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# Different perspectives in psychiatry: how family-oriented are professionals in Germany?

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## Abstract

**Background** Children of parents with a mental illness have up to 50% chance of developing a mental illness themselves. Numerous studies have shown that preventive family-oriented interventions can decrease the risk by 40% and that professionals are a decisive factor influencing family-oriented practice. There are also substantial differences between professions in terms of their family-oriented practices. This study examines the level of family-oriented practice for different professional groups in Germany.

**Methods** Data were used from the baseline assessment of the two-group randomized controlled multicenter trial *ci-chimps* as a subproject of CHIMPS-NET, which took place from January 2020 to May 2021 in 18 clinical centers in Germany. Child and adolescent mental health systems as well as adult mental health systems took part and every professional involved in the treatment was invited to participate. Data was used from 475 mental health professionals including physicians, psychologists, psychotherapists for adults and for children and adolescents, occupational/music/ physio/ art therapists/ (social) education workers and nursing/ education service. Family-oriented mental health practice was examined using the translated version of the Family-Focused Mental Health Practice Questionnaire (FFMHPQ) with means and standard deviations calculated for each of the 18 FFMHPQ-GV subscales. ANOVAs were computed to compare professions and significant differences were examined via post hoc analyses (Scheffé). Additionally, effect sizes were calculated (Omega squared).

**Results** Differences were seen between the professions in all aspects of family-oriented practice: Both regarding organizational policy and support aspects, issues concerning working with parent-clients, as well as professional skills and knowledge aspects. Psychotherapists for children and adolescents scored the highest family-oriented practices compared to all other professional groups on almost all subscales.

**Conclusion** This study examines the level of family-oriented practice for different professional groups in Germany. Apart from skills and knowledge about the impact of mental illness and parenting, psychotherapists for children and adolescents had the highest scores and engaged most in family-oriented practice. Psychotherapists for adults got the least workplace support for family-oriented practice but were competent providing resources and referral information to the concerned families and feel confidence working with them. Due to these results, a training need exists

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to improve skills and knowledge about the impact of mental illness and parenting. Additionally, there is still potential for institutional support in promoting family-oriented work.

**Trial registration** The CHIMPS-NET-study was registered with the German Clinical Trials Register on 2019–12–19 (DRKS00020380) and with Clinical Trials on 2020–4–30 (NCT04369625), the ci-chimps-study was registered with the German Clinical Trials Register (DRKS00026217) on 2021–08–27 and with Clinical Trials on 2021–11–04 (NCT05106673).

**Keywords** Professional differences, Family-oriented mental health practice, Children of mentally ill parents, Child and adolescent mental health system, Adult mental health system

## Background

Worldwide, 15–23% of children live with a parent with a mental illness. These children have up to 50% chance of developing a mental illness themselves [1, 2]. Numerous studies highlight that preventive family-oriented interventions can decrease the risk by 40% of developing mental disorders within the children of mentally ill parents [2–6]. Although the huge benefit of family-oriented practice is verified, there is a lack of what exactly is meant by it, why there is an immediate need for an agreed definition [7, 8]. One exemplary definition is: “Family-oriented mental health practice is defined by how professionals involve the whole family in treatment, including responding to the parenting role of the patient” [9]. Foster et al. pointed out in their definition that family-oriented practice is often conceptualized variously in child, adolescent and adult mental health services depending on how practitioner decide, who the “family” consisted of [10].

Numerous studies show that family-oriented practice is important in the child and adolescent mental health system as well as in the adult mental health system identifying and treating families with children of mentally ill parents. But it could also be shown that several preconditions are required for a successful family-oriented practice: organizational factors (policies, leadership and management of the clinical center must support family-oriented practice), routines and procedures (time and workload for family-oriented practice), professional aspects like self-reported skills and knowledge about children of mentally ill parents and family-oriented practice, beliefs about job role (e.g. is it my task working family-oriented) and perception of workplace support [11–13]. Gregg et al. summarized in their systematic review as well both aspects influencing family-oriented practice: worker and workplace factors. Worker factors included similar aspects to those found by Maybery [11, 12] and Reupert [13]: Personal attitudes like beliefs about family-oriented practice and own abilities as well as aspects regarding training and education, job role and length of service. Workplace factors included available resources, work setting, workplace support and time and workload [7].

The German mental health system bases on a complex interplay of outpatient, day-care, inpatient and complementary services, whereby the present study focuses on the inpatient setting. In an inpatient context numerous different professional groups work together and have different perspectives on the patient. There is also a subdivision in Germany for children and adolescents as well as adults. It is system inherent, that child and adolescent mental health systems work more family-oriented compared to adult mental health systems and that this influences the professionals. But both mental health systems are relevant identifying families with children of mentally ill parents, however with different focuses: While talking to parents about their children can be an important preventive factor in adult mental health systems for example [14], in child and adolescent mental health systems more attention should be paid screening the mental health of the parents upon a child’s admission to the hospital [15]. To the best of our knowledge, there are no studies so far that have examined professional differences in both child and adolescent and adult mental health systems. The review from Foster et al. (2016) found that concept and scope of family-oriented practice differs in adult and child and adolescent mental health settings [10].

Measuring all aspects of family-oriented practice Maybery et al. developed the Family-Focused Mental Health Practice Questionnaire (FFMHPQ) [16]. It has already been used in different settings and countries, and it could be shown, that there are substantial differences between professions in terms of family-oriented practice. In Australia [17] and Thailand [18] social workers scored highest overall in family-oriented practice and psychiatric nurses had lower scores on almost all aspects of family-oriented practice. Similar results could be found in Norway, where social workers scored highest and physicians scored lowest in terms of family-oriented practice [19]. Using a Chinese version of the FFMHPQ, Yao et al. stated that psychiatric nurses reported less support to families and children and psychiatric nurses were more likely to think that there was no opportunity for engagement with families [20].

Gregg et al. concluded in their systematic review that social workers may be more likely than nurses, psychologists, and psychiatrists to use a family-oriented approach in their work, particularly in terms of offering support [7]. Furthermore, they determined, that psychiatrists may incorporate more family-oriented assessment practices into their work than other professions [7].

