



Release of Information to Families

We are the families of people living with mental health disorders. With rare exceptions, we are their closest, strongest and most caring allies. We are the people best informed, most invested, and best able to support our loved ones over the long haul – during periods of illness and when they are well. We are the people both expected and willing to, assume the on-going support of our family members, particularly after exacerbations of their illness. As such, we should be an integral part of their care.

All too often though, we are excluded from being given information about, or providing input to their care. This is not a routine feature of any other disease process. We see many forward-looking, excellent family centered care practices in psychiatry in other parts of the world and even other parts of Canada. We recognize that the Ontario Mental Health Act has additional requirements for consent for people with mental health diseases, however, it is our view that this requirement is routinely overemphasized and some quite easy options to include the family are routinely neglected, to the detriment of our family members' clinical outcomes and general interests. We would reference a growing body of evidence worldwide around the model of family centred care and more locally the work of Dr. Billy Chan, University of Toronto, a social worker at the Law and Mental Program at the Centre for Addiction and Mental Health and Ann-Marie O'Brien a social worker at Royal Ottawa Hospital and adjunct professor at Carleton University, in a 2011 article in the International Journal of Law and Psychiatry, as well as a legal opinion by Professor R. Solomon, Faculty of Law, Western University, London, ON.

Beyond favouring changes to the Ontario Mental Health Act, we endorse the following measures that could be instituted immediately, easily, and without legislation changes.

1. As a person is admitted to care (including regular and emergency wards, clinics, doctor's care, recovery homes, etc.,) that there be an immediate discussion about family members or others that they would be willing to have 'broad information' shared with. While the general consent to care is being signed seems an obvious time for this. If the person is not amenable at that time because of crisis, psychosis, agitation..., the issue could be broached with them again as their condition stabilizes.
2. If the person is deemed not competent to make rational/reasonable decisions, the family then is informed and able to be the default decision maker.
3. Families should be informed if there is a perceived risk to them. We note that many instances of family violence, and even deaths, stem from a failure to sufficiently appraise and advise families of these risks.
4. Families should be included in the discharge plan as they are almost always implicated in the discharge care.

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