A New Engagement Strategy in a VA-Based Family Psychoeducation Program

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Objective: **This brief report describes the engagement strategy used in the Reaching out to Educate and Assist Caring, Healthy Families (REACH) program, a nine-month family psychoeducation program for veterans with serious mental illness or posttraumatic stress disorder (PTSD).** ***Methods:*** **A motivational interviewing–based strategy was created and implemented in a Veterans Affairs hospital to engage providers and veterans and their families into the intervention.** ***Results:*** **Of the 1,539 veterans told about the program, 41% had a family member living nearby and were willing to meet with a provider to learn more. REACH providers met with 505 veterans for a motivational-interviewing session to explore family participation. Of the 436 veterans who were eligible to participate in REACH, 28% of veterans with PTSD, 34% of veterans with an affective disorder, and 25% of veterans with a schizophrenia spectrum disorder went on to participate in at least one session of the REACH program with a family member; these rates compare favorably with those for programs requiring a much shorter commitment.** ***Conclusions:*** **This engagement strategy shows promise as an effective tool in recruiting veterans and their families into family psychoeducation. (*Psychiatric Services* 60:254–257, 2009)**

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Family psychoeducation is widely considered an evidence-based practice in the treatment of psychotic disorders (1), resulting in reduced risk of relapse, remission of residual psychotic symptoms, and enhanced social and family functioning for the affected individual (2,3). Family psychoeducation is increasingly used with a variety of other mental illnesses (4). Across disorders, family members report desires for more education about the illness (5) and communication with mental health professionals (6). Families who receive services report feeling less burdened, are more effective in helping their loved one (7), report fewer psychosomatic symptoms, endorse having less burnout (8), and experience decreases in their levels of distress (9). Despite these striking findings, few families receive psychoeducation. Evidence from administrative claims data suggests that nationally less than 10% of families of outpatients with schizophrenia receive services (10). Until recently, very few facilities in the Veterans Affairs (VA) health care system have offered evidence-based family psychoeducational programs (11).

In an effort to align VA's mental health care system with the recovery movement described in the President's New Freedom Commission report, the VA's Office of Mental Health Services funded 19 initiatives between 2005 and 2007 to implement family psychoeducation (personal communication, McCutcheon S, Apr 25, 2007).

Implementation of family psychoeducation requires overcoming the challenge of engaging mental health clinicians and consumers and their families into the program. Although many strategies have been suggested (12,13), few engagement strategies have been formally evaluated. One project compared the effectiveness of distributing pamphlets to veterans, sending invitation letters to families, and making phone calls to family members. Engagement was limited (7%–13% attended one family-member-only class or attended the veteran's psychiatric appointment), and there were no significant differences across strategies (14).

In this context, after briefly describing the REACH program intervention, we focus on the engagement strategies employed in the program's first year.

Methods

Since 2006 the Oklahoma City VA Medical Center (OKC VAMC) has provided the Reaching out to Edu-

cate and Assist Caring, Healthy Families (REACH) program. REACH is based on the multifamily group model (4) of family psychoeducation, and its creator, William McFarlane, M.D., has provided training and ongoing supervision. The nine-month intervention begins with single-family sessions and psychoeducation, but it is primarily composed of multifamily group sessions. Because the model was created for schizophrenia, adaptations were necessary for affective disorders (major depressive disorder and bipolar disorder) and posttraumatic stress disorder (PTSD) and to tailor it to the VA system. (Additional details of the intervention are available in an appendix available online at ps.psychiatryonline.org.)

From the outset, we recognized the need to commit significant time and resources to engaging three constituent groups, namely clinicians, veterans, and family members. The strategies used to engage each group are described next, followed by a more detailed discussion of procedures.

Because REACH providers are not veterans' primary mental health clinicians, it was essential to educate and engage veterans' primary clinicians in this new program. Before beginning the intervention, REACH providers made presentations to 16 mental health providers in the targeted clinics. The presentations explained family psychoeducation, potential benefits for veterans and their families, eligibility criteria, and the referral process; we problem solved regarding possible obstacles for the clinician. REACH reminder cards (laminated sheets of paper explaining REACH and the referral process) were distributed to clinicians. Once the intervention was under way, we monitored trends in referring patterns weekly and implemented an incentive system that recognized the clinician who referred the largest percentage of his or her caseload. After six months an appreciation luncheon was held to provide feedback on participation and satisfaction to referring clinicians and to encourage continued referrals.

To assist in the engagement of veterans, we created the REACH Program Checklist, which begins with: "In our appointment today, we are going to talk about a new program, REACH (Reaching out to Educate and Assist Caring, Healthy Families). In order for us to think about how this program might help you, please check the goals below that apply to you right now. What would you like different in your life? We believe we can help you move toward your goals." The checklist (available upon request from the first author) contains 18 goals that could be addressed in the program. In the first year of the project, 539 veterans completed this checklist and agreed to meet with a REACH psychologist to learn more about the program. The most frequently endorsed goals were to learn how to relax (N=380, 71%), have less tension and fewer arguments with people (N=374, 69%), communicate better with family and friends (N=365, 68%), and do more fun things (N=353, 65%). A veteran's responses on the checklist provide the framework for the engagement session described below.

