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**Psychiatric Services article on our Engagement process**

**Professional Psychology: Research and Practice article on the REACH Program**
Acknowledgments

The creation and provision of the REACH Program is truly a team effort, and we are humbled to have outstanding collaborators and consultants.

We warmly thank Dr. Ellen Fischer, our evaluation director, who has provided her expertise, guidance and wisdom from the very beginning. She has been involved in shaping and evaluating the intervention, and is a joy with whom to work. We greatly appreciate the contributions of Xiaotong Han, MS., Dr. Richard Owen and Mr. Silas Williams, all of whom play integral roles with data management and analyses.

We are deeply indebted to our consultants, Dr. Lisa Dixon and Dr. William McFarlane, both of whom have shared their wisdom and support throughout the evolution of REACH. Thanks, Bill, for trusting us with your intervention in applying it to PTSD in the VA system!

We appreciate our program support assistants, Josie Freeman, Dr. Jeff Anderson and Shavon Toles, for daily operations of REACH, and being the friendly “first contact” many Veterans/families have with REACH. You epitomize customer service and outstanding organizational skills, and REACH runs smoothly because of you! We thank our research assistants who have toiled diligently with data entry and management, including Denise Harrison, Adrienne Prince, Linda Muse, Laura Geczy and Brad Townsend.

The REACH Program and associated Oklahoma City VAMC family programs would never have been possible without the support of both local (Dr. Jeanne Morgan, Dr. William Leber, and Dr. Richard Carothers) and national (Dr. Susan McCutcheon and Dr. Shirley Glynn) leaders. We are humbled and honored by your commitment to us and support of our initiatives.

The creation and dissemination of this manual were supported by a clinical educator grant from the VISN 16 South Central Mental Illness Research, Education, and Clinical Center (MIRECC) under the leadership of Greer Sullivan, M.D., M.S.P.H. and Michael Kauth, Ph.D. Thank you, Greer and Michael, for your unending support, mentorship and wisdom, as well as your commitment to family services. Special thanks to Dr. Kristy Straits-Troster for her expert review and very helpful feedback on the curriculum. Thanks to Sonora Hudson, M.A., for her excellent copy editing of this manual. We appreciate Zac Logsdon of Old Hat Design for the graphic design of the manual.

Finally, and most importantly, thank you to the many Veterans and families who have served our country and have taught us about post-traumatic stress disorder (PTSD) and relationships. We are honored to learn from and serve you.

Michelle D. Sherman, Ph.D.
Alan “Dutch” Doerman, Psy.D. ABPP
Ursula B. Bowling, Psy.D.
Lee Thrash, Ph.D.

Family Mental Health Program, Oklahoma City Veterans Affairs Medical Center
South Central Mental Illness Research, Education and Clinical Center (MIRECC)
University of Oklahoma Health Sciences Center, Department of Psychiatry & Behavioral Sciences

September, 2011
Overview of the REACH Program Manual

The purpose of this manual is to assist clinicians and administrators in implementing the REACH program in your facility. It contains everything you need to start your own family psychoeducational program to support Veterans living with post-traumatic stress disorder (PTSD) and their families.

Inside you will find:

- Background information on the development and history of the REACH program
- Guiding principles for clinicians for conceptualizing care in this model
- An overview of the format/structure of the program (including indications and contraindications for participants, therapist prerequisites, and logistical information)
- Specific instructions on billing, coding and documentation
- Recruitment strategies (including sample publicity pamphlets)
- A participant satisfaction assessment measure
- Engagement interview curriculum
- Four-session Phase 1 (Joining) session curriculum
- Six-session Phase 2 curriculum
- Six-session Phase 3 curriculum
- Graduation session curriculum
- Two published articles (in the public domain) describing the adapted program, the rationale for the modifications, and data from the Oklahoma City VA programming.

The student workbook (identical for Veterans and support persons) is used primarily in Phase 2. It is a compilation of resource information and worksheets (for in-class activities and between-session assignments). All of the workbook pages are also contained in this manual.
Background of the REACH Program

The Oklahoma City VA Medical Center was fortunate to receive Mental Health Enhancement Funds from the VA Central Office in 2005 to implement an “evidence-based practice.” Specifically, the funding was to implement family psychoeducation.

