Families at the Centre:

Reducing the Impact of Mental Health and Substance Use Problems on Families

A Planning Framework for Public Systems in BC

Families at the Centre is a deliverable of *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in BC*

BRITISH COLUMBIA

Table of Contents

Introduction

In November 2010, the Province released *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*. *Healthy Minds, Healthy People* defines a transformative vision for how stakeholders across government, sectors and disciplines can work together to promote mental health and well-being for all British Columbians, while simultaneously reducing the impact of mental illness and substance use problems on individuals, families and communities. *Healthy Minds, Healthy People* also includes a suite of initial priority actions intended to guide the efforts of partners inside and outside of the health and social service systems. Each of these actions reflects a priority drawn from both scientific evidence and the lived experience of people with a mental health and/or substance use problem and those who care for them.

One of these actions focuses specifically on families and the dynamics within a family structure that can lead to trans-generational vulnerability: "Implement supports for families with parents who have mental health and/or substance use problems to facilitate healthy family development." The inclusion of this deliverable in *Healthy Minds, Healthy People* was due, in part, to a priority determined by the set-term, cross sector Child and Youth Mental Health and Substance Use Strategic Coordinating Committee in 2009 and its interest in addressing the specific needs of children whose parents have a mental illness, in order to help them thrive.

In response, the multi-partner Family Mental Health and Substance Use Task Force was established (see Appendix #1 for details on composition/membership) to coordinate related efforts and enable required collaboration, and ultimately to initiate the development of *Families at the Centre*.

The Task Force created *Families at the Centre* to help guide transformation in BC systems[1] in order to achieve better results for families affected by a mental health and/or substance use problem – defining a new way of engaging and working with them. *Families at the Centre* is designed for those working within and across systems, including ministries, health authorities, school boards, and local governments, as well as publicly funded for-profit and non-profit organizations, community-based services, consumer organizations, independent professionals, and system-specific, regulated professionals. *Families at the Centre* acknowledges that improving mental health and reducing harms from substance use are everyone's responsibility, and that no single system can make a meaningful difference on its own. It also suggests that people working in systems view and include families as part of the solution.

Families at the Centre is strongly influenced by *Families Matter: a Framework for Family Mental Health in British Columbia*, which was developed by the F.O.R.C.E. Society for Kids' Mental Health in

---

[1] Public systems refer to publicly funded and/or publicly administered services and supports organized into distinct systems with specific legal and program mandates, such as health, child and adult mental health, education, child and family development, child welfare, income support, housing, law enforcement, justice and corrections. For the remainder of this document public systems will be referred to as "systems".

consultation with families across the Province, and released in May 2012.[2] *Families Matter* calls for a holistic, family-oriented approach to supporting families affected by a mental health problem, and subsequent to its development, the scope of *Families at the Centre* was broadened to include any family member experiencing a mental health and/or substance use challenge at any time in their life. To achieve this, the document emphasizes services and supports that promote good mental health and prevent or lessen the impact of mental health and substance use challenges for the whole family.

Families at the Centre has also been informed by *Taking Action on Domestic Violence in British Columbia* (Province of British Columbia, 2012), the Province's response to the report by the Representative for Children and Youth into the deaths of Kaitlynne, Max and Cordon Schoenborn at the hands of their father, who suffered from longstanding, untreated mental illness and severe substance related disorders. *Families at the Centre* emphasizes that the entire family needs to be considered in the context of one member's mental health and/or substance use problem – this is important not only for the purpose of building strengths and resiliency, but also in terms of assessing and ensuring safety for individual family members and the family as a whole.

Families at the Centre provides a framework to assist public system planners to move towards a family-centred approach in policy and practice, services, and supports. Building on the recommendations and suggestions advanced by families within the *Families Matter* framework, this document reflects the collective voice and endorsement of both those with lived experience and of those working in systems supporting child, youth, adult, and family mental health.

---

[2] *Families Matter* was prepared at the request of the Task Force and funded by the *Healthy Minds, Healthy People* Directorate

Purpose

In a healthy, compassionate society, individuals, families, and communities benefit from supportive environments that promote their mental well-being and reduce their risk for mental health and substance use problems at every stage of life. Public service systems play a critical role in supporting individuals and their families to flourish by providing them with opportunities to enhance their strengths and resiliencies, as well as to address problems when they occur. Whether these initiatives serve to promote positive mental health and well-being, prevent mental illness and/or substance use problems, respond to emerging problems, or address more debilitating and longer-term challenges, families must be actively involved and at the heart of all efforts.

We are all family members, whether our family is natural or chosen, large or small, temporary or permanent, conventional or unconventional, resilient or fragile. Our experiences with family shape us. At some point, we are all touched by mental health and substance use challenges—our own, or those of the people we know and love. These are things we have in common; they unite us.

Families are often an essential and enduring support to people with mental health and substance use challenges. Family mental health is a resource for personal and collective growth and transformation. It is holistic, multigenerational, and embedded within a web of sustaining relationships with kin and community. Since people with mental health and substance use challenges are often cared for by family members, systems need to recognize the importance of families and their unique role in building and sustaining resilience in a complex world.

When the supportive role and needs of families impacted by a family member of any age with mental health and/or substance use problems are not acknowledged and supported, and the context of family is absent from the care provided to the affected family member, the health, well-being, and functioning of both the individual family member and the whole family itself may be compromised. Not only does this potentially undermine the effectiveness of the care and treatment provided, it increases the risk of mental health and substance use problems for other family members.

BC continues to demonstrate national leadership by recognizing the importance of family mental health. Having already used dialogue to inform a framework on family mental health, the present work, which is ground-breaking in Canada, has involved family members with lived experience at every step. The purpose of this planning resource is to increase understanding of a family-centred service orientation, and identify actions that respond to the needs of families experiencing mental health and substance use challenges with effective system responses that support all members to thrive.

This will be accomplished in two important ways, by:

- Encouraging greater collaboration among all systems that touch and influence the lives of these families; and,
- Helping systems and their representatives to make a cultural shift that embraces a family-centred approach to policy and practice, services and supports.

Vision

The overarching vision to support this change is:

Families in all their diversity are at the centre of service system cultures and responses.

In family-centred systems, people working within and across systems recognize families and individual family members as influencers, co-providers, and co-creators of service, and decision makers in their own care. Members of these systems engage with individual family members and whole families, to the extent to which they want to or can be involved, to improve understanding of the different experiences of mental health and substance use. Then, they translate what families say they need into effective action. The systems and the people who work within them acknowledge the inherent capacity of families, no matter how fragile or robust. They mobilize the resources and skills required to help families build upon strengths and assets in order to mitigate the progression of existing problems, as well as the risk of new mental health and substance use problems within the family.

Families at the Centre starts with the premise that public systems are accountable to the people they serve. For families, this means having a relationship with people working in systems built on respect, trust, and reciprocity. For systems, this means prioritizing the needs and aspirations of families to the greatest extent possible within their legal and program mandates, including ensuring relevant information is shared appropriately, and that the required capacities to support this are fostered and retained. For both, it is the shared recognition that positive outcomes are best achieved when families and system representatives see themselves as valued partners, learning from each other and working together on mutual goals.

For people with mental health and substance use challenges, family-centred systems provide access to strengths-based care that is continually adapted to meet their needs. This orientation requires more than simply renaming existing practice; it involves a philosophical shift affecting every member within a system and all aspects of service delivery. It requires that systems acknowledge the interdependence among family members, families, and the broader community, understand the diverse social and cultural contexts of families, and adapt responses to reflect the significance of these contexts for mental health and substance use.

Relationship dynamics within families are rich and complex. In optimal circumstances, these dynamics positively affect the healthy developmental and life course pathways of individual family members and the family as a whole. They act as protective influences or factors. By contrast, more challenging and complex conditions or contexts contribute to risk for mental health issues and substance use problems. The relationship dynamics between a parent and child are particularly influential and warrant careful consideration and support as systems engage with families affected by mental health and substance use problems. However, the needs of all members of a family affected by such issues deserve consideration, regardless of age or relationship with other family members. Ultimately, the aim is to prevent the experience of a mental health and/or substance use problem in a family from creating similar problems

for other family members. This is accomplished when the whole family is considered and correspondingly equipped to thrive.

In BC, there are already many examples of successful practice across systems that reflect and build on the relationship between families and mental health. Collectively, we can learn from and capitalize on these resources in order to cultivate a broader family-centred orientation.

Context

The development of *Families at the Centre* is a priority action of *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (Province of British Columbia, 2010). It is strongly influenced by *Families Matter: A Framework for Family Mental Health* in British Columbia which was released by the F.O.R.C.E. Society for Kids Mental Health in 2012.[3]

The development of *Families at the Centre* was initiated by the Family Mental Health and Substance Use Task Force (see Appendix #1). Secretariat support was provided by the BC Ministry of Children and Family Development (MCFD), the F.O.R.C.E. Society for Kids Mental Health and the BC Ministry of Health. Through direction in *Healthy Minds*, *Healthy People*, the Task Force's original mandate was to create a cross sector planning resource to facilitate healthy family development for families with parental mental health and/or substance use challenges. The resource would ensure these families receive more coordinated services and supports, which would in turn reduce the risk of future mental health and substance use problems for the children in the family. The inclusion of this deliverable in *Healthy Minds, Healthy People* was due, in part, to a priority determined by the set-term, cross sector Child and Youth Mental Health and Substance Use Strategic Coordinating Committee in 2009 and its interest in addressing the specific vulnerabilities and needs of children whose parents have a mental illness in order to help them thrive.

With the publication of *Families Matter* – which calls for a holistic, family-oriented approach to supporting families affected by a mental health problem in order to mitigate corresponding family problems – the scope of *Families at the Centre* was broadened to include any family member experiencing a mental health and/or substance use challenge at any time in their life. To achieve this, the document emphasizes services and supports that promote mental health, and prevent or lessen the impact of mental health and substance use challenges for the whole family.

The document draws upon four main sources of evidence: peer-reviewed and grey[4] literature; experience in BC and other jurisdictions; insights since 1997 of the Supporting Families with Parental Mental Illness Community of Practice; suggestions from policy makers and service providers; and input from families with the lived experience of mental health and substance use challenges.

---

[3] *Families Matter* was prepared at the request of the Task Force and funded by the *Healthy Minds, Healthy People* Directorate

[4] Grey literature is information produced by all levels of government, academics, business and industry, in electronic and print formats not controlled by commercial publishing. Sources of grey literature include: conference proceedings, dissertations/theses, books, clinical trials, guidelines, and government information.

Families at the Centre is also intended to complement a number of related government and health authority initiatives. For example, it aligns with the *Helping Relationship Framework* and the *Aboriginal Practice Framework* (under development) of the MCFD. It supports the family-centred approach asserted in the *Safe Relationships, Safe Children* project that is improving access to coordinated health and social services for families impacted by parental mental health challenges, problematic substance use and/or intimate partner violence. This latter project, led by MCFD, the Ministry of Health and the health authorities, is part of *BC's Provincial Domestic Violence Action Plan*.

The family-centred approach advanced within *Families at the Centre* also links to and expands on efforts to shift to a more patient-centred orientation for health service delivery informed by standards and guidelines established by the Planetree Organization. As a result, *Families at the Centre* is aligned with and supportive of the Ministry of Health's *Setting Priorities for the B.C. Health System*, and the recently released policy documents that focus on primary and community care, rural health services, and surgical services. The emphasis on opportunities to promote health and well-being and prevent secondary problems for families is supportive of the goals within BC's guiding framework for public health: *Promote, Protect, Prevent*. In addition, the document links to province-wide efforts to apply a trauma-informed approach to work with patients, and to explore evidence-based therapeutic models including family and couples therapy. Finally, *Families at the Centre* is linked to specific family-oriented initiatives underway in some of the regional health authorities (see pages 42-43).

Please see Appendix #2 for further details regarding the development of *Families at the Centre*.

First Nations and Aboriginal Families

Careful consideration and dedicated processes are required to reflect the distinct needs and desires of First Nations and Aboriginal individuals and families. A number of First Nations and Aboriginal individuals participated in engagement and consultation activities related to *Families at the Centre*, but given the need to respect other engagement processes already underway, full and meaningful engagement of First Nations and Aboriginal families specific to this planning resource has not been carried out.

As a result, this document serves only as a preliminary foundation for better engagement with and support for First Nations and Aboriginal families with mental health and substance use challenges. First Nations and Aboriginal people have indicated that in order for First Nations and Aboriginal families to truly thrive, they must be supported in identifying their own solutions.

The recent release of *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10 Year Plan* (2013) signals a new approach to how First Nations and Aboriginal individuals, families, and communities are engaged in efforts to support their overall mental wellness and prevent or reduce harms associated with substance use. *A Path Forward* envisions that partnerships within regions—collaboratively designed by First Nations and Aboriginal people with local, regional, provincial, federal partners, individuals, families, and communities—will emerge to mobilize all stakeholders, identify the appropriate and desired solutions, and implement related actions. Regional forums to initiate the first step in the process of community-led mental health and substance use planning began in the spring of 2013.

Rationale

Who is Affected?

Global estimates suggest mental disorders, including substance use disorders, affect more than 25% of all people at some time during their lives, and are present at any point in time in about 10% of a given adult population.[i] These estimates do not include people with symptoms that do not meet the diagnostic criteria for mental illness.

Approximately six out of ten people with a substance use disorder also suffer from a mental illness.[ii] This is referred to as a concurrent disorder. People with substance use disorders are roughly twice as likely to be diagnosed with mood or anxiety disorders. Similarly, people with mood or anxiety disorders are about twice as likely to also suffer from a substance use disorder.[iii] The rates of specific co-morbidities vary by gender. Among men and women in substance use-related treatment, antisocial personality disorder is more common in men, while women have higher rates of major depression, post-traumatic stress disorder, and anxiety disorders.[iv]

ADULTS

It is estimated that each year in BC, approximately one in five individuals will experience significant mental health and/or substance use problems.[v] Using 2012 population data, this translates into approximately 744,000 British Columbians over the age of 18.[vi] Among those affected, an estimated 130,000 people have a severe mental illness and/or substance related disorders.[vii] Nearly one third of adults in the BC corrections system have substance use challenges, and of these, more than three quarters also have non drug-related mental health challenges. In general, those with both substance use and mental health challenges have the greatest repeat involvement with the corrections system, as well as the highest utilization of health and income assistance services within the provincial corrections population.[viii]

In 2005, mental disorders and substance use disorders combined were the third largest contributor to disability adjusted life years (DALY) in BC, behind cancer and cardiovascular disease. The DALY measure is the sum of future years expected to be lost due to both premature mortality and impairment resulting from a disease or risk factor.[ix]

It is difficult to estimate how many individuals with a mental health and/or substance use problem are also parents. While in many instances the parenting rate may be the same as the general population, some disorders are associated with much lower rates. For example, evidence suggests that people with schizophrenia parent less frequently than the general population.[x]

CHILDREN AND YOUTH

Nearly 13% of children and youth between the ages of 4 and 17 in Canada experience clinically significant mental disorders and associated impairments at any given time. That is roughly four students out of every classroom of 30 across the country who may consequently struggle to learn, make friends, participate in activities, and function in their families and communities. Just over two thirds of children and youth with mental disorders currently do not receive specialized mental health services.[xi] Nearly 70% of young adults aged 15-24 years with mental illness reported that their symptoms started before the age of 15[xii] and, without timely intervention, this can compromise quality of life, impair functioning, diminish productivity in later life, and have significant intergenerational consequences.[xiii]

In Canada, an estimated 12% of children under the age of 12 live in families where a parent has a diagnosed mental illness, including substance use disorder.[xiv] Children in these families are at greater risk for developing mental health problems than children in the general population. Longitudinal studies have shown that the risk of developing mental illness among children whose parents have a mental illness ranges from 41% to 77%.[xv]

Young carers are children and youth who assume responsibilities for vulnerable family members. A recent study found that 12% of adolescents 12-17 years of age in Vancouver were caring for a vulnerable family member, including a parent with a mental health and/or substance use challenge.[xvi] Many young carers have restricted opportunities for social, recreational, and occupational participation, due to their caring roles. Young carers often encounter particular difficulty completing their secondary education, maintaining social networks, and getting into paid employment.

