Advancing Family-Centred Care in Child and Adolescent Mental Health

A Critical Review of the Literature

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Abstract

Family-centred care (FCC) is a key factor in increasing health and related system responsiveness to the needs of children and families; unfortunately, it is an unfamiliar service model in children's mental health. This critical review of the literature addresses three key questions: What are the concepts, characteristics and principles of FCC in the context of delivering mental health services to children? What are the enablers, barriers and demonstrated benefits to using a family-centred approach to care in children's mental health? And how can we facilitate moving an FCC model forward in children's mental health?

A range of databases was searched for the years 2000–2011, for children ages zero to 18 years. Articles were selected for inclusion if a family-centred approach to care was articulated and the context was the intervention and treatment side of the mental healthcare system.

This literature review uncovered a multiplicity of terms and concepts, all closely related to FCC. Two of the most frequently used terms in children's mental health are *family centred* and *family focused*, which have important differences, particularly in regard to how the family is viewed. Initial benefits to FCC include improved child and family management skills and function, an increased stability of living situation, improved cost-effectiveness, increased consumer and family satisfaction and improved child and family health and well-being.

Significant challenges exist in evaluating FCC because of varying interpretations of its core concepts and applications. Nonetheless, a shared understanding of FCC in a children's mental health context seems possible, and examples can be found of best practices, enablers and strategies, including opportunities for innovative policy change to overcome barriers.

Family-centred care (FCC) is a key factor in increasing health and related system responsiveness to the needs of children and families; unfortunately, it is an unfamiliar service model in children's mental health. This critical review of the literature was commissioned in 2007 by the Southern Alberta Child and Youth Health Network (SACYHN), a dynamic, voluntary collaboration among individuals and organizations in southern Alberta concerned with the health and well-being of children, youth and families. The following key questions guided this critical review of the literature:

- What are the concepts, characteristics and principles of FCC in the context of delivering mental health services to children? (References to *child* and *children* in this document include children, adolescents and young adults.)
- What are the enablers, barriers and demonstrated benefits to using a family-centred approach to care in children's mental health?
- How can we facilitate moving an FCC model forward in children's mental health?

Literature Review Methods

A range of databases (e.g., MEDLINE, PsycINFO, ERIC, Cochrane, Social Sciences Abstracts) was initially searched for the years 2000–2007, for children ages zero to 18 years; it was updated in 2010–2011. A search for grey (unpublished) literature was undertaken as well, reviewing materials and websites noted by local experts and referenced in the literature. Google and Google Scholar search engines were also used.

> **A paradigm shift** is required in which families are viewed as a key part of the solution rather than as part of the problem.

Articles were selected for inclusion if a family-centred approach to care was articulated (see "Multiplicity of Terms and Concepts," below, for the conceptualization of FCC used) and the context was the intervention and treatment side of the mental health care system. The initial search yielded a total of 270 full-text articles that were retrieved and reviewed; of these, 68 articles – 42 from the peer-reviewed literature and 26 articles/reports from the grey literature – were included in the literature review report (Spragins 2007). The update search conducted in 2010–2011 yielded an additional 10 articles for inclusion in this review.

Conceptualizing Family-Centred Care in Children's Mental Health

There are many definitions and descriptions of family-centred care (FCC; Allen and Petr 1996; Dunst et al. 2002; Institute for Family-Centered Care n.d.; MacKean et al. 2005), but central to most are these core principles (MacKean et al. 2005):

- Placing the patients and their family at the centre of every care decision
- Providing care that is focused on the persons as individuals, rather than the diseases, in the context of their family and community
- Considering patients and their families as the experts on their own needs and values
- Enabling patients (and their families) to be active participants in the decision-making around their own (or their family member's) care
- Developing a truly collaborative relationship or partnership between health professionals and patients and their families that is based on mutual respect

Because partnership is so critical to FCC, it is important to be clear about what *partnership* means. True partnership involves working together to achieve something that would be difficult or impossible to do alone, and it is characterized by the following (Jeppson and Thomas 1997; MacKean et al. 2005; Thompson 2007):

- The identification of a common goal to work toward and joint evaluation of progress
- Mutual respect about what each partner brings to the partnership
- Open and honest communication and two-way sharing of information
- Shared planning and decision-making
- Ongoing negotiation about the role that each partner can and wants to play in the partnership over time

