A Continuum of Family Services and Cognitive Behavioral Therapy Interventions for Persistent Psychotic Symptoms: Programming for those affected by schizophrenia

Northeast Ohio Medical University
Best Practices in Schizophrenia Treatment (BeST) Center

LEARNING OBJECTIVES

- Review relevant research of effectiveness of family-based interventions and CBT-p for psychosis.
- Review the BeST Center's continuum model of family services and the CBT-p model.
- Describe the key techniques for addressing symptoms of psychosis.
- Discuss implementation of these programs within mental health agencies, including training and family engagement.

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT (BeST) CENTER AT NEOMED

The BeST Center's mission:
- Promote recovery and improve the lives of as many individuals with schizophrenia as quickly as possible.
- Accelerate the use and dissemination of effective treatments and best practices.
- Build capacity of local systems to deliver state-of-the-art care to people affected by schizophrenia and their families.

The BeST Center offers:
- Training
- Consultation
- Education and outreach activities
- Services research and evaluation

The BeST Center was established:
- Department of Psychiatry, Northeast Ohio Medical University (NEOMED)
- Through an initial generous grant from The Margaret Clark Morgan Foundation.
BEST PRACTICES IN SCHIZOPHRENIA TREATMENT (BeST) CENTER GUIDING PRINCIPLES

The BeST Center's guiding principles:

- People with schizophrenia and their families have an absolute right to the most effective treatments.
- The gap between effective clinical practices and delivery must be closed.
- Translating breakthroughs in mental health treatments into practice is an urgent, essential and achievable task.

Implementing BeST Center Operating Principles

BUILDING ON FAMILY STRENGTHS:
SUPPORT, EDUCATION AND ADVOCACY

DANIELLE R. HUPP, PH.D.
HISTORICALLY...

- 1940s – 1970s: Providers believed schizophrenia resulted from bad parenting. Subsequently, family members were often blamed for mental illnesses in their families (e.g., "the schizophrenogenic mother;" Reichmann, 1948)

- 1970s: The grassroots organization, National Alliance on Mental Illness (NAMI), was founded by families of individuals with mental illnesses to advocate on behalf of family members and for families to support each other

HISTORICALLY...

- Late 1970s – early 1980s: Researchers (e.g., Fallow, Hogarty) began to recognize and understand the importance of family involvement in treating mental illnesses

- This became known as "Family Psychoeducation"

MENTAL ILLNESS AND FAMILIES

- A diagnosis of mental illness is upsetting and often bewildering for most individuals and their family members and significant others

- Family members often serve as under-supported advocates, informal case managers and crisis intervention specialists for their relatives with mental illnesses

- Family members may also forget to take care of their own needs when caring for someone with a serious and persistent mental illness
FAMILY EDUCATION AND SUPPORT

Studies consistently show that family and significant others' engagement in mental health education and support leads to:

- reductions in relapse and re-hospitalization rates for individuals affected by schizophrenia
- improved family well-being: decreased burden, improved family relationships

(Choo & Lorraine, 1992; Jowell, McFarlane, Choo, & Melnick, 2002; Peralta & Masa, 2006)

OTHER BENEFITS ASSOCIATED WITH FAMILY EDUCATION AND SUPPORT

- Clients' employment rates improved
- Clients' social functioning improved
- Clients' psychiatric symptoms decreased
- Costs of care decreased
- Clients' medication adherence increased

(Choo et al., 2000; McFarlane et al., 1995; McFarlane et al., 2002; Mowen et al., 2009)

The mental health system has struggled — and continues to struggle — to support families of those diagnosed with schizophrenia in both policy and practice.

Why is this the case?
SCHIZOPHRENIA PATIENT OUTCOMES RESEARCH TEAM (PORT)

- Provides evidence-based treatment recommendations for people affected by schizophrenia
- One recommendation is to provide family-based services
  - Ideally, this would be in the form of the evidenced-based Family Psychoeducation of 6-9 months duration
  - PORT recommends shorter-term interventions (at least four sessions in less than six months) when longer-term interventions are not feasible or acceptable

THE BeST CENTER’S RESPONSE

- Recognizing that families are vital members of the recovery team led the BeST Center to develop

  Building on Family Strengths: Support, Education and Advocacy (BOF'S:SEA)

"FAMILY"

- Anyone who cares for or about an individual diagnosed with a mental illness
- Could be a blood relative, significant other, neighbor, friend or other support person
BUILDING ON FAMILY STRENGTHS: SUPPORT, EDUCATION AND ADVOCACY PROGRAM

- Overarching goal: To meet each consumer and family where they are in the recovery process with the understanding that the needs and desires of every family are different

- Implemented at an agency that encourages family involvement

CONTINUUM OF SERVICES: FOUR COMPONENTS

- Distress Interventions

- Consumer Centered Family Consultation (CCFC)

- Behavioral Family Therapy (BFT)

- Family-to-Family (F2F) Preview Session
DISTRESS INTERVENTIONS

• All staff at the agency are prepared to assist families
• Staff can also match each family's unique needs with resources that are available in the agency and in the community
• Family members are assisted in coordinating appointments within the agency

