Clinical Models & Core Components Continued

Webinar 4

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Webinar Logistics

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Aims

- Examine further the features of each core component of early intervention (EI) services:
  - What/why it is a core component.
  - Training needs.
  - Staffing/workforce considerations.

Multifamily Group:

A Form of
Family Psychoeducation

Donna Downing, MS, OTR/L
Research Study Coordinator
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What is Family Psychoeducation?

A structured approach designed to

- reduce stigma and shame
- help families and consumers better understand mental illness while working together towards recovery.
- recognize the family's important role in recovery.
- help clinicians see markedly better outcomes for consumers and families.

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Who can participate in multifamily group (MFG)?

Anyone who cares about the consumer and can consistently attend MFG sessions!

- Parents
- Spouses
- Siblings
- Aunts, uncles, grandparents
- Friends
- Case managers

Benefits of Family Psychoeducation

- Consumers choose the ***support people*** they want involved in their recovery.
- Families/supports get ***information*** that helps them play an active role in the recovery process.
- The consumer and support people ***work together*** towards recovery.
- Consumers get back into the ***mainstream of life*** with support and understanding.
- **FPE has been shown to be as beneficial as medication in the recovery of schizophrenia and severe mood disorders.**

Relapse outcomes in clinical trials with schizophrenia

70
60
50
40
30
20
10
0

65
41
15
9

No medication
Individual therapy & medication
FPE & medication
PEMFG & medication

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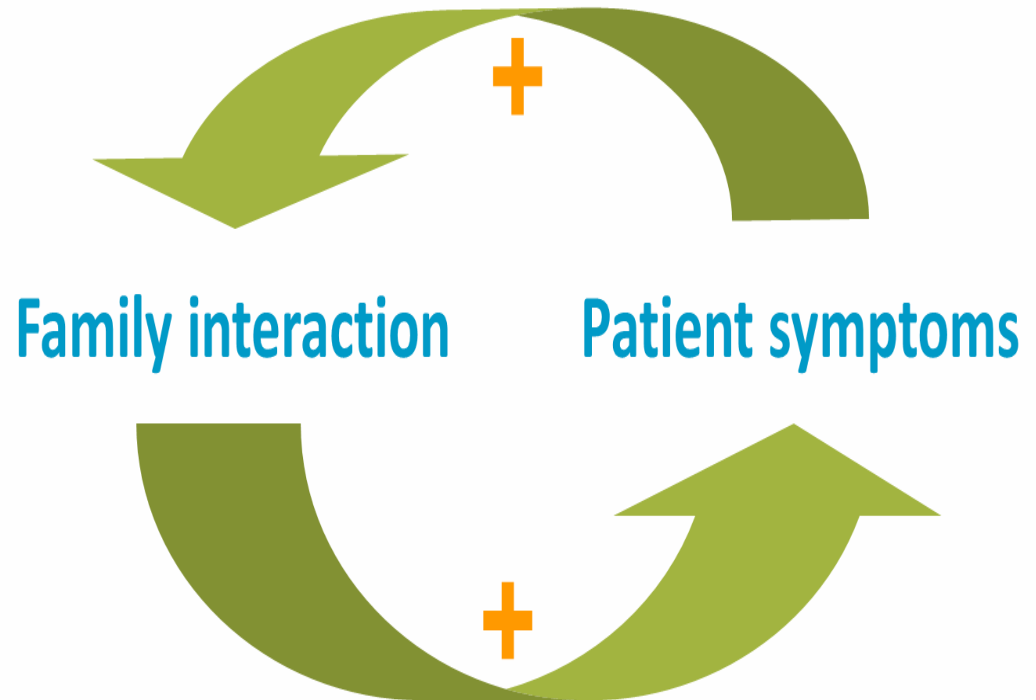
MFGs help reduce high expressed emotion (EE)

What is EE?

