Family work in Psychosis models and modalities: an evidence review

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Family Interventions in Psychosis Aims

Improve Service User Outcomes:

- Promote recovery
- Improve social functioning
- Reduce relapse risk

Improve Carer Outcomes

- Improve carer wellbeing
- Reduce carer burden
- Promote coping

Improve Family Functioning and Relationships

- Improve understanding about psychosis
- Improve communication
- Reduce unhelpful patterns of interaction
- Promote family coping skills and problemsolving

Family Work Models

Family Work Models in Psychosis

Family Psychoeducational approaches including Behavioural Family Therapy (BFT) focus on education and skills development to improve coping/reduce stress levels

Systemic Family Therapy incl. Solution Focused Brief Therapy (SFBT): working with the significant others as well as the individual and focuses on the relationships within which the patient's problem behaviours/ symptoms are manifested

Integrated Family Intervention (IFI): integrates systemic interviewing skills, such as circular questioning and the exploration of interactions which are maintaining problems, with psychoeducation behavioural and cognitive behavioural skills such as problem solving, communication skills training and cognitive reappraisal

Open Dialogue: a family/ network based approach including crisis intervention and minimising the use of psychotropic medication

Family Psychoeducational Approaches: Key Components

- Information sharing (psycho-education)
- Emotional processing
- Stress management
- Problem solving
- Communication skills

Family Psychoeducation: Evidence

Robust and consistent extensive evidence for efficacy and value of psychoeducational family interventions for psychosis:

- Cochrane Database of Systematic Reviews (Pharoah et al 2010).
- NICE Guidelines (NICE 2002, 2009, 2014)
- Systematic review meta analysis evidence of 32 RCts with 2858 carers (Sin et al 2017)

Evidence for cost-effectiveness of FI (Mihalapoulos et al (2004) **and significant cost savings** linked to a reduction in relapse rates and subsequent hospitalisation (Knapp et al (2014)

Most studies have been conducted with long term service users but **growing evidence base for First Episode Psychosis (FEP) -**systematic reviews and meta-analyses (Bird 2010, Claxton et al 2017) have shown FI also significantly improved functioning and reduced relapse for FEP patients. Carer wellbeing and burden improved at end of treatment but were not sustained

Systemic Family Therapy: key elements

Burbach (2018)

Problems are seen as occurring between people in relationship, and maintained by unhelpful beliefs and patterns

Thinking about 'process' and pattern to **help the family to see things differently and from different perspectives as well as the development of mutual empathy and positive affect**

Therapist does not hold an 'expert' position -'being with' rather than 'doing to' the family system and aware of own prejudices; curiosity; not-knowing approach; listening & responding

Does not focus on the 'pathology' of the family but views the family as a (potential) resource where expertise, competence and resources of the family system are valued.

Therapy focuses on competence and solutions and challenges the prevailing 'problem saturated' discourses of 'illness', 'pathology' & 'dysfunction'

Systemic family therapy: approaches

4 main approaches (schools):

- **Structural** (Minuchin)
- **Strategic** (Haley; Watzlawick)
- **Brief Solution Focused Therapy** (de Shazer)
- **Milan & post Milan/ Social Constructionist** (Palazzoli, Boscolo, Cecchin & Prata)

Current approaches: **Collaborative** (post-modern)

Systemic family therapy: Evidence

Meta analyses and reviews of research studies show that **systemic family therapy is at least as effective as other therapies and/ or medication** (and is not harmful).

"A review of the existing evidence base finds **substantial evidence for the efficacy and effectiveness of family interventions.** Where economic analyses have been carried out, **family therapy is found to be no more costly and sometimes significantly cheaper, then alternative treatments** without loss of efficacy" Stratton (2005) Report on the evidence base of systemic family therapy Association for Family Therapy www.aft.org.uk

BUT limited evidence for systemic family therapy working with psychosis- mainly small scale studies.