For numerous reasons detailed elsewhere (Sherman et al., 2009), we selected Dr. William McFarlane’s evidence-based Multifamily group model (McFarlane, 2002) and implemented it in the VA system for the first time. This model was originally developed for and has been extensively researched with schizophrenia and has been also used with mood disorders, some personality disorders, and medical illnesses. However, per Dr. McFarlane, it had not been used with PTSD, and no research existed with a Veteran population.

We named our program REACH, Reaching out to Educate and Assist Caring, Healthy Families. Since August 2006, we have provided the REACH Program to three diagnostic groups of Veterans and their families, namely, those with PTSD, affective disorders (depression and bipolar disorder) and schizophrenia-spectrum disorders. Although the general format and structure are identical across cohorts, this manual includes only the PTSD curriculum.
Guiding Principles for Therapists in Providing REACH

Before describing the format, session content, and logistics of the REACH Program, we want to share some guiding principles that shaped our creation and continue to drive how and why we provide the program. These themes should be reviewed and reflected upon by clinicians working with Veterans living with PTSD and their families. Knowing that engaging families can be challenging, we intentionally developed this style and believe it has been instrumental in our success in engaging and retaining families in care.

- **Instillation of hope.** Many families feel discouraged, alone, hopeless, confused and afraid. As therapist, it’s important to have a realistic yet hopeful approach in all interactions with Veterans and their support persons. REACH sessions and classes need to be positive and upbeat, while allowing for some discussion of the challenges of living with PTSD.

- **Acknowledgment of PTSD as a real phenomenon, yet empowering to make positive changes.** Although psychoeducation about the disorder and its relational consequences is a necessary component of REACH, you should discourage Veterans from using a symptom as an “excuse” for unhelpful/hurtful behavior. Validating the difficulty and how risky it can feel to make changes (while simultaneously encouraging making changes) is important.

- **Focus on making small “1 millimeter” changes.** Veterans can feel overwhelmed and even frozen by the thought of making big changes in their behavior, so encourage them to think about taking small steps in a healthy direction. Emphasizing the positive ripple effects (individually and in the relationship) from such changes can inspire hope.

- **Treat Veterans/support persons as “guests in your living room”** (quote from Dr. Alan “Dutch” Doerman). In creating a welcoming environment, you are encouraged to engage families as you would guests in your home. Truly having this mindset changes how we approach and deal with families, and they can really “feel” the difference! This can mean everything from remembering details of interests or important events in Veterans’ lives to making sure that the environment for the groups is comfortable and welcoming.
- Emphasis on a “long-haul” mentality (a “marathon” rather than a “sprint”). Some families have been dealing with PTSD and its sequelae for decades; for others (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans or new relationships/marriages), it may be a recent adjustment. As growing research is documenting that some relational difficulties with PTSD can be chronic, it can be helpful to approach REACH with a “managing the condition over time” model rather than a “short-term fix” approach. Dealing with PTSD can be compared to managing diabetes in the family, requiring involvement and changes by both Veterans and support persons.

- Challenge by choice. In every REACH session, view the Veteran/support person as the experts in their experience, feelings and needs. Offer skills, exercises and information in a respectful, gentle, hopeful manner; but avoid pressuring them to do anything that would feel overwhelming or too stressful. Similarly, in classes, avoid asking anyone a direct question; and allow participants to “pass” even on simple matters such as the “check-in” time. The goal is to create a welcoming, relaxing, nonthreatening environment in which they feel comfortable and safe.

- REACH is not solely about/for the Veterans. Although we are honored to provide care for Veterans in a VA hospital/clinic, this program is equally for the support persons. REACH focuses on both parties’ gaining sensitivity, understanding and awareness of each other and their experiences/needs.

- Honor family strengths. The Veterans and their family members have tremendous strengths and internal resources. These resources have allowed them to serve in the military, to cope with sometimes considerable challenges, to maintain their relationships, and to make it to this point in their lives. REACH works best when these strengths are regularly acknowledged and celebrated.
Format of the REACH Program

Clinicians intending to implement this program are strongly encouraged to first read the following sources that address general issues about multifamily groups as well as format and implementation issues:


This article provides a description of the adapted model, the rationale for modifications, and initial experiences implementing the program in the VA healthcare system.