In the United Kingdom, analysis of the UK Millennium Cohort Study, which followed just over 18,500 children born in 2000, identified the 10 most common risk factors for poor child health, safety and development. Parental depression was the most common issue, found in nearly 20% of families. Problematic alcohol use in at least one parent was present in 12% of families, and domestic violence was present in 4% of families. In 28% of families, children were exposed to two or more risk factors, although no one combination of risk factors dominated.[xvii]

SUBSTANCE USE PATTERNS

According to data from the Canadian Alcohol and Drug Use Monitoring Survey, patterns of substance use that are associated with increased risks and harms have been decreasing in BC since 2008.[xviii] The lifetime prevalence of alcohol and other drug use in BC in 2008 and 2009 was 89% for alcohol use, 48.7% for cannabis use, and 21% for use of other illegal drugs.[xix] In terms of non-medical pharmaceutical drug use, available evidence suggests that, in general, adolescents, older adults, women, and Aboriginal people are at elevated risk to use prescription drugs without or contrary to a physician's guidance.[xx]

The 2008 BC Adolescent Health Survey shows a decline over the past 10 years in the rate of students ever using alcohol, marijuana, and tobacco. However, alcohol remains the most commonly used substance among youth of all ages. By the age of 18 years, 78% of students had tried alcohol, 50% had tried marijuana, and 40% had tried tobacco. Older students were more likely to report problems associated with substance use. For example, 25% of 18- year-olds reported they had passed out as a result of their substance use, and 31% were unable to remember things they had said or done.[xxi]

The rate of students ever using pharmaceutical drugs without a doctor's consent, and the rate of students using hallucinogens, such as ecstasy, have increased since 2003. Around 15% of students had tried ecstasy, 10% had tried cocaine, and close to 3% had tried crystal meth. Females were more likely to have tried taking prescription medications without a doctor's consent. Males were more likely to have tried hallucinogens, heroin, and steroids.[xxii]

SOCIAL COSTS

The Canadian Centre on Substance Abuse estimated the total cost of substance use problems in Canada at nearly $40 billion in 2002 (most recent cost data), with tobacco accounting for $17 billion, alcohol for $15 billion and illegal drugs for $8 billion. Productivity losses, due to short- and long-term disability and premature death, constituted the largest part of the social costs, at just over 60% of total costs for tobacco, alcohol, and illegal drugs combined. Direct health care accounted for 22% and direct law enforcement for 14% of total costs.[xxiii] In BC, the total cost of substance use problems in 2002 was approximately $6 billion for tobacco, alcohol, and illegal drugs combined,[xxiv] with direct health care costs accounting for nearly $1.3 billion (22%).[xxv]

POPULATION-LEVEL HEALTH INEQUITIES

For a variety of social, economic, and/or physiological reasons, some groups of people may experience greater vulnerability than others to poorer health outcomes, such as shorter life expectancy or more years living with disabling health problems. Health programs and services must actively consider the needs of disadvantaged individuals, communities and populations in order to avoid the risk of increasing, rather than reducing, health inequities.[xxvi] While families with a mental health and/or substance use problem have increased vulnerability to additional problems such as depression and anxiety,[xxvii] other factors or conditions may increase the likelihood that they will experience even greater health inequities. For example, research directly links the experience of a chronic physical health condition with a greater risk of mental health problems.[xxviii]

What Works?

As mentioned earlier, *Families at the Centre* was informed by multiple streams of evidence. This section highlights selected examples of research evidence demonstrating the family as an effective focus for interventions, opportunities to support prevention of additional problems within the family, and the role of the family in effective mental health and substance use service provision.

FAMILY INTERVENTIONS

Family interventions are a set of clinical practices for working with families that have a specific supportive, educational, or treatment function, and include problem-solving, crisis management and clinical treatment. Professionally led, family psycho-education is an evidence-informed practice.[xxix]

Family therapy is shown to reduce symptoms of conduct disorder, substance use disorder, anorexia nervosa and other select disorders in children and youth. Providing parents with relevant education and skills is helpful in preventing substance use disorders in children and youth and in reducing symptoms of attention hyperactive deficit disorder and conduct disorder in children.[xxx]

Family-based interventions are highly effective in preventing mental illness and psychological symptoms among children of parents living with mental illness. A systematic review of 13 randomized controlled trials, conducted with almost 1500 children, concluded the risk of children developing the same mental illness as the parent decreased by 40% with family-based interventions.[xxxi]

Supporting families where a child or youth is looking after an older family member with chronic mental illness and/or substance use problem (young carer) helps to reduce relapse rates and psychotic symptoms for people with a mental illness and increase the carers' sense of control and ability to manage situations.[xxxii] In the United Kingdom, legislation is in place that mandates the provision of peer support networks, respite care, advocacy services, and counselling for young carers.[xxxiii] In Australia, emphasis is on a whole family approach to addressing young carers' needs. Services aim to be family-focused, flexible, coordinated, and non-stigmatizing.[xxxiv]

The updated Cochrane review on family intervention for adults with schizophrenia[xxxv] concluded that family-based interventions, when compared to standard care, may result in:

- Clinical outcomes such as reduced relapse rates, reduced re-hospitalization rates, and better adherence to medications
- Family outcomes such as reduced negative expression of emotions, increased understanding of patient needs, and lessened caregiving burden
- Economic outcomes such as net savings in direct or indirect costs to health care systems

Finally, family involvement and support has also been shown to be effective for the treatment of other disorders including bipolar disorder, depression, substance related disorders, and borderline personality disorder.[xxxvi,xxxvii]

FAMILY-CENTRED SERVICE

Family-centred service is a key factor in increasing health and related system responsiveness to the needs of children, youth, adults, and families. While this approach is considered a best practice in child and youth health care, it is relatively new to the field of child and youth mental health care as well to adult mental health and substance use services. MacKean et al.[xxxviii] note there are many terms and concepts closely related to and used synonymously with family-centred, including "family-based,"

"family-friendly," "family-focused," and "family-driven." The main difference between these terms is how service providers and policy makers see individuals and families, and the corresponding intensity of family engagement and involvement. Family-centered systems see individuals in the context of their families and communities, recognize them as experts on their own needs, and place them at the centre of decision-making and planning. These systems recognize and engage individuals and families as partners in collaborative relationships focused on shared goals, to the degree they can and want to be involved (for more details, see the 'Spectrum of Family Engagement' figure on page 18).

The following key elements and benefits of a family-centred approach are adapted from work by MacKean et al.[xxxix] to advance family-centred care in child and youth mental health and from the best practices for family-centred care developed by the Centre for Addiction and Mental Health, Community Support and Research Unit.[xl,xli]

KEY ELEMENTS

- See people as individuals and vital members of families, networks, and communities
- Focus on the inherent strengths, capabilities, and interconnectedness of families as core protective factors

- Appreciate that individuals, families, and professionals bring different strengths, assets, and resources to the service relationship

- Know that the ongoing work of the relationship is to identify concerns, needs, family strengths, and resources and to empower those receiving services

- Acknowledge that individuals and families are experts on themselves; are capable of making informed choices when given the appropriate information, time, and support; and, whenever possible, should be involved in all decisions that affect them

- Recognize that the ability of individuals and families to participate in decision-making is influenced by the individual's developmental capacity, the acuity of the individual's mental health and substance use challenge(s), and the roles negotiated for this purpose

- Tailor services to fit families' needs and preferences, and ensure that services are appropriate for a family's culture and traditions

- Use and build informal support systems rather than relying solely on professional services

HEALTH AND WELL-BEING BENEFITS FOR CHILDREN, YOUTH, ADULTS AND FAMILIES

- Improved child and family management skills and function

- Hastened recovery from mental health and substance use challenges

- Decreased risk of additional mental health and substance use problems for current and future family members

- Decreased family/caregiver stress and stress-related problems

- Increased family/caregiver employment

- Increased stability of living situation

- Greater educational attainment for children and youth

- Increased child, youth, adult, and family satisfaction

- Lowered risk of mortality from substance related disorders and suicide

- Improved health, safety, and well-being of child, youth, adult, and family

BENEFITS RELATED TO SYSTEMS AND SERVICES

- More timely access to services

- Improved quality of services

- Increased professional satisfaction

- Improved cost effectiveness of services

- More effective use of health care resources

- Reduced out-of-home placement of children

- Reduced rate of re-hospitalization or relapse

- Reduction of stigma through opportunities for dialogue across systems and with families

- Reduced incidence of mental health and/or substance use problems

CLIENT FEEDBACK

There is a natural fit between a family-centred approach to clinical services and the use of client feedback to tailor services and improve effectiveness. Psychotherapy research identifies a range of "common factors" in therapy that are strongly related to effectiveness. These common factors include practitioner characteristics (e.g., empathy), client characteristics (e.g., culture, preferences, hope, expectancy for change), and characteristics associated with the relationship between the client and the practitioner (e.g., trust, safety, collaboration). In the Client-Directed and Outcome-Informed (CDOI) approach,[xlii] the client's voice is privileged and the service provider purposefully forms a strong partnership with the client to:

- consistently and formally obtain feedback at each session about the client's experience of the therapeutic alliance and the client's functioning in key areas of their life;

- use the client's ideas and preferences, including cultural values and perspectives, to guide choice of goals and therapy techniques; and,

- use feedback to collaboratively build a strong therapeutic alliance.

As with family-centred approaches, the emphasis in CDOI is on meaningful collaboration, and therapy research indicates that this makes a big difference in outcomes. In successful psychotherapy, most change occurs earlier rather than later in the treatment process. The client's experience of meaningful change in the first few sessions is critical to continuing treatment and achieving a positive outcome.[xliii] Moreover, there are significant improvements in both retention and outcome when therapists receive formal, real-time input and feedback from clients regarding the process and results of therapy. Evidence suggests that treatment informed by ongoing client feedback and corresponding clinical support tools may be almost twice as effective as treatment without feedback.[xliv] Clients whose therapists do not seek formal feedback are three times *less* likely to return to therapy and have much poorer outcomes if they do stay, compared to clients with therapists who attend to the health of the relationship by receiving client feedback.[xlv]

Challenges

Despite advances in research and understanding of the family's importance in care and recovery from mental health challenges, a family orientation and corresponding family involvement is not always easily incorporated into the routine of mental health services.[xlvi,xlvii] Mohr, Lafuze and Mohr[xlviii] noted that mental health clinical training programs continue to use textbooks, terms, and concepts that focus on family pathology rather than family coping, adaptation, and competence.

Research on barriers to family involvement in mental health care includes barriers identified by family caregivers and those identified by mental health and substance use professionals.[xlix,l,li,lii,liii,liv,lv,lvi]

Some of the barriers in the literature identified by family caregivers include:

- Confidentiality issues, refusal of service providers to share information with families
- Professionals do not always understand or acknowledge family caregiver experiences
- Services lack continuity and integration across settings, making it difficult for families to develop trusting relationships with professionals e.g. high turnover of therapists; lack of coverage for emergencies; inadequate funding for community services
- Overemphasis on medical conditions relative to presenting mental illness in hospitals e.g. shorter length of stay for inpatient care; premature discharges

Some of the barriers identified by professionals include:

- Time constraints and high caseloads limit or prevent professionals from working with families
- Families' reluctance to being involved and their stage of readiness for change
- Lack of knowledge by mental health professionals regarding the impact of mental illness on families and of the burdens faced by families; lack of skills to meet needs of families
- Loss of hope and giving up by families; families' feelings of guilt and shame
- Clients not wanting their families involved; families' difficulty communicating with the client
- Professionals' feelings of conflict about treating the client versus the family
- Professionals' belief that family involvement may be harmful to the client; perception that parents are responsible for the client's illness
- Professionals' feared loss of power
- The benefits of including families in care and treatment of the client are not viewed as a result to be measured and reported
- Perception that families referred by child protection are resistant to the planning and treatment process
- Stigma and discrimination against people who have substance use problems

In addition, issues related to professional capacity and compensation structures are seen as challenges to adopting the family-centred approach to care. For example, with regard to compensation structures, as most family physicians are paid on a fee-for-service basis, they can only bill for one issue per person, per appointment. Such a remuneration structure does little to optimally support a family-centred approach, and in some cases may inadvertently serve to discourage it.

Conceptual Basis: A Family-Centred Approach

Families experiencing mental health and substance use challenges need responsive service systems and collaborative relationships with professionals to enhance their protective factors, build resilience, and reduce the risk of related problems, as well as to support them to play a stronger role in their own mental health and well-being. *Families at the Centre* promotes a family-centred approach to increase system responsiveness to the needs of both individual family members and whole families experiencing mental health and substance use challenges.

For the purposes of *Families at the Centre*, the term "family" is broadly defined as an interactive group consisting of one or more relative, partner, close friend or supportive person. In a family-centred approach, the individual is continuously viewed in the context of their family and community. This approach starts with the premise that most individuals have biological or chosen families who are central to their lives and who continue to support them at every stage of life.

A family-centred approach welcomes and involves families in services to the greatest extent possible, based on the choice of the family member receiving service, the families' desire and capacity for involvement, and any relevant considerations related to individual and/or family health and safety. A family-centred approach identifies the needs of whole families, as well as those of individual family members. It supports families in contributing to the health, safety, and well-being of all family members and the family unit.

Family-centred service may look very different as people age and as they move back and forth along the continuum of wellness and illness. As MacKean et al.[lvii] note, a child's involvement in treatment decisions will evolve with their developmental capacity. When a person requires immediate and critical intervention, it may not be possible to involve the family in treatment planning and decision making to the extent the individual or the family would like. The ultimate goal is to engage and work collaboratively with the individual and their family in the contexts of their everyday lives and their current challenges.

In family-centred service, the degree and nature of family involvement is dynamic and changeable. For many people, their family is understood to be a vital resource to be engaged at the outset and throughout the service delivery process. In some cases, a person may choose initially not to involve their family or not to allow any information to be shared with them at a particular point of the service involvement. In these situations, the service provider can still listen to the family and acknowledge their concerns without violating the individual's privacy, and while continuing to support both the individual and the family. At the same time, the service provider can help the individual to acknowledge the impact their family has had, and likely continues to have, on their life. The service provider can also identify and engage additional or alternate support systems for the individual and the family.

The degree of family engagement must always be determined by the choices of individual family members affected by a mental health and/or substance use problem as well as the willingness, capacity, and ability of other family members and the service providers involved. In many cases, a family-centred

approach may be a relatively easy orientation to achieve, while in some instances a true partnership as described by MacKean et al. may not be feasible or desirable at any point, for a variety of reasons. In other situations, although a family-centred orientation may not be possible at the outset, an individual, their family and involved service providers may actively and incrementally move towards a more family-centred partnership over time. For example, family involvement may be an explicit goal of service, and the service provider can create a safe and welcoming space in which to bring the individual and their family together in order to work towards greater involvement. The service provider can also support families, especially fragile families, to remain involved for as long as the individual wants their continued participation.

Family support can entail the provision of wraparound services to address complex family needs and address potential risks and vulnerabilities, education to dispel myths about the causes and progression of mental health and substance use challenges, and continued attention to promoting productive working relationships among the individual, their family, and the service provider. Strengths-based practices, that focus on enhancing the assets and strengths of families rather than fixing deficits, are likely to positively influence the extent to which families actively engage in service, and their potential experience of additional, related problems.