A Multiplicity of Terms and Concepts

This literature review uncovered many terms and concepts closely related to or used synonymously with *family-centred care*. *Family-centred care, family-centred service, family-centred practice, family-focused care, family-focused service* and *family-focused practice* are the most commonly used terms in the literature reviewed. In the children's mental health literature from North America, the terms *system(s) of care* and *wraparound* are also commonly seen. Another term closely related to FCC predominant in the adult mental health literature is *recovery*, and there is increasing discussion about how recovery might be used in the context of child and youth mental health. The concept of recovery is the foundation for transforming adult mental health systems across much of the developed world, including here in Canada where *Out of the Shadows at Last* (Kirby and Keon 2006) called for recovery to be placed at the centre of mental health reform (Mental Health Commission of Canada 2009).

Is It Family Centred or Family Focused?

Family-centred and family-focused approaches are often portrayed as similar or equal to each other, but there are important inherent differences between the two, especially in relation to how the family is perceived (Dunst et al. 2002). The differences (Table 1) are clearly reflected in the early literature on FCC from the disability sector.

Benefits of a Family-Centred Approach

In the literature reviewed, many benefits of a family-centred approach to care were described. These benefits, identified through evaluation or research (American Academy of Pediatrics 2003; Centre for Addiction and Mental Health 2004; Chenven 2010; Cook and Kilmer 2004; Huang et al. 2005; Kaas et al. 2003; MacKean et al. 2005; President's New Freedom Commission on Mental Health 2003; Winters and Pumariega 2007), include those shown in Table 2.

Given these potential benefits of taking a family-centred approach to care, increasing interest is being expressed by policy makers, service delivery organizations and mental health practitioners in advancing FCC in a variety of settings. Many children with mental health issues and their families, realizing that the traditional mental health service delivery models are not meeting their needs, are also advocating for change.

Advancing FCC in Policy and Practice

Barriers and Challenges

Moving from theory to practice is never an easy thing to do, and putting FCC into practice generally, and specifically in the context of children's mental health services, is no exception. Many challenges and barriers to the implementation of FCC were noted in the literature reviewed (Canadian Medical Association 2004; Cavanaugh et al. 2008; Handron et al. 2001; Hanna and Rodger 2002; Kaas et al. 2003; Kamradt 2001; Kirby and Keon

TABLE 1.
Comparison of family-centred and family-focused approaches to patient care

Family-Centred Approach	Family-Focused Approach
Sees the patient and family as the experts on themselves. Patients and their families are active participants in all aspects of services and involved in decisions about care.	Believes that professionals are the experts on patient and family issues. Patients and their families can be helpful to professionals.
Feels patients, families and professionals bring different strengths and resources to the working relationship.	Sees the patient and family as having important information about themselves to share with professionals.
The helping relationship is set up as a partnership based upon trust, respect, honesty and open communication. Patients, families and professionals work collaboratively in addressing needs and concerns.	Professionals are friendly and respectful to families and want to have a positive working relationship. Family education is a focus of intervention.
The purpose of any intervention is patient and family empowerment.	The purpose of treatment is patient and family progress as defined by professionals.
Family-centred care begins with the first contact.	Family involvement begins after intake, eligibility and assessment take place, but before placement.
The identification of concerns and needs, family strengths and resources from various sources of support is the ongoing work of the partnership.	Patient and family input about long-range goals and plans is solicited, but professionals assume primary responsibility for planning interventions. Plans are made yearly and reviewed quarterly.
A broad-based perspective of patient and family needs permits flexibility for planning outcomes and for seeing different options for addressing outcomes.	Families are consulted about the appropriateness of existing services and agencies.
Each helping interaction is an opportunity for patients and their families to use their abilities and capabilities (strengths) or to learn new skills and abilities.	Family strengths are identified through an assessment process but not utilized in ongoing helping interactions.
Efforts are made to use and build patients' and families' informal support systems rather than to rely solely on professional services.	Professionals make information available on a variety of community services or assign a staff person to take care of patient/family needs and support as identified during assessment.

Source: Adapted from Western Carolina Centre (n.d.).

