

# Mental Health Commission of Canada

Development of a Mental Health Strategy for Canada – Phase II

## Roundtable Meeting on Family Involvement & Support

April 15-16, 2010, Ottawa



## Roundtable Highlights Report

Prepared May 12, 2010 by



**1. Participant Profile:** A total of 23 participants attended the roundtable, representing all regions except the Territories. 'Baby boomers', those aged 45-64, made up the largest age group at 72%. Only 5% of participants were over 75 and there were no representatives in the under 25 age category. When asked about their primary perspective, 40% of the room indicated health or social service professionals, and another 40% indicated family members/friends. When asked about their secondary perspective, families/friends scored the highest at 29%, with another one-fifth choosing health or social service professionals and one-quarter indicating other.

### 2. Key Issues

**Summary of participants' recommended actions and approaches in response to the key issues discussed:**

- 1. Families are to blame:** There was a general view that this is no longer the burning issue that it once was, and as a result garnered little focused attention.
- 2. Stigma:** mandatory mental health curriculum in all jurisdictions' education systems and in health and social service professional education and training curricula; anti-stigma campaigns using mass media; mental health services available at the primary level (e.g. walk-in clinics; GPs); psychotherapy and psychologists' services available in schools.
- 3. Privacy Rights:** Plenary discussion probed this issue as it was not addressed in Tables' key points presented. The general view was that privacy rights is indeed a significant issue which requires attention – they also felt that the background paper had framed the issue well and as a result participants did not have a lot to add.
- 4. Family Members' Voices:** need for front line workers and mental health professionals to be adequately trained on how to actively include families; treat families as partners in providing care for loved ones; engage families early.
- 5. Defining Family:** Diversity of family types (e.g. non-traditional nuclear, blended, extended, evolving – non-static), cultures and situations needs to be addressed; flexibility required to adapt to different contexts; families do not necessarily equate to caregivers.
- 6. Lack of Support:** fragmentation / lack of coordination in the mental health system exacerbated by inadequate or lack of funding for programs and supports; rectify power imbalances and engage families and persons with lived experience as co-experts; support for families regardless of whether or not they are caregivers; need to address needs of non-ill family members; create families and circles of support for those who lack them.
- 7. Downloading of responsibilities:** Switch from talking about family involvement in the current paradigm to implementing the new recovery paradigm; repositioning families as real partners in care will require significant system change.

- 8. Additional Issues:** Implement the recovery model; develop innovative, ongoing, consistent and relevant training for health care practitioners and professionals to reduce stigma and encourage collaborative care; increase accountability in the system (e.g. through integrated family assessments, caregiver rights legislation); recognize that the recovery model “is the biggest paradigm shift we’ve ever had”; include concurrent issues (i.e. addictions and mental health) .

Results of keypad voting showed high levels of support for the key issues identified in the background paper, particularly ‘difficulty in getting the voices of family members heard in the mental health system,’ the ‘lack of support for families in navigating the mental health system,’ and ‘downloading of responsibilities onto families due to shortages of services and supports,’ all of which were seen to be ‘important’ or ‘very important’ by almost all participants [95%] (Figures 1.4, 1.6, 1.7). The only issue that did not garner strong support was ‘the generalization that families are to blame for mental health problems and illnesses’ - only 58% of participants felt that it was ‘important’ or ‘very important’ (Figure 1.1).

The post vote on key issues (after table and plenary discussion) resulted in an increased number of those who ‘agreed’ or ‘agreed strongly’ that the issues identified captured what needs to be addressed to develop a strategic plan for family involvement and support, going from 81% to 89% (Figure 1.8)