Summarized, it can be assumed, that there are substantial differences between professions in terms of their family-oriented practices in the mental health practice. According to previous research we assume that social workers (summarized in the category “e” with occupational/ music/physio/art therapists) score the highest and nurses the lowest in family-oriented practice. Due to the fact, that there is less information about how family-oriented psychotherapists are working no clear assumption can be formulated. This study examines the level of family-oriented practice for different professional groups in Germany. As this is the first study using the FFMHPQ-GV in Germany measuring family-oriented practice no precise hypotheses can be formulated.

## Methods

### Study setting and design

Data were used from the first measurement of ci-chimps (baseline assessment), which took place from January 2020 to May 2021 in 18 clinical centers in Germany. Ci-chimps stands for “clinical implementation of CHIMPS” and is a questionnaire-based, two-group randomized controlled multicenter trial. For more information about this study see the study protocol of ci-chimps [21]. Ci-chimps is one part of a larger project, called CHIMPS-NET (children of mentally ill parents-research network), which is a stepped care model for families with a mentally ill parent. For further information about the family-oriented preventive and therapeutic interventions in CHIMPS-NET see the study protocol of the central project CHIMPS-NET [22].

### Participants

From each participating center, both the child and adolescent mental health system and adult mental health system participated. Every professional involved in the treatment of the mental health clients of the 18 clinical centers that are part of the CHIMPS-NET project were invited to participate and there were no exclusion criteria. A total response rate can't be given because the exact number of employees for each clinical center is unknown. But we sent out 50 questionnaires per clinic, which is why we can assume at least 900 employees in total.

### Demographics and occupational information

Nine professional groups self-registered for the study including medical specialist, medical assistant, psychologist, psychotherapist, child and adolescent psychotherapist, occupational / music/physio/art therapist, (social-) education worker, nursing/education service and others. In order to take this important aspect into account and at the same time not to lose sight of the bigger picture, some professional groups were summarized. Finally, six professional groups were compared regarding their family-oriented practice: Physicians (including psychiatrists), psychologists (people, who studied psychology), psychotherapists for adults (people, who studied psychology and graduated a further education getting a psychotherapists specialized for adults (at least three years afterwards), psychotherapists for children and adolescents (people, who studied psychology or pedagogics and graduated a further education getting a psychotherapists specialized for children and adolescents (at least three years afterwards), occupational/ music/ physio/ art therapist/ (social) education worker and nursing/ education service.

Since family-oriented practice is system inherent in child and adolescent mental health systems, we decided not to compare the professions regarding their allocation to their mental health system but rather focus on the question which professions generally work in a particularly family-oriented manner.

Table 1 shows demographics and occupational information of the sample. As seen the mean age of all participants was 38.08 years, with a wide range from 19 to 68 years. 74.3% of the total 475 participants were female and 22.1% were male. Professionals working in the nursing/ education service worked the longest within their profession with 21.93 years. More than half of the participants worked in child and adolescent mental health systems.

### Outcome measures

Along with the FFMHPQ-GV [23], the Implementation Components Questionnaire (ICQ) [24] and Implementation Satisfaction Scale (ISS) [24] as well as a short self-constructed questionnaire was given to professionals eliciting age, gender, education, mental health service, profession type, place of service, and length of service (Fig. 1). Because of the covid-19 pandemic, an online medium was used in addition to a hard copy version. For the online assessment the platform “LimeSurvey” was used, the link was sent to all employees via the respective project employee of each center.

For the present research question, namely measuring professional differences in family-oriented mental health practice, only the FFMHPQ-GV was considered.

**Table 1** Demographics and occupational information

| Characteristics  | Age in years<br>M (range) | Gender<br>N (percentage) |             |                     | Time working in...<br>M (range) in years |              | Mental health system<br>N (percentage) |              |            |
|--|---------------------------|--------------------------|-------------|---------------------|--|--------------|--|--------------|------------|
|  |                           | Female                   | Male        | Diverse / no answer | Department                               | Profession   | Child and Adolescent                   | Adult        | Other      |
| All (n = 475)  | 38.08 (19–68)             | 353 (74.3%)              | 105 (22.1%) | 17 (3.6%)           | 6.13 (0–42)                              | 11.26 (0–42) | 287 (60.42%)                           | 168 (35.37%) | 20 (4.21%) |
| Physicians (n = 120)   | 40.37 (25–68)             | 76 (63.3%)               | 37 (30.8%)  | 7 (5.8%)            | 5.27 (0–25)                              | 11.71 (0–38) | 64 (53.33%)                            | 54 (45%)     | 2 (1.67%)  |
| Psychologists (n = 99)   | 31.39 (24–58)             | 81 (81.8%)               | 16 (16.2%)  | 2 (2%)              | 2.52 (0–18)                              | 4.45 (0–32)  | 59 (59.6%)                             | 34 (34.34%)  | 6 (6.06%)  |
| Psychotherapists for adults (n = 54)   | 39.55 (29–54)             | 42 (77.8%)               | 11 (20.4%)  | 1 (1.9%)            | 6.45 (0–28)                              | 11.68 (0–30) | 17 (31.48%)                            | 36 (66.67%)  | 1 (1.85%)  |
| Psychotherapists for children and adolescents (n = 56)                         | 36.41 (25–54)             | 47 (83.9%)               | 9 (16.1%)   | 0                   | 5.55 (0–20)                              | 9.02 (0–25)  | 55 (98.21%)                            | 0            | 1 (1.79%)  |
| Occupational/ Music/ Physio/ Art Therapist/ (Social) education worker (n = 74) | 42.38 (24–66)             | 61 (82.4%)               | 11 (14.9%)  | 2 (2.7%)            | 10.21 (1–39)                             | 15.46 (1–40) | 39 (52.7%)                             | 29 (39.19%)  | 6 (8.11%)  |
| Nursing/ education service (n = 43)  | 43.44 (23–60)             | 26 (60.5%)               | 15 (34.9%)  | 2 (4.7%)            | 11.03 (0–42)                             | 21.93 (2–42) | 32 (74.42%)                            | 11 (25.58%)  | 0          |
| Others (includ. Trainee) (n = 29)  | 33.50 (19–57)             | 20 (69%)                 | 6 (20.7%)   | 3 (10.3%)           | 4.80 (0–30)                              | 9.17 (0–38)  | 21 (72.41%)                            | 4 (13.79%)   | 4 (13.79%) |

The other two questionnaires (ICQ and ISS) focus more on the implementation process of ci-chimps and will be evaluated regarding other research questions. The FFMHPQ has 53 items with 18 subscales and measures different components of, and contributors to family-oriented practice on a 7-point Likert scale (ranging from strongly disagree to strongly agree plus not applicable). From the professional’s point of view, it records organizational and political aspects (e.g., workplace support, practice guidelines, local conditions, workload), the needs of the professionals (e.g., knowledge about families, skills about dealing with family issues, their interest in working with children, parents, and families) and what they might deliver to parents and children (e.g., psychoeducation). Additionally, it also gauges "external" factors such as health policy (see Table 2).

