental health (Thurston 2003), and is characterized by mutual partnership and consumer empowerment. A positive therapeutic alliance has been associated with positive healthcare experiences and outcomes for consumers (Zugai et al. 2015). When parents have mental illness, the alliance requires careful consideration by the clinician of factors that may conspire to make a parent

reluctant to form a relationship and openly discuss aspects of parenting, family life and the impact of mental illness on their children. Consumers' experiences may range from never having been asked about their parenting status before, to having been quizzed about their child's family life by workers, to having been thoroughly investigated in their home by child welfare workers (Hine et al. 2018). Consequently, parents may think talking about parenting is not important, inappropriate, or even risky, if the custody of their children has ever been in question (Grant et al. 2018). This hesitancy or reluctance may have been viewed by clinicians in the past as non-compliance, avoidance or manipulation on the part of the parent.

A non-judgmental approach will promote engagement in the clinician/parent relationship (Nicholson et al. 2014; Reupert & Maybery 2014), and assumes that a parent has the capacity to parent regardless of their illness status. The engagement approach involves open-ended questions to curiously explore the consumer's parenting status and family relationships, details about their children, key values and goals in relation to parenting and their family, and building the foundations for a collaborative partnership focused on addressing the parent's (and as relevant their partner's/child's) current key needs in relation to the parent's mental illness.

Assess

Assessment here is focused on essential aspects of the impact of mental illness on family functioning rather than a comprehensive family assessment. Assessment involves identifying consumers as parents of dependent children and any adult children, and the current parent/child situation (e.g. whether parents and children are living together), whether the parent has a partner, key family relationships, and strengths and needs as a parent (Foster et al. 2016). Asking these key questions early in the working relationship with parents can support the therapeutic alliance

through showing interest and concern, and encourage positive change in families (Reupert & Maybery 2014). This does not mean the clinician must meet with each family member; they may only have contact with the consumer who is a parent to reflect on their family needs. Parents may be at different ages and life stages, with dependent children living with them or adult children with whom they have supportive or conflicted relationships. Children may provide support and caring themselves, perhaps appropriate for adult children but less so for young children.

An understanding of family relationships and circumstances will inform family-focused treatment planning and discharge planning (Reupert & Maybery 2014). Respect for these relationships and working together on issues associated with a parent's goals for their parenting in treatment will contribute to engagement in the clinician/parent relationship and a positive therapeutic alliance – an example of the feedback loops in EASE practices. Importantly, any assessment and actions that clinicians take as a result of interactions with parents or family should be documented in the parent/consumers' case notes.

Support

Support includes brief practical or instrumental support such as helping organizing transport and referring parents to other relevant services (Foster et al. 2016; Reupert & Maybery 2014) for example, Family Support Services or Carer Support Services. Parents also benefit from support in developing and pursuing realistic goals, to take successful steps and achieve their vision for the future. Support includes emotional support and empathy with regard to parenting needs and family relationships (Bartlett et al. 2006; Foster et al. 2016). All parents benefit from support, particularly those whose current functioning may be compromised by illness. While a clinician may focus on routine clinical recommendations, a parent may be focused on meeting practical

family needs, which may conflict with the parent's ability to participate in or benefit from treatment. Alignment of parenting and treatment goals can help improve parents' willingness to engage in mental health and family support service plans, and ability to achieve success. Parents and family members may also benefit from advocacy (Foster et al. 2016) in securing community-based resources, identification of appropriate peer support groups, and/or assistance navigating the appropriate service system.

Educate

Evidence-based family psychoeducation is a well-established process in mental health (Ward et al. 2017) and is the foundation for this component. Educate includes raising parents' awareness of the impact of parenting on their mental health, and the impacts of parental mental illness on child and family wellbeing (Foster et al. 2012). Empowering parents to understand more about their mental illness, and to take the lead in the process of informing their family, is aligned to the recovery approach (Ward et al. 2017). Parents may request help in talking with their children or partner about their illness (Grant et al. 2018). Parents and their children benefit from accurate, credible information about their disorder, relevant treatment approaches, and potential pathways to recovery. For children, gaining a basic understanding of mental illness and dispelling myths (e.g. that they are to blame for their parent's illness) can be powerful messages that alleviate worry and distress and contribute to prevention of intergenerational mental illness (Foster et al. 2012; Grove et al. 2013). Psychoeducation can also encourage children to initiate conversations with parents about their parents' illness (Grove et al. 2015) and may lead to them engaging in peer support programs. Information for parents and family can be provided verbally, in written form (e.g. pamphlets), and through online or web-based, audiovisual (e.g. DVD), or smart-phone

