

Family Bridger Pilot Program: Preliminary Feasibility and Acceptability of a Peer Navigator Model of Support for Caregivers of Loved Ones Experiencing Early Psychosis



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INTRODUCTION

- Most young adults experiencing early psychosis (EP) live with family caregivers.¹
- Caregiver engagement is associated with improvement in client outcomes including increased adherence to treatment, reduction in symptoms, and lower rates of relapse.² Caregivers often experience a large burden of care, stress, burnout and depression.^{3,4}
- Peer Bridger (or “Peer navigator”) programs and models deliver short-term support to individuals transitioning from inpatient to community settings.
- This project pilots a “Family Bridger” (FB) model in which caregivers with long-term lived experience caring for an individual experiencing psychosis work collaboratively with and provide support to newer caregivers.
- The pilot program was adapted for caregivers in first episode psychosis Coordinated Specialty Care programs due to hospital restrictions during COVID-19 pandemic.

Background

- 9 focus groups were conducted with family caregivers at 6 locations across Washington state ($N=58$, $M_{age}=56.3$, $SD=10.4$, 74% female, 74% white).
- Content analysis identified five core areas of need which served as the foundation of the model:



METHODS

Participants

- Caregivers ($N=11$) were referred by Family Education Clinicians ($N=5$) from Coordinated Specialty Care teams in WA state. Pilot is ongoing. 7 Caregivers have completed the program). Preliminary results display midpoint data (up to 10 weeks or 5 meetings).

Procedures

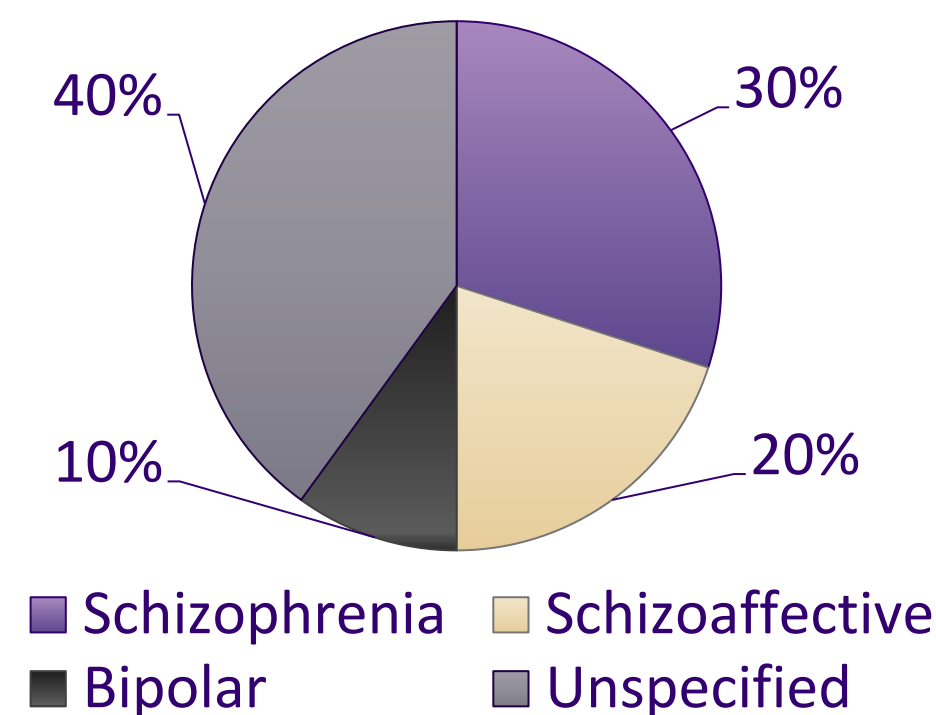
- Family Bridgers ($N=3$) were recruited from an intensive CBTp-informed skills training, completed three initial trainings, and received weekly, then bi-weekly and ad-hoc consultation.
- Caregivers meet with Family Bridgers via teleconsultation up to 10 times over 20 weeks, as frequently as once per week.
- Caregivers complete a feedback survey and a semi-structured interview at two timepoints: (1) either 4 weeks or following their 2nd meeting, and (2) 20 weeks or following their 10th meeting.
- Family Bridgers collect program metrics & provide feedback following each meeting and participated in semi-structured interviews at 10 weeks.
- Referring clinicians completed Acceptability of Intervention (AIM), Intervention Appropriateness (IAM), and Feasibility of Intervention (FIM) Measures⁵ at the same timepoint as their first referred Caregiver.