This is the original textbook describing this mode of treatment. In particular, we recommend reading chapter 5 (“An Overview of Psychoeducational Treatment”).


This free publication describes the family psychoeducation model and provides tips on implementation, including sample curricula and model progress notes.


This free publication supports the process of training clinicians in use of the model, including description of the core clinical processes and sample problem-solving exercises.
Structure of Program

Excluding the initial engagement/screening interview, the REACH program consists of 16 sessions, provided over the course of 9 months. As seen in the table below, 4 sessions are single-family sessions (provider, Veteran, and support person), and 12 are multifamily group meetings. Thus, although the program is relatively long in duration, the clinical dose is actually rather small, with 75% of the program being group treatment.

<table>
<thead>
<tr>
<th>WHO</th>
<th>Engagement Interview</th>
<th>Phase 1 (Joining)</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran (support person as well if present)</td>
<td></td>
<td>Single family: Veteran and support person (dyad)</td>
<td>Multifamily group (4-6 dyads)</td>
<td>Multifamily group (4-8 dyads)</td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>Once</td>
<td>Weekly</td>
<td>Weekly</td>
<td>Monthly</td>
</tr>
<tr>
<td>NUMBER OF SESSIONS</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SESSION LENGTH</td>
<td>20-40 minutes</td>
<td>50 minutes</td>
<td>90 minutes</td>
<td>90 minutes</td>
</tr>
<tr>
<td>PROVIDERS</td>
<td>1</td>
<td>1</td>
<td>2 (due to breakout sessions)</td>
<td>1</td>
</tr>
<tr>
<td>LOCATION</td>
<td>Referral source (e.g., outpatient clinic, inpatient unit)</td>
<td>Provider’s private office</td>
<td>Group room that has a table and comfortably holds 18 people</td>
<td>Group room that has a table and comfortably holds 18 people</td>
</tr>
</tbody>
</table>
Engagement Interview

Entry into the REACH Program begins with an engagement interview. The procedure for this interview (as well as possible outcomes) is described on page 21 of this curriculum.

To participate in the REACH Program, both the Veteran and a “support person” need to commit to regular participation. Veterans cannot participate if they do not have someone who will attend regularly. This person does not have to be biologically related to the Veteran. Support persons have commonly included spouses/partners, parents, siblings, and friends. Others who have served as support persons include a pastor/clergy person, neighbor, 12-step sponsor, and another Veteran; in essence, a “support person” can be anyone the Veteran feels is supportive and is willing to participate. Occasionally, one member of the dyad is no longer willing or able to complete the program, but the other party wants to continue. If they are in Phase 1 (Joining sessions) at the time this arises, a final closing session with the willing participant is appropriate. If they are in Phase 2 or 3, the willing party (“adopted” group member) is encouraged to continue. One of the Phase 2 or 3 facilitators can act as their support person during in-class activities. Typically, the rest of the group welcomes and supports the “adopted” group members in group sessions.

Following the engagement interview, the program consists of three phases:

**Phase 1** (Joining sessions): Four 50-minute, single-family sessions provided by one clinician

These are scheduled to accommodate the Veteran/support person’s schedule and do not have to be the same time every week. Sessions are typically held weekly, but frequency can vary somewhat to support the dyad until the next Phase 2 cohort begins. For example, sessions can be spread out to every other week if needed, and a “booster” session can be offered to tide the dyad over until the next Phase 2 cohort begins. Or, if a new cohort is about to start, sessions can be held twice per week to get a dyad ready.

Detailed outlines of these sessions are described in this manual on page 27. The major goals of Phase 1 include rapport building, assessment, goal setting, encouragement to broaden social support and expand coping skills repertoire, and preparation for Phase 2.
**Phase 2**: Six weekly, 90-minute multifamily group psychoeducational sessions co-facilitated by two clinicians

These are provided in the evenings (5-6:30 pm) to allow Veterans/family members who work outside the home to attend. Time is allotted at the beginning and after the session for socialization.

Cohorts of 4-8 dyads go through the six Phase 2 classes together. If a dyad must miss the first class, they can join in on the second class; however, dyads cannot join after that time. In our experience, about 85% of dyads who begin Phase 2 actually complete it, so some small attrition is expected.

