

**FAMILY-CENTRED CARE FOR PARENTS PROVIDING CARE FOR INVOLUNTARY
ADULTS WITH A MENTAL HEALTH DIAGNOSIS: IMPLICATIONS FOR SERVICE
PROVIDERS**

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DEDICATION

I dedicate this project to all the parents who show unwavering resilience in caring for their children, especially in moments of adversity. To my parents, thank you for your unconditional love, sacrifice, and support. I would not be here without you.

ABSTRACT

Caregivers who provide care for an involuntary adult with a mental health diagnosis often experience significant emotional and psychological distress. Limited recognition from healthcare providers frequently leads to the marginalization of parents and families, raising concerns about their overlooked experiences in the healthcare system. Despite growing awareness of the importance of family involvement in involuntary adult mental health, there has been little effort in healthcare systems to integrate the support of families due to complex systemic barriers, with confidentiality being a primary concern. There is limited research for Canadian service providers on how to make their practice more inclusive for clients and families without breaching confidentiality. To address this gap, a comprehensive review of the research and literature on this topic was conducted, resulting in ethically informed recommendations for service providers. The final contribution of this project includes a draft manuscript discussing these recommendations to inform service providers of parents' perspectives and to offer insight into how families can be supported in the treatment of involuntary adults without breaching confidentiality.

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CHAPTER 1: INTRODUCTION

This project intends to address the ethical, clinical, and systematic implications associated with supporting parents of an involuntary client with a mental health diagnosis. While there is increased awareness of this issue in the media, not enough research exists on the topic, particularly in a Canadian context. Therefore, the focus of this project is to fill this gap, analyze what little literature is available, and provide practical implications for service providers in Canada. This chapter will introduce and discuss the issue alongside an overview of the problem. Additionally, the foundation for the topic and objective of this project will be provided. And lastly, a draft manuscript identifying key implications of family-centred care for the practical use of service providers will be attached as the practical component of the completed project.

1.1 INTRODUCTION TO THE ISSUE

For the purpose of clarity, *involuntary* refers to a client's denial or reluctance towards receiving psychological treatment or hospital admission. When clients are involuntary, family involvement becomes crucial, as families provide unique insight into the client's struggles and mental health conditions and encourage the continuation of care. Involuntary clients with a mental health diagnosis may have impaired decision-making capabilities and reject care, even when it would benefit them, due to limited insight into their need for treatment (Szmukler & Bloch, 2018). Family involvement is beneficial to both clients and service providers and plays a vital role in adult mental health treatment (Cameron et al., 2024; Lohrasbi et al., 2023). In particular, families can contribute by assisting with treatment compliance, promoting hopefulness, and helping manage daily tasks for clients (Cameron et al., 2024). However, despite these benefits, there has been little effort to integrate the support of families due to the complexities surrounding their involvement (Cameron et al., 2024; Kokorelias et al., 2023).

1.2 OVERVIEW OF THE PROBLEM

A primary barrier to involving parents in the context of involuntary treatment is the risk of compromising the client's confidentiality (Cameron et al., 2024; Kokorelias et al., 2023). Confidentiality is a core ethical principle in psychology and is fostered by respect for autonomy, interest in client security, and encouraging open dialogue and collaboration (Szmukler & Bloch, 2018). In the Canadian Code of Ethics for Psychologists (CPA), confidentiality generally falls under Principle I: Respect for the Dignity of Persons and People, which states that all communication between clients over 18 and their service providers must remain confidential (CPA, 2017). The only exception to this ethical commitment is found in considering the limits to confidentiality and/or if the client provides consent allowing for disclosure (CPA, 2017). As a result, service providers find themselves in an ethical dilemma between upholding their ethical responsibility of confidentiality and seeking the best interest of the client and family (Kokorelias et al., 2023).

The dilemma is particularly complex for service providers involved in involuntary treatment, as clients often have differing needs and may express concerns about involving their families (Hansson et al., 2022a). Service providers often encounter clients refusing to involve families and must comply, as breaching confidentiality can result in legal or disciplinary consequences (Hansson et al., 2022a). Although service providers recognize the meaningful contributions families can make to care, they are restricted by their duty of confidentiality (Hansson et al., 2022a). Furthermore, many service providers lack appropriate training in family involvement and are unaware of how to ethically resolve barriers to information sharing, which further complicates the situation (Hansson et al., 2022a). In a meta-analysis conducted by Kokorelias et al. (2023), the most prevalent ethical dilemmas found were client confidentiality, client autonomy, client's private boundaries, moral choices, and dual-role tensions of family members being both caregivers and sources of information. Matters become more complex with clients

who are diagnosed with conditions like schizophrenia and bipolar disorder, which impair their ability to make informed decisions (Szmukler & Bloch, 2018). Parents have expressed that their lack of involvement in treatment has contributed to treatment dropout, high relapse rates, hallucinations, social withdrawal, and emotional dysregulation (Raymond et al., 2017; Szmukler & Bloch, 2018).

1.3 PURPOSE OF THE PROJECT

Although parents and families understand and respect the general measures around confidentiality, they feel that working with involuntary clients requires greater competence and specialized care (Wyder et al., 2018). Due to limited recognition from healthcare providers, parents and families often experience marginalization when navigating health systems for their adult children's care (Jankovic et al., 2011; Wyder et al., 2018). This is a significant concern, as the experiences and mental health of parents are often overlooked within the system. Lohrasbi et al. (2023) highlighted that parents assume caregiving responsibilities from the onset of their child's diagnosis and throughout their life, often leading to caregiver burnout, difficulty coping, and exposure to social stigma. The societal stigma surrounding mental health further isolates families and worsens their mental well-being, underscoring the need for additional support (Lohrasbi et al., 2023).

Cameron et al. (2024) called for increased specialized competence in family-centred care to help raise awareness and confidence in this area of practice; thus, this project will address the gap in the literature and practices. The development of this project and production of the draft manuscript (see Appendix 1) will offer recommendations based on a comprehensive review of existing literature related to the topic and will draw on practical guidelines from related fields, such as psychiatric nursing and emergency medicine, allowing for interdisciplinary analysis.

1.4 CONTRIBUTION OF THIS PROJECT

Despite the concern about the mental toll the crises associated with involuntary treatment have on families, limited literature explores families' experiences in detail (Jankovic et al., 2011; Wyder et al., 2018). How parents and families are treated needs to be reevaluated, as parents report lacking empathy and feeling unheard by service providers (Lohrasbi et al., 2023). No previous study has focused on parents' experiences and recommendations for implementing family-centred care in a Canadian context. The proposed draft manuscript has the potential to address the gap in the literature, inform service providers of parents' perspectives, and provide recommendations for supporting families in the treatment of involuntary adults without breaching confidentiality. The intent is for this project to help increase awareness towards understanding the barriers that impact parents when accessing psycho-social support and exploring the perceived impact and mental health outcomes of parents. This project aims to serve as an educational resource and provide potential guidelines for service providers to refer to and improve their practice when working with families.

1.5 CHAPTER SUMMARY

The mental health of caregivers and family members of involuntary adults with a mental health diagnosis appears to be overlooked in research, resulting in limited information accessible to service providers working with families. Therefore, there is a need for systematic change that recognizes and supports families without breach of confidentiality (Jankovic et al., 2011; Hansson et al., 2022b; Lohrasbi et al., 2023). The final project aims to help fill the gap on the implications when supporting caregivers by thoroughly studying the literature on adult mental health, ethics, and family-centred care. Furthermore, a draft manuscript outlining key implications for service providers when working with families will come out of this project's findings from the literature. Chapter 2 will outline how the literature compiled in Chapter 3 was searched and obtained and provide an overview of the structure of this project and a statement of

ethical conduct. In Chapter 3, the current literature on this final project's topic will be explored. Chapter 4 of this project will deliver a list of practical recommendations and learning objectives, identify the strengths and limitations of this project, and suggest areas for future research. Lastly, Appendix 1, the applied portion of this project, contains a draft manuscript recognizing the mental health outcomes of caregivers and describing key recommendations about supporting caregivers of adults with a mental health diagnosis.

CHAPTER 2: METHODS

This chapter will outline how the articles, studies, and practices referenced were researched and obtained. The search terms and search engines used to search the literature for this final project will also be identified. This chapter also includes a statement of ethical conduct and specifies the structure of this project.

2.1 RESEARCH PROCESS

The development of the project encompassed a comprehensive review of existing literature related to counselling psychology and practical guidelines from related fields, such as psychiatric nursing and emergency medicine. Between October 2023 and November 2024, online academic databases were accessed to build the literature review that will inform the manuscript development as secondary research. The search was focused on peer-reviewed articles about the mental health outcomes of parents supporting involuntary adults, confidentiality as a barrier, and considerations relevant when working with families. Due to the lack of Canadian-based literature on this topic, the search included practice-based implications from other regions, such as Europe and Australia, which were then applied to the Canadian Psychological Association [CPA] Code of Ethics (2017) to evaluate their relevance and fit within Canadian ethical frameworks. This process involved comparing the ethical principles and recommendations found in the literature with the CPA Code, identifying areas of alignment, and considering how these insights could be meaningfully applied within the Canadian context. Overall, the following search terms were used in various combinations to acquire an overview of the available literature: involuntary adults, adult mental health, family-centred care, psychiatric nursing, involuntary hospital admission, barriers to family-centred care, ethical implications, confidentiality, client autonomy, the impact of adult mental health of families, and long-term caregiving. The focus was on retrieving literature published in approximately the last decade, 2014 to 2024, to explore emerging research

in this area. However, due to the limited research on this topic, articles published from the early and mid-2000s were also included. Google Scholar was used to search for peer-reviewed articles, and reference lists from retrieved articles were reviewed to identify and access additional relevant sources.

2.2 STATEMENT OF ETHICAL CONDUCT

This project did not involve human subjects; thus, an ethics application was not commanded. During the development of this project, the University of Lethbridge's Standards of Professional Conduct for MEd (Counselling Psychology) Students was adhered to. The writing format, structure, and style of this project followed the Publication Manual of the American Psychological Association 7th Edition (American Psychological Association, 2020) standards.

2.3 PROJECT STRUCTURE

The final project was composed of a thorough exploration and comprehensive compilation of relevant literature and research related to the impact and barriers in supporting adults with a mental health condition, practical considerations for service providers, and the need for change at a systematic level. The last section of this final project is a draft manuscript (see Appendix 1) from the first portion of this project to highlight the most salient findings from the literature for service providers to increase their awareness regarding the barriers parents experience and build their confidence when working with families. The contribution of this project to the field of counselling psychology is important given its focus on the mental health outcomes of caregivers (i.e., anxiety, depression, social withdrawal) and the application of the implications to the CPA (2017) Code of Ethics.

