An Overview of Family Services Being Supported by the VA Office of Mental Health Services

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In the Field

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Debbie Perlick
Fred Sautter
Steve Sayers
Michelle Sherman

Presentation Organization

- Review of Recovery Orientation in Mental Health
- Review of Development of VA Services for families
- Evidence Base for Family Interventions
- Review of Evidence Base for Family Work in Serious Psychiatric Illness
- Overview of the Family Services continuum in the UMHSP
- Brief Description of Family Psychoeducation in VA
- Overview of New Couples Treatment Initiative

New Freedom's Definition of Recovery

"the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms... Science has shown that having hope plays an integral role in an individual's recovery".

Highlighting family importance in providing recovery-based mental health services

- **Called for in the President's New Freedom Commission (2003)**

  "...services and treatments must be consumer and <u>family centered</u>, geared to give consumers real and meaningful choices about treatment options and providers - not oriented to the requirements of bureaucracies".

Highlighting family importance in providing recovery-based mental health services

- **Called for in the VA Secretary's New Mental Health Strategic Plan (2004)—**

  "Implement veteran and family care that is recovery-oriented, high quality, and maximizes the delivery of evidenced-based practices"

Development of Family Services in VA Mental Health

- Many veterans develop mental health problems while they are *away* from their family; natural distancing, families can feel disconnected
- Original VA structure—large, centrally located inpatient medical centers with residential facilities created systemic barriers to family involvement in care
- However, there have always have been “pockets” of VA family service excellence
- Intermittent efforts to fund “family” clinics--some of these have existed for 25 years—but less emphasis on family work in typical VA services

Development of Family Services in VA Mental Health con't

- Increasing interest in family work as part of the evidence-based treatment movement
- After Presidents New Freedom Commission (2003) and VA Secretary's Mental Health Strategic Plan (2004), 19 VA sites provided dedicated funding for Family Psychoeducation (FPE) 2006-2007; spurred training efforts in behavioral family therapy and multiple family group treatment
- Increasing recognition of family needs and pressures with newer armed conflicts

Development of Family Services in VA Mental Health con't

- 2008- Publication of Uniform Mental Health Services Package, with guidance on family services
- PL 110-387 Veterans' Mental Health and Other Care Improvement Act of 2008 added marriage and family counseling to VA services
- 2010--Family psychoeducation being rolled out as a VA evidence-based treatment
- 2010-Implementation of a couples training initiative

“He’s fine as long as I take my medication.”

Evidence-Base for Family Interventions for SMI

So what kinds of disorders are we talking about?

- Adults;
- "Family" here does NOT necessarily include presence of children NOR preclude couples work
- Many axis I disorders have an evidence-base for family interventions
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar illness
  - Other psychotic disorders
  - Depression with a significant impact on functioning
  - May have co-morbid substance use
- Less empirical support for family work with PTSD and personality disorders at this point—though of course there is need for assistance

