The Potential Impact of the Recovery Movement on Family Interventions for Schizophrenia: Opportunities and Obstacles

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Many types of family interventions have been found to be effective in reducing exacerbations in schizophrenia; some also improve consumer social functioning and reduce family burden. Regardless of their origins, these interventions share a number of common features, such as showing empathy for all participants, providing knowledge about the illness, assuming a nonpathologizing stance, and teaching communication and problem-solving skills. Importantly, these family interventions have many characteristics that are consistent with the growing recovery movement in mental health in that they are community-based, emphasize achieving personally relevant goals, work on instilling hope, and focus on improving natural supports. Nevertheless, these interventions are generally reflective of older models of serious and persisting psychiatric illnesses that are grounded in a “patient being treated for a chronic illness” rather than a “consumer assuming as much responsibility as possible for his/her recovery” stance. These interventions could be made more consistent with recovery principles by (1) expanding the definition of family to include marital, parenting, and sibling relationships, (2) identifying better ways to match consumers with treatments, (3) broadening the research focus to include systems change that promotes making family members a part of the treatment team (with the consumer’s consent), and (4) overcoming implementation obstacles that preclude access to effective family interventions for most consumers and their relatives.

Key words: psychosocial/family treatment/consumer/recovery/schizophrenia

The growth of the recovery movement for serious and persisting psychiatric illnesses provides a welcome opportunity to revisit the field of family-based interventions for schizophrenia in order to identify ways these programs are already consistent with a recovery orientation and ways they might benefit from further refinement to be more recovery-compatible. Recovery from a serious and persisting psychiatric illness has been defined by the President’s New Freedom Commission on Mental Health as “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.”1,p7 In serious and persisting psychiatric illnesses, the broader notion of recovery has been postulated to involve 2 interrelated concepts.2 The first views recovery as a process in which one is engaged, often connoted in the word “recovering” (a term used comparably in the substance abuse literature) and including attitudinal and dispositional dimensions. In a factor analysis of consumers’ responses to a series of items reflecting recovery orientations, Resnick and colleagues3 identified 4 domains that can be seen as aspects of this process: life satisfaction, hope and optimism, knowledge of mental illness, and empowerment. Consumer-directed care is understood to be integral to the process of recovering. The second concept of recovery views it more as a state or outcome, related to objective symptom management and improved functioning. Importantly, for serious psychiatric illnesses recovery has not been defined as absence of symptoms with treatment no longer required. It is not denoted as “cure.”2

The last 35 years have witnessed a proliferation of psychoeducational family interventions for schizophrenia that have been associated with reductions in relapse and readmissions.4,5 At a basic level family interventions can be understood as being entirely in accord with a recovery orientation insofar as they are primarily community-focused and deal with “the real world”—the consumer and his/her loved ones. Consistent with the recovery factors noted by Resnick et al.,3 these programs

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that every consumer has the opportunity for the best satisfaction with the interventions and makes them consistent with the recovery focus. Small steps towards larger goals are acknowledged and praised in order to instill hope and optimism. Improving quality of life for all participants is a key objective. Participation in family psycho-education has been correlated with higher consumer scores on the knowledge, empowerment, and hope and optimism recovery dimensions, although not on the satisfaction with life dimension.3

Nevertheless, most of the validated family interventions would benefit from further refinement to be totally consistent with recovery values. Modifications in language, content, and outcomes of concern are necessary to reflect fully a recovery orientation. In this article we first provide a brief introduction to the recovery movement in mental health and then the rationale for family interventions in schizophrenia. Next, we synthesize the findings from recent meta-analyses and research reports of family interventions for schizophrenia. Finally, we present issues that merit attention to render family interventions more consistent with a recovery orientation, guided by the recommendations from the President’s New Freedom Commission on Mental Health.1

The Recovery Movement in Mental Health

A confluence of factors has contributed to the evolution of the recovery movement in mental health over the past 25 years, including the development of better-tolerated medications, a decline in the number of beds available for hospitalization and/or institutionalization and the resulting emphasis on community life,7,8 a growing human rights movement reflected in policies such as the Americans With Disabilities Act, and psychiatric consumers’ own desires to be more in control of their destinies. Similarly, family members of consumers have been long-standing advocates of improved services to assure that every consumer has the opportunity for the best treatment and quality of life.9

Nevertheless, the challenges of transitioning from the medical model to the recovery model of mental health should not be underestimated. The well-entrenched medical model10 proposes that ill individuals have biologically based disorders. The primary treatment goal is thus, optimally, “cure” of the illness. With more chronic disorders such as schizophrenia, where cure is less likely, the medical model proposes “control” of symptoms as the treatment goal, and physicians and other medical personnel treat “patients” to achieve this goal.