2.4 CHAPTER SUMMARY

This project aims to help address an identified gap in the literature about supporting families involved in the care of involuntary adults in line with the Canadian standards of ethical practice

for psychology (CPA, 2017). This project also emphasizes the need to continue research and build on the practical information available to service providers to reduce the marginalized experiences of caregivers.

CHAPTER 3: LITERATURE REVIEW ON FAMILY-CENTRED CARE FOR CAREGIVERS SUPPORTING AN INVOLUNTARY ADULT

Caregivers of involuntary adults with mental health diagnoses play a pivotal yet often unrecognized role in supporting their loved ones. Parents often experience unique challenges resulting in emotional distress, stigma, and barriers, leaving them feeling excluded from their adult child's care (Aass et al., 2020a; Dehbozorgi et al., 2022). These challenges often lead to symptoms of anxiety, depression, and loneliness (Clarke & Windsor, 2010). One of the primary barriers to family involvement is confidentiality, which often places service providers in an ethical dilemma between respecting clients' rights to autonomy and addressing the concerns of family members (Hansson et al., 2022a; Szmukler & Bloch, 2018). Despite these challenges, family involvement is vital for fostering treatment adherence and improving outcomes for involuntary clients (Ong et al., 2021). Consequently, there is a growing need for service providers to adopt interdisciplinary approaches that address both the needs of individuals with mental health diagnoses and the well-being of their family members.

This chapter provides an overview of the current literature on family-centred care in the context of adult mental health. It begins by discussing the principles of family-centred care and its application to parents of adults with mental health diagnoses. The chapter then explores the barriers caregivers face, including issues related to confidentiality, stigma, and the lack of systematic support. Additionally, parental distress is examined to highlight the profound impact of this situation on families. Lastly, the potential benefits of incorporating family-centred care are considered, along with practical implications for service providers.

3.1 FAMILY-CENTRED CARE

Family-centred care is comprised of substantial and unpaid support to an adult with a mental health disorder from parents or family members who serve as primary caregivers

(Goodwin & Happell, 2009). Family-centred care encompasses long-term relationships between service providers and people, particularly family members (Hansson et al., 2022b). This stems from recognizing that long-term relationships play a unique role in the treatment process by increasing treatment adherence and decreasing relapse rates (Hansson et al., 2022b; Szmukler & Block, 2018). As a result, treatment outcomes are far more successful when the family's priorities and perspectives are integrated. Although family-centred care is a collaborative process among clients and health practitioners requiring each member to be committed, the family's perspectives are considered the most influential (Szmukler & Bloch, 2018). An active effort to integrate the voice of family members in treatment planning and execution is required to positively impact treatment outcomes, as solely having them present is insufficient (Bruns et al., 2004; Hansson et al., 2022b).

Alberta Health Services (AHS) outlines respect and dignity, information sharing, participation, and collaboration as the core values of family-centred care (Alberta Health Services, 2024). These values prioritize family knowledge, diversity, strengths, and values as essential components in planning and delivering care. AHS commits to ensuring that families receive timely, complete, and accurate information on the treatment decision-making in a manner they understand best (Alberta Health Services, 2023). Thus, families are expected to be essential members of the care team and collaborate with service providers in the development, implementation, and evaluation of services (Alberta Health Services, 2023). However, despite these values playing an integral role in shaping family-centred care, family members express their disappointment with the quality of care they receive (Jankovic et al., 2011). Although there is limited literature that explores this concern in a Canadian context, it has been prevalent on social media platforms.

In addition to positive treatment outcomes, family-centred care supports family members in exploring their perspectives and expressing themselves during the treatment process. Dehbozorgi et al. (2022) highlighted the overwhelming emotions family members experience with the involuntary admission of a loved one. Providing care for an adult with a severe mental health condition affects caregivers emotionally, financially, and physically (Dehbozorgi et al., 2022). It is common for family members to be looked down upon and blamed for the client's diagnosis (Dehbozorgi et al., 2022). Due to the increased likelihood of experiencing stigma and shame, it is very likely for parents to feel hesitant in seeking social support and sharing their perspectives (Aass et al., 2020a; Dehbozorgi et al., 2022). In the context of parents and adult children, Bruns et al. (2004) referred to parents as the support network with the most profound attachment and commitment to their adult child's well-being, which further solidifies the importance of family-centred care. Despite research highlighting the importance of family involvement, this area continues to be poorly implemented (Hansson et al., 2022a). Hansson et al. (2022a) described family involvement as a complex and controversial process influenced by various barriers, including confidentiality, mistrust between clients, parents, and professionals, and a lack of appropriate training. The factors contributing to this topic's complexity will be explored in depth throughout this chapter.

3.2 INVOLUNTARY HOSPITAL ADMISSION

Involuntary hospital admission against the client's desire is a stressful experience for the client, healthcare providers, and family members (Clarke & Windsor, 2010; Jankovic et al., 2011). Despite being a time of crisis for families, parents are often in the hospital admission process. However, parents often are not informed of why clients are discharged earlier or admitted later (Aass et al., 2020a; Finlay-Carruthers et al., 2018). Moreover, if the situation is not deemed urgent by service providers, parents are often dismissed from receiving emergency help

(Jankovic et al., 2011). This situation is further complicated as service providers and parents usually have conflicting views on when hospitalization is required, mainly when involuntary (Jankovic et al., 2011; Lindgren et al., 2010). Refusal of hospitalization and appropriate care increases the burden on parents to take appropriate measures to ensure the safety and well-being of their adult children. As a result, parents experience isolation and confusion as they are unaware of the resources they can access or where to seek appropriate treatment (Harden et al., 2005; Jivanjee et al., 2008).

3.2.1 INITIAL HOSPITALIZATION

In most cases, the time of initial hospitalization is the first encounter between primary service providers and parents. Considering this event is an emotionally overwhelming and confusing time for parents, it is a primary opportunity for healthcare workers to build rapport with parents (Andershed et al., 2016; Clarke & Windsor, 2010). Ideally, the first meeting should include informed consent, including a discussion of privacy/confidentiality and plans for treatment collaboration (Clarke & Windsor, 2010). Prioritizing building a strong working alliance on day one can promote optimism and provide parents with security and support (Clarke & Windsor, 2010). However, despite the potential of initial solid contact setting the stage for positive treatment outcomes, initial meetings tend to need improvement (Clarke & Windsor, 2010). In the literature, the most negative experiences reported were parents dissatisfied with their initial encounter with service providers.

Up until initial hospital admission, parents reported experiencing high levels of anxiety due to their unfamiliarity with recognizing their adult child's symptoms as signs of mental health problems or understanding how to provide adequate support (Clarke & Windsor, 2010). In addition to anxiety-related symptoms, parents reported feeling grief as they felt they had lost their parental responsibilities and suddenly lost the expected dreams for their adult child (Harden et al.,

2005). Upon hospital discharge, some parents reported being invited to the discharge meeting on the day of their adult child's discharge with no prior invitation to discuss treatment planning (Rapaport et al., 2006). In such situations, parents typically feel powerless due to the inadequate information shared, which is a recurring challenge for caregivers because they are unprepared to support their loved ones (Lohrasbi et al., 2023).

3.3 MENTAL HEALTH DISORDERS IN EARLY ADULTHOOD

The long-term effects of young adults with mental health disorders impact their emotional well-being, future employment, economic security, ability to live apart from family, and to form secure relationships (Aass et al., 2020b; Raymond et al., 2017). Chronic mental health disorders, such as schizophrenia and bipolar disorder, have long-term cognitive effects, which can lead to physical and social consequences, including death (Szmukler & Bloch, 2018). Such symptoms can lead to poor academic functioning, loss of self-esteem, and a lack of interest in socializing (Aass et al., 2020b; Andershed et al., 2016). This risk is further heightened by the vulnerabilities associated with earlier adulthood, including risk of social isolation, academic and work pressures, as well as the stigma surrounding mental health (Harden et al., 2005). In such cases where adults are experiencing loneliness, family involvement becomes more crucial. Experiencing stigma and shame of mental health disorders increases the likelihood of adults refusing to seek professional treatment and instead opt for self-reliance techniques (Aass et al., 2020a; Mottaghypour & Bickerton, 2005; Szmukler & Bloch, 2018).

3.3.1 EARLY ADULTHOOD

Although individuals over 18 are considered adults and independent legally, those between the ages of 18-25 are in a transitional period (Andershd et al., 2016). The United Nations describes this age group as part of the fluid youth age group where individuals transition from childhood dependence to adulthood independence (United Nations, 2008). Thus, early adulthood

is a period of change, growth, and uncertainty. This period is encompassed by unpredictable challenges and changes in responsibility, making it a lengthy and challenging period, especially for those with a mental health diagnosis (Andershed et al., 2016). For instance, early adulthood brings increased vulnerabilities, such as low educational success, high unemployment rates, and high rates of substance abuse, further emphasizing the need for this age group to require ongoing family support (Andershed et al., 2016).

In addition to the challenges young adults experience, parents also experience a shift in responsibilities with their child becoming an adult. From being advocates for their dependent child's treatment to being excluded from treatment planning is a difficult transition for parents (Aass et al., 2020a; Jivanjee et al., 2008). Parents reported increased loneliness due to the loss of legal mandate and sudden ignorance from service providers (Andershed et al., 2016). Although all families experience some form of transition with their children entering adulthood, this change can be more intense for families with loved ones who have pre-existing mental health challenges (Jivanjee et al., 2008). Like young adults, parents are also susceptible to receiving judgement from community members and extended family, further impairing a parent's desire to seek support from social networks (Jankovic et al., 2011).

3.4 CONFIDENTIALITY

Confidentiality is a core ethical principle in both psychology and medicine. It is fostered by respect for autonomy, interest in client security, and encouraging open dialogue and collaboration (Szmukler & Bloch, 2018). Healthcare providers know that family members are vital resources; however, laws and ethical standards in place can inhibit practitioners from providing information to families (Hansson et al., 2020a; Szmukler & Bloch, 2018). This can be hard to balance, given the growing concern about clients' inability to make the best decision for themselves (Andershed et al., 2016; Cameron et al., 2024). Therefore, by integrating family

support into the equation, there is a greater likelihood of improved treatment decision-making and the client's overall well-being.