Systems embracing a family-centred approach empower all parties – families, policymakers, and service providers – to be true partners in policy, program design, service provision, workforce development and research. This requires a philosophical shift in a system's culture, structure, and processes. For example, family members can be involved in advisory committees to inform strategic planning. In addition, some levels of decision making may be given to middle management and service providers so that they can be more responsive to families' needs.[lviii]

A family-centred system accepts that many families can be engaged at all levels. However, family-centred systems recognize and honor the rights of individuals, and the degree to which families are involved is always informed by the desires and the safety of the individual and their respective family members. In addition, the empowerment of families does not come at the expense of the people who work within systems. Empowerment is not authentic if it results in the disempowerment of other parties to the relationship. As MacKean et al.[lix] note, a true partnership between families and systems involves people working together to achieve something that would be difficult or impossible to do alone. It is characterized by:

- Identification of common goals to work toward

- Mutual respect about what each partner brings to the partnership

- Open and honest communication and multi-lateral sharing of information

- Shared planning, decision making, and evaluation of progress in achieving goals

- Ongoing negotiation about the role that each partner can and wants to play in the partnership over time
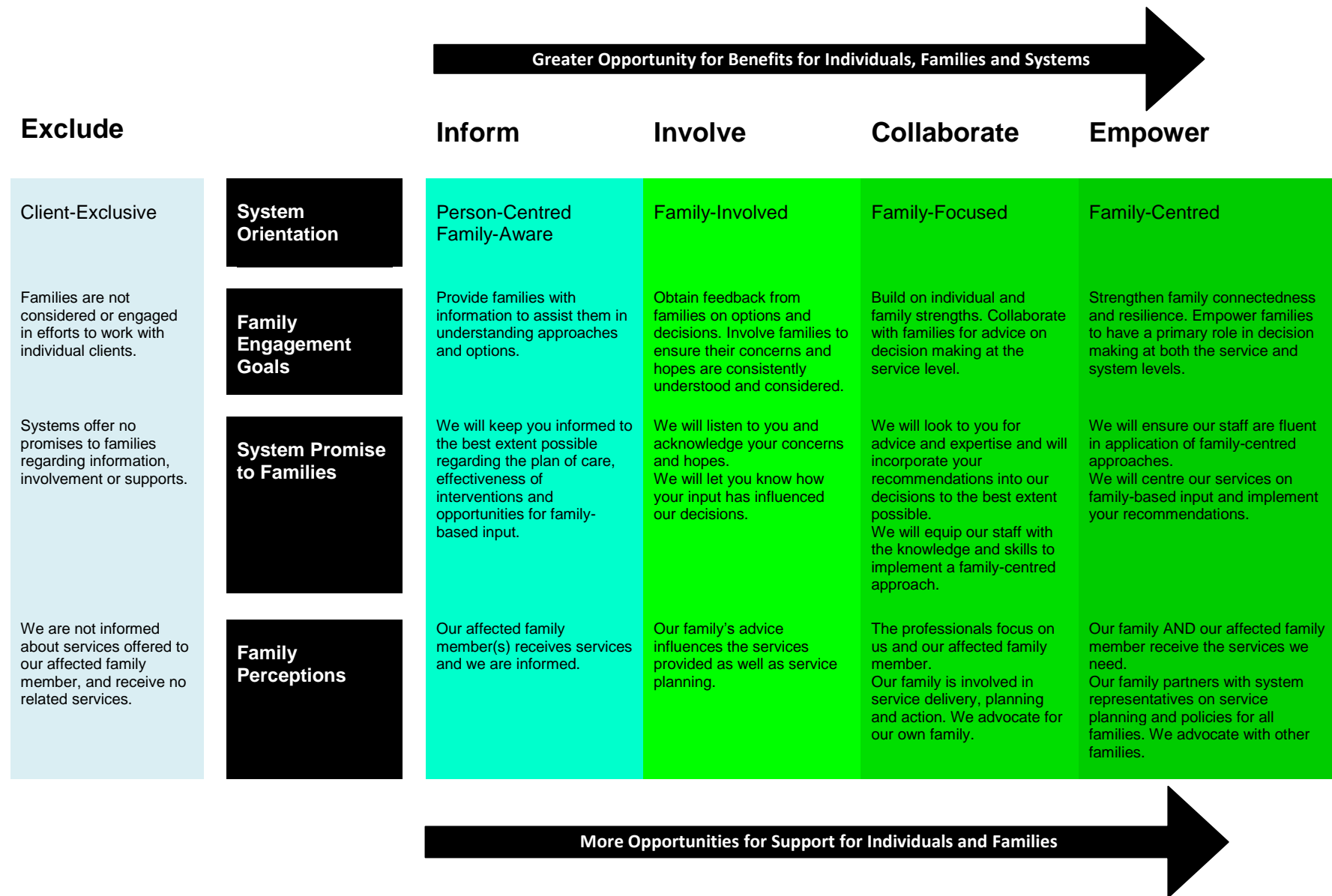
A family-centred orientation is not an 'all-or-nothing' approach. Systems, like the families they interact with, are dynamic and move back and forth along a spectrum of family engagement based on a variety of factors. The degree of family engagement and involvement is influenced by legislative and regulatory constraints, system and service provider capacity, as well as the acuity of the individual's mental health needs, individual and family needs for safety, and developmental and family capacity. Regardless of where a system or service is located on this spectrum, and the specific nature of each individual family's requirements, the system can facilitate greater family engagement and participation, from an individual family level to a broader community level, by addressing policy, practice, and organizational culture barriers.

Systems and services can move towards becoming more family-centred by understanding where they are in the spectrum of family engagement, and taking steps to improve partnerships with families and share decision making with them. The following diagram illustrates this spectrum and its various stages. At every stage of family engagement along this spectrum, there are opportunities for individuals, families, and systems to benefit.

The diagram also includes a column to illustrate an undesirable and deficient orientation that impedes families affected by a mental health and/or substance use from thriving. This column has been assigned the heading 'Exclude' in order to emphasize that families here are not included in any aspect of policy-making or service planning, delivery or evaluation. Specific characteristics of this orientation include: deliberate and consistent exclusion of family members from any involvement in care or treatment planning and delivery; no or limited opportunity for information exchange between service providers and family members despite the individual's desires; and, inability to access services to address the family's needs.

Spectrum of Family Engagement:
When a Family Member is Experiencing a MH/SU Challenge

Greater Opportunity for Benefits for Individuals, Families and Systems →

Exclude		Inform	Involve	Collaborate	Empower
Client-Exclusive	**System Orientation**	Person-Centred Family-Aware	Family-Involved	Family-Focused	Family-Centred
Families are not considered or engaged in efforts to work with individual clients.	**Family Engagement Goals**	Provide families with information to assist them in understanding approaches and options.	Obtain feedback from families on options and decisions. Involve families to ensure their concerns and hopes are consistently understood and considered.	Build on individual and family strengths. Collaborate with families for advice on decision making at the service level.	Strengthen family connectedness and resilience. Empower families to have a primary role in decision making at both the service and system levels.
Systems offer no promises to families regarding information, involvement or supports.	**System Promise to Families**	We will keep you informed to the best extent possible regarding the plan of care, effectiveness of interventions and opportunities for family-based input.	We will listen to you and acknowledge your concerns and hopes.\nWe will let you know how your input has influenced our decisions.	We will look to you for advice and expertise and will incorporate your recommendations into our decisions to the best extent possible.\nWe will equip our staff with the knowledge and skills to implement a family-centred approach.	We will ensure our staff are fluent in application of family-centred approaches.\nWe will centre our services on family-based input and implement your recommendations.
We are not informed about services offered to our affected family member, and receive no related services.	**Family Perceptions**	Our affected family member(s) receives services and we are informed.	Our family's advice influences the services provided as well as service planning.	The professionals focus on us and our affected family member.\nOur family is involved in service delivery, planning and action. We advocate for our own family.	Our family AND our affected family member receive the services we need.\nOur family partners with system representatives on service planning and policies for all families. We advocate with other families.

**More Opportunities for Support for Individuals and Families** →

Adapted from ©2007 International Association for Public Participation, Spectrum of Public Participation www.iap2.org.; Ferreira, K. et al, Family Movement Milestones Poster (2012)

Putting it All Together

Families at the Centre charts a path for BC systems to work with each other, and with families experiencing mental health and substance use challenges. It supports all systems that touch the lives of families to take steps along the continuum towards becoming more family-centred. It also promotes broader engagement of families with lived experience in policy, program design, service provision, workforce development and research; an orientation that is focused on the health and well-being of the entire family.

The vision and goals listed below represent **what** systems can accomplish with and for families. The values, operating principles, and focus areas with opportunities for action represent **how** to achieve the vision and goals of *Families at the Centre.*

Vision → Values → Goals

Guiding Principles → Focus Areas → Opportunities for Action
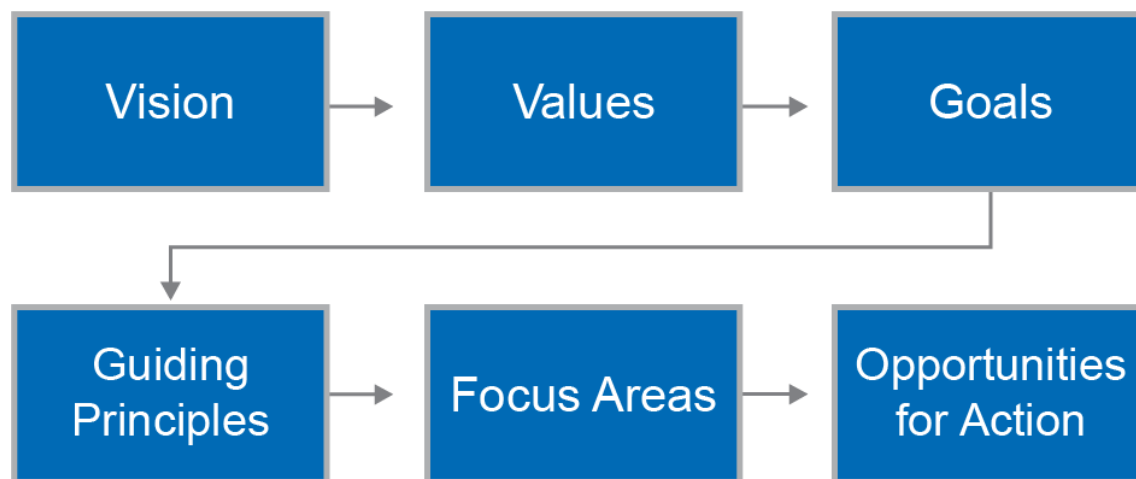
As previously noted, the vision statement to support *Families at the Centre* is:

Families in all their diversity are at the centre of service system cultures and responses.

When families are at the centre of the service planning and delivery, and evaluation of responses, they are better equipped to thrive in the face of a mental health and/or substance use challenge. This supports the affected family member's successful care and treatment, and reduces the likelihood that other family members will experience additional mental health and/or substance use problems.

Values

These foundational values are based on a similar set of values determined by families consulted through the development of the *Families Matter* framework. They have been affirmed and enhanced through the various engagement activities undertaken to develop this document. Taken together, these values form the ethical basis of family-centred systems and services:

HOPE

Hope is the limitless belief that positive change can and does happen, and is an important aspect of resilience for individuals and families. Systems can create a culture of hope by building alliances with families. This starts with families defining what hope means to them—in the moment and over time—and systems mobilizing and adapting to help families reach their full potential. When families see their aspirations shaping how a system responds, they are more likely to believe in that system. When service providers and families share a belief in the capacity for growth, the results can be transformative for everyone.

COMPASSIONATE PRAGMATISM

Compassion involves cultivating an attitude of universal and unconditional acceptance, where boundaries that define self and the other dissipate.[lx] Pragmatism is about taking action to resolve problems, while acknowledging the limits of our understanding and the constraints on what will work. This means focusing on positive outcomes for people, while tolerating ambiguity, as we strive to integrate different explanatory concepts in a rigorous and evidence-based fashion.[lxi]

INCLUSION

An inclusive society is one where all people feel valued, their differences are respected, and their basic needs are met so they can live with dignity. A system that fosters inclusion starts by examining its own attitudes, values, and beliefs to ensure a culturally safe environment for all families. It treats families with respect and empathy, ensuring they experience services free from discrimination. It recognizes the wealth of support in extended families and kinship networks, and builds on these resources to facilitate community integration. An inclusive system understands that individuals are part of families and families are part of the larger community, in addition to being key partners in service delivery.

EMPOWERMENT

Empowerment is about building self-awareness, competence, and determination, as well as about developing proactive strategies to achieve goals. It is a process of creating a personal or shared vision and acquiring the confidence, skills, and support to move towards the vision. Systems can enable this process by creating a continuum of opportunities to inform, consult, involve, collaborate with, and empower families.

INTERDEPENDENCE

Interdependence is the state of being connected to and influenced by others. It is the interplay of self-reliance, being relied upon, and relying on others. Interdependence balances personal and group responsibility, and autonomy and cooperation. In families, individual members function as interdependent parts of an ecosystem. Once a system engages with a family, the system itself becomes an interdependent element and adds to the complexity of the family ecosystem.

Goals

1. Support families affected by mental health and substance use challenges to thrive:

   - families struggle less with mental health and substance use challenges and rebound to live more fully, progressing from 'surviving' to 'thriving';

   - policy makers and service providers value the diversity of families and family strengths and assets; and

   - systems and services engage families as full partners in planning and decision making.

2. Minimize individual and family harms associated with mental health and substance use challenges:

   - affected individuals are impacted less by mental health and substance use challenges, and their present and future family members are less likely to develop related challenges of their own;

   - policy makers and service providers take a whole family, multi-generational approach to addressing mental health and substance use-related needs; and

   - systems and services see both the individual and the family as the clients, and understand the many ways they can support the healthy development and resilience of children, youth, and families experiencing mental health and substance use challenges.

3. Combat stigma and discrimination experienced by families affected by mental health and substance use challenges:

   - families experience public systems and services as safe, welcoming and inclusive;

   - policy makers and service providers work with families to consistently challenge the fears, myths, and stereotypes surrounding mental illness, substance use, and concurrent disorders; and

   - systems and services see the family as a valuable resource for health and healing, and the distinction between 'us' and 'them' disappears.

Guiding Principles

These principles can help to guide public systems and those who work in them to be more family-centred and achieve better results with families. Systems and service providers:

- **Explicitly acknowledge the importance of family and community contexts** in providing services and supports to infants, children, youth, and adults. Families and communities—of shared bond, interest, or geography—are valued for their roles in fostering well-being and providing care, and are actively engaged by systems to fulfill these roles.

- **Work collaboratively with families and each other** to identify and promote individual and family strengths, build resiliency, and mitigate vulnerabilities across the life span, the family lifecycle, and multiple generations.

- **Work collaboratively to contribute to the safety, well-being, and healthy development** of individuals and families in each phase of life. Recognize and keep a close and sustained focus on infants, children, youth, and vulnerable adults in unstable and volatile situations.

- **Work collaboratively to provide adequate levels of services and supports** for all families experiencing mental health and/or substance use challenges—when, where, and for as long as they are needed. The services and supports are comprehensive, ranging from health promotion and prevention, through early intervention and harm reduction, to treatment, care, and recovery. They are evidence-informed, developmentally appropriate, and delivered in a highly coordinated manner within and across systems.

- **Be "concurrent disorders capable,"** and be equipped with the corresponding critical mass of expertise and supporting infrastructure to effectively identify, treat, and support people with complex mental illness, substance related disorders, and co-occurring health conditions. Allow for province-wide consultation and treatment services, education and training of clinicians, and dissemination of evidence-based practices.

- **Engage in continuous dialogue with families, policy makers, and service providers** about the family-centred nature of services and supports. Family-centred services and supports are non-judgmental, culturally safe, and built upon the richness and diversity of families' lived experience. They enable participation of all family members.

- **Engage in comprehensive knowledge exchange** by working with families, communities, service providers, researchers, and other systems to generate, translate, disseminate, and integrate new knowledge and evidence. Sources of knowledge and evidence include research, practice, lived experience, and cultural teachings.

- **Focus on collaborative practice that engages the public, private, and voluntary sectors.** By working together, families, communities, professionals, and service systems each play a part in promoting family mental health and informed choices about substance use.

- **Adopt a human rights approach** that addresses the major legal, structural, and attitudinal barriers to health for families experiencing mental health and substance use challenges. Work to

develop and implement legislation, policies, and practices that respect, protect, and fulfill human rights of people experiencing mental health and substance use challenges.

- **Develop a thorough understanding of the confidentiality and privacy issues** flowing from the legislative and regulatory frameworks that guide work with families and manage information sharing and privacy effectively to achieve the best results for children, youth, and families.