Programmatically, frequency of provision of Phase 2 depends on your site’s referral rate. In Oklahoma City, we typically take a 1- or 2-week break between each Phase 2 cohort. You need to balance having a sufficient number of families ready to begin with avoiding making families wait too long before the next Phase 2 begins.

Detailed outlines of each Phase 2 class are described later in this manual on page 59. Each session addresses a specific topic (e.g., communication skills, managing anger and conflict). Each session involves large group psychoeducation, breakout sessions (separate simultaneous meetings of Veterans and support persons), and teaching of new skills.

**Phase 3**: Six monthly, 90-minute multifamily group sessions provided by one clinician

These are also provided in the evenings (5-6:30 pm) but on a different day of the week than Phase 2. Time is allotted at the beginning and after the session for socialization.

Phase 3 classes are provided year-round. By design, these groups are a combination of more than one cohort. Depending on the calendar, a particular class may have participants from two or even three cohorts. As Phase 3 is intended to help families practice their skills and broaden their social networks, such opportunities for interacting with other families can be beneficial.

Depending on your participation rates, you may choose to split up your cohorts and offer Phase 3 twice a month. For example, our “odd-numbered” cohorts come on the first Monday of the month; our “even-numbered” cohorts come on the third Monday of the month.

Detailed outlines of each Phase 3 class are provided later in this manual on page 219. Each session involves review of one of the topics addressed in Phase 2, as well as group problem-solving.
To successfully complete a phase (and move on to the next phase), families have to have attended at least two Phase 1 sessions and at least four Phase 2 and 3 sessions.

**Participants**

Veterans who have symptoms of PTSD from any kind of trauma (including military sexual trauma [MST], experiences as an adult civilian, etc.) and from any era (WWII, Vietnam, Korea, Operation Desert Storm/Shield, OEF/OIF/OND, etc.) may be appropriate for the REACH program. The program is not designed to address PTSD resulting from childhood trauma. The Veteran does not need a chart diagnosis of PTSD, and he/she may have comorbid depression and anxiety issues/diagnoses. Contraindications include the following:

- Active alcohol or drug abuse
- Imminent suicidality/homicidality
- Active interpersonal violence
- Pedophilia or paraphilias
- Dementia

Veterans designate a “support person” to participate in REACH with them. Support person contraindications are identical to those listed above for Veterans.

**Facilitators**

Due to the breakout sessions in Phase 2, two mental health professionals are required to participate in each Phase 2 session.

Facilitators need to possess at least a masters’ degree in psychology, social work, counseling or psychiatric nursing. A doctoral degree (in psychology or psychiatry) is preferred in at least one of the facilitators. Independent of the specific degree, facilitators need skills and confidence in:

- The literature on PTSD and its impact on relationships
- Working with couples
- Facilitating group psychoeducational workshops/classes (not process groups). In our experience, providers who have only provided individual therapy and process groups often struggle initially with learning how to provide REACH classes. It is imperative that REACH classes are structured and follow the curriculum; the sessions are not purely peer-support/discussion groups. Empowering clinicians to conceptualize providing REACH Phases 2 and 3 as similar to classroom teaching can be useful.

If an interested clinician lacks some of these skills, reading, consultation and supervision will be essential for program success.
Logistics

Because Phase 2 and 3 classes are held in the evenings, light refreshments are served at class.

If possible, small items (e.g., notepads, pencils, post-it notes, all with the REACH logo and phone number on them) are distributed as attendance awards at the end of each phase to reinforce ongoing participation and commitment to the relationship.

A list of the necessary materials for each session is on page 62.

Location

It is best that the REACH Phase 2 and 3 classes are held in a comfortable, private room with a table large enough for everyone to sit around. The room needs a dry-erase board, poster board, or chalkboard for board work (especially for problem-solving). Preferably, the classroom is not located in a mental health area. The room should comfortably hold 18 people.

A second, smaller private room located nearby is needed for the breakout session. This room should comfortably hold 10 people. Chairs should be put in a circle for the discussion. If space limitations are a challenge, sites can be creative in finding appropriate meeting areas (e.g., use a quiet waiting room for the breakout if after hours).
Documentation and Workload Credit

Consistent with VACO policy for family psychoeducation services when services are provided to Veterans and family members simultaneously, one progress note is written for each visit. Enter the note in the Veteran’s record in CPRS.