Although young adults still rely on family support to some extent after the age of 18, they have the right to refuse the involvement of family in their treatments (Aass et al., 2020b; Andershed et al., 2016). As discussed earlier, parents often struggle with this transition and are displeased with the limited information they receive about their adult child's diagnosis. This matter is not solely due to parents' desire to be informed about their adult child's health but is also driven by concerns about safety. For example, parents express that the limited information they receive is not enough to distinguish between warning signs of relapse or medication side effects (Eassom et al., 2014; Hansson et al., 2022b). As a result, parents must always be available at any given time and prepare for unpredictable scenarios, which is unhealthy for them to live through (Aass et al., 2020b).

3.4.1 ETHICAL OBLIGATIONS OF SERVICE PROVIDERS

In the Canadian Code of Ethics for Psychologists (CPA), confidentiality falls under Principle I: Respect for the Dignity of Persons and People, which states that all communication between adult clients and their service providers must remain confidential (CPA, 2017). The only exception to this ethical commitment is the limits to confidentiality and if the client provides consent allowing for disclosure (CPA, 2017). The limits of confidentiality include instances where there is an imminent risk of harm to the client or others, or abuse or neglect of a vulnerable person, such as a child (CPA, 2017). Additionally, confidentiality may be breached if there is a legal requirement to disclose information, such as a court order (CPA, 2017). Thus, protecting an individual's confidentiality is the primary cause of a reluctance to disclose information to family members (Hansson et al., 2022a).

Service providers often face a dilemma between supporting parents and fulfilling their ethical and legal commitments to their profession, as confidentiality is a primary barrier (Hansson et al., 2020b). The literature indicated that service providers value building a strong relationship with their individual clients, often fostered upon developing a deep level of trust, promoting autonomy, and advocating that confidentiality is a legal right for clients (Hansson et al., 2022b). Therefore, the working alliance will likely be strengthened by protecting a client's right to confidentiality and fostering treatment compliance through trust (Hansson et al., 2022a). Coincidentally, service providers also expressed their respect towards parents and acknowledge the pressure they undergo (Cameron et al., 2024). Considering that the priority of protecting a client's right to confidentiality conflicts with respecting caregivers' experiences, service providers are very likely to be caught in an ethical dilemma (Aass et al., 2020a).

Hansson et al. (2022a) argued that healthcare workers fear legal liability and the liability of failing to warn family members to take protective action in emergencies. Although some ethical challenges may be resolved through increased competence, there continues to be a legislative barrier (Hansson et al., 2022a). For instance, a practitioner providing minimum confirmation that a family member is being cared for may be an example of an unlawful disclosure in some jurisdictions (Hansson et al., 2022a). This poses a challenge for service providers as most registration bodies do not differentiate the degree of sensitivity of health information. Despite the rising belief that family is crucial for client treatment success, practitioners continue to be in an ethical bind as they do not want to rupture the alliance formed with the client and that breaching confidentiality is not only against the code of ethics but also against the law (Cameron et al., 2024; Hansson et al., 2022a; Hansson et al., 2022b). As such, Hansson et al. (2022a) encouraged minor legal changes as the current legislation leaves little room for discretion or consideration of family members.

A sensitive approach to confidentiality that considers parental perspectives can reduce the distress parents experience. For example, adopting a family-inclusive approach can encourage service providers to approach caregivers with empathy and collaboration (Lohrasbi et al., 2023). Service providers who supported parents by positively responding to family members reported experiencing fewer problems with confidentiality (Lohrasbi et al., 2023). This can be explained by parents feeling validated and by service providers offering their support in ethically appropriate ways. Another approach to the dilemma is to discuss confidentiality with the client to raise the issue openly (Hansson et al., 2022a; Szmukler & Block, 2018). While doing so, it is recommended to express the dilemma, be open about the requirement of extra support, and discuss long-term benefits and the personal need for family members to understand the treatment and diagnosis (Szmukler & Bloch, 2018). Additionally, practitioners can provide options on how the client would like to disclose information; it could be done in intervals, collaboratively, or the client may choose to do it themselves (Ong et al., 2021).

Alternatively, suppose the client decides to refuse to consent to family involvement. In that case, the discussion can allow service providers to understand clients better and potentially explore barriers such as family communication errors, disputes over the family's value system, previous incidents, fear of family reactions, or stigma (Ong et al., 2021; Szmukler & Bloch, 2018). In line with Principle II: Responsible Caring in the CPA, such discussions also allow service providers to conduct a risk and benefit analysis before releasing information to an individual outside of the working relationship (CPA, 2017). Additionally, practitioners can provide information on specific diagnoses by referring families to educational groups or by providing written information via fact sheets and reprints from articles (Jankovic et al., 2011). To seek the client's best interest, practitioners must develop strategies to ensure they are helping families be informed without violating confidentiality (Aass et al., 2020b). It is essential to

consider that parents are both service providers and service consumers; therefore, they must be dealt with positively and be informed on what can and cannot be disclosed to them (Cameron et al., 2024).

3.4.2 IMPACT ON TREATMENT FACILITATION

Inclusive care with family involvement has been associated with lower relapse rates and rehospitalizations (Eassom et al., 2014; Ong et al., 2021). The findings recommended integrating families through all phases of treatment in caring for the client (Hansson et al., 2022b; Ong et al., 2021; Peljert, 2001). However, due to confidentiality barriers and ethical regulations, several family members often are not involved in the treatment process or given any information about the client's diagnosis (Hansson et al., 2022b). As a result, parents reported losing confidence in the healthcare system, as many were unsatisfied with the care their family received (Jankovic et al., 2011; Lindgren et al., 2010). Further disappointment was expressed by parents who had spent months and years convincing their adult child to seek appropriate professional help, only to be in the dark about whether they had received it (Jankovic et al., 2011).

Lindgren et al. (2010) argued that parents struggle to uphold their perceived responsibility for ensuring their adult child complies with treatment if they are not included in treatment planning or interventions. Similarly, research highlighted that caregivers need access to relevant information to provide effective support, connect with appropriate services, and monitor treatment progress (Dehbozorgi et al., 2022; Ong et al., 2021). Ideally, treatment plans can be better facilitated with parents' input due to their helpful information about the client and their prominent role in supervising medication, encouraging participation, and fostering a recovery-friendly environment (Clarke & Windsor, 2010; Raymond et al., 2017). However, ethical implications and laws around confidentiality do not allow for optimal family involvement,

resulting in most caregivers rarely receiving a care plan (Aass et al., 2020a; Cameron et al., 2024).

3.5 PARENTAL PERSPECTIVES AND INVOLVEMENT

Familial upbringing influences development, behaviours, and habits; thus, mental health disorders may have some association with an individual's social and psychological processes in their family of origin (Ong et al., 2021). For instance, parental conflict and affection, emotional detachment from parents, parenting style, time spent with family, low socioeconomic status, and family cohesion are all factors that may hinder or promote one's mental health (Ong et al., 2021). Therefore, Ong et al. (2021) argued that parental involvement may provide valuable insight into better understanding and treatment of the client. Typically, parents are willing to provide housing, financial assistance, emotional support, case management, and advocacy (Raymond et al., 2017). In the case of most severe and persistent mental disorders, families may be unwilling to provide such support, as they may be unexpectedly put in situations to deal with challenging symptoms such as hallucinations, delusions, social withdrawal, and mood swings (Raymond et al., 2017). Given these challenges, it is essential to further explore and understand the experiences and perspectives of caregivers in the literature (Jankovic et al., 2011).

Goodwin and Happell (2009) coined family members as non-paid carers due to their vital role in smoothly delivering services to the client. It is estimated that unpaid caregivers devote about 104 hours a week to “client” care (Goodwin & Happell, 2009). Parents are required to restructure their lives to accommodate their entire family, which can be challenging to do as the family member with a mental health diagnosis impacts the entire family's lives (Cameron et al., 2024; Ong et al., 2021; Raymond et al., 2017). Service providers want to ensure families are being supported and bring in additional support for them; however, low funding provided by the government does not allow for the additional resources to connect families (Goodwin & Happell,

2009; Lohrasbi et al., 2023). Consequently, non-paid caregivers are of greater use and a low-cost option for the government (Goodwin & Happell, 2009).

Parents report high levels of distress, anger, grief, anxiety, and loneliness (Clarke & Windsor, 2010; Lohrasbi et al., 2023). They often struggle to grasp and understand their adult-child's diagnosis and want to be involved during significant stages such as diagnosis and treatment (Jankovic et al., 2011). Goodwin and Happell (2009) argued that participation in care planning is a fundamental human right. Ideally, parents should be able to participate with service providers at a micro level and with their family members at a macro level (Goodwin & Happell, 2009).

3.5.1 PARENTAL DISTRESS

In addition to the psychological burden of caring, parents are very likely to experience physical burden and conflict (Degbozorgi et al., 2022; Jankovic et al., 2011). Caring for a non-voluntary adult-child is also likely to disrupt the family dynamic. For instance, 68% of families reported an increase in the level of verbal abuse and 33% reported physical due to familial conflict due to disagreements between family members and the client (Finlay-Carruthers et al., 2018). Jankovic et al. (2011) introduced the concepts of objective burden and subjective burdens. Objective burden includes costs to the family and disruption in day-to-day activities. In contrast, subjective burden encompasses the perception of the diagnosis and the toll it takes on overall health (Jankovic et al., 2011). Hence, there is a growing concern about parents harming their health due to the poor recognition by service providers and their adult (Harden et al., 2005; Jankovic et al., 2011)

Parents' primary source of frustration was the multiple challenges they had to undergo in receiving basic services that ensured their adult child received supervised care (Finlay-Carruthers et al., 2018). Although hospitalizations lower levels of distress among parents, families still feel

accountable for their adult child's full recovery during the stay and upon discharge (Finlay-Carruthers et al., 2018; Lindgren et al., 2010). Considering that these parents are looking after their children beyond what is considered normal in a life cycle, mental health services have underestimated the extent to which these parents experience burnout (Finlay-Carruthers et al., 2018). It was found that parents believed their adult child required more assistance and help compared to what mental health practitioners believed (Finlay-Carruthers et al., 2018). Finlay-Carruthers et al. (2018) found that parents respected the measures taken around confidentiality; however, they felt more should be done to value parents and build a collaborative relationship with caretakers. There is a growing need for more service providers to build a strong working alliance with whole families, ensure they have practical coping abilities, and regularly assess how families feel about the support they receive (Aass et al., 2020a).