TABLE 2.
Benefits of a family-centred approach

At the Child and Family Levels	At the Service and System Levels
Improved child and family management skills and function	Improved cost-effectiveness of services
Increased stability of living situation	More effective use of healthcare resources
Greater educational attainment	Earlier access to services
Enhanced medication compliance	Reduced reliance on healthcare services
Hastened recovery from mental illness and addiction	Reduced out-of-home placement
Decreased family/caregiver stress	Reduced rate of re-hospitalization or relapse
Increased family/caregiver employment	Improved quality of care or services
Fewer contacts with law enforcement	Increased professional satisfaction
Lowered risk of mortality from substance abuse and suicide	Reduction of stigma through creating opportunities for dialogue
Increased child and family satisfaction	
Improved health and well-being of the child and the family	

2004; MacKean et al. 2005; McCammon et al. 2001; Osher and Osher 2002; Pierpont et al. 2001; Powell et al. 2001; Robinson et al. 2005; Rose et al. 2004; Tolan and Dodge 2005; Winters and Pumariega 2007). Some of the most critical are described below.

Defining Family

In today's context, family diversity should play a key role in the development and delivery of children's mental health care services. In a family-centred approach to service delivery, it is important to recognize that families define their own boundaries based on function, not form (Around the Rainbow 2006). They may not necessarily resemble a traditional nuclear family with children and their biological parents. Families may be temporary and live under many roofs; and they may include foster parents, step-siblings, grandparents and friends, to name a few examples. Families also vary greatly in their "beliefs, values, normative expectations for development and adaptive behaviours, parenting practices, relationship and family patterns, symptomatic expressions of distress, and explanations of mental illness" (Winters and Pumariega 2007: 290).

There is a shift from a crisis-oriented, professionally directed, acute-care approach focusing on unique episodes to a model that stresses continuing care, an ecological approach and long-term supports.

Transition to Adulthood

The transition to adulthood, which entails moving from the child to the adult healthcare system, is rarely smooth for children with chronic health conditions and can be a particularly challenging time for children with mental health problems. In many jurisdictions, the decision to transition a youth to the adult mental health system is most often guided by bureaucratic constraints and not a young person's developmental needs (Davis 2003). The result is that many youth receive services in settings designed either for younger children or older adults, neither of which address their particular needs. New approaches to transition planning are described as an important component of any system of care that emphasizes long-term recovery support (United Way of Calgary 2011; White et al. n.d.).

Working in partnership with children and their families can become increasingly complex in this context. While protecting the rights of children, legislation and guidelines about confidentiality and consent can cause major difficulties for families. In some cases, personal information cannot be shared without the young person's permission (Kirby and Keon 2006).

Stigma and Blame

The stigma associated with childhood mental illness – specifically that the parents or caregivers are at the root of the problem – has been linked to the reluctance of some professionals to include families as full partners in treatment plans (Osher and Osher 2002). In the areas of children's mental health, child welfare and juvenile justice, families have traditionally been blamed for the children's problems, and children have been seen as too young, too troubled or too disobedient to participate in decision-making (Osher and Osher 2002). Children with mental illness and their families often feel ashamed, with a major contributing factor being the perception they are responsible for the illness. As Michael Kirby stated, "My vision is that public attitudes will shift so much that parents won't feel stigmatized and discriminated against if their children need mental health help" (Haddad and Kirby 2010: 80). Pursuing a family-centred approach requires addressing the stigma associated with mental illness.

FIGURE 1.
An ideological orientation continuum

Professional-Driven Model	**Family-Infused Model**	**Professional-Infused Model**	**Family-Driven Model**
Characterized by:	*Characterized by:*	*Characterized by:*	*Characterized by:*
• Decisions made by professionals following professional assessment • Processes and practices determined by professionals • Heavy reliance on alternative care options such as foster care	• Professionals select the times for family involvement in decision-making processes • Professionals determine the processes regarding meeting venues, involvement of others etc.	• Family-driven processes, but with professional involvement at times of critical decision-making • Family more obviously dependent on professional help (compared with family-driven model) and professional keen to be involved	• Family-driven decision-making following full information access • Processes at all phases of the work focused on family solutions • Family development and monitoring of safety plans etc.

Professional Driven ⟷ Family Driven

Source: Adapted from Connolly (2007).

Traditional Training of Health Professionals

Traditional models of training in the healthcare professions have provided little orientation to working with families (Chenven 2010; Kaas et al. 2003; McCarthy et al. 2009) and inter-professionally (Handron et al. 2001). FCC can present a challenge because of its emphasis on collaboration. Recent evolving collaborative mental health care services require professionals from various disciplines to work together. These collaborative services do not, however, necessarily incorporate FCC approaches, in that the child and the family are often not considered to be part of the inter-professional team.

