

REVIEW ARTICLE

Barriers and facilitators to implementing family support and education in Early Psychosis Intervention programmes: A systematic review

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Family support is a core component of the Early Psychosis Intervention (EPI) model, yet it continues to have relatively low rates of implementation in practice. This paper reports results of a literature review on facilitators and barriers to delivering family interventions in EPI programmes. A search was conducted of 4 electronic databases, Medline, EMBASE, PsycINFO and Joanna Briggs, from 2000 to 2015 using terms related to early onset psychosis, family work and implementation. Four thousand four hundred and two unique studies were identified, 7 of which met inclusion criteria. Barriers and facilitators were coded and aggregated to higher-level themes using a consensus approach. Five of 7 studies examined structured multifamily psychoeducation. Uptake by families was affected by: family/client interest and readiness to participate; ability to access supports; and support needs/preferences. Implementation by programmes was affected by staff access to training and resources to provide family support. A key finding across the identified studies was that families have different needs and preferences regarding the timing, length, intensity and content of the intervention. One size does not fit all and many families do not require the intensive psychoeducational programmes typically provided. The reviewed literature suggests that flexible, tiered approaches to care may better meet family needs and increase rates of uptake of family support. However, more research is needed on the effectiveness of different models of family support in early psychosis and how they can be successfully implemented.

KEYWORDS

Early Medical Intervention, guideline adherence, health plan implementation, psychotic disorders, review

1 | INTRODUCTION

The importance of providing support to the families of individuals with mental illness has been widely recognized in the mental health field (Lynch, Mason, & McFarlane, 2013). Families often play an important role in caring for the ill individual and can experience considerable burden as a result (Awad & Voruganti, 2008). The provision of family support has been shown to lead to benefits for the family (eg, decreased stress, improved quality of life) and for the client (eg, reduced relapse, improved treatment adherence) (Dixon et al., 2010). A range of individuals, including family and friends, may provide support to those with mental illness; for the purpose of this paper we will refer to this whole group inclusively as “family.”

Support has been identified as particularly relevant for the families of individuals in the early stages of psychosis (Addington, Coldham, Jones, Ko, & Addington, 2003; Sin, Moone, & Wellman, 2005). Psychotic spectrum illnesses affect approximately 3% of the population over the course of their lifetime (Perala et al., 2007), and the majority experience their first episode between the ages of 14 and 35 (Kessler et al., 2005; McGorry, 2012). Evidence that early intervention for individuals with psychosis can lead to improved outcomes, including a decreased likelihood of relapse and hospital admissions and fewer symptoms, has led to the development of the Early Psychosis Intervention (EPI) model (Bird et al., 2010; Nordentoft, Rasmussen, Melau, Hjorthøj, & Thorup, 2014). The EPI model is a holistic, comprehensive model of medical and psychosocial

interventions provided early in the disease trajectory. One of the core components of the EPI model is providing support and education to families (Department of Health, 2001; Early Psychosis Guidelines Writing Group, 2010; International Early Psychosis Association Writing Group, 2005; Ontario Ministry of Health and Long Term Care, 2011).

The first episode of psychosis usually occurs during adolescence or early adulthood, and the ill individuals are often still living with or have moved back with their families (Addington, McCleery, & Addington, 2005; Addington et al., 2003; Patterson, Birchwood, & Cochrane, 2005). Family members therefore often take on the central role of caregiving and treatment seeking for their ill relative. An estimated 60% to 70% of the families of individuals with early psychosis have caring roles (Sin, Moone, & Newell, 2007).

Families new to psychosis can experience a number of challenges and needs specific to the early stage of the illness (Sin et al., 2005; Slade, Holloway, & Kuipers, 2003). They may feel grief over the perceived lost potential of their ill relative or changes in their relationship. They may be dealing with uncertainty about the diagnosis and the future trajectory of the illness. These families generally have high information needs, including the symptoms and behaviours associated with psychosis, medications and side-effects, available health services and supports, and coping mechanisms. Families may experience stigma from others and may still be trying to manage their own stigma towards the psychosis (Lepage, 2005; Petrakis, Bloom, & Oxley, 2014; Slade et al., 2003).

1.1 | Evolution of family support

Efforts to support families of persons with mental illness have been underway in the broader mental health field since the 1950s. Initially, this support was delivered in the form of family therapy, premised on the now rejected notion that family dysfunction caused schizophrenia. In the late 1970s, there was a shift away from blaming families to recognizing that they can be a major source of support for the ill person, though the demands of caregiving can be considerable. This led to the rise of family psychoeducation (Lynch et al., 2013).