Integrated Family Intervention (IFI)

Systemic and psychoeducational approaches are increasingly being integrated (Bertrando, 2006; Burbach & Stanbridge, 1998, 2006; Burbach, 2013; Lobban & Barrowclough, 2016)

Integrated approaches can contain a range of ingredients:

Systemic interviewing skills: circular questioning (Hedges, 2005; Tomm, 1988) and exploration of interactions which are maintaining problems

Behavioural and cognitive behavioural skills: problem solving, communication skills training (Falloon et al., 2004) and cognitive reappraisal (Kuipers et al., 2002)

Integrated FI framework
(Burbach, 2018; 2016a)

Seven phases:

- provision of information and emotional and practical support
- identification of patient, family and wider network resources
- encouraging dialogue and mutual understanding
- identification and alteration of unhelpful patterns of interaction
- improving stress management, communication and problem solving
- relapse prevention planning
- ending

Integrated Family Intervention (IFI)

Development and increased interest in IFI over the last few years with published service descriptions and IFI training courses eg Somerset Model (Burbach and Stanbridge)

Lack of controlled trials of IFI so difficult to specifically assess the effectiveness or added benefits of integrated family intervention, although intuitively attractive.

Open Dialogue Principles

A programme designed to treat early onset psychosis developed in Finland (Seikkula et al 1995; Aaltonen 2011)

Standard psychiatric model in Western Lapland, Finland since mid-1990s

Similarities with CRHT and EIP approaches

7 main principles (Seikkula et al 2006,Olsen 2014):

Network approach (organisational features)

- **Immediate help**
- **Social network perspective**
- **Flexibility and mobility**
- **Responsibility**
- **Psychological continuity**

Dialogic Practice (therapeutic conversation)

- **Dialogue (polyphony)**
- **Tolerance of uncertainty**

Open Dialogue Intervention

Resource oriented approach mobilising a persons psychosocial network resources: '*a cross between a crisis team and family therapy' (Langford 2015)*

Every patient in crisis seen within 24 hours and whoever takes the call organises/responsible for subsequent care (inpatient and community settings)

Meetings lasting up to 1.5hrs, in the family home, involving 2-3 therapists as well as key people in patients life share crisis experience, develop shared understanding and work out a plan

Focus on avoiding antipsychotic medication for as long as possible

Combine key components of excellent clinical care with unique facets:

- **Dialogic Practice**', a distinct form of therapeutic conversation exchange(non judgemental co-creative approach, shared language and narrative)
- **Tolerance of uncertainty** within the treatment meeting (Olsen 2014)- allowing joint solutions to emerge

Open Dialogue Model

All staff trained in family therapy and related systemic and psychological skills

Overlaps with:

Systemic family therapy: circular questioning and team reflection but doesn't seek to change behaviour of the family system

Narrative therapy: social constructivism but focus on following vs leading and being present to what is arising vs re-authoring problem centred narratives

Psychoeducation programmes: family as active agent but wider social and community network involvement and not communicating around a specific diagnosis or involving in relapse prevention

Open Dialogue: Evidence

Proponents of OD model in Finland claim significant benefits in terms of recovery (employment, welfare benefits use), social inclusion, reduced hospitalisation and relapse, need for MH services and long term cost savings (Seikkula 2011a, Aaltonen 2011)

- *75% of those experiencing psychosis have returned to work/study within 2yrs,only 20% taken antipsychotic medication at 2yr follow up* (Seikkula et al 2011b) *19% relapsed within 5 yrs* (Seikkula et al 2006)

Largely quantitative studies of poor methodological quality: small samples size, non RCT, limited controlled comparisons and follow up

International interest and take up in Scandinavia, Europe, US and UK although social and cultural generalisability is still uncertain

Promising, attractive approach to mental health care **requiring substantial staff and resource investment** to be successfully adopted

Need good quality independent RCT blind evaluation/replication

Multi centre RCT UK pilot trial underway in 4 teams led by UCL comparing with TAU underway (NE London, Nottingham, N Essex and Kent/Medway)

Cochrane review of OD underway (Pavlocic et al 2016) but not yet published

Evidence that Open Dialogue is more effective than other forms of intervention is currently non existent