RESULTS

- There were a total of **47 meetings**, across which the rates of provisioned services were:
 - 78.7% Education, 53.2% Resources, 2.1% Advocacy, 91.5% Emotional Support, 74.5% Skills
- Caregivers reported (1=Poor, 7=Excellent) **a better understanding of mental illness** ($M=6.55$, $SD=0.93$) **and available resources** ($M=6.45$, $SD=1.21$), **and believed they had an ally in the mental health system** ($M=6.60$, $SD=0.97$), **their feelings had been validated** ($M=6.64$, $SD=0.92$), and that they had **developed better coping strategies** ($M=6.18$, $SD=1.17$).
- Referring Clinicians (scored 1-5, where 5 is high) found the program **acceptable** (AIM: $M=4.63$, $SD=0.60$, $\alpha=0.94$) **appropriate** (IAT: $M=4.63$, $SD=0.43$, $\alpha=0.75$), and **feasible** (FIM: $M=4.31$, $SD=0.47$, $\alpha=0.93$).
- **100% of Caregivers said that they would recommend the program to others.**

Caregivers	N=11*	% / M(SD)
Age		49.45 (7.90)
Gender		
Male	1	9.1
Female	10	90.1
Race		
White	7	63.6
Black	1	9.1
Multiracial	3	27.3
Highest Education		
Some College	3	27.3
Trade/Tech School	2	18.2
Associates	2	18.2
≥ Bachelors	4	18.2
Household Income		
< \$49,999	3	27.3
\$75,000-\$99,999	5	45.5
≥ \$100,000	3	27.3