Provider-Driven or Medical Model

A healthcare providers' lack of collaborative orientation is closely related to the *provider-driven* or *medical model* that dominates the culture of healthcare (Chenven 2010; MacKean et al. 2005; Osher and Osher 2002). Osher and Osher (2002) describe a provider-driven model of service delivery where professionals and agencies are viewed as key to solving problems and, by virtue of their training, are assumed to possess the expertise and tools to diagnose problems and prescribe solutions. Treatment failures are often attributed to a lack of co-operation from the child and family.

Other authors (Lawlor and Mattingly 1998, cited in Hanna and Rodger 2002) describe this as a clinic culture, features of which include the persistence of the *therapist as expert* view; the idea that spending time to develop rapport with and elicit perspectives and priorities from parents and the child themselves does not constitute real work or involves "soft skills"; and the tendency for services to be provided in a fragmented and specialized way, where each professional presents to the family a different definition of the child's problems. It is not possible to simply add the principles of an FCC philosophy to these traditional models of care – an ideological shift is required. Connolly (2007), for example, describes an *ideological orientation continuum* from a professional-driven model to a family-driven model (Figure 1). A family may ask for more professional help either in making difficult decisions or in providing specialized care or treatment (i.e., the professionally infused model in the continuum). This is still a family-centred approach to care as the family members are determining the role they want to play and what they feel comfortable handling at a particular point in time.

Enablers

An awareness of these barriers and challenges provides important contextual knowledge that can be used to identify enablers for moving a family-centred approach to services into practice. There are promising practices where mental health services have been transformed to be more family centred, with clear benefits to the children they serve, their families and the mental health professionals themselves (American Psychiatric Association 2002; Cavanaugh et al., 2009; Chenven 2010; Huang et al. 2005; Kamradt 2001; Lepage 2005; Taccheri 2005; Winters and Metz 2009; Winters and Pumariega 2007). Through the research done in this field, and the documentation and evaluation of promising practices, some clear enablers for advancing FCC are emerging. System-wide change efforts are more likely to be successful if applied at multiple levels.

The Macro- or System Level

Central to the concept of FCC is the development of true collaborative relationships with children and their families. Such relationships can only be developed if mental health systems and the people working within them recognize and build upon the strengths and capabilities of children and families. Closely related is the importance of recognizing that people who access children's mental health services have valuable expertise about what does and does not work in our systems from a client perspective (Canadian Mental Health Association 2006). There is increasing recognition that this client expertise contributes toward the development of a safer mental health care system (Brickell et al. 2009), and one that is more responsive to the needs of children and their families.

A family advocacy movement, in the context of other societal trends, has driven the move to FCC in child health at a policy level. However, the required shift in thinking from seeing families as part of the problem to seeing them as part of the solution has been particularly slow in coming in children's mental health (Kirby and Keon 2006). Due to the stigma associated with mental health issues, families have not been as strong in advocating for change in mental health as they have been in other areas of child health, but this is beginning to change (Winters and Pumariega 2007). There are recent signs of positive change occurring in Canada. The Institute of Families for Child and Youth Mental Health, founded in 2009, acts as a catalyst for connecting families with service providers, educators, researchers, policy makers and others, all of whom have a common desire to improve mental health outcomes for children, youth and families. Its first initiative was to establish "Family Smart™, an identity that will be used to identify and endorse programs, practices, policies, services and research that families have identified as meaningful and helpful to them" (Institute of Families, n.d.).

The principles of FCC need to be incorporated into the research and education agendas. The more opportunities that mental health professionals and researchers have to work with and hear the perspectives of children and their families, the more likely they are to see them as part of the solution and the greater the relevance of research and education. The more opportunities that children and families have to be involved in shaping these agendas and in sharing their perspectives, the greater their confidence in their own strengths and capabilities (McCammon et al. 2001). Once again, the Institute of Families has identified this as one of their priorities, hosting a child mental health research forum where families and youth worked collaboratively with researchers, service providers and policy makers to identify user-defined research directions (Davidson et al. 2010).