Structured family psychoeducation is the most widely evaluated family intervention for mental illness (Dixon et al., 2010; Lucksted, McFarlane, Downing, & Dixon, 2012). It is an intensive multicomponent intervention, generally lasting at least 9 months, that provides a combination of information about the illness, practical and emotional support, crisis intervention, and training in communication and problem solving (Cohen et al., 2008; Dixon et al., 2010; Lynch et al., 2013). The benefits of family psychoeducation have been well documented in the literature (Lucksted et al., 2012; McFarlane, Dixon, Lukens, & Lucksted, 2003) and it is currently recommended in best practice treatment guidelines for persons with schizophrenia (Dixon et al., 2010) as well as included in the suite of evidence-based toolkits developed by the Substance Abuse and Mental Health Services Administration (2009).

More recently, it has been recognized that not all families want or need intensive psychoeducation (Dixon, Adams, & Lucksted, 2000; Dixon et al., 2010). Alternative models of family support have been proposed, including briefer interventions (Dixon et al., 2010; Lucksted

et al., 2012) and tiered models of care, premised on the idea that different families require different levels of support (Mottaghypour & Bickerton, 2005). Evaluation of these briefer models is still needed (Lucksted et al., 2012).

1.2 | Implementing family support

The importance of supporting families has received widespread recognition in the literature and in best practice guidelines, yet family support programmes remain “startlingly unimplemented” (Eassom, Giacco, Dirik, & Priebe, 2014) across mental health services. EPI specific studies also report low rates of implementation and uptake of family support in comparison with other components of the model (Addington et al., 2012; Gorrel et al., 2004; Leavey et al., 2004; O’Kearney, Garland, Welch, Kanowski, & Fitzgerald, 2004; Durbin, Selick, Hierlihy, Moss, & Cheng, 2014).

Two studies of EPI programmes in Australia reported challenges implementing family support with only 28% and 44% of families of programme clients, respectively, receiving some form of psychoeducation (Gorrel et al., 2004; O’Kearney et al., 2004). Addington et al. (2012) looked at the number of families who had received at least 4 psychoeducation sessions and similarly found it to be below half of the families in the programme. Although implementation rates have not been directly studied in Ontario, a recent survey of Ontario EPI programmes found that almost two-thirds said they needed more time to work with families (Durbin et al., 2014). It should also be noted that the threshold for receipt of family support used in these studies (generally between 1 and 4 interactions) is far lower than the 9 or more months of ongoing psychoeducation recommended in the literature.

The challenge of implementing research or guidelines into practice is not unique to family support. A broad evidence base shows that the existence of an evidence-based practice alone is insufficient to ensure implementation (Saeed, Bloch, & Silver, 2015). Rather, a proactive implementation process is needed that considers the programme context, and any potential barriers and facilitators which need to be addressed to increase the likelihood of success (Damschroder et al., 2009; Fixsen, Blase, Naoom, & Wallace, 2009). Learning more about barriers and facilitators is important to inform efforts to improve delivery and uptake of family support in EPI.

EPI families experience unique challenges related to the early stage of illness that may affect their use of family support (Sin et al., 2005; Slade et al., 2003) and it cannot be assumed that learnings from other populations will necessarily apply. The aim of this study was to synthesize published literature on barriers and facilitators to implementing family support in EPI programmes.

2 | METHODS

An electronic database search was performed of Medline, EMBASE, PsycINFO and Joanna Briggs databases from January 2000 to December 2015. This period was selected as the EPI model of care is relatively new; the international guidelines were only published in 2005 (International Early Psychosis Association Writing Group, 2005). Given the paucity of literature identified by early exploratory

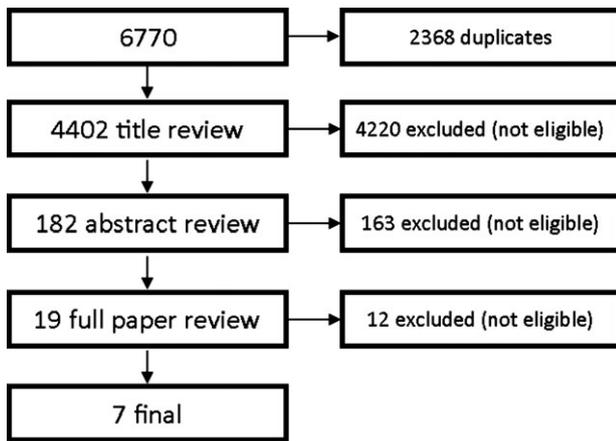


FIGURE 1 Search results.

searches, our search terms were broad to ensure that no studies were excluded. These included:

- (early OR early onset OR first onset OR first episode) AND (psychoses OR psychosis OR psychotic) AND (family OR families OR carer* OR caregiv* OR relative*)

As indicated in Figure 1, 3 rounds of screening were conducted to assess the relevance of papers to the review, first based on title, then abstract and finally full text. The first 2 rounds of screening were conducted independently by 2 team members and disagreements were resolved by a third. Full text reviews were conducted by 3 team members for the remaining articles and decisions were based on consensus.