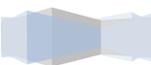
### 3. Strategic Directions

#### Summary of participants’ recommended actions and approaches:

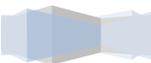
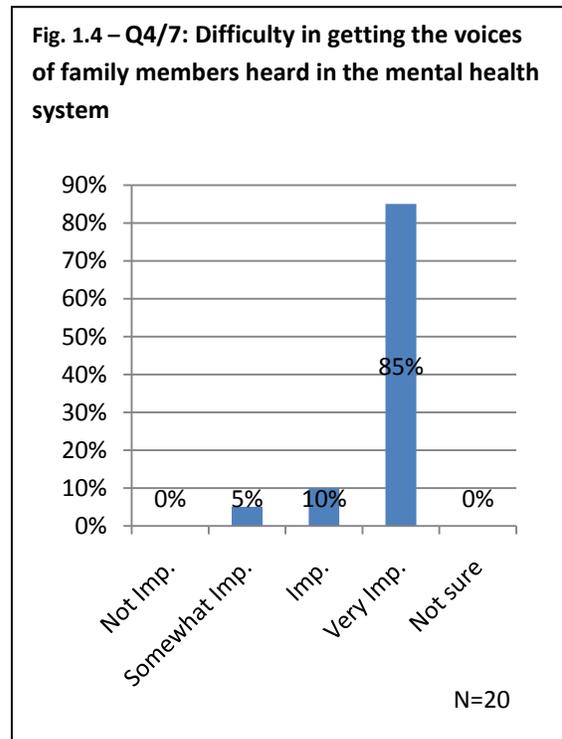
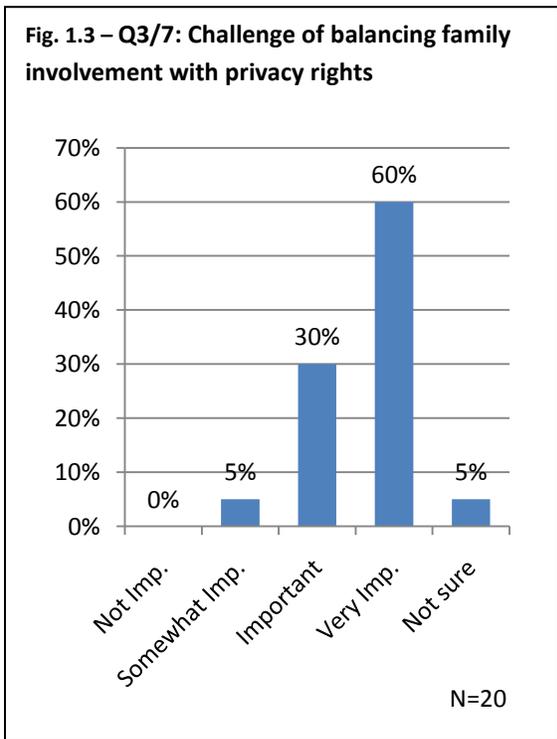
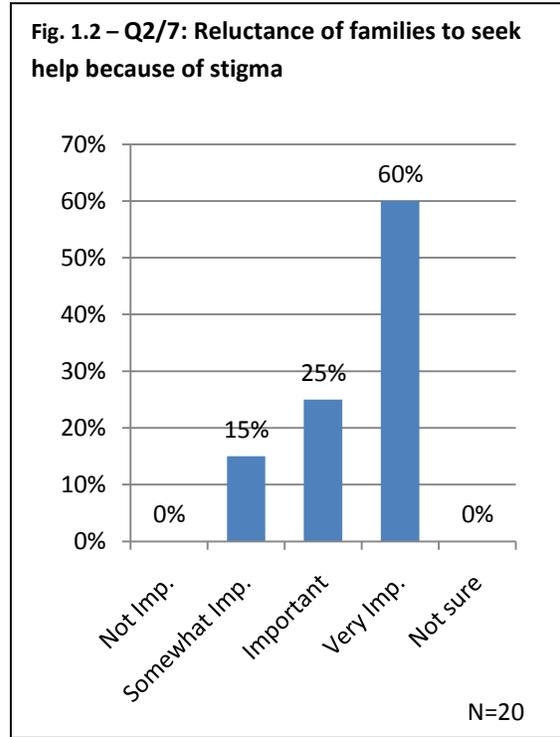
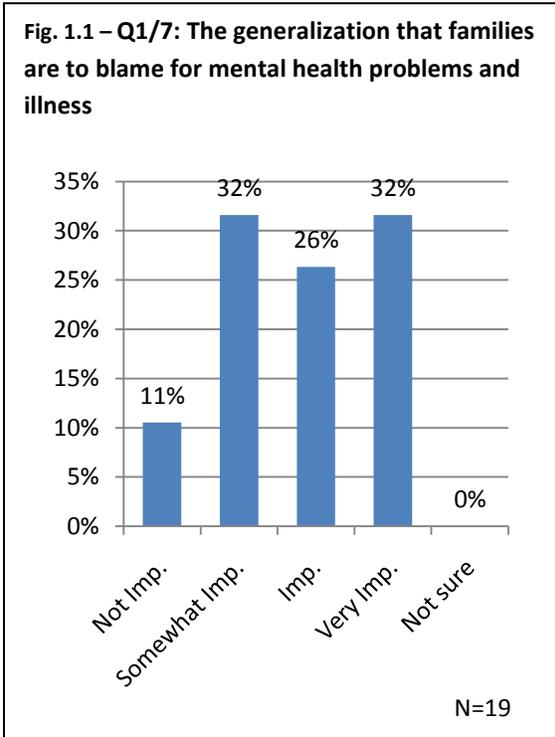
- 1. Promote mental health and wellness within families:** focus on the Biopsychosocial model; engage doctors as allies with families in providing consumer care; take risks to fund innovative services; account for urban/rural differences; and need for education and clarification on psychiatric advance directives (PADs)
- 2. Facilitate family inclusion:** relationships and connections are key to inclusion; navigator function should be embedded in the whole system; shared care approach needed; use a physical and mental development check list (values, body, mind and spirit); and addressing funding shortfall is critical; common consent form used by all hospitals.
- 3. Strengthen family:** adopt a recovery model for families, including family education for the whole family; recovery-based training for professionals/law enforcement agencies/communities; provide family advocates within recovery programs; improved mental health literacy at community level will lessen family stress; and define family centred care.