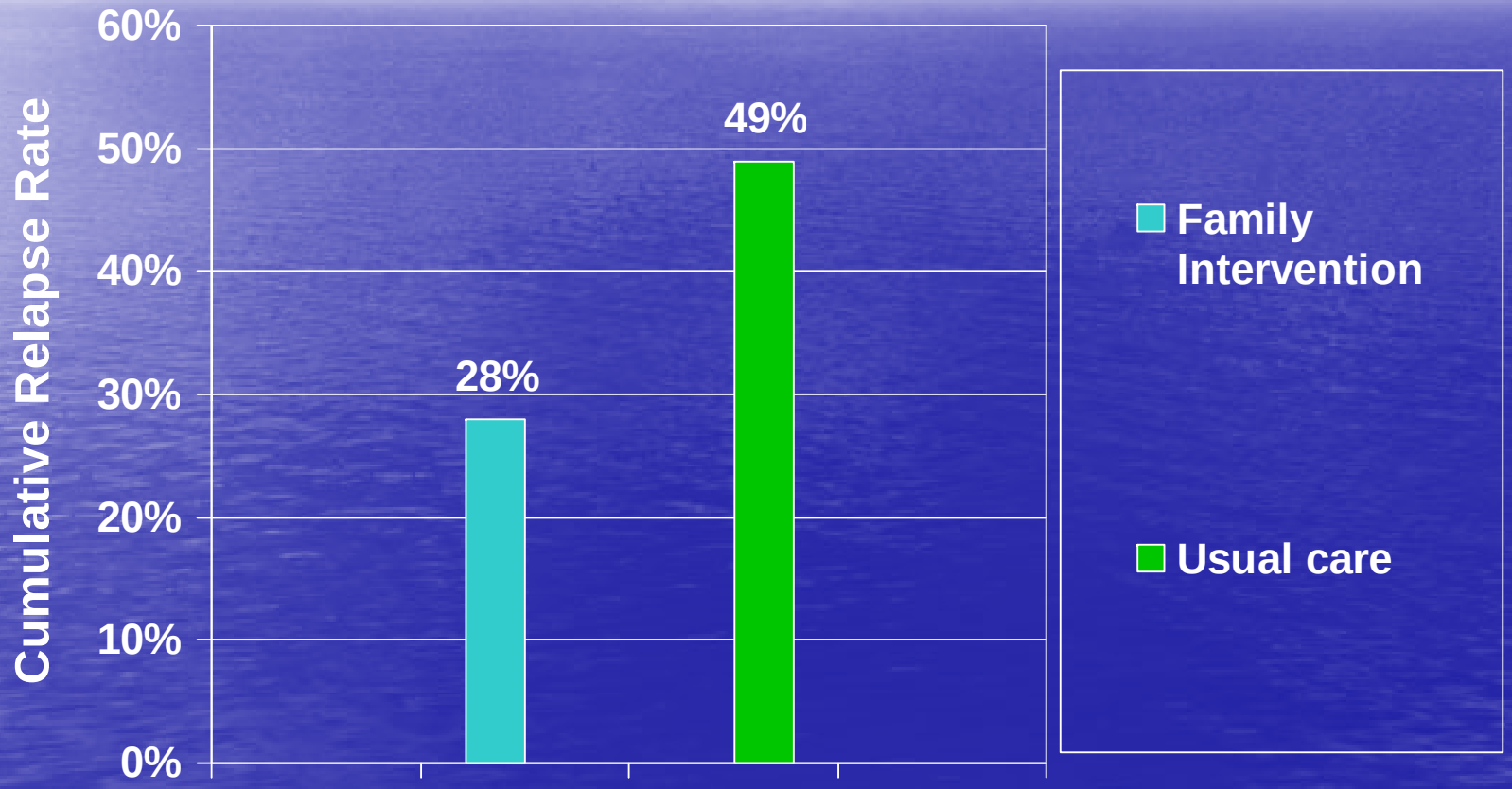
Research on FPE

- Single-family & multiple-family family programs standardized and empirically validated
- Outcome studies report a reduction in annual relapse rates for medicated, community-based people of as much as 50% by using a variety of educational, supportive, and behavioral techniques

Key outcomes of Family Psychoeducation (2004 Cochrane Review)

- Family intervention reduces relapse
  - N=723, 14 RCTs
  - RR 0.72; CI = 0.6 – 0.9
- Family intervention improves compliance with medication
  - N=369, 7 RCTs
  - RR = .74, CI = 0.6 – 0.9