A study was retained if it met the following criteria: (1) was an original collection of data; (2) focused on unpaid caregivers; (3) focused on early psychosis; (4) focused on family support or education; (5) included results describing barriers or facilitators to implementation or uptake. Studies that evaluated client outcomes but not implementation were excluded. Also excluded were conference abstracts, book chapters, dissertations, non-peer reviewed reports and papers not in English.

The database search identified 4402 unique articles. After excluding those not meeting inclusion criteria, 7 articles were included for review (see Table 1). With 1 exception, all were qualitative examinations of the experiences of families, clients and programme staff in using or delivering family support.

2.1 | Analysis

Different approaches to qualitative research synthesis have been proposed. Given the early stage of this literature, we conducted a narrative synthesis using a thematic analysis approach to identify and describe the emerging themes from the identified studies. Higher-level synthesis methods (eg, meta-synthesis) are relevant when the evidence base is more mature and there is interest in exploring relationships or developing theory (Kastner et al., 2012; Pope, Mays, & Popay, 2007; Thomas & Harden, 2008).

Three research team members participated in abstracting, coding and theming papers. Each article was independently abstracted by at least

2 members of the research team using a structured template capturing the study objective, methods, sample, intervention description, intervention participation, results and author recommendations. The results were entered in the template spreadsheet as barriers, facilitators and other findings. The text on barriers and facilitators was coded independently by 2 team members and the identified codes were reviewed by 3 team members and discussed until consensus was reached. A final step aggregated the codes to higher-level themes using a similar consensus process.

3 | RESULTS

3.1 | Study characteristics

Table 1 describes the 7 reviewed papers. One study reports quantitative intervention participation data (Fjell et al., 2007), the others are qualitative examinations of delivery and use of family support. Three include feedback from programme staff (Nilsen, Norheim, Frich, Friis, & Røssberg, 2015; Petrakis et al., 2014; Slade et al., 2003), 4 include feedback from families (Mccann & Lubman, 2014; Nilsen, Frich, Friis, & Røssberg, 2014; Petrakis et al., 2014; Riley et al., 2011), and 1 includes feedback from the client (Nilsen et al., 2014). Client and family feedback were generally obtained from individuals recruited during or after their programme participation. Only 1 article (Petrakis et al., 2014) includes the perspective of families who had dropped out or declined to attend the programme.

The studied interventions all included some components of family psychoeducation. Five offered primarily multifamily psychoeducation, 3 of these (Fjell et al., 2007; Nilsen et al., 2014, 2015) based on the full Macfarlane model (McFarlane et al., 2003) and 2 (Petrakis et al., 2014; Riley et al., 2011) with shorter, modified programmes. The intervention studied by Slade et al. (2003) offered a range of services with escalating intensity based on need, including psychoeducation components. Only 1 intervention (Mccann & Lubman, 2014) did not offer face-to-face services. Supports were instead provided through a structured self-help manual, an approach also known as bibliotherapy. Three of the interventions included the family only (Mccann & Lubman, 2014; Petrakis et al., 2014; Riley et al., 2011), and 4 included both the client and the family (Fjell et al., 2007; Nilsen et al., 2014, 2015; Slade et al., 2003).

3.2 | Barriers and facilitators

Four key themes were identified in the reviewed literature related to barriers and facilitators to implementing family support: family/client interest and readiness; family ability to access supports; family support needs/preferences and supports for staff. These themes should be understood in the context that the majority of the interventions studied were structured multifamily groups. Table 2 summarizes barriers and facilitators per study.

3.2.1 | Family/client interest and readiness

The first theme pertains to the family and/or client interest or readiness to participate in a family support programme. This theme can be broken down into 3 subthemes: family interest; client interest and timing.