The FFMHPQ-GV showed a good reliability and validity. Cronbach’s alpha coefficients were between  $\alpha = 0.34$  to  $\alpha = 0.82$ , whereby 10 of the 18 subscales have a value  $> 0.70$  and 6 subscales show at least values ranging between 0.50–0.60. Rules of thumb suggest that internal reliability is good above 0.70 [25]. In the interpretation of the results, we did not take the subscales S9 ( $\alpha = 0.64$ ), S10 ( $\alpha = 0.34$ ) and S11 ( $\alpha = 0.57$ ) into account due to the insufficient reliability with low Cronbach’s alpha values [23]. The face and content validity were

estimated by a sample of clinicians and employees and was well rated [23].

**Results**

All statistical analyses were performed with SPSS (version 26.0 or newer). For the participants who had less than 5% missing values, the missing values were replaced with the Expectation–Maximization-algorithm [26]. From the 594 cases, finally, data was used from 475 mental health professionals.

**Professional differences**

To compare different professional groups regarding their family-oriented mental health practice in Germany, means and standard deviations (SD) were calculated for each of the 18 FFMHPQ-GV subscales (dependent variable). ANOVAs were computed for the professions (independent variable) and significant differences were examined via post hoc analyses (Scheffé).

Additionally, effect sizes were calculated (Omega squared,  $\Omega^2$ ) to estimate, whether the effect is large, small or medium, regardless of the significance. Omega squared is the effect size of choice for ANOVAS [25]. Values with  $\Omega^2 = 0.01$  represent according to Cohen a small effect size, with  $\Omega^2 = 0.06$  a medium effect and  $\Omega^2 = 0.14$  a big effect [25].

**ci-CHIMPS**  
**Befragung im Rahmen des CHIMPS-NET-P**  
**(Messzeitpunkt 1 – vor Beginn der Implem)**

Das zentrale Ziel von ci-CHIMPS (clinical implementation of C Interesse und den Weiterbildungsbedarf für familientherapeutische Gesundheitswesen zu ermitteln.

Der „Fragebogen zur familientherapeutischen Arbeit in Gesundheitswesen“ befasst sich übergeordnet mit den Fähigkeiten von Mitarbeitern, Richtlinien und Verfahren am Arbeitsplatz, Zeit- und Standortproblemen, Möglichkeiten für berufliche Weiterbildung sowie Selbstvertrauen in Bezug auf die Arbeit mit psychisch erkrankten Patienten, ihren Familien und Kindern. Die Fragen betreffen Kapazitäten und das Interesse der Mitarbeiter, mit Familien und Patienten zu arbeiten.

Im „Implementierungs-Komponenten-Fragebogen“ werden diese für die Vorbereitungszeit vor der Implementierung der f Intervention CHIMPS erhoben.

Die „Implementierungs-Zufriedenheits-Skala“ erfasst Ihre Zufriedenheit mit der Implementierung der familientherapeutischen Intervention.

Wir bitten Sie im Rahmen des CHIMPS-NET-Projektes an teilzunehmen und sind an Ihrer ehrlichen Rückmeldung zu Ihrer Organisation interessiert. Es gibt keine richtigen oder falschen Antworten. Ihre Teilnahme entscheidet, dauert das Ausfüllen 20 Minuten.

Bitte beachten Sie, dass der Begriff „familientherapeutische Arbeit“ all um den Prozess der Arbeit mit Kindern und Familien sowie mit Eltern zu beschreiben. Unter dem Begriff „Eltern-Patienten“ we psychisch erkrankte Eltern verstanden, die an einer Therapie/ Beratung teilnehmen. Die Vereinfachung wird im folgenden Text verwendet. Die jeweiligen Begriffe gelten jedoch in der männlich Form entsprechend.

Bitte kreuzen Sie für jede Frage die Antwort / Nummer ein, die Erfahrung entspricht.

**Vielen Dank!**

Chiffre: 1) \_\_\_\_ 2) \_\_\_\_ 3) \_\_\_\_

Alter: \_\_\_\_\_ Geschlecht:  W  M

In welcher Klinik arbeiten Sie?  
 Klinik für Kinder- und Jugendpsychiatrie  
 Klinik für Psychiatrie (Erwachsene)  
 Sonstige

In welcher Abteilung arbeiten Sie?  
 \_\_\_\_\_

Wie lange arbeiten Sie in dieser Abteilung? \_\_\_\_\_ (Anzahl Jahre)

Wie lange arbeiten Sie insgesamt in Ihrem aktuellen Beruf? \_\_\_\_\_ (Anzahl Jahre)

Ihre Qualifikation  
 Facharzt  Ergotherapeut / Musiktherapeut / Kunsttherapeut  
 Assistenzarzt  Sozialpädagoge  
 Psychologe  Pflege- oder Erziehungspraktikant / Auszubildende  
 Psych. Psychotherapeut  Praktikant / Auszubildende  
 Kinder- und Jugendlichpsychotherapeut  Sonstiges