Adopting a “recovery model”11,12 of serious psychiatric illness dramatically transforms this conceptualization. First, the language used by all the key stakeholders is modified. At the most basic level, the center of care becomes an active “consumer” of services, not a passive “patient” to be treated. The consumer is seen as a person, not a case. The consumer becomes an equal, if not a more important and necessary, care team member, as opposed to a static recipient of a care plan. The consumer is viewed as a whole person with preferences, goals, and needs that drive and define care. Each consumer is understood to have a unique background, family constellation, and culture, which must also be acknowledged. Treatment goals emanate from the consumer and are conceptualized around community integration and enhanced functioning rather than just management of symptoms. Goals are skill, not deficit, focused.13,14

Moving beyond these semantic changes to more substantive recovery-oriented policy and practice has been an uphill battle. Instituting changes in intervention content and outcomes in research and clinical programs involves adjustments in knowledge, attitudes, and skills in all key stakeholders, including both policymakers and line staff. In addition, consumers must often overcome years of conditioning as passive patients with little hope of change. Consumer growth builds on system change and vice versa. Consumers can assume their new roles as informed experts on their own care who are activated to lead a team who works diligently toward recovery.15

Changes in the consumer must mirror changes in the professional treatment team. Recovery-focused interventions should incorporate (1) the promotion of a level of independence comfortable for the consumer and in line with his/her cultural norms and values concerning family relationships, (2) the development and fostering of good support systems; (3) the reduction of symptoms and the development of social skills, and (4) the enhancement of strengths while minimizing deficits.13 Consumers should be educated and informed in order to advocate for themselves.13 Recovery-based professional care optimizes natural supports13; however, issues regarding the involvement of family, including which family members, participating in which intervention, and for what duration, would be at the discretion of the consumer.

A critical aspect of the recovery movement is accepting the role that cultural values, beliefs, and norms play in influencing consumer-selected treatment goals.13 For example, in some cultures familial interdependence may be valued over individual independence. Furthermore, the family itself, rather than the individual consumer, may be the driving force behind the selection of preferred treatments and outcomes. Clearly, mental health professionals need to be sensitive both to the varying influence other family members may have in determining treatment goals and to relatives’ comfort with various family modalities, whose effectiveness may differ based on cultural group.16
The Rationale for Family Interventions in Schizophrenia

Grounded in the diathesis-stress model of serious psychiatric illness,17,18 most extant family intervention programs incorporate components that address both the biological vulnerability and the increased sensitivity to stress inherent in the illness. To minimize biological vulnerability, these programs support medication compliance and discourage illicit alcohol and substance use, using both didactic and problem-solving strategies. With regard to reducing stress, these programs typically involve an educational component to assure that all members have a realistic expectation of consumer functioning and communication and problem-solving components to reduce family conflict and improve adjustment.

The foundation for these interventions was work conducted in England in the 1950s–1970s19,20 that demonstrated that family attitudes reflective of high levels of distress measured at the time of a loved one’s psychotic relapse tended to predict greater rates of subsequent relapse. This high level of family distress, which has been labeled high “expressed emotion” (EE), is reflected in critical comments or tone or reported extreme self-sacrificing behavior during a semistructured interview (the Camberwell Family Interview, or CFI) at the time of the initial relapse20 and is likely evidenced in actual interactions with the consumer.21,22 These findings, however, should be considered within a sociocultural framework, as EE may operate differently in some ethnic groups. For example, among Mexican Americans, EE has not reliably predicted relapse.23 Instead, a lack of family warmth has been shown to be an even more potent predictor of relapse than criticism, hostility, or extreme self-sacrificing behavior.24

In light of the extreme confusion and behavioral disorganization that typically accompanies a psychotic episode, it is not at all surprising that caregivers might respond with high levels of distress or lack of warmth when confronting the illness. The finding that high EE predicts relapse in schizophrenia is among the most robust findings in the psychosocial literature on schizophrenia.25 Successful means of moderating the relationship between expressed emotion and subsequent relapse include effective and consistent pharmacological treatment,26,27 reduced contact between the consumer and relatives with high EE attitudes,26,27 and participation in some types of family interventions for schizophrenia.28

In spite of the difficulties many relatives have coping with a serious psychiatric illness in their loved one, it is important to note that naturalistic studies have established many benefits of ongoing family contact for adults with schizophrenia. For example, Brekke and Mathiesen29 found that, among persons with schizophrenia not living with their relatives, those with family contact had better work and overall role performance. Evert et al.30 reported a similar positive association between family contact and social role functioning. Clark31 found that, among a sample of persons with severe psychiatric illnesses (over half of whom were diagnosed with schizophrenia) and co-occurring substance use disorders, those with more family contact and/or financial support from their families were more likely to reduce or eliminate their substance use. In light of the importance that most individuals (whether or not they have psychiatric illnesses) place on family relationships, the benefits of ongoing family contact in the lives of persons with serious and persisting psychiatric illnesses are not surprising. Thus, interventions that can shore up family support under times of extreme stress, such as those often associated with episodes of serious and persisting psychiatric illness, could be expected to be an important component of a comprehensive recovery.