TABLE 1 Characteristics of included studies

Study (author, date, country)	Title	Intervention	Study design/sample
Fjell et al. (2007); Norway and Denmark	Multifamily group treatment in a programme for patients with first-episode psychosis: experiences from the TIPS project	Type: Modified family psychoeducation. Three stages: individual sessions, multifamily educational workshop and multifamily groups (closed format) Length: Minimum of three individual sessions and will continue to meet bi-weekly until sufficient families to start a group; workshops were offered at start and completion of group; groups were 90 min, offered bi-weekly for 1 y Participant: Individual sessions and educational workshops are held separately for clients and families; multifamily groups include both client and family	Quantitative; cohort of 246 clients and their families invited to join family group
McCann & Lubman (2014); Australia	Qualitative process evaluation of a problem-solving guided self-help manual for family carers of young people with first-episode psychosis	Type: Bibliotherapy (self-help manual based on problem-solving therapy for families) Length: 5 modules, up to 2 h to complete each module; study participants were expected to complete one module per week Participant: Family only	Qualitative; semi-structured interviews; 24 family members who had participated in the programme ¹
Nilsen et al. (2014); Norway ²	Patients' and family members' experiences of a psychoeducational family intervention after a first-episode psychosis: a qualitative study	Type: Individual or multifamily psychoeducation ³ Length: Multifamily group was bi-weekly for 2 y; Individual was bi-weekly for 1 y (closed format) Participant: Family and client	Qualitative; semi-structured interviews; 12 patients (8 completed the programme, 4 attended less than half of the sessions) and 14 family members (all completed the programme)
Nilsen et al. (2015); Norway ²	Challenges for group leaders working with families dealing with early psychosis: a qualitative study	Type: Individual or multifamily psychoeducation ³ Length: Multifamily group was bi-weekly for 2 y; Individual was bi-weekly for 1 y (closed format). Participant: Family and client	Qualitative; semi-structured interviews (4 staff) and a focus group (5 staff); 9 of 19 staff recruited agreed to participate in study
Petrakis et al. (2014); Australia	Family perceptions of benefits and barriers to first-episode psychosis carer group participation	Type: Multifamily peer support and psychoeducation group Length: 2 h sessions held monthly; standalone sessions, open format (new families can join at any time) Participant: Family only	Semi-structured interviews; 8 staff and 10 family members (includes attended, dropped out and declined to attend)
Riley et al. (2011); United Kingdom	Carer's education groups for relatives with a first episode of psychosis: an evaluation of an 8-wk education group	Type: Multifamily group to provide support, information and social networking Length: 11 sessions, 2 h each (closed group) Participant: Family only	Qualitative; focus group; 12 family members who had participated in the programme ¹
Slade et al. (2003); United Kingdom	Skills development and family interventions in an early psychosis service	Type: All families offered home visit, assessment, psychoeducation and support. Intensity of support based on need Length: Variable depending on need Participant: Family and client	Qualitative; structured interview: 5 (EPI staff), 4 (staff from comparison site); focus group (EPI staff only); study participation rate not reported

Abbreviation: EPI, Early Psychosis Intervention.

¹ Extent of programme completed not specified.

² These were 2 separate studies both conducted as components of the Thematic Research Area Psychosis Program at the University of Oslo and Oslo University hospital.

³ Only 1 family member and one client interviewed participated in the single family intervention.

3.2.1.1 | Family interest

Some families are disengaged from their ill relative and are not interested in participating (Slade et al., 2003). Others do not believe that support is needed or relevant to their experience (Petrakis et al., 2014; Slade et al., 2003). This may occur if the families do not identify as caregivers and therefore do not see the programme as relevant for them (Riley et al., 2011). It is also possible that once the first episode of psychosis has resolved, the family may not believe their relative has an ongoing problem and may not see the need for ongoing involvement in the programme (Slade et al., 2003). Some families believe that their experiences are private and do not feel comfortable discussing them with service providers or other families (Petrakis et al., 2014).

3.2.1.2 | Client interest

The young person with psychosis may not want to participate or may not want their family to be involved (Fjell et al., 2007; Nilsen et al., 2015). Clients may be anxious about participating, especially early in their illness trajectory. At this stage, they may also be eager to "return to normal" and unwilling to continue treatment (Nilsen et al., 2014, 2015). One study found that older clients were more likely to refuse to participate, perhaps due to a desire for more independence (Fjell et al., 2007). Both Nilsen et al. (2014) and Fjell et al. (2007) found that clients were much less likely to participate than families. In some programmes, families are offered support directly, independent of the young person's status as a client, but often the young person must be

