Families Matter: A Framework for Family Mental Health in British Columbia

Promoting the mental health of families living with mental health challenges
Acknowledgements

Families Matter: A Framework for Family Mental Health in British Columbia would not be possible without the unstinting honesty and courage of the families, advocates, service providers and policy makers in British Columbia who shared their stories and expertise with us.

It has been a privilege and an honour to walk with you on this journey. This framework is richer and more relevant for your thoughtful and considered input. We thank you.

We thank the BC Ministry of Health and BC Ministry of Children and Family Development who provided the opportunity and funding for this framework.

We also thank the BC Provincial Family Council for Child and Youth Mental Health and the BC Parental Mental Health and Substance Use Task Force for their guidance and support.

And we thank consultants Kim Balfour, Mark Littlefield and Avril Orloff for their efforts in developing the framework.
As a mother, Rob’s story has had a profound effect on me. I found myself thinking back to when my son was nine years old and didn’t want to live anymore. I wondered how long it had been since I had seen him skip. I couldn’t think of the last time.

My son, who has grown into a fine young man, has bipolar disorder. He is mentally well at present, but my family continues to experience times when he is mentally ill. Every day, his courage and strength as a human being inspire me to do the work I do with families through the FORCE. My daughter and my husband are a reminder to me of the journey we have taken together as a family.

When the FORCE was asked to be part of the Provincial Working Group for Parental Mental Illness over five years ago, I wondered whether we should join. Many times when I was seeking treatment and support for my son, I had been questioned and offered parenting programs. The implication was that my parenting had caused, or contributed to, my son’s challenges. Sadly, this is the case for too many families grappling with mental illness.

I agreed to join the working group, but only if we could think in terms of mental health, rather than illness, and look at families for their strengths, rather than deficits. Our involvement eventually led to the FORCE being asked to develop this framework. Families Matter: A Framework for Family Mental Health in British Columbia is intended to reflect the mental health needs of whole families experiencing a wide range of mental health challenges, and to identify opportunities to promote mental wellness for all family members across the life course.

The framework started out as the Parental Mental Health Framework, but it changed in the very early days because of what parents had to say, namely, that everyone in a family is deeply affected by a loved one’s mental illness, whether the ill person is the parent or child. In my own case, to think for one minute that my husband, daughter and our extended family have not been impacted, both good and bad, by my son’s illness is dangerously inaccurate.

Families Matter is first and foremost about mental health promotion and prevention. It is intended to advocate for the best possible mental health for families in the face of ongoing illness. Families Matter acknowledges that those who are ill need specific, targeted treatment and support. The absolute necessity to provide adequate, appropriate and timely mental health care does not diminish with the framework’s upstream focus.

What does need to change, however, is our currently fragmented approach to mental health and mental illness, and our focus on the individual at the expense of the whole

Foreword

Dr. Robert Lees, who has long been a champion of supporting families with mental illness, tells a beautiful story of watching his grandchild skipping in front of him as he and his wife walk together. He reflects on how joyful it is to see this and then asks, “When is the last time you skipped?”
family and community. With Families Matter, we are hoping to spark a dialogue about the need to radically shift our policies and practices from an over-reliance on singular, individualistic perspectives to more holistic, family perspectives. We believe this will open up a wealth of untapped resources in families and communities to collectively tackle mental illness and improve mental health for everyone.

I am grateful for the opportunity to present this framework on behalf of the FORCE and the individuals and families who shared their needs with us. It is always a privilege and a tremendous learning opportunity when families allow us to walk with them (and sometimes even to skip) on their journey towards greater mental health.

Keli Anderson  
Executive Director  
The FORCE Society for Kids’ Mental Health  
www.forcesociety.com

“We’re better together”  
(FORCE stakeholder)
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Framework at a Glance

The purposes of this framework are to:

1. Assist policy makers and service providers to understand the mental health needs of families experiencing mental health challenges, and to work with families to meet these needs;

2. Advocate for a collaborative, systemic approach to supporting families experiencing mental health challenges across all BC’s service systems;

3. Promote a shift in thinking and doing that acknowledges the profound relationship between families and mental health and prioritizes whole family approaches to research, policy and practice;

4. Enable families experiencing mental health challenges to improve their mental health by strengthening resilience and coping capacity.

The FORCE believes this approach will help to improve family mental health, prevent or minimize family mental health challenges, and reduce the impacts of mental illness on all family members.
Vision Statement

Family mental health is the infinite capacity for health and healing in families and communities. It is about thriving together during illness and health, not just surviving.

Core Values
- Hope
- Empowerment
- Interdependence
- Compassionate action
- Inclusion

Key Concepts
- Family at the centre
- Family engagement
- Child and youth focus
- Resilience
- Recovery
- Collaboration

Action Guidelines
- Build strong policy platforms that address determinants of family mental health
- Create environments that influence risk and protective factors for family mental health
- Strengthen community action for family mental health
- Develop skills and capacities that support family mental health
- Re-orient public and private services to promote family mental health

Focus Areas
- Family resilience
- Family stigma and discrimination
Framework at a Glance

Outcomes

These are desired results that build on each other. In general, immediate outcomes need to be achieved before progress can be made on intermediate outcomes. Longer term outcomes are influenced by many factors and may not be fully realized, but progress is based on the previous results.

Families – individual members and the family as a whole

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<tr>
<th>Immediate</th>
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<tr>
<td>• More involvement in supportive relationships</td>
<td>• Increased sense of:</td>
<td>• Improved mental health</td>
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<td>• Greater mental health and substance use literacy</td>
<td>- belonging and security</td>
<td>• Optimal functioning of parents, children, youth and families</td>
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<tr>
<td>• More opportunities for meaningful participation in community and economic life</td>
<td>- self esteem</td>
<td>• Fewer and less severe mental health / substance use problems</td>
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<td>• Better access to timely, evidence-based services and supports</td>
<td>- mastery and control</td>
<td>• Less illness, injury, disability and death from mental health / substance use problems</td>
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<td>- self determination</td>
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<td>• Increased resilience and coping capacity</td>
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<td>• Stronger connections to family, community, school and workplace</td>
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Public Systems and Service Providers

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<td>• Embedded family mental health values</td>
<td>• Valuing of diversity</td>
<td>• Service systems are accessible, respectful and responsive for families</td>
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<td>• Informed and engaged families and advocates</td>
<td>• Expanded use of best and promising practices</td>
<td>• Social environments are inclusive, safe and supportive for families</td>
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<td>• Prepared and proactive policy makers, service providers and community partners</td>
<td>• More collaboration across settings and sectors</td>
<td>• Less discrimination linked to mental illness and / or addiction</td>
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<td>• Productive relationships between families, systems and community partners</td>
<td>• Greater capacity to create, monitor and evaluate mental health-promoting environments</td>
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Introduction

“The positive mental health of families is about more than access to mental health care services”

(FORCE stakeholder)
When one person in a family has a mental health challenge, everyone is affected.”

(FORCE stakeholder)
**Families Matter** focuses on families where at least one person is experiencing a mental health challenge or mental illness, including those where:

- Parents have a mental health challenge or mental illness
- Children (including adult children) have a mental health challenge or mental illness
- Mental health challenges or mental illness span multiple generations
- A family member has a concurrent disorder

**Families Matter** targets public policy makers, service providers and advocates working in the areas of:

- Child, youth and family development, including childcare
- Child protection, including foster care
- Child, youth and adult mental health and addictions, including forensic mental health
- Education
- Health, including population health, public health, primary health and maternal health
- Housing and homelessness
- Employment and income support
- Policing, courts and corrections, including youth justice
- Family violence

**Families Matter** is well aligned with mental health policies at the provincial, national and international level (see Appendix #1). In a nutshell, this framework is an opportunity to test-drive an upstream approach to mental health with a family lens. It affords us the chance to apply mental health promotion to children, youth and adults living with a wide range of mental health challenges, who are coping in the face of entrenched stigma and discrimination, and who are sophisticated consumers of mental health care.

More importantly, **Families Matter** is a conscious effort to shift our thinking from what is best for the individual with a mental health challenge, to what is best for that person and the natural or chosen family that loves and cares for them, each step of the way. It is also a call for shared action and accountability. The mental health of children, youth and families is not, and cannot be, the responsibility of one sector or jurisdiction. We all have a role to play.
Scope of the Framework

*Families Matter* looks at ways to improve the positive mental health of families experiencing a wide range of mental health challenges and mental illness.

It recognizes the diverse support needs of families and acknowledges that our responses must rise to the challenge by integrating cutting edge science with significant family engagement.

We need to ‘get it right’ for families—whether it’s a family with a new mother struggling with perinatal depression, a young child showing signs of anxiety, a sibling feeling overwhelmed by a brother’s attention deficit disorder, a lone parent grappling with a teen’s emerging psychosis, a child valiantly caring for a bipolar parent, a spouse dealing with the family impact of a partner’s deep depression and substance use, an elderly mother worrying for her adult son with schizophrenia, or a grandparent providing respite for an ill grandchild and his exhausted parents.

Specifically, *Families Matter* is intended to help:

- Children and youth flourish despite their own or their parents’ mental illness
- Parents get the support they need to cope and parent well despite their own or their children’s mental illness
- Child-, youth- and family-serving systems become more mental health-promoting
- Mental health services have a stronger family focus
- Individuals, families and communities increase control over their own mental health
Families Matter explores strategies for mental health promotion, mental illness prevention and early intervention for individual family members and the whole family. It emphasizes the need to build individual and family strengths, resilience and coping capacity, as well as create supportive environments for mental health. Families Matter stresses the importance of reducing malleable risk factors and enhancing protective factors for mental health across the life course, at different developmental stages and key transitions. It also acknowledges the crucial role of early identification and early intervention in child and youth mental health.

Two important themes inform Families Matter. First is the powerful influence of stigma and discrimination on people’s ability to achieve and sustain mental health. Second is the critical role of collaboration—among families, advocates, policy makers and service providers—in creating mental health-promoting service systems, whether we are talking about health care, education, income assistance, housing or justice.

Families experiencing mental illness engage with service systems at various points along a continuum of services and supports from promotion, prevention and early intervention, to treatment, care and recovery. The decision to seek help is determined by numerous factors, such as the severity of a family’s mental health challenge, their confidence in reaching out, the receptivity of service providers, the effectiveness of services and supports, and the availability of services in a community.

In the course of developing Families Matter it became clear that the treatment needs of families are profound. We heard repeatedly that families want better access to evidence-based mental health care when and where they need it, whether that is access to a clinical psychologist, psychiatrist, community mental health and substance use team or residential treatment facility. In particular, families experiencing severe and complex mental illness want to know that the formal health care system can mobilize to meet the whole family’s needs for specialized treatment, support and recovery. This means ready access to a variety of treatment options for the child, youth or adult with mental illness, as well as respite and clinical support for family members in their critical role as caregivers—all using best practices in drug treatment, psychotherapies and community integration.

Although the focus of Families Matter is upstream on promotion, prevention and early intervention, we acknowledge the necessity of comprehensive, downstream treatment and care options—especially for families grappling with severe and complex mental illness. As noted in the provincial government’s Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia, these families require a robust and highly coordinated response that includes community interventions across the lifespan, housing with supports, community residential treatment, and access to hospital and specialized bed-based treatment.