3.5.2 PARENTAL COPING

Transitioning into working with the healthcare system results in parents experiencing grief for losing their primary and individualized role as parents (Harden et al., 2005). Harden et al. (2005) found that all parents expressed concern to some extent about their lack of knowledge and the increased reliance on service providers. Parents reported being called overreactive solely for wanting more information about their adult-child's diagnosis (Harden et al., 2005). Family members have shared that they were unable to use social means as a method of coping due to the taboo nature of discussing mental health disorders (Aass et al., 2020a; Ong et al., 2021). Some families also experience a loss of social network due to community members having less respect for families with adult children who are combating severe mental health disorders (Andershed et al., 2016).

In a study by Lindgren et al. (2010), mothers felt powerless and as though they had failed in their role as parents. This is likely due to the perception that they are not good enough or are

not responding appropriately (Lindgren et al., 2010). Although parents are expected to provide active parenting to children from infancy through adolescence, they are viewed as dysfunctional or over-involved when this support is extended into adulthood (Dehbozorgi et al., 2022). As a result of lengthy recovery and inability to cope with the uncertainty of the illness, helpless parenting emerged as a common theme in the literature (Harden et al., 2005). Helpless parenting can result in self-blaming attitudes and feeling accountable for the circumstances of their adult-child, both of which are precursors for anxiety and depression disorders (Lindgren et al., 2010).

3.5.3 INTEGRATING PSYCHOTHERAPY

Given the findings of the above section, it is important to find ways to support parental caregivers. Coping methods can be emotion or problem-focused and may be more or less helpful or healthy (Clarke & Windsor, 2010). Parents often use emotion-focused coping when they believe they cannot change or control the situation. This can include escaping, substance abuse, and experiencing irregular mood swings. Such coping methods are concerning and often stem from a lack of support or referral to appropriate resources. Ideally, service providers should ensure that parents are using problem-solving coping techniques. Typically, emotion-focused coping techniques are used when individuals believe a situation is changeable; however, psychotherapy is effective in helping families develop healthy coping strategies. For example, a Cognitive-Behavioural Therapy (CBT) approach can be integrated by providing psychoeducation to parents about the diagnosis and appropriate interventions that can be implemented. Additionally, group counselling referrals can be made so that parents can network and connect with other individuals going through a similar experience. Moreover, Acceptance and Commitment Therapy (ACT) interventions can help parents focus on positive aspects of life, accept the diagnosis, and hope for a better future. In the literature, parents suggested that service

providers build relationships, offer appropriate resources, communicate during discharge, and instill hope as keyways to provide effective support (Clarke & Windsor, 2010).

3.5.4 PARENT AND ADULT-CHILD RELATIONSHIP

Family members reported mixed experiences when working alongside service providers and clients (Jankovic et al., 2011). Parents reported feeling frustrated when negotiating crises, advocating for clients, and combating legal barriers (Hansson et al., 2022b; Ong et al., 2021; Jankovic et al., 2011). This is primarily due to the client's preference for autonomy conflicting with the family's preference for collaborative interventions (Hansson et al., 2022b; Jankovic et al., 2011). Specifically, young adults believe parents interfere too much and are aggressive, whereas parents report continuously feeling worried throughout the day about how to support their adult-child (Aass et al., 2020b; Cameron et al., 2024). In an ideal situation where parents and their adult children communicate effectively, parents express that they would prefer their adult children to be capable of living alone, gain responsibility, and develop self-confidence (Aass et al., 2020b). However, the poor health condition of the client is what drives them to be overinvolved as they feel anxious about not being able to keep an eye on them (Aass et al., 2020b). Moreover, involuntary young adults are more likely to engage in rebellious and manipulating behaviour and refuse to accept the severity of their symptoms (Andershed et al., 2016; Dehbozorgi et al., 2022). Understandably, parents have big reactions when hearing their adult child talking about self-destructive behaviours and suicide that often accompany certain mental health problems (Andershed et al., 2016). However, this often frustrates the client and leads to additional family conflict (Lindgren et al., 2010). Parents often cannot differentiate between rebellious behaviours and medical symptoms, which further amplifies the need for guidance from service providers (Andershed et al., 2016; Dehbozorgi et al., 2022). Therefore, the

discrepancy in preference among families and clients is a growing concern (Cameron et al., 2024; Jankovic et al., 2011).

Cameron et al. (2024) explored clients' perspectives and found that it is critical to adhere to their perspectives as they reported strong beliefs about who and when they want to be involved in their care. Interestingly, several participants reported viewing service providers as responsible for facilitating the role of involving family and mentioned that service providers often do not invite family involvement. This can be attributed to the lack of training professionals have on family-centred care. In various studies, practitioners reported insufficient knowledge, training, and experience in family-centred care. Research suggests offering professionals with specialized competence in family-centred care and introduce routine procedures, such as checklists and regular professional development, to help increase awareness and confidence in this area of practice (Cameron et al., 2024). Contrarily, some clients have reported blaming their parents for causing their illness, which has led to feelings of guilt among parents and a desire to distance themselves from the treatment process (Ong et al., 2021). Likewise, many studies report the burnout parents experience when assisting their adult children with mental illness; however, Ong et al. (2021) argued that family engagement helps ease family burden and stress. This can be explained by an argument made by Pejler (2001) that highlights a feeling of satisfaction achieved through caregiving behaviours. Ideally, in this context, caring is a mutual exchange that clients reciprocate with their families. It is when caregivers adopt active parenting, which encompasses involvement, protecting, and sacrificing personal needs for their child's safety (Pejler, 2001). However, this is often unachievable due to the conflicting perception between the client and parents. Aass et al. (2020b) suggested parents reform the bond through other tasks, such as sports and arts, to decrease the regular discussion about the health diagnosis. Through

this, there is a possibility of increased psychological well-being and a strengthened relationship when done under the guidance and recommendation of a health professional (Aass et al., 2020b).

3.5.5 PARENT AND CLINICIAN RELATIONSHIP

Families are often ignored as mental health practitioners do not have the additional responsibility or capacity to care for the family members (Jankovic et al., 2011). Additionally, the difference in power dynamics gives clinicians a substantial role in deciding the level of care the clients will receive (Jankovic et al., 2011; Lindgren et al., 2010). As a result, parents reported losing confidence in the healthcare system, as many wanted more than they received (Lindgren et al., 2010). Losing rights over their children and the slow response of the healthcare system resulted in parents feeling invisible due to high levels of ignorance and not being taken seriously as parents (Lindgren et al., 2010). Having said that, when healthcare providers engaged in empathetic and comforting behaviours, parents expressed thankfulness and satisfaction (Andershed et al., 2016). Despite that, parents expressed disappointment as such behaviours were often short-term and did not continue throughout treatments (Andershed et al., 2016; Lohrasbi et al., 2023).

Dissatisfaction and disagreement are common themes when parents describe their experiences with healthcare providers, as most interactions were perceived as neglectful and critical (Lohrasbi et al., 2023). Furthermore, extreme stress resulted from poor communication between parents and healthcare providers due to the client's right to confidentiality being given the highest priority (Hansson et al., 2022b; Lindgren et al., 2010). Parents strongly appreciated when nurses can build relationships with families and view them beyond a part of their caseload but recognize and express that nurses are under pressure and overworked (Goodwin & Happell, 2009). However, they continue to point out the need for basic communication, such as a simple question asking, "Is everything okay?" (Goodwin & Happell, 2009). Lindgren et al. (2010)

highlighted the power of language as positive language was associated with increased optimism (Lindgren et al., 2010). When parents were asked to share what they wished they received more of, hope was the most common response (Lindgren et al., 2010; Lohrasbi et al., 2023).

Parents and family members tend to have the most interactions with physicians, which was reported to be the most stressful experience of their care experience (Lohrasbi et al., 2023). As a result, Lohrasbi et al. (2023) suggested that medical professionals help connect families with mental health professionals through referrals. Mental health professionals are trained to provide care through counselling, promoting self-care activities, sharing coping strategies, and emotion-focused support, which can fulfil the concern of family members feeling neglected and not receiving empathy (Lohrasbi et al., 2023). Although mental health professionals cannot offer insight into their loved one's conditions, they can help prevent physical, mental, and social burnout of caregivers, which serves as a protective factor (Lohrasbi et al., 2023). However, implementing this suggestion requires increased collaboration at the systematic level (Ong et al., 2021).

3.5.6 THE ROLE OF PARENTS IN TREATMENT OUTCOMES

Aass et al. (2020a) found that one-third of clients are unable to perceive the severity of symptoms they are experiencing and are unable to express their needs, therefore making it crucial for family members to be attentive and present in the treatment process (Aass et al., 2020a). Severe mental health disorders can have a substantial impact on an individual's self-esteem and confidence in executing day-to-day tasks, making them more vulnerable to additional health concerns and social withdrawal (Andershed et al., 2016). A strong family support system has been found to act as a buffer against severe symptoms, increase rates of recovery, resiliency, motivation to seek treatment, and protection against suicide (Aass et al., 2020b; Andershed et al., 2016; Ong et al., 2021). Contrarily, the lack of social support and stigma increases dropout rates

and low willpower to comply with the treatment (Andershed et al., 2016; Ong et al., 2021). Thus, there is a need for a balance of support for family involvement, as too little or too much can have detrimental impacts (Aass et al., 2020b; Andershed et al., 2016). It is recommended to perceive mental health diagnosis as a family affair, as all members are often impacted by the diagnosis and treatment approach (Aass et al., 2020b).

3.6 MODELS FOR FAMILY-INCLUSIVE CARE

Models of family-inclusive care emphasize the importance of integrating family members into the care process. The Theory of Human Caring and the Pyramid of Family Care are two notable frameworks that inform these models. These frameworks provide a strong foundation for understanding how interdisciplinary approaches can address the needs of caregivers and clients.

3.6.1 THEORY OF HUMAN CARING

Proposed by Jean Watson (1979), the Theory of Human Caring can be a helpful guiding framework for conceptualizing and promoting positive treatment outcomes when working with adult client's and their families. According to Watson (1979), ideal care encompasses positive emotional, spiritual, aesthetic, comforting, calming, and healing elements (Gürcan & Turan, 2021). These factors are often implemented through a positive clinician-client relationship essential to psychological safety and physical healing (Gürcan & Turan, 2021). Clinicians can foster a positive healing environment for the whole family through caring behaviours such as eye contact, smiling, active listening, and empathy (Gürcan & Turan, 2021). Furthermore, this theoretical framework emphasizes the importance of social relationships in identifying client needs and tailoring treatment planning to the unique needs of clients (Gürcan & Turan, 2021). As discussed by Andershed et al. (2016), clinicians' attitudes directly impact how parents perceive themselves and the treatment. This is due to the increased dependency parents have on clinicians when supporting family members with a severe diagnosis. Therefore, a positive encounter with

clinicians is sufficient to buffer against the adverse effects of the family member's diagnosis (Andershed et al., 2016). Ultimately, client treatment success is associated with a strong working alliance between family and healthcare providers (Andershed et al., 2016).