CONSUMER CENTERED FAMILY CONSULTATION (CCFC)

• CCFC is an emerging best practice developed by the New York State Office of Mental Health, University of Rochester Medical Center and the Family Institute for Education, Practice and Research
• Adapted by the BeST Center and used with permission

CONSUMER CENTERED FAMILY CONSULTATION (CCFC)

• CCFC is a brief (3-5 session) intervention. It is a consultation model; it is not therapy
• Goals are to:
  • Promote recovery and collaboration among consumers, family members, significant others and clinicians
  • Provide information about mental health diagnoses, treatments and services
  • Provide guidelines for how to support consumers and family members and how to solve problems
  • Facilitate referrals to agency, program and community resources
BEHAVIORAL FAMILY THERAPY (BFT)

- BFT is not therapy; instead it focuses on education and skill-building
- Family psychoeducation that is offered to single families
- BFT is a longer intervention (18+ sessions) delivered by a licensed clinician
- Evidence-based practice developed by Mueser and Glynn; part of evidence-based practices project by SAMSHA

BEHAVIORAL FAMILY THERAPY (BFT)

- Goals are to:
  - Develop strong communication and problem-solving skills and techniques
  - Provide information about schizophrenia spectrum disorders, treatments, substance abuse and relapse planning
  - Help individuals learn to balance personal needs with those of their loved one
  - Achieve a satisfactory quality of life for the individual diagnosed with schizophrenia and all family members

FAMILY-TO-FAMILY (F2F) PREVIEW SESSION

- Preview is co-developed by NAMI Ohio and the BeST Center; sessions are co-facilitated by the local NAMI affiliate, the BeST Center Consultant and the agency’s clinical lead
- Sessions are offered in the community
- Opportunity to meet with other families and join NAMI’s Family-to-Family and other programming
- Offers additional education, support and advocacy
- Preview is offered to all families – regardless of where they are in the continuum of services
STRUCTURE OF BOFS:SEA WITHIN AN EXISTING SYSTEM

- The BeST Center consultant is embedded at an agency (Murtis Taylor) to train staff about a continuum of services that are offered in a family-friendly way.

- The consultant spends two days per week at the agency providing continuous consultation and training for the first year of implementation.

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STRUCTURE OF BOFS:SEA WITHIN AN EXISTING SYSTEM

- Request for Partnership was issued
  - Murtis Taylor selected.

- Cultural/philosophical shift for entire agency

- Family-friendliness

- Referrals

- Engaging clients and families

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WHAT DOES THIS LOOK LIKE FOR STAFF?

- All staff is provided with a BOFS:SEA overview
- CPST staff is trained in model with additional brief training in CCFC
- Clinicians trained in CCFC and BFT
- Two agency "leads" are identified
  - Clinical lead/agency "champion"
  - Administrative lead
NEXT STEPS

- Murtis Taylor is site for a pilot program
- Program getting underway
  - Kick-off
  - Initial trainings
  - Working with QA, IT

IMPLEMENTING A RANGE OF COGNITIVE BEHAVIORAL THERAPY INTERVENTIONS FOR PERSISTENT PSYCHOTIC SYMPTOMS

HARRY J. SIVEC, PH.D.

TREATMENT OF PERSISTENT PSYCHOTIC SYMPTOMS

- Roughly 25 – 50% of individuals diagnosed with a schizophrenia-spectrum illness continue to experience persistent symptoms despite adherence to medication (Gould et al., 2001).
- Psychosocial treatments have been recommended to help ease the distress of psychotic symptoms
  - CBT-p is one promising approach (see PORT and NICE guidelines; Dixon, et al., 2010; National Collaborating Centre for Mental Health, 2008)
Efficacy of CBT for Psychosis (Sivec & Montesano, 2012; Wykes et al., 2008)

- Average effect size for individual CBT-p = .40
- Average effect size when CBT-p is compared to another psychotherapy = .20

Effect sizes: small = .20; medium = .50; large = .80 (Cohen, 1988)

Smaller Number of Studies in Routine Clinical Practice Settings ("Effectiveness")

  - 15 sets, 15 sets change, 15 no change (6-month study)
  - CBT-p and supportive therapy showed benefits with attrition at 3-month follow-up
  - No difference in outcomes compared to TAU
  - Higher satisfaction ratings for CBT
  - Improvements found in depression scores; other findings less clear
  - Suggest using CBT-p for high-stress settings and providing ongoing supervision for staff
- Lincoln, et al., (2012) (Germany)
  - CBT-p showed effect sizes ranging from .77 to .39 in practice setting.
  - Positive effects maintained at one-year follow-up

How Does it Work?
Therapeutic Process of CBT-p

- There is a strong focus on individualized engagement of the client
- Sessions are structured flexibly; agendas are less explicit, feelings are elicited with great care and homework is used sparingly
- Assessment is based on clinical practice
- Emphasis is placed on understanding the client’s experience
- Information on current beliefs and how they were arrived at is assembled into a formulation
OVERALL AIM OF CBT FOR PSYCHOSIS

AIM
To reduce distress and disability

Work with hallucinations (persistent/abusive)

Work with delusions (systematized & high conviction)

Work with negative symptoms

WHY NOT OFFER CBT-P TO ALL CLIENTS WHO EXPERIENCE PERSISTENT PSYCHOTIC SYMPTOMS?