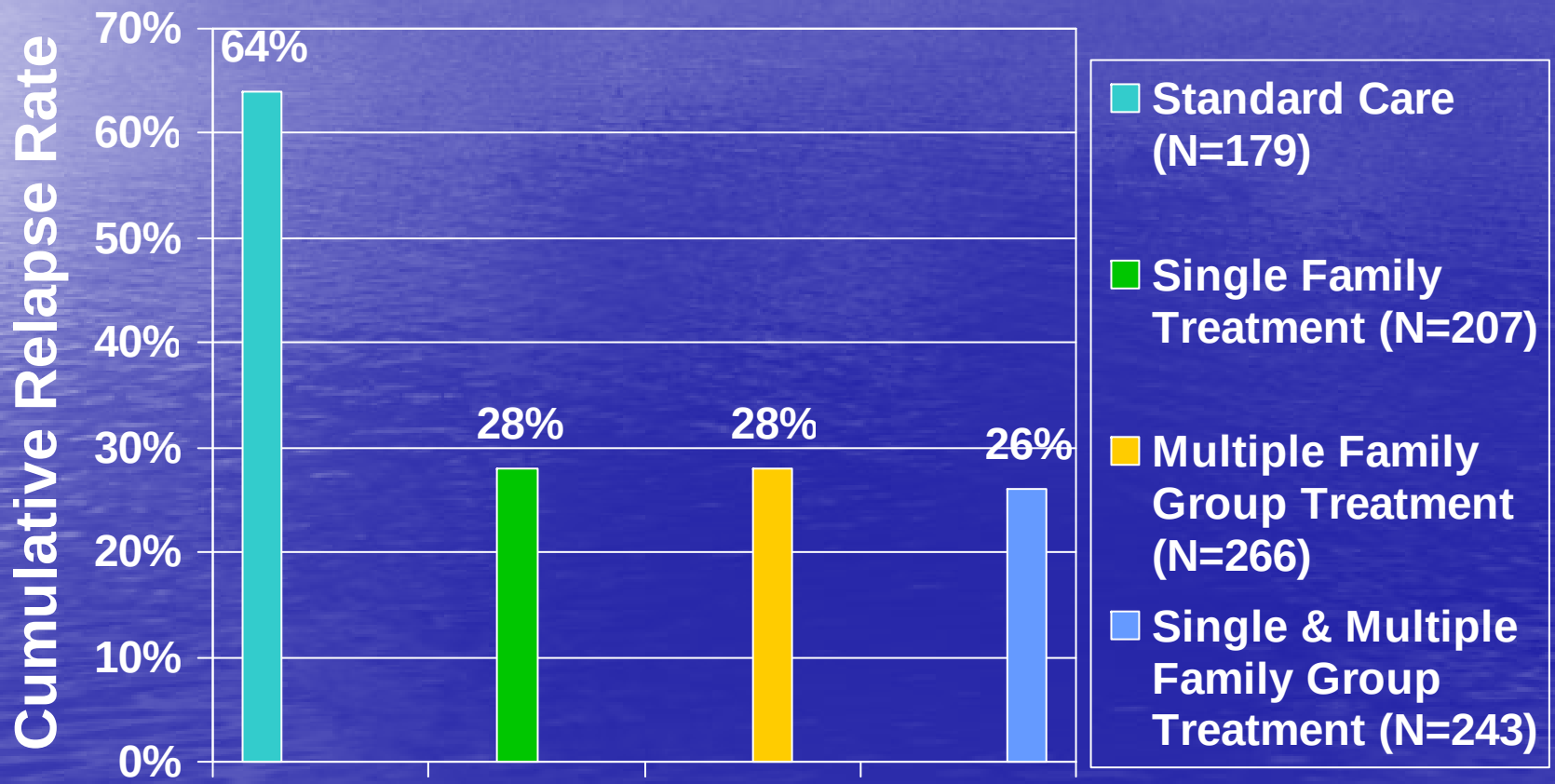
Mean Relapse Rates-18 Studies Comparing Relapse Rates in Family Intervention to Usual Care in Schizophrenia (n=895)[1]



Pitchel-Walz G, Leucht S, Bauml J, Kissling W, Engel RR.