3.6.2 PYRAMID OF FAMILY CARE

The pyramid system is an integrated hospital community mental health service that increases the capacity to work with families and clients with severe mental illness (Mottaghipour & Bickerton, 2005). Mottaghibour and Bickerton (2005) argued that respectful interaction with families is possible when clinicians shift away from solely focusing on the client. The hierarchical model provides practitioners with a template for incorporating simple family-based interventions without the risk of breaching confidentiality. The bottom of the pyramid consists of general approaches that can be applied to most families, with more specific approaches at the top. Through this approach, collaboration is incorporated at a general level, and the clinician is required to move up the pyramid based on the situation and needs of the family. Some family-related factors to consider are high levels of distress, pre-existing family risks, concurrent problems in other members, ability to access resources, and coping strategies. These factors determine a family's ability to be resilient, seek support, and cope with high stress levels (Mottaghipour & Bickerton, 2005).

The first level is connection and assessment (Mottaghipour & Bickerton, 2005). During this phase, clinicians are recommended to introduce and explain family partnership objectives, assess the family's urgent and basic needs, and develop a plan and involvement of other agencies. There is a strong emphasis on discussing the objectives of family-service partnership, normalizing family distress, and discussing concerns about stigma, all of which help create a safe and collaborative relationship. Level two consists of general education, which begins by assessing the client's needs and current resources. Family members are then educated on the

quality of current services and client rights. The next level encompasses psychoeducation, where families are offered inclusive community interventions that offer insight into the struggles with mental health disorders. Through psychoeducation, family members can understand the extent of the impact of the diagnosis, the rationale behind the chosen interventions, and the importance of healthy coping strategies. The fourth stage comprises a consultation with the continuation of contact and support as needed. Considering that there are chances of relapse, it is essential to ensure families are aware of long-term resources. Finally, the last stage is using family therapy as a treatment modality, where referrals are made for the family. Assuming client's and family members receive individualized support, family therapy aims to rebuild relationships and mediate family conflict. The pyramid approach allows for quality assurance, supports families using techniques requiring minimum effort and funding, and does not breach client confidentiality. When using the pyramid of care, clinicians should have basic counselling and collaboration competencies, such as empathetic listening, building a working alliance, and a trauma-informed approach (Mottaghipour & Bickerton, 2005).

3.7 IMPLICATIONS FOR SERVICE PROVIDERS

An ethical approach to family-inclusive care would consist of family perspectives and values on interventions while balancing the client's interests, their right to informed consent, and confidentiality. Although clinical staff are required to follow the client's call and implement treatment planning based on their judgement of the diagnosis, family interests are also relevant, without exception (Szmukler & Bloch, 2018). Therefore, an ethical approach to the dilemma is to consider the best interest of the client and the family while respecting the reputation of the regulatory body the professional adheres to (Szmukler & Block, 2018).

3.7.1 REFRAMING THE DUTY OF CONFIDENTIALITY

Hansson et al. (2022a) suggested reframing the duty of confidentiality, which suggests practicing the legislation more flexibly while still being legally correct. This is supported by the argument that clinicians are too focused on the disclosure of information due to their lack of understanding of confidentiality. The literature suggests a distinction between general and personal information, a concept where clinicians struggle to differentiate between the two. General information refers to content that can be shared without consent, and personal information encompasses new and detailed information about the client. For instance, general information on the symptoms of a mental health disorder without the mention of the client falls under general information. Hansson et al. (2022a) found that parents often do not seek personal information and would feel relief with some general information to help them better understand how to support their loved ones. Thus, a movement towards family involvement without breaching confidentiality is possible but requires additional training and attention from legislative bodies.

3.7.2 THE DUTY OF CONFIDENTIALITY PARADOX

Hansson et al. (2022a) highlighted clinicians' increased focus on client autonomy and the working alliance, which explains how confidentiality is typically approached in relation to other ethical principles. For instance, the duty of confidentiality results in clinicians putting a lot of weight on client autonomy compared to beneficence, non-maleficence, and justice. Hence, reframing the duty of confidentiality highlights the importance of a holistic approach to ethical practice. Hansson et al. (2022a) introduced 'the duty of confidentiality paradox' to challenge clinician's current practice of emphasizing client autonomy. The paradox explains how clinicians unintentionally fail to empower clients to make informed decisions by not providing adequate information about what family involvement entails. As such, the lack of understanding and transparency limits the purpose of client autonomy and confidentiality. In line with the CPA

(2017) Code of Ethics, the risks and benefits should be discussed so clients can make autonomous choices. In the context of family involvement, this would entail discussions on how family involvement can provide support and its impact on treatment, why it is beneficial, potential downsides and the client's choice in how much or little information is shared with family members (Hansson et al., 2022a). Therefore, it is vital to understand how providing clients with an unclear understanding of family involvement may hinder their ability to make an autonomous and informed decision.

3.7.3. REFERRALS AND COLLABORATION WITH OTHER SERVICE PROVIDERS

Despite ethical dilemmas, measures can be taken to improve the working alliance with parents by being aware of the burden on parents and the risks of ignoring their needs (Jankovic et al., 2011; Ong et al., 2021). Referrals made to mental health agencies that offer joint crisis family planning can provide support and are a good resource for parents to reach out to when needed (Jankovic et al., 2011). Ong et al. (2021) recommended increased collaboration with family physicians due to various factors, such as increased accessibility, better rapport, and less stigma. For the most part, families have access to a family physician, and there is greater flexibility for appointments at no cost (Ong et al., 2021). Hence, family members are more likely to discuss their concerns with family physicians (Ong et al., 2021). Moreover, the literature indicates that families feel more comfortable confiding in a family physician instead of a psychologist or psychiatrist due to the stigma associated with mental illness (Ong et al., 2021). Thus, considering that family physicians often provide care to different generations within the same family, they can be an accessible point of contact that could refer family members to other services, such as individual and group counselling (Ong et al., 2021).

3.7.4 PSYCHOEDUCATION PROGRAMS

Mental health awareness initiatives and psychoeducation workshops can assist parents in processing and understanding the diagnosis better, providing them with an active role in seeking out information (Jankovic et al., 2011; Ong et al., 2021). Most importantly, there is a need for improved attitudes when communicating with the family about what can be shared and what cannot be respectfully shared (Jankovic et al., 2011). By engaging in a meaningful conversation with families, they can understand the concept of confidentiality better (Jankovic et al., 2011). Although these approaches are found to alleviate parental distress, parents continue to express the need for legislative changes to be made, as the exclusion of parents in adult-child care has been found to have negative implications for clients (Raymond et al., 2017). Most parents would prefer a generalized and approachable program that would provide information on mental illness and resources to give families a head start on how to act and who to contact (Raymond et al., 2017). The influx of information on the internet can be overwhelming; thus, there is a need for a central agency that can confirm and make appropriate referrals for parents (Raymond et al., 2017).

Lohrasbi et al. (2023) highlighted the effectiveness of psychosocial empowerment programs in enhancing the caregiver's knowledge about the illness and treatment while developing essential skills to reduce the caregiver's burden and improve quality of life. These programs, often called problem-solving interventions, help family members feel a greater sense of control and instill hope, an important factor for therapeutic growth. By implementing such programs, caregivers are more likely to improve their relationship with clients through effective communication skills, which helps foster family tolerance and emotional regulation. This is because psychoeducation may assist in mediating family conflict as it allows family members to empathize with the client, avoid blaming them for their symptoms, and recognize signs of relapse (Ong et al., 2021). Family-focused psychoeducation assumes that caregivers need information

and support, combining elements of therapy and communication to reduce anger, confusion, and emotional distress. Ultimately, psychoeducation can be used as a tool to increase knowledge, foster social connection, and promote self-efficacy for family members (Lohrasbi et al., 2023).

3.7.5 PEER SUPPORT GROUPS

Peer support groups have emerged as an effective intervention in mental health systems worldwide, offering psychosocial benefits for caregivers of clients with mental disorders (Lohrasbi et al., 2023). Moreover, long-term follow-ups conducted at 12 months, 24 months, and four years sustained overall caregiver well-being. A peer is an equal individual with whom one can share social similarities. Peer support involves mutual relationships where individuals with shared experiences provide empathy, encouragement, and assistance, transforming from service recipients to support providers. These groups enhance caregivers' self-efficacy by sharing knowledge and adapting strategies and are supported by international clinical guidelines as evidence-based interventions. Studies demonstrated that peer support effectively reduces caregiver burden, improves family functioning, and enhances social support due to emotional release when paired with psycho-educational components (Lohrasbi et al., 2023).

3.7.6 WORKING ALLIANCE

Raymond et al. (2017) highlighted the importance of establishing a working alliance with caregivers as it has been found to be successful with nurses who approach families with empathy. Participants reported having a positive experience with nurses who assisted parents in connecting with resources and provided management strategies for families (Raymond et al., 2017). This was achieved without providing specific information about the client; therefore, there was no breach of confidentiality (Raymond et al., 2017). Empathy is vital as it helps caregivers feel supported and validated in a lonely and complex situation (Raymond et al., 2017). This can be done by maintaining open dialogue, supporting parents in advocating for their adult child, and admiring

their resiliency as devotion to their adult child's health (Jankovic et al., 2011). Cameron et al. (2024) addressed the need for increased competency in family-centred care, as many professionals reported lacking confidence in approaching family members. Additionally, research showed a lack of funding and a shortage of staff, which overwhelmed clinicians in terms of being able to support clients and families (Raymond et al., 2017). Hence, increasing the number of psychiatric nurses may assist in tasks such as screening families and making referrals to ensure the needs of caregivers are met.

3.8 CHAPTER SUMMARY

In this chapter, a review of the literature was provided in considerable depth, including an introduction to family-centred care, involuntary admission, and mental health disorders amongst young adults, followed by the role of parents in treatment facilitation and the marginalization and emotional toll they experience. Factors that complicate this area of practice, such as systematic and ethical barriers, were also explored. Additionally, literature that discussed the complexity of this issue and the dilemmas professionals experience were also investigated. Lastly, implications for service providers to consider when working with this population were explored and highlighted.

