FAMILY WORK IN FOUR EARLY PSYCHOSIS INTERVENTION PROGRAMS: AN EXPLORATORY STUDY (APPLIED HEALTH RESEARCH QUESTION)

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CONTEXT

Family support is a recommended practice in guidelines for Early Psychosis Intervention (EPI) programs worldwide and is included in the Ontario *Early Psychosis Intervention Program Standards*[1]. However, implementation is often a challenge due to time and resource constraints. Additionally, a lack of fit between delivered support and family needs and preferences can affect family uptake. The Pyramid of Family Care[2] is a hierarchical framework of family support options based on the premise that many families require minimal support within the scope of most programs to provide, while a smaller portion requires more intensive support and the expertise of specialist providers. The Pyramid outlines five levels of family support of increasing intensity and specialization: 1 – Connection and assessment services, 2 – General education, 3 – Psycho-education, 4 – Consultation, and 5 – Family therapy.

Recent surveys of Ontario Early Psychosis Intervention (EPI) programs found variation in family support implementation in relation to the *Standards*. Additionally, programs varied in their approaches to delivery (e.g., through a dedicated family worker or a distributed role among staff alongside client care).

The present project responded to an Applied Health Research Question posed by the Early Psychosis Intervention Ontario Network (EPION) to learn more about family work delivery in relation to the Pyramid levels of care. It builds on a previous ARHQ project for EPION – a systematic literature review of the barriers and facilitators to implementing support for families of individuals experiencing early psychosis. The aim of both projects is to inform EPI program efforts to meet the *Ontario EPI Program Standards*.

OBJECTIVES

To examine delivery of family support in relation to the Pyramid of Family Care in four Ontario EPI programs with differing service delivery models, and to learn about the barriers and facilitators to implementing such services.

METHODS

Programs were sought that represented the following service delivery models:

- dedicated family worker
- family work distributed role among EPI clinicians
- partnership arrangement with another agency to deliver family work.

Four EPI programs participated - one each for the dedicated and partner models and two for the distributed model to capture large and small programs. A key informant from each program was interviewed on: the services offered to families and how they related to the five Pyramid levels; implementation challenges and successes; and strategies used to monitor implementation. Based on interview texts, a profile of family work was developed for each program and key informants were given an opportunity to review and amend their own program profile.

FINDINGS

Programs in all four service models were able to directly provide Level 1 and 2 Pyramid components and make Level 3 support available to families, either directly or through a partner organization. Clinicians in three of the models could consult (Level 4) with their multidisciplinary team or nearby colleagues on issues pertaining to family work, whereas those in the partnership program referred families to their partner agency. None of the four models offered family therapy (Level 5) but referred families as appropriate.

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[1] Ontario Ministry of Health and Long Term Care, 2011.

[2] Mental Health Commission of Canada. (2013). *National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses.*

Among strategies used to facilitate family participation were having the clinician meet the family early to begin building a relationship, and being flexible in when and how supports were offered – e.g., offering evening support groups and home visits. Participation was also facilitated when families were offered opportunities to connect with one another, such as in support and education groups. A challenge for the partnership model was that some families were reluctant to go to another organization for support after developing a relationship with EPI program staff.

Program capacity to deliver family support varied across the four models. Balancing both clinical and family work was a challenge for the distributed role model teams. The partnership approach enhanced capacity but took time to develop. The dedicated worker model seemed less hampered by resource limitations. There was a moderate effort from the programs to systematize family work delivery through a care path and through some data collection.

CONCLUSIONS

Despite differing models and resources, all four programs were able to provide, directly or indirectly, family services related to all levels of the Pyramid of Family Care. However, programs varied in support options they offered to families at each level. Moreover, extent to which delivery was systematic in response to family needs is unknown. More clearly defining service delivery approaches, combined with related measurement, is an important next step for elucidating implementation successes and challenges, and to inform understanding of how to more effectively meet family needs.

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