applications. Parents can benefit from information about the array of services (e.g. housing, childcare, social services) helpful to their recovery as well as to support optimal family functioning. As Reupert and Maybery (2014) contend, parents may also benefit from knowing the value of developing a care plan for their children, should the parent become unwell again in the future.

CONCLUSION

We present the EASE framework as a tool that may be beneficial for clinical practice. The framework addresses essential aspects of family-focused practice and sits at the foundational end of a continuum of family-focused practices. It is a brief, low intensity intervention that aims to strengthen clinicians' capacity to address key psychosocial needs of parents and to strengthen relational recovery in families where parents have mental illness. The framework is intended to be integrated as part of routine clinical practice in adult mental health settings and potentially other contexts such as child welfare and primary health care. From an implementation science perspective (Fixsen et al. 2009), translating the EASE framework into practice requires development of tailored training and resources to support the integration of the framework into routine clinical practice, and the monitoring and evaluation of resulting practices. From a research perspective, a hybrid design would be appropriate, with the collection of both implementation process and outcome data. This approach suggests the relevance of measuring proximal and distal outcomes for clinicians and parent consumers.

IMPLICATIONS FOR PRACTICE

Clinical practice may be enhanced with a clearly articulated brief practice framework which provides nurses and other clinicians with an evidence-informed practice tool to guide them in essential family-focused practices. The application of these essential practices could make practice more effective, and therefore more rewarding, and support positive parent, child, and family outcomes. Practice which meets consumers' family-related needs can improve their understanding of their situation, their satisfaction with service provision, and self-efficacy. A succinct, well-articulated and pragmatic framework such as EASE can be readily implemented, facilitate FFP and fit seamlessly into everyday practice, making work easier and potentially more rewarding for the consumer and the clinician. Following training in applying the EASE framework, these impacts could be documented, monitored and sustained. Research on the process of implementation as well as impact of this approach, measured in terms of clinicians' practice change as well as parents' outcomes, would support and enhance the contribution of the EASE framework to the field of family-focused practice.

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TABLE 1: EASE Framework with Practice Guidelines and Examples

| EASE Framework Element | Practice Guidelines | Practice Examples |
|---|--|---|
| <p>Engage: the process of approaching the person, building positive rapport, and strengthening a relationship with the person</p> | <p>Identify the person’s parenting status, whether they have a partner, and other significant family relationships.</p> <p>Briefly explore basic details about their children (e.g., age, where living, school, who provides care, frequency of contact, nature of relationship).</p> <p>Acknowledge that talking about mental illness with children and family may be challenging (or, alternatively, quite rewarding).</p> | <p>“Could you tell me a little about your family?” “Do you have children?” “Do you have a partner?”</p> <p>“How old are your children?” “Where do they live?” “Are they in school?” etc.</p> <p>“It sounds like you’re worried that managing your illness/hospitalization is stressful for your children and your partner. They may also be relieved that you are safe, managing your illness and getting help. We can talk about ways to help them and you cope.”</p> |
| <p>Assess: the process of obtaining information about the person’s responsibilities, goals and needs as a parent and a partner, along with some understanding of their life context and family needs and concerns.</p> | <p>Explore parenting/family roles and responsibilities, and what the person has talked about in terms of their illness with their family.</p> <p>Ask about person’s partner; the ways they communicate; and what their partner’s main concerns might be in relation to their mental health.</p> | <p>“Have you talked with your child/ren about your mental health?” “You have [#] children, what do you think [child] would say if s/he was here with you?” “What do you think your children’s concerns are in relation to your mental health?”</p> <p>“Have you talked with your partner about your mental health?” “What do you think your partner worries about?” “Does your partner have ideas about solution(s)?”</p> <p>“What would be the most helpful for talking about your mental health with your child/partner?”</p> |