The proposed final project was inspired in part by initial research indicating the marginalization parents experience despite their ability to enhance treatment outcomes (Jankovic et al., 2011; Szmukler & Block, 2018). The more extensive literature review then highlighted the need for systematic and legislative changes as service providers are bound by confidentiality laws, which impacts family involvement (Jankovic et al., 2011; Hansson et al., 2022b; Lohrasbi et al., 2023). Despite confidentiality being a prevalent issue in family involvement in healthcare, only one empirical study was retrieved within a Canadian context from an occupational therapy perspective. In the context of family involvement in adult mental health, researchers identified a

general lack of awareness regarding the mental health impacts on families, a lack of competency and confidence in this area of practice, and a strong ethical commitment to confidentiality and autonomy (Aass et al., 2020a; Cameron et al., 2024; Hansson et al., 2022a). Future practice recommendations included a need for enhanced competence, reframing the duty of confidentiality, fostering a strong working alliance, increased collaboration between service providers, and implementation and referral to psychoeducational programs and peer support groups (Cameron et al., 2024; Hansson et al., 2022a; Lohrasbi et al., 2023; Ong et al., 2021). After developing the literature review, it is apparent that there is little research exploring the extent of the impact on parents regarding involuntary young adults (i.e., financial, social, physical), and no studies addressing the implications for a counselling perspective on the current ethical standards of practice. As such, the intended objective of this final project is to consider the practice recommendations and apply them to the CPA (2017) Code of Ethics to provide service providers with research-based knowledge applicable in a Canadian context. This will expand on the current literature and address the gap in this area of practice.

CHAPTER 4: DISCUSSION AND CONCLUSION

This project provided ample evidence of the troubling mental health outcomes of caregivers of involuntary adults and the lack of knowledge service providers have in this realm of practice. Considering that the vast majority of parents experience high levels of distress, anxiety, and grief, it is concerning that most service providers report a lack of training and confidence in family-centred care (Finlay-Carruthers et al., 2018; Hansson et al., 2022a). As such, this project aimed to advocate for increased family involvement in treating adult mental health and the need for service providers to adopt flexible, ethically informed practices that align with their respective codes of ethics. The intent of this project was to contribute to the need to increase awareness of the mental health impacts on family members and expand the limited available information for Canadian service providers.

This chapter will introduce three key recommendations to guide service providers in increasing their knowledge and adopting practical considerations for supporting their clients through family inclusive caring. Although various studies have addressed the need for legislative changes, these recommendations aim to help service providers develop a better awareness of the overlooked perspective of parents and use existing support and resources more effectively. Ultimately, these recommendations are intended to assist service providers in making their practice more inclusive for both clients and families without breaching confidentiality. This chapter will also identify the strengths and limitations of this project and suggest areas for future research.

4.1 SYNTHESIS AND RECOMMENDATIONS

Current research on family involvement in adult mental health care, barriers to care, and the impact families have on treatment facilitation and outcomes were thoroughly reviewed, along with ethical implications for service providers. Key practical takeaways were consolidated and

applied to the CPA (2017) Code of Ethics, developing three recommendations for Canadian service providers working with families (see below and Appendix 1). This integration of research into practice resulted in a list highlighting important considerations at the intersection of ethical standards, family involvement, and treatment facilitation, with a particular focus on mental health. An overview of the three recommendations is presented in this section in bullet form. The draft manuscript provided in Appendix 1 discusses each recommendation in detail.

4.1.1 PRACTICE CONSIDERATIONS

Key Recommendations to Enhance Support for Families:

1. Reframe confidentiality to include collaboration and informed decision-making.
2. Develop comprehensive psychoeducational and peer support programs.
3. Focus on professional development to enhance service provider competency.

The list provided in this chapter and Appendix 1 integrated research into practice by translating the research reviewed in Chapter 3 into considerations for service providers working with families of clients experiencing severe mental health conditions. Appendix 1 is intended to be used as an educational resource to inform service providers and stakeholders of an area requiring greater consideration in practice, foster awareness, and encourage the implementation of meaningful changes that better support this population. Additionally, this list may serve as a resource to support the development of policies that reform family-centred care and interdisciplinary collaboration and guide advocacy efforts to improve support for caregivers within mental health services.

This information can be shared by service providers, educators, and mental health professionals who work directly with families and by advocacy groups focused on improving mental health services. The information can be presented through workshops, training sessions,

or professional development events for service providers to ensure it reaches the right audience. Additionally, the information can be shared through digital platforms, such as webinars and organizational newsletters, and included in policy briefs designed for stakeholders.

4.2 PROJECT STRENGTHS

The primary strength of this project lies in the comprehensive literature review presented in Chapter 3, which was developed based on peer-reviewed literature and analyzed for approximately a year. In fact, it was approved as the literature review chapter for a thesis proposal. This thorough process led to the development of a manuscript that aims to be highly relevant and valuable to professionals working with involuntary adults and their families in the healthcare sector.

This project also offers valuable insight into public calls for support for families and parents navigating the distressful experience of caring for an adult with a mental health condition. Moreover, the interdisciplinary focus of this project highlights collaboration between professionals from various areas (i.e., nursing, counselling, medicine), thus enhancing its applicability across different professional settings. Overall, this project will help fill the gap in the Canadian literature by advocating for caregivers' mental health, which is often neglected.

4.3 PROJECT LIMITATIONS

The literature analysis for this project was based on a lack of available research findings specifically addressing ethical barriers to involving families with adult involuntary clients within a Canadian context. Much of the existing research and literature on family-centred care focused on the specific regions where the studies were conducted, resulting in limited content generalizable to Canadian service providers. Considering that no literature explicitly discussed the implications or prevalence of these concerns in Canada, it was difficult to determine how aware Canadian service providers are of this issue or how it impacts their practice. Furthermore,

there was a lack of research that focused on counselling psychology and the how the CPA code is implicated. While mental health outcomes were discussed in the available studies, the service providers involved were predominantly from nursing backgrounds. This posed a challenge because, although psychologists and other service providers are also involved in this area of practice, their professional roles differ. For instance, the literature emphasized the importance of a working alliance, a core value of counselling psychology. However, other professionals do not value a working alliance to the same extent, as their approaches may be more focused on clinical interventions. This suggests that not all recommendations in the literature are equally relevant for psychologists. Hence, this project prioritized those most applicable to psychologists.

The three key recommendations introduced in this chapter are based on analysis and interpretation of the limited research findings rather than on knowledge gaps among counselling psychologists. Due to the lack of research in counselling psychology, this project used the CPA (2017) Code of Ethics as a guiding framework. Therefore, it is important to address that, depending on a service provider's regulatory body, the code of ethics may be similar but slightly different from other professionals working in this area of practice (i.e., family physicians, nurses, psychiatrists). Thus, this may impact the generalizability of the recommendations, and service providers must ensure that the practical considerations fit with the code of ethics to which they are bound.

4.4 AREAS OF FUTURE RESEARCH

An important area for future research involves exploring the experiences, knowledge, and awareness of psychologists for this topic. This gap in the literature is significant, as limited research explores collaboration among various service providers in this area of practice despite its potential value, as highlighted by Ong et al. (2021). Counselling and clinical psychologists are often a primary point of contact for individuals with mental health disorders, making it crucial to

examine their insights and identify areas where they could enhance existing practices. Based on the findings of this project, it can be inferred that counselling psychologists could have a pivotal role in developing psychoeducational and peer support groups. Additionally, their expertise in providing services while prioritizing the working alliance can be a valuable opportunity for research to investigate how other service providers can incorporate these skills to improve service delivery. By addressing this gap, future research could explore the significant contributions that psychologists can make to further progress toward collaborative and interdisciplinary care.

There is also a need for research on additional barriers beyond confidentiality. Eassom et al. (2014) and Hansson et al. (2022b) are among the few researchers who introduced organizational challenges as a barrier, highlighting its role in limiting collaboration and successful integration of family-centred care. There is value in expanding research into organizational factors, such as resources, funding, and policies, as these components are necessary for effective service delivery. Without a clear understanding of these organizational issues, it becomes difficult to assess how efficiently the recommendations proposed in this project can be implemented, as they are partially reliant on organizations and their willingness to adopt and act on these suggestions. While this project intends to raise awareness at the institutional level, further research on organizational barriers can provide a greater understanding of systematic factors and lead to more impactful recommendations.

4.5 CONCLUSION

This project addresses the significant gap in the literature and aims to introduce a Canadian-wide initiative to support caregivers of involuntary adults with mental health diagnoses. Through a comprehensive review of the literature and the development of practical recommendations, this project highlights the importance of family-centred care and the need for interdisciplinary collaboration to better support caregivers. While there continue to be significant

challenges, such as organizational and confidentiality barriers, this project serves as a foundation for raising awareness, encouraging further research, and guiding meaningful changes in practice. Ultimately, this project is a step in the right direction to inspire service providers and policymakers to prioritize the needs of caregivers, ensuring their voices are heard and their mental health is supported.

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**APPENDIX 1: FAMILY-CENTRED CARE: THE MENTAL HEALTH OUTCOMES OF
CAREGIVING FOR INVOLUNTARY ADULTS AND IMPLICATIONS FOR
CANADIAN SERVICE PROVIDERS**

TITLE PAGE

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Family-Centred Care: The Mental Health Outcomes of Caregiving for Involuntary Adults and Implications for Canadian Service Providers

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Abstract

Caregivers who provide care for an involuntary adult with a mental health diagnosis often experience significant emotional and psychological distress. Limited recognition from healthcare providers frequently leads to the marginalization of parents and families, raising concerns about their overlooked experiences in the healthcare system. Despite growing awareness of the importance of family involvement in involuntary adult mental health, there has been little effort in medical systems to integrate the support of families due to complex systemic barriers, with confidentiality being a primary concern. There is limited research for Canadian service providers on how to make their practice more inclusive for clients and families without breaching confidentiality. A comprehensive review of the research and literature on this topic was conducted to address this gap, resulting in ethically informed recommendations for service providers. These recommendations are rooted in ethical principles such as respect of autonomy, beneficence, and justice, ensuring both client rights and family support needs are balanced. The recommendations include reframing the duty of confidentiality, developing comprehensive psychoeducational and peer support programs, and enhancing professional development to improve service provider competency.

Keywords: family-centred care, involuntary adult mental health, interdisciplinary collaboration, confidentiality, caregiver burnout.