- **Introduce robust accountability frameworks in partnership with families** that have the capacity to:
    - define, measure, report, and evaluate performance
    - generate meaningful, reliable, and accurate information
    - identify lessons learned
    - celebrate, build upon, and replicate success
    - adjust system responses based on feedback and new learning
    - reframe professional discourse on family mental health and substance use

Focus Areas

Families at the Centre recognizes the complexity of family relationship dynamics, as well as the capacity of individuals and families to thrive in the face of mental health and substance use challenges. Instead of one single trajectory to reduce vulnerability or strengthen resilience, there is a nuanced relationship between healthy individual and healthy family development. The convergence of mental health and substance use challenges with child, youth, and family development, child safety, and approaches to parenting provides unique opportunities for positive intervention across the lifespan, including the reducing risk of additional problems.

The following four areas for focused action emerged from consultations with families, policy makers and service providers:
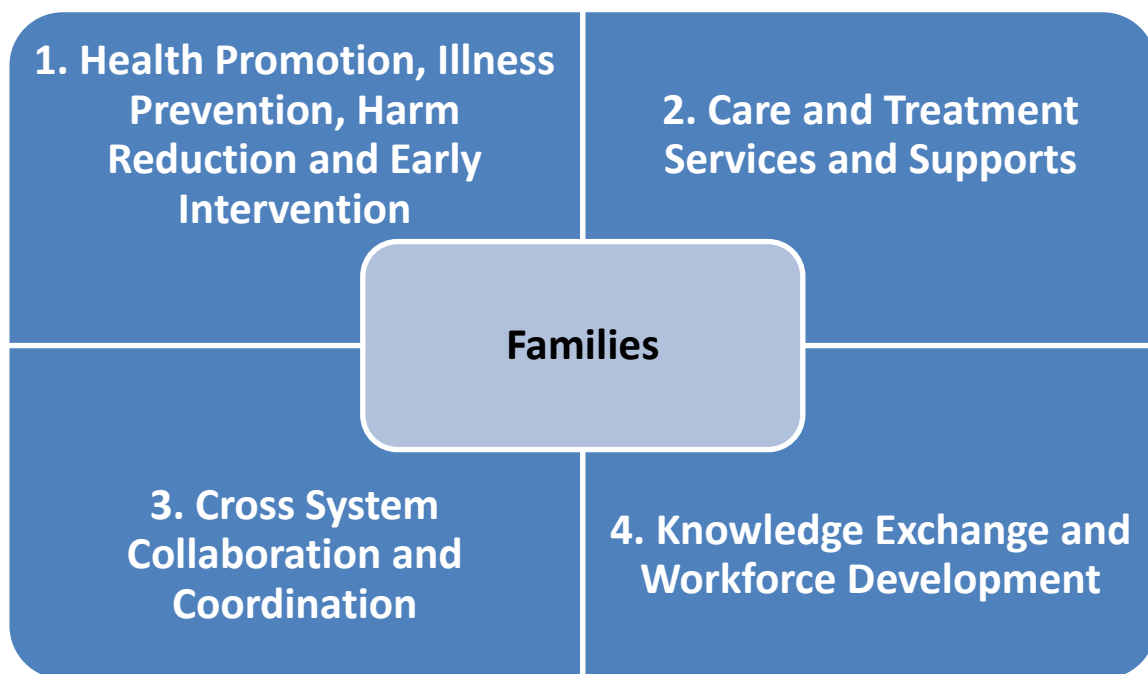
For each focus area, there is an overview and set of recommended actions that can be considered by policy makers and service providers to achieve better results for families. For most actions, there are examples of promising practices in BC and elsewhere and/or contact information for organizations working in these areas.

Focus Area #1:Health Promotion, Illness Prevention, Harm Reduction and Early Intervention

OVERVIEW

Positive mental health is created and experienced by people where they live, learn, work, play, and care for one another. This is true for all families, whether or not they are experiencing mental health or substance use challenges.

Mental health-promoting policies and services focus on creating the conditions that allow everyone in the family—infants, children, youth, and adults—and the family as a whole to achieve and sustain the best possible mental health and to reduce harms from substance use.

For policy makers and service providers, this means making the healthy choice the easy choice for families by targeting structural and behavioural change within the settings of everyday life.

This, in turn, requires consideration of the social determinants of health, including income, employment, housing, early childhood development, education, and social support, and their relationships to individual and family mental health and substance use.

From a prevention perspective, it also means understanding the risk and protective factors for mental health and substance use challenges that are present across the lifespan, throughout the family lifecycle, and at key transition points. The developmental pathways approach acknowledges that some risk factors are dynamic and others, such as genetic endowment, are less malleable. Still others, such as social isolation, financial instability, and trauma, respond to different interventions: for example, knowledge and skills acquisition, behaviour change, targeted services and supports, and broader social and systemic change. By addressing both risk and protective factors at each stage of life, families and service providers are in a stronger position to promote the healthy development, safety, and well-being of infants, children, adults, and families.

Early intervention is the link between prevention and treatment. Early identification and intervention are critical for addressing mental health and substance use challenges before they become more problematic. This is particularly important for children and youth for whom the threat to safety and the emotional, social, and developmental costs of untreated mental health and substance use challenges are immense.
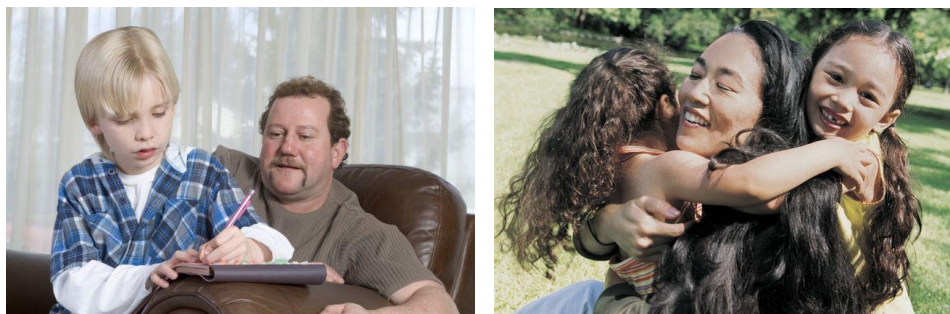
Early intervention can be provided early in the lifespan, for example with infants and young children of parents with a mental illness, and at first signs of a mental health or substance use challenge, such as generalized anxiety in children, early psychosis or chronic, excessive drinking in adolescence, or signs of depression in adults.

All systems that engage with families in any capacity—education, housing, income security, food security, health, and mental health—can play a role in helping to recognize and reach out to families experiencing mental health and substance use challenges. In this way, we can all help to build individual and family resilience, reduce the risk of additional problems, and promote mental health and well-being.

RECOMMENDED AREAS FOR ACTION

1. Identify opportunities to promote the well-being of families experiencing mental health and substance use challenges, including ways to prevent the development of secondary problems in the family, and to minimize the impact of existing challenges on present and future family members:

   a. **Provide families with accurate, reliable, and impartial information about:**
      - Mental health and illness
      - Problematic substance use, addiction, and low-risk drinking
      - Tobacco use and other chemical exposure
      - Trauma and adverse experiences
      - Healthy decision making about substance use
      - Healthy infant, child, and youth social and emotional development
        - Child safety and well-being
        - Healthy living
      - Healthy aging
      - Treatment and recovery-centred mental health practice
      - Related policies and legislation
      - Individual and family rights

   Promising practices and resources:

   ✓ For more information and resources, contact these BC organizations:
      - BC Healthy Child Development Alliance (www.childhealthbc.ca/bchcda)
      - BC Healthy Living Alliance (www.bchealthyliving.ca)
      - BC Partners Here to Help (www.heretohelp.bc.ca)
      - Canadian Mental Health Association – BC Division (www.cmha.bc.ca)
      - F.O.R.C.E. Society for Kids' Mental Health (www.forcesociety.com)
      - Kelty Mental Health Resource Centre (www.keltymentalhealth.ca)

   ✓ A *Child and Youth Mental Health Information and Resources Tool Kit* to help connect families and professionals to information they need as quickly as possible. This toolkit was created by the Ministry of Children and Family Development, in partnership with the Kelty Mental Health Resource Centre. It provides up-to-date information on Child and Youth Mental Health services in BC and links to province-wide organizations, websites, and phone services. (www.mcf.gov.bc.ca/mental_health/)

   ✓ The *Children of Parents with a Mental Illness Initiative* in Australia offers on-line evidence-based, psycho-education resources developed for mental health and other professionals supporting parents with depression and anxiety. Intended to help parents foster resilience in their children and family, resources include toolkits and videos intended to promote and support family dialogue around depression and anxiety. (www.copmi.net.au/)

✓ *Triple P Parenting* is a multi-level parenting and family support strategy intended to reduce children's emotional and behavioural problems by enhancing the skills of their parents. (www.triplep.net/glo-en/home)

b. Connect families experiencing mental health and substance use challenges to each other:
- Provide families with information on and linkages to peer and social support services, such as family-led support groups for families living with mental health and substance use challenges

Promising practices and resources:

✓ For more information and resources, contact these BC organizations:
  - o BC Schizophrenia Society (www.bcss.org)
  - o F.O.R.C.E. Society for Kids Mental Health (www.forcesociety.com)
  - o From Grief to Action: When Addiction Hits Home (www.fgta.ca)
  - o Nar-Anon (www.nar-anonbcregion.org)
  - o Narcotics Anonymous (www.bcrna.ca)

c. Connect families experiencing mental health and substance use challenges to professional services and community resources through Health Authorities and other health system partners and the Ministry of Children and Family Development:
- Provide families with information on and linkages to professional services, such as counselling, psychotherapy, psychoeducation, psychogeriatric care, and respite care

Promising practices and resources:

✓ The *BC Healthy Connections Project* has been established to scientifically evaluate the effectiveness of a new-to-BC home-visiting program called the *Nurse-Family Partnership* (NFP). Offering focused support to young, low-income pregnant women who will be mothers for the first time, NFP has demonstrated impressive long-term results for participating families in other jurisdictions. (www.healthyfamiliesbc.ca/home/bc-healthy-connections-project)

✓ The Safe Relationships, Safe Children project is one of the initiatives arising from *Taking Action on Domestic Violence in British Columbia*. Key to the project founded on a partnership between the Ministry of Children and Family Development, Ministry of Health, and regional health authorities are approaches that are family-oriented and family-sensitive, while promoting the safety and well-being of children. (www.domesticviolencebc.ca/dvbc/index.page)

✓ *HerWay Home* is a "one-stop access" program in Victoria, BC for women in the perinatal period who are affected by substance use, mental health issues, and/or violence. Services include prenatal care, a drop-in centre, short-term stabilization housing, substance use counselling, and parenting support. *HerWay Home* is child-focused, women-centred, and family-oriented. Similar successful programs in BC include *SheWay* in Vancouver's Downtown Eastside and The *Maxxine Wright Community Health Centre* in Surrey.

✓ The Canadian Mental Health Association BC Division provides *Confident Parents, Thriving Kids*, an early intervention, parent management program for families of children with mental health challenges. This no cost program is provided to parents and/or caregivers via telephone in the comfort and privacy of their own homes at times that work for family life. (www.cmha.bc.ca/how-we-can-help/children-families/confident-parents)

✓ The *Provincial Youth Concurrent Disorders Program* at BC Children's Hospital in Vancouver provides outpatient psychiatric consultations for BC youth (ages 12-24). The clinic provides outpatient psychiatric consultation for adolescents with substance use problems who may have additional co-occurring mental health issues. (www.bcmhsus.ca/programs-and-services/provincial-youth-concurrent-disorders-program)

✓ The *Strengthening Families Together* course, offered by the BC Schizophrenia Society, is for people who have a relative with a severe mental illness. This 10-week course teaches family members about the illness and how to access resources. It is a successful national program that has over 55 trained facilitators throughout BC. (www.bcss.org/programs/2007/05/strengthening-families-together/)

✓ The BC Schizophrenia Society's *Reaching Families Project* involves assertive outreach to families and referrers using web-based tools. Online support groups, a multi-agency calendar of family-specific events in BC, and e-resource newsletters for various populations are available at (www.bcss.org/programs/2008/11/reaching-families-project/)

✓ The *Partnership Education* program of the BC Schizophrenia Society (BCSS) uses a story-telling approach to provide information on the lived experience, nature, and prevalence of mental illness to a wide variety of audiences. Presentations are developed by a person with a mental illness, a family member of someone with a mental illness and either a mental health clinician or a BCSS coordinator and then tailored to the audience. For example, a session for medical students would emphasize the importance of involving families in supporting someone with a mental illness (www.bcss.org/programs/2007/05/partnership-education/)

✓ The *Clinician-Based Cognitive Psychoeducational Intervention* program was developed for families with parents with significant mood disorder. The program provides information about mood disorders to parents, equips parents with skills to communicate this information to their children, and promotes dialogue in families on the effects of parental depression. (www.nrepp.samhsa.gov/viewintervention.aspx?id=156)

▪ Provide information on and linkages to community resources that support children and youth with mental health and substance use challenges and their families, and parents with mental health and substance use challenges and their children.

Promising practices and resources:

✓ *Kids in Control* (BC), a group support program run by the BC Schizophrenia Society, provides information, education, and support to children who have a parent or an older sibling with a serious mental illness. The goal of the program is to help children cope with and understand their parent's or sibling's mental illness. (www.bcss.org/programs/2007/05/kids-in-control/)

✓ *Transitioning to Parenthood* (BC), a pilot project of the F.O.R.C.E. Society for Kids Mental Health, engages young people with lived experience of mental health challenges in conversations about the risk and protective factors for a successful transition to parenthood for first time parents with a mental health challenge. (www.forcesociety.org/sites/default/files/T2P%20Press%20Release%202013a.pdf)

✓ *Supporting Families with Parental Mental Illness*, a community-based program for families affected by parental mental illness or substance use in Richmond, BC, offers support groups for children, youth, and parents, recreational events to improve resilience for children and youth and social supports for families. (www.vch.ca/locations-and-services/find-health-services/?program_id=14229)

✓ *The Coping Kit: Dealing with Drug Addiction in Your Family,* developed by From Grief to Action (BC), is for parents and caregivers who are dealing with a son's or daughter's substance use. *The Coping Kit* contains information about drugs and substance use, strategies for supporting their loved one, self-care strategies for parents and caregivers, and treatment options—all from families who have been there themselves. (www.heretohelp.bc.ca/workbook/fgta-coping-kit)

  ▪ Provide information on community resources that support families to address basic needs, make positive social connections, and build skills and capacities.

2. Build the capacity of communities to be aware of, respond to and support families experiencing mental health and substance use challenges.

Promising practices and resources:

✓ *In the Know*, presented by the F.O.R.C.E. Society for Kids' Mental Health, is a monthly telecast about a different, parent-selected topic in child, youth, and family mental health. Some of the community child and youth mental health teams are sharing the telecasts with families engaged in their services, including with those involved in the intake process. (www.forcesociety.com/)

✓ *Supporting Families with Parental Mental illness: a Community Education and Development Workshop* (BC) is a practical resource for guided community development and education on parental mental illness. (www.mcf.gov.bc.ca/mental_health/pdf/supporting_families1.pdf)

3. Support families experiencing mental health and substance use challenges to meet basic needs, participate fully in community and economic life, and experience an improved quality of life.

Promising practices and resources:

✓ *The Government, Non-Profit, and Volunteer Secretariat* is a new division under the Deputy Minister's Office in the Ministry of Social Development and Social Innovation. The Secretariat was formed in September 2008 to foster the ongoing relationship between the BC Government and the non-profit and volunteer sector, who often provide support and services to families with mental health and substance use challenges. Working with a broad spectrum of ministries and non-profit foundations, associations and service agencies, the Secretariat develops and implements strategies to improve the efficiency, effectiveness, accountability and sustainability of the government, non-profit, and volunteer sector alliance in achieving strong and positive service and policy outcomes for the people, families and communities of British Columbia. (www.aspect.bc.ca/resources/government-non-profit-initiative)

A family's story:

Elizabeth is a 35 year old new mother who gave birth 3 months ago to a six week premature baby girl. The baby was kept in hospital for 4 weeks, and the worry and strain of the baby being in hospital, nursing the baby, and the travel back and forth contributed to Elizabeth experiencing low mood and irritability.