| EASE Framework Element | Practice Guidelines | Practice Examples |
|---|--|--|
| <p>Support: the process of supporting the parent, helping the parent to support children/partner/ other family members, accessing professional services and building natural supports.</p> | <p>Ask about immediate unmet needs in relation to person’s children & family</p> <p>Ask about informal or natural and professional supports for the parent and family members.</p> <p>Suggest available resources and make referrals.</p> | <p>“If there’s one thing we could help you (your partner/child) with today, what would it be?”</p> <p>“Who do you (your partner) turn to when you need help?” “Who depends on you? For what kinds of things?”</p> <p>“It sounds like you would like more support with parenting when you’re unwell. Here’s some contact information for support services (eg. Family Support/Carer Support/Peer Support) that could be helpful”.</p> |
| <p>Educate: the process of providing information and access to psychoeducation resources to help the individual & their partner/child understand his/her illness and recovery and support the development of children’s resilience to mitigate the potential impact of their parent’s mental illness on their lives.</p> | <p>Identify the main information needs at present for the parent (partner/child)</p> <p>Provide verbal, written and/or online psychoeducation resources for person, their child/ren, and partner, as relevant.</p> <p>Leave parent and/or family member with a verbal list of things that are going well, and the strengths and resources they have in place.</p> <p>Remind the parent that change happens in small steps and leave them with hope for the future.</p> | <p>“If there’s one helpful thing you’d take away from our conversation, what would it be?” (If patient/parent can’t think of anything, e.g. “Could you give me some clues?”)</p> <p>“There have been lots of resources developed for parents and families living with mental illness. Here’s some information (verbal/written/online) that may be helpful for you/your partner/child”.</p> <p>“You’ve told me about some ways in which you are quite successful at” “You’ve made real progress in.....”</p> <p>“Change happens in small steps. What would the next step look like?” “How will you know when you have taken that next step?” “How can we help?”</p> |

PRACTICE EXAMPLE – USING EASE IN AN INPATIENT SETTING

Tony and Mary have been together for 7 years and recently had their first child. Mary also has a 9 year old boy (Danny) from a previous relationship. After years of IVF treatment, Mary gave birth to a baby girl (Hayley) 4 months ago. While excited, Tony, who had a history of major depression but had not had any major episodes during their relationship, continued to work long hours. Mary had stopped work to care for the baby. In the first months since Hayley was born Tony has become more and more engrossed in his work, and talked incessantly with Mary about being watched by others. Mary noticed Tony withdrawing from Hayley, rarely responding to her cues, nor helping Mary parent the children. Mary and Tony's relationship deteriorated further after Tony was sacked from his job for sending messages to his boss' wife, believing they could run away together. Tony agreed to go to the emergency department with Mary and was admitted to the mental health inpatient unit as a voluntary patient.

James, a registered nurse, had admitted Tony to the unit and asked him as part of the initial assessment about his family [ASSESS], so knew he had a partner and two children. James saw that Mary visited Tony regularly with Hayley and Mike, and they went to the Family Room in the unit. Tony had been commenced on oral antipsychotics, with significant side effects. Mary kept in regular communication with staff about Tony's treatment plans, and it was decided that Tony would be transferred shortly to a step-down facility for monitoring with his medication. James approached Tony a few days before his transfer, and chatted with him about his children and family [ENGAGE]. James acknowledged that Tony's admission might be challenging for him, Mary and the children [ENGAGE], and asked Tony what he thought Mary's main concerns might be in relation to his illness and admission [ASSESS]. Tony thought Mary was trying to understand his illness as this was the first time he had been really unwell during their relationship. James also asked Tony whether he and/or Mary had talked with Danny about his illness [EDUCATE]. They had explained to Danny that Tony was unwell but not specifically about his illness as they didn't want to worry him.