Family-Centred Care: The Mental Health Outcomes of Caregiving for Involuntary Adults and Implications for Canadian Service Providers

Family-centred care is a crucial yet often overlooked component of mental health care, especially for parents and caregivers of involuntary adults with a mental health diagnosis. This article refers to *involuntary* as a client's denial or reluctance towards psychological treatment or hospital admission. This reluctance can create significant barriers to accessing appropriate care and leaves families struggling to navigate the healthcare system with limited support. Jankovic et al. (2011) highlighted this challenge, noting that families often have a strained relationship with service providers due to challenges in obtaining help and the overwhelming burden of care that is placed on them. Despite the vital role that family caregivers have in the treatment of adult mental health and the benefits of their involvement in treatment, it is alarming that most caregivers experience high levels of distress, anxiety, grief, and marginalization (Finlay-Carruthers et al., 2018; Hansson et al., 2022a; Lohrasbi et al., 2023). Consequently, the following discussion will provide up-to-date recommendations for service providers supporting parents of involuntary adults with a mental health diagnosis. It will emphasize the importance of recognizing caregiver burnout, understanding its impact on their well-being, and how appropriate support can be offered.

The recommendations in this article are timely because a recent exhaustive review revealed the need for systematic and legislative changes as service providers are limited by confidentiality laws which impact family involvement (Jankovic et al., 2011; Hansson et al., 2022b; Szmukler & Bloch, 2018). A lack of awareness among service providers regarding the mental health outcomes of caregivers is one factor that may contribute to inadequate recognition of their needs and a lack of confidence in providing effective support (Cameron et al., 2024). With the recommendations embodied within, service providers will be able to increase their knowledge and adopt practical considerations for supporting their clients. Although various studies have addressed the need for legislative changes, these recommendations aim to help service providers develop a better awareness of the experiences of parents and thereby use existing support and resources more effectively. Ultimately, these recommendations are intended to assist service providers in making their practice more inclusive for clients and families without breaching confidentiality.

Background

Family-centred care prioritizes respect, dignity, information sharing, participation, and collaboration for all those involved (Alberta Health Services, 2023). This model of care recognizes that long-term family involvement plays a crucial role in improving treatment adherence, promoting hopefulness, and reducing relapse rates (Cameron et al., 2024; Hansson et al., 2022b; Szmukler & Bloch, 2018). Kokorelias et al. (2023) suggest that family involvement in client care should be flexible and exist on a continuum, as some individuals have less cognitive ability than others to make informed decisions about their treatment. This is significant because, for example, conditions such as schizophrenia can impair decision-making and cause clients to underestimate their symptoms and the urgency of professional interventions (Szmukler & Bloch, 2018).

Despite the proven benefits of family involvement, it is often minimized due to ethical and systemic barriers restricting service providers' ability to integrate caregivers into treatment plans (Eassom et al., 2014; Ong et al., 2021). One of the primary barriers to family-centred care

is confidentiality, which can place service providers in an ethical dilemma between respecting clients' right to autonomy and addressing the concerns of family members, providing responsible caring (Hansson et al., 2022a; Szmukler & Bloch, 2018). While confidentiality is essential for protecting client privacy, Hansson et al. (2022b) and Cameron et al. (2024) argue that service providers frequently struggle to balance their legal and ethical obligations with the practical need for family involvement. Considering that parents are usually the first to recognize a change in their adult child's symptoms, their lack of involvement in treatment planning impacts early interventions and significantly increases the likelihood of treatment dropout and relapse (Raymond et al., 2017; Szmukler & Bloch, 2018).

Family-centred care comprises substantial and unpaid support, with families often taking on extra responsibilities (Goodwin & Happell, 2009). As such, Finlay-Carruthers et al. (2018) highlighted the need for increased attention to the psychological and emotional consequences of caregivers. This need was evident by the prevalence of high levels of stress and feelings of isolation due to the burden of caregiving amongst parents supporting adults with mental health conditions (Aass et al., 2020; Clarke & Windsor, 2010). Additionally, in Lindgren et al.'s (2010) study, most parents reported feeling responsible for their adult child's diagnosis and presented self-blaming attitudes, both of which are precursors for anxiety and depression disorders. Without adequate support from mental health professionals, parents are more likely to resort to unhealthy coping mechanisms or experience caregiver burnout (Aass et al., 2020; Lohrasbi et al., 2023).

Following a comprehensive review of available research and literature on family-centred care for caregivers of involuntary adults with mental health diagnoses, there is a need for a shift in the delivery of mental health services to better accommodate families while upholding ethical commitments (Hansson et al., 2022b; Jankovic et al., 2011; Raymond et al., 2017). The treatment of families needs to be reevaluated as parents report receiving not only feeling unheard by service providers, but receiving little empathy (Lohrasbi et al., 2023).

Method

Between October 2023 and November 2024, the primary author accessed online academic databases to complete a comprehensive review of available research and literature related to counselling psychology and practical guidelines from related fields, such as psychiatric nursing and emergency medicine. The search was centred around compiling peer-reviewed articles about mental health outcomes of parents supporting involuntary adults, confidentiality as a barrier, and considerations relevant when working with families. Due to the lack of Canadian-based literature on this topic, the search included practice-based implications from other regions, such as Europe and Australia, which were then applied to the Canadian Psychological Association [CPA] Code of Ethics (2017) to evaluate their relevance and fit within Canadian ethical frameworks. This process involved comparing the ethical principles and recommendations found in the literature with the CPA Ethical Code, identifying areas of alignment, and considering how these insights could be meaningfully applied within the Canadian context. Overall, the following search terms were used in various combinations to acquire an overview of the available literature: involuntary adults, adult mental health, family-centred care, psychiatric nursing, involuntary hospital admission, barriers to family-centred care, ethical implications, confidentiality, client autonomy, the impact of adult mental health of families, and long-term caregiving.

A focus was placed on scanning literature for primary articles published in approximately the last decade, 2014 to 2024. However, due to the limited research on this topic, articles published from the early and mid-2000s were also included. Google Scholar Search and Summon via the University of Lethbridge online library were two search engines used to obtain peer-reviewed academic articles. In addition, to expand the pool of resources, article recommendations by the databases and the reference lists of already obtained articles were reviewed.

Key recommendations were derived by categorizing the information collected from the literature review findings into themes, which were then organized into three practical categories. The recommendations are designed to support service providers in recognizing caregiver burnout, navigating confidentiality dilemmas, and fostering collaborative care. The selection of these recommendations was informed by literature on ethical decision-making, interdisciplinary collaboration, and mental health service delivery, ensuring their relevance for professionals working with caregivers of involuntary adults. As the authors all study or work in a graduate training program for psychologists, we used the CPA Ethical Code to provide more structure and context for our recommendations.

Main Recommendations

Reframing the Duty of Confidentiality

The first recommendation is for service providers to reframe the duty of confidentiality, allowing for increased flexibility and informed decision-making. Understandably, service providers often face a dilemma between supporting parents and fulfilling their ethical and legal commitments to their profession, as confidentiality is a primary barrier (Hansson et al., 2020b).

The CPA (2017) Standard I.43 and I.45 states that psychologists must respect a client's right to privacy and confidentiality while also considering ethical obligations to promote well-being. A starting point is for service providers to offer informed choices by engaging in open discussions with clients to clarify the role of confidentiality and explore what information can or cannot be shared. For instance, service providers should let clients know the benefits and risks of sharing general, non-identifiable information about mental health conditions and treatment approaches and how that may be useful to them or their caregivers.

Clients often experience hesitancy regarding disclosure as they fear a loss of control, burdening family members, or uncertainty surrounding the impact of their involvement (Cameron et al., 2024). Therefore, encouraging discussions about how clients may choose to disclose information, including the level of detail they feel comfortable sharing can help ensure their autonomy is respected while fostering a collaborative approach to care. Similarly, Hansson et al. (2022a) discuss the concept of the 'duty of confidentiality paradox' which challenges the emphasis service providers place on autonomy. This paradox highlights how clinicians, by withholding information about family involvement, unintentionally limit clients' ability to make fully informed decisions (Hansson et al., 2022a). As such, autonomy should not be limited to protecting client confidentiality but should also ensure that clients have the necessary information to make informed choices. This also aligns with Standard I.23 from the CPA (2017), which highlights that informed consent must include clear communication about risks and benefits, allowing clients to make fully autonomous decisions regarding family involvement.

Service providers also have a critical role in fostering collaboration between clients, caregivers, and other health professionals. However, this responsibility is often overlooked due to clinicians' focus on individual client care, which may limit opportunities for interdisciplinary support. The CPA (2017) Standard II.8 emphasizes that psychologists must ensure individuals receive competent care, including making timely and appropriate referrals when needed. Likewise, the CPA (2017) Standard II.19 encourages psychologists to be aware of the knowledge and skills of other disciplines and engage in interdisciplinary collaboration to enhance client well-being. One way to integrate both principles, which initially may cause an ethical dilemma, is through interdisciplinary referrals and partnerships with family physicians, who are often caregivers' primary point of contact and can provide valuable guidance and connections to additional resources (Ong et al., 2021). Other services, such as joint crisis family planning, can provide caregivers with immediate family-inclusive support while maintaining confidentiality (Jankovic et al., 2021).

By reframing the duty of confidentiality and approaching ethical responsibilities beyond only considering autonomy, service providers can recognize broader responsibilities (e.g., beneficence, non-maleficence, etc.) and foster a more inclusive health care system.

Develop Comprehensive Psychoeducational and Peer Support Programs

Caregivers of involuntary adults with mental health diagnoses often experience distress, anxiety, and social isolation (Aass et al., 2020; Finlay-Carruthers et al., 2018). Despite their crucial role in supporting clients, caregivers lack access to psychoeducational programs and peer support. These programs have been shown to reduce these outcomes (Lohrasbi et al., 2023). Therefore, it is advised for service providers integrate psychoeducational programs and peer support groups into mental health services. This aligns with Principle II: Responsible Caring, outlined by the CPA (2017), which emphasizes the importance of considering the well-being and best interests of the individuals and groups (e.g., couples, families, and communities) they encounter as psychologists.

As Ong et al. (2021) discussed, psychoeducational programs should provide caregivers with essential knowledge about mental health conditions, symptom management, and resources (e.g., community resources and crisis management). These programs should be structured to deliver general, evidence-based information without breaching client confidentiality. General information may include details such as symptom expression of the involuntary adult and medication side effects while excluding any specifics related to the individual receiving treatment to maintain confidentiality (Raymond et al., 2017).