The Benefits of Participation in Family Interventions for Schizophrenia

Professionally-Conducted Family Intervention Programs

The literature indicating that family attitudes have an impact on consumer outcomes, and the increasing pressure on families to absorb illness management issues in the face of deinstitutionalization and limited community resources, prompted tremendous enthusiasm about developing useful family intervention models.32 Many published family intervention manuals are available33–37 with empirically validated models that vary in theoretical orientation from behavioral to systems psychodynamic. It is probably not an accident that most of the early work in these types of family interventions coincided with the growth of behavior therapy applications to serious psychiatric illnesses in the late 1970s.38 These family interventions tend to be somewhat directive and prescriptive, and many integrate components of formal social skills training (eg, behavioral rehearsal, out-of-session assignments). Most of these family intervention programs share a number of overarching principles (see Table 1).

Regardless of their origin, these interventions emphasize 2 therapeutic goals: (1) educating participants in order to enhance understanding and coping with the illness, and (2) improving communication and problem-solving skills to reduce negative interaction cycles. They should be embedded in a comprehensive set of mental health services. Key components of family treatment in controlled trials have included psychoeducation, crisis intervention, emotional support, and teaching of skills in order to cope with symptoms and other difficulties. These specific components of treatment were developed out of the rationale that a psychotic episode produces a crisis for all members of the family and for the family system itself.39 Family interventions, which require a notable degree of structuring by the clinician, provide families with a model for understanding the nature of the illness, as well as guidance in solving everyday problems.
were not found when compared to an active patient approach. Regarding relapse within 1 year. Once again, differences in treatment reduced relapse rates by 20%. Study between 1977 and 1997 concluded that family participation is offered because recurrent crises are common following a psychotic episode and may require access to the family network.

Table 1. Common Characteristics of Effective Family Intervention Programs in Schizophrenia

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<td>Show concern, sympathy, and empathy to all family members who are coping with mental illness</td>
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<td>Provide information about the illness</td>
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<tr>
<td>Avoid blaming the family or pathologizing their efforts to cope</td>
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<tr>
<td>Foster the development of all family members</td>
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<tr>
<td>Enhance adherence to medication and decrease substance abuse and stress</td>
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<td>Provide treatment that is flexible and tailored to the individual needs of families</td>
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<td>Encourage family members to develop social supports outside their family network</td>
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<td>Instill hope for the future</td>
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<tr>
<td>Take a long-term perspective</td>
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<td>Strengthen communication and problem-solving</td>
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Enhancing communication skills among family members also lessens family conflict and reduces disordered thought processes in the consumer. Finally, crisis intervention is offered because recurrent crises are common following a psychotic episode and may require access to clinicians on short notice.

Meta-analyses of family interventions in schizophrenia have provided extensive evidence for the efficacy of such treatments. Using relapse and rehospitalization as outcomes, a meta-analysis of 25 treatment studies published between 1977 and 1997 concluded that family participation in treatment reduced relapse rates by 20%. Study durations ranged from 2 weeks to 4 years and were primarily psychoeducational models. The effect size comparing family intervention to treatment as usual was .20 (CI: .14–.27), indicating superior outcomes in the family condition. Similar effect sizes were calculated when comparing family intervention plus patient intervention with treatment as usual. Effect sizes for family interventions versus structured patient-only interventions (for example, social skills training) did not significantly differ. The individual patient intervention studies, however, had very heterogeneous effect sizes, perhaps due to the differences in the effectiveness of each of these patient approaches.

Another meta-analysis of 18 randomized controlled trials of family interventions with a minimum duration of 6 weeks reported even stronger findings than those established by the Pitschel-Walz et al. study. Family interventions conferred greater benefits than all other treatments combined (effect size = .63; CI: .46–.86) or standard care alone (effect size = .37; CI: .23–.59) in regard to relapse within 1 year. Once again, differences were not found when compared to an active patient-only condition. Finally, this meta-analysis showed better medication compliance following family interventions, compared with other treatments (odds ratio = .63). Both the American Psychiatric Association’s best practice guidelines and the Schizophrenia Patient Outcomes Research Team (PORT) have recommended family services for schizophrenia.