While Families Matter does not address the specific treatment and support needs of families with severe and complex mental illness, we strongly urge policy makers and service providers to collaborate with families to enhance the government’s response.
Aboriginal Family Mental Health

The Mental Health Commission of Canada states that Aboriginal people largely share an understanding of health and wellness as a state of balance among the body, mind, emotion and spirit. Wellness is embedded in culture, tied to the land, and deeply rooted in family, community and self-determination. However, the legacy of residential schools, cultural dislocation and economic exclusion has had a devastating impact on Aboriginal health—an impact that continues to be felt from one generation to the next.

Families Matter does not presume to speak for or on behalf of Aboriginal people. Although we did not exclude Aboriginal families from our consultations, we believe Aboriginal families and communities must be supported in identifying their own challenges and solutions. We look to the tripartite partners—Government of Canada, Province of British Columbia, and First Nations and their leadership groups—to provide this support.

At the same time, we are committed to ensuring this framework is responsive to Aboriginal people’s unique circumstances and contributions. We believe the mental health of all people will benefit from approaches that incorporate Aboriginal perspectives on wellness, healing, decision making, community engagement and cultural safety, as well as indigenous knowledge and traditional health practices.
A note on our terminology

**Mental health** refers to a state of social and emotional well-being.

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

**Mental disorders** are diagnosable health conditions that affect the way a person feels, thinks or acts that are 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*.

**Substance use disorders** and **substance dependence** are mental disorders. Where substance use disorders and mental disorders occur together, they are called **concurrent disorders**.

**Mental health challenges** and **substance use problems** refer to signs and symptoms that do not meet the diagnostic criteria for a particular mental disorder, but which are nonetheless disabling for the individual, their family and community.

“People will call my mental health problems by lots of names; I just want to feel and live well”

(FORCE stakeholder)
Introduction

Process

Families Matter drew its inspiration from three sources: families and service providers, the research literature and the experience of our own and other jurisdictions.

The FORCE conducted a highly targeted engagement of families, advocates, policy makers and service providers in each health region over a three month period, April to June 2010. The engagement process comprised large and small group formats using an adapted Appreciative Inquiry technique, as well as key informant interviews using an adapted Critical Incident technique (see Appendix #2). We engaged approximately 119 people across five health regions, including:

- youth and parents with diagnosed mental illness
- parents with diagnosed mental illness whose children also had mental health challenges and diagnosed mental illness
- parents and grandparents of children/adult children, ranging in age from 6 to 45 years, with mental health challenges and diagnosed mental illness
- frontline staff and managers from health authorities, regional ministry operations and community agencies (approximately half the professionals identified themselves as having direct experience with mental health challenges in their own families)
- policy makers from BC ministries of health, education and child and family development

As part of the adapted Appreciative Inquiry technique, participants created a series of community maps illustrating what their community is like today for people experiencing mental health challenges and what an ideal, mental health-promoting community would look like in the future. The future scenarios were consolidated into one compelling community map which forms the basis of Families Matter’s vision.

Although the consultation process to develop Families Matter was compressed, we anticipate there will be opportunities for more stakeholder and public input through the implementation of the framework and its continual refinement. We truly see this framework as a living document that will need to reflect changes in knowledge, practice and the lived experiences of families.

The literature scan included evidence reviews and model program descriptions prepared for the BC ministry of health services and health authorities on mental health promotion, mental disorders prevention and prevention of substance-related harms. We also reviewed published and grey literature on family engagement, parental mental illness and recovery. It should be acknowledged that in many key areas the experience base is much stronger than the evidence base.

The jurisdictional scan included relevant policy and planning frameworks from Canada, Australia, New Zealand, European Union member states, United Kingdom, United States and the World Health Organization.
Overview: What is mental health?

“Mental Health is more than the absence of mental illness”

(FORCE stakeholder)
What is mental health?

The World Health Organization describes mental health as 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.

Similarly, 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. Any change in the mental health of one person is a change in the mental health of the entire family. Families are also part of the community; family mental health contributes to, and is keenly influenced by, community health.

What is mental health promotion?

Mental health promotion is the process of enabling individuals, families and communities to take control over their lives and improve their mental health. It uses strategies that foster supportive environments and resilience, while respecting the fundamental principles of equity, social justice and personal dignity (Centre for Health Promotion, 1997).

There is a profound, reciprocal relationship between families and mental health. Families play a critical role in the promotion, protection and maintenance of mental health. They conserve wellness across the lifespan and across the continuum of health and illness. Mental health promotion by and for families is crucial as families assume more responsibility for preventing mental illness and caring for ill family members. This, in turn, requires greater respect and advocacy for families’ self-determination and unique role in building and strengthening resilience in a complex world (Bomar, 2004).

Consistent with health promotion generally, mental health promotion is concerned with social norms, public policies and service systems, as well as personal practices and coping skills. The emphasis is on making lasting social and structural changes that will improve mental health for everyone, and enable individuals and families to improve their own mental health (Keleher & Armstrong, 2005).

To this end, the public, private, and voluntary sectors must work collaboratively to promote factors that strengthen mental health, such as adequate housing, vibrant communities and nurturing relationships, and to reduce those factors that increase the risk of mental illness, such as poverty, abuse and social isolation. These efforts need to be directed at the population as a whole, at people and communities at risk, and at families living with mental health challenges and mental illness (Mental Health Commission of Canada, 2009).
What is mental illness prevention?
The distinction between mental health promotion and mental illness prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health while prevention seeks to reduce the risk, incidence, recurrence, severity and impact of mental health challenges.

A major prevention focus is the risk and protective factors that influence child and youth development. This developmental pathways approach acknowledges that there are common risk and protective factors associated with mental health across the life course. Risk factors are the individual, social and environmental factors that independently predict mental illness. Protective factors limit the negative impact of the risk factors.

Some risk factors are fixed, meaning there is little if anything we can do about them (e.g. genetic endowment and brain development), and others are malleable (e.g. social isolation, financial instability and trauma) and respond to different interventions. Certain modifiable risk factors can be influenced by timely knowledge and skills acquisition, behaviour change, targeted services and supports, and broader social and systemic change. Research indicates that children and families who are at greater risk for mental illness can benefit from targeted efforts to reduce their risk and prevent problems earlier where possible.

When prevention seeks to reduce risk factors and enhance protective factors, it is generally described as universal, selective and indicated prevention. When prevention aims to reduce the incidence, recurrence and severity of problems, it is often referred to as primary, secondary and tertiary prevention. It is generally agreed that a combination of broad-based (e.g. universal and/or primary) and targeted (e.g. selective, indicated, secondary and/or tertiary) prevention is best.

Families Matter is chiefly concerned with mental health promotion and prevention within the context of active mental illness. Broad-based prevention helps raise awareness of the mental health needs of families and combat the stigma associated with family mental illness. It also helps disseminate critical information and resources to vulnerable family members in a non-stigmatizing setting.

For example, FRIENDS is a school-based, universal prevention program that effectively reduces the risk of anxiety disorders for all participating students. Targeted prevention enables families experiencing mental illness to
leverage their unique strengths with specific knowledge, skills and support, and in so doing limit the impact of mental illness on present and future family members. At the provincial level, examples are Dealing with Depression for youth; Strongest Families for parents with children aged three to 12 years; and Bounce Back for adults.

As we continue to learn more about the complex origins of mental illness—genetic, biological, psychological and environmental—we continue to develop new service approaches. Today, we know that strengths and assets-based approaches are effective in achieving the behaviour change and broader social change needed to address malleable risk factors for mental illness.

What is early intervention?
Early intervention is often considered the link between prevention and treatment. Early recognition, identification and intervention are critical for addressing mental health challenges before they become diagnosable conditions. Research shows that early intervention reduces the severity of illness and offers the best chance for recovery.

This is particularly important for children and youth where the emotional, social and developmental costs of untreated mental health challenges are immense. It is estimated that 70% of mental illnesses originate in childhood and adolescence and without timely intervention they can compromise quality of life, impair functioning, diminish productivity in later life, and have significant intergenerational consequences (Waddell, 2002).

Partners outside the mental health sector can play a significant role in helping to identify, intervene early, and support people and communities experiencing problems. Evidence is mounting about the central role of public systems in recognizing and responding to mental health challenges—before they become entrenched, impair functioning and compromise quality of life. For example, there is a growing body of research and initiatives that target schools as a setting for early identification and intervention, and these could be enhanced by greater partnerships and strategic plans for connecting home and school.

What is harm reduction?
Harm reduction is both a philosophy and a practice. As a philosophy, it is about keeping people as safe and healthy as possible in the face of higher risk behavior, while recognizing the behaviour is likely to continue despite the risks. As a practice, it is perhaps best known as an approach to minimize the harms from substance use without requiring abstinence. Common examples of harm reduction in other life arenas include seat belts, bicycle helmets and condoms.

While harm reduction practices offer a clear benefit for individuals with substance use problems and concurrent disorders, as a philosophy harm reduction provides an empowering perspective for families experiencing mental illness. The following principles resonate for families struggling to manage the harms to all family members associated with a loved one’s chronic mental health challenge:

- Harm reduction recognizes that drug use is complex and multifaceted, encompassing a spectrum of behaviours that can produce varying degrees of personal and social harm.
- Harm reduction acknowledges the individual substance user has a right to self-determination. Harm reduction supports informed decision making in the context of active substance use. It emphasizes personal choice, responsibility and self-management.
- Harm reduction recognizes that people benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. Choice and prompt access to a broad range of interventions are what helps keep people alive and safe.
- Harm reduction establishes a hierarchy of achievable steps that, taken one at a time, can lead to a fuller, healthier life for substance users and a safer, healthier community. It starts with “where the person is” in their substance use, with the immediate focus on the most pressing needs. Harm reduction is
based on the importance of incremental gains built over time.

- Substance users are seen as the best source of information about their own substance use, and are empowered to join with service providers to determine the best interventions to reduce harm from substance use. Harm reduction recognizes the competency of substance users to make choices and change their lives.

*Families Matter* poses the question, “what do parents and children need us, as advocates, service providers and policy makers, to do to ensure everyone in the family is as safe and healthy as possible within the context of mental illness?” We want to meet parents where they are in their parenting capacity and focus on practical supports, whether the parent is dealing with perinatal depression, has just had a child apprehended because of their own mental illness, is struggling with an addiction to illegal drugs, or is worried sick about a child with bipolar who feels more at home on the street than in their own house.

**What does this mean for families experiencing mental health challenges?**

Quite simply, there is no health without mental health. As one stakeholder noted, “the human body does not end at the neck.” Good health is fundamental to human, social and economic development. Mental health promotion, with its focus on the structural determinants of health, can lead to safer and healthier families, workplaces and communities, as well as lower rates of certain mental disorders and improved physical health. To this end, it is important that mental health promotion is applied equally to the general population, vulnerable groups, and those experiencing mental illness.