Creation of a Clinic

Clinics should be created to be used specifically for the REACH Program; this will be useful when reviewing workload. Depending on local needs, it may be useful to create separate clinics for different REACH phases (e.g., REACH engage interviews, REACH Phase 1, REACH Phase 2, and REACH Phase 3 sessions).

Completing the Encounter and Progress Notes

A. Create the appointment in the designated clinic, and complete the check-out/encounter. For REACH, the following information can be used:

CPT codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804</td>
<td>Psychotherapy in an office or outpatient facility; 20-30 minutes</td>
</tr>
<tr>
<td></td>
<td>For brief outpatient REACH engage sessions</td>
</tr>
<tr>
<td>90806</td>
<td>Psychotherapy in an office or outpatient facility; 45-50 minutes</td>
</tr>
<tr>
<td></td>
<td>For longer outpatient REACH engage sessions</td>
</tr>
<tr>
<td>90816</td>
<td>Psychotherapy in a hospital or residential care facility 20-30 minutes</td>
</tr>
<tr>
<td></td>
<td>For brief inpatient REACH engage sessions</td>
</tr>
<tr>
<td>90818</td>
<td>Psychotherapy in a hospital or residential care facility; 45-50 minutes</td>
</tr>
<tr>
<td></td>
<td>For longer inpatient REACH engage sessions</td>
</tr>
<tr>
<td>90801</td>
<td>Psychiatric diagnostic interview evaluation</td>
</tr>
<tr>
<td></td>
<td>First REACH joining session</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy, conjoint psychotherapy with patient present</td>
</tr>
<tr>
<td></td>
<td>Subsequent joining sessions</td>
</tr>
<tr>
<td>90849</td>
<td>Multifamily group psychotherapy</td>
</tr>
<tr>
<td></td>
<td>All REACH multifamily group sessions</td>
</tr>
</tbody>
</table>
**Diagnosis**

Provide Axis I diagnosis (if present) for the Veteran; list V61.1 (partner relational problem) as secondary diagnosis if applicable. Do not provide a diagnosis for the support person.

B. Include the following disclaimer at the end of every REACH Progress note:

All non-Veteran participants are reminded that they are not eligible for individual mental health care at this VA Medical Center. They are instructed to report to their local emergency room or the Oklahoma Department of Mental Health and Substance Abuse Crisis Center if feeling like they are a danger to themselves or others. Any treatment that they receive therein will be at their own expense.

C. You may choose to use/adapt this progress note template:

Progress Note TITLE = MH: Psychology OUTPT REACH Progress Note
REACH Project
Family Mental Health Program
The REACH Project (Reaching out to Educate and Assist Caring, Healthy Families), is a three-phase family psychoeducational intervention designed to support Veterans and their families in living with mental illness and PTSD.

Time Spent: ______ minutes

Primary Mental Health Provider: ________________________________.

Session number for this individual:
- Engage 1
- Engage 2

- Phase I – 1 Joining One
- Phase I – 2 Joining Two
- Phase I – 3 Joining Three
- Phase I – 4 Joining Four

- Phase II – 1
- Phase II – 2
- Phase II – 3
- Phase II – 4
- Phase II – 5
- Phase II – 6

Phase III

Graduation Session
Topic: (select one)
☐ Informing Veteran/family about the REACH Project
☐ What causes mental illness?
☐ PTSD and its impact on the family
☐ Communication skills
☐ Problem-solving skills
☐ Creating a low-stress environment and promoting wellness
☐ Depression and its impact on the family
☐ Managing anger effectively in the family

O - Presentation was: (check all that apply)
☐ Alert, oriented x4
☐ Appropriately dressed & groomed
☐ Disheveled appearance
☐ Attentive
☐ Appeared tired or sleepy
☐ Distracted
☐ Involved in discussion
☐ Little participation
☐ Thought process clear & coherent
☐ Active hallucinations
☐ Active delusions
☐ No suicidal or homicidal ideation at this time
☐ Suicidal ideation no intent
☐ Suicidal intent
☐ Homicidal ideation no intent
☐ Homicidal intent