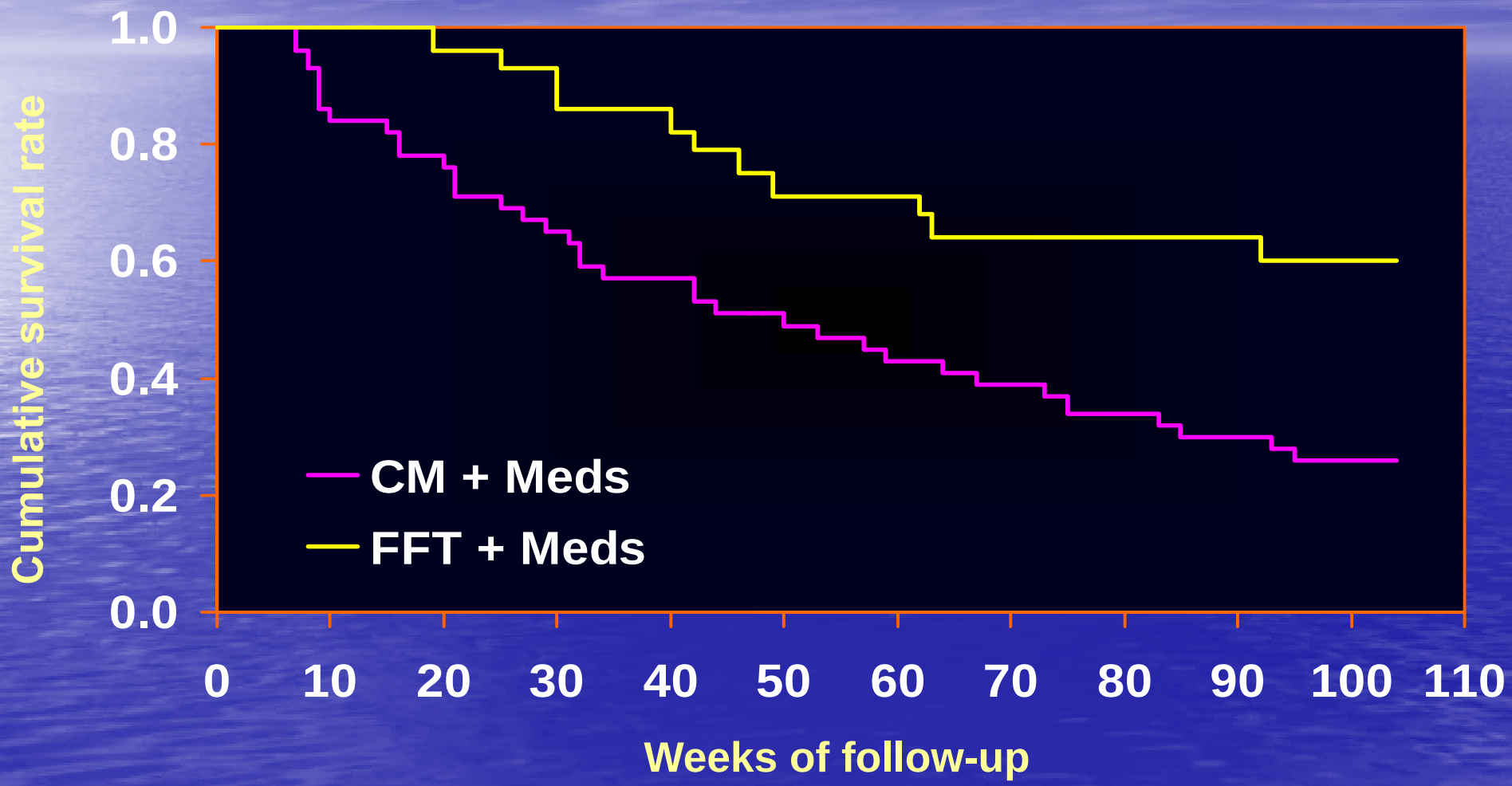
Schizophr Bull. 2001

Combined Results of Family Intervention Programs on 2-year Cumulative Relapse Rates in Schizophrenia (11 Studies)



FFT + Medication Delays Relapse More than Crisis Management + Medication in Bipolar Illness