In REACH "family" is defined as anyone who cares about the veteran, including relatives, friends, and neighbors. REACH providers emphasize to the family their importance as valued members of the treatment team. Providers schedule appointments to accommodate families' needs, including offering evening classes and coordinating sessions with existing appointments.

The actual recruitment process begins with chart reviews of the following day's appointments for two outpatient clinics (outpatient mental health clinic and PTSD clinic) and the previous day's admissions to the inpatient psychiatric unit to identify veterans who have a primary diagnosis of PTSD, major depressive disorder, bipolar disorder, or a schizophrenia spectrum disorder and live within 90 miles of the VAMC. (Exclusion criteria include active suicidality, current substance abuse, or significant axis II traits.) Upon clinic check-in, the clerk asks veterans to complete the REACH checklist. The psychiatrist assesses the availability of nearby family, and if family members are present, discusses the potential benefits of REACH participation. If the veteran is interested, the on-call REACH psychologist comes to the clinic within ten minutes for the "engagement" session. Veterans who decline this meeting are reapproached two additional times at subsequent appointments.

The first meeting between the REACH psychologist and veteran (and accompanying family member, if present) involves rapport building and determining the appropriateness of REACH for the family (including identifying a support person). Using a manualized semistructured interview, the psychologist uses motivational interviewing techniques (15) to help the veteran weigh the advantages and disadvantages of participating. Using reflective listening, affirmation of the veteran's openness, and reinforcement of the veteran's self-motivating statements (for example, "It sounds like you hope your wife would participate and you both could really benefit from learning more about your illness"), the psychologist takes a collaborative, empowering approach. As the psychologist reviews the marked items on the REACH checklist and the veterans describe their hopes for the future, these goals are mapped to the relevant components of the REACH intervention. Because many veterans are resigned to the current unhappy state of their relationships and have little hope for improvement, instilling hope and clearly describing how REACH might contribute to improved well-being and family functioning are important.

The psychologist discusses logistical issues, including the three-phase REACH structure, the content areas addressed, confidentiality, and how staff coordinates care with existing mental health clinicians. The psychologist describes the optional evaluation component of REACH (completing self-report measures—at baseline and the end of each phase—that assess clinical status, interpersonal relationships, and program satisfaction) and the $20 compensation for their time and effort for completing the measures. If the veteran attends this appointment alone, we provide coaching on how to invite a family member to participate.

If the veteran agrees to participate, the next appointment is scheduled immediately. If the veteran is ambivalent or wishes to discuss the program with a

family member, the REACH psychologist schedules a time several days later to call the veteran and follow up. Veterans who are clearly not interested are given REACH literature and are encouraged to call any time. This initial 20- to 30-minute engagement session is vital in enlisting veterans' participation and in creating clear expectations.

The REACH program and its evaluation were approved by the University of Oklahoma Health Sciences Center Institutional Review Board and the OKC VAMC's Research and Development Office. After complete description of the study to the participants, written informed consent was obtained.

Results

From July 31, 2006, to July 30, 2007, medical records for 2,495 veterans were reviewed: 80% (N=1,996) were from the outpatient mental health clinic, 9% (N=225) were from the outpatient PTSD program, and 11% (N=274) were from the inpatient psychiatric unit. Sixty-nine percent of the veterans whose charts were reviewed (1,734 of 2,495) had an appropriate diagnosis and lived within 90 miles: specifically, 75% (N=673) of veterans with PTSD, 67% (N=828) of veterans with affective disorders, and 62% (N=233) of veterans with schizophrenia-spectrum disorders.

Of these 1,734 veterans, 1,539 were informed about the REACH Program by their psychiatrists; 41% (N=632 of 1,539) indicated that they had an available family member and were willing to meet with REACH to learn about the program. Almost half of veterans with PTSD (N=294 of 624, 47%) met these criteria, a higher rate than that for veterans with an affective disorder (N=269 of 697, 39%) or a schizophrenia spectrum disorder (N=69 of 218, 32%). A REACH psychologist met with 80% (N=505 of 632) of the veterans who had an available family member and expressed interest, almost all within ten minutes of their agreement. We do not know how many of the 907 (59%) veterans who were not referred to REACH did not have a family member or had a family member but were unwilling to consider REACH.

As shown in Table 1, 14% of interviewed veterans were found to be ineligible to participate during the engagement session, resulting in 436 veterans being eligible for REACH. Almost half of these veterans had PTSD (48%), 40% had an affective disorder, and 12% had a schizophrenia spectrum disorder.

Program "participation" (that is, engagement) was defined as attending at least one phase 1 session (after the initial engagement session). As summarized in Table 1, among the 436 veterans who were eligible to participate in REACH, 28% of veterans with PTSD, 34% of veterans with an affective disorder, and 25% of veterans with a schizophrenia spectrum disorder attended at least one phase 1 session. Every veteran in REACH is accompanied by a family member, so the number of family participants in REACH equals the number of veteran participants.