For some mental disorders, comprehensive prevention and early intervention can stop mental health challenges from becoming diagnosable conditions. They can also reduce the severity of mental illness and offer the best chance for recovery. This is particularly important for children and youth. Timely access to effective care not only improves a young person’s quality of life, today, it enables them to become tomorrow’s self-aware and confident adult in their chosen roles as volunteer, employee, employer, parent and/or leaders in their community. Using evidence-based interventions to tackle problems early and take action to boost the resilience and emotional well-being of children and youth will improve their wider life chances.

However, families need more than information, practical supports and access to services to build resilience. They also need inclusive communities, responsive and integrated service systems, collaborative relationships with professionals, and the social and economic resources to nurture and provide for their members.

Over the past few decades much progress has been made in understanding the causes, developmental pathways and effective responses to mental illness. Advances in neuroscience, understanding the malleable aspects of mental health, and recognizing the role of individual strengths and social resources in recovery have led to the development of interventions that produce lasting results.
For families experiencing mental health challenges, we believe that evidence-based promotion, prevention and early intervention that target the broad determinants of health, when combined with appropriate care and treatment, can:

- Strengthen resilience and psychological well-being
- Promote healthy child, youth and family development
- Tackle problems early on before they become more serious
- Enable all family members to flourish and achieve their fullest potential
- Facilitate and sustain the journey of recovery
- Help safeguard the health of future generations
- Empower families as partners in care
“We want to be living rather than surviving; thriving rather than coping.”

(FOREC stakeholder)
Families Matter Framework

Our Vision

We believe that family mental health is the infinite capacity for health and healing in families and communities. It is about balance, harmony and thriving together during illness and health.

A community that supports family mental health does not fear mental illness. It embraces mental illness the same way it does physical illness. The community works collectively to meet the needs of the unwell person and minimize the impact of illness on the whole family. It surrounds the family with helping hands, recognizing that families are capable and valued members of the community who, with well-placed support, can 'struggle well' with illness and rebound to live more fully.

A supportive service delivery system puts families at the centre and acknowledges that the family is the place where caring and healing can happen. Effective and collaborative responses value both the common and unique features of a family’s experience of illness. Coordinated services and supports take into account each family’s unique perspective, resources and challenges, and the common ground it shares with other families.

From the acceptance of uniqueness comes an appreciation for the diversity of family strengths and assets, and the wealth of approaches that can help families to be productive members of the community. This valuing of diversity leads to more creativity, connection, collaboration and respect for each family’s potential and for the role of professionals. Families are no longer defined by their illness, but by their competency. Families are recognized as co-creators of health and co-providers of care.

“I believe it’s possible to create a transformation by putting families at the centre”

(FORCE stakeholder)
Our Values

Values are the beliefs and norms that shape our attitudes and responses to mental health. They establish the ethical basis for this framework and move us from concept to action.

Hope

“See me . . . things can work out . . . there’s light at the end of the tunnel.”

(FORCE stakeholder)

Hope is the limitless belief that things do not have to remain the same and that change can and does happen. It is about concentrating on strengths rather than weaknesses, focusing on the future rather than the past, and celebrating small successes rather than insisting on rapid change. Hope fuels the recovery process by expanding the sphere of possibility and sustaining individuals, even during periods of relapse. Hope lays the groundwork for the process of healing. It is vital that service systems entrench a spirit of hope and service providers demonstrate hope by continually offering choices, even if they are repeatedly rejected (Queensland Health, 2005).

Empowerment

“Nothing about us without us”

(FORCE stakeholder)

Empowerment is the process of creating a personal vision and having the confidence, skills and support to move toward it. Empowerment is about building self-awareness, competence and determination, as well as proactive strategies to achieve goals. It is a willingness to make choices, take responsibility, live with the consequences, learn from them and exert control over one’s own life. For families experiencing mental illness, an empowerment-oriented service system enables meaningful participation and shared decision making with service providers.

Interdependence

“My choices really matter—more to others than to me.”

(FORCE stakeholder)

Interdependence is the state of being connected to and influenced by others. It is about being self-reliant while at the same time being responsible to others. In families, individual members function as interdependent components of a complex system which is bonded by strong emotional connections. Each member of the family has an effect on the other members’ thoughts, feelings and actions -- and these effects are reciprocal. A change in one family member affects the entire family. Interdependence in families can fulfill family members’ social, emotional and physical needs. It can serve as a bond that holds families together and it can define the relationships between family members. Families can vary in their degree of interdependence.
Compassionate Action

“If it helps, then use it.”
(FORCE stakeholder)

Compassion involves cultivating an attitude of universal and unconditional acceptance, where boundaries that define self and other tend to dissipate (Kumar, 2002). Pragmatism is about taking action to resolve problems, while acknowledging the limits of our understanding and the constraints on what will work. In terms of mental illness, this means focusing on positive outcomes for people, while tolerating ambiguity and uncertainty as we strive to integrate different explanatory concepts in a rigorous and evidence-based fashion (Brendel, 2003). Compassionate action balances human rights, good science, common sense and strategic opportunity.

Social Inclusion

“I am a person, not an illness.”
(FORCE stakeholder)

Social inclusion represents the degree to which individuals feel connected to each other, their families and their communities. To make these connections, people need to establish valued roles for themselves through supportive relationships and meaningful participation in community and economic life. An inclusive society is where all people feel valued, their differences are respected and their basic needs are met so they can live in dignity (Keleher & Armstrong, 2005).
Families Matter Framework

Key Concepts

The following concepts form the foundation of our approach to promoting family mental health and reducing the impact of mental illness on families.

Family at the Centre

“I believe it’s possible to create a transformation by putting families at the centre.”

(FORCE stakeholder)

A family-centred philosophy starts from the premise that families have a critical role to play in promoting mental health and supporting people with mental illness. It recognizes the centrality of the family in the lives of individuals. Family-centred practice recognizes that families are fully capable of making informed choices and acting on them. It focuses on the inherent strengths, capabilities and interconnectedness of families. Professionals view themselves as family agents and help families strengthen existing skills or acquire new ones. Interventions which strengthen the family as a whole are viewed as helping individual members (Wells & Fuller, 2000).

Family Engagement

“I have met various professionals and families along the way who have made my son’s recovery possible, and assisted our family in feeling less isolated, less judged and more engaged in our journey. We were able to do better as a family because we had people who valued and engaged us.”

(FORCE stakeholder)

Family engagement is any role or activity that enables families to have direct and meaningful input into and influence on systems, policies or practices that affect services for children and families (New York State Council on Children and Families, 2008). On a philosophical level, family engagement is about motivating and empowering families to recognize their own needs, strengths, and resources, and to take an active role in changing things for the better. On a practical level, it is about directly involving families in the design, delivery, management and evaluation of services and supports for individual family members and the family as a whole. Family engagement is what keeps families working in the long and sometimes slow process of positive change (Steib, 2004).

Child and Youth Focus

“Youth have a right to know what is happening to them and those around them.”

(FORCE stakeholder)

A child and youth focus means we listen to and engage with young people in addressing their mental health needs. The balance between a child and youth focus and a family-centred approach to mental health respects and supports the rights of young people, as well as the essential care-giving role that families play in their lives. When young people and families are provided with access to sufficient support, resources, education and opportunities, they are empowered to be actively and meaningfully involved in decisions that affect their mental health (Kutcher & McLuckie, 2010).
Recovery

“Know what you are really feeling—fear, betrayal, loss, all of it . . . and move forward.”

(FORECE stakeholder)

Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness. It is about living well despite any limitations resulting from mental illness, its treatments, and personal and environmental conditions. Recovery is intensely personal, unique and more about the process than the destination. It involves an overall upward trend marked by growth and setbacks, as well as periods of slow and rapid change. Recovery does not necessarily mean the elimination of symptoms or a return to a pre-illness state (Queensland Health, 2005). Recovery-oriented services help people achieve or maintain valued roles and participate meaningfully in all aspects of community life.

Resilience

“Everyone in a family needs help, not just the person with the mental health problem.”

(FORECE stakeholder)

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. Family resilience is the ability of the family as a whole to fulfill its core functions with competence and to flourish in the face of risks. Family resilience is both a result and a process. Protective factors that contribute to family resilience can emerge from within individual members, from the family unit and from multiple community contexts. Key internal attributes of resilient families are family cohesiveness, flexibility and good communication. Important external attributes are social connectedness, access to social and economic resources, and collaborative relationships with professionals. Family resilience recognizes that all families have inherent strengths and the potential for growth, whether they are dealing with the normal challenges of daily life or exposed to significant risk (Patterson, 2002).

Collaboration

“We are better together.”

(FORECE stakeholder)

Collaboration means working together to achieve common results. It provides an opportunity to overcome philosophical, professional, organizational and procedural differences. The keys to successful collaboration are a shared understanding of an issue, common language, trust, respect for each participant’s viewpoint and expertise, willingness to share power and decision control, commitment to action, continuous knowledge exchange, focus on results and accountability. The mental health of infants, children, youth and families is too precious to be at the mercy of uncoordinated, single-system approaches.
Action Guidelines

The following guidelines define key areas for action to promote family mental health.

The guidelines are drawn from the Ottawa Charter for Health Promotion (1986) and subsequent refinements in the Jakarta Declaration (1997) and Bangkok Charter (2005). They are intended to leverage efforts by families, communities and governments to improve the mental health of families experiencing mental illness, and to create mental health-promoting environments for families.

Families Matter has identified two focus areas (see next section) and encourages families, service providers and policy makers to apply these guidelines to achieve key results in each area.

1. Build strong policy platforms that address determinants of family mental health

Mental health promotion puts mental health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the mental health consequences of their decisions and to accept responsibility for mental health.

Strong, mental health-promoting policies combine diverse but complementary measures, such as legislation and regulations, funding, taxation and organizational change to foster greater equity. These policies advocate for a human rights approach to mental health, one that ensures people’s basic human rights are respected, fulfilled, protected and any rights violations are remedied.

These policies also address determinants of health to increase opportunities for mental health and reduce disparities in mental health among different groups of people. Health determinants are interacting biological, behavioural and structural conditions that influence risk for disease, as well as opportunities for individual and population health.

They can be organized into four broad categories:

- Living and working conditions - e.g. income, education, employment, housing and social support
- Individual capacities and skills - e.g. biology and genetic endowment, healthy child and youth development, personal practices and coping skills
- Social environments - e.g. values, norms and attitudes; gender and culture; systems of care and control; and specific life contexts
- Access to services - e.g. equitable access to highly coordinated, multi-system services that maintain and promote health, prevent diseases, and restore health and function
2. Create environments that positively influence risk and protective factors for family mental health across the life course

Mental health promotion acknowledges the inextricable links between people and their environments, whether those are natural, built or social environments. Mental health is created and experienced by people where they live, learn, work, play and love. The goal is to create the conditions that allow everyone—in the family and community—to achieve and sustain mental health. For policy makers and service providers, this means targeting behavioural and structural change within the settings of everyday life. This, in turn, requires a focus on common risk and protective factors for mental health that occur across the life span and at key transition points.