- Critical comments
- Hostility
- Over-involvement
- Lack of warmth



Effects of Social Networks

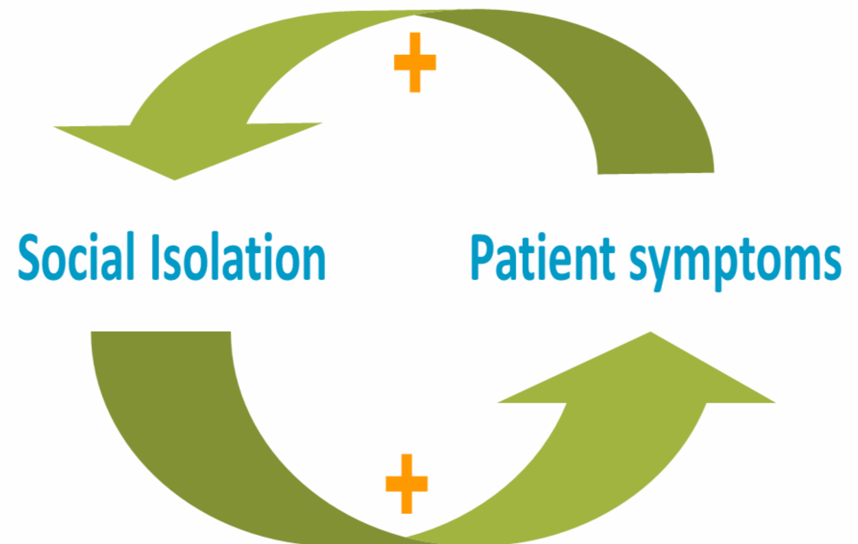
Networks

- buffer stress and adverse events
- determine treatment compliance
- predict relapse rate
- correlate with coping skills and burden

UNFORTUNATELY…

Family network size

- diminishes with length of illness
- decreases in the period immediately following a first episode
- is already smaller at the time of first admission



MFGs create family social networks and...

- Lead to improved:
  - social supports
  - well-being for all participants
  - access to information
  - coping strategies
- Decrease effects of stigma.
- Increase morale.
- Decrease burden.

MFG Format

1. Socializing with families and consumers	15 m.
2. A Go-around, reviewing: a) The week's events b) Relevant biosocial information c) Applicable guidelines	20 m.
3. Selection of a single problem	5 m.
4. Formal Problem-solving: a) Problem definition b) Generation of possible solutions c) Weighing pros and cons of each d) Selection of preferred solution e) Delineation of tasks and implementation	45 m.
5) Socializing with families and consumers	5 m.
Total:	90 m.

Family Guidelines

- 12 key guidelines related to the biology of illness.
- Based on the stress-vulnerability model.
- Referred to during MFG sessions—posted on the wall!

Rehabilitation Effects of MFG

Minimizing internal family stressors:

- Strengthening relationships and creating an optimal, protective home environment
- Reducing confusion, anxiety and over-involvement
- Preventing onset of negativity and criticism
- Ongoing problem-solving

Buffering external stressors:

- Tuning and ratification of goals
- Coordinating efforts of family, team, consumer and employer
- Developing informal job leads and contacts

Research with Family Psychoeducation

- This EBP is an elaboration of models developed by Anderson, Falloon, McFarlane, Goldstein and others since the 1960's.
- Different cultures are receptive to and benefit from this EBP.
- Families of different ethnicities benefit from working together in a MFG.
- Outcome studies report a reduction in annual relapse rates for medicated, community-based individuals with schizophrenia of as much as 50% by using a variety of educational, supportive, and behavioral techniques.
- Current research with EFEP populations is showing promising outcomes in terms of family cohesion, maintaining functioning, and reducing symptoms.