The Meso- or Organizational Level

Advancing FCC across an organization requires a commitment from the very top to support mental health professionals and staff to work in a family-centred way. This can involve multiple strategies, including the development of a vision, mission and values that promote FCC; the creation of enabling organizational policies (e.g., flexible visiting policies); hiring staff who believe in and wish to practise in a family-centred way; orienting mental health professionals and providing ongoing opportunities for them to learn about family-centred approaches, including learning from children and families; engaging children and families to work with organizations in the development and evaluation of services; and celebrating and rewarding exemplary family-centred practice (Bruns et al. 2006; Canadian Mental Health Association 2006;

TABLE 3.
Examples of enabling a family-centred approach at the direct service level

Partnership between families and direct service providers
• Use child- and family-driven team treatment planning, where the child and family define the desired outcomes and select individuals to add to the team • Include children as fully franchised members of the team • Use a strengths-based orientation that looks at needs rather than problems • Promote hope and optimism • Involve children and their families meaningfully in multiple aspects of intervention • Provide children and their families with accurate, understandable and complete information so they can make informed choices • Make decisions collaboratively that reflect family rather than therapist goals • Include foster parents as partners in the treatment of children in their care • Recognize and celebrate family diversity
Ecologically targeted interventions
• Address barriers to care • Access strengths and resources in the natural environment of the child and family, including peer support • Use system resources strategically to meet the child and family's needs in multiple domains • Provide services that are flexible and responsive to child and family needs, concerns and priorities • Provide services in primary care settings, pediatric settings and schools • Adopt culturally specific therapeutic modalities • Promote the active involvement of children and families in decision-making, including pharmacology decisions

Sources: Data from Austin (2004); Friesen (2005, 2007); Hanna and Rodger (2002); Osher and Osher (2002); Tolan and Dodge (2005); Winters and Metz (2009); and Winters and Pumariega (2007).

Centre for Addiction and Mental Health 2004; Institute for Family-Centered Care n.d.; MacKean et al. 2005; McCammon et al. 2001; Winters and Pumariega 2007). Both front-line service providers and children and their families need forums where they can voice their positive experiences as well as the challenges with working together in this new way (Cavanaugh et al. 2009; Institute for Family-Centered Care n.d.).

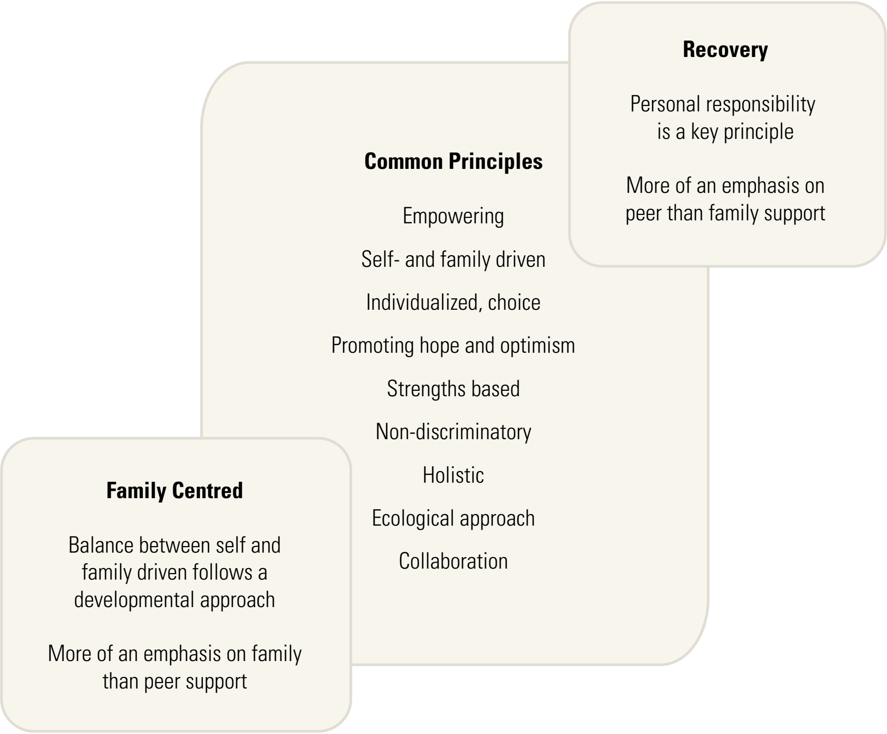
The Micro- or Direct Service Level

In a family-centred approach to services, assessment and treatment are guided by the ecological context of the family, incorporating information about formal and informal community supports (Winters and Metz 2009; Winters and Pumariega 2007). Consideration is given to both the immediate and extended family systems, as well as to extra-familial systems such as school, work, peers, primary healthcare and community or cultural institutions (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment 2001; Storck and Vander Stoep 2007; Winters and Pumariega 2007). Systemic issues related to legal, social and financial concerns that affect care are also considered (Winters and Pumariega 2007). A social ecological assessment facilitates the development of targeted interventions that are matched to the particular circumstances of the child and family and address any barriers to care (Tolan and Dodge 2005; Winters and Pumariega 2007). Some practical examples of enabling FCC are outlined in Table 3.