Sind Sie (auch) Mitarbeiter im CHIMPS-Projekt?  ja  nein

Wenn ja, in welcher Rolle:  
 \_\_\_\_\_

Schwerpunkt der eigenen Tätigkeit  
 Kinder- und Jugendliche  
 Erwachsene

Arbeitszeit  
 Vollzeit

**Fragebogen zur familientherapeutischen Arbeit in psychosozialen Gesundheitswesen**

(Lasert et al., 2019)

| Nicht zufrieden | Stimme überhaupt nicht zu   | Stimme eher nicht zu | Stimme eher zu | Stimme voll und ganz zu |   |
|-----------------|---|----------------------|----------------|-------------------------|---|
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 1               | Mein Arbeitsplatz bietet Supervision an, um Mitarbeiter bei der kindbezogenen Arbeit bezüglich ihrer Eltern-Patienten zu unterstützen.                  |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 2               | In meiner Region mangelt es an Angeboten (z.B. anderen Beratungsstellen), an die man Kinder von psychisch kranken Eltern verweisen kann.                |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 3               | Es fehlt Zeit, um mit Familien oder Kindern zu arbeiten.  |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 4               | Die gesetzlichen Vorgaben bezüglich familientherapeutischer Arbeit sind sehr klar.  |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 5               | Fachliche Weiterbildung bezüglich familientherapeutischer Arbeit wird an meinem Arbeitsplatz nicht gefördert.   |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 6               | Ich erhalte häufig Unterstützung von meinen Arbeitskollegen bezüglich familientherapeutischer Arbeit.   |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 7               | Ich habe immer mal wieder Familientherapie (nicht Therapie) mit Eltern-Patienten und deren Familie.   |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 8               | Ich fühle mich unsicher mit Eltern-Patienten an ihren Erziehungskompetenzen oder familiären Themen zu arbeiten.   |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 9               | Ich informiere Bezugspersonen und/oder Familien nicht über die Medikation und/oder Behandlung des Eltern-Patienten.                                     |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 10              | Viele Eltern-Patienten betrachten ihre psychische Erkrankung nicht als Problem für ihre Kinder.   |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 11              | Ich kann den Entwicklungsfortschritt der Kinder meiner Eltern-Patienten einschätzen.  |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 12              | Ich wünsche mir manchmal, dass ich besser darin wäre, mit Eltern-Patienten die Auswirkungen ihrer psychischen Erkrankung auf ihre Kinder zu besprechen. |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 13              | Ich besitze Kenntnisse darüber, wie sich psychische Erkrankungen der Eltern auf deren Kinder und Familie auswirken.                                     |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |
| 14              | Es gibt keine speziellen Programme für Eltern (z.B. zu Erziehungskompetenzen), an die man Eltern-Patienten verweisen kann.                              |                      |                |                         |   |
| N/Z             | 1   | 2                    | 3              | 4                       | 5 |

|    |  |  |  |  |  |     |   |   |   |   |   |   |   |
|----|--|--|--|--|--|-----|---|---|---|---|---|---|---|
| 15 | Ich kann einschätzen, wie wichtig es Eltern-Patienten ist, dass ihre Kinder tägliche Aktivitäten wie Schule und Hobbies aufrechterhalten (z.B. Sport, Tanzen).   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16 | Ich verweise Kinder von Eltern-Patienten nicht an spezielle Angebote für Kinder (z.B. Selbsthilfegruppen) abgesehen von Angeboten zur psychischen Gesundheit von Kindern und Jugendlichen.               |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17 | Die Zusammenarbeit mit anderem Fachpersonal verbessert meine familientherapeutische Arbeit.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18 | Mein Arbeitsplatz bietet keine Supervision an, um Mitarbeiter in ihrer familientherapeutischen Arbeit zu unterstützen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19 | In meiner Region ist es schwierig, Familien und Kinder mit den notwendigen Angeboten in Verbindung zu bringen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20 | Das Arbeitspensum ist zu hoch, um familientherapeutisch zu arbeiten.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21 | An meinem Arbeitsplatz sind Richtlinien und Verfahren für die Arbeit mit Eltern-Patienten hinsichtlich ihrer familiären Anliegen sehr klar geregelt.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22 | Mein Arbeitsplatz bietet wenig Unterstützung für die fachliche Weiterbildung in familientherapeutischer Arbeit an.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23 | An meinem Arbeitsplatz fördern andere Mitarbeiter familientherapeutische Arbeit.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24 | Ich stelle Eltern-Patienten schriftliches Material (z.B. Psychoedukation, Informationen) über Erziehung und familiäre Themen zur Verfügung.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25 | Ich fühle mich unsicher mit Familien von Eltern-Patienten zu arbeiten.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26 | In der Kommunikation mit anderem Fachpersonal trete ich nur selten für die Belange der Bezugspersonen und/oder Familienangehörigen ein, wenn es um die psychische Erkrankung der Eltern-Patienten geht.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27 | Das Besprechen der Probleme von Eltern-Patienten mit anderen (einschließlich der Familie) würde die Schwierigkeit brechen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28 | Ich kann einschätzen, inwieweit die Kinder in die Symptomatik oder den Substanzmissbrauch ihrer Eltern involviert sind.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29 | Ich sollte mehr darüber lernen, wie ich Eltern-Patienten in ihrer Erziehung, ihren Erziehungskompetenzen oder anderen familiären Themen unterstützen kann.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30 | Ich verfüge nicht über die notwendigen Kompetenzen, um mit Eltern-Patienten daran zu arbeiten, inwieweit sich ihre psychische Erkrankung auf ihre Kinder und Familie auswirkt.                           |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31 | Es gibt keine Familientherapie- oder Beratungsangebote, an die Eltern-Patienten und ihre Familien verwiesen werden können.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32 | Ich kann einschätzen, wie wichtig es Eltern-Patienten ist, dass ihre Kinder enge Beziehungen zu anderen Familienmitgliedern aufrechterhalten (z.B. anderen Elternteil, Geschwister).                     |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 33 | Ich verweise Eltern-Patienten an spezielle Programme für Eltern (z.B. zu Erziehungskompetenzen, Krankheitsbewältigung).  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34 | Kinder und Familien profitieren letztendlich davon, wenn Fachpersonal zusammenarbeitet, um deren familiäre Probleme zu lösen.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35 | Es ist zeitlich möglich, sich regelmäßig mit anderen Beratungsstellen bezüglich Familien, Kindern oder Eltern-Patienten auszutauschen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36 | Ich stelle Kindern von Eltern-Patienten regelmäßig Informationen (einschließlich schriftlichem Material) zu psychischen Problemen zur Verfügung.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37 | Ich ziehe selten in Betracht, ob es notwendig ist, die Kinder meiner Eltern-Patienten an spezielle Programme für Kinder (z.B. Gruppenprogramme) zu verweisen.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38 | Die Kinder möchten oft nicht mit mir über die psychische Erkrankung ihrer Eltern sprechen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39 | Ich würde mich gerne zukünftig weiterbilden, um meine Fähigkeiten und Kenntnisse für die Arbeit mit Kindern von Eltern-Patienten zu verbessern.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40 | Ich habe keine Erfahrung im Umgang mit Problemen von Kindern, die im Zusammenhang mit der psychischen Erkrankung ihrer Eltern stehen.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41 | Ich kann nicht einschätzen, wie wichtig es Eltern-Patienten ist, dass ihre Kinder enge Beziehungen zu anderen Personen außerhalb der Familie aufrechterhalten (z.B. andere Kinder/ Geschwister, Schule). |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42 | Teamfähigkeit ist notwendig für Fachpersonal, das familientherapeutisch arbeitet.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43 | Ich ziehe häufig in Betracht, ob es notwendig ist Eltern-Patienten an unterstützende Programme für Eltern (oder Ähnliches) zu verweisen.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44 | Ich würde mich gerne zukünftig weiterbilden, um meine Fähigkeiten/ Kenntnisse für die Unterstützung der Eltern-Patienten hinsichtlich familiärer Themen zu verbessern.                                   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 45 | Ich verfüge über die notwendigen Kompetenzen, um mit Eltern-Patienten daran zu arbeiten, das Wohlbefinden und die Resilienz ihrer Kinder aufrecht zu erhalten.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 46 | Ich möchte mein berufliches Verständnis von einem teamorientierten Ansatz in der Gesundheitsversorgung für die Arbeit mit Kindern und Familien vertiefen.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 47 | Ich biete Psychoedukation und andere Informations- und Unterstützungangebote für erwachsene Familienmitglieder an (z.B. zur psychischen Erkrankung, Behandlung).   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 48 | Ich fühle mich unsicher in der Arbeit mit Kindern von Eltern-Patienten.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49 | Ich bin gut über die wichtigsten Maßnahmen informiert, die Eltern-Patienten ergreifen können, um das Wohlbefinden (und die Resilienz) ihrer Kinder zu stärken.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 50 | Ich kann nicht einschätzen, wie gut die Bindung zwischen Eltern-Patienten und ihren Kindern ist.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 51 | Ich kenne mich nicht mit den wichtigsten Erziehungsproblemen oder familiären Themen von Eltern-Patienten aus.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 52 | Ich bin erfahren darin mit Eltern-Patienten zu arbeiten.   |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 53 | Ich fühle mich unsicher Eltern-Patienten bezüglich ihrer Erziehung und ihrer psychischen Probleme zu beraten.  |  |  |  |  | N/Z | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Fig. 1** Self-constructed sociodemographic questionnaire and Family-Focused Mental Health Practice Questionnaire for Germany (FFMHPQ-GV)

