



## The Pyramid of Family Care: A framework for family involvement with adult mental health services

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### Abstract

Working with families of patients with severe mental illness has proven to be effective in reducing the relapse rate for patients and the distress level of families. However, there is no general framework available for adult mental health professionals on incorporating family work in their everyday practice. The Pyramid of Family Care discussed in this paper is based on the same conceptual work as Maslow's Hierarchy of Needs. The bottom levels include the family's basic needs for information about the illness and orientation to the mental health service. This contrasts with the top level which represents complex needs for interventions such as intensive family therapy. This paper will expand on this model of family care. The different levels of the Pyramid will be discussed and a minimum level of care defined.

### Keywords

*mental health services, mental disorders, family education, psychoeducation, family therapy, mental health professionals*

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### Introduction

Working with families of patients with a mental illness has proven to be effective in reducing the relapse rate for patients and the distress level of their families (Dixon, Adams & Lucksted, 2000; Penn & Mueser, 1996; Pharoah, Rathbone, Mari & Streiner, 2003). In recent years important developments have occurred in terms of focussing on collaboration with families and building on their strengths and resources (Hatfield & Lefly, 1987; Marsh, 1992) as opposed to the previous tendency to pathologise families. These developments are reflected in the National Standards for Mental Health Services in Australia whose guidelines on mental illness strongly recommend involving carers and developing partnerships with families of

patients (National Standards for Mental Health Services, 1997).

However, despite this significant research and policy development, implementation of family work at the service delivery level is rarely available and not without difficulty for a number of reasons (Dixon, McFarlane, Lefley et al., 2001; Fadden, 1997). Few mental health professionals have specific skills for working with families. Workers are often unsure how to connect with families and what outcomes to aim for. Confidentiality issues and limited resources are further barriers commonly cited (Bogart & Solomon, 1999; Szmukler & Block, 1997). Family work is often seen as a 'highly specialised' intervention and not the role of an adult mental health professional who has an individual client focus (Kavanagh, 1995). No

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blueprint exists for incorporating family work into the everyday practice of adult mental health clinicians. Thus families largely remain unseen by clinicians.

The notion of family work as compartmentalised, specialist work has inadvertently been promoted by the family intervention literature. Most family intervention studies are conducted by highly trained research teams or small groups of specialised clinicians (Fadden, 1997; Kavanagh, 1995).

However, this notion of specialist family intervention starkly contrasts with what families and carers state as their needs. Families request information about the illness and medication, some education about coping skills and information for dealing with crisis situations. They are rarely interested in therapy (Hatfield, 1983). In a study that investigated the family caregivers' perceived relationship with mental health professionals, caregivers ranked more communication with professionals as their greatest need (Biegel, Song & Sharon, 1995). This lack of engagement and communication with families is likely to be reflected in the significant number of drop outs from family intervention programs (Leavey, King, Cole et al., 1997; Smith & Birchwood, 1990). Referring families for more specialist interventions is not as efficacious if the basic task of engagement has not been carried out.

These tasks of engaging, providing education and collaborating with most families are well within the scope of an adult mental health worker; with minimal extra training provided the clinician has a general framework for incorporating family work in their everyday practice.

## **The Pyramid of Family Care**

### ***The context***

The Pyramid of Family Care was developed as part of the 'Working with Families' Project of the Sutherland Adult Mental Health Service (Sydney, Australia); an integrated hospital-community mental health service. The project was developed to increase the capacity of all arms of the service to work with families of patients with severe mental illness. The need

for a framework for involving families in the everyday practice of clinicians rapidly became evident.

### ***Using the Pyramid - the concept***

Pyramids have been successfully used to convey information in a visual way in a number of settings. For example, the extensive use of the nutritional pyramid in public health campaigns has made the pyramid concept readily recognised and understood. Maslow's Hierarchy of Needs (1998) has proved a useful way of conceptualising the physical and psychological needs of an individual. The bottom level of Maslow's pyramid covers physiological needs followed by the next level, needs for safety, security and order. This hierarchy of needs also goes from a general universal need to more specific categories. The underlying assumption is that basic needs must be met before higher level needs can be developed and fulfilled. However, there are significant differences between the underlying assumptions of Maslow's pyramid and the Pyramid of Family Care which will be illustrated in this paper.