The broader benefits of participation in family intervention programs have been examined in supplementary analyses in some studies, with benefits noted on aspects of social adjustment. Relatives often sustain reductions in burden and/or distress from their participation as well. McFarlane et al. designed one of the only studies that directly focused on improving community adjustment, in this case vocational outcomes, by involving families in care, and they found an overall benefit for the relative intervention.

Interventions can take the form of individual family sessions or multifamily groups. Some reports suggest that multiple family groups lead to slightly lower relapse rates than individual family therapy, although other studies have not found this advantage for multiple family groups. Multiple family groups are often conducted with less formal structure and frequency than single family interventions. The multifamily format has also been reported to result in significant reductions in caregivers’ stress and psychological distress. Multiple family groups offer the additional benefits of possible increased social support from other participants and the opportunity for vicarious learning. Groups are often less vulnerable to staff turnover, as they are typically facilitated by at least 2 therapists and thus can maintain continuity of care even if a therapist leaves. The multiple family format may be particularly effective for first-episode patients, patients who do not achieve full remission of symptoms may be particularly effective for first-episode patients, patients who do not achieve full remission of symptoms at hospital discharge, and families who are low in EE.

Although multiple family group formats may be more cost-effective than single family formats, participation in multiple family groups has been associated with less treatment adherence and greater attrition. It can also be more difficult to enroll family members in group, rather than individual, treatments.

Although the preponderance of family intervention research has focused on behavioral models, different theoretical models of family intervention appear to be equally effective. As long as treatments are matched in duration and intensity, there is no strong evidence for any specific theoretical orientation used. The notable exception to this trend is that psychodynamically informed family interventions seem to have negative consumer outcomes and are contraindicated for families of persons with schizophrenia. Given the lack of outcome differences between the remaining models of family therapy, it is not yet clear what specific elements of family interventions are essential beyond the key components already listed.

Duration of treatment is a key issue in maximizing benefits, with longer family treatments (9 months to
2 years of intervention) yielding better outcomes, even if they vary significantly on characteristics such as format (e.g., multiple vs single family), setting (home vs clinic), and consumer presence (yes or no). Most short-term family interventions (2–10 hours of participant involvement) tend to improve relatives’ knowledge of the illness and sense of mastery in coping with it, and to decrease experience of burden.59–62 However, the lack of efficacy of these programs for improving the long-term course of schizophrenia has tempered enthusiasm for them.5

In a meta-analysis comparing family interventions and standard care, effect sizes for short duration and longer duration family treatments significantly differed.5 Specifically, the mean effect size for short-term interventions lasting less than 3 months was .14 (CI: .06–.22), and the mean effect size of interventions lasting 9 months or longer was .30 (CI: .19–.41). The 1 exception to the poor outcomes of short-term family intervention for schizophrenia was a study by Goldstein et al.,63 which reported reduced relapse rates at 6 months for a 6-week crisis-oriented program conducted immediately following a hospitalization in a recent-onset sample.

Data addressing the issue of whether the benefits of family work are sustained after treatment termination are mixed. There is some evidence that treatment effects do not persist.4,44 Other studies, however, have shown support for the long-term effects of family interventions.64,65 More studies are necessary to determine if the effects of family interventions persist long after treatment termination. With the sustained benefits after termination being unclear, referrals to participation in ongoing community-based support groups, such as the National Alliance for the Mentally Ill (NAMI), and/or the availability of booster sessions seem to be in order.

Two studies suggest that family intervention programs result in lower overall mental health costs than other treatment modalities. A comparison of home-based family treatment and individual treatment over 1 year found family treatment to cost 19% less than individual treatment.66 Compared with standard care, 9 months of family therapy resulted in a cost savings of 27% per consumer, despite the extra costs associated with therapists’ salary.67 Considering the high cost of inpatient psychiatric treatment, it is not surprising that the positive effects of family intervention on reducing relapse and rehospitalization also translate into economic benefits. However, with the current emphasis on limiting access to inpatient psychiatric hospitalizations, the savings accruing from participation in family therapy may be more limited.

Non-Professional Support Programs as Family Interventions

It is important to note that there has been a robust relative-based family movement in the field of serious psychiatric illnesses since the mid 1970s, culminating in the creation of NAMI in 1979. NAMI also now has a strong consumer section as well. An emphasis on advocacy, self-determination, and peer-to-peer support is shared by NAMI and the consumers in the recovery movement. In many ways, the relative advocacy and support movement reflected in groups such as NAMI can be seen as a parallel to the consumer recovery movement, as it is also intended to promote life satisfaction, hope and optimism, knowledge of mental illness, and empowerment.