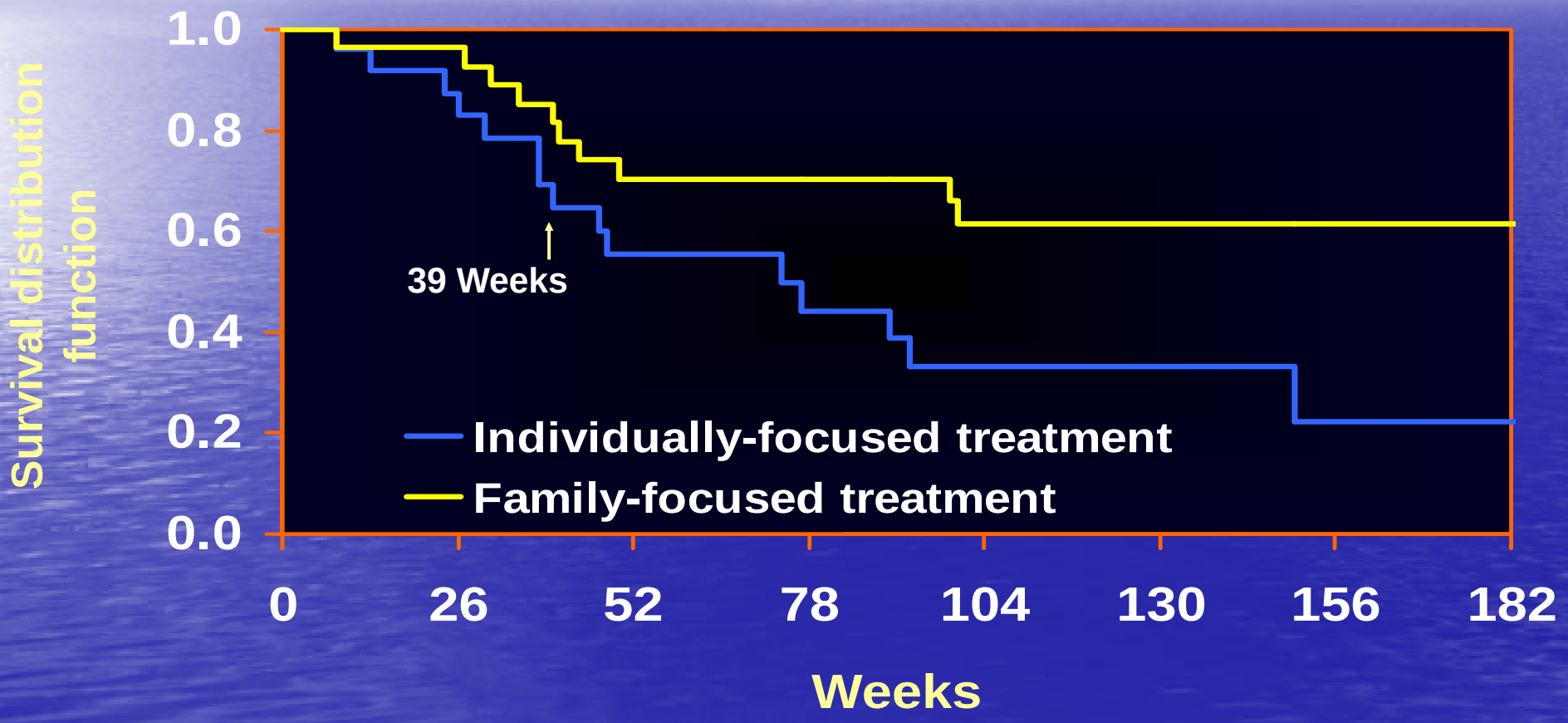
(N = 101)



CM vs. FFT χ^2 (1) = 8.71, p = .003; FFT, mean survival = 73.5 weeks; CM, 53.2 weeks.
Miklowitz DJ, et al. *Arch Gen Psychiatry*. 2003

Greater Persistence of Effects of Family vs. Individual Therapy in Bipolar Illness: Time to Rehospitalization

UCLA FFT Study (N=53)



X^2 (1) = 3.87, P <.05

Rea, Tompson, Miklowitz et al. J Consult Clin Psychol. 2003.

Summary of Evidence Supporting EBP

- Relapse rates in schizophrenia can be reduced by 20% if relatives are included in treatment; equally effective in bipolar illness and depression.
- If programs last six months or more, relapse rates are reduced by 30% to 50%.