**Table 2** Overview scales and items FFMHPQ-GV

| Scale                                       | Description   | Included Items     |
|---|---|--------------------|
| Organizational Policy and Supports          |   |                    |
| Scale 1: Workplace support                  | The workplace provides support (e.g. supervision) for family-focused practice         | 1, 18              |
| Scale 2: Location issues                    | Transport and services to refer family members to are not a problem in this area      | 2, 19              |
| Scale 3: Time and workload                  | Time or workload constraints regarding family-focused practice                        | 3, 20, 35          |
| Scale 4: Policy and procedures              | Family-focused policy and practices are clear at the workplace                        | 4, 21              |
| Scale 5: Professional development           | There are opportunities for professional development regarding working with families  | 5, 22              |
| Scale 6: Coworker support                   | The support from other workers regarding family-focused work                          | 6, 23              |
| Working with Parent-Clients                 |   |                    |
| Scale 7: Family and parenting support       | Providing resources and referral information to consumers and their families          | 7, 24, 36, 43, 47  |
| Scale 8: Worker confidence                  | The level of confidence the worker has in working with families, parents and children | 8, 25, 48          |
| Scale 9: Support to carers and children     | The level of information, advocacy and referral provided to carers and children       | 9, 26, 37          |
| Scale 10: Engagement issues                 | The opportunity for engagement with family members                                    | 10, 27, 38         |
| Workers Skill and Knowledge                 |   |                    |
| Scale 11: Assessing the impact on the child | How well the worker assesses the impact of the parent illness on the child/ren        | 11, 28             |
| Scale 12: Training                          | Worker willing to undertake further training  | 12, 29, 39, 44     |
| Scale 13: Skill and knowledge               | Worker skill and knowledge regarding impact of parental mental illness on children    | 13, 30, 40, 45, 49 |
| Scale 14: Service availability              | There are programs to refer families to   | 14, 31             |
| Scale 15: Connectedness                     | Workers assessment of parent awareness of child connectedness                         | 15, 32, 41         |
| Scale 16: Referrals                         | Referring family members to other programs  | 16, 33,            |
| Scale 17: Interprofession practice          | Team work and interprofessional practice  | 17, 34, 42, 46,    |
| Scale 18: Parenting and mental illness      | Worker skill and knowledge about the impact of mental illness and parenting           | 50, 51, 52, 53     |

Table 3 shows the level of family-oriented practice for different professional groups in Germany.

Table 3 shows that in all aspects of family-oriented practice differences were seen between the professions: Both regarding organizational policy and support aspects (S1, S5), issues concerning working with parent-clients (S7, S8, S9, S10), as well as professional skills and knowledge aspects (S11, S13, S16, S18). Overall, psychotherapists for children and adolescents had almost everywhere the highest scores compared to the other professional groups.

**Organizational policy and support**

Psychotherapists for children and adolescents got the most workplace support (S1) and opportunities for professional development (S5), psychotherapists for adults got the least workplace support (S1).

**Working with parent-clients**

Psychotherapists for children and adolescents, physicians and psychotherapists for adults had the highest scores for the subscale “family and parenting support (S7)”. The lowest scores had nurses and other professional groups.

Regarding the subscale “worker confidence (S8)” psychotherapists for adults and children and adolescents

had the highest scores, other professional groups had the lowest scores.

**Worker skill and knowledge**

Psychotherapists for children and adolescents, psychotherapists for adults and physicians had the highest scores on the subscale “skill and knowledge (S13)”. Psychotherapists for children and adolescents and physicians referred family members to specific programs the best (S16). Nursing / education service and psychologists had the highest scores at the subscale “parenting mental illness (S18)”, psychotherapists for children and adolescents had the lowest score.