Local affiliates of NAMI sponsor 12-week psycho-educational classes called “Family-to-Family,” which provide information on a wide-ranging list of topics pertinent to managing a psychiatric illness successfully. These programs are typically led by relatives and may be co-led by consumers as well. In comparison to time spent on a waiting list, participation in these groups has been related to increases in knowledge, empowerment, and self-care, as well as reductions in subjective burden; these benefits were sustained at 6-month follow-up.68 Pickett-Schenk and colleagues69 found that participants randomized to the “Journey of Hope” program, which is similar to the Family-to-Family program, experienced reduced depressive symptoms, greater emotional role functioning, and less negative views of their relations with their consumer relatives than those assigned to the waiting-list control group. Participation in these relative-led groups may be especially important for families of individuals who are not in treatment, which may then limit access to professionally conducted services.70

Challenges in the Interface Between Family Interventions for Schizophrenia and the Recovery Movement

Two conclusions can be drawn from the discussion thus far: (1) there are many ways that family interventions are in accord with the recovery movement in serious and persisting psychiatric illnesses, and (2) participation in many types of family programs increases community tenure and may improve social functioning and reduce family burden. Nevertheless, there are some fundamental ways in which core aspects of the recovery movement, as articulated in the President’s New Freedom Commission on Mental Health1 and the literature on family interventions for serious and persisting psychiatric illnesses, have yet to be adequately integrated.

The content of many of the most empirically validated family interventions were designed in the 1970s and 1980s and embrace more of a “successful management of a chronic illness” theme rather than a recovery orientation. In fact, the treatment that served as the cornerstone of the National Institute of Mental Health (NIMH) trial of family interventions in schizophrenia51 was called “behavioral family management,”34 and the tenets of the educational materials used for this program include the notions of illness chronicity and lifelong treatment.

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While the importance of social networks is acknowledged, a review of the earlier manuals for these interventions reveals there is almost no attention paid to the peer support movement or utilizing other persons with disabilities as primary support persons. Finally, while participants are encouraged to select personal goals on which to work, there is relatively little emphasis on consumers’ “owning” their own recoveries and asserting their own rights. In fact, in many family sessions, much of the therapeutic work involves resolving conflicts among consumers and family members about progress and goals, and the consumers’ opinions and attitudes do not always prevail.

As described in the President’s New Freedom Commission on Mental Health, the mental health system in this country requires not just reformation but rather transformation to embrace recovery values and improve access to quality care and services. The commission made 6 recommendations with regard to improvements in mental health, and several of these pertain to family issues:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered, and research is accelerated.
6. Technology is used to access mental health care and information.

We consider meeting the second and fifth goals as the ones that will require the greatest evolution of thinking about family issues. We next discuss the pertinent recommendations from the commission on these 2 goals, with specific emphasis on identifying challenges to meeting these recommendations based on the currently available family intervention literature.

**Recommendation 2.1 and Challenges**

Recommendation 2.1 from the President’s New Freedom Commission: Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Challenge: Individualized plans of care are difficult to develop because specific family interventions are not tailored to the kin relationships of many consumers.

Much of the seminal work on the family interventions for serious psychiatric illnesses by authors such as Bateson and Haley focused on adolescents or young adults in treatment with their parents. Even as more behavioral and educational approaches were developed in the early 1980s, much of the emphasis remained on families of origin. Tests of these interventions have often only defined parents as key relatives (though other family members may have attended), especially in US studies. However, with the growth of the community care movement and respect for consumer autonomy, more and more persons with serious psychiatric illnesses are partnering. Although marriage rates tend to be lower in schizophrenia, many persons with the illness marry, often before the development of the illness. Unfortunately, there is very little empirical work to guide professionals in assisting consumers with managing issues that have special importance in couples, such as sexuality and decisions about children. Even more complicated is the issue of accepting impaired role functioning in a partner.

Many of the existing interventions are grounded in the idea that the person with the serious psychiatric illness may have significant limitations, especially during a period of exacerbation, and that slow steady progress toward symptom improvement and achievement of functional goals is the key. Unfortunately, accommodating these limitations can place a great strain on the other partner and may contribute to the high rate of divorce in these couples. Treatment can be even more difficult to provide when separation seems imminent. While there are a few descriptions of specialized programs for couples in which one (or both) have a serious psychiatric illness, overall this is a too often ignored aspect of family interventions for persons with schizophrenia.