Who Can Benefit from FPE?

- Clients living with or in regular contact with family members (> 4 hours contact per week)
- Wide range of family relationships (e.g., parents, siblings, spouses, children)
- Relatives who want to help the client re-integrate into the community

Overview of the Family Services Continuum Outlined in the Uniform Mental Health Services Package

Continuum of Family Services

Uniform Mental Health Services in VA Medical Centers and Clinics

Minimal clinical requirements for VHA Mental Health Services:

- Providers discuss family involvement with patient at least yearly & at inpatient discharge
- Treatment plan to identify family contact or reason for lack of contact
- Providers must seek consent from veterans to contact families in the future, as necessary

Uniform Mental Health Services in VA Medical Centers and Clinics

Minimal clinical requirements for VHA Mental Health Services:

- Family consultation, family education or family psychoeducation for veterans with serious mental illness must be provided at VA Medical centers and very large CBOCs
- Opportunities for these family services must be available to all veterans with serious mental illness on site, by telemental health, or with community providers through sharing arrangements, contracting, or non-VA fee basis care

Uniform Mental Health Services in VA Medical Centers and Clinics

Continuum of Family Services

- Consistent with a recovery philosophy, flexibility is a key principle
- Services must be tailored to veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences

Uniform Mental Health Services in VA Medical Centers and Clinics

Continuum of Family Services:

- Family Engagement
- Family Education and family access to the treatment team
- Family Involvement in treatment planning
- Family Consultation focused on problem-solving
- Family Psychoeducation

Continuum of Family Services

Family Education (FE)

- Treatment team provides factual information necessary to support the veteran and partner
- Distinguished from Family Psychoeducation, which involves includes education *and* skills training
- Offered in many formats, regularly scheduled and conducted over time including:
  - By professionals (e.g., SAFE Program)
  - By trained family members (e.g., NAMI Family-to-Family Education Program)
  - Ad hoc meetings with families

Continuum of Family Services

Family Consultation (FC)

- Family meets with mental health professional as needed to resolve specific issues related to the veteran's treatment and recovery
- Intervention is brief; typically 1 – 5 sessions for each consultation
- Provided on as needed or intermittent basis
- If more intensive ongoing effort is required, family can be referred to Family Psychoeducation

Continuum of Family Services

Family Psychoeducation (FPE)

- Type of evidence-based Family Therapy
- Focuses on developing coping skills for handling problems posed by mental illness in a member of the family
- Can be used in single family format (e.g., Behavioral Family Therapy) or multi-family group (e.g., Multiple Family Group Therapy)

GOALS OF FAMILY PSYCHOEDUCATION

- Legitimizing the psychiatric disorder
- Reducing negative emotions in family members
- Enlisting consumer's and family members' cooperatio with the treatment plan
- Facilitating consumer and family members' ability to monitor the disorder
- Improving outcomes

One Form of FPE -
Behavioral Family Therapy

Behavioral Family Therapy

- Patient & family attend together
- Behavioral
- Weekly → Biweekly → Monthly
- Minimum 9 months; more can be useful

Behavioral Family Therapy Includes

- **Assessment**
  (individual session with each participant)
- **Education about mental illness and its treatment - *4-6 sessions***
- **Communication skills training - *3-6 sessions***
- **Problem-solving skills training - *6-12 sessions***
- **Work on specific problems**
  (as needed)