Diagnosis of Loved One

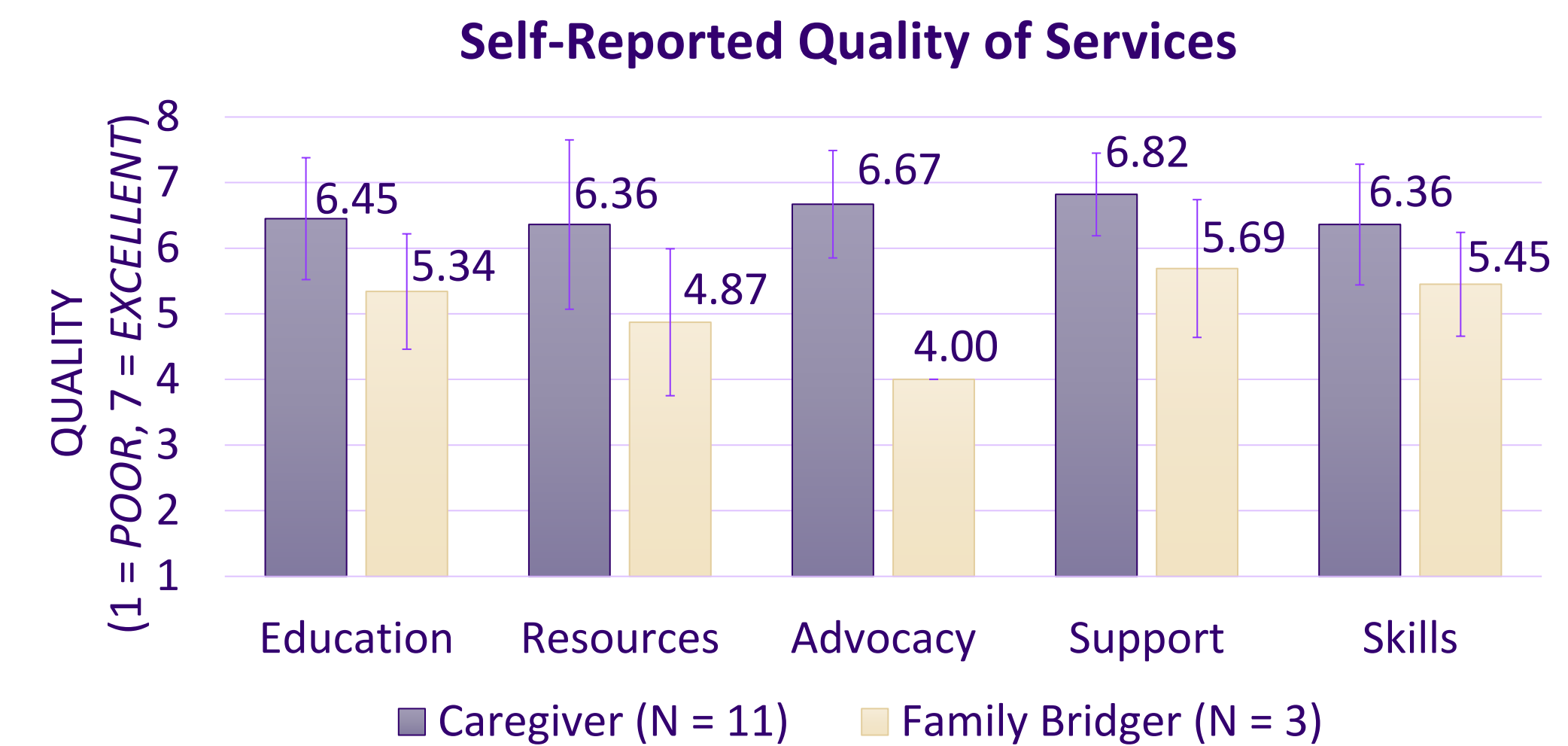


Loved One (N=10)*	% / M(SD)
Age	22.30 (3.10)
Age at Diagnosis	21.10 (2.38)
Previously Hospitalized, % yes	90.0
Total Hospitalizations	25.56 (26.57)

*2 caregivers from the same household.

Quotes from Caregivers

- “I’m so happy for this opportunity to speak with someone who knows what I’ve gone through with my son. I have a few friends I can talk to about my situation, but it’s not the same. They don’t know, they don’t understand the effect it has on me as a mom.”
- “She’s (Family Bridger) listening to me from my perspective, from my point of view, which to me feels worthy. And sometimes, I don’t feel like people are considering my point of view worthy as much as I want it to be.”
- “If something comes up like a situation or while we’re talking... she’ll (Family Bridger) just very casually mention it, [...] informing me of other resources out there for the situation that I may be describing at the time, which is nice, kind of just sharing some extra resources that maybe you hadn’t head about, kind of more relevant to your situation.”
- “[W]hen I talk about things that have happened with [my son] that I have seen when he was in psychosis, she (Family Bridger) can tell me that that is-- I don’t even know-- that that is truly what it is. This is what happens when they’re in that way. She has made me conscious of how I speak-- more conscious.”



DISCUSSION

- Preliminary results indicate high feasibility and acceptability among Caregivers, Family Bridgers, and Referring Clinicians.
- Caregivers also reported several positive impacts from engaging with a Family Bridger. Having someone with similar lived experiences as a resource may benefit caregivers in ways clinicians can not.
- Future versions of this program may test embedding the Family Bridger within Coordinated Specialty Care teams to be able to provide more advocacy, resources, (the two lowest rated areas of self-assessment among Family Bridgers themselves), and overall continuity of care.
- While this pilot connected caregivers of individuals in CSC programs, a need still exists to support individuals transitioning between inpatient and community settings.
- A full program evaluation will be completed after all enrolled caregivers complete their enrollment by late November 2021.

REFERENCES

1. Addington, J., Addington, D., Jones, B., & Ko, T. (2001). Family intervention in an early psychosis program. *Psychiatric Rehabilitation Skills*, 5(2), 272–286. <https://doi.org/10.1080/15487760108415433Addingt on>
2. McFarlane, W. R., Lynch, S., & Melton, R. (2012). Family psychoeducation in clinical high risk and first-episode psychosis. *Adolescent Psychiatry*, 2(2), 182–194. <https://doi.org/10.2174/2210676611202020182>
3. Addington, J., Coldham, E. L., Jones, B., Ko, T., & Addington, D. (2003). The first episode of psychosis: The experience of relatives. *Acta Psychiatrica Scandinavica*, 108(4), 285-289. <https://doi.org/10.1034/j.1600-0447.2003.00153.x>
4. Kuipers, e., Onumere, J., & Bebbington, P. Cognitive model of caregiving in psychosis. *British Journal of Psychiatry*, 196(4), 259-265. <https://doi.org/10.1192/bjp.bp.109.070466>
5. Weiner, B. J., Lewis, C. C., Stanick, C., et al. (2017). Psychometric assessment of three newly developed implementation outcome measures. *Implementation Science*, 12(108). <https://doi.org/10.1186/s13012-017-0635-3>