### ***The Pyramid of Family Care – overview***

The Pyramid of Family Care provides a user-friendly template on which the adult mental health worker can base their everyday work with families. The hierarchical model assumes that significant clinical gain can be made by broad application of simple interventions and techniques with a large number of families, and conversely that applying specialised techniques within a service will fail to produce broad benefits without a foundation of basic skills and approaches. It is a useful clinical tool and can be adapted with minimal training. Specific tasks are outlined and categorised in a hierarchical way. A minimum level of care is clearly defined to guide the worker and ensure the basic tasks are fulfilled before undertaking higher level, more specialised interventions. By defining and breaking down the tasks, workers are empowered to involve families as an achievable part of their everyday practice. At the tip of the Pyramid, specialised interventions are acknowledged as being built upon the basic levels and required by fewer families. The focus is on collaboration with families.

### ***Accessing the Pyramid of Family Care - the confidentiality dilemma***

Working with the families of adult mental health clients ideally requires the consent of the client and concerns about breaching confidentiality are commonly mentioned as a barrier to any involvement with the family (Bogart & Solomon, 1999). However for clinicians aware of the benefits of working with families, these issues are rarely insurmountable and some sort of respectful family contact is usually possible. Techniques for negotiating difficulties in this area have been discussed elsewhere (Zipple, Langle, Tyrell et al., 1997). Of particular assistance are the concepts of confidential and non-confidential information (Bogart & Solomon, 1999).

### ***Moving up the Pyramid***

The clinician moves through the interventions at a pace congruent with the family's needs. The different levels are negotiated over varying timeframes depending on the complexity of the situation and the family's readiness and need to progress to the next level of intervention. It should be noted that most families do not require involvement in higher levels. Reassessment of the family's needs on entering each intervention level is important. This serves to identify whether tasks on earlier levels have been successfully negotiated or need re-visiting. It also ensures the clinician is aware of new challenges for the family and it acts as a re-contracting and review point.

Factors which may be associated with a family requiring higher level intervention can be divided into family-related and illness-related.

*Family-related factors* include a high level of family distress, concurrent problems in other family members (e.g. physical or emotional illness), pre-existing family risk factors (such as a history of maltreatment or family violence), the family's capacity to access resources, and family's coping strategies. These factors affect the family's resilience, capacity to cope with the superimposed stress of mental illness and their capacity to connect with services.

*Illness-related factors* may include the type of illness, chronicity of the illness, associated

disability and treatment resistance. These factors are likely to increase the burden of care on the family.

### ***Baseline clinician skills***

The Pyramid has been developed with an assumption that a clinician using it has baseline skills in counselling and collaborating with individual clients. Such basic competencies include empathic listening, skills in developing a working alliance, general support, awareness of grief and loss issues and their impact, an ability to gauge a client's capacity to incorporate information, a knowledge of mental illness, along with structuring session time, and high ethical standards such as the preservation of boundaries. In training clinicians in using the Pyramid, they are encouraged to recognise their own competency at an individual client level and then apply these to working with the family system.

Only in a minority of cases, often characterised by chaos and dangerousness, it is so difficult to develop a family-service partnership, that a highly skilled family clinician is needed to assist the adult mental health worker in connecting in a productive way with the family.

### **The Pyramid of Family Care: different levels and specific tasks**

The Pyramid of Family Care is divided into five intervention levels numbered from one to five from the base up (see Figure 1). The two base levels (level I - Connection and Assessment and Level II - General Education) together comprise a minimum level of care. Tasks outlined in these levels should be offered to all families of clients accessing the mental health service.

After the minimum level of care has been provided moving onto higher levels then depends on the needs of the client and their family. Higher levels interventions include Psychoeducation (Level III), Consultation (Level IV) and finally Family Therapy (Level V). Each level includes a number of key tasks. Assessment and referral/liaison are two key tasks that are included in all levels of the Pyramid.