Elizabeth's family lives out of province and were unable to be there to support her during this difficult time. She has few friends as she recently moved to town with her new husband, Darryl. Her husband's family lives in town and their attempts to help are experienced by Elizabeth as intrusive and this causes even more strain between Elizabeth and Darryl.

Elizabeth blames Darryl's family for the conflict between them– and she feels he is becoming more distant. Darryl's family is concerned about Elizabeth's mental health – in addition to concern about the strain their son is under, and the possible effect on the baby. They are unsure where to go to seek advice about what they might do to help, and what resources might be available to Elizabeth and Darryl.

How a family centered approach could improve outcomes for Elizabeth, Darryl and their baby:

A family-centered approach initiated over the month that the baby was hospitalized would include involvement of the hospital social worker with Elizabeth, Darryl and the extended family. Elizabeth has active and clear risk factors for postpartum depression – including the premature birth of her child, and social isolation with moving to a new town. Recognizing and addressing these potential risks and identifying potential protective factors are critical not only for Elizabeth and her husband, but also for the health and well being of her baby, now and for its future development.

Information on postpartum depression and healthy infant and early childhood development would have been provided to Elizabeth and Darryl, in addition to information about peer support and other community resources. The hospital social worker would have explored Elizabeth's psychological adjustment following the birth of the child, the need for involvement of other professionals, and the presence of social supports for Elizabeth and Darryl.

Supporting the involvement of Darryl's family who are willing and available to help, and discussing appropriate approaches to support may have helped Elizabeth to better accept the family's involvement. If Elizabeth was still not willing to involve Darryl's family – the social worker would met with the family to acknowledge their concerns, provide relevant information and resources, identify and support their strengths and appropriate roles, and continue to provide support to the entire family. The hospital would utilize formal processes to obtain feedback from Elizabeth and Darryl on their experience during their daughter's hospitalization. Preparation for discharge and ensuring that continued support and follow up from primary health care was in place would help Elizabeth and Darryl as they adjust to their new life as a young family, and better ensure healthy development and well being for the whole family.

Focus Area #2:Care and Treatment Services and Supports

OVERVIEW

People thrive within a network of sustaining relationships with family, friends, and community. In addressing the needs of families experiencing mental health and substance use challenges, two fundamental shifts in thinking are required. First, individuals are viewed as vital members of families and communities, rather than as singular entities. Second, families are seen as a key part of the solution.

The first shift is gaining momentum, particularly in the substance use field, where growing evidence supports an ecological view of health and substance use, as well as a contextual model of service delivery. The second shift has been slower due in large part to the stigma associated with mental illness and substance related disorders, and practice models that emphasize a focus on the individual.

In some cases, families may be perceived as the cause of a family member's problem or problems, whether it is a parent with depression, a child with anxiety or a youth with problematic substance use. As a result, some service providers are reluctant to include families in treatment planning and decision-making. In other situations, service providers consider children, youth, and vulnerable adults too young or too troubled to participate in their own care and the care of their parents. Some service providers are reluctant to serve families when there is a referral from a child protection worker, due to concerns that these families may be harder to engage because they may not be participating on a voluntary basis. In any of these instances, reluctance to consider the family in its entirety could undermine the success of care and treatment for the affected individual, and may contribute to additional stressors and corresponding problems within the family unit.

Central to the concept of family-centred care is the development of truly collaborative relationships between systems and families. Such relationships develop when the systems and people working within them recognize and build upon the strengths and capabilities of families.

Of equal importance is the recognition that people who access mental health and substance use services have expertise in what does and does not work in our systems. In a family-centred approach, families are valued partners in developing, implementing, and evaluating services and supports to meet challenges related to mental health and/or substance use.

For service providers, it is important to recognize the diversity of families (e.g. in form, beliefs, relationship dynamics, parenting practices, expectations for child and youth development, managing conflict, and adapting to change) and the role that family diversity plays in the development and delivery of effective mental health and substance use services.

In a family-centred approach, services and supports are informed by an understanding of the individual's immediate and extended family, as well as the family's social, cultural and economic contexts. This awareness enables the development of interventions tailored to the family's particular circumstances and address any barriers to service. Ultimately, the goal is to work collaboratively with individual family members and the whole family in the contexts of their everyday lives.

RECOMMENDED AREAS FOR ACTION

1. Using this planning resource, clearly articulate what constitutes family-centred service in each system, and what the benefits are for families and service providers.

    Promising practices and resources:

    ✓ The Community Support and Research Unit at the Centre for Addiction and Mental Health in Toronto, in partnership with the Centre's Family Council, has been leading a *Family-Centered Care Initiative* since 2004. The initiative's goals are to improve the care and support that the Centre provides to family members and to work with families to improve the quality of life of clients. This requires a centre-wide commitment to families and the development of a clearly articulated philosophy of care and support for families. (www.camh.ca/en/hospital/care_program_and_services/support_for_families_and_friends/Pages/fcci_philosophy_outcomes.aspx)

2. Develop lenses, checklists, tools, and other practical resources to ensure that policies, services, practice guidelines, and standards are family-centred, culturally safe, and, where appropriate, informed by an understanding of trauma and how it affects the individual (e.g. potential impact of trauma on brain development and child development) and the whole family.

    Promising practices and resources:

    ✓ Discovery, Youth & Family Substance Use Services with Island Health has adopted family-centre practices that involve the families whenever possible and appropriate. For example, they recruit staff with family therapy skills, provide a trauma-informed and culturally safe approach, and have developed materials specifically for family members and caregivers: *Raising Resilient Teens - A Workbook for Parents and Caregivers of Teens Using Substances*, 2012. (www.viha.ca/NR/rdonlyres/2CC6E168-D562-440B-B906-0DFEB72CE470 /0/recognizingresilience.pdf)

    ✓ *The Trauma-Informed Practice (TIP) Guide* and *TIP Organizational Checklist* was developed in consultation with researchers, practitioners and health system planners across BC. The TIP Guide, which includes concrete strategies to guide the professional work of practitioners assisting clients with mental health and substance use concerns, will support the translation of trauma-informed principles into practice. (bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf)

    ✓ The Center for the Advanced Study of Excellence in Early Childhood and Family Support Practices uses the *Family-Centred Practices Checklist* developed by Wilson & Dunst (2002) as a tool for practitioners working with families. The tool is used to determine the extent to which relational and participatory help-giving practices are integrated into work with families. It is intended to form the basis of individual or joint reflection on help-giving behaviours. (www.fipp.org)

3. Explore options for integrating family-oriented treatment models, such as family therapy, into mental health and substance use services.

   Promising practices and resources:

   ✓ The F.O.R.C.E. Society for Kids' Mental Health partners with the Ministry of Children and Family Development to support and engage families in order to improve outcomes for children and youth with mental health challenges. For example, the F.O.R.C.E supports families involved with some of the Child and Youth Mental Health community teams by providing the Parents in Residence. This arrangement offers families direct access to a parent or youth who provides support, mentorship, and assistance finding resources, and is available by phone, email and/or in person at the Kelty Centre at BC Children's Hospital. A similar service for youth is available at and supported by BC's Children's and Women's Health Centre. (www.forcesociety.com/parent-in-residence)

   ✓ The Psychosocial Rehabilitation Services Framework is currently under development by Douglas College, in collaboration with the Ministry of Health and health authorities. An important component is family involvement and support, including psychoeducational interventions and informational resources for families, involving families in the assessment process, addressing barriers to family involvement, and referring clients to family therapy, when appropriate.

   ✓ The Ministry of Health, in collaboration with health authorities and community partners, is developing a guiding document on the quality and use of evidence-supported therapies for the treatment of a wide range of mental health and substance use conditions. The document highlights a variety of family, couple and peer oriented approaches to treatment, in addition to individual approaches.

4. Involve families in all aspects of monitoring, auditing, and evaluation, including process and outcome evaluation, to determine if families are better off because of services. Build continuous feedback loops into aspects of service provision to obtain immediate, real-time client feedback to inform and construct treatment, inspire innovation, and evaluate effectiveness and service quality.

   Promising practices and resources:

   ✓ Since 2006, Discovery, Youth & Family Substance Use Services with Island Health has been using outcome data provided by youth and family members to monitor change and adjust their services and treatment. Their model is based on *The Heart & Soul of Change: What Works in Therapy* (Hubble, Duncan, & Miller. 1999).

5. Address barriers to and extend the reach of services by addressing families' basic needs, including childcare, accommodating work commitments, supporting involvement in decision making, and promoting mastery and self-determination. For example:

- Provide opportunities for service providers to engage with families in the community—where they live, learn, work, and play
- Meet children, youth, and families "where they are at" in their experience of mental health and substance use and emphasize the importance of incremental gains built over time
- Strengthen outreach to families involved with child welfare

Promising practices and resources:

✓ A *Ulysses Agreement* is a non-legal document that serves as an advance care plan. It allows a parent who is currently mentally stable to outline provisions for their own care and the care of their children and family when they are incapacitated due to mental illness. (www.bcss.org/programs/2009/12/ulysses-agreement-planning-for-support)

6. Clarify information sharing, privacy, and access to information requirements in different legislative frameworks and promote consistent family-centred practice to improve service quality for children, youth, adults, seniors, and families.

Promising practices and resources:

✓ Privacy, Confidentiality & Information Sharing within Mental Health and Substance Use Care Systems: Clients, Family Members & Service Providers, is a project led by the *Healthy Minds, Healthy People* Directorate at the Ministry of Health and the Canadian Mental Health Association. It is examining the policies, practices, standards, and culture of service providers regarding the sharing of information with each other and with family members. The goal of this project is to support development of tools and resources for service providers and families that clarify information-sharing parameters.

7. Regularly review system policies and practices to eliminate discriminatory behaviour against individuals and families experiencing mental health and substance use challenges.

A family's story:

Ben is a 22 year old who struggles with both mental health and substance use problems. Ben was adopted at birth. Both of his biological parents struggled with problematic substance use, and his father was diagnosed with bi-polar disorder. Ben started using drugs when he was 12 years old. Ben has a loving and supportive relationship with his adoptive parents but they were unprepared and surprised when he began acting out, including behaving violently, missing school and using drugs. Despite the advocacy of Ben's family at his school, the school suspended him multiple times, which left the family feeling isolated and shunned. After Ben dropped out of school in grade 9, he gravitated to the "outsiders" in his peer group, and his drug use escalated. Ben's parents wondered if he was using substances to cope with a mental health problem, and took him to a child and youth mental health counselor who told the family to return when Ben wasn't using substances. Ben's parents eventually found a youth substance use program. However, at that time Ben was increasingly violent and experiencing delusions associated with substance use. He refused to have his parents involved in his treatment and subsequently, the counsellor would not talk to the family even though Ben was living at home and punching holes in the walls. Ben continued to see the same substance use counsellor intermittently for 7 years, who continued to have no contact with the family.

When Ben was 19 years old, his family facilitated a referral to a youth concurrent (mental health and substance use) disorder program. His mental health assessment included a diagnosis of ADHD, anxiety, and problems with multiple substances. Ben participated willingly and this time, he agreed to have his parents involved. The centre provided Ben with options for treatment and included his parents and family doctor in the treatment planning process. Although Ben was experiencing anxiety as well as unwanted and intrusive thoughts, he refused medication and believed he could get better with the support of his family and friends.

Currently, Ben has crack cocaine and heroin use disorders. He engages in illegal activities to support his addictions. He is facing charges for possession of illegal substances and is often so anxious he cannot leave the house or sleep. The doctor at the youth concurrent disorders clinic indicated that Ben's challenges may be treatable, and that the mental health issues could be part of his addiction problems. Recently, Ben and the family tried again to get mental health-related treatment and were told Ben was not eligible until he addressed his problematic substance use. Subsequently, his mother advocated very strongly on behalf of her son and his family has hope that he will receive concurrent disorders-focused treatment. Nonetheless, the family is quite exhausted.

How a family-centred approach could improve outcomes for Ben, his parents:

Staff at the school Ben attended would meet with Ben's parents at an earlier stage in order to discuss emerging behavioural concerns and options for response. When the serious behavioral issues did emerge, school staff would again engage Ben's parents and professional support from the community in order to identify alternatives to suspension and expulsion.

The first child and youth mental health counselor would provide services founded on a family-centred approach, which would have engaged Ben and his parents from the first point of contact as well as addressing the concurrent mental health and substance use problems. They would find a way to work with Ben without requiring abstinence or would work with Ben's family to find an alternative source of immediate support and assistance.

With Ben's permission, staff at the substance use treatment program would work with Ben to find a way to include his parents more directly in some of the assessment and treatment planning as well as offer them updates on Ben's progress. They would also consider the needs of the parents and offer them support, education and possibly family therapy. Service models such as the one used by Island Health's 'Discovery, Youth & Family Substance Use Services' are examples of the kind of family-centred support that Ben and his family required, whose model engages families in the assessment, treatment and evaluation processes.

Focus Area #3:Cross System Collaboration and Coordination

OVERVIEW

A whole family approach to mental health and substance use is challenged by separate systems for children and adults, especially when those systems may have differing legislation, mandates, policies, and organizational cultures. It is also challenged by the assumption that only one system is responsible or accountable for mental health and substance use responses.

The systems of care for children and youth and adults have evolved independently over time in response to a variety of factors, including:

- the need to ensure the safety of children and youth

- age-related diagnostic challenges

- impact of developmental stages on risk, illness progression and treatment effectiveness

- need for parental involvement in the treatment of younger clients

- age-related social and educational needs of clients, particularly when treated in hospital.

This has led to a degree of specialization with clear benefits for research, clinical practice and resource allocation. However, the specialization has also created significant barriers for youth as they transition from a child- and youth-serving system into an adult-serving system. While there are pockets of integration, this is often the exception, rather than the rule. At present, the two systems of care do not consistently provide one seamless continuum of services and supports for families experiencing mental health and substance use challenges across the lifespan.

A whole family approach is also compromised by separate service philosophies and treatment modalities for mental health care and substance use services. Families that are facing complex problems such as concurrent disorders can experience significant difficulties and barriers navigating between the distinct service system streams. Additionally, programs and services that support mental well-being, or to prevent mental health and/or substance problems from occurring are further separated from systems of care.

There are clear challenges to providing continuity of care across child and adult systems and among systems of primary, secondary, and tertiary care, as well as public health and prevention services. While these challenges create opportunities for collaboration, they can also lead to children, youth, and adults receiving duplicate, conflicting, or no services at all. For many young people, having to tell their personal stories repeatedly to different service providers may be traumatizing and can result in loss of motivation to seek help.

What is needed is a collaborative and coordinated systemic approach to working with families experiencing mental health and substance use challenges. Strengthening collaboration within and among systems that touch the lives of families can bridge divides and ensure smooth transitions for individuals and families across the lifespan.

RECOMMENDED AREAS FOR ACTION

1. Provide leadership, legislation, and policy direction to support cross system collaboration, coordination and effectiveness at multiple levels to improve outcomes for children, youth and families.

    Promising practices and resources:

    ✓   The United Kingdom has developed a promising approach to "whole family" service provision that guides the interaction between families experiencing parental mental illness and various systems of care. *Think child, think parent, think family: A guide to parental mental health and child welfare* (UK) starts from the premise that parents with mental health problems and their children often find it difficult to get support that is acceptable, accessible, and effective for the whole family. This guide for service providers identifies ways to improve service planning and delivery and achieve better outcomes for families. (socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/scie/think12.aspx)

    ✓   New Zealand's High and Complex Needs (HCN) Unit was created as part of an intersectoral strategy developed to encourage collaboration between agencies with the goal of streamlining service delivery and improving outcomes for children and young people. The HCN website contains resources related to good practice guidelines for collaboration including a literature review, a guide to good practice and a self-assessment tool for agencies to assess how effectively they are working collaboratively. (www.hcn.govt.nz/about-hcn/index.html)

2. Support service providers across systems to work in highly collaborative, coordinated, and accountable relationships with each other and with families.