A second critical but also too often ignored family issue is that of persons with schizophrenia as parents. Articles on fathers with schizophrenia are virtually nonexistent, and articles on mothers with schizophrenia tend to be disheartening, with an emphasis on issues such as postpartum psychosis and loss of child custody. There are a few reports of positive programs that support women in their attempts to care for their children, and even some reports on how children of mothers with serious and persistent psychiatric illnesses can be resilient. However, the lack of research in this area and the emphasis on negative outcomes rather than building on strengths are in conflict with the recovery literature and fail to provide adequate direction to mental health professionals who are working with individuals confronting these issues.

A final area of concern involves aging consumers and their social supports. While most studies were conducted using families of origin, many consumers are aging, and their sibling or other family members are becoming primary support persons. For example, in a recent study by our group (manuscript in preparation) of VA outpatients with family contact and schizophrenia or schizoaffective disorder, 71% of the participants under age 45 reported their parents were their most supportive relatives, while only 32% of those over age 45 reported their parents were supportive; here siblings assumed a larger caretaking role (42%). While many of the basic materials in most family interventions should apply to...
both parents and siblings, siblings also confront some unique issues\textsuperscript{84} (e.g., survivor guilt, worries about their own risk of illness or their children’s, competing role strains) that are not always addressed in the typical family literature and may limit their availability to assist their brother or sister with schizophrenia. These issues merit much more attention from family intervention researchers.

A cornerstone of the recovery movement is individually tailored treatment recovery plans. Optimal planning requires the availability of information on the appropriate matching of interventions to individuals, and yet we have almost no information on who benefits most from which (or any) family interventions. Individuals with schizophrenia usually live with the illness for decades, and a key aspect of recovery is developing a rich, rewarding life in spite of the struggles the illness might impose. Unfortunately, there has been very little attempt to address phase of life issues in most family interventions for schizophrenia.\textsuperscript{85} Until very recently, most family interventions were designed with reduction of relapse as the primary goal, and thus individuals who have recently relapsed (and thus were thought to be at risk for subsequent relapse) served as the target population for these interventions, whether they were 22 or 52 years old.

In the last 10 years, there has been a modest attempt to begin to integrate ideas about illness phase in treatment plans insofar as there is a growing focus on either prevention of schizophrenia or reduction of the disability resulting from a first admission.\textsuperscript{86} Comprehensive programs, usually incorporating some type of family intervention, have been developed and implemented with these recent onset individuals with some success,\textsuperscript{87} although the long-term benefits are less clear.\textsuperscript{88} In any case, once individuals are past their first or second admission/relapse, there is very little empirical data to guide the timing and type of family intervention that might be most beneficial. There is little information on the benefits (if any) of these programs with more stable participants, although there are a few exceptions to this observation.\textsuperscript{49} The failure to integrate notions of developmental life tasks into most psychosocial work with schizophrenia, including family interventions, is a significant and unfortunate omission.

Matching interventions to the specific characteristics of consumers and their families is also an understudied area. Many published family intervention studies are underpowered to test whether subgroups of participants benefit differentially. There are a few studies that have attempted to examine the issue of differential benefit more directly, but the guidance accruing from these studies to assist consumers, families, and professionals to optimal treatment planning regarding family issues is limited and sometimes contradictory. For example, Montero and colleagues\textsuperscript{89} compared participants in a relatives’ support group with those attending behavioral family management.\textsuperscript{34} They found the strongest predictors of overall attrition from either program were older age of consumer, greater number of prior admissions, smaller households, and relatives with little initial information about schizophrenia. They also found that consumers who benefited most from the relatives’ support group were older, had been ill longer or had fewer hospitalizations, were living with 3 or more relatives, and had relatives who reported lower levels of psychosocial stress.\textsuperscript{89} The authors suggest that these results indicate that relative support groups may be appropriate for families and consumers with long-standing but not acutely severe problems, while the individual structured behavioral treatment might be best for younger consumers, those with recent onset, or in acute distress. Similarly, McFarlane et al.\textsuperscript{50} reported that their structured behavioral multiple family groups had greater benefits over single family groups only among more symptomatic consumers.

Cultural differences have long been known to influence how family interventions are conducted and experienced.\textsuperscript{24,90} In the field of family interventions for persons with serious and persisting psychiatric illnesses, some studies indicate that interventions are equally effective with some ethnic groups\textsuperscript{48} but not with others.\textsuperscript{16} For example, in the McFarlane et al. study\textsuperscript{50} consumers in the multiple family groups at most sites did better than those in the single family intervention; however, in the 1 predominantly African American site, consumers in the individual treatment did better. The nuances of family norms regarding their own communication and problem-solving efforts and their specific needs, as well as conceptualizations of mental health problems and expectations about interactions with the mental health treatment team, all likely color the impact of family interventions. As called for in the President’s New Freedom Commission,\textsuperscript{1} disparities resulting from the lack of understanding of these issues must be addressed.