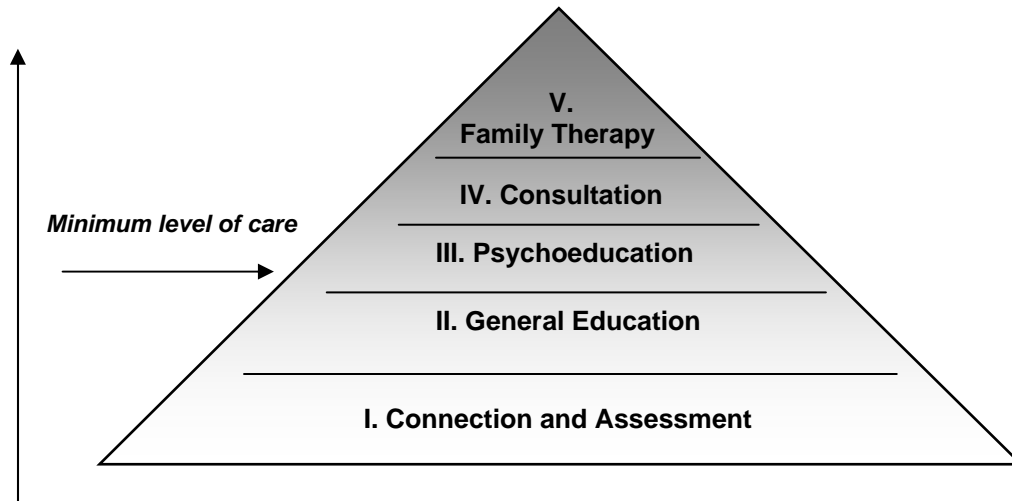


Figure 1. Pyramid of Family Care

### ***Level I - Connection and Assessment***

Successfully connecting with the family to establish a strong partnership is the essential foundation upon which all further interactions and interventions are built. The success of the connection and assessment phase determines how effectively families can utilise interventions provided further up the Pyramid. Persistent attempts at connection and the provision of practical resources to the family can often secure the beginnings of a collaborative relationship in those families in which connection initially is difficult. The connection and assessment phase consists of a number of key tasks:

#### ***a) Introduction and explanation of the objectives of family-service partnerships***

The key worker introduces themselves and their role in the mental health service. It is essential to be open in discussing the objectives and benefits of a family-service partnership. This serves to allay the family's fears, especially of being blamed. It is important to acknowledge and normalise the family's distress and concerns about stigma and to encourage them to discuss their often traumatic experiences. Such empathy and openness will serve to create a safe and collaborative context in which to build a relationship.

#### ***b) Documentation of the contact details of all key family members***

A genogram is recommended as a useful way of documenting family connections. Documenting contact numbers of key family members at the front of the file is essential. Rapid access to family members may have important safety implications for later management.

#### ***c) Assessment of the urgent and basic needs of the family***

Safety issues must be addressed as a matter of urgency. It is important for the clinician to be aware of children involved in the client's family and to immediately consider whether there are any child protection issues. Good therapeutic relationships can be promoted by actively attending to basic needs such as advice about accommodation or sickness benefits.

#### ***d) Establishment of a system of safety***

This concept was initially developed by one of the authors (Bickerton) in her work with suicidal adolescents when they were not hospitalized (Austin, Bickerton & O'Brien, 1997). It refers to the network of professionals, friends and family who can come together in a coordinated way to support a distressed person, offering 24 hour containment and care (Bickerton, Hillin,

Austin et al., 1998). This concept can be usefully generalised to work with adult mental health clients and their families. A system of safety must be developed as a matter of urgency before safe community management can proceed. It may be that two systems of safety need to be developed and documented, one around the mentally ill client and one around family members, especially children, who may become unsafe when the client is seriously distressed. An example may include the system of safety around a single mother who has a relapsing psychotic illness. She will need her own system of safety outlining whom to contact in and out of hours if she becomes acutely unwell. Her children also need a system of safety clarifying who will care for them during their mother's relapses to ensure minimal trauma and 24 hour protection. In such cases often a number of agencies (e.g. child protection services) need to work closely together with family and other friends. Depending on the family's needs and resources the clinician may need to do extensive liaison and organise multi-agency meetings to successfully establish complex systems of safety.

**e) Further assessment**

Once safety is secured the clinician can proceed with understanding other family needs. It is important to give the family an opportunity to discuss illness-related issues. This may include the history of the mental illness, previous contact with mental health services, the impact on the family, and their knowledge and attitudes to the illness and medications. Next the clinician can screen for specific problems (e.g. physical or emotional illnesses) in other family members and note any connection between exacerbations of these problems and the client illness. Other specific family stressors or losses also need to be noted.

**f) Orientation to the mental health service**

The clinician provides orientation for the family to other aspects of the mental health service (e.g. contact details for the after hours emergency team). Written information should supplement the discussion wherever possible.

**g) Development of a plan and involvement of other agencies (referral/liason as needed)**

At this point the clinician and family can collaborate in developing a plan for addressing the key identified needs. With the family's consent the clinician may agree to liaise with other agencies and make any appropriate referrals.

**Level II - General Education**

**a) Reassessment of needs**

The clinician reassesses the family's needs, reviews the outcomes of the Level I interventions (especially the outcomes of the system of safety and any referrals made) and assesses the family's readiness for incorporating more information.

**b) Education**

This may focus on a number of areas including further education about the resources offered by the mental health service and other services, information about the illness and treatment, information about the mental health act, family and client's rights as well as community and non-government organisations available to assist carers. The clinician's awareness of the multiple resources available for educating families is important, and written materials or videos are useful in supplementing discussion. It is essential that education is provided in keeping with the family members' educational levels, literacy and knowledge of English. It is essential to involve children with some education about the client's illness, taking into account their developmental level.