TABLE 2 Included studies: results and recommendations

Study details	Study results	Author comments and recommendations
Fjell et al. (2007)	<p>Intervention participation (for 246 clients/families offered multifamily group):</p> <ul style="list-style-type: none"> • 147 (60%) agreed to join • Main reasons for non-participation: client refusal (79 clients), family refusal (20 clients), no family/too far away (28 clients), problems in family (26 clients) • 131 families (89%) participated with the client present • Older clients more likely to refuse to participate • Family attendance much higher than client attendance • Most families waited 6 to 12 mo to join a group; 16% waited more than 1 y <p>Barriers (based on participation data):</p> <ul style="list-style-type: none"> • Client reluctance, which increased with age 	<ul style="list-style-type: none"> • Client reluctance was major barrier • Different clients have different needs so consider multiple types of groups (eg, for married clients, for older clients who may not be living with their families) • Adapt group content and delivery to EPI families • Gathering sufficient families for a group delays start; consider offering interim family counselling, letting families join existing groups, establishing multifamily group centres that serve several districts
McCann & Lubman, (2014)	<p>Intervention participation:</p> <ul style="list-style-type: none"> • Not reported <p>Facilitators (family perspective):</p> <ul style="list-style-type: none"> • Manual is comprehensive, understandable and informative • Easy to access, portable • Overcomes difficulties of face-to-face options (inconvenience, time, travel) • Low cost <p>Barriers (family perspective):</p> <ul style="list-style-type: none"> • Some would also like access to group support • Motivation to read manual • Literacy 	<ul style="list-style-type: none"> • Manual is cost effective to provide • Could potentially use other delivery mode options (eg, DVD, online) • Consider combining with small group face-to-face or online discussion forums
Nilsen et al. (2014)	<p>Intervention participation (# eligible not reported):</p> <ul style="list-style-type: none"> • 11 clients and 13 families joined multifamily group • One client and 1 family joined single family group • All families attended all meetings; 33% clients attended fewer than half <p>Facilitators (family/client perspective):</p> <ul style="list-style-type: none"> • Providing information about intervention during joining in phase so families/clients know what to expect • Size of group—smaller reduced anxiety for some • Predictable structure and session length that was adhered to • Programme length (1-2 y) was seen as valuable but important for families/clients to have clear end date • Mixed views on multifamily format, for example, benefit of sharing experiences and support vs privacy • Being able to talk to group leaders individually <p>Barriers (family/client perspective):</p> <ul style="list-style-type: none"> • May disrupt group if client struggling with active symptoms • Timing of entry—often the family was ready early in the course of the client's illness while the client wanted to wait until they were more stable 	<ul style="list-style-type: none"> • Engagement phase is important for establishing foundational alliance for rest of intervention, and determining what type of intervention will best meet client and family needs • Need to consider client and family readiness, fit of group format, client symptoms, social skills, etc. • Both single or multifamily group options should be offered
Nilsen et al. (2015)	<p>Intervention participation:</p> <ul style="list-style-type: none"> • Not reported <p>Facilitators (staff perspective):</p> <ul style="list-style-type: none"> • Engaging clients early • Using problem-solving method <p>Barriers (staff perspective):</p> <ul style="list-style-type: none"> • Difficult motivating clients to participate—many reluctant/anxious, some just want to be "normal"; time-consuming for staff • Clients often reluctant to participate due to intervention length • Challenge including different kinds of families in the same group (eg, at different stages of illness)—can make group difficult to manage; for some single family format more appropriate • Challenge to find balance between customization and adherence to protocol 	<ul style="list-style-type: none"> • Good relationship between staff and client is critical to successful engagement • Clients and families need time to accept illness before they will be ready to participate • The decision whether to participate in multifamily and single family interventions must be individualized • Clinicians should balance rigour and flexibility in programme delivery
Petrakis et al. (2014)	<p>Intervention participation (# eligible not reported):</p> <ul style="list-style-type: none"> • 12 family members participated • Average attendance per session was 4 family members <p>Facilitators</p> <ul style="list-style-type: none"> • Family perspective: <ul style="list-style-type: none"> ○ A priori clarification from staff on expectations for attendance and topics ○ Access to internet resources ○ Mixed preferences for time of group (morning vs evening) • Staff perspective: <ul style="list-style-type: none"> ○ Include session on resilience and self-care 	<ul style="list-style-type: none"> • Tension between benefit of group support and exposure to negative emotions • Tension between being family driven and providing clear topics/structure • We need more study of valued elements of group participation (eg, social support, information) • Timing is important—consider when families are ready

(Continued)