Two interconnected models of care that exemplify a family-centred approach in children's mental health – systems of care and wraparound – have been evolving in the United States in particular over the past 20 years. *Systems of care* was developed in the 1980s to address the needs of children with serious mental and emotional disorders (Chenven 2010; Huang et al. 2005; Winters and Metz 2009; Winters and Pumariega 2007). In a systems-of-care approach, agencies work together and collaboratively with families to ensure that children and their families have access to the services and supports that they need to succeed (US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration n.d.). The systems of care model is described as a community-based,

FIGURE 2.

Common values and principles underlying the concepts of family-centred care and recovery, as well as some key differences



Sources: Data from Cavanaugh et al. (2009); Friesen (2007); MacKean et al. (2005); and White et al. (n.d.).

child-centred, family-focused, culturally appropriate service approach in which care is tailored to the needs and preferences of individual children and families (Chenven 2010; Huang et al. 2005). Within the context of their families, the children are placed at the centre of the clinical process, and their families are acknowledged as full partners at all levels of system planning (Winters and Metz 2009). Families are included at every level of the process, and services are collaborative, integrated and provided in the least restrictive settings possible (Chenven 2010; Huang et al. 2005; Winters and Pumariega 2007).

Only by openly inviting the child and family perspectives will the development of truly collaborative working relationships at all levels of children's mental health systems continue to evolve.

A core component of the systems of care model is its use of wraparound. *Wraparound* is an "integrated assessment and planning process" (Winters and Pumariega 2007: 287) that literally wraps services around the children by using the strengths, needs and goals of individual children and their families along with services in the families' natural support system in developing the treatment plans (Huang et al. 2005; Winters and Metz 2009). In the United States, wraparound has become the national standard for service planning for children and youth with complex mental health needs and their families, and systems of care is the national standard for service delivery (Cavanaugh et al. 2009; Chenven 2010; Winters and Metz 2009). Although systems of care and wraparound are described here as direct service level examples of FCC, moving forward with these care models requires policy changes at the organizational and systems levels.

A parallel movement in the adult mental health and addictions field has been the advancement of the *recovery* concept. A recovery approach to mental health service delivery is one that focuses on the strengths and capabilities of individuals, and on people recovering a meaningful life in their respective communities while striving to achieve their full potential. Peer support is an important component of any recovery-oriented service delivery system. Underlying key recovery principles include hope, empowerment, choice and responsibility (Mental Health Commission of Canada 2009).

While the concepts of recovery, systems of care and family-centredness originate from different sources and use different words, there are common key values and principles that cut across these concepts (North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services 2011): they all indicate a shift from a crisis-oriented, professionally directed, acute-care approach focusing on unique episodes to a model that stresses continuing care, an ecological approach and long-term supports (Cavanaugh et al. 2009; White et al. n.d.). Figure 2 outlines the common values and principles that underlie both FCC and the recovery model, as well as some of the key differences.

There is ongoing debate about how the benefits and limitations of recovery as an organizing concept fit for child and youth mental health and addictions services (Cavanaugh et al. 2009; Friesen 2005, 2007; White et al. n.d.). Certainly, the related elements of hope, optimism, planning for the future and peer support that are central to the recovery concept are greeted very enthusiastically by youth and family members (Friesen 2005, 2007). A major concern about using recovery is the confusion associated with the actual term or definition of recovery (Cavanaugh et al. 2009; Friesen 2005, 2007; Mulvale and Bartram 2009; White et al. n.d.). Confusion arises because the term applies to so many different concepts in everyday usage. For example, in the Canadian context, *recovery* may refer to anything from "recovering from a bout of flu" to "recovering the puck" in a hockey game (Mulvale and Bartram 2009). With respect to the healthcare context, the term *recovery* implies "cure" (Friesen 2007).