**c) Referral/liason as needed.**

**Level III - Psychoeducation**

**a) Reassessment of needs**

**b) Psychoeducation**

Psychoeducation refers to interventions in which the family is offered coping strategies or specific ways of dealing with the challenges of mental illness, in addition to general education. Psychoeducation can take place in multiple family groups or with single family sessions. Psychoeducation interventions have been extensively documented (Falloon, Boyd & McGill, 1984; Anderson, Reiss & Hogarty,

1986; McFarlane, Lukens, Link et al., 1995; Mueser, Gingerich & Rosenthal, 1994) and some specialist training is required. The family's attendance at the sessions and the success of the intervention is reliant on the referring clinician's relationship with the family and their capacity to assist the family in understanding how psychoeducation may benefit them.

*c) Referral/liaison as needed.*

**Level IV - Consultation**

*a) Reassessment of needs*

It is essential to carefully re-assess the needs of the family reaching this level. After completion of the first three levels, some families remain highly distressed or may have a major problem connecting with the service in a way that is most helpful for the mentally ill client. In a parallel process, the clinician may be experiencing difficulty connecting with the family. At this point the family-service partnership may be threatened which may, in turn, risk a further deterioration of the client's clinical condition. Some risk factors were noted earlier which might pre-dispose clients and their families to this situation.

*b) Continuation of contact and support*

This is essential to ensure an ongoing partnership. It may address some families' fears of abandonment and hopelessness which may escalate distress.

*c) Consultation as needed*

This will serve to open up new therapeutic possibilities for the family and to support clinician-family partnerships. Consultation may take a number of forms depending on the resources available. The family may or may not need to attend the consultation however it is important to let the family know about the consultation. Professional supervision or peer consultation may be available. It may be possible to enlist another team member to serve as a consultant at a family interview. An example of an innovative consultation is the 'Working with Families' Consultation Session developed as part of the 'Working with Families' Project. This is a consultation session for the family and key clinician with a consulting team comprised of members of the

service with specific family intervention skills and experience. The consultation utilises a one-way screen in a respectful family-friendly way aimed at empowering the family and building on family strengths. Immediate feedback is given to the family by the consultation team and these ideas are also documented in a therapeutic summary letter to the family. The referring clinician is given time to debrief and seek support and new ideas.

*d) Referral/liaison as needed.*

**Level V - Family Therapy**

*a) Reassessment of needs*

It is likely that a family reaching this level of intervention has complex needs which necessitate services from a number of professionals or agencies. A careful review of these ongoing needs and clarification of the roles of various professionals is essential.

*b) Referral for family therapy*

Family therapy refers to family sessions provided by a specialist family therapist aimed at creating change in the family interactional system. Such an intervention is required by few families. Longer term family therapy requires significant resources and a high level of motivation. In the current funding climate few adult mental health services can offer this type of therapy and referral to other agencies is often required. Again successful referral is highly reliant on the key clinician's ability to engage the family in understanding the goals and importance of such a referral.

*c) Continuation of ongoing liaison*

This is essential to ensure ongoing coordinated and integrated involvement of professionals and various agencies with the family. Even if the mental health service temporarily is not involved with the family it is essential that the family and other agencies are aware of how to get involved again with the mental health service if needed.

**Uses of the Pyramid of Family Care**

In addition to serving as a clinical tool as described above, the Pyramid of Family Care may be useful in a number of other situations. By providing a minimum level of care, the

Pyramid can be utilised for quality assurance across the service. The Pyramid serves to facilitate an integrated and coordinated approach to families across the different arms of the service.

Additionally, the Pyramid of Family Care can provide a useful basis for tailoring training sessions to the specific needs of teams within the mental health service. By utilising the Pyramid in planning for training sessions, a team's competencies may be gauged, allowing training to be implemented at the appropriate level. Training can be tailored based on professional competency of the team as well as the service needs. For example, if a team is already delivering the minimum level of care to families of patients, then the training sessions for team members could focus on the third level of the Pyramid (psychoeducation) for families.

Furthermore, the Pyramid of Family Care can serve as a useful tool in collecting data on the level of needs of the families within the service which may assist in resource allocation and service development planning.

Finally the Pyramid may provide a useful framework for much-needed research into implementing family involvement at a service delivery level.

## Conclusion

The Pyramid of Family Care serves as a useful framework in guiding the adult mental health worker in involving families in their everyday practice. The Pyramid outlines a minimum level of care for all families and in a hierarchical fashion builds higher level, more specialised interventions, upon basic service-family partnerships. By dissecting family involvement down to key tasks, it empowers clinicians to work with families as an integral part of their everyday practice, intervening in the notion of family work as a compartmentalised specialist intervention.

## Note

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