Voting on the strategic directions revealed high levels of satisfaction on articulation of strategic directions, with 91% of participants ‘agreeing’ or ‘strongly agreeing’ that they capture what needs to be addressed to develop a strategic plan for family involvement and support (Figure 2.1).

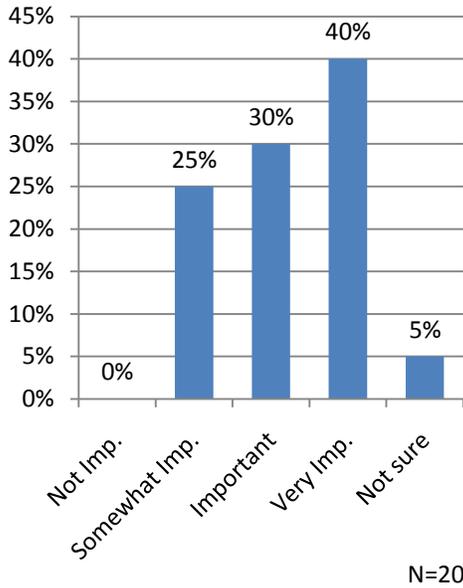
**4. Priority Actions:** Each participant had an opportunity to put forth a concrete action to advance a strategic plan for family involvement and support. Many actions centred on mental health education (for youth, general population and professionals); family inclusion and empowerment (family advisory committees; embedding family involvement from the start of treatment); family supports (e.g. navigators, education for families, standards for family inclusion, support groups), while others focused on high-level leadership (appointing provincial independent commissioners of mental health, developing national statement and campaign on recovery), changing terminology around mental health, and building on the body of existing good practices.



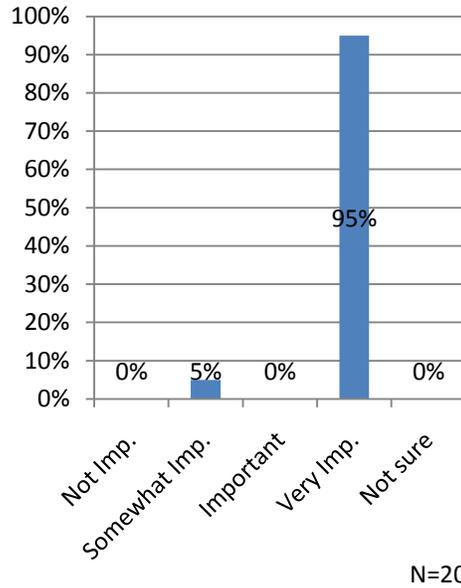
**5. Participant Evaluations:** The evaluations were very positive. Participants valued the opportunity to participate, found the facilitation to be effective, and felt that the agenda and discussion time were adequate. Some participants felt that there should have been more diversity in the room.