**Recommendation 2.2 and Challenges**

**Recommendation 2.2** from the President’s New Freedom Commission: Involve consumers and families fully in orienting the mental health system toward recovery.

**Challenge:** Researchers have emphasized the development of contained intervention programs to the exclusion of designing overall “family-friendly” service systems.

The President’s New Freedom Commission executive summary states that “when a serious mental illness or a serious emotional disturbance is first diagnosed, the
health care provider—in full partnership with consumers and families—will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing who, what, and how appropriate health care will be provided: choosing which mental health care professionals are on the team, sharing in decision making, and having the option to agree or disagree with the treatment plan. The recovery movement is grounded in the principle that the consumer assumes greater responsibility for directing his or her own path to improvement, and the availability of high-quality, comprehensive consumer- and family-centered services are understood to be integral components of this endeavor. Most often, these services are provided by a professional mental health treatment team, whose efforts are substantially augmented by nonprofessional activities, such as participation in peer-to-peer programs and the provision of family support.

Under the best circumstances, the consumer and family will agree on the level of involvement of the family in the consumer’s overall care, recognizing that for many consumers, their families are a primary source of support. When differences arise, help from the professional mental health team in negotiating the bounds of this involvement can often be vital. Clinicians can be proactive in exploring with the consumer the pros and cons of family involvement in care, as well as helping set limits of what information is to be shared with the consumer’s consent (perhaps relapse prevention plans and information on side effects of medications) and what is to be not (perhaps romantic problems or ongoing urges regarding substance use). Sharing information among the consumer, the family, and the professional staff can best be understood as a continuum rather than a dichotomy.

Although the concept of the interdisciplinary mental health treatment team has been around for decades, most developers of family interventions have expended little effort in addressing the specifics of family interaction or inclusion in the treatment team per se. Most empirically validated family interventions were designed as contained “treatments” to be provided by mental health professionals for a specific number of sessions to accomplish well-articulated goals (eg, improve knowledge about the illness, increase problem-solving skills). Although participants might be coached informally about how to interact optimally with members of the mental health treatment team, this effort was almost never a core component of any of the existing manuals, and little systemic effort was spent on the provider’s side to expand the concept of the treatment team formally to include family members.

Outside of participation in formal family therapy programs, most relatives have severely limited access to the treatment team, and interventionists have done little to remedy the situation. In the PORT survey and VA extension of 902 individuals with schizophrenia and family contact, only 31% of the families had had contact with the treatment team in the past year. In their investigation of quality of care at a community and VA clinic, Young et al. found that, while 68% of their sample reported having a close family member, almost 40% of these families did not have any contact with the treatment team documented in their charts. Similarly, Dixon et al.’s survey of therapists at an urban community mental health center found that therapist-family contact was reported for 61% of the consumers, but most was often by telephone during a crisis. The majority of families were not having ongoing regular contact with the treatment team. In our recent survey of 398 outpatient veterans with schizophrenia in Southern California (manuscript in preparation), over 60% of participants reported that their families had not had contact with the treatment team in over a year; over 40% reported that their families had never had contact with the treatment team. The paucity of contact between families and mental health treatment teams is especially troubling, given a recent report by Prince that, 3 months postdischarge, individuals with schizophrenia whose families were not helping to cope with their illnesses were much more likely to be dissatisfied with their mental health treatment.

While developing a family collaboration in consumer-driven care is desirable, it will not happen spontaneously, and experts in the field of family interventions could play a key role in designing and testing programs to enhance family involvement in these efforts. To date, lack of attention to increasing communication and cooperation between mental health professionals and families has been an unfortunate omission in the field.

**Recommendation 5.2 and Challenges**

**Recommendation 5.2** from the President’s New Freedom Commission: Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

**Challenge:** There has been limited dissemination of effective family intervention programs.

A cornerstone of the recovery movement is easy access to appropriate interventions. In spite of the recognition that participation in formal family psychoeducation (FPE) programs can improve outcomes in schizophrenia and serious psychiatric illness, involvement in such programs is almost nil. A recent reanalysis the PORT results and a VA extension found that less than 8% of consumers had participated in a formal support program. A national VA survey conducted within the last 2 years indicated that 0% offer FPE programs that conform to evidence-based practice guidelines. An analysis of third-party claims from participants in the PORT survey found that only 0.7% of Medicare claims and 7.1% of Medicaid claims were for any kind of family therapy.
rates have been reported, of the potential 198 participants. While lower refusal and family consent could only be obtained for 53.5% givers of person with first-episode psychosis, consumer study of a psychoeducational intervention for carefusal rate of 46%. Leavey et al. found that, in their members refused to participate, leading to an overall reduction in family support programs. Active recruitment cline the opportunity to participate in family programs not noted the high number of consumers or families who deponent of providing family interventions. Many have his or her family is a critical but too often ignored component of providing family interventions, may be provided with no support from management to meet the special needs of families (eg, longer sessions, meeting in the evenings, larger meeting rooms), and/or they may be concerned about lack of reimbursement for family services. Furthermore, the consumer, family member, or provider may be too demoralized to want to engage in a new round of intervention.