    Promising practices and resources:

    ✓   In 2013, Vancouver Coastal Health (VCH) implemented the Family Involvement Policy to guide its clinical staff working in the Mental Health & Addictions services, programs, and units to support, educate and involve family members of their clients. This policy is aimed at improving outcomes for clients with mental health and or substance use problems and their families, by collaborating with families, sharing as much information as is possible with families within BC's privacy legislation, and involving families as partners in the individual family member's care team. VCH is developing staff orientation and education to facilitate implementation of the policy.

    ✓   In 2012, the Fraser Health Authority launched their *Families Are Part of the Solution Strategic Direction* initiative in mental health and substance use services. The goal is to enhance the capacity of families so they may participate effectively with their family member in their treatment and recovery process. This work will begin at the 'first point of contact' (the Mental Health Centres and Inpatient Psychiatric Units) for families. In partnership with the BC Schizophrenia Society, a number of Family Peer Facilitators are trained and available to meet

families and friends on the Inpatient Units, and co-facilitate with staff the Family and Friends Mental Health Information Groups at the hospitals with an Inpatient Unit. Family members will be included in working groups that will develop clinical practice guidelines/policies on family inclusion and on the sharing of information between families, clients and staff. (www.fraserhealth.ca/media/Strategic%20Direction%20Family%20Support%20and%20Inclusion .pdf)

✓ The Burnaby Centre for Mental Health and Addiction is a province-wide resource for people who are affected by problematic substance use, mental health issues and health care concerns. The goal of this 100-bed facility is to support people to regain their health, benefit from treatment, and eventually return to community life, with continued support for recovery. The Centre integrates mental health, substance use and primary care to provide a holistic approach and focuses on a person's individual strengths. The Burnaby Centre is a partnership among the Ministry of Health, Provincial Health Services Authority, Vancouver Coastal Health and Fraser Health. Clients and their families can access the Centre through referrals from hospital, community and the criminal justice system. (www.vch.ca/media/burnaby-centre-brochure.pdf)

3. Foster seamless transitions for families across systems over time, and as their mental health and/or substance use service needs change.

    Promising practices and resources:

    ✓ The *Wraparound Surrey Project* brings together several community partners in Surrey to provide longer-term, encompassing services and support for gang-associated youth and their families, as well as resources and education for the broader community. Through the project, 11 to 17-year-old Surrey school district students exhibiting risk factors are provided a personalized care plan to address the risks that may lead to gang-associated behaviour. The plan extends into most facets of the young person's life; personal, family, school, peer and community and "wraps" around the student with a network of support and encouragement. The Wraparound Surrey Team consists of five full-time Surrey school district staff trained in youth intervention strategies and three full-time police officers from both the BC Integrated Gang Task Force and Surrey RCMP. The Surrey School District will create a video-based resource and teacher/parent educational guide for use in communities where gang intimidation and violence are identified as disrupting school cultures and communities, based on the wraparound model. (www.gangprevention.ca/partners/about-us)

A family's story:

Mary is 38 years old and living with her 14-year-old daughter, Chloe. Over the past 11 years, Mary has become progressively more isolated and has separated herself and Chloe from friends and family. She has exhibited a number of odd beliefs and suspicions, and been increasingly challenged to attend to Chloe's basic needs. Mary's parents are concerned about their adult daughter's increasing isolation and state of mind and do not know if Mary has received relevant health care because Mary will not discuss this with them. They are concerned for Chloe's well-being and safety. They contacted Mary's family doctor with their concerns; however, it was suggested that no information could be disclosed to the family without Mary's consent.

A month later, Mary is admitted to the hospital on an involuntary basis. Shortly after Mary's admission, her daughter Chloe is admitted to a different hospital in response to suicidal behaviors. On admission, hospital staff notice that Chloe is malnourished, has poor hygiene, and is expressing suspicions similar to her mother's. The hospital staff involve child welfare services, in accordance with the Child, Family and Community Service Act, which requires reporting any concern about possible abuse or neglect, including when a parent may be unable or unwilling to protect their child.

With a pending release from hospital for both Mary and Chloe, Mary's parents' request that Chloe's hospital stay be extended until Mary's stability is assured and Chloe's symptoms have diminished. They also write to the hospital to request that they be included in the treatment planning for Mary's ongoing care. Although the hospital staff agree initially to set up a family meeting to discuss this, Mary refuses to participate and asks that her parents not be involved, and the hospital staff abandon the suggestion. Mary's parents feel helpless.

How a family-centred approach could improve outcomes for Mary, Chloe, and Mary's parents:

At the first sign of symptoms, Mary's family doctor would ask about her family and related family supports – this would be followed by the suggestion of a family meeting at a much earlier stage, when Mary may be more receptive to including her parents in a discussion about her and her daughter's current and future needs. The resulting family supports, drawing on strengths, assets and resources may help to promote Mary's mental health and slow the progression of Mary's illness while increasing support to Chloe.

Even though Mary was not agreeable to her family's active involvement, her treatment plans and care would occur within the context of her family that includes an understanding of Mary and her family's strengths, challenges and needs. The family would have the opportunity to share their concerns, have them acknowledged and receive information to help them understand potential helpful approaches to take with their daughter and granddaughter. Recognizing the important role that the family could play and offering an appropriate level of involvement would have helped the family feel heard and empowered and become involved in their daughter and/or granddaughter's lives. Policies such as the Vancouver Coastal Health's new Family Involvement Policy would support this.

Chloe's needs would be recognized earlier, and connection to services and supports in the community made to foster her resilience and promote her health and wellbeing. With Chloe's consent, her school counselor would be alerted to her family situation, and in turn would offer options for enhanced activities and connections at school. Child welfare would be contacted earlier to discuss the types of supports and resources available to Mary, Chloe and the family. For example, they could have considered a Ulysses Agreement, which is a voluntary process that allows a parent with mental health or substance use problems to plan how their children will be cared for should they relapse and be temporally unable to care for their children. Broader communication and collaboration across systems may have mitigated Chloe's suicidal behavioral and need for hospitalization. Mary's hospital discharge plans would include plans for cross system collaboration to support Mary and protect Chloe's health, safety and well-being. Prior to discharge, local child welfare staff would engage the whole family in a process to assess and enhance Chloe's health and safety. The hospital staff would contact Mary's family doctor and suggest follow up family sessions once Mary is stabilized at home. The family would receive ongoing contact with service providers, to keep communication lines open, and further explore opportunities for their involvement with Mary's care and support their relationship with Chloe.

Focus Area #4:Knowledge Exchange and Workforce Development

OVERVIEW

Workforce development, underpinned by robust knowledge exchange strategies, relevant research evidence and meaningful family engagement, is critical in building system and service capacity to address mental health and substance use from a family-centred perspective. It is also integral to reducing the stigma and discrimination experienced by individuals and families with mental health and substance use challenges, and to effectively addressing risk for additional problems within families.

In order for BC's diverse systems to provide effective family-centred services, many policy makers, researchers and service providers will require new knowledge and skills to:

- Work more collaboratively across disciplines and systems
- Work with families as part of multidisciplinary and interdisciplinary teams
- View individuals in the context of their families and communities
- Identify and build on individual and family strengths

Within the specialized treatment workforce, building capacity for family-centred service delivery must be complemented by the ongoing acquisition of specific knowledge and skills to care for children, youth, and adults experiencing mental health challenges, substance use challenges, and concurrent disorders.

Organizational structures and policies informed by related research evidence are needed to support service providers in using their new knowledge and skills. These can range from compensation options for physicians (e.g. explore the possibility of a new MSP billing code for working with families), to processes for meeting the service needs of parents when there is child protection involvement, to enhanced professional practice standards and codes of ethics.

A comprehensive approach to clinical training and education will be required to ensure the capacity for sustainable, family-centred care and service provision. It is critical to narrow the "knowing-doing" gap and to begin putting into practice what we know works—what the research, other jurisdictions, and the lived experience of families tell us makes a lasting difference. It also means engaging with universities, colleges, and accreditation bodies to ensure that future generations of helping professionals are well trained in family-centred values and practices.

For new service providers, this means family-centred curricula (e.g. family systems and family resilience) and related clinical placements in undergraduate, graduate, and residency programs across a variety of health disciplines. For established service providers, this means opportunities for continuing education and professional development to stay abreast of new knowledge and emerging best practice in family-centred care.

Ultimately, the goal is to ensure that policy makers and service providers across BC systems have the values, attitudes, knowledge, skills, and support to provide effective services to families experiencing mental health and/or substance use challenges in a way that enhances prevention and care outcomes.

RECOMMENDED AREAS FOR ACTION

1. Create family-centred organizational cultures:

   - Secure commitment at all levels in organizations to support staff to work in a family-centred way
   - Develop change management strategies that include the communication of visions, missions, and values that promote family-centred care and create corresponding and enabling organizational policies
   - Recruit staff who believe in and wish to practice in a family-centred way
   - Orient existing and new staff to the family-centred approach and provide ongoing opportunities for them to learn more about it
   - Value the family contexts of staff by implementing policies in the workplace that recognize family responsibilities and the need for flexibility and accommodation
   - Engage children, youth, and families to work with organizations in the development and evaluation of services
   - Provide family-centred facilities and meeting spaces
   - Celebrate and reward exemplary family-centred practice

2. Build capacity of service providers to engage in family-centred practice:

   - Engage families and knowledge partners in dialogue on what it means to be family-centred in practice; incorporate family-centred approaches into practice guidelines across systems

Promising practices and resources:

✓ The Institute of Families for Child & Youth Mental Health (IF) is working to improve child and youth mental health in Canada by involving families in partnerships, education and consultation. This independent non-for-profit organization is defining what it means for an organization, practice, service or policy to be Family Smart ᵀᴹ· (www.familysmart.ca)

✓ The Mental Health Commission of Canada, 2013 National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illness, was spearheaded by the Family Caregivers Advisory Committee of the Commission. The 41 recommendations directed at system planners, policy makers, and mental health managers intend to improve the capacity of family members in caregiving roles to care for their adult family members with mental illness and to promote their own self-care. (www.mentalhealthcommission.ca/English/issues/caregiving/family-caregivers-guidelines)

   - Identify family-centred competencies in collaboration with organizations with a family mental health perspective, such as the National Institute of Families for Child and Youth Mental Health, F.O.R.C.E. Society for Kids Mental Health, From Grief to Action, and BC Schizophrenia Society

- Equip service providers with the training, tools, resources, and support to engage in effective family-centred practice, such as:
  - Assessment processes such as genograms or family maps
  - Resources to facilitate family journey mapping
  - Knowledge and skills related to family systems models that enhance service providers understanding of the family (e.g. the McMaster Model of Family Functioning, Circumplex Model, or Satir Brief Systemic Family Therapy)
  - Protocols for balancing individual privacy and confidentiality with family engagement
  - Management support of family-centred practice as a new way of doing business rather than a new set of responsibilities to be layered on top of existing workloads

Promising practices and resources:

✓ The BC Council of Families, in partnership with the ministries of children and family development and health and community partners, is developing mental health literacy materials. These resources will enhance the capacity of social service and health care providers to respond to the mental health needs of pregnant and postpartum women experiencing mental health challenges and/or problematic substance use and their families, including their infants and children under three years of age.

✓ *Keeping Families and Children in Mind* (Children of Parents with a Mental Illness Initiative, Australia) is a free, six module e-learning course for developing a "family sensitive" approach to services for parents with a mental illness and their children. (www.copmi.net.au/professionals-organisations/what-can-i-do/professional-development/elearning-courses/keeping-families-and-children-in-mind)

- Build opportunities for cross-system training, mentoring, and job shadowing to acknowledge that family mental health and substance use are not managed within one system

- Support family-centered practice through related coaching and clinical supervision

Promising practices and resources:

✓ Post-secondary institutions such as Douglas College and University of Fraser Valley have created space in some of their programs for the F.O.R.C.E. Parent in Residence to speak to students and share with them what is helpful and meaningful to families.

- Create forums for service providers from multiple sectors and families to share their positive experiences and challenges with working together

3. Disseminate *Families at the Centre* to post-secondary educational institutions
   Ensure services and supports that touch families' lives across multiple systems are informed continuously by new knowledge and evidence of effectiveness that are relevant to families experiencing mental health and/or substance use challenges.

Promising practices and resources:

✓ The *Health Compass* (BC) is a new service model that integrates evidence-informed mental health promotion practice into the physical health care culture. Led by BC Mental Health and Substance Use Services, it is a collaborative initiative involving BC Cancer Agency, BC Centre for Disease Control, and BC Children's Hospital & Sunny Hill Health Centre for Children. A key component involves patient/client and family engagement. An e-learning tool for health professionals has been developed to facilitate the adoption of a more holistic approach to care based on the premise that there is "no health without mental health." (www.phsa.ca/health-professionals/education-development/health-compass)

4. Create opportunities for families to collaborate with researchers and educators to influence the development, translation, dissemination, and uptake of knowledge and skills that support family-centred practice.

Promising practices and resources:

✓ The F.O.R.C.E. Society for Kids' Mental Health provides presentations on the impact of child and youth mental health challenges on families through the lens of lived experience to university students, as a way of promoting family-centred practice. The F.O.R.C.E. 's Parent In Residence and Youth in Residence have presented to the Social Work, Education, Criminology, Psychology, Nursing, and Child and Youth Care departments in post-secondary institutions, including Thompson Rivers University, Kwantlen College, University of the Fraser Valley, University of British Columbia, Simon Fraser University, University of Victoria, Douglas College, and Langara College.

✓ A mental health and addictions course at the University of the Fraser Valley, School of Child and Youth Care includes a learning unit on family mental health. The course includes invited speakers from the F.O.R.C.E. Society for Kids' Mental Health, exposure to resources on children of parents with mental illness and young carers, and analysis of mental health issues in the context of family experience. Assignments are structured to encourage students to understand their own mental health and that of people close to them and its impacts on their whole family system.

A family's story

Tom, 24 years old, was diagnosed with schizophrenia at age 19. For the first 4 years after diagnosis, Tom followed his treatment plan and experienced good results including a high level of stability. About 8 months ago, Tom decided to discontinue the prescribed medications. Subsequently, he became paranoid and distrustful, distanced himself from his family and refused to eat. Tom's health continued to deteriorate to the point where he required one month of hospitalization.

Since his discharge from the hospital, Tom missed two medical appointments and was evicted from his apartment. His family lost track of him, and although he still has a phone, Tom won't return calls from any of his family members. Concerned for his safety and well-being, Tom's family contacted the mental health assessment team and mental health emergency services who were involved with their son and asked them to intervene. Both teams told Tom's family that although they had had contact with him, they couldn't do anything because he is refusing medical assistance and doesn't meet the criteria for involuntary hospitalization.

Tom's family is willing to have him live with them; however, they want to ensure that he gets the medical attention he requires to stabilize. They have no way to contact him or convey this message to him.

How a family-centred approach could improve outcomes for Tom and his Tom's family and the system they interacted with:

In the context of family-centred relationship between the doctor that oversaw Tom's treatment and Tom's family, the family members would be able to share their concerns about his condition earlier, and at a time when he may have been more receptive to discussing his concerns about the medications.

Staff from the mental health assessment team and mental health emergency services team would be trained in family centred approaches. This would assist them to skillfully work collaboratively and facilitate contact with Tom and coordinate a meeting between Tom and his family in a family-friendly setting. Together, they would explore the available options, including community-based services, assertive forms of treatment and/or hospitalization, if required. They would actively include Tom's parents as part of the team to contribute to planning and decision-making earlier in the process. The staff would have reasonable time and organizational resources to engage Tom and his parents and support all of them through the current crises and following stabilization. These steps would improve Tom's prognosis and reduce the risk for relapse and more intensive and costly interventions.

As an ongoing support to Tom, his family may have benefitted from the approaches and strategies outlined in the Mental Health Commission of Canada's "*National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illness*".

Using *Families at the Centre*

Families at the Centre is a multisystem planning resource to assist staff across multiple public service systems to work with families affected by mental health and substance use challenges in a way that best equips them to thrive and mitigates their risk of additional problems. Ideally, the process to move towards a family-centred approach is led by organizational leaders and managers who can integrate the family-centred approach into all aspects of those systems, from policy to practice, and throughout all services and programs.

At the same time, change can also start with one passionate and committed practitioner, service provider, or manager who incorporates a family-centred approach into their work. Others start to notice how this person views and empowers the individuals and their families with whom they work and, as a result, begin to emulate their efforts. Ultimately, there is no right or wrong place from which to start the movement towards a family-centred approach.

