Analysis of variables as predictors of number of days family members attended visits with program staff during the first 6 months of program participation (n=63)[a]

Variable	β	SE	t[b]	P
Age (reference: over 18)	-0.66	1.41	-7.07	<.0001
Gender (reference: male)	-0.06	0.99	-0.67	0.51
Using any substances[c]	-0.28	1.33	-3.02	<0.01
PANSS Total Score[d]	0.21	0.05	2.15	0.04
MIRECC GAF-Occupational Functioning[e]	-0.15	0.03	-1.41	0.16
MIRECC GAF-Social Functioning[e]	0.21	0.05	1.94	0.58
Inpatient stay in past 6 months	0.06	1.02	0.62	0.54

[a] Overall model F=11.12, df=7 and 54, R^2 =.59, p<.0001

[b] df=1

[c] Endorsed Addiction Severity Index items indicating either current alcohol use or current drug use

[d] PANSS total score: 20-item version (Stefanovics et al., 2014)

[e] MIRECC Global Functioning Subscale

Analysis of client-provider discussions about family and family involvement variable as predictors of number of days family members attended visits with program staff during the first 6 months of program participation (n=56)[a]

Variable	β	SE	t[b]	P
Helped client talk with family about thoughts and feeling	0.17	0.76	1.06	0.30
Talked with client about how he/she would like family involved in treatment	-0.17	0.84	-1.03	0.31
Talked with client about how they would like family to help him/her reach goals	0.13	0.93	0.68	0.50

[a] Overall model F(3, 52)=.92, R^2 =.05, p=.44

[b] df=1

Connection Family Program Goals and Key Components

Family Program Goals: The goals of the family component of the Connection program were to engage family members in the care of clients involved in the program and to offer a variety of services/ opportunities for involvement to meet the individualized needs and preferences of clients and family members. Using a shared decision making framework, team members engage in discussions with the client and family member to identify potential needs and how working together with the team might help to address those needs.

Key Components: The program involved three key components: 1) active efforts to engage families in care, 2) opportunities for family involvement in ongoing care and 3) the provision of specialized family services. First, efforts were made to include family, both traditional and non-traditional (e.g. others identified as supportive individuals), in all aspects of treatment. The Team Leader was the primary contact for family members, working closely with clients and family members to better understand how to support the family and link them to rest of the team for specialized work. To assist in this process, a needs assessment around family involvement was conducted with each client at the outset of the

program, the goal of which was to gain a better understanding of the clients relationship with the family, his/her preferences for involving family in their care, and what services they believe might help the family in supporting them. For those interested in family involvement, a similar assessment was conducted with the family member(s) to better understand their concerns, their preferences for being involved, and family services they believe could be helpful. Using shared decision making, the client, family, and team members then worked together to make decisions about family involvement and support. In all cases, team members encouraged family involvement in treatment planning, treatment decisions, and ongoing care, and assisted family members in establishing a collaborative relationship with the treatment team. This included involving family in treatment team meetings, appointments with the psychiatrist, or with the IPS worker to help ensure that the clients had adequate supports in place at school/work. In addition, the Team Leader and other team members worked to maintain an ongoing dialogue with the family, allowing regular access to team members in order to answer questions and share pertinent information.

More intensive family services including a monthly family psychoeducational group and individual family consultation were also made available to all families. Designed to improve family knowledge and skills and offer family support, monthly family psychoeducational groups (~1 ½ hours in length) were offered on an ongoing basis. Core topics included understanding psychosis, etiology and causes of psychosis, recovery from psychosis, and treatment of psychosis, with additional topics determined by group member preferences/needs. Individual brief family consultation (1-3 sessions) was also available when a particular problem or need could not be addressed in regular meetings with team members. Consultations focused around a specific goal or need (e.g. communication skills between the young person and the family or between family members, conflict resolution skills). Finally, information on community services as well as individual and couples treatment were also provided to family members if needed.

Additional Information: For additional information regarding the RAISE IES Connection Family Program and/or the RAISE IES Connection Program as a whole see http://www.ontrackny.org/Resources.