Clinical trials in other disorders

- Dual diagnosis of schizophrenia and substance abuse
  - McFarlane, Lukens et al., 1995
  - Barrowclough, Haddock et al., 2001
- Bipolar disorder
  - Miklowitz, Simoneau et al., 2000
  - Tompson, Rea et al., 2000
- Major depression
  - Emanuels-Zuurveen, 1997
  - Leff, Vearnals et al., 2000
- Depression in mothers with disruptive children
  - Sanders and McFarland, 2000
- Mood disorders in children
  - Fristad, Gavazzi et al.,1998
- Obsessive-compulsive disorder
  - Van Noppen, 1999
- Anorexia nervosa
  - Geist, Heinmaa et al., 2000
- Alcohol abuse
  - Loveland-Cherry, Ross et al.
- Alzheimers disease
  - Marriott, Donaldson et al., 2000
- Suicidal children
  - Harrington, Kerfoot et al., 1998
- Intellectual impairment
  - Russell, John et al., 1999
- Child molesters
  - Walker, 2000
- Borderline personality disorder
  - Gunderson, Berkowitz et al., 1997
- Secondary effects of chronic medical illness
  - Steinglass,1998

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MFG Training

- 3 days of intensive, “hands on” learning.
- Training manual provided.
- Followed by monthly supervision for up to 2 years:
  - Begins 1 month after the training.
  - Assistance provided with every phase of implementation.
- Support from agency administration is necessary for success.

Stages of MFG

Joining

Family & consumer separately + together
3-6 weeks

Educational workshop

Families (all members)
1 day or 2 evenings

Ongoing MFG

Families and consumers
1-2 years

Staffing needs for MFG

- **2-3 facilitators**
  - 3 facilitators allows for group coverage during vacations, sickness, etc.
  - This is NOT a 1-person facilitated group!
- **Intensive front-end effort** which can interfere with other job responsibilities—especially during the joinings and family education workshop.
- **Most MFGs are held in the evenings** because families work = need for flex time in practitioners' schedules

Peer Specialists & Peer Support

Nev Jones, PhD
Mind & Culture Postdoctoral Fellow
Stanford University

Peer Support & Leadership in EI: *What?*

- Integrating peer staff as members of existing treatment teams.
- Augmenting and expanding services through the addition of special peer-led groups and programs.
- Involving peers (more broadly) in the operations and/or mission of the program.

Peer Support: Forms it Might Take I

- Peer Specialist(s)
  - Integrated members of the treatment team
  - Dedicated 1:1 peer counseling
  - Facilitation of peer support and/or activities groups
  - Family and/or client outreach (including social media)
  - Managing peer speaker's bureaus
  - Co-facilitation of multi-family groups
  - Role in supported employment/education interventions

Peer Support: Forms it Might Take II

- "Non-Clinical" Forms of Peer Involvement
  - Non-clinical outreach (psychoeducation, anti-stigma presentations)
  - Administrative leadership
  - Quality improvement & evaluation
  - Policy interface
  - Program or project advisory board(s)
  - Participation in staff hiring or governance committees

Peer Support & Involvement: Why?

- Peer involvement and/or support increasingly mandated in the delivery of community-based MH services.
  - (e.g. federally qualified behavioral health centers)
- Core tenet of the consumer/recovery movement(s).
  - "Nothing about us, without us."
- Growing conceptual and empirical evidence base suggesting significant benefits.

Peer Support: Conceptual Benefits

- Conceptual work on peer support:
  - Helper-helpee principle
  - Upward social comparisons
  - Social modeling/mentoring
  - Specific, concrete insights into what works/helps
  - Greater credibility (to patients) & trust
  - Absent/lessened power differentials
    - Reciprocal support

(Solomon, 2004; Davidson, Davidson et al., 2006)

Peer Support: Empirical Benefits

- Peer support interventions have demonstrated to increase:
  - Client engagement
  - Symptom-based outcomes (depression, demoralizations)
  - Functional outcomes (community involvement, work/school)
  - Patient self-advocacy
  - Hope and investment in setting and meeting goals

Suggested Reading

- Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, *11*(2), 123-128.
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin*, *32*(3), 443.
- Jones, N. (2015; forthcoming). *Peer involvement and leadership in early intervention in psychosis services*. National Association of State Mental Health Program Directors.
- Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*(4), 392.
- Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*, *36*(1), 28.