Consistent with the hospital's general population, most veterans engaged in treatment (N=131) were male (N=115, 88%) and Caucasian (N=107, 82%). Twelve percent (N=16) were African American, 4% (N=5) were Hispanic, and 2% (N=3) were Native American. Three-quarters (N=95, 73%) were married, and most (N=93, 71%) selected their spouse to participate with them. Other common family members included parent (N=16, 12%), child (N=5, 4%), and sibling (N=5, 4%). Most veterans were from the Vietnam era—in their 50s (N=39, 30%) and 60s (N=38, 29%)—followed by 19% (N=25) in their 30s and 14% (N=18) in their 40s. Almost half (N=58, 44%) had some college education.

Discussion

REACH, one of the first VA mental health enhancement–funded family programs, has had notable success in engaging veterans and families. The nine-month commitment required for REACH participation and its provision by psychologists not otherwise involved in the veterans' mental health care make engagement especially challenging. The engagement strategies REACH employs are complex and time consuming, in part because REACH engagement requires buy-in, time, and commitment from referring clinicians, as well as from veterans and families.

Our education of clinicians about the benefits of REACH was very effective, as all 16 clinicians made regular referrals. We believe that the decision to elicit provider buy-in through face-to-face, often individual, discus-

Table 1

Rates of participation by veterans in the Reaching out to Educate and Assist Caring, Health Families (REACH) program, by diagnosis

	Posttraumatic stress disorder		Affective disorder[a]		Schizophrenia spectrum disorder		Total	
Variable	N	%	N	%	N	%	N	%
Met with REACH psychologist for engagement session	240	100	207	100	58	100	505	100
Found ineligible to participate during engagement session	31	13	31	15	7	12	69	14
Eligible to participate	209	87	176	85	51	88	436	86
Attended at least one phase 1 session (among those eligible to participate)	59	28	59	34	13	25	131	30

[a] Major depressive disorder or bipolar disorder

sions with clinicians, frequent expressions of appreciation for referrals, desk cards as prompts, an incentive system, and ongoing dialogue and process improvement, rather than through administrative mandates, formal lectures, or onerous paperwork, contributed to our success.

Veterans were quite receptive to the possibility of family involvement; the fact that over 500 veterans (almost half of veterans with PTSD and about 40% of veterans with affective disorders) met with a REACH psychologist to learn about a family program reflects considerable openness to family involvement (especially because many did not meet because no family was available). Less than one-third of veterans with schizophrenia were willing to meet with a REACH psychologist, likely reflecting lack of available family, paranoia or anxiety surrounding a new venture, and more difficulty understanding the potential benefits of REACH after just one orientation session.

Thirty percent of veterans who had an engagement interview enlisted a family member and both participated in REACH—that is, attended at least one phase 1 session. The family psychoeducation literature provides little information regarding how many consumers must be approached and evaluated to enroll a sufficient number in the intervention. This study makes an important contribution by providing the first data regarding enrollment rates. Further, for several reasons, we consider the 30% participation rate quite high. First, many veterans seen in these outpatient clinics are accustomed to 15-minute medication-management appointments every three to four months as their sole mental health treatment; therefore, participation in REACH involves a dramatic increase in required time and personal investment. Second, some veterans want to keep their mental health care private, preferring that their family know as little as possible about their emotional difficulties; similarly, some families are not interested in being involved in the veteran's care. Some families are burned out, have had negative experiences with mental health providers, and fear being blamed; therefore, some are hesitant to engage with a system that has not always been supportive and attentive to their needs. Third, because over half of participants were in their 50s and 60s, many had long-term relationships. Many veterans and families fear change and do not want to "rock the boat" in their relationships. Fourth, in contrast to some other family psychoeducational programs, the clinicians providing REACH are not the veterans' primary clinicians, so this strategy challenges veterans to develop trust and rapport with a new therapist. Fifth, veterans and families must overcome numerous possible barriers to participation—for example, work schedules, distance from the VA, reliable transportation, child care, and stigma. Finally, our engagement rate exceeds that found in previous research (14) for engagement in much lower-intensity activities (accompanying the veteran to one psychiatrist appointment or attending a single family-member-only class).

Conclusions

Although the effects of the engagement session on veterans who declined REACH were not measured, this dialogue may be useful clinically—for example, the intervention may plant seeds for viewing families as allies in recovery and for considering future family involvement in health care. Further, this study examined only engaging veterans and their families into treatment (coming to one session); future research will need to address issues of program retention and completion.

Because of the large number of barriers facing the veteran, family member, and system, engaging families into long-term psychoeducation is an intensive process. The yield from our approach is greater than that of any other program described in the literature. Consistent with the motivational-interviewing literature, the REACH engagement strategy of face-to-face contact with enthusiastic providers who help veterans consider achievable goals is demonstrating success in this challenging endeavor.

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