TABLE 2 Continued

Study details	Study results	Author comments and recommendations
	<ul style="list-style-type: none"> ○ Balance between being clear/informative and family driven ○ Ensure sessions are not too long <p>Barriers</p> <ul style="list-style-type: none"> • Family perspective: <ul style="list-style-type: none"> ○ Getting to programme—competing family/work commitments, location and time ○ Discomfort revealing emotions/hearing emotions in others, belief that experiences are private ○ Do not see relevance • Staff perspective: <ul style="list-style-type: none"> ○ Time of day and location, transportation ○ Group format—talking about feelings (especially for men), overwhelming and confronting nature of the group, difficulty communicating or relating with other families ○ Lack of shared sessions for families and clients ○ Lack of access for migrant, refugee and linguistically/culturally diverse families 	
Riley et al. (2011)	<p>Intervention participation:</p> <ul style="list-style-type: none"> • Not reported <p>Facilitators (family perspective):</p> <ul style="list-style-type: none"> • Clarity about group purpose and expectations for participants • Having point of contact for families • Interest in maintaining connection after programme completion <p>Barriers (family perspective):</p> <ul style="list-style-type: none"> • Physical distance, timing • Anxiety about leaving their relative • Discomfort with venue (psychiatric inpatient unit where ill relative had been treated) • Timing of invitation to join group (too early for some, not early enough for others) • No knowledge of the group • Embarrassment of ill relative • Did not identify as a caregiver 	<ul style="list-style-type: none"> • Family may be uncertain about purpose of group, and if it is appropriate for them • Important to choose location carefully • consider timing of invitation to group; readiness to attend varies for each person; use of a screening tool on readiness to participate may be helpful • Creative ways of engaging families are needed to maximize uptake; consider not using term “carer” • Offer post-group options (eg, help others as graduates, attend another support group, continue current group)
Slade et al. (2003)	<p>Intervention participation (for 30 family members):</p> <ul style="list-style-type: none"> • Used minimal support—client or family perceived no need (n = 10) • Were in needs assessment phase (n = 7) • Used intensive support (n = 5) • Completed family work—receiving low level supportive contact (n = 4) • Declined—no interest (n = 4) <p>Facilitators (staff perspective):</p> <ul style="list-style-type: none"> • Providing single point of contact for family members • Supervision, especially co-working with experienced staff • Skill training on unique needs of EPI families (grief, unknown prognosis, information) • Access to resources (psychoeducational materials, structured assessment tool) • Adequate time, lower caseload • Valuing family work <p>Barriers (staff perspective):</p> <ul style="list-style-type: none"> • Family reluctance to stay in service after initial illness if they did not believe the illness was ongoing • Competence to address needs of children of persons with psychosis 	<ul style="list-style-type: none"> • Supporting EPI families does not need to be a high programme burden; families often accept information and a clear contact point, but do not want intensive ongoing support; more study needed on family needs • Staff unsure how to deal with younger siblings and children of persons with psychosis; would welcome expertise of child/adolescent sector • Important to prepare staff to provide support that matches family needs; determine where staff need more training to deliver family work

Abbreviation: EPI, Early Psychosis Intervention.

an active client in order for the family to receive support from the programme.

3.2.1.3 | Timing

Timing also emerged as a significant issue in uptake. Nilsen et al. (2014) and Riley et al. (2011) both found that offering a group-based intervention too early or too late relative to the illness onset can pose a barrier to participation. If the intervention is offered too early, before families have accepted the illness and their role as caregivers, they may not see the intervention as relevant. If they do attend, they may find the group overwhelming and distressing.

Conversely, many families also complained that the intervention was offered too late. They felt that they needed support most when still in the early overwhelming stages of having a relative diagnosed with psychosis and yet had to wait months or years before getting into a family support programme (Nilsen et al., 2014; Riley et al., 2011). Fjell et al. (2007) reported that most families waited 6 to 12 months to join a group, and 16% waited more than a year.

3.2.2 | Family ability to access supports

The second theme relates to the family's ability to access services. Many families have competing home and work commitments

preventing them from attending services (Petrakis et al., 2014; Riley et al., 2011). Sometimes the programme is located in an inconvenient location or offered at an inconvenient time, and families may lack access to transportation. If the programme does not include the individual with psychosis, the family may be anxious about leaving him or her alone (Petrakis et al., 2014; Riley et al., 2011). The bibliotherapy intervention described in McCann and Lubman (2014) offers a possible alternative. The study reported positive feedback on the benefits of the programme manual being available to use at any time, in any location.

3.2.3 | Family support needs/preferences

The third theme includes barriers related to the nature of the intervention offered. While the first 2 themes deal with reach (ie, getting families in the door), this theme deals with retention (ie, how do you get families to stay in the programme). A key learning that emerged across the identified articles was that families have different needs and preferences regarding the type of support services they receive and, thus, one size does not fit all. There are 3 core aspects of family support where differing preferences were identified: intervention intensity/length, intervention participants and intervention content.

3.2.3.1 | Intervention intensity/length

Slade et al. (2003) found that only a minority of families required more intensive supports; others required minimal supports or none at all. For multifamily psychoeducation groups, the frequency and duration of each session and the length of the programme varied between the reviewed studies. Nilsen et al. (2014) reported that families found a 1- to 2-year intervention to be demanding but extremely valuable. Nilsen et al. (2015) emphasized that a lengthy, intensive intervention was not appropriate for everyone while Riley et al. (2011) found that some families wanted opportunities to continue their involvement following the completion of the group.

3.2.3.2 | Intervention participants

Several studies found that some families preferred individual supports, citing concerns over the overwhelming nature of the group and discomfort revealing emotions publically, whereas other families appreciated meeting as a group, finding it helpful to meet and hear the experiences of other families in similar situations (McCann & Lubman, 2014; Nilsen et al., 2014; Petrakis et al., 2014). In Nilsen et al. (2015), staff noted the challenge of including families at different stages of recovery in the same group. They argued that while multifamily groups had many benefits, for some families a single family format was more appropriate and that, therefore, it is important for staff to work closely with families to identify the best format to meet their needs.