Psychoeducational workshops and peer support groups are likely to empower families by equipping them with problem-solving skills, reducing caregiver burden, and fostering a sense of control over their caregiving responsibilities (Lohrasbi et al., 2023). Providing such support is crucial, as families often experience stigma due to mental health disorders, making it difficult for them to seek social support (Aass et al., 2020; Dehbozorgi et al., 2022). As such, peer support groups are likely to foster hope and provide emotional relief as they offer a valuable opportunity for caregivers to connect with others experiencing similar challenges (Lohrasbi et al., 2023). It is advised for trained mental health professionals to facilitate these groups and use the opportunity

to educate families on coping strategies and distress tolerance skills, as many caregivers adopt maladaptive coping over time, predisposing them to burnout and long-term mental health challenges. Furthermore, encouraging the sharing of lived experiences amongst group members can help provide them with a sense of community and the ability to learn from those with firsthand experiences.

Enhancing Professional Development to Improve Service Provider Competency

A significant barrier to family-centred care is the lack of competency and confidence among service providers (Cameron et al., 2024; Hansson et al., 2022a). Service providers typically believe breaching confidentiality is necessary for family involvement despite evidence that families primarily seek guidance rather than client-specific details (Hansson et al., 2022b). Most professionals feel underprepared to navigate the complexities of family involvement, confidentiality, and ethical dilemmas as there is limited training for this issue as the experiences of families are overlooked (Hansson et al., 2022a).

The CPA (2017) Standard II.9 highlights the importance of psychologists engaging in peer consultation, supervision, and continuous education to be knowledgeable about current clinical situations impacting individuals and groups. As such, clinical directors and supervisors are advised to offer professional development training focusing on understanding the ethical frameworks guiding family involvement in mental health care. Given that service providers often struggle with balancing the duty of confidentiality with the potential benefits of including family members in treatment discussions, training programs should include case-studies that explore scenarios where ethical dilemmas arise and how to approach them (Hansson et al., 2022a; Szmukler & Bloch, 2018).

In addition to ethics-based training, interpersonal communication skills may be helpful for improving engagement with families. Caregivers often face significant mistreatment from service providers, resulting in feeling unheard and dismissed. As a result, families are likely to experience high levels of anxiety, grief, and burnout while struggling to navigate a system that does not adequately recognize their role (Finlay-Carruthers et al., 2018; Lindgren et al., 2010). In contrast, families had reported feeling respected when service providers listened and validated their concerns, highlighting the importance of the therapeutic alliance (Aass et al., 2020). Therefore, professional development training should emphasize key skills such as reflective listening, validation, and fostering empathic connection. Moreover, interdisciplinary collaboration should be encouraged through joint training programs for psychologists, social workers, and medical professionals to enhance collaborative care approaches and increase awareness of available services and client referral options (Ong et al., 2021).

Discussion

The analysis of the literature behind these recommendations is based on limited resources and research findings specific to the Canadian context. The scarcity of academic and peer-reviewed Canadian research was a barrier to developing an educational resource to address the level of awareness among Canadian service providers and the impact of ethical legislation on their practice. To ensure the recommendations align with the ethical standard for Canadian psychologists, they were reviewed in reference to the CPA (2017) Code of Ethics as a guiding

framework. As a result, their generalizability may vary depending on the regulatory bodies of different professions. With growing public awareness and concern about family involvement, service providers need to be educated on how to support families while adhering to ethical guidelines. The recommendations presented in this article may be of great interest to other professionals who work with adults and their families in the public, but more specifically in the mental health sector (e.g., psychologists, nurses, social workers, psychiatrists, and family physicians). Future research may help inform training initiatives, guide policy reform, and explore organizational barriers that impact the implementation of family-centred care.

Future Research Suggestions

An important area for future research involves exploring the experiences, knowledge, and awareness of psychologists with respect to this issue. As highlighted by Ong et al. (2021), this gap in the literature is significant, as limited research explores collaboration among various service providers in this area of practice despite its potential value. Counselling and clinical psychologists are often a primary point of contact for individuals with mental health disorders, making it crucial to examine their insights and identify areas where they could enhance existing practices. These psychologists may play a pivotal role in developing psychoeducational and peer support groups. Additionally, their expertise in providing services while prioritizing the working alliance may be a valuable opportunity for research to investigate how other service providers can incorporate these skills to improve service delivery (Raymond et al., 2017). By addressing this gap, there can perhaps be increased opportunities to progress towards collaborative and interdisciplinary care.

Another area of needed attention would be research on barriers beyond confidentiality to family inclusion in treatment planning. Eassom et al. (2014) and Hansson et al. (2022b) are among the few researchers who discuss organizational challenges as a barrier, highlighting their role in limiting collaboration and successful integration of family-centred care. There is value in expanding research into organizational factors, such as resources, funding, and policies, as these components are necessary for effective service delivery. Without a clear understanding of these organizational issues, it will be difficult to assess the feasibility of the recommendations in this article, as they are partially reliant on organizations and their willingness to adopt and act on these recommendations.

Conclusion

This article aims to inspire a pan-Canadian initiative to educate service providers on the mental health outcomes of families caring for involuntary adults with a mental health diagnosis. Its intent is to support an increase in awareness and training for service providers so that they may be better equipped to offer appropriate support without breaching confidentiality and how to best ensure that the mental health of caregivers' is sufficiently supported.

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APPENDIX 2: INSTRUCTIONS FOR AUTHORS FROM FAMILY, SYSTEMS, & HEALTH

The draft manuscript provided in Appendix 1 will be submitted to Family, Systems, & Health in accordant with the submission preparation guidelines provided next. The following instructions are extracted directly from the source below:

Families, Systems, & Health. (n.d.). American Psychological Association. Retrieved March 9, 2025, from <https://www.apa.org/pubs/journals/fsh>

Journal Scope Statement

Families, Systems, & Health[®] is a peer-reviewed, interdisciplinary journal addressing integrated care, with a particular focus on health, systems, and family science.

We are using the Peek Lexicon definition of integrated care: “The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.” (Peek & National Integration Academy Council 2013, p. 2).

Families, Systems, & Health seeks to develop the knowledge base of a systemic approach to healthcare that integrates mind and body; individual and family; and communities, clinicians, and health systems while considering cost-effectiveness and distributive justice.

The journal's scope includes the following three domains:

- **Family Functioning:** emphasizes understanding health, illness, and treatment from birth to death within the family context rather than focusing on individuals in isolation. The term "family" is used broadly to include but not be limited to the legal, biological, or psychological family, household members unrelated by blood or marriage, and intimates who have a relationship over time.
- **Systems Thinking:** an overarching concept that recognizes the interrelatedness of all human systems (e.g., biological, psychological, interpersonal, familial, societal, political, economic, cultural, spiritual). This perspective is useful in examining dynamics within a profession or among clinical staff, relationships among patients, families, communities, and clinical staff, and the coordination of care across levels of the health system.
- **Health:** refers to the optimal state of the body, mind, and spirit of individuals, families, or communities. Healthcare includes the practice of all health professionals, including physicians, mental health professionals, nurses, pharmacists, and many other disciplines.

Instructions to Authors

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Please use the [Manuscript Submission Checklist \(PDF, 40KB\)](#) as a guide for submission. Authors must review all items on this checklist before submitting to the journal.

Manuscript Submission

All manuscripts are considered on the understanding that they have not been published previously in print or electronic form and that they are not under consideration by another publication or medium. All manuscripts should respect patient confidentiality; research involving human subjects must include ethical approval.

Submit manuscripts electronically (.rtf, .doc, or .pdf) via the Manuscript Submission Portal.

Manuscript Criteria

All manuscripts should be concise, well organized, and clearly written using active voice to present ideas relevant to the journal's scope of integrated care and should address health and at least one of the two other domains of family functioning and/or systems thinking.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Authors should ensure bias-free language (see Chapter 5 of the *Publication Manual*). [APA Style and Grammar Guidelines](#) for the 7th edition are available. Review APA's [Journal Manuscript Preparation Guidelines](#) before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the [APA Style website](#).

When required, structured abstracts should follow the Introduction, Methods, Results, Discussion (IMRAD) format.

Reporting standards: Adhere to relevant Equator Network reporting guidelines, such as CONSORT for randomized trials, STROBE for observational studies, SQUIRE for quality improvement studies, or prisma for systematic reviews and meta-analyses. Submit a completed reporting guideline checklist as a Document for Reviewers and include a participant flow diagram in the manuscript. Adhere to the APA Journal Article Reporting Standards (JARS) for items that are not addressed in the Equator Network guidelines.

Manuscript Categories

Manuscripts should be organized using the Introduction, Methods, Results, and Discussion (IMRAD) structure with references using APA Style. All research articles and brief reports must state in the Methods section which institutional review board (IRB) provided ethical review and oversight of the study or exemption from IRB review.

Word count does not include the content of the title page, abstract, appendices, tables, figures, or reference list following the manuscript. Reference terms in the text are included in word count.

Research Articles (Qualitative/Mixed Methods): Up to 5500 words

Research Articles (Other Methods): Up to 3500 words

Brief Reports: Up to 1500 words

Review Articles: Up to 5500 words

Commentaries: Up to 1000 words

Comments and Replies: Up to 600 words

Conceptual Articles: Up to 3000 words

- Conceptual articles are well-constructed explorations of topics consistent with integrated care and health, as well as family functioning and/or systems thinking. Specific areas of interest include but are not limited to: behavioral health in primary or specialty health care, health system process change (including rigorous quality improvement efforts), and health outcomes, and family-centered interventions (especially in medical settings). These articles rely on the integration of relevant literature combined with the authors' effort to analyze, synthesize and, evaluate clinical, research, and educational topics. On this foundation it is appropriate for authors to propose new clinical, educational and research ideas.

Cover Letter/Title Page

Both the cover letter and the title page of the manuscript should include the title, authors' names in order of contribution, and affiliations.

Designate a corresponding author and include address, e-mail, phone, and fax. **A word count should also be included on the title page** (excluding title page, abstract, appendices, tables, figures, and reference list following the manuscript).

An author note on the title page should also indicate:

- full names of authors, in the order of their institutional affiliations, with lead author listed first;
- affiliation and location during the study plus current affiliation and location if they have changed since the study;
- grant support and role of funder if any in role of preparation;
- any acknowledgment the authors wish to convey regarding collaborators whose contributions did not merit authorship; and
- any real or perceived conflict of interest that the author may have, considering the ICMJE criteria for authorship.

Please see the *Publication Manual of the American Psychological Association* (7th edition) for further guidance on the format of an author note.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statement

Authors submitting manuscripts to *Families, Systems, & Health* are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public. This description should be included within the manuscript on the abstract/keywords page.

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