Common Processes

Burbach (2018) DCP Guidelines (draft)

•**Focus on inter-personal relationships** and see individual problems within a wider family/network context

•**Concerned with improving communication (v**erbal /non-verbal) and **reducing stress/conflict** within the family/network

•**Strengths based, non-pathologising, non-blaming collaborative therapeutic stance**

•**Assume that family members are acting with the best of intentions**, even if they are inadvertently contributing to the problems

•**Seek to form a therapeutic connection with each member of the significant system, by making sure that they feel heard**, including absent members (and encouraging their attendance future sessions)

.

•**Collaboratively agree the focus of the sessions with family members,** including working on goals that might appear contradictory and working hard at getting everyone on board

Family Work Models: Review and Conclusions

Family work models have distinctive elements but also **commonalities and common processes**

Convergence and blurring of divisions between traditionally different approaches in IFI and the call for 'open dialogue informed' family work (Val Jackson, Burbach et al 2015)

Need more research to identify key therapeutic components of Fip and understand mechanisms by which FIp affects positive change: changes in EE, knowledge, cognitive appraisal, self efficacy? (Claxton et al (2017)

Majority of evidence for efficacy and cost effectiveness of family interventions relate to RCT evaluations of family psychoeducation

Lack of controlled trials for other family work models

No 'head to head' comparisons of different family work models

Evidence that IFI or OD may be more effective is currently non existent

Modes of Delivery

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Family Work: Modes of Delivery

- **Self Help Manualised Bibliotherapy**
- **Web based e-interventions delivered via the internet (e-health) or mobile phone apps (m-health**)
- **Face to face intervention** (with/without service user involvement):
  - **Individual family**
  - **multi-family groups**

Self Help Manual Guided Bibliotherapy

- Structured, manual guided self help learning/problem solving programme
- Self contained workbooks for carers (hard copy or online)
- Used as a stand alone independent resource for carers or to augment/support a carer training programme
- Offers flexibility and control: carers work through it in own time and at own pace
- Recognises difficulties for families to participate in face to face interventions due to time, stigma, caregiving responsibilties, cultural and access difficulties
- Empowers family to identify problems and address own needs
- Minimises professional manpower input/resources

Examples:

Smith and Birchwood (1987) Postal and video educational intervention

McCann et al 2013 Bibliotherapy in FEP

Chien et al (2016) Hong Kong RCT trial SHB programme in FEP

Rethink and Meriden (2014): **'Caring for Yourself' workbook**

Self Help Manual Guided Bibliotherapy

Evidence from family support programmes for physical health conditions such as stroke (Foster et al 2015) and chronic pain (Valeberg et al 2015)

Research on feasibility and preliminary systematic review/meta analysis evidence on positive effects of bibliotherapy for people with other MH problems (Cuijpers et al 2010)

Small scale controlled trials showing enhanced carer and patient outcomes at follow up (Mc Cann et al 2013; Chien 2016; Lobban et al 2013) but insufficient evidence to date

Systematic review and meta-analysis evidence for the value of self help/ bibliotherapy is inconclusive due to very limited, low quality evidence (Yesefu-Udechuku et al 2015)

For psychosis, cant yet conclude that SHB is an effective intervention for carers

Family e-Support Programmes

- **Delivered via the internet (e-health)**
- **Delivered using mobile phone apps (m-health) and text messaging**
- **Stand alone psychoeducational interventions or**
- **To augment face to face family support**
- **With/without social networking and peer/expert moderation**

Examples:

Sin (2013); **COPe-support** (Carers of People with Psychosis e-support))

Lobban et al (2013,2017) **Relatives' Education And Coping Toolkit (REACT)**

Gleeson et al (2017): **MOST (Moderated Online Social Therapy for Families)**

Healios: outcome-focused online family intervention service www.helios.org

Meriden Family Programme: **MyCARE App**

Family e-Support Programmes: Benefits

Offers flexibility in terms of standardization, personalization, interactivity, and carer engagement where families can :

- Decide which components/strategies they access/order they work through steps
- Shape, personalise and adjust the intervention to meet specific needs
- Determine how much time to spend accessing the site and when to do so

Improves accessibility - potential to address the gap between the identified need for services and the limited capacity and resources to provide sustained availability/ access to conventional face to face family intervention

Reduced costs (although start-up, research and development costs)

Delivers standardised evidence based psychoeducation

Facilitates peer support and social networking through online forums.