Risk and protective factors interact with genetic traits and other aspects of brain function to influence mental health and the emergence of mental health problems. Risk factors are individual, social and environmental factors that independently predict the early occurrence of mental disorders. They exist for each developmental stage and include elements that impede healthy neurobiological, psychological and social development in key domains (e.g. at home, school, workplace, community). Protective factors limit the negative effects of risk factors, although they do not directly influence the likelihood of mental health or ill health (Loxley et al., 2004). Protective factors range from prenatal nutrition and avoidance of harmful substance use during pregnancy, to positive engagement and bonding with family, friends and community, to optimum levels of cognitive functioning and emotional self-regulation (Toumbourou & Catalano, 2005).

3. Strengthen community action for family mental health

Mental health promotion is about empowering individuals, families and communities to take ownership and control of their own mental health and life circumstances. It advocates both personal and social responsibility for mental health. Mental health promotion works through concrete and effective community action. The capacity for community action can be strengthened through leadership (e.g. political, policy, clinical, community and family leadership), public awareness and education, knowledge exchange, targeted investments in community infrastructure, and mobilization of partnership resources. The latter is particularly important and includes building partnerships and strategic alliances among public, private, non-governmental and community-based organizations across all sectors that influence mental health.

4. Develop skills and capacities that support family mental health

The development of skills and capacities is essential for families to increase control over their mental health and make choices that are conducive to good mental health. The provision of factual information, education, skills training and social support are key aspects of capacity development. However, this is not limited to the individual or family experiencing mental illness. It is also directed at organizations and service systems that families interact with on a daily basis. Targeted anti-stigma campaigns and comprehensive workforce development ensure that service providers have the values, attitudes, knowledge base and skills that are essential to promote mental health and prevent or minimize mental illness.
We will know that we have been successful when we have achieved positive results for people experiencing mental illness in key life domains, such as health, housing, education, employment, and arts and culture.

5. Re-orient public services to promote and sustain family mental health and well-being
The most powerful step in re-orienting public services to promote family mental health is to see people as complex and capable human beings, not a bundle of diagnoses or service needs. Also, understanding that mental health is everyone’s responsibility, while acknowledging that people are their own best mental health resource, can go a long way in transforming service systems. This means moving beyond an exclusive focus on clinical and curative services to support individuals and families in creating and reinforcing their own mental health.

It also means strengthening collaboration between the mental health care system and other service systems that influence mental health. A whole family approach to mental health is deeply challenged by separate service systems for children and adults, especially when those systems may have conflicting mandates, policies and organizational cultures. On a practical level, re-orienting public services to promote mental health requires a much stronger attention to research, knowledge exchange, workforce development and service organization. Many young people and their families are unable to access what they need, when they need it, and opportunities to mitigate or prevent deterioration in their lives are lost.
Focus Areas

Families Matter believes it is essential to push for societal change in the way we view mental health, and systemic change in the way we support families to promote and sustain mental health—today and for future generations.
Focus Areas

Our goal is for families to be fully informed, engaged and supported in taking control of their own mental health. This will require service systems to acknowledge, and work collaboratively to reinforce, the central role of families in creating the conditions for mental health and healing.

The following areas for focused and deliberate action emerged from our consultations with families, policy makers and service providers: (1) supporting family resilience and (2) tackling family stigma and discrimination.

Families Matter believes it is essential to push for societal change in the way we view mental health, and systemic change in the way we support families to promote and sustain mental health—today and for future generations. By applying the action guidelines described in the previous section to each focus area—developing evidence-based public policies, creating supportive environments, building skills and capacities, mobilizing people and resources, and re-orienting services—we believe that a lasting, positive difference can be made in the lives of families experiencing mental health challenges.
Focus Area #1: Supporting Family Resilience

“There comes a time when we realize that our experience becomes our greatest asset.”

(FORCE stakeholder)

Resilience is the ability to withstand and rebound from disruptive life challenges. Individual resilience is a person’s capacity to draw upon their own resourcefulness to cope with the demands of life, return to full functioning after setbacks, and learn from such experiences to function better in the future. Family resilience recognizes that families perform unique functions for their members and for society. It goes beyond seeing individual family members as resources for individual resilience and focuses on the family as a functional unit (Mangham, Reid & Stewart, 1996; Luthar & Zelazo, 2003).

Defining Family Resilience

Family resilience applies our understanding of healthy family functioning to adverse situations, whether those situations represent significant risk or the normal risks associated with daily living. The basic premise is that adversity impacts the whole family and, in turn, key family processes help all members and the family system to respond and adapt. 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 hardness in its broadest sense. It goes beyond the parent-child bond to include significant relationships with family, kin, mentors and community. It acknowledges that people always live in context, and that family resilience is deeply influenced by larger social, cultural and economic conditions. As such, family resilience needs to be supported by adequately funded public policies, systems and practices that reduce disparity and foster full inclusion (Walsh, 2003; Patterson, 2002).

Family resilience draws attention to family success and competence. It involves a crucial shift in emphasis from family deficits to family strengths. From this perspective, families are seen as challenged—rather than irreparably damaged—by life’s adversities. Family members are viewed as wanting to do their best for each other while struggling with overwhelming challenges. Efforts are aimed at enhancing family functioning over the multigenerational family life cycle and as challenges unfold.

Family resilience is not about bouncing back unscathed, but rather about struggling well. It is grounded in a deep conviction that recovery and growth for all members and the family as a whole can be forged out of adversity (Walsh, 2003).
Focus Areas — Focus Area #1

Resilience over the Life Course
Family development has a dynamic trajectory similar to individual development. For families experiencing mental health challenges, there are key stages and transition points in the family life cycle where evidence-based interventions can strengthen resilience and improve mental health for all family members.

The stages of the family life cycle are generally understood to be: independence, coupling or marriage, parenting, launching adult children, retirement and adjustment to the challenges of aging. The skills and capacities needed to successfully navigate each life stage build on each other. However, deficits in earlier stages can be remedied in later stages through education, skill development and practical support.

At each stage there can be normal or significant risks to family functioning and competence. The demands of each stage are considered normal risks for most families. However, these demands can become significant risks if the timing or meaning of the demands differs radically from family or societal expectations. Also, the lack of social and economic resources to deal with the normal demands of family life could make them more difficult. Crises and persistent adversity, as with the experience of mental illness, are considered significant risks and test both individual and family resilience.

Regardless of the nature of risks, effective clinical interventions to strengthen family resilience target key protective processes in family functioning, such as family belief systems, family organizational patterns, and family communication (Walsh, 2003). Effective public policy interventions ensure adequate resources to facilitate protective processes within families and enable families to fulfill their core functions for individual members and society (e.g. family formation and membership, economic support, nurturance and socialization, and protection of vulnerable members) (Patterson, 2002).

In addition, understanding the nuanced relationship between individual and family development can guide prevention and early intervention strategies. These strategies build on the willingness and ability of families to confront the ambiguity of mental illness, craft a new normal, and see possibilities for the future as they negotiate the shifting demands of child and youth development. As noted in the New South Wales Children of Parents with a Mental Illness Framework (2010-2015), the convergence of mental illness, parenting and child development provides unique and exciting opportunities for positive intervention, over time and across generations.

What Does Success Look Like?
The families we spoke to identified these factors to help them bounce back from adversity related to mental illness:

- Positive, respectful relationships and skills for effective communication within families and between families and service providers
- Opportunities to gain a new perspective on family mental health challenges, whether through diagnosis, education, acceptance, seeing the positive side or support
- Opportunities and resources to meet basic family needs

- Ability to seek help, practice self-care and maintain a healthy lifestyle
- Ability to develop and maintain a caring community
- Community resources that welcome and accommodate children, youth, parents and families with mental health challenges
- Availability of respite or reprieve for parents and caregivers
- Acknowledge and supports the needs of siblings
- Timely access to specialist mental health care when needed
Families Matter believes the following actions can make a real difference to family resilience over the life course (see Appendix #4 for examples of individual and family interventions across the life course):

1. Develop and implement policies and strategies that enhance protective factors for family resilience and mental health, with an emphasis on:

   **Nurturing and attachment**
   Support to new mothers to promote early bonding and nurturing throughout childhood

   **Knowledge of child and youth development**
   Information about the transition to parenthood combined with what to anticipate as children develop and support to meet the age/life needs

   **Specific knowledge of mental illness**
   Information about what to anticipate as mental illness of parent or child evolves and strategies for managing symptoms, ensuring family members’ safety and access to needed services along the way

   **Social connections**
   Network of family, friends, mentors and neighbours to build base of individual and family support

2. Focus on helping families to identify and build on their strengths and empower them to develop strategies to improve family functioning and well-being of individual family members

3. Explicitly integrate family mental health with other child, youth and adult systems through ‘whole family’ public policies, administrative practices and service provision

4. Incorporate family resilience into the education, training and professional development of the specialist and non-specialist health workers and allied professionals

**Community resources**
Coordinated and adequately funded public policies, institutional practices, and programs and services to meet survival needs, assure full community integration and contribute to a high quality of life for families

**What Does Success Look Like?**
My ex-husband is my hero. He struggles with bipolar disorder, alcohol dependence and the legacy of childhood sexual abuse. After many years of marriage, with no shortage of love for each other and lots of help from family, friends and professionals, it was the drinking that finally overwhelmed us. He is still a huge part of our lives, for which our children and I are so grateful. He is managing his mental health challenges with grace and a balanced centeredness we could all learn to emulate. It amazes me what he has been through in this life, and what he has always had to live with, and yet he works hard to be there for those he can with a smile and kind word - no matter what, I think I admire him most of all.
**Resilience and Collaborative Partnerships**

Collaborative partnerships between families experiencing mental health challenges and the people, organizations and systems that influence daily life are critical to supporting family resilience. They enable all family members to engage and flourish in valued social roles—whether as a student, employee, friend or volunteer—and to not be defined solely by mental health challenges.

Families whose lives have been affected by mental illness are in a unique position to help make social environments and service systems mental health-promoting by sharing what works for them with decision makers and service providers. Collaborative partnerships help to embed the expertise of families in research, policy, practice and evaluation. They help to raise awareness of what works well for families and fast-track the uptake of promising practices.

*Families Matter* believes that collaborative partnerships among families, decision makers and service providers in the following settings will help promote and sustain family resilience:

**School**

“Schools are vital to kids' well-being but, however well intentioned, discipline and surveillance are not the answer. Some communities in particular are vulnerable to regressive school policies. You have to advocate hard when cracks start to show—get to know the teachers, go to parent teacher interviews and ask for help.”

*(FORCE stakeholder)*

Considerable work is underway to make public schools in British Columbia mental health-promoting environments. The most consistently effective strategies are comprehensive, multi-component and focus on changing school ecology. These programs also engage parents and the community in creating environments that are conducive to learning.1

To date, efforts have focused largely on program and curriculum development that emphasize individual skills and capacities. More extensive work is required to address classroom dynamics, school culture, and partnerships between the school, family and community. *Families Matter* believes this valuable work could benefit from a more direct engagement with families and young people.

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1. For more information, please see: Centre for Addiction Research of BC - Helping Schools: Promoting Mental Health Literacy in BC Schools; Joint Consortium for School Health - Schools as a Setting for Promoting Positive Mental Health: Better Practices and Perspectives (2010); Mental Health Commission of Canada School-based Mental Promotion Initiative.
“Mothers are primary caregivers for their children in crisis—the fatigue and demands of mentoring, empowering, nurturing our kids in crisis all comprise invisible labour of mental illness. Employers need to respect the grey areas of mental illness that sabotage productivity.”