- Most research and training in this approach has been conducted outside of the U.S.
- There are limited training/supervision opportunities in U.S.
- Different health care delivery systems
- Limited role of therapy for individuals with schizophrenia in community mental health care settings

ONE SOLUTION

- Develop a spectrum of CBT-p related services based on treatment models developed and tested in other countries
- Insight CBT Partnership- UK consultant group contacted to help train staff and to help develop modified CBT-p approach.
- Direct clinical support for new practice. Offer ongoing training and supervision by a consultant placed within the agency and who works directly with the treatment providers
- Work with the administrative staff to develop processes and strategies to enhance implementation and sustainability of the model specific to the needs of the agency
ADAPTING CBT-P FOR USE IN THE U.S.

- Train individuals who spend the most time with clients - case managers
  - To stay within scope of practice, techniques were identified from CBT-p research and modified for use with case managers.
- Train licensed staff in a more advanced version of the modified approach to address cases that require counseling services - counselors and supervisors

HIGH-YIELD COGNITIVE BEHAVIORAL TECHNIQUES FOR PSYCHOSIS: HYCBT-P

- Brief meetings (15-20 minutes)
- Clients encouraged to talk about what is distressing to them (in contrast to "ignore" or "talk about later")
- Focus on issues important to the client and "doing with" rather than "doing for"
- Straightforward coping ideas could be taught
- Help clients to monitor symptoms in a more consistent manner

SPECTRUM OF CBT-P SERVICES

Level Three
CBT-P
- Level Three CBT-P is a high-intensity treatment using psychoeducation and skills training in CBT to address severe and persistent psychotic symptoms

Level Two
CBT-P
- Cognitive Behavioral Techniques
  - A high-intensity treatment using psychoeducation and skills training in CBT to address severe and persistent psychotic symptoms

Level One
CBT-P
- Cognitive Behavioral Techniques
  - A high-intensity treatment using psychoeducation and skills training in CBT to address mild to moderate psychotic symptoms
THE FIVE KEY PHASES IN HYCBT-P

- Engagement
- Gaining Understanding
- Symptom Management
- Medication Monitoring
- Staying Well

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THE SEVEN KEY HIGH-YIELD TECHNIQUES

- Engagement & Forming an Alliance**
- Working on Self-Esteem**
- Education and Normalizing
- Teaching the A-B-C Model
- Reality Testing
- Enhancing Adherence
- Relapse Prevention and Recovery

** Present in all phases

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Cognitive Behavioral Therapy (Psychoanalysis)
An integrated and focused form of cognitive therapy. Formulation and therapy are based on the integration of traditional cognitive therapy with techniques based on the formulation of clients' thought processes. Techniques include therapy, behavioral therapy, and psychological therapy. This approach is especially effective for clients with depression and anxiety disorders.

Cognitive Behavioral Techniques (Psychoanalysis)
Engagement, modeling, relaxation, guided imagery, and narrative techniques. Techniques are based on the formulation of clients' thought processes. Techniques include therapy, behavioral therapy, and psychological therapy. This approach is especially effective for clients with depression and anxiety disorders.

High Yield Techniques (Psychoanalysis)
Strategies for engagement and forming an alliance, education and normalizing methods, helping clients to understand the A-B-C Model, simple reality testing, supporting self-identification by working on goals together, identifying critical assumptions, and ways to stay well.
PILOT PROJECT: PRELIMINARY DATA

- HYCBt-p training provided in CMHC
- N=38 clients received 12 HYCBt-p encounters
- Initial results are promising
  - Symptom improvement
  - Satisfaction among case managers
- Paper is currently under review

THE TWIN PILLARS OF PROMOTING EVIDENCE-BASED PRACTICES: LESSONS LEARNED

- Implementation
- Sustainability
ACCESS MODEL (Stirman et al., 2010)

IMPLEMENTATION: clinical skills training

- Assess/Adapt
  - HYCBT
- Convey the Basics:
  - Team-based vs. agency-wide training - lessons learned
  - Intensive (full day) versus spaced training - lessons learned
- Consult
  - Ongoing supervision with trainer placed at the agency
- Evaluate work samples
  - Fidelity in process of development
- Study outcomes
  - Use of PANSS and Outcome Review Form
- Sustain

SUSTAINABILITY

- Administrative issues:
  - Time/productivity issues: reserve and protect time for training and supervision
    - The #1 challenge
  - Referral and communication systems need to be developed/modified
    - How does the newly formed program function within the larger organization?

SUSTAINABILITY

Administrative issues:

- IT services
  - Specific progress notes for CBT-p/HYCBT
  - Data tracking processes - clinical outcomes, service utilization, etc.; making the clinical and business case for the practice

- QA/QI:
  - How to measure fidelity to the treatment model
  - Link to agency's process for continuous quality improvement
QUESTIONS

- Family-based interventions
- CBT-p
- BeST Center

BEST CENTER CONTACTS

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