Unfortunately, we have little data to clarify the actual impediments to providing stronger family-based services for persons with serious and persisting psychiatric illnesses. However, an emerging body of evidence suggests that initial treatment engagement of the consumer and his or her family is a critical but too often ignored component of providing family interventions. Many have noted the high number of consumers or families who decline the opportunity to participate in family programs when offered. For example, Barrowclough et al. note that, in their evaluation of a needs-based family intervention, 35% of eligible consumers and 27% of family members refused to participate, leading to an overall refusal rate of 46%. Leavey et al. found that, in their study of a psychoeducational intervention for caregivers of person with first-episode psychosis, consumer and family consent could only be obtained for 53.5% of the potential 198 participants. While lower refusal rates have been reported, potential participants need to be actively encouraged to consider participation in family support programs. Active recruitment can be an especially complicated endeavor when staff members are themselves ambivalent about the approach or feel unsupported in offering it by their own management.

There is a small but growing body of literature on the provider impediments to family service provision. Findings in implementation science broadly indicate that keys to the successful adoption of new innovations, like providing family services, include (1) early involvement of opinion leaders that can influence future, potential users; (2) set plans for roll-out, adoption, and sustenance of the new innovation; (3) personal contact between the innovation developer and adopters, especially live demonstrations, for purposes of modeling and building momentum for use; (4) ongoing contact between developer and adopters in order to address implementation barriers; and (5) set incentives for adoption and competent use of new innovation. Barriers generally include a top-down mandate to implement the new innovation, individual resistance from line staff, and varying opinions about adopting the new innovation by different governing bodies (eg, nursing administration versus clinic administration versus hospital administration). Passive approaches to disseminating new information to health care providers (eg, simple distribution of literature on efficacy studies) do not induce behavior change, lead to implementation success, or improve care.

Reports of the implementation and dissemination of family psychoeducation specifically indicate that the involvement of an opinion leader during training of line staff helped lead to an increase in the offering of family services at several clinics. Additionally, the intensity and style of training was found to be critical in making a sustainable change. Extended training over several months and training involving multiple methods (eg, readings, demonstrations, videos, role playing) produced superior outcomes to brief trainings of 1 or 2 sessions or those training sessions that only used didactic methods. Access to outside consultants and intervention developers, early involvement of key stakeholders in the implementation process, and a step-by-step plan for roll-out were all seen as helpful in successful implementation in community mental health clinics across 2 states. There are several reports from multiple clinic implementation projects that a very common perceived obstacle to implementation is staff stress from their workload. Other common impediments found in multiple studies and rated as important were cost, agency bureaucracy, and staff skepticism about the intervention. Predictors of successful implementation of family services were initial positive assumptions by stakeholders about family services and where the family services to be implemented were different from the current family services offered, while inducements (money to the clinic from the state) were considered less important. It is clear that there must be careful consideration of the process of implementation of family services rather than top-down mandated directions for family programs. With the anticipation of resistance
to a recovery orientation, special care will need to be taken prior to and during implementation to ensure success and sustainability. Much more effort should be expended in designing and evaluating interventions to address impediments to the implementation of family intervention.

Summary and Conclusions

Moving from the medical model to the recovery orientation requires a paradigm shift for providers, consumers, policymakers, and researchers in terms of language, content, and outcomes of concern. Family psychoeducation has been shown to reduce symptoms and improve functioning in individuals with schizophrenia and to reduce burden in their families. There are aspects of existing family interventions that resonate with a recovery outlook, including consumer-directed goal setting and problem focus, educating consumers about their own illness, and focusing on the whole person by assessing his or her quality of life and not simply symptom constellations and hospitalizations. Yet, there is still work to do to align family research and services with a recovery orientation, including working toward recognition of different family constellations, adjusting for illness phases and unique consumer characteristics, and broader operationalization of family services. Lastly, we need more translational studies, and these trials would benefit from process evaluations of the implementation process. These efforts will not be easy, but they are vital if the field is to continue to grow. Families can play a key role in supporting consumer recovery and will be greatly benefited by the refinement of effective interventions to more closely embrace the tenets of the recovery movement.

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