Considering the effect size a small effect with values with  $\Omega^2 \leq 0.06$  was found for the subscales “workplace support (S1)”, “location issues (S2)”, “time and workload (S3)”, “policy and procedures (S4)”, “prof. development (S5)”, “coworker support (S6)”, “assessing the impact on the child (S11)”, “skill and knowledge (S13)”, “service availability (S14)”, “connectedness (S15)” and “interprofession practice (S17)”.

A medium effect with values with  $\Omega^2 \leq 0.14$  was found for the subscales “worker confidence (S8)”, “support to carers & children (S9)”, “engagement issues (S10)”, “training (S12)”, “referrals (S16)” and “parenting mental illness (S18)”.

**Table 3** Professional differences regarding the FFMHPQ-GV

|  | a                       | b                         | c                                       | d   | e   | f  | g                                       | Sign. Post-hoc<br>-tests Scheffé    | Effect size<br>Omega<br>squared ( $\Omega^2$ ) |
|--|-------------------------|---------------------------|---|---|---|--|---|-------------------------------------|--|
| All<br>(n = 475)                             | Physicians<br>(n = 120) | Psychologists<br>(n = 99) | Psychotherapists<br>for adults (n = 54) | Psychotherapists<br>for children and<br>adolescents<br>(n = 56) | Occupational/<br>Music/Physio/<br>Art Therapist/<br>Social-educ.<br>worker (n = 74) | Nursing/<br>education<br>service<br>(n = 43) | Others (includ.<br>Trainee)<br>(n = 29) |                                     |  |
| M(SD)  | M(SD)                   | M(SD)                     | M(SD)                                   | M(SD)   | M(SD)   | M(SD)  | M(SD)                                   |                                     |  |
| Organizational policy and supports           |                         |                           |   |   |   |  |   |                                     |  |
| Workplace support (scale 1)                  | 3.90 (2.09)             | 4.03 (2.08)               | 3.68 (2.06)                             | 4.97 (1.74)   | 3.77 (2.15)   | 4.05 (2.35)                                  | 3.39 (1.95)                             | d > b,c                             | .057   |
| Location issues (scale 2)                    | 3.53 (1.48)             | 3.28 (1.29)               | 3.45 (1.54)                             | 3.79 (1.47)   | 3.68 (1.61)   | 3.64 (1.40)                                  | 2.89 (1.83)                             |                                     | .036   |
| Time and workload (scale 3)                  | 3.22 (1.39)             | 3.16 (3.03)               | 3.03 (1.49)                             | 3.79 (1.29)   | 3.44 (1.46)   | 3.21 (1.29)                                  | 2.71 (1.24)                             |                                     | .054   |
| Policy and procedures (scale 4)              | 2.84 (1.36)             | 2.66 (1.26)               | 2.58 (1.42)                             | 2.84 (1.38)   | 3.12 (1.47)   | 3.16 (1.32)                                  | 3.29 (1.47)                             |                                     | .027   |
| Prof. development (scale 5)                  | 4.28 (1.71)             | 4.34 (1.75)               | 4.21 (1.85)                             | 4.84 (1.57)   | 4.41 (1.56)   | 4.00 (1.75)                                  | 3.43 (1.53)                             | d > g                               | .058   |
| Coworker support (scale 6)                   | 4.19 (1.60)             | 4.22 (1.49)               | 4.18 (1.65)                             | 4.47 (1.51)   | 4.22 (1.76)   | 3.98 (1.68)                                  | 3.96 (1.85)                             |                                     | -.001  |
| Working with Parent-Clients                  |                         |                           |   |   |   |  |   |                                     |  |
| Family and parenting support (scale 7)       | 3.56 (1.59)             | 4.03 (1.43)               | 3.26 (1.52)                             | 4.33 (1.30)   | 3.27 (1.67)   | 2.61 (1.54)                                  | 2.48 (1.89)                             | a > b,f,g<br>d > b,e,f,g<br>c > f,g | .218   |
| Worker confidence (scale 8)                  | 4.31 (1.78)             | 4.22 (1.80)               | 4.16 (1.85)                             | 5.06 (1.72)   | 4.21 (1.59)   | 4.04 (1.73)                                  | 3.24 (2.12)                             | c > g<br>d > g                      | .072   |
| Support to carers & children (scale 9)       | 3.80 (1.81)             | 4.38 (1.77)               | 3.32 (1.79)                             | 3.95 (2.13)   | 3.64 (1.75)   | 3.69 (1.42)                                  | 2.73 (2.01)                             | a > b,g                             | .087   |
| Engagement issues (scale 10)                 | 3.42 (1.29)             | 3.56 (1.22)               | 3.08 (1.38)                             | 3.99 (1.09)   | 3.45 (1.16)   | 3.32 (1.15)                                  | 2.62 (1.64)                             | a > g<br>d > b,g                    | .062   |
| Worker skill and knowledge                   |                         |                           |   |   |   |  |   |                                     |  |
| Assessing the impact on the child (scale 11) | 3.62 (1.66)             | 3.87 (1.55)               | 3.45 (1.80)                             | 4.13 (1.71)   | 3.63 (1.54)   | 3.76 (1.60)                                  | 2.74 (1.88)                             | d > g                               | .040   |
| Training (scale 12)                          | 4.81 (1.54)             | 4.93 (1.68)               | 4.83 (1.60)                             | 4.42 (1.46)   | 4.69 (1.48)   | 4.87 (1.53)                                  | 4.75 (1.91)                             |                                     | .065   |