(FORCE stakeholder)

There are significant stresses involved in maintaining a work life while coping with a personal mental health challenge or caring for children, spouse or parents with mental health challenges. Employers need to recognize the multiple impacts of self-care and caregiving and offer reasonable accommodations that permit employees to contribute to the workplace at a high level while fulfilling personal and family responsibilities.

A mental health-promoting workplace is characterized by policies that allow employers the flexibility and discretion to support their employees in dealing with their own mental health challenges and the stresses of family caregiving. This support can range from helping the employee to become aware of their own state of physical, emotional and mental health, to providing opportunities for employees to meet both work and family responsibilities in creative and respectful ways. For employees who are dealing with their own mental health challenges, employers need to assist them in getting appropriate professional help, facilitating a gradual return to work after a leave for mental health issues, and returning to full engagement and productivity at work. For employees whose children are experiencing mental health challenges, employers need to provide greater flexibility at work, as well as support and assistance in obtaining help for the children. This requires, among other things, training, tools and resources for managers to attend to needs of their employees.

Families Matter believes there are opportunities for families to work collaboratively with local employers, unions and chambers of commerce to pursue initiatives that will help to create mental health-promoting workplaces in BC communities.

Emerging Best Practice

The success of organizations is intimately connected to their ability to support employees to effectively navigate the overlapping spheres of work, family and caregiving in the workplace. As employers, this means articulating respectful and caring policies, educating management about the impact of caregiving on the lives of employees and the workplace, and building healthy workplace cultures that encourage people to attend to their own needs in ways that enable them to bring the best of who they are to the workplace and their home lives.

I wish that I had been able to keep my job but my son’s wellness couldn’t be supported by my workplace benefits that only covered my illness, not his...

(FORCE stakeholder)

Focus Areas — Focus Area #1

What Does Success Look Like?

Doug has been off work for eight months due to a major depressive episode. His colleagues regularly call him up and invite him for coffee and a good gossip. Doug was recently invited to the company's Christmas party where he was treated with respect, dignity and compassion. His boss has emailed several times, saying that he admires Doug for taking care of himself. He reminds Doug that he is a valued member of the team who can solve problems that few others can, and that everyone looks forward to his return to work when he is ready.

Mary has just been offered a major promotion. It's an opportunity she has longed for but it comes at the same time that both her teenage children are struggling with mental health crises. The family is stretched to the breaking point. When Mary explains why she is declining the offer, her boss offers to restructure her work load in the short term and refers Mary to the Employee Assistance Program for support to manage her own mental health while she advocates for her children.
Emerging Best Practice

The treatment of mental health problems at the primary care level is time consuming and complex. Until recently, there have been few financial incentives for general physicians, who are paid on a fee for service basis, to spend the time needed to accurately detect and treat mental health problems.

The BC Community Mental Health Initiative, which took effect in January, 2008, supports general physicians in providing accurate diagnosis, patient plans and longitudinal follow-up of patients in the community with an Axis I diagnosis and a level of severity that interferes with the activities of daily living.

Under this initiative, a mental health planning fee is available to physicians upon development of a patient mental health plan. This fee requires the physician to:

- conduct a comprehensive review of the patient’s chart/history
- conduct an assessment of the patient’s current psychosocial symptoms/issues
- use appropriate, validated assessment tools in a face-to-face visit with the patient, with confirmation of diagnosis through DSM IV diagnostic criteria.

In addition, a mental health management fee is payable for follow-up clinical interactions between the physician, or delegated practice staff, and the patient.

A clear need exists to enhance training, education and clinical support to primary care practitioners in child, youth and family mental health. Medical practitioners and allied professionals in a variety of primary care settings require a better understanding of the mental health and illness continuum as it relates to individuals and families, specifically developmental pathways, risk and protective factors, initial presentation, illness progression, challenges with diagnosis and co-occurring conditions. Equally important is the need to support physicians in working collaboratively with care providers in other systems that influence the mental health of their patients.
**Emerging Best Practice**
The BC Medical Association’s Practice Support Program was launched in 2007 to improve care for patients throughout the province and to increase job satisfaction among BC physicians. The program offers focused training sessions and in-practice support for physicians and their medical office assistants to help improve practice efficiency and to support enhanced delivery of patient care. The program offers learning modules in a number of practice areas, including adult mental health. All clinical modules are accredited for continuing medical education.

The emerging Child and Youth Mental Health Module is designed to enhance the skills and confidence of general practitioners to identify, assess, manage and treat children and youth with Axis 1 mental health conditions (e.g. mild to moderate anxiety, ADHD and depression). The module strengthens physicians’ ability to work collaboratively with children, youth and their families, and with allied care providers in the community. The overall aim of the module is to improve mental health outcomes for children and youth by enabling physicians to provide effective primary care, and by supporting the alignment of interacting service systems, such as primary care, education and child and youth mental health.

For example, through **joint training and practice, community-based clinical teams seek to:**

- Build relationships among children, youth and their families, physicians, school counsellors, mental health clinicians and community-based services
- Create a common language and set of tools
- Optimize roles
- Improve coordination of care
- Communicate more effectively

*Source: BC Medical Association, General Practice Services Committee (http://www.gpscabc.ca/psp)*

“My family doctor was the first place I went to when my son was having mental health problems”

(Force stakeholder)
Service Systems

“Let’s take the bureaucracy out of our systems so we can care creatively for people. Responsibility for family mental health belongs to more than one [government] ministry.”

(FORCE stakeholder)

Collaborative partnerships between families and service providers are integral to bringing a whole family perspective to services and supports across the continuum, from promotion and prevention to early intervention and treatment. This is critical as families often serve as an extension of the mental health care system, providing important case management functions such as assessment, monitoring, crisis management and advocacy.

Parents and professionals play different but equally valuable roles in meeting the treatment and support needs of a mentally ill child. Parents are often experts on their children. They can bring specific and unique knowledge of their children to the partnership. Professionals have specialized training and years of experience caring for many children with similar conditions. They bring a broad knowledge of mental illness and effective treatments to the partnership.

In addition to strengthening collaboration between families and service providers, it is just as important to forge connections among different service systems. When crises hit, collaborative partnerships among schools, community mental health teams and child protection workers can prevent children and youth from falling through system cracks.

Emerging Best Practice

The capacity of service systems to support families living with parental mental illness is significantly enhanced through well-articulated practice frameworks, use of peer specialists or family partners, and collaborative partnerships between service providers and family members. Through these participatory and inclusive arrangements, families and service providers are better positioned to identify and address barriers, gaps, duplication and fragmentation of services and supports.

What Does Success Look Like?

Whether we’re talking health, education, mental health or justice, a mental health-promoting system has these attributes:

- Mental health is understood as holistic, dynamic and influenced by social, cultural and economic contexts
- Mental illness is understood to range from mild, moderate and acute problems to severe and persistent disorders
- Families are treated with respect and empathy; they enjoy services free from discrimination
- Families are active, valued partners in the planning, design, delivery and evaluation of services to meet their needs; this includes a clear role for youth in families
- Services and supports focus on strengths and assets, rather than symptoms and deficits; they emphasize informed choice, autonomy, connectedness and dignity
- Services and supports build on natural support networks and facilitate community integration
- Services and supports are informed by knowledge and evidence interpreted through a family lens
- Service systems aim for navigational excellence and seamless transition as family needs change; policy, program, practice, cultural and other barriers are removed
- Service systems collaborate with each other to actively promote family mental health and reduce the burden of mental illness on families across the life course
- Service providers are educated, trained, supported, mentored and rewarded in providing effective whole-family services across the health and illness continuum
A Note on Young Carers

Young carers are children and youth who assume adult responsibilities for vulnerable family members. Often mature beyond their age, young carers are forced by family situations to assume care-giving roles which would normally be the responsibility of a parent or elder.

Young carers may undertake a variety of tasks for parents with mental health challenges, including advocacy, help with correspondence and bills, liaising with professionals, administering medicines, emotional support and domestic tasks. In BC it is estimated that 12% of the general adolescent population is caring for a vulnerable family member (Charles, Stainton & Marshall, 2009).

Being placed prematurely in adult caring roles may have both positive and negative consequences. Research shows that supporting families and carers contributes to reducing relapse rates and psychotic symptoms for people with a mental illness (Dixon & Lehman, 1995) and increased family/carer sense of control and their ability to manage situations (Smith & Birchwood, 1987).

While caring can have positive outcomes and protective factors for children and their families, it can sometimes come at a price. As a result of their caring roles many young carers have restricted opportunities for social, recreational and extra-educational participation. Young carers often encounter particular difficulty completing their secondary education, maintaining social networks and getting into paid employment. These restraints come on top of the issues often encountered by other carers, such as isolation and feelings of helplessness. Young people who live with or care for an adult with mental illness sometimes miss out on education, joining in sports and having a social life (Falkov, 1998).

In jurisdictions such as Australia and the United Kingdom, support for young carers starts by clearly acknowledging their caring role and not pathologizing it. 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 (Charles, Stainton & Marshall, 2009). 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. An assessment of the needs of young carers, and those they support, is viewed as a key gateway to information, services and support for all family members (NSW COPMI, 2010).
Note on the Interaction between Child Protection and Mental Health Systems

While all families experiencing mental health challenges can benefit from comprehensive support, families living with parental mental illness may need additional medical care, mental health care and parenting support.

Yet these parents are often reluctant to acknowledge their mental health issues because the very nature of the illness may prevent self-reflection, or they may fear negative and judgmental service provider attitudes, or they may fear losing custody of their children.

Evidence shows that parents living with mental illness are at greater risk of repeat involvement with the child protection system (Libby et al., 2007). Unfortunately, child protection workers often do not have the support or tools needed to work effectively with parents with a mental illness, and mental health practitioners generally have little ability to support the parenting role of adults with mental illness.

The child protection and mental health systems have distinct mandates, cultures and practices. These discipline-specific approaches allow for highly focused, specialized services and they advance knowledge attained through years of research and experience. However, they do not easily allow for comprehensive responses to families with complex health and social needs.

By their very nature, families experiencing mental health challenges require a high degree of collaboration among different service providers working in multiple systems. A fragmented service approach can result in miscommunication, ineffective case management and passive responses by those charged with protecting children and supporting the mental health of all family members. At worst, it can expose children and families to known and preventable risks of harm (Office of the BC Representative for Children and Youth, 2012).

What is needed is a collaborative, systemic approach to working with families experiencing mental health challenges. Such an approach would integrate BC’s diverse systems of support and protection and, within those systems, remove unintended barriers to family mental health that result from the separate provision of child and adult services. This is particularly important for families dealing with severe mental illness where the health and safety of individual family members may be in jeopardy.

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. Please see Appendix #3 for a summary of key practice recommendations from Think child, think parent, think family: a guide to parental mental health and child welfare (2011), produced by the UK Social Care Institute for Excellence. Many of these recommendations could be adapted for use in BC.
What Does Success Look Like?