Affect was: (check all that apply)
☐ Cheerful
☐ Sad
☐ Angry
☐ Flat
☐ Calm
☐ Anxious
☐ Distracted/withdrawn
☐ Confused
☐ Supportive of other group members
☐ Tearful
☐ Disgusted
☐ Tense
☐ Other

A - Current diagnosis is: ________________________________

P - Gave REACH Project flyer

All non-Veteran participants are reminded that they are not eligible for individual mental health care at this VA Medical Center (unless they have suffered a research adverse event or injury from their participation). They are instructed to report to their local emergency room or the Oklahoma Department of Mental Health and Substance Abuse Crisis Center if they feel like they are a danger to themselves or others. Any treatment that they receive therein will be at their own expense.
Recruitment

Recruitment is a time-intensive, ongoing, extremely important component of any successful family program. Addressing the intricacies of this issue is beyond the scope of this manual. The approach must be tailored to the specific needs of your clinics, providers, Veterans and families.

The original strategy we developed is described in detail here:

However, we have modified our approach over time to meet the fluctuating needs of our referral sources and Veterans. Sites need to be flexible, creative, willing to shift approaches, able to work with a variety of staff/units/disciplines, and persevering.

Recruitment approaches we have found helpful include:

Utilizing the following referral sources: the outpatient mental health clinic, PTS Recovery program, OEF/OIF/OND mental health and case-management programs, Traumatic Brain Injury clinic, inpatient psychiatry, the Psychosocial Rehabilitation and Recovery Center, and Primary Care Mental Health.

Strategies with referrers

- REACH clinicians present regularly to VAMC staff, Vet Center staff, and community organizations. We have found that repetition is golden! We have published articles in peer-reviewed journals, internal Oklahoma City VA magazines, and profession-specific newsletters. We provide workshops in a variety of settings, such as grand rounds at the university, state social work conferences, and staff meetings. We meet with each new mental health staff member of the Oklahoma City VAMC to educate them about our program and request referrals.

- In the outpatient mental health clinic, we review rosters of Veterans scheduled for each day. We talk directly to the provider about their eligible patients for that clinic day (or place a hand-written note attached to a REACH flyer in the provider’s mailbox). We ask providers to talk to their Veterans about meeting with a REACH provider after the appointment. We have found that such a “warm handoff” is much more effective than a “cold call” or approaching them without such context.
For the inpatient psychiatry unit, we review the roster for eligible Veterans. In coordination with the treatment team, we connect with the Veteran on the inpatient unit once he/she is stabilized to tell him/her about REACH.

We are available for walk-ins for provider referrals from other clinics as well. Similarly, a provider can add a REACH clinician as a co-signer on a progress note in CPRS, and we will follow up with the Veteran within 1 to 2 days.

**Veterans we target:** When reviewing rosters, we look for Veterans with PTSD who live within 90 miles of our hospital and have a support person listed as next of kin. However, these are not rigid rules, and we defer to the primary provider for the judgment as to appropriateness.

**Approaches to engage Veterans/families in treatment**

- REACH clinicians make presentations throughout the medical center and in the community (e.g., to Veteran Service Organizations) to inform Veterans and their families about the program. For example, clinicians provide group therapy sessions and give brief presentations in the PTS Recovery program and numerous psychoeducational classes (e.g., Anger Management class; Adjustment to Traumatic Stress class); in these presentations, common family challenges with PTSD are explored, and information about REACH is provided.

- Because Veterans may be hesitant to engage in a lengthy treatment program, we provide multiple engagement interviews (up to three) as needed. For example, a Veteran may begin a new relationship or reconnect with a family member, thereby acquiring a support person that may be appropriate for REACH. Similarly, a Veteran may be dealing with severe depression at one appointment but may be more receptive to participation at a subsequent visit.

**Approaches to retain Veterans/families in treatment**

- If a dyad does not attend a session or group, we call the next day to follow-up.

- If a dyad must discontinue a phase (e.g., extended travel, health problems), we encourage them to join the next cohort and/or repeat a phase.