James asked Tony if there was one thing he could help with today in relation to his family's needs, what would that be? [EDUCATE] They agreed that information for Mary about Tony's illness, and some ideas on how to talk with Danny about his illness, would be most helpful. James got two information packs that were kept on the unit and discussed them with Tony [EDUCATE] – one pack for family/carers, and one for parents with school-aged children. They included psychoeducation material – a 'flip' book with information for parents with mental illness, and on the 'flip' side information and key messages for their children that parents and children could talk about together. There were brochures for Mary on depression and psychosis, Carer Support Services, and a local Peer Support Group for children of parents with mental illness [SUPPORT], and fridge magnets for a website which had information and videos for children and parents about mental illness. James encouraged Tony to discuss the packs with Mary when she visited [EDUCATE] and acknowledged Tony's and Mary's strength and

commitment to each other and to their children [SUPPORT]. James later documented their discussion and his actions in Tony's case notes, and referred Tony and Mary [SUPPORT] to the local Family Support Services team for when Tony moved to the step-down unit.

PRACTICE EXAMPLE – USING EASE IN A COMMUNITY SETTING

Helen, aged 20, is the single mother of Jonah, a baby boy aged 8 months. Jonah was born four weeks prematurely and has been quite unsettled since birth. Helen and Jonah live with Helen's father, Tom, a widower since Helen's mother died a year ago. Helen's father suspects that Helen suffers from post-partum depression, and has encouraged her to talk with her GP, which she has refused. Helen is afraid that child protection services will take her son away, particularly as she was treated at an out-patient clinic for anorexia nervosa when she was 18. Helen had however fully recovered from what she called "her youth problems" after receiving treatment for a year.

A couple of months ago, Helen re-connected with Jonah's father; Chris and they agreed to cooperate together on Jonah's upbringing. Chris is ten years older than Helen; he owns his own apartment and has a secure job. Even though Helen realizes she may have post-partum depression, she is afraid to talk with Chris about it. After Helen's mood further deteriorates, her father has gained her permission to speak with the community mental health team (CMHT) for advice. Helen's father Tom rang the CMHT and spoke with a mental health nurse and asked if Helen could get some help with establishing a wider social network for young mothers and if she could be referred to the CMHT. Tom also indicated he would like to discuss his own concerns in supporting Helen and Jonah.

The following week, an experienced registered nurse, Patricia, visited Helen at home. Patricia asked Helen how she was doing [ASSESS], and talked with her about usual challenges for a first time mother [ENGAGE]. Helen said she suffered from lack of sleep, and that she worried a lot about the baby. Patricia asked who Helen could ask for help and assistance [SUPPORT]. Helen explained that she really missed her mother who used to be an important support for her, and that her father was really not able to help her as she felt like he was interfering. Patricia acknowledged that it must be hard for Helen not having her mother there for support [ENGAGE]. They also talked about Chris and how he might further support Helen [SUPPORT]. Helen acknowledged she was a bit worried that she might suffer from post-partum depression.

Patricia asked Helen if she had talked with her father or Chris about her worries and her mental health [ASSESS] and whether she thinks either of them might have some worries or questions, or even some ideas about solutions [ASSESS]. Helen said she would like to include Chris more, but she's also afraid he might withdraw if he thinks that she's unwell. On the other hand, her father might need some explanation and support about parenting young babies; Helen has noticed that he worries a lot about the baby, which is also stressful for her. Patricia says she understands Helen's concerns and affirms that most parents can find parenting stressful, particularly if the baby is unsettled, and that parenting support can be beneficial in helping them cope [EDUCATE]. She gives Helen some booklets on parenting tips for young babies and suggests Tom might also like to read them [EDUCATE]. Patricia offers to meet with Helen and Tom at a convenient time to talk about any concerns he might have and how he can best support Helen

and Jonah [EDUCATE]. Patricia observed Helen cuddling Jonah throughout the visit and reassured Helen she was being responsive and loving [SUPPORT]. Patricia suggested that Helen might benefit from meeting other young mums and their children in her local community mother-baby group [SUPPORT]. She also sought Helen's permission to refer her to a psychiatrist within the CMHT to discuss her postpartum symptoms [SUPPORT] and Helen agreed. Patricia recorded the home visit, her assessment and actions taken when she returned to the CMHT.