Another Form of FPE -

Multi-family Group Therapy

STAGES OF MULTIPLE FAMILY GROUP INTERVENTION

Family Outreach & Engagement	JOINING Session #1	JOINING Session #2	JOINING Session #3	FAMILY EDUCATION WORKSHOP	1st MFG Meeting	2nd MFG Meeting	Ongoing MFG Problem-Solving Meetings
5 min - 30 min	60 min each			ALL DAY (6-7 Hrs)	90 min	90 min	90 min each
• Discuss with consumer • Obtain consumer's consent • Outreach via letters, phone calls, invitation from consumer, flyers, etc. • Invite family to partner with consumer and clinician	• Three 1-hour meetings with individual families • Separate 30-min. meetings with consumer • Goals: - Begin building relationship / partnership - Gather info. that will assist consumer - Give people opportunity to share concerns - Prepare for Education Workshop and MFG • Socializing and getting to know one another as people is an important aspect of Joining • Cover topics such as: - Early warning signs of relapse - Family/consumer social network & strengths - Short-term & long-term goals - Past experience with mental health system - Overview of Workshop & MFG Sessions			• One time only • All families • Can include consumer • Clinicians act as hosts and educators • Cover topics such as history and biology of illness, treatments, Family Guidelines, and problem-solving methods	• 1st meeting with family members & consumers • "Getting to Know You" • No talking about mental illness • Share personal information and positive aspects of life	• 2nd meeting with family members & consumers • "How Has Mental Illness Changed Our Lives" • Share personal stories • Continue relationship & partnership building	• Structured PROCESS of life updates and problem solving by participants • CONTENT of each group depends on issues raised by consumers & family • Constantly ask, "What's the next step?" • Consumer, family and clinicians work togethe to implement the Family Guidelines

Comparing group and individual interventions

Advantages of Single and Multiple Family Formats of Family Interventions Programs

Single Family Format

- Easier to conduct outreach to families
- More suitable for addressing specific problem area, etc.
- More flexible
- Easier to engage family, especially early in illness
- Home visits

Multiple Family Format

- More economical (?)
- More social support provided by other families
- Less vulnerable to effects of staff turnover
- Easier to provide multiple sources of input to family member

Currently OHMS is rolling out BFT and MFGT as EBPs with initial trainings and 6 months of consultation

Characteristics of a Good FPE Referral

- Correct dx
- Participants seem to have good will towards each other
- Psychiatric Illness is driving much of the conflict or problem in family (as compared to adultery, ipv, etc)
- Participants are committed to each other—little or no active discussion of separation
- Participants can commit to therapy—scheduling, transportation, etc
- Participants in regular contact at least weekly—can be by phone

What do we need to do to make FPE work at the VA?

Address System Issues

- Longer sessions-60 mins
- Schedules permit weekly or biweekly sessions
- Protected time for engagement and case finding
- Evening or weekend sessions
- Protected time for prep work

New Developments

- PL 110-387 Veterans' Mental Health and Other Care Improvement Act of 2008
  - Sec 301 amends 38 USC 1782
  - Adds marriage and family counseling to services for family members of all veterans eligible for VA care
  - Rescinds prior stipulation that limited services which include family members for veterans receiving non-service connected treatment.
  - Informational letter going out soon to VAMCS
  - Hiring of marriage and family therapists within the year

Planned Roll-out of Couples Therapy for Marital Distress

Overarching Principles Guiding Selection of Appropriate Intervention Couples Model

- *Supportive evidence*
- *Expert recommendations*
- *Build on skills taught in other EBPs*
- *Accessible for clinician sample with highly variable skills—many have little if any family expereince*

First training effort will disseminate Integrate Behavioral Couples Therapy for general marital distress

(Christensen & Jacobson 1998)

Other disorder-specific interventions may follow

Primary Supportive Study (Christensen et al, 2004, JCCP)

N= 134 chronically distressed couples

- Randomized to TBCT vs IBCT
- 26 sessions over 36 weeks
- Primary Outcome-Marital Distress

Traditional Behavioral Couples Therapy (TBCT)

- direct instruction and skills training
- behavioral exchange
- communication skills training
- problem-solving training