A family-centred approach to policy and practice resonates with many professionals who interact with families where an individual family member is experiencing a mental health and/or substance use problem. Some of these professionals are developing promising practices by integrating concepts or elements of a family-centred approach into existing or new programs, services, policies, and initiatives.

How to Start Using *Families at the Centre*

✓ Become a champion of family-centred approaches.

✓ Develop your knowledge of family-centred approaches, digest the concepts in this planning resource, explore the references, and discover what a family-centred approach means in practice, and in an organization.

✓ Draw inspiration from some of the many examples of promising practices of family-centred approaches underway in BC and other jurisdictions that are listed in this planning resource under most of the recommended areas of action for each of the four focus areas.

✓ Share ideas and gain support – try to reach as many people as possible, and discuss with management.

✓ Use a tool, such as the *Family-Centred Practices Checklist* developed by Wilson & Dunst (2002), to gauge the extent to which current practices are using a family-centred approach. Consider drawing from the experience of others on how to engage the voice of families to inform service planning and policy development.

✓ Engage families. Families can be engaged through formal and informal mechanisms. For example, ask individual families involved in the system how they would like to be involved in the services they and/or their family member are receiving or bring families together in a focus group or advisory committee or council to inform your movement towards a family-centred orientation.

✓ Determine priorities. Work collaboratively with supervisors, colleagues, system partners and families to identify quick wins and strategies that will have the most impact on families and are easiest to adapt.

✓ Develop a plan and share the responsibility for implementation whenever possible.

✓ Identify data sources and indictors that can help to assess change and corresponding success.

✓ Implement the plan, celebrate the successes, and learn from the challenges.

✓ Evaluate the outcomes and continue to refine your efforts.

Next Steps for Consideration

Families at the Centre is a planning resource for government and its public system service partners. The document aims to facilitate the development of legislative, regulatory, policy, funding, and service delivery environments that support improved mental health and well-being, and reduced harms from substance use across the lifespan for families experiencing mental health and/or substance use challenges.

The specific task of engaging families in the child- and youth-serving and adult-serving mental health and substance use service systems requires a shift in orientation, focused and deliberate attention, and reshaping of training and resource allocation. Required efforts will involve:

- Enabling these systems and services to become more family-centred
- Empowering families to become true partners in treatment planning, service delivery, and system development
- Enhancing research into the effectiveness of such enabling activities for both systems and families
- Evolving policies and practices to better reflect the needs of families experiencing mental health and substance use challenges.

Working in Partnership

To support a coordinated approach to these efforts, upon the release of the plan, the existing *Healthy Minds, Healthy People* governance structure and other existing senior government committees will be used to champion the philosophical and practice shift to a family-centred approach, and promote change in order to achieve meaningful results for systems and families. The Family Mental Health and Substance Use Task Force will be reconfigured as the *Families at the Centre* (FATC) Advisory Committee. The membership of the FATC Advisory Committee will continue to encompass representatives of ministries serving families, health authorities and other government agencies, and non-governmental organizations that represent the interests of families affected by a mental health and/or substance use problem. This cross-disciplinary, multi-level Advisory Committee will foster coordinated efforts to move to a family-centred orientation across public systems in BC by:

- Promoting use of *Families at the Centre* as a planning resource and lens for mental health and substance use cross-system public policy and practice
- Identifying opportunities within and across systems planning
- Developing knowledge translation and exchange strategies to promote understanding of a family-centred approach
- Exploring and facilitating linkages with other systems planning priorities such as trauma-informed practice
- Fostering collaborative processes and mechanisms that bring together families with lived experience and planners and decision makers in BC's public systems

Further, the FATC Advisory Committee will explore opportunities to disseminate consistent practice and service tools such as:

- core components of a family-centred approach
- family-centred service assessment criteria and practice guidelines
- tools to assist with the interpretation of legislated privacy requirements

These tools and resources will support a shift to more consistent family-centred practice across the province.

Conclusion

Ultimately, *Families at the Centre* aims to support collaborative, family-centred responses that will better address the needs of families experiencing mental health and substance use challenges, and empower them to thrive. Keeping families at the centre of their own care requires a shift in philosophy as well as practice – a shift that recognizes the critical role of family members as influencers, co-providers, and co-creators of services.

A successful shift will mean that families with a mental health and/or substance use challenge are engaged and welcomed by public systems in a respectful and inclusive way. This in turn will help to mitigate the isolation, stigma and discrimination that is too often associated with the experience of such problems.

Correspondingly, families with a mental health and/or substance use challenge will be better equipped and supported to thrive. This will mean that the family member affected by the mental health and/or substance use problem will be better positioned for success with their care and treatment, and the likelihood that other members of their family will develop an associated problem will be greatly diminished. Stakeholders in family-centred systems will actively seek ways to mitigate the additional harms and vulnerabilities for families associated with these challenges, and will benefit from reduced incidence in mental health and substance use problems, as well as increased reach and cost-effectiveness of services through enhanced collaboration.

Glossary

Concurrent disorders generally describes a situation in which a person has both a mental health and a substance use challenge. In the past, this condition was called "dual diagnosis" or "multiple diagnosis."

Source: http://www.heretohelp.bc.ca/factsheet/concurrent-disorders

Early intervention is often considered the link between prevention and treatment. It is targeted to individuals showing early signs and symptoms of mental health or substance use challenges. Early intervention is intended to slow progression of mental health and substance use challenges, limit disability, and promote individual functioning within the family and community. It involves identification, referral, and prompt initiation of treatment.

Source: BC Ministry of Health. (2004). Every door is the right door: A British Columbia planning framework to address problematic substance Use and addiction. Victoria: Author.

Family mental health is more than the absence of illness in a family member or the absence of dysfunction in family dynamics; it is a resource for personal and collective growth and transformation. Family mental health is holistic, multigenerational and embedded within a web of sustaining relationships with kin and community

Source: Bomar, P. (2004). Promoting Health in Families: Applying Family Research and Theory to Nursing Practice. Third ed. Philadelphia: Saunders.

Family resilience is the extent to which families faced with challenges can meet the needs of individual members, function optimally as a unit and stay connected to the community. Family resilience is about relational hardiness in its broadest sense.

Source: Walsh, F. (2003). Family Resilience: A Framework for Clinical Practice. *Family Process*, 42: 1–18.

Harm reduction refers to policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive substances. Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease, and injury associated with higher risk behaviour, while recognizing that the behaviour may continue despite the risks.

Source: BC Ministry of Health Services and Ministry of Children and Family Development (2010). *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia.* Victoria, BC: Author.

Health promotion is the process of enabling individuals, families and communities to take control over and improve their health. It uses strategies that foster supportive environments and resilience, while respecting the fundamental principles of equity, social justice, and personal dignity.

Source: World Health Organization. (1986). *Ottawa charter for health promotion*. Geneva: Author.

Knowledge exchange is both a process and an outcome. It links those who produce knowledge with those who use it to help translate knowledge into practice and narrow the "knowing-doing" gap. The key aspects of knowledge exchange are knowledge creation, knowledge translation, diffusion and dissemination, adoption and uptake, and evaluation.

Source: BC Mental Health and Addiction Services Knowledge Exchange Model.

Mental disorders are diagnosable health conditions characterized by an alteration in thinking, mood or behaviour associated with distress and/or impaired functioning. Mental disorders are the result of interacting biological, developmental, psychological, behavioural, and environmental factors. Mental disorders are catalogued in the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Source: United States Surgeon General. (1999). *Report of the Surgeon General on mental health: Executive summary*. Washington, DC: Department of Health and Human Services.

Mental health is a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively, and contributes to his or her community. Mental health is much more than the absence of mental illness; it is a resource for daily living, vital to individuals, families, and communities.

Source: World Health Organization. (2001). Mental health: New understanding, new hope. The world health report. Geneva: Author.

Mental health challenges refer to signs and symptoms of insufficient intensity or duration to meet the diagnostic criteria for a particular mental disorder but which are, nonetheless, disabling for the individual, their family, and community. These are also referred to as "mental health problems".

Source: United States Surgeon General. (1999). *Report of the Surgeon General on mental health: Executive summary*. Washington, DC: Department of Health and Human Services.

Mental health literacy is defined as the knowledge, attitudes, and beliefs about mental health and/or substance use challenges which aid in their recognition, management, and prevention. It encompasses the beliefs and attitudes about mental health, mental illness, and psychoactive substance use. Mental health literacy can improve how members of society promote good mental health and respond to children, youth, and adults with mental health and substance use challenges.

Source: BC Ministry of Health Services and Ministry of Children and Family Development (2010). *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia.* Victoria, BC: Author.

Mental health promotion is a process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health.

Source: World Health Organization. (2005). Promoting mental health: Concepts, emerging evidence, practice. Geneva: Author.

Mental illness is an umbrella term that refers to all diagnosable mental disorders.

Source: United States Surgeon General. (1999). *Report of the Surgeon General on mental health: Executive summary*. Washington, DC: Department of Health and Human Services.

Prevention refers to actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability or, if none of these is feasible, slowing the progress of disease and disability (World Health Organization, 1984). Primary prevention is directed towards preventing the initial occurrence of mental health or substance use challenges. It includes universal prevention, which targets whole populations at low to average risk, and selected prevention, which targets groups with identifiable risk factors. Secondary prevention is directed towards preventing the spread and minimizing the impact of mental health or substance use challenges. It includes indicated prevention which targets individuals who are predisposed to developing a mental health or substance use challenge. Tertiary prevention seeks to eliminate or reduce impairment, disability, and harm that may result from a mental health or substance use disorder. It aims to minimize suffering and maximize life expectancy and quality of life.

Source: BC Ministry of Health. (2004). Every door is the right door: A British Columbia planning framework to address problematic substance Use and addiction. Victoria: Author.

Recovery is the ability to live a meaningful life with a mental health or substance use challenge *despite* its health and social impacts. Recovery-oriented services help people achieve or maintain valued roles (e.g. employee, student, parent) and participate in community life. While recovery to some may entail being able to eliminate or completely control symptoms, to others it is about being able to live well and with dignity in the presence of ongoing symptoms. People with mental health and substance use challenges often speak of recovery from illness, as well as from the impacts of stigma, discrimination, and exclusion.

Source: BC Mental Health and Addiction Services (2007). *Supporting Recovery and Community Integration: What Works.* Prepared for the BC Ministry of Health. Vancouver: Author**.**

Resilience is doing well in the face of adversity. It is about the ability to withstand and rebound from disruptive life challenges, significant or otherwise. Resilience is broadly understood to include both the individual's role in creating health when faced with multiple risks, and the family, community, and cultural factors that must be present to help create and sustain that health.

Source: BC Ministry of Health. (2007). Core public health programs for BC evidence review: Mental health promotion. Victoria: Author.

Stigma refers to the combination of prejudice and discrimination. Prejudice is holding negative attitudes or beliefs about people who are viewed as different. Discrimination is acting on these ideas or beliefs.

Source: http://www.heretohelp.bc.ca/factsheet/stigma-and-discrimination-around-mental-health-and-substance-use-problems

Substance use refers to the ingestion or administration of any substance that is psychoactive or alters consciousness. Psychoactive substances include alcohol, tobacco, caffeine, illegal drugs, some medications and some kinds of solvents and glues. Substance use may range from beneficial to problematic, depending on the quantity, frequency, method, or context of use.

Source: BC Ministry of Health. (2004). Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction. Victoria: Author.

Substance use challenges refer to instances or patterns of substance use associated with physical, psychological, economic, or social problems or use that constitutes a risk to health, security, or well-being of individuals, families, or communities. Other common terms are "problematic substance use" or "substance use problems."

Source: BC Ministry of Health. (2004). Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction. Victoria: Author.

Substance use disorders refer to substance use behaviours or patterns of use that meet the criteria of a clinical disorder. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (5th Edition), or the DSM-5, outlines a range of substance-related disorders, including substance use disorder or "addiction".

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Appendix #1:   Family Mental Health and Substance Use Task Force

EXECUTIVE SPONSORS

Warren O'Briain	Ministry of Health
Sandy Wiens	Ministry of Children and Family Development

TASK FORCE MEMBERS

Debbie Saari, Co-chair	Ministry of Children and Family Development
Stephen Smith, Co-chair	Ministry of Health
Keli Anderson	National Institute of Families for Child and Youth Mental Health
Mae Burrows	From Grief to Action: When Addiction Hits Home
Dr. Connie Coniglio, R.Psych.	Provincial Health Services Authority
Joanne Crandall	Ministry of Children and Family Development
Reg Fleming	Vancouver Island Health Authority
Angela Guy	Vancouver Coastal Health Authority, Rural
Dr. Elizabeth Hartney, R. Psych.	Ministry of Health
Sally Hull	BC Schizophrenia Society
Chris Huston	Interior Health Authority
Stan Kuperis	Fraser Health Authority
Dr. Robert Lees, R. Psych.	Ministry of Children and Family Development
Jeannie MacPherson	Ministry of Children and Family Development
Tammy Music	F.O.R.C.E Society for Kids Mental Health
Nancy Needham	Ministry of Education
Sanja Ristic	Ministry of Education
Anthony Neptune	Fraser Health Authority
Olga O'Toole	Ministry of Children and Family Development
Gayle Read	Ministry of Children and Family Development
Susan Rechel	Vancouver Coastal Health Authority
Sheila Robinson	Ministry of Children and Family Development
Duncan Shields	BC Association of Clinical Counsellors
Carolyn Solomon	Ministry of Health
Dr. Roxanne Still, R. Psych.	Ministry of Children and Family Development
Caroline Wilkin	Ministry of Children and Family Development

Appendix #2:   Development of *Families at the Centre*

The Family Mental Health and Substance Use Task Force (see Appendix #1) initiated the development of *Families at the Centre*. Secretariat support was provided by the BC Ministry of Children and Family Development (MCFD), the F.O.R.C.E. Society for Kids Mental Health and the BC Ministry of Health.

Families at the Centre has been developed to respond to actions in Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia (Province of British Columbia, 2010). It has also been strongly influenced by Families Matter: a Framework for Family Mental Health in British Columbia (F.O.R.C.E. Society for Kids' Mental Health, 2012).[5]

Through direction in *Healthy Minds*, *Healthy People*, the Task Force's original mandate was to create a cross sector planning resource to facilitate healthy family development for families with parental mental health and/or substance use challenges. The resource would ensure these families receive more coordinated services and supports, which would in turn reduce the risk of future mental health and substance use problems for the children in the family. The inclusion of this deliverable in *Healthy Minds, Healthy People* was due, in part, to a priority determined by the set-term, cross sector Child and Youth Mental Health and Substance Use Strategic Coordinating Committee in 2009 and its interest in addressing the specific needs of children whose parents have a mental illness in order to help them thrive.

With the publication of *Families Matter*, which calls for a holistic, family-oriented approach to supporting families affected by a mental health problem, the scope of *Families at the Centre* was broadened to include any family member experiencing a mental health and/or substance use challenge at any time in their life. To achieve this, the document emphasizes services and supports that promote good mental health and prevent or lessen the impact of mental health and substance use challenges for the whole family.

The document has also been informed by *Taking Action on Domestic Violence in British Columbia* (Province of British Columbia, 2012), the Province's response to the report by the Representative for Children and Youth into the deaths of Kaitlynne, Max and Cordon Schoenborn at the hands of their father, who suffered from longstanding and untreated mental illness and severe substance related disorders. *Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now* (Representative for Children and Youth, 2012) makes recommendations for cross system collaboration and coordination in providing for the safety and well-being of vulnerable children and families. With the release of *Taking Action on Domestic Violence,* this document's emphasis on risk and protective factors is strengthened to address the safety, healthy development, and well-being of children who have experienced parental mental illness, parental substance related disorders, and/or domestic violence. *Families at the Centre* emphasizes that the entire family needs to be considered in the context of a single member's mental health and/or substance use problem – this is important not only for the purpose of building strengths

---

[5] *Families Matter* was prepared at the request of the Task Force and funded by the *Healthy Minds, Healthy People* Directorate

and resiliency, but also in terms of assessing and ensuring safety for individual family members and the family as a whole.