**Table 3** (continued)

|                                     | <b>a</b>    |             | <b>b</b>    |             | <b>c</b>    |             | <b>d</b>    |             | <b>e</b> |       | <b>f</b> |       | <b>g</b> |   | Sign. Post-hoc -tests Scheffé | Effect size Omega squared ( $\Omega^2$ ) |
|-------------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|----------|-------|----------|-------|----------|---|-------------------------------|--|
|                                     | M(SD)       | M(SD)       | M(SD)       | M(SD)       | M(SD)       | M(SD)       | M(SD)       | M(SD)       | M(SD)    | M(SD) | M(SD)    | M(SD) | M(SD)    |   |                               |  |
| Skill and knowledge (scale 13)      | 4.38 (1.32) | 4.49 (1.22) | 4.19 (1.39) | 4.76 (1.02) | 4.98 (1.07) | 4.44 (1.27) | 3.94 (1.15) | 3.15 (1.71) |          |       |          |       |          | a > g<br>b > g<br>c > g<br>d > b, f, g<br>e > g | .020                          |  |
| Service availability (scale 14)     | 4.14 (1.61) | 4.10 (1.58) | 3.88 (1.84) | 4.65 (1.24) | 4.25 (1.62) | 4.46 (1.42) | 3.98 (1.32) | 3.41 (1.90) |          |       |          |       |          |   | .049                          |  |
| Connectedness (scale 15)            | 4.49 (1.57) | 4.67 (1.49) | 4.11 (1.85) | 4.54 (1.12) | 4.67 (1.86) | 4.62 (1.45) | 4.71 (1.15) | 3.93 (1.52) |          |       |          |       |          |   | .029                          |  |
| Referrals (scale 16)                | 3.36 (1.94) | 3.87 (1.73) | 2.78 (1.93) | 3.58 (1.71) | 4.12 (1.87) | 3.32 (2.15) | 2.82 (1.62) | 2.24 (2.09) |          |       |          |       |          | a > b, g<br>d > b, g                            | .130                          |  |
| Interprofession practice (scale 17) | 5.82 (95)   | 5.96 (72)   | 5.80 (1.05) | 5.79 (62)   | 5.97 (70)   | 5.75 (1.05) | 5.77 (86)   | 5.27 (1.70) |          |       |          |       |          |   | .027                          |  |
| Parenting mental illness (scale 18) | 3.04 (1.27) | 3.09 (1.35) | 3.24 (1.28) | 2.94 (1.01) | 2.49 (1.16) | 2.93 (1.16) | 3.57 (1.21) | 2.90 (1.56) |          |       |          |       |          | b > d<br>f > d                                  | .092                          |  |



A big effect with value with  $\Omega^2 \geq 0.14$  was found for the subscale “family and parenting support (S7)”.

## Discussion

It could be clearly shown that there are relevant differences regarding the level of family-oriented practice for different professional groups in Germany. These results are consistent with previous studies [17–20].

## Profession

Psychotherapists for children and adolescents had almost everywhere the highest scores and engaged most in family-oriented practice. They got the most workplace support (S1) and opportunities for professional development (S5), had high worker confidence (S8), skill and knowledge (S13) and referred family members to specific programs the best (S16). Remarkable is, that psychotherapists for children and adolescents had the lowest score at all at the subscale “parenting mental illness (S18)”. Nursing / education service and psychologists had the highest scores here.

Psychotherapists for adults got the least workplace support for family-oriented practice (S1). Nevertheless, regarding their work with parent-clients they had high scores for subscales “family and parenting support (S7)” and “worker confidence (S8)”, which means that they provided resources and referral information to the concerned families and felt confidence working with them. Additionally, they perceived skills around being able to assess the impact of parental mental illness on children and had knowledge around the impact of parental mental illness on family members including children (S13).

Other professional groups had on many scales the lowest scores, e.g., the subscales “skill and knowledge (S13)” and “worker confidence (S8)”.

Physicians had high scores for the subscales “family and parenting support (S7)” and “skill and knowledge (S13)”.

Overall, the most relevant difference was found for the subscale “family and parenting support (S7)”, which was also reflected in the effect size, which showed a large effect ( $\Omega^2 = 0.218$ ): Psychotherapists for children and adolescents, physicians and psychotherapists for adults had the highest, nurses and other professional groups the lowest scores.

One possible explanation for these professional differences could be training. While training to become a child and adolescent psychotherapist focuses on learning how to work in a family-oriented way, other professional groups such as nurses or doctors have almost always focused on the individual patient and the acquisition of knowledge, up to know. In order to increase the likelihood of identifying children of mentally ill parents at an

early stage, it is important that numerous professionals are sensitized for this issue.

## International comparison

International comparisons show that social workers had almost everywhere the highest scores [17–19] and psychiatric nurses the lowest scores [17, 18, 20]. Many relevant differences could be found between the professional groups for the subscale “time and workload (S3)” in Thailand [18], Norway [19] and China [20], but not in Germany. Likewise, it could not be confirmed for Germany that social workers scored the highest and nurses the lowest. One possible explanation for this could be, that we summarized social workers with other professional groups.

## Mental health system

As Gregg et al. concluded in their systematic review both worker and workplace factors influence family-oriented practice [7]. Thus, making a comparison of the professional groups regarding their family-oriented practices, you can't avoid considering the mental health systems their working in.

In our sample psychotherapists for children and adolescents worked in child and adolescent mental health systems, where family-oriented practice is system inherent. For this system working with families has traditionally been seen as a particular area of expertise, both the organization, the structures and the professionals are oriented towards a family-oriented practice. It could therefore be expected that they report more activity in this area than others.

This is in contrast with the adult mental health system, where the focus is almost more on the individual patient so far. According to Maybery [12] the most important predictor for family-oriented practice by adult mental health professionals were their perceived skill, knowledge and confidence for working with parental mental illness [12]. Tchernegovski et al. [27] found in their study, that for some mental health clinicians it is difficult to maintain a dual focus that incorporates the needs and experiences of parents and their children. Such feelings could lead professionals to believe that the needs of parents, conflict with the needs of children [27].

## Implications

Due to these results the following implications for practice can be derived: Even when psychotherapists for children and adolescents had almost everywhere the highest scores, it exists a training need, as shown by the low values for the subscale “parenting and mental illness (S18)”, to improve their skills and knowledge about the impact of mental illness and parenting. Additionally, it would be

important, that organizational structures support more the early detection and treatment of families with children of mentally ill parents.

Considering the current findings, we would also recommend a specific training to psychotherapists for adults and psychologists regarding family-oriented practice to ensure an early detection and treatment of families with children of mentally ill parents.

Besides training for professionals, it seems like there is potential for institutional support regarding the adult mental health system. It needs an organizational culture which generally promotes family-oriented work and makes time and sources available.

Furthermore, these results point out that it could be helpful to sensitize other professional groups regarding family-oriented practice, who do not have specialized education, but still work with families. It's not necessary and reasonable having a deep knowledge about parental mental illness, but a training in basic family-oriented practice would be a benefit.

### Strengths and limitations

The key strength of the current study is that it's the first time using the FFMHPQ-GV examining professional differences in both child and adolescent and adult mental health systems in Germany. Remarkable is especially the heterogeneity and completion of the professions (all major professions are represented) as well that child and adolescent and adult mental health systems from all over Germany were included. Another force is that the FFMHPQ has been used in other countries, whereby it is possible comparing the outcomes. It would be exciting using the questionnaire in other settings and samples to evaluate, audit and improve family-oriented practice.