Michelle, a child protection worker, has been told by her colleagues to maintain strict professional boundaries with her new client, Laura, a single mother with a mental illness whose two children have been taken into care. Michelle’s job is to focus on the safety of the children. On one home visit Michelle asks Laura what her main concern is around parenting. Laura replies without hesitation: safe housing. She needs to find a better place to live, but first she has to get rid of some of her stuff. Laura is overwhelmed at the prospect of sorting through the family’s belongings and doesn’t know where to begin. Michelle offers to help. While they are busy, the two women talk and it becomes apparent to Michelle that Laura has strengths that could be harnessed to resolve some of the child protection issues. Michelle’s willingness to extend her helping role to assist Laura with her move, and to see Laura as a complex person, built trust and strengthened their relationship. Together, Michelle and Laura found a basement apartment in a house where the owner was willing to provide practical support at no extra cost. After successfully addressing the other concerns that led to the children’s removal, the children were able to return home and Laura was able to continue with her community outpatient treatment.
Focus Area #2: Tackling Family Stigma and Discrimination

“I definitely had been offered enough advice on parenting to feel like, somehow, if I just parented my son better, he wouldn’t want to die.”

(FORCE stakeholder)

The stigma of mental illness refers to the negative stereotypes, opinions, or attitudes people have about mental illness and about people who have mental health challenges. Discrimination is the harmful behaviour towards people with mental health challenges that flows from stigma.

Despite advances in scientific knowledge about mental illness and effective treatments, mental illness continues to be engulfed by stigma and discrimination. This silences people and stops them from seeking help and reinforces harmful behaviour. It affects the way schools, employers, health care providers and child protection workers respond to people with mental illness and their families. It erodes individual and family efforts to stay mentally healthy.

Families Matter is keenly aware of the pervasive and debilitating nature of stigma—how it is internalized by the person and family with a mental health challenge, by the professionals and service systems designed to help them, and promulgated by the media and popular culture. Overcoming stigma and discrimination will require concerted and sustained action in the following spheres of influence:

Self and Family

“Mental health issues can be an obstacle, but other people’s reactions to you having a mental health problem—and your own reaction—can be obstacles, too.”

(FORCE stakeholder)

Stigma and discrimination can create profound changes in the self-identity of the person with mental health challenges and the way others perceive them. People with mental illness often self-stigmatize, even though accepting the passive role as victim does not assist in their recovery. For those with mental illness and substance use problems, particularly addiction to illegal substances, the burden of “double stigma” can be debilitating.

Family stigma is the prejudice and discrimination experienced by relatives of people with mental illness. It is sometimes called “stigma by association.” Parents often feel blamed for causing their child’s mental illness, children are fearful of being “contaminated” by their parent’s mental illness, and siblings and spouses feel blamed for not assuring that ill relatives adhere to treatment plans.

For most individuals with a mental health challenge, families are their primary source of support. For some, however, families do not understand or do not wish to have anything to do with mental illness. In these situations, family members may judge the ill person, believing he or she is “going through a phase”, being intentionally difficult, or being a bad parent. Family members may also fear the consequences of disclosure, such as social isolation, child apprehension or family breakdown. This can lead to the denial of illness and its severity and a refusal to accept help.

In families where a child has a mental illness, the mental health needs of siblings are often overlooked. As with other illnesses in families, the energy, attention and resources go to the person who is ill. Many well siblings feel ignored and less important than their ill sibling, or guilty about being well, or angry at what they perceive as lenient treatment or a double standard. Others maintain silence to protect themselves from remembering a traumatic experience with an ill sibling, or protecting that person from public embarrassment, or from upsetting their parents. In some families, siblings become allies and advocates for their ill sibling.
In other families, siblings internalize the stigma and negative reactions of others and become critical or aggressive towards their family.

**Community**

“I long for the day that I will be able to step outside my front door and have my neighbours smile and wave at me, rather than turn away in disgust. If they only knew how hard we are trying to help our son.” (FORCE stakeholder)

*Families Matter* believes that mental health literacy is a critical first step to promoting healthy, inclusive communities. Mental health literacy refers to the knowledge, skills, attitudes and beliefs about mental health and illness. People and communities with a high degree of mental health literacy are better able to take care of their own mental health, to recognize signs of mental distress and emerging problems in themselves and others, and to know how to find appropriate help. Most importantly, people with improved mental health literacy can challenge the stigma and discrimination associated with mental illness and advocate for more effective responses.

The key to mental health literacy is access to reliable, factual information about mental health and illness, as well as practical support for help-seeking behaviour and adoption of self-management tools and resources.

However, interventions that focus solely on improving knowledge of mental health are often ineffective on their own. Changes in knowledge do not necessarily lead to changes in attitude and behaviour.

The issue of employment is a prime example. Employment offers a social network, a route out of poverty, and a source of social status. Yet people living with mental illness face many challenges to gain and retain meaningful employment from family, health care providers and employers. In addition to mental health literacy, what is also needed are efforts to inform employers and service providers of their legal obligations under disability laws, the introduction of supported work and housing options, and providing economic incentives rather than disincentives to encourage people with mental health challenges to return to work.

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**What Does Success Look Like?**

Youth living with a mental illness often have a hard time socializing with others due to the stigma and isolation that surrounds mental illness. Laing House, in Halifax, Nova Scotia, provides a safe, supportive, fun environment for members to meet friends, make connections, and bridge the gap between social isolation and re-entering the greater world. It also provides opportunity for members to go into the community to educate the public about mental illness.

Laing House is an organization for youth, ages 16 to 30 years, who have a diagnosis of a mood disorder, anxiety disorder and/or psychosis. The organization is youth-driven, community-based and strives to help youth living with mental illness to rebuild their lives. Through a program called Youth Speak, participants go into junior high, high school and university classrooms to share success stories of living with mental illness, as well as to create awareness of mental illness and available community resources and treatments. The aim is to connect on a peer-to-peer level to reduce the stigma and discrimination surrounding mental illness.

Laing House is a ray of hope where there are too few resources for teens—the age when mental illness usually appears. It is an opportunity for support and friendship. It is an opportunity to try new things, get involved, and practice life skills. It is the first big step towards getting life back on track.
Emerging Best Practice

Effective anti-stigma and discrimination strategies have these characteristics:

- Engage families affected by mental illness in all stages of design, delivery and evaluation, including the person living with mental illness and extended family
- Focus on the rights and entitlements of people with mental illness
- Use repeated, direct contact with individuals and families with mental illness to challenge widely held prejudices
- Target behavior change, not just attitudes
- Develop a multi-level, multi-faceted approach with actions that can be customized over time
- Partner with local groups and organizations to ensure approaches and messages are shaped by the unique cultural needs of the community and specific target groups
- Leverage local efforts by aligning with provincial and national anti-stigma and discrimination campaigns

Service Systems

“It shouldn’t be on families’ backs to change the culture. It’s up to the systems that work with families.”

(FORCE stakeholder)

Effective service systems tackle stigma and discrimination by creating culturally safe services and by providing comprehensive workforce development.

The concept of cultural safety was first articulated in New Zealand nursing practice as an approach to providing health care to Maori people (Ramsden, 2002). It has evolved as Aboriginal people around the world have used it to define new approaches to health and healing. Cultural safety is now part of professional practice to improve service provision for diverse groups and communities.

Cultural safety argues that to provide quality care for people from different cultures, professionals must provide that care within the cultural values and norms of the client. Cultural safety does not require professionals to become knowledgeable about other cultures, but rather to understand and respect that cultures have different ways of seeing and doing things. It means being up front about their own cultural identity and be willing to talk about it with the client. The onus is on the professional to create a relationship based on genuine respect, trust and sharing.

The main difference between cultural safety and concepts of cultural sensitivity or competence is the issue of power. Cultural safety transforms the relationship between professional and client by privileging the voice of the client. It puts the power to define the quality of care squarely in the hands of the client. In a culturally safe exchange, the client makes decisions regarding their care in accordance with their individual, ethnic and cultural norms, as well as their aspirations for the future. The client, not the professional, determines if the exchange has been culturally safe.

A culturally safe approach to service delivery depends on the knowledge, confidence and capacity of both the professional and client. As a result, cultural safety can be viewed as a form of mutual empowerment, where both parties take an equal role through collaborative decision making and joint effort.

Comprehensive workforce development builds the capacity to provide services that are not only evidence-informed, but also value diversity and are free from discrimination. By directly involving people with mental health challenges and their families as educational resources, service providers are encouraged to examine and address their own attitudes and behaviours towards people experiencing mental health challenges.

We need to ensure that service systems provide access to a range of high quality, community-based services and supports, and professionals who are respectful and welcoming. For medical practitioners and allied professionals alike, we need to make sure they have the knowledge, skills and tools to deal effectively with people with mental health challenges, and not resort to inappropriate measures.
Emerging Best Practice
Five Principles of Cultural Safety:

- Protocols – respect for cultural forms of engagement
- Personal Knowledge – understanding one’s own cultural identity and sharing information about oneself to create a sense of equity and trust
- Process – engaging in mutual learning, checking on cultural safety of the service recipient
- Positive Purpose – ensuring the process yields the right outcome for the recipient according to that person’s values, preferences and lifestyle
- Partnerships – promoting collaborative practice


What Does Success Look Like?
Comprehensive workforce development includes these key elements:

**General**

- Curricula and learning resources that incorporate new knowledge and evidence, including science, practice, cultural knowledge and lived experience
- Inter-professional education at the post-secondary level
- Competency-based professional accreditation or certification
- Continuing education for service providers to increase their skill set and competencies
- Recruitment and retention of people from multiple disciplines and sectors

**Specific**

- Training for policy makers and service providers in concept and practice of:
  - cultural safety
  - multigenerational family resilience
- Knowledge and skills to provide holistic, relationship-focused care

- Recruitment and retention of people with lived experience of mental illness and involvement with service systems
- Peer mentoring
- Job supervision and supports
- Safeguards to prevent burn-out
- Performance evaluations and incentives
- Succession planning
Media

“Real life is way more complicated.”

(FORCE youth stakeholder)

The media has an important role in determining public attitudes to mental illness and is an essential player in any movement for change. Myths and misconceptions about mental illness abound and are often reinforced by stereotypical and destructive media images. In general, media portrayals of mental illness and people living with mental illness are not accurate. The media often misrepresent the chronic, relapsing nature of mental illness and dumb down the complexity of relationships with family and friends. The role of medication in successfully managing mental illness is generally under-reported. Popular culture tends to depict mental illness as uniformly negative with individuals ending up dead through suicide or the “necessary” use of force, in jail, or homeless and cut off from society.

The media rarely reports on the positive aspects of mental illness or the skills and abilities acquired in learning how to live with mental illness. There is little mention that the majority of people with mental health challenges live ordinary, productive lives. The media doesn’t talk about the gifts of heightened receptivity and creativity that result from some types of mental illness.

Or that, regardless of severity, mental illness provides a unique view of the world that can spark new ways of living, learning and solving problems. The media often pays little attention to the insights and compassion that flow from a mentally ill person’s experience of being different, their ability to be persuasive advocates for change, or the strength of character that comes from persevering each day in the face of pain and setbacks.