- We send hand-written letters of support and encouragement to acknowledge major life events, such as deaths in the family, hospital admissions, major illnesses, etc.
Other Approaches

Another promising approach currently being developed is the Family Member Provider Outreach Program. This brief, manualized approach consists of 4-6 sessions in which motivational interviewing techniques are used to explore the benefits of engaging family members in an individual's care. Information about this approach is described here:


Another article that addresses implementation of family programming and provides specific suggestions for overcoming barriers at the Veteran, family, provider and administrator level is:

# REACH Engagement Session

<table>
<thead>
<tr>
<th>WHO</th>
<th>Engagement Interview</th>
<th>Phase One (Joining)</th>
<th>Phase Two</th>
<th>Phase Three</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO</strong></td>
<td>Veteran (support person as well if present)</td>
<td>Single family: Veteran and support person (dyad)</td>
<td>Multifamily group (4-6 dyads)</td>
<td>Multifamily group (4-8 dyads)</td>
</tr>
<tr>
<td><strong>FREQUENCY</strong></td>
<td>Once</td>
<td>Weekly</td>
<td>Weekly</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>NUMBER OF SESSIONS</strong></td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>SESSION LENGTH</strong></td>
<td>20-40 minutes</td>
<td>50 minutes</td>
<td>90 minutes</td>
<td>90 minutes</td>
</tr>
<tr>
<td><strong>PROVIDERS</strong></td>
<td>1</td>
<td>1</td>
<td>2 (due to breakout sessions)</td>
<td>1</td>
</tr>
<tr>
<td><strong>LOCATION</strong></td>
<td>Referral source (e.g., outpatient clinic, inpatient unit)</td>
<td>Provider's private office</td>
<td>Group room that has a table and comfortably holds 18 people</td>
<td>Group room that has a table and comfortably holds 18 people</td>
</tr>
</tbody>
</table>

**Engagement Session Goals:**

1. To connect with and build rapport with the Veteran (and support person if present)
2. To describe the REACH Program
3. To briefly assess the appropriateness of the Veteran for the REACH program
4. To connect some of the Veteran’s goals for recovery with the REACH Program
5. If appropriate, to elicit a commitment to participate further in REACH
Therapist Note: These sessions are usually held with the Veteran alone in the clinic or unit in which he/she is being seen. However, if a support person is present (even in the waiting room) and the Veteran is willing for him/her to participate, include that person in the session as well.

Although you may wish to experiment with brief phone-based engagement interviews, we have not found this approach to be successful. Our experience has shown that the face-to-face connection proves much more powerful in engaging Veterans/families in care. If you do have a brief phone call, consider coordinating a face-to-face session with the Veteran’s next appointment at your facility.

Throughout the engagement interview, the primary focus of the REACH provider is to build a sense of connection and rapport with the Veteran and to highlight how the program could be helpful. Doing so reduces anxiety and increases the likelihood that the Veteran will be willing to talk to the support person about participation. The time frame for the engagement session is 15-30 minutes (averaging 20 minutes).

If you have the opportunity to review the medical record prior to considering a Veteran for an engagement interview, look at psychiatric diagnoses to determine appropriateness (see the Introduction section of this manual for a description of inclusion criteria). If you do not have sufficient background information on the Veteran prior to the interview, you need to assess for comorbid contraindications (substance abuse, dementia, and active suicidality) in this engagement session as well. If the Veteran is not appropriate for REACH, be prepared to provide appropriate referrals for both the Veteran and support person (if present).

I. **Rapport building.**

   Topics you may discuss include

   - **Military service**
     Therapist Note: If you are not a Veteran, familiarize yourself with basic terminology of the military culture (e.g., branch, jobs); a basic understanding of military terms and culture is an important rapport-building tool.

     - Branch of service
     - Years served
     - Job in military
     - Where stationed
- Work history
  - Type of work
  - Companies
  - Favorite thing about job/least favorite thing about job

- Hobbies
  - Interests
  - Membership in organizations
  - Skills (woodworking, sewing, car repair, etc.)