Families at the Centre has also been developed against the backdrop of two national policy documents released by the Mental Health Commission of Canada: *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012) and *Evergreen: a Child and Youth Mental Health Framework for Canada* (2010). *Changing Directions, Changing Lives* is the first national mental health strategy for Canada. It identifies six strategic directions and supporting actions which provide a comprehensive blueprint for change. *Evergreen* articulates the values and strategic directions to ensure children, youth, and their families living with mental health challenges and mental illness are actively engaged in responsive systems of care.

Families at the Centre provides a roadmap that can lead the way for others as they move towards a family-centred approach in policy and practice, services, and supports. Building on the recommendations and suggestions advanced by families within the *Families Matter* framework, the document reflects the collective voice and endorsement of both those with lived experience and of those working in systems supporting child, youth, adult, and family mental health.

The document draws upon four main sources of evidence: peer-reviewed and grey[6] literature; experience in BC and other jurisdictions; insights since 1997 of the Supporting Families with Parental Mental Illness Community of Practice; input from policy makers and service providers; and, input from families with lived experience of mental health and substance use challenges. (see Appendix #2 for more detail)

The literature scan included evidence reviews prepared for the Province on core public health programs (e.g. mental health promotion, mental disorders prevention, prevention of substance-related harms), comprehensive school health, eating disorders, family violence, and trauma-informed care. The Task Force also reviewed published and grey literature on family resilience, family-centred care, parents living with mental illness, children of parents with mental illness, young carers, and stigma and discrimination. The jurisdictional scan included policy and planning frameworks from Canada, Australia, New Zealand, United Kingdom, United States, and the World Health Organization. Family, policy maker, and service provider input was obtained from multiple sources, including:

- *Healthy Minds, Healthy People* knowledge exchange event on family mental health, led by the *Healthy Minds, Healthy People* Directorate, that engaged families, advocates, and service providers and managers from health authorities and MCFD regions

---

[6] Grey literature is information produced by all levels of government, academics, business and industry, in electronic and print formats not controlled by commercial publishing. Sources of grey literature include: conference proceedings, dissertations/theses, books, clinical trials, guidelines, and government information.

- A follow-up, full-day workshop, hosted by the Family Mental Health and Substance Use Task Force, to discuss a preliminary version of the resource with family representatives, youth, and policy makers and service providers from multiple systems

- Facilitated consultations on the preliminary framework with:

  - BC Care Advisory Network for Child and Youth Mental Health

  - BC Mental Health and Substance Use Health Literacy Network

  - BC School-Centred Mental Health Coalition

  - BC Substance Use Network

  - BC Youth Concurrent Disorders Network

  - Physicians (e.g. pediatricians, family physicians)

  - Infant and reproductive mental health staff

  - MCFD Child protection staff

  - Health authority and MCFD staff who could not attend the full day sessions

- Dissemination of the final draft document by Task Force members to their networks for review and comment.

FIRST NATIONS AND ABORIGINAL FAMILIES

Careful consideration and dedicated processes are required to reflect the distinct needs and desires of First Nations and Aboriginal individuals and families. A number of First Nations and Aboriginal individuals participated in engagement and consultation activities related to *Families at the Centre*, but given the need to respect other engagement processes already underway, full and meaningful engagement specific to this planning resource has not been carried out.

As a result, this document serves only as a preliminary foundation for better engagement with and support for First Nations and Aboriginal families with mental health and substance use challenges. First Nations and Aboriginal families have indicated that in order for First Nations and Aboriginal families to truly thrive, they must be supported in identifying their own solutions.

The recent release of *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10 Year Plan* signals a new approach to how First Nations and Aboriginal individuals, families, and communities are engaged in efforts to support their overall mental wellness and prevent or reduce harms associated with substance use. *A Path Forward* envisions that partnerships within regions—collaboratively designed by First Nations and Aboriginal people with local, regional, provincial, federal partners, individuals, families, and communities—will emerge to mobilize all stakeholders, identify the appropriate and desired solutions, and implement related actions. Regional forums to initiate the first step in the process of community-led mental health and substance use planning began in the spring of 2013.

Endnotes

[i] World Health Organization (2001). *Mental health: New understanding, new hope. World Health Report 2001.* Geneva. Retrieved from http://www.who.int/whr/2001/en/

[ii] National Institute on Drug Abuse. (2007). Topics in brief: Comorbid drug abuse and mental illness: A research update from the National Institute on Drug Abuse. National Institutes of Health, US Department of Health and Human Services.

[iii] Conway, K.P., Compton, W., Stinson, F.S. & Grant, B.F. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 67(2):247-57.

[iv] National Institute on Drug Abuse. (2007). Topics in brief: Comorbid drug abuse and mental illness: A research update from the National Institute on Drug Abuse. National Institutes of Health, US Department of Health and Human Services.

[v] BC Ministry of Health Services and Ministry of Children and Family Development (2010). *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*. Victoria, BC: Author.

[vi] BC Stats. (2013). British Columbia-Level Population Projections (April 2013): *British Columbia Population by Selected Age Groups*. Victoria: Author. Retrieved from: http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationProjections.aspx.

[vii] Patterson, M., Somers, J., McIntosh, K., Shiell, A., & Frankish, C.J. (2007). *Housing and supports for adults with severe addictions and/or mental illness in British Columbia*. Centre for Applied Research in Mental Health and Addiction, Simon Fraser University. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2007/Housing_Support_for_MHA_Adults.pdf

[viii] Somers, J., Cartar, L. & Russo, J. (2007). *Corrections, health and human services: Evidence-based planning and evaluation.* Centre for Applied Research in Mental Health and Addiction, Simon Fraser University. Retrieved from http://summit.sfu.ca/item/11163

[ix] BC Ministry of Health Services. (2007). *Estimating the Burden of Disease and Injury in British Columbia: Context for Mental Health Planning*. Prepared for Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia. Victoria, BC.

[x] Haukka, J., Suvisaari, J., Lönnqvist, J. (2003). Fertility of patients with schizophrenia, their siblings, and the general population: A cohort study from 1950 to 1959 in Finland. *American Journal of Psychiatry*. 160:460-463.

[xi] Waddell, C., Sheperd, C.A., Schwartz, C., Barican, J. (2013). *Child and youth mental disorders: Prevalence and evidence-based interventions,* a research report for the British Columbia Ministry of Children and Family Development. Vancouver, BC: Children's Health Policy Centre, Simon Fraser University.

[xii] Minister of Public Works and Government Services Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada.* Ottawa: Government of Canada.

[xiii] Waddell et al. (2005). A public health strategy to improve the mental health of Canadian children. *Canadian Journal of Psychiatry*, 50: 226-33.

[xiv] Bassani, D. G., Padoin, C. V., Philipp, D., & Veldhuizen, S. (2009). Estimating the number of children exposed to parental psychiatric disorders through a national health survey. *Child and Adolescent Psychiatry and Mental Health, 3*(1), 6-6.

[xv] Hosman C., van Doesum K., & van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach. *Australian e-J for the Advancement of Mental Health* 8(3).

[xvi] Charles, G., T. Stainton and Marshall, S. (2012). Young carers in Canada: The hidden costs and benefits of young caregiving. Ottawa: The Vanier Institute of the Family. P.4. Retrieved from Http://www.vanierinstitute.ca/modules/news/newsitem.php?ItemId=4444#.

[xvii] Dex, S. (2012). One family problem too many? Families with multiple problems. *Teaching Times 3(1)*: 34-39.

[xviii] Centre for Addictions Research BC. Fact Sheet: *General Population Surveys*. Retrieved from: http://www.carbc.ca/FactsStats/AODMonitoring/GeneralPopulationSurveys.aspx.

[xix] Zhao, J., Martin, G., Macdonald, S., and Stockwell, T. (2011). *The prevalence of alcohol and illicit drug use in British Columbia*, Victoria: Centre for Addictions Research of BC, University of Victoria, British Columbia, Canada. Retrieved from http://carbc.ca/Portals/0/AOD/GeneralPopulationSurveys/CADUMSReport0809.pdf.

[xx] Rehm, R. & Weekes, J. R. (2005). Abuse of controlled prescription drugs. In Canadian Centre on Substance Abuse (Ed.), *Substance Abuse in Canada: Current Challenges and Choices.* Ottawa: Canadian Centre on Substance Abuse.

[xxi] Stewart, D., Vallance, K., Stockwell, T., Reimer, B., Smith, A., Reist, D. & Saewyc, E. (2009). *Adolescent substance use and related harms in British Columbia*. Victoria: Centre for Addictions Research of BC, University of Victoria, British Columbia and McCreary Centre Society, Vancouver, British Columbia.

[xxii] Ibid.

[xxiii] Rehm et al. (2006). *The costs of substance abuse in Canada, 2002*. Ottawa: Canadian Centre on Substance Abuse. Retrieved from http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-011332-2006.pdf

[xxiv] Ibid.

[xxv] Ibid.

xxvi Advisory Committee on Population Health and Health Security. (2004). *Reducing health disparities: Roles of the health sector.* Ottawa, ON. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/disparities/ddp-eng.php

xxvii Van Doesum, K.T.M., Hosman, C., & Riksen-Walraven, J.M. (2005). A model-based intervention for depressed mothers and their infants. *Infant Mental Health Journal, 26*(2), 157–176.

xxviii O'Briain, W. (2007). *Evidence review: Prevention of mental disorders*. Victoria, BC: Population Health and Wellness, BC Ministry of Health. Retrieved from http://www.health.gov.bc.ca/public-health/pdf/Prevention_of_Mental_Disorders-Evidence_Review.pdf

xxix Drapalski, A. Marshall, T, Seybolt, D., Medoff, D., Peer, J., Leith, J. & Dixon, L. (2008). Unmet needs of families of adults with mental illness and preferences regarding family service. *Psychiatric Services, 59*(6), 655-662

xxx Waddell, C., Sheperd, C.A., Schwartz, C., Barican, J. (2013). *Child and youth mental disorders: Prevalence and evidence-based interventions,* a research report for the British Columbia Ministry of Children and Family Development. Vancouver, BC: Children's Health Policy Centre, Simon Fraser University.

xxxi Siegenthaler, E., Munder, T. & Egger, M. (2012). Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis. *J Am Acad Child Adolesc Psychiatry* 51(1): 8-17.

xxxii Dixon, L. & Lehman, A. (1995). Family interventions for schizophrenia. *Schizophrenia Bulletin, 21*(4), 631-643.

xxxiii Charles, G., T. Stainton and Marshall, S. (2009). "Young carers: Mature before their time." *Reclaiming Children and Youth*, 18(2), 37–41.

xxxiv New South Wales Department for Health. (2010). NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015. North Sydney, NSW: Author.

xxxv Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2010). Family intervention for schizophrenia. Cochrane Database of Systematic Reviews 2010, Issue 12.

xxxvi Shimazu, K., Shimodera, S., Mino, Y., Nishida, A., Kamimura, N., Sawada, K., Fujita, H., Toshi A. Furukawa, T.A. & Inoue, S. (2011). Family psychoeducation for major depression: randomised controlled trial. *British Journal of Psychiatry Online*, 1-7.

xxxvii Miklowitz, D.J., Justo, L.P., Soares, B.G., Calil, H.M. (2007). Family interventions for bipolar disorder. Cochrane Database System Review.

xxxviii MacKean. G., Spragins, W., L'Heureux, L., Popp, J., Wilkes, C., & Lipton, H. (2012). Advancing family-centred care in child and adolescent mental health: A critical review of the literature. *Healthcare Quarterly*, Vol. 15, Special Issue, 64-75.

xxxix Ibid.

xl Centre for Addiction and Mental Health, Community Support and Research Unit. (2004a). Best practices for family-centred care: *Putting family-centered care philosophy into practice.* Toronto, ON. Retrieved from http://www.camh.ca/en/hospital/Documents/www.camh.net/Care_Treatment/Community_and_social _supports/Social_Support/FCCI/FCC_Better_Practices_PDF.pdf

xli Centre for Addiction and Mental Health, Community Research, Planning and Evaluation Team Community Support and Research Unit. (2004b). *Putting Family-Centred Care Philosophy into Practice*. Toronto, ON. Retrieved from http://www.camh.ca/en/hospital/Documents/www.camh.net/Care_Treatment/Community_and_social _supports/Social_Support/FCCI/FCC_Better_Practices_PDF.pdf

xlii Duncan, B. L., Miller, S.D. & Sparks, J.A. (2004). The Heroic Client: A Revolutionary Way to Improve Effectiveness Through Client-Directed Outcome-Informed Therapy (Rev. ed.). San Francisco, CA: Jossey-Bass.

xliii Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R. & Chalk, M.B.(2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy*, Vol. 5, No. 1, 5-22.

xliv Whipple, J.L. et al. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology*, 50(1), 59-68.

xlv Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R. & Chalk, M.B.(2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy*, Vol. 5, No. 1, 5-22.

xlvi Dixon, L. & Lehman, A. (1995). Family interventions for schizophrenia. *Schizophrenia Bulletin, 21*(4), 631-643.

xlvii Fadden, G. (1997). Implementation of family interventions in routine clinical practice following staff training programs: A major cause for concern. *Journal of Mental Health,* 6(6):599-612.

xlviii Mohr, W. K., Lafuze, J. E., & Mohr, B. D. (2000). Opening caregiver minds: National Alliance for the Mentally Ill (NAMI) Provider Education Program. *Archives of Psychiatric Nursing*, 14(5), 235–243.

xlix Kaas, M.J., Lee S., & Peitzman, C. (2003). Barriers to collaboration between mental health professionals and families in the care of persons with serious mental illness. *Issues in Mental Health Nursing,* 24, 741-56.

[l] Rethink. (2003). Who Cares? The experiences of mental health carers accessing services and information. Kingston-upon-Thames, UK: Author.

[li] Rose, L.E., Mallinson, R.K., & Walton-Moss, B. (2004), Barriers to family care in psychiatric settings. Journal of Nursing Scholarship, 36:1, 39-47.

[lii] Winefield, H.R. & Burnett, P.L. (1996). Barriers to an alliance between family and professional caregivers in chronic schizophrenia. *Journal of Mental Health*, 5, 223-232.

[liii] Wright, E. (1997). The impact of organizational factors on mental health professionals' involvement with families. *Psychiatric Services*, 48, 921–927.

[liv] Zipple, A., Spaniol, L., & Rogers, E.S. (1990). Training Mental Health Practitioners to Assist Families of Persons Who Have a Psychiatric Disability, *Rehabilitation Psychology*, 35(2), 121-129.

[lv] Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, 32(7), 1331-1346.

[lvi] Velleman, R. D. B., Templeton, L. J., & Copello, A. G. (2005). The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people. *Drug and Alcohol Review*, 24(2), 93-109.

[lvii] MacKean. G., Spragins, W., L'Heureux, L., Popp, J., Wilkes, C., & Lipton, H. (2012). Advancing family-centred care in child and adolescent mental health: A critical review of the literature. *Healthcare Quarterly*, Vol. 15, Special Issue, 64-75.

[lviii] Centre for Addiction and Mental Health, Community Research, Planning and Evaluation Team Community Support and Research Unit. (2004b). *Putting Family-Centred Care Philosophy into Practice*. Toronto, ON. Retrieved from http://www.camh.ca/en/hospital/Documents/www.camh.net/Care_Treatment/Community_and_social_supports/Social_Support/FCCI/FCC_Better_Practices_PDF.pdf

[lix] MacKean. G., Spragins, W., L'Heureux, L., Popp, J., Wilkes, C., & Lipton, H. (2012). Advancing family-centred care in child and adolescent mental health: A critical review of the literature. *Healthcare Quarterly*, Vol. 15, Special Issue, 64-75.

[lx] Kumar, S. (2002).An introduction to Buddhism for the cognitive-behavioral therapist. Cognitive and Behavioral Practice, 9, 40– 43.

[lxi] Brendel, D. (2003). Reductionism, eclecticism and pragmatism in psychiatry: The dialectic of clinical explanation. *Journal of Medicine and Philosophy*, Vol. 28, Issue 5-6, 563-580.