Training Needs: Existing Staff

- Prepare non-peer staff to work with (and embrace) peer staff:
  - Preparatory workshop
  - In-service
  - In house "environmental" assessment
- Identify supervisors and determine training needs:
  - Experience supervising a peer?
  - Understanding of core differences between peer and non-peer supports/services?

Training Needs: Peer Staff

- **Training for new peer staff:**
  - Assess existing training
    - (e.g. state-mandated peer specialist training & certification)
  - Determine gaps
    - ("new" knowledge to cover; training in specific early intervention models or principles; psychosis-specific group facilitation such as hearing voices network groups, trauma-informed groups)
  - Assess ongoing training & supervision needs

**Ideally, view the above as opportunities for growth & career development*

Training Needs: Additional Considerations

- **Models for peer involvement in supported employment and education less developed.**
  - Peerlink Technical Assistance Center maintains a list of model "peer delivered employment supports" programs
  - www.peerlinktac.org/focus-areas/employment/
- **Specific models or approaches may require external training.**
  - (e.g. WRAP, intentional peer support, hearing voices network groups)

Staffing: Peer-Specific Considerations

- **Finding the “right” peer specialist:**
  - Already certified or certification-eligible?
  - Lived experience of psychosis (specifically)?
  - Experience working with psychosis in a targeted way?
  - Age parameters?

- **Contractors vs. employees**
  - What programs are local peer-run organizations already operating?
  - Weigh pros/cons

Staffing: General Considerations

- Opportunity to assess & improve overall recovery orientation of program:
  - Proactively address any tensions between non-peer/peer staff.
  - Proactively address stigma/resistance to peer leadership.
  - Senior staff/administrators ideally “model” respect for peer staff/peer volunteers.
- Avoid tokenism (i.e. a single peer staff member).
- Long-term, consider or aim for peer inclusion/leadership at all levels, including inclusion of program alumni.

Individual Placement & Support:

A Key Element of Treatment

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Psychologist/Therapist
Training Coordinator
UCLA Aftercare Research Program

What is IPS?

Individual Placement and Support Model (IPS): An evidenced-based practice of supported employment.

- Developed to help people with SMI return to work
- Community-based model
- Adapted for prodromal and recent onset

What is IPS? Why is it Important?

- 8 Principles of IPS.
- Principles have been edited over the years.
- Returning to work and school is a key component of treatment and recovery.

What is IPS? Why is it Important?

- Critical phase of development
- Most individuals not interested in treatment
- Symptoms interfere with functional outcome

Training Needs

- Principles
- Dartmouth Website: www.dartmouthips.org
- Fidelity Scale
- Integration of treatment team principle

Staffing/Workforce Needs

- Sophisticated position: mental health and business
- Cross-training
- Supervisor
- Caseload

Discussion/Questions

Next Month: EI in the Larger Context

- **Prodromal and first episode programs in greater system/state context**
- **Organizational change/leadership buy-in**

September 10 – 12-1pm ET

COP: Next Steps

- **Peer to peer phone calls.**
  – Indicate your interest in today's post-webinar survey.

- **August office hours with Donna, Nev and Luana**
  – Selections must be made by COB 8/17.

National Council for Behavioral Health Hill Day 2015

October 5-6, 2015

Washington, D.C.

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Webinar Dates Reminder

- ~~Thurs., May 14; 12pm-1pm EDT~~
- ~~Thurs., June 11; 12pm-1pm EDT~~
- ~~Thurs., July 16; 12pm-1pm EDT~~
- ~~Thurs., August 13; 12pm-1pm EDT~~
- Thurs., September 10; 12pm-1pm EDT
- Thurs., October 15; 11am-1pm EDT