- Family
  - Marital status
  - Children or grandchildren
  - City of residence

*Therapist Note: As you discuss these topics, look for possible "links" between you and the Veteran/support person (e.g., you both enjoy gardening or old cars). You will draw upon these connections in future sessions.*

II. Briefly describe the REACH Program.

A. Give the Veteran/support person the REACH flyer and direct his/her attention to the triangle in the middle of the flyer:

```
\[\text{VETERAN} \quad \text{SUPPORT PERSON} \quad \text{PROVIDER}\]
```

Explain how this illustration summarizes the rationale for the REACH Program. Often, Veterans attend psychotherapy and take medications, both of which can be helpful. Sometimes family members/support persons have questions for the provider about PTSD and the way it impacts relationships; they may attend their own psychotherapy or educational workshops (such as the SAFE Program).
The goal of REACH is to get everyone “on the same page,” in the same room, and working together to support the dyad in dealing with the PTSD. We bring all three of these groups together to **improve communication**, to **enhance understanding of PTSD and ways to manage it effectively as a dyad/family**, and to **maximize both partners’ well-being**. We also know that Veterans who have support from their families tend to do better in treatment and experience a better quality of life.

Including someone very important in the Veteran’s life in treatment makes a lot of sense on many levels!

- The support person does not have to be a family member. It could be a
  - Neighbor
  - Church buddy
  - Fellow Veteran
  - AA sponsor
  - Friend

- Support-person characteristics include
  - Someone the Veteran trusts
  - Someone who is willing to participate in the sessions

B. **Explain the rationale for involving a support person in REACH.**

- PTSD has an impact on relationships. Many symptoms of PTSD (numbing, avoidance, hyperarousal) impact family life and relationships.
- A calm home environment helps people with PTSD function better.
- People with social support tend to have better mental health than people with more limited support.

C. **Emphasize that REACH focuses on the "here and now," not the "there and then."** Explain that Veterans will not talk about their trauma experiences (or anything else they are not comfortable discussing).

D. **Explain that a diagnosis of PTSD is not a "free pass" and that the REACH Program does not explain away all difficult behaviors.** Instead, the REACH Program is focused on helping BOTH members of the dyad adjust to and deal with the Veteran’s symptoms in the best way possible.
III. **Explain the three phases of the REACH Program and the basic logistics of each.**

Emphasize that the dyad can discontinue participation at any time (e.g., they can select to do only Phase 1, or 1 and 2, if their goals have been met).

IV. **Ask the Veteran to complete the REACH checklist.**

A. Discuss how his/her goals fit with the goals of the REACH Program and how the REACH Program might help the dyad move forward in achieving those goals.

B. Suggest that REACH might help bridge the gap between current and desired functioning.

C. Review that during REACH, the "family is in the driver's seat" in regards to shaping treatment goals and deciding its level of participation.

V. **Discuss availability of a support person (who lives within 90 miles and would be willing to participate) and interest in REACH.**

   - If the Veteran has a support person and appears interested, see if he/she is willing to schedule the first joining session.
   - If the Veteran wants time to think it over, ask if you can call in a couple of days to discuss his/her participation. Make it clear that you will not pressure the Veteran or his/her family to participate.
   - If the Veteran/dyad is not interested, provide your contact information, and encourage them to contact you at any time if they become interested.
   - If the Veteran does not have a support person
     - Consider referrals to other programs at your facility or in your area.
     - Ask the Veteran to "keep an open mind" and think about whether there is someone that might actually be a good support.
     - Provide your contact information, and ask the Veteran to contact you if he/she thinks of or develops a support person and would like to participate in REACH.

VI. **End the session by thanking the Veteran/dyad for their time and engaging in brief socializing.**
Date: __________________  Name ________________________________

In our appointment today, we are going to talk about a new program at our hospital for Veterans and their families/friends, the REACH Project (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 to be different in your life? We believe we can help you move toward your goals.

I would like to:
(please CHECK all that apply)

☐ Communicate better with my family and friends
☐ Have my family more involved in my mental health care without sacrificing my privacy
☐ Have less tension and fewer arguments with people
☐ Learn how to better manage my temper
☐ Do more fun things
☐ Manage money more effectively
☐ Learn how to relax
☐ Have less stress at home
☐ Feel less lonely
☐ Be able to trust people more
☐ Have my family/friends better understand what I’m going through
☐ Help my family/friends learn to back off and stop pressuring me
☐ Find a job that I can enjoy
☐ Learn what I can do to stay out of the hospital
☐ Feel closer to important people in my life
☐ Learn how to better manage my medications and their side-effects
☐ Find some hobbies
☐ Learn how to solve problems more effectively

Thank you.