Implications for Policy, Practice and Research

This critical review of the literature indicates that there has been a sufficient body of evidence accumulated to support FCC as best practice in children's healthcare, including mental health. There are, however, unique challenges in moving forward with FCC in children's mental health. The emphasis in the literature is clearly beginning to shift away from trying to understand the concept of FCC and whether it represents a positive systems change, to how to practise FCC in the varied contexts in which children's mental health services are delivered. Keeping both this shift in focus and the complex context of children's mental health service delivery in mind, implications for policy, practice and research are raised here for consideration.

An important implication relates to the definition of *family*, with a particular focus on the transition between adolescence and adulthood. There is a need to identify the best approach, with a goal of ensuring that care is not interrupted or compromised, to supporting families who are able to remain involved when the young person wants their continued participation. As children mature, it becomes increasingly important to pay attention to who they identify as their main source of support. Although evidence indicates that parents and other immediate family are often still major sources of support, this is not always true. Mechanisms need to be developed that enable young people to identify and engage additional or alternative support systems.

A second implication relates to the issue of stigma and blame.

Children do not live in isolation; they are cared for and nurtured in their families and communities. A paradigm shift is required in which families are viewed as a key part of the solution rather than as part of the problem. Professionals working in children's mental health services should actively invite youth and families to be involved at all levels. Policies need to be developed that both support this social ecological approach and enable the identification of and building on strengths and function. The Mental Health Commission of Canada has recently been established, a major focus of which is addressing stigma. It has identified advancing a patient- and family-centred approach to care as a key strategy for doing so (Kirby and Keon 2006). As Haddad and Kirby recently stated, "The system is very much organizationally driven … but we've got to get beyond that approach and focus on how we're going to build a patient-centred system" (2010: 79).

Third, issues of acuity, competence and children's stages of development mean that FCC may look very different throughout the continuum of a child's mental illness. At times when a child requires immediate and critical intervention, it may not be possible to involve the family in treatment planning and decision-making to the extent one would like. The child's involvement in treatment decisions will evolve with their development and fluctuate with acuity and competence. Ultimately, FCC is occurring as long as the child is continuously viewed as an individual in the context of the family and community, and the ultimate goal is to work collaboratively with the child and the family in the contexts of their everyday lives.

A fourth implication relates to the education of, and ongoing professional development for, children's mental health professionals. Service providers must be supported in acquiring the skills needed to practice FCC. Working collaboratively, with children and families recognized as part of the interdisciplinary team, viewing children in the context of their families and communities, and being able to identify and build on child and family strengths with a focus on instilling hope and optimism require new knowledge and skills.

Fifth, organizational structures and policies need to support service providers in using their new knowledge and skills. Compensation options for physicians and allied health professionals, for example, must support professionals working together with each other and with children and families, recognizing that relationship development takes time. Professional practice standards and codes of ethics also need to incorporate these new ways of working.

Finally, policy development is required that enables child and family involvement at all levels (i.e., system, organization, direct service provision) so that children's mental health service delivery systems are safe and responsive and support service providers to work in partnership with children and families. Only by openly inviting the child and family perspectives will the development of truly collaborative working relationships at all levels of children's mental health systems continue to evolve. This is true not only for service policy, planning and delivery but also for research and evaluation.

As noted previously, the concept of recovery is providing the foundation for transformation in adult mental health and addictions services. The distinction between recovery and FCC is more related to the developmental stage of children than to differing underlying values and principles. The relationship with the children's families is more central to the concept of FCC, but this is developmentally appropriate given that children and youth are more dependent on their families. As youth transition to adulthood and they become more autonomous and responsible, the weight shifts from being largely family driven to being more youth driven. Ultimately, the difference is more on the emphasis as, ideally, all individuals have families (broadly defined) that are central in their lives and continue to support them on their recovery journey.

In conclusion, FCC is the standard of practice for child healthcare. Many children have both mental and physical health issues, so having a common standard of care across child healthcare is essential. The literature clearly shows that a family-centred approach must be integrated into policy and practice if we are to move forward with developing a high-quality, safe children's mental health system. FCC will become increasingly important as more mental health services are delivered in the community, where the majority of ongoing care and support of children is being provided by families. Our role as practising health professionals and policy makers is to continue to work in partnership with children and their families, in all their diversity, to optimize the mental health and well-being and, thus, the present and future quality of life of children and youth. HQ

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