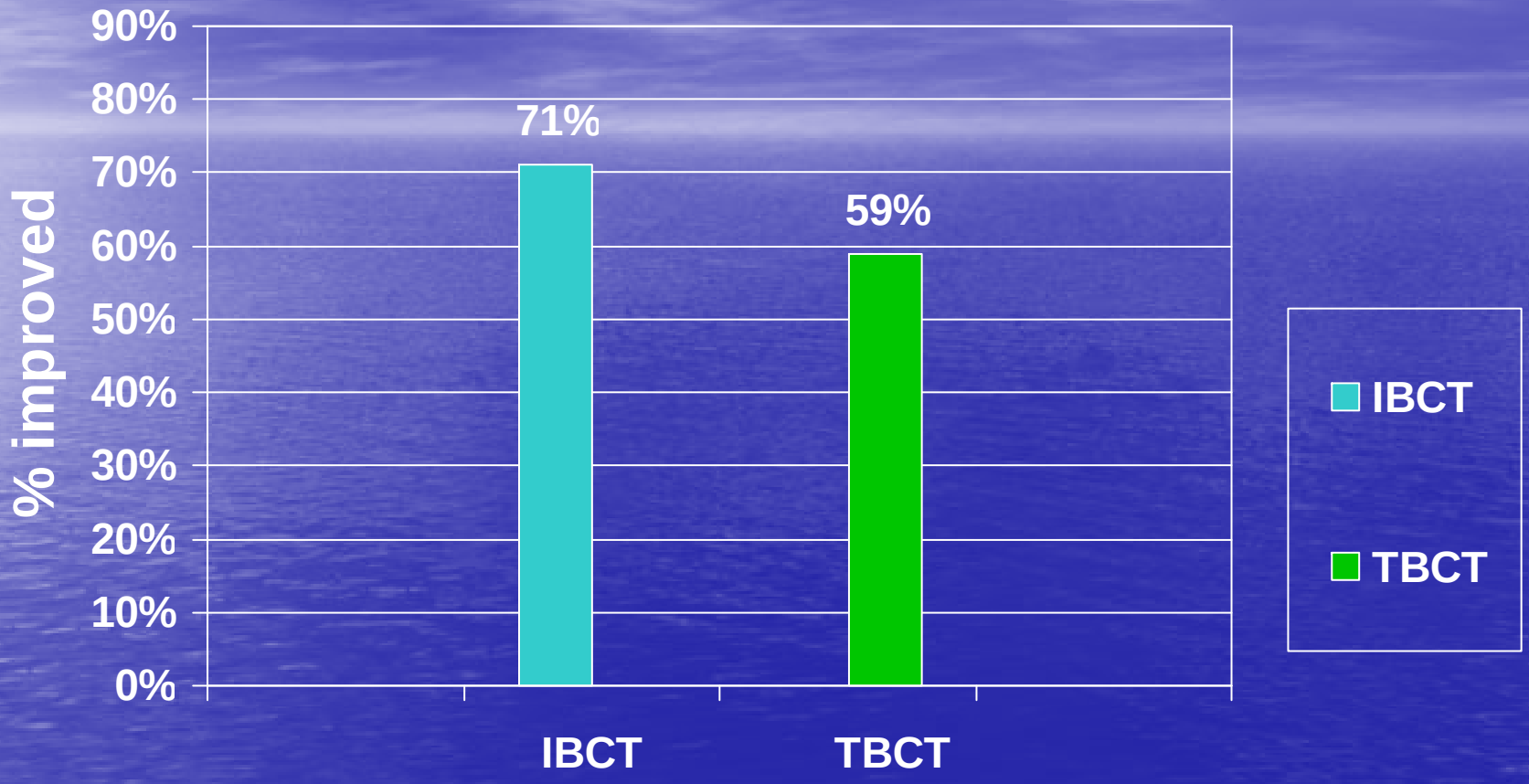
Jacobson & Christensen, 1996

Integrated Behavioral Couples Therapy (IBCT)

- promoting emotional acceptance of differences
- empathic joining
- eliciting vulnerabilities
- unified detachment
- Step back from problem together
- Building tolerance
- Positive and negative functions of differences
- Also could use direct change strategies in TBCT

Jacobson & Christensen, 1996

Dyadic Adjustment Scale Scores



Clinically Significant Improvement of DAS Improvement

x^2 3) = N = 130, =332, n.s

JCCP, Christensen et al., 2004

VA Roll-out of Couples Treatment commencing August 2010

IBCT will be supplemented with additional training on parenting and domestic violence