Additionally some of the interventions described included the individual with psychosis, whereas others did not. In Nilsen et al. (2014), families expressed appreciation for the opportunity to speak to staff without the young person present. Conversely, Petrakis et al. (2014) reported concerns over the lack of shared sessions available for both the family and young person.

3.2.3.3 | Intervention content

Most of the reviewed interventions included education and support components; however, the specific topics covered and time devoted to each varied from study to study. In Petrakis et al. (2014), staff expressed concern that they were not meeting the needs of families from culturally or linguistically diverse groups. There is also tension between the desire for structured, predictable programmes and the ability to be flexible and responsive to the needs of the group. In Nilsen et al. (2014), families appreciated having a constant, predictable structure to the meetings so they always knew what to expect. In Nilsen et al. (2015) and Petrakis et al. (2014), staff emphasized the importance of balancing customization and adherence to protocol.

3.2.4 | Supports for staff

The fourth theme shifts from challenges to uptake by families to challenges related to programme implementation. Slade et al. (2003) found that staff need education both in how to provide family support and in the importance of family support. Ongoing supervision and opportunities to co-work with experienced staff were emphasized as important to improve staff skills in this area.

Both material and human resources were raised as important factors affecting implementation. Nilsen et al. (2015) reports that family support can be time-consuming for staff. Slade et al. (2003) stresses the importance of having access to material resources such as psychoeducation materials and assessment tools.

4 | DISCUSSION

Family support is a core component of the EPI model, yet programmes report low rates of implementation and uptake (Addington et al., 2012; Gorrel et al., 2004; O'Kearney et al., 2004; Durbin et al., 2014). This review looked at barriers and facilitators to implementing family support in EPI programmes to better understand the challenges faced by programmes and to identify strategies for success.

A very modest literature was identified on this topic with 7 articles meeting inclusion criteria. Although family, client and staff perspectives were all captured, limited information on sample recruitment and characteristics was provided which may have biased the results. For example, only 1 study (Petrakis et al., 2014) included families who had dropped out of the programme or declined to participate. Also, the majority of the studies focused on multifamily psychoeducation. The challenges identified may be less relevant for programmes who offer different types of family support. With the oldest study published in 2003 and most of the studies published in the past 5 years, it is clear that the field is only beginning to turn its attention to these issues.

This literature review identified 4 key themes related to barriers and facilitators to implementing family support: family/client interest and readiness; family ability to access supports; family support needs/preferences and supports for staff. The first 3 themes include issues related to uptake (ie, families choosing to participate in the intervention), whereas the last theme focuses on implementation (ie, the programme's ability to deliver the intervention). Although programmes have no direct control over uptake, a closer examination of

the reasons why families are refusing services suggests that there is an opportunity for programmes to be more responsive to the needs of families, which would likely improve uptake.

4.1 | Alignment with the literature

Although the identified literature was limited, the findings resonate with the experiences of EPI programmes in our jurisdiction (Ontario, Canada), the general mental health literature and the implementation science literature.

In recent surveys of the Ontario EPI programmes, staff reported barriers related to 3 of the 4 themes: family/client interest and readiness; family ability to access supports and supports for staff. Their feedback focused largely on issues related to supports for staff including: insufficient time to connect with families; insufficient time to organize education and peer support activities; limited staffing resources and insufficient staff training (Standards Implementation Steering Committee, 2012). Almost two-thirds of programmes said that their ability to deliver EPI services would be helped a fair amount or a great deal by more time to work with families (Durbin et al., 2014) and over half said they would benefit from additional training in family support (Standards Implementation Steering Committee, 2015). Survey respondents did not comment on the importance and challenge of responding to variation in family needs/preferences, but based on the present review, this is a critical issue for more successful implementation moving forward.

The themes identified in this review also resonate closely with the general mental health literature on caregiver support (Bond, Drake, McHugo, Rapp, & Whitley, 2009; Eassom et al., 2014; Lucksted et al., 2012; Smith & Velleman, 2002). For example, the general mental health literature also highlights issues related to lack of resources, insufficient staff training and reluctance from families to participate. However, there are some key differences. The timing of the intervention (ie, at what point in the illness trajectory families were invited to participate), which emerged as a critical issue in the EPI literature (Nilsen et al., 2014; Riley et al., 2011), is not a focus of the general mental health literature (Eassom et al., 2014). Another significant issue raised in the EPI literature is that some families and clients do not initially believe that the client has an ongoing problem, leading them to believe that family support is not needed (Slade et al., 2003). Although family engagement is an issue in the general mental health literature, this particular challenge is not highlighted (Eassom et al., 2014; Smith & Velleman, 2002).