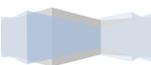
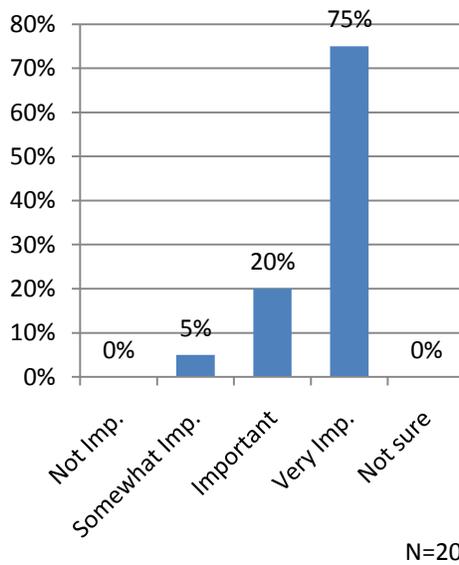
**Fig. 1.5 - Q5/7: Multiple views regarding who constitutes 'family'**



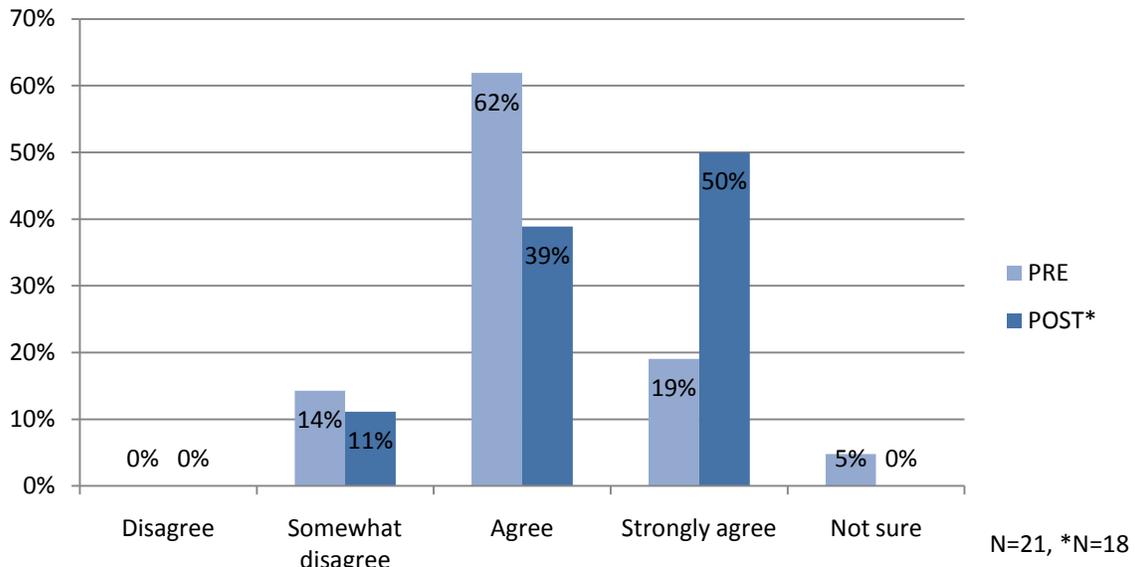
**Fig. 1.6 - Q6/7: Lack of support for families in navigating the mental health system**



**Fig. 1.7 - Q7/7: Downloading of responsibilities onto families due to shortages of services and supports**



**Fig. 1.8 - COMPARISON Overall, the issues identified capture what needs to be addressed to develop a strategic plan for mental health promotion and mental illness in Canada.**



**Fig. 2.1 - Overall, the strategic directions identified, including those identified by roundtable participants, capture what needs to be addressed to develop a strategic plan for family involvement and support**