Emerging Best Practice

In Australia, the federal government’s comprehensive Mindframe National Media Initiative aims to influence media representation of issues related to mental illness and suicide by encouraging responsible, accurate and sensitive portrayals. Mindframe provides resources and education opportunities for:

- media professionals
- journalism students
- film, TV and theatre sector
- police and judiciary
- mental health and suicide prevention sector

Mindframe also supports SANE Australia’s Media Centre and StigmaWatch program, media monitoring studies, as well as projects to help build the evidence base for this work.

Source:
http://www.mindframe-media.info
Human Rights

“The sad reality for most people with mental illness is that living in the community does not mean being part of the community.”

(FORCE stakeholder)

The stigma associated with mental illness often means that affected individuals are marginalized and ostracized from society. People with mental illness experience violations of basic human rights and freedoms, as well as denials of civil, political, economic and social rights by institutions, systems and communities. They tend to be discriminated against in areas of employment, education and housing. Consequently, many live in poverty and are unstably housed or at risk of homelessness. These negative consequences of stigma are magnified by increased feelings of hopelessness which impedes their ability to gain access to appropriate care, integrate into society and recover from their illness.

Human rights protection for people with mental illness is at the core of efforts to reduce stigma and discrimination. Three key areas of government focus are: ensuring legislation and institutional policies and practices respect, protect and fulfill human rights conditions; and training key stakeholders on the rights of people with mental illness. A rights-based approach to mental health acknowledges the importance of lived experiences and voices of affected people and their families. It consists of actions aimed at changing the major legal, structural and attitudinal barriers to health for people experiencing mental illness.
“The positive mental health of families is about more than access to mental health care services”

(FORCE stakeholder)
Appendices
Appendix #1: Policy and Planning Context

Families Matter is well aligned with mental health policies at the provincial, national and international level. In a nutshell, this framework is an opportunity to test-drive an upstream approach to mental health with a family lens. It affords us the chance to apply mental health promotion to children, youth and adults living with a wide range of mental health challenges, who are coping in the face of entrenched stigma and discrimination, and who are sophisticated consumers of mental health care.

More importantly, Families Matter is a conscious effort to shift our thinking from what is best for the individual with a mental health challenge, to what is best for that person and the natural or chosen family that loves and cares for them, each step of the way. It is also a call for shared action and accountability. The mental health of children, youth and families is not, and cannot be, the responsibility of one sector or jurisdiction. We all have a role to play.

**British Columbia**

Over the past 15 years, mental health and substance use services for children and adults have generally been delivered in silos. Inclusive, cross-system collaboration has been the exception, more than the norm. Families, in particular, have been a neglected resource for healing and recovery. The Province of BC has started to reverse this trend with Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in BC (2010), which establishes a long-term vision for collaborative and integrated action on mental health and substance use.

Healthy Minds champions the importance of promoting and sustaining good mental health and addressing problematic substance use. It outlines population-centred priorities to meet the mental health and substance use needs of all British Columbians, as well as those with the most severe challenges.

The plan places a strong emphasis on children and families, recognizing the inter-generational importance of preventing problems, delaying their onset and reducing their impact. In so doing, Healthy Minds builds on the lessons learned from the successful implementation of the Child and Youth Mental Health Plan for BC (2003), which broadened the continuum of services to include mental health promotion, prevention and risk reduction, as well as evidence-based interventions to support children and youth with serious mental disorders.

**Canada**

The Mental Health Commission of Canada has released two strategic policy documents, *Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada (2009)* and *Evergreen: A Child and Youth Mental Health Framework for Canada (2010)*. In particular, 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 and supported in their journeys toward recovery. Evergreen has provided the national policy context for Families Matter.
Appendix #2: Stakeholder Engagement

Key stakeholder input was obtained using an adapted version of Appreciative Inquiry (AI). This approach was chosen in order to tap into the collective wisdom of those with lived experience and those working in the mental health system within a relatively short timeframe.

With the adapted AI approach, we were able to engage people who both deliver and benefit from mental health services and supports across the continuum of mental health promotion, prevention, harm reduction, early intervention, specialist treatment and supported recovery. At each AI event, we met with people experiencing mental health challenges, family members, advocates, community and institutional service providers, and policy makers and engaged in a hands-on visioning session.

As noted below, the full AI approach has five phases. Our engagement process took us through the first three AI phases: initiate, inquire and imagine. The development and validation of this framework will take us through the ‘innovate’ and ‘implement’ phases and complete the AI approach.

Appreciative Inquiry
Appreciative approaches to change are strengths-based philosophies that focus on what goes well in organizations, teams, and communities. These approaches are positive, have a future orientation and emphasize what people want, not what they want to avoid.

One popular approach is Appreciative Inquiry. There are five iterative phases in Appreciative Inquiry, known collectively as the 5-Is: Initiate, Inquire, Imagine, Innovate and Implement.

Appreciative Inquiry acknowledges that difficulties exist in human relationships without getting stuck in those difficulties. These are heard, reframed and discussed in terms of what the parties to the conversation want to accomplish. Appreciative Inquiry emphasizes the strengths in a community, not weaknesses; it emphasizes a community’s opportunities, not the threats facing it.

An appreciative valuing of communities and the people that live in them does not ignore negatives and weaknesses. It does, however, place an emphasis on focusing our attention on what we want more of and how we will get it. Appreciative Inquiry explicitly acknowledges the importance of people in the accomplishment of organizational and community outcomes and it infers a need to invest in people.
Appendix #3: Flourishing with Mental Health Challenges

The proposed actions address modifiable risk and protective factors across the life course and are organized by developmental stage (e.g. when an action is appropriate or needed for healthy child, youth and family development) and by setting (e.g. where an action is delivered, recognizing that most actions are best delivered across multiple settings). For each developmental stage, the proposed actions are accompanied by a brief summary of the evidence base and a best practice example.

Within each developmental stage, the actions will need to be tailored to meet the specific needs of:

- Children and youth with a mental illness
- Parents and siblings of children with a mental illness
- Parents with a mental illness
- Children of parents with a mental illness
- Whole families

The actions will also need to be designed and delivered in ways that are culturally respectful, competent and safe for families from diverse cultural communities. Regardless of age or diagnosis, the following factors are essential to maintaining individual and family mental health. Families Matter acknowledges that action on these key determinants of mental health is best undertaken by decision makers and stakeholders who are positioned to lead broad, multi-sectoral change at the community and population level. For the purposes of this report, we are assuming that work is ongoing to address these determinants:

- Adequate nutrition, sleep and regular exercise
- Adequate, affordable and secure housing
- Adequate income or income support
- Acceptance by family, friends, peers, co-workers, neighbours and community members
- Freedom from discrimination and violence
- Human rights protection and access to full legal entitlements
Perinatal Period

Focus is on needs of mother and baby from conception to first year after birth

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support for mother from caring adult</td>
<td>• Information for people with mental illness who plan to become parents or who are pregnant</td>
<td>• Information for people with mental illness who plan to become parents or who are pregnant</td>
<td>-</td>
<td>• Regular perinatal care, including outreach to pregnant teenagers who are not attending school</td>
<td>-</td>
</tr>
<tr>
<td>• Support for abstinence during pregnancy for mother and partner</td>
<td>• Nurse-led, in-home parent education and support for first time parents</td>
<td>• Regular perinatal care, including outreach to pregnant teenagers who are not attending school</td>
<td>-</td>
<td>• Vaccinations</td>
<td>-</td>
</tr>
<tr>
<td>• Self-management tools and resources</td>
<td>• Information for people with mental illness who plan to become parents or who are pregnant</td>
<td></td>
<td></td>
<td>• Timely mental health assessments and follow-up for mothers with mental illness</td>
<td>-</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management for mothers with mental illness</td>
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</tbody>
</table>
Infancy & Early Childhood (0 – 4 years)

Focus is on needs of the mother and young child

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support for positive attachment and early bonding</td>
<td>• Access to quality, licensed childcare (e.g. childcare subsidies, staff trained in working with parents with mental illness)</td>
<td>• Support for regular attendance at preschool</td>
<td>–</td>
<td>• Regular contact with primary care services for physical health, mental health and substance use (e.g. mother and child)</td>
<td>• Support for family reunification</td>
</tr>
<tr>
<td>• Support for early cognitive stimulation</td>
<td></td>
<td></td>
<td></td>
<td>• Immunizations</td>
<td></td>
</tr>
<tr>
<td>• Presence of alternative, caring adult to respond to child’s health, safety and developmental needs for mothers with mental illness</td>
<td></td>
<td></td>
<td></td>
<td>• Timely mental health assessments and follow-up for mothers with mental illness</td>
<td></td>
</tr>
<tr>
<td>• Nurse-led, in-home parent education and support for first time parents</td>
<td></td>
<td></td>
<td></td>
<td>• Medication management for mothers with mental illness</td>
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</tr>
</tbody>
</table>

Appendices — Appendix #3: Flourishing with Mental Health Challenges
Childhood (5 – 13 years)

Focus is on needs of the child with mental illness and the child of a parent with mental illness (COPMI)

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support for positive parent-child interactions</td>
<td>• Friend(s) for mutual support</td>
<td>• Support to stay connected to school</td>
<td>-</td>
<td>• Regular contact with primary care services for physical health, mental health and substance use (e.g. annual ‘neck up check-ups’)</td>
<td>• Support for family reunification</td>
</tr>
<tr>
<td>• Support for positive sibling interactions</td>
<td>• Mentor or trusted adult to discuss worries or sensitive issues</td>
<td>• Mental health-promoting schools (e.g. focus on student, teacher, class, whole school, school-family-community partnerships)</td>
<td></td>
<td>• Outreach to children not attending school (e.g. COPMI)</td>
<td></td>
</tr>
<tr>
<td>• Presence of alternative, caring adult to respond to child’s health, safety and developmental needs (e.g. for COPMI)</td>
<td>• Positive social networks outside the family</td>
<td>• Social and emotional competence curricula</td>
<td></td>
<td>• Timely mental health assessments and follow-up for children (e.g. COPMI and children with mental illness)</td>
<td></td>
</tr>
<tr>
<td>• Self-management tools and resources</td>
<td>• Peer support groups</td>
<td>• Cognitive behavioural therapy and Dialectical behavioural therapy curricula</td>
<td></td>
<td>• Referral to early interventions programs</td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills to separate from stressful situations physically and psychologically</td>
<td>• Inclusive and accommodating community facilities and programs</td>
<td>• Stress management techniques</td>
<td></td>
<td>• Being taught different ways of coping and knowing what to do if parent is incapacitated (e.g. for COPMI)</td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills to understand parent’s substance use in terms of illness</td>
<td>• Participation in organized community activities – sports, active recreation, arts, culture, heritage, spirituality</td>
<td>• Anti bullying programs, including cyber bullying</td>
<td></td>
<td>• Information on how to contact professionals if parent in crisis (e.g. for COPMI)</td>
<td></td>
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<tr>
<td></td>
<td>• Opportunities to engage with natural environment</td>
<td>• Age appropriate, factual information about mental illness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Suicide prevention and postvention</td>
<td>• Age appropriate, factual information about substance use</td>
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<td></td>
<td></td>
<td>• Age appropriate, factual information about sexuality, safe sex, contraception</td>
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</table>
## Adolescence & Young Adulthood (14 – 24 years)