Family e-Support Programmes: Challenges

Digital access to a PC/mobile phone and reliable internet wireless connections and associated costs particularly for low income families and in developing countries

Digital literacy of carers (particularly older carers) although internet penetration in UK is 89% (ONS 2017) it is lower in developing countries

Clinician attitudes/confidence with technological interventions and concerns about being swamped with messages and time to respond

Managing risks: inappropriate postings/communications

How to foster social connectedness between carers and sustain longer term motivation

Low frequency usage:<50% log in once/week (Gleeson et al 2017)

Relatives dip in and out of sections vs working through systematically page by page (Lobban (2018) IMPART trial pers comm)

Digital interventions can be challenging to health care providers: IT failures, system compatibility, concerns about data breaches, lack of technical expertise and infrastructure

Family e-Support Programmes: Evaluation
Reviews: Alvarez-Jimenez (2014); Sin et al 2017)

e-health and m-health are **evolving technologies and early state of current research…**

- **Recruitment and retention rates are comparable** between face to face and online intervention

Data supports their **feasibility and acceptability**

Preliminary evidence that **improve clinical and social outcomes**

- **Heterogeneous, poor quality, feasibility studies but RCT, well powered implementation studies underway** (Gleeson et al (2017); Lobban et al (2017) Sin et al (2017)
- **Long way to go to ensure e-and m-health interventions are incorporated and integrated into routine clinical practice** (Lobban et al (2018): IMPART)

- **For psychosis, cant yet conclude that they are effective interventions for carers**

Multi-Family Group Therapy (MFGT)

Evidence based intervention for people with psychosis and their families

Integrates psychoeducation and BFT

Multi-family group format

Coherent theoretical model and empirical support (McFarlane 1983.2002) with 4 major stages:

- Building rapport/alliance
- Educational workshop for families
- Relapse prevention through problem solving format groups
- Vocational and social skills rehabilitation

Delivered by 2 clinicians to 5-8 families over a 2 yr period

Multi-Family Group Intervention (MFGT): Benefits

- Increases social network and support for families through group access
- Enables families to benefit from each others experience in solving problems

Multi-Family Group Therapy: Evaluation

Over 2 yr treatment period:

- **Decreases relapse and rehospitalisation**
- **Improves family wellbeing**

American Psychiatric Association (APA 2204) recommended MFGT as best practice for SMI

Limited evidence that treatment gains are sustained beyond the intervention period although appears to reduce inpatient hospitalisation 1 yr post treatment (McDonnell et al 2006)

Effectiveness across different ethnic groups not known as studies generally focussed on European and American populations- Chien and Wong (2007) RCT supported efficacy of a culturally adapted MFGT with Chinese participants

Evidence for effectiveness of multi-family Group Therapy but less strong and effects not sustained compared to individual FI

Family Work Modes of Delivery: Review and Conclusions

Range of modalities has potential to offer:

- **a continuum of Interventions** ranging from low intensity/self help bibliotherapy options to more intensive therapist guided face to face family interventions (Individual or multi group)
- **A flexible support menu** to families to enable access, improve availability of family intervention and support, address resource limitations/cultural acceptability issues, meet range of needs by providing 'horses for courses'

Available evidence for the value of bibliotherapy and e-interventions as stand alone interventions is limited and inconclusive Their current value may be to augment/supplement face to face Fip but potential to stand alone and offer therapist 'face time' facility and regular therapist e-contact.

No 'head to head' comparisons of different modalities or studies which identify carer characteristics in terms of who might benefit most from which modality…yet!