Additionally, the general mental health literature raises a challenge that does not appear in this review. Several studies report the presence of attitudinal barriers, with family support not being valued at organizational and team levels and even facing resistance from programme staff and managers (Eassom et al., 2014). This issue did not emerge in any of the EPI specific studies. Possibly, this is due to the limited nature of the reviewed literature but it may also be explained by the fact that family support is clearly embedded as a core component of the EPI model. Although some EPI programmes may not have the resources to provide family support, it seems less likely that there would be resistance to the idea.

Finally, the findings from the EPI literature also resonate with the implementation science literature. Implementation science has been developed to address the fact that evidence-based practices and clinical guidelines do not automatically translate into practice. This field has demonstrated that an active supported implementation process is needed to effectively change practice (Fixsen et al., 2009). Although many different frameworks have emerged on factors that can influence the implementation of evidence-based practices, a number of core elements are commonly recognized as critical to successful implementation. These include staff training and supervision, leadership, feedback for programme improvement and sufficient resources (eg, time, space, materials, staff) (Damschroder et al., 2009; Feldstein & Glasgow, 2008; Fixsen et al., 2009).

Provision of staff training, supervision and sufficient resources emerged as important factors in the reviewed EPI literature. Leadership and feedback received less attention, possibly because the focus of the included studies was mostly frontline clinical provision, rather than the broader organizational context. The implementation science literature also stresses that the nature of the intervention itself is critical to successful implementation. This was clearly reflected in the EPI literature; if the intervention is burdensome to provide or does not meet the needs of clients and families, then it is less likely to be successfully implemented (Damschroder et al., 2009; Feldstein & Glasgow, 2008).

4.2 | Moving forward

The combined challenges identified in this review, of insufficient resources for programmes to work with families, and varying family readiness and preferences for support, point to the limitations of only offering lengthy, intensive psychoeducation programmes. For over 15 years, it has been recognized that family psychoeducation is not appropriate for all families, though it continues to be the commonly recommended practice due to the lack of evidence on alternative models (Dixon et al., 2000). A number of promising frameworks have been developed with tiered levels of care based on the needs of the family (eg, Cohen et al., 2008; Mottaghipour & Bickerton, 2005), although more research is needed on their effectiveness.

One of these frameworks, the *Pyramid of Family Care* (Mottaghipour & Bickerton, 2005), has gained prominence in Canada and was recently included in the *National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses* (MacCourt, Family Caregivers Advisory Committee, & Mental Health Commission of Canada, 2013). The *Pyramid of Family Care* includes a hierarchy of family interventions of escalating intensity. The theory is that all families should receive the bottom tier, which includes basic engagement and assessment, and fewer families will require the more intensive supports indicated in the higher tiers, respectively: general education, psychoeducation, consultation and family therapy. The present literature review suggests that this type of model may be very appropriate for EPI programmes. It would ultimately reduce the burden on programmes, as few families require intensive supports, and could increase uptake from families if more flexible options were available to meet their needs.

Some programmes are already shifting in this direction. For example, 1 programme in the United Kingdom has developed a care pathway for families which reflects the ideas behind the tiered models (Sin et al., 2007). The care pathway includes: identify family caregivers at initial contact, assess needs, provide information package, provide multifamily psychoeducation group and link to other services as needed (eg, respite care, social club, family therapy).

Another consideration is the extent to which family support is being prioritized by EPI programmes. One theory suggested by O'Kearney et al. (2004) is that programmes tend to prioritize the "traditional" medical care components, whereas less traditional components such as public education or family support are seen as lower priority. Funding structures may also influence implementation. A challenge in our jurisdiction is that, for accountability reporting, caseload size is sometimes only based on the individuals with psychosis, so programmes are not incentivized to support families. Whether or not families are considered clients can affect whether they receive services (Feinberg & Newman, 2004).

Additionally, despite the overwhelming evidence on the stresses and burdens associated with caregiving and the direct risks to the physical and mental health of the family member, much of the evidence on the benefit of family support in EPI looks primarily or exclusively at client outcomes (Sadath, Muralidhar, Varambally, Jose, & Gangadhar, 2015). This suggests that although family support is a core component of the EPI standards, programmes may still view it primarily in terms of its benefit for the individual with psychosis, which is indirect at best. For family support to receive higher rates of implementation, perhaps a shift is needed to recognize the validity and importance of supporting families for their own sake, regardless of any direct effect for the client.

More research is needed to identify effective models of family support specific to EPI families and how they can be successfully implemented. Future research needs to examine a broader range of intervention approaches, from a more diverse sample of family and staff perspectives, including the perspectives of families that drop out or decline to participate in programmes.

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