Focus is on needs of the youth with mental illness and the youth of a parent with mental illness

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support for positive parent-child interactions</td>
<td>• Friend(s) for mutual support</td>
<td>• Support to stay connected to school</td>
<td>• Support for transition to working</td>
<td>• Regular contact with primary care services for physical health, mental health and substance use (e.g. annual ‘neck up check-ups’)</td>
<td>• Support for family reunification</td>
</tr>
<tr>
<td>• Presence of alternative, caring adult to respond to youth’s health, safety and developmental needs (e.g. for COPMI)</td>
<td>• Mentor or trusted adult to discuss worries or sensitive issues</td>
<td>• Mental health-promoting schools (e.g. focus on student, teacher, class, whole school, school-family-community partnerships)</td>
<td>• Meaningful employment, including supportive employment</td>
<td>• Outreach for youth who have dropped out of school</td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills for basic living, problem solving and conflict management</td>
<td>• Positive social networks outside the family</td>
<td>• Social and emotional competence curricula</td>
<td>• Mental health-promoting workplaces (e.g. self assessments, coping skills training, employee assistance, reasonable adaptation policies, organizational culture shifts)</td>
<td>• Timely mental health assessments and follow-up for youth</td>
<td></td>
</tr>
<tr>
<td>• Practical help with daily living</td>
<td>• Peer support groups</td>
<td>• Cognitive behavioural therapy and Dialectical behavioural therapy-based curricula</td>
<td>• System navigation support</td>
<td>• Referral to early interventions programs</td>
<td></td>
</tr>
<tr>
<td>• Self-management tools and resources</td>
<td>• Inclusive and accommodating community facilities and programs</td>
<td>• Stress management techniques</td>
<td>• Medication adherence support and relapse prevention</td>
<td>• Medication adherence support and relapse prevention</td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills to separate from stressful situations physically and psychologically</td>
<td>• Participation in organized community activities - sports, active recreation, arts, culture, heritage, spirituality</td>
<td>• Anti bullying programs, including cyber bullying</td>
<td>• Being taught different ways of coping and knowing what to do if parent is incapacitated (e.g. for COPMI)</td>
<td>• Being taught different ways of coping and knowing what to do if parent is incapacitated (e.g. for COPMI)</td>
<td></td>
</tr>
<tr>
<td>• Knowledge &amp; skills to understand parent’s substance use in terms of illness</td>
<td>• Opportunities to engage with natural environment</td>
<td>• Factual information about mental illness</td>
<td>• Information on how to contact professionals if parent in crisis (e.g. for COPMI)</td>
<td>• Information on how to contact professionals if parent in crisis (e.g. for COPMI)</td>
<td></td>
</tr>
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<td></td>
<td>• Involvement in community decision making, social justice activities, voting</td>
<td>• Factual information about substance use</td>
<td>• Acknowledgement and support from professionals for care-giving role (e.g. for COPMI)</td>
<td>• Acknowledgement and support from professionals for care-giving role (e.g. for COPMI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Opportunities to develop employability skills</td>
<td>• Factual information about sexuality, safe sex, contraception, sexually transmitted infections management</td>
<td>• Support for transition from youth systems of care to independent adulthood or adult systems</td>
<td>• Support for transition from youth systems of care to independent adulthood or adult systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Suicide prevention and postvention</td>
<td>• Support for abstinence in young adolescents (e.g. substance use and sex)</td>
<td>• Advance care plans (e.g. Ulysses Agreements)</td>
<td>• Advance care plans (e.g. Ulysses Agreements)</td>
<td></td>
</tr>
</tbody>
</table>

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Appendices — Appendix #3: Flourishing with Mental Health Challenges
Adulthood (25 – 64 years)

Focus is on needs of adult with mental illness, adult parents with mental illness, and parents of children with mental illness

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Extended family involvement in addressing parenting needs (e.g. of parents with mental illness, of parents with kids with mental illness)</td>
<td>• Friend(s) for mutual support</td>
<td>• Factual information about mental illness</td>
<td>• Meaningful employment, including supportive employment</td>
<td>• Regular contact with primary care services for physical health, mental health and substance use (e.g. annual ‘neck up check-ups’)</td>
<td>• Support for family reunification</td>
</tr>
<tr>
<td>• Parenting education with self help materials and multi-level family interventions</td>
<td>• Positive social networks outside the family</td>
<td>• Factual information about substance use</td>
<td>• Mental health-promoting workplaces (e.g. self assessments, coping skills training, employee assistance, reasonable adaptation policies, organizational culture shifts)</td>
<td>• Timely mental health assessments and follow-up</td>
<td>• Transition support between civil and forensic mental health systems</td>
</tr>
<tr>
<td>• Respite opportunities for parents and foster parents (e.g. for parents of kids with mental illness)</td>
<td>• Inclusive and accommodating community facilities and programs</td>
<td>• Factual information about sexuality, safe sex, contraception, sexually transmitted infections management</td>
<td>• System navigation support</td>
<td>• Medication adherence support and relapse prevention</td>
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</tr>
<tr>
<td>• Self-management tools and resources</td>
<td>• Participation in organized community activities - sports, active recreation, arts, culture, heritage, spirituality</td>
<td></td>
<td>• Information on how to contact professionals if child in crisis</td>
<td>• Mental health assessments for foster parents as part of screening and ongoing evaluation</td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills to separate from stressful situations physically and psychologically</td>
<td>• Involvement in community decision making, social justice activities, voting</td>
<td></td>
<td>• Acknowledgement and support from professionals for caregiving role</td>
<td></td>
<td>• Support for family reunification</td>
</tr>
<tr>
<td>• Knowledge and skills for basic living, problem solving and conflict management</td>
<td>• Parenting support groups</td>
<td>• Transition from work to retirement</td>
<td></td>
<td>• Advance care plans (e.g. Ulysses Agreements)</td>
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</tbody>
</table>
Senior Years (65+)

Focus is on needs of older adult with mental illness, older parent of adult child with mental illness, grandparent of child with mental illness

<table>
<thead>
<tr>
<th>Home &amp; Family</th>
<th>Community</th>
<th>School</th>
<th>Workplace</th>
<th>Health Care Setting</th>
<th>Legal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Extended family involvement in caregiving</td>
<td>• Friend(s) for mutual support</td>
<td>• School partnerships with grandparents actively involved in caring for children (e.g. kids with mental illness, kids of parents with mental illness)</td>
<td>• Post retirement support</td>
<td>• Regular contact with primary care services for physical health, mental health and substance use (e.g. annual ‘neck up check-ups’)</td>
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</tr>
<tr>
<td>• Respite opportunities (e.g. for aging parents of adult child with mental illness)</td>
<td>• Positive social networks outside the family</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Knowledge and skills for basic living, problem solving and conflict management</td>
<td>• Inclusive and accommodating community facilities and programs</td>
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<tr>
<td>• Understand difference between aging and change in mental illness (e.g. for senior with mental illness)</td>
<td>• Participation in organized community activities - sports, active recreation, arts, culture, heritage, spirituality</td>
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</tr>
<tr>
<td>• Self-management tools and resources</td>
<td>• Involvement in community decision making, social justice activities, voting</td>
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</tr>
<tr>
<td>• Knowledge and skills to separate from stressful situations physically and psychologically</td>
<td>• Parenting support groups (e.g. for those with adult child with mental illness)</td>
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<tr>
<td></td>
<td>• Stress management</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Suicide prevention and postvention</td>
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</table>
Appendix #4: Parental Mental Health and Child Welfare

Key Practice Recommendations
Source: Think child, think parent, think family: a guide to parental mental health and child welfare (United Kingdom Social Care Institute for Excellence, 2011)

1. Signposting and improving access to services
   Organizations should develop a multi-agency communications strategy to tackle the stigma and fears that parents and children have about approaching and receiving services. This should be a priority to enable families to get the support they need as soon as possible and should focus on promoting good mental health and well-being for all family members.

2. Screening
   Ensure screening and referral systems and practice routinely and reliably identify and record information about which adults with mental health problems are parents, or live with children, and which children have parents with mental health problems. This means developing systems and tools in collaboration with parents and young people, to ensure the right questions are asked and the data is recorded for future use.

3. Assessment
   All organizations need to adapt existing assessment and recording processes to take account of the whole family and train staff in their use. This means developing and implementing ‘family’ threshold criteria for access to services to take into account the individual and combined needs of parents, carers and children. Strategies for the management of joint cases should be recorded where the situation is complex or there is a high risk of poor outcomes for children and parents.

4. Planning care
   Care planning needs to be flexible enough to meet the needs of each individual family member as well as the family as a whole, and staff should aim to increase resilience and reduce stressors. Allocating an individual budget could provide this flexibility. Increasing every family member’s understanding of a parent’s mental health problem can strengthen their ability to cope.

5. Providing care
   Commissioners and providers of care should ensure that they can meet the full spectrum of needs, including the practical priorities of parents with mental health problems and their children. This means developing non-traditional and creative ways of delivering services as a way of targeting families and improving access.

6. Reviewing care plans
   Reviews should consider changes in family circumstances over time, include both individual and family goals, and involve children and carers in the process.
7. **Strategic approach**

Multi-agency, senior-level commitment is required and we recommend that a ‘Think Family Strategy’ is developed to implement this guidance and that parents, children and carers are involved in all stages of development.

8. **Workforce development**

Investment is needed in training and staff development for adult and children’s frontline managers and practitioners to support the changes recommended in this guide about how to ‘think child, think parent, think family’ and work across service interfaces.

9. **Putting it into practice**

Combining the authority of senior managers and the dynamism of the voluntary sector and users is the most effective way of supporting staff seeking to put whole family approaches into practice. Embedding the messages into induction, training, supervision and performance management can help promote the work and, altering assessment and recording tools, can prompt people to ‘think family’.
References

NOTE: References to come
Your Opinions Matter

Your input is vital to the success of *Families Matter: A Framework for Family Mental Health in British Columbia*. We want to capitalize on the wealth of knowledge, experience and expertise of families living with mental health challenges.

The draft framework and discussion questions are posted online at [www.forcesociety.com](http://www.forcesociety.com). Please complete your answers by June 30th, 2012.

**Discussion Questions**

1. Will a whole family approach to mental health promotion, prevention and early intervention work in BC?

2. What steps need to be taken to ensure this approach is successful?

3. Does our vision adequately describe a world that embraces family mental health? What is missing?

4. Do we have the right values and concepts to inform our responses to family mental health along the continuum from wellness to illness? What is missing?

5. Do we have the right action guidelines to ensure comprehensive action? What is missing?

6. For each focus area, and within each setting, what specific actions can we take right now that build on promising practices and/or use existing relationships, resources and expertise?

7. Are there other focus areas and settings where we should be concentrating our efforts?

8. How will we know if we are successful? What results should we be seeking for individuals, their families, communities and public systems?

THANK YOU