But there are also weaknesses with this research that limit the generalizability of the findings: Due to the insufficient reliability with low Cronbach's alpha values, we could not take the subscales S9 ( $\alpha=0.64$ ), S10 ( $\alpha=0.34$ ) and S11 ( $\alpha=0.57$ ) into account within the interpretation [23]. Another limitation is that the family-oriented practice data relied on professional's self-assessment of practice in this study. This may not reflect what professionals actually do in practice and might be biased.

Moreover, when considering the results, it should also be taken into account, that the employees work in the 18 clinics that are part of the Chimps-net network. It can therefore be assumed, that there is a selection bias because they are already interested in this topic of children of mentally ill parents. Similarly, usually only those people take part in studies who are interested in research and this topic.

### Conclusion

Differences were seen between the professions in all aspects of family-oriented practice. Psychotherapists for children and adolescents had almost everywhere the highest scores and engaged most in family-oriented practice except their skills and knowledge about the impact of mental illness and parenting. Psychotherapists for adults got the least workplace support for family-oriented practice but were competent providing resources and referral information to the concerned families and felt confidence working with them. Other professional groups had on many scales the lowest scores. Due to these results, it exists a training need to improve skills and knowledge about the impact of mental illness and parenting. Additionally, there is still potential for institutional support in promoting family-oriented work.

### Ethics statement

The studies involving human participants were reviewed and approved by the Ethik Kommission der Ärztekammer Hamburg. Participants provided their written informed consent to participate in this study.

### Abbreviations

|            |   |
|------------|---|
| ANOVA      | Analysis of Variance  |
| CHIMPS     | Children of mentally ill parents  |
| CHIMPS-NET | Children of mentally ill parents research network                                   |
| Ci-chimps  | The clinical implementation study of CHIMPS with three implementation interventions |
| FFMHPQ     | Family-Focused Mental Health Practice Questionnaire                                 |
| FFMHPQ-GV  | Family-Focused Mental Health Practice Questionnaire-German Version                  |
| ICQ        | Implementation Components Questionnaire   |
| ISS        | Implementation Satisfaction Scale   |
| M          | Mean  |
| MCAR-test  | Missing Completely at Random Test   |
| SD         | Standard deviation  |
| SPSS       | Statistical Package for the Social Sciences   |

### Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12888-024-05562-0>.

**Additional file 1.**

### Acknowledgements

We would like to thank all cooperation partners and clinical centers in Germany, who participate in the study and support us in the collection of data: Clinic for Psychiatry and Psychotherapy and Clinic for Child and Adolescent Psychiatry of Josefinum Augsburg and Kempten; Clinic for Psychiatry and Psychotherapy and Clinic for Child and Adolescent Psychiatry of the Evangelical Clinic Bethel, Bielefeld; Clinic for Psychiatry and Psychotherapy, Charité, Berlin; University Medical Center, Department of Psychiatry and Psychotherapy, Cologne; Psychiatry, Psychotherapy and Psychosomatics of Helios Clinics, Erfurt; University Medical Center, Department of Psychiatry, Psychosomatics and Psychotherapy, Frankfurt/Main; University Medical Center for Psychiatry and Psychotherapy at the Immanuel Clinical Center Rüdersdorf, Frankfurt/Oder and the Child and Adolescent Psychiatry Frankfurt/Oder; University Medical Center, Department of Psychiatry and Psychotherapy, Freiburg; Clinic for General Psychiatry and Psychotherapy at the LWL Clinic Gütersloh and the

Child and Adolescent Psychiatry at the LWL Clinic Hamm-Bochum; Center for Psychosocial Medicine, University Medical Center Hamburg-Eppendorf; University Medical Center Saarland, Department of Psychiatry and Psychotherapy, Homburg; Clinical psychology and psychotherapy of adulthood at the University Hospital, Koblenz – Landau and Clinic for Psychiatry and Psychotherapy Pfalz; University Medical Center, Department of Psychiatry and Psychotherapy, Leipzig; University Medical Center, Department of Psychiatry and Psychotherapy and Department for Child and Adolescent Psychiatry, Magdeburg; University Medical Center, Department of Psychiatry and Psychotherapy and Department for Child and Adolescent Psychiatry, Marburg; University Medical Center for Psychiatry and Psychotherapy, Munich; Clinic for Psychiatry, Neurology, Psychosomatics and Psychotherapy in Childhood and Adolescence at the University Medical Center, Rostock; Psychiatry and Psychotherapy of Helios Clinics, Schwerin, Germany; General psychiatry and psychotherapy with polyclinic of the University Hospital, Tübingen; University Medical Center, Department of Psychiatry and Psychotherapy II, Ulm-Günzburg, Germany.

#### Authors' contributions

CL is the PhD candidate and responsible for the data- and implementation study management. SWG is the principal researcher of this implementation study ci-chimps, and of the whole CHIMPS-NET. CL drafted the manuscript with the help of SWG and SP. SWG, AZ and SP were substantially involved in the conception of the study and contributed to its design. AD and AZ supported the paragraphs on statistical methods and the randomization of the clinical centers. AD supervised data management and statistical analyses. All authors have participated in the editing of the manuscript and have read and approved the final manuscript.

#### Funding

Open Access funding enabled and organized by Projekt DEAL. The study described in this protocol is funded by the German Federal Joint Committee (G-BA).

#### Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due we do not have the consent from the participants and the participating clinical centers, but are available from the corresponding author on reasonable request.

#### Declarations

##### Ethics approval and consent to participate

The research ethics committee of the medical association Hamburg, which is the primary ethics committee for the multicenter project CHIMPS-NET, has approved CHIMPS-NET on 14.10.2019 (PV7072), the last amendment concerning ci-chimps has been approved on 30.04.2021. The confidentiality of participating professionals will be protected through encrypted and anonymous data processing. The studies involving human participants were reviewed and approved by the Ethik Kommission der Ärztekammer Hamburg. Participants provided their written informed consent to participate in this study.

##### Consent for publication

Not applicable.

##### Competing interests

The authors declare that they have no competing interests.

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Received: 11 August 2023 Accepted: 26 January 2024

Published online: 20 February 2024

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