FAMILY INCLUSION COMPETENCIES FOR PRACTICING PSYCHIATRISTS

WORKING WITH ADULTS

BY THE PENNSYLVANIA PSYCHIATRIC LEADERSHIP COUNCIL

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Scope: Psychiatrists practicing in State Hospitals, Community Health Provider Settings, Behavioral Managed Care Organizations, Primary Care/Psychiatry Collaborative, Private Practice.

Purpose: To provide recommendations for competencies for family inclusion needed by psychiatrists, fellows and residents to enhance treatment for persons with behavioral health challenges and support their families.

The need for family inclusion — a mandate.

In this paper, we define family as a group of connected people bound by ties of obligation and affection, most often biological or legal kin but often including other significant people.

For people in recovery from psychiatric disabilities, the development and maintenance of family/significant supports is critical to sustaining a functional life. While not all individuals have available families, the majority have some significant people who can affect their recovery in more positive ways if given support. Involved families and other significant people may at times be challenging, but they provide a way for the person to be part of the relational world. Whether they live with the person or not, they are often aware of their relative's evolving health or illness, serve as a potential early warning system for relapse, support treatment adherence and carry the burden of dealing with setbacks and emergency care. The principles of recovery, and of responsible psychiatric care, mandate that whenever possible families should be engaged in as members of the treatment team. They should be offered support for their wellbeing and needs as caregivers.

Unfortunately, behavioral health systems in this country have consistently marginalized families. Lack of training, lack of time and lack of financial supports for family care have allowed us to ignore the body of research providing strong evidence that family involvement assists recovery oriented care, decreases relapse and sharply decreases re-hospitalization. In the meantime, options for hospitalization and respite care have greatly decreased, and families are left shouldering most of the responsibilities of care.

Psychiatrists should see families as partners in treatment and have knowledge of and some experience with all types of family care. They should be familiar enough with systems theory to use these concepts in treatment, and to be able to assume a leadership role in wider community systems. As psychiatrists have widely varied skills and experiences in dealing with families, we offer these competencies to help determine their educational needs and to support them in obtaining the knowledge and skills needed to care for family members while caring for their patients.

These family competencies for psychiatrists are geared to creating leaders who understand the needs of families and the issues of larger systems, and are skilled enough to advocate for family inclusive care at their facilities. Beyond curriculum, psychiatrists and their institutions must model family involvement within its

teaching and practice sites. The best curriculum will be useless if the leadership of the program does not model the relevance of family inclusion.

In summary, family inclusion in the treatment and recovery process may at times be problematic because you are often seeing family members in pain or crisis, but the potential benefits most often outweigh the potential risks.

1. Research has consistently demonstrated that constructive family inclusion, in which the family is kept informed, involved, and not blamed for the illness, is critical to good psychiatric care, as it reduces relapse and improves recovery.

2. Whether they live with the individual or not, family members are often aware of the person's evolving health or illness, serving as an early warning system and supporting treatment adherence.

3. Family inclusion facilitates social support, an often cited principle of recovery.

4. Serious psychiatric illness is a source of caregiver burden, which often produces depression, anxiety and burn-out in the caregivers. They may need support for their own welfare.

Curriculum/competencies

This curriculum is geared to adult families; that is, families where both the individual and caregivers are late adolescents or adults. While there may be dependent children in the families, they are not designated as the primary individual. Family work in the context of child psychiatry requires additional skill sets and supports. However, since non-symptomatic children with parents or siblings with psychiatric illness may need support and education, several relevant resources are noted in the bibliography section of this document. This curriculum is not designed to produce experienced family therapists. Family therapy is seen as only one of many potential family inclusive interventions, and can be delivered by a variety of trained persons.

Scope and Nature of Potential Family Interventions

Family intervention may take many forms. From least to most intensive, they include:

- The basic family interview (assessment, check-in) to gather information and answer questions. This may be done with or without the individual present.

- Family consultation, focused on the family's needs and questions, to determine the appropriate type of help. This is commonly done without the individual present.

- Family education, either individually or in family workshops, which usually does not include the individual with the illness.

- Family support groups for peer support.

- Family Psychoeducation, which commonly includes the individual and family members, either one-to-one or in multi-family group format.

- Couples or Family therapy, if necessary and agreed upon by all parties, preferably done by therapists with knowledge of the individual's specific disorder.

The majority of families want access to health care providers, basic information on how to help their loved ones and reduce their own caregiver burden, and information about the causes and course of the illness, the

prognosis, and the treatment plan. Family therapy should not be assumed to be the first or most common intervention, but should be available if appropriate and agreed to by all concerned. It is best done by a family therapist with expertise in treating the relative's particular disorder. While individuals may initially reject the idea of any form of family involvement, it is important for therapists to explain the benefits of family collaboration and return to the issue periodically.

COMPETENCIES NEEDED

Specifically, the Psychiatrist must have the following Attitudes, Knowledge and Skills regarding families:

ATTITUDES:

1. Demonstrate empathy, interest in, respect for all family members, and balanced concern for multiple points of view. The Psychiatrist must accept differences in perspectives on the problem and solutions as normal and potentially useful phenomena.

2. Work collaboratively with families as allies, assessing and building on their strengths, as well as having empathy for their stresses.

3. Understand the meanings of psychiatric illness for individuals and families, including issues of stigma. We would hope that psychiatrists would help to reduce stigma by speaking appropriately, publicly or privately, if they have had a personal experience with psychiatric illness.

4. Cultural humility and acceptance of the fact that family norms and practices are not the same for everyone but are heavily determined by specific cultural and subcultural beliefs. Culture and family are inextricably connected

5. Acknowledge realistic limitations while maintaining an attitude of hopefulness. Show patience and willingness to take a long term perspective. Understand that the process of illness and recovery is non - linear and takes time, and that family members, and therapists may be at different points in the process.

6. Openness to, and use of, models of treatment that are not limited to the medical model, but integrate motivational interviewing, recovery, psychiatric rehabilitation, various forms of psychotherapy, and community integration with medical management.

KNOWLEDGE

The Psychiatrist is expected to demonstrate knowledge of family factors as they relate to psychiatric and medical disorders, based on scientific literature and accepted standards of practice. The Psychiatrist is expected to demonstrate knowledge of the following:

1. Basic concepts of systems theory, applicable to families, multidisciplinary teams in clinical settings, and medical/government organizations impacting the individual and doctor.

2. Principles of adaptive and maladaptive relational functioning in family life; family organization, communication, problem solving, emotional regulation and resilience.

3. Normal couple and family development over the life cycle and the importance of multi-generational patterns, understanding that "normal" may vary within culture, community and level of acculturation to mainstream American culture.

4. The interrelationship between specific psychiatric disorders and family dynamics, and how these interrelationships change throughout the family life cycle. In particular, this includes understanding of the grieving process in families who are newly introduced to diagnosis, subjective and objective burdens of different family subsystems (parents, siblings, spouses, and children) in families where there is long term illness, issues of strength and gratification derived from caregiving, issues of stigma for both the individual and family members.

5. Factors of age, gender, class, culture and spirituality that affect family functioning.

6. The variety of family forms (single parent, stepfamily, same-sex parents, etc.).

7. Special issues in family life including divorce and remarriage, family member loss from death or ambiguous loss, immigration, illness, sexuality, secrets, affairs, relationship/family violence, alcohol and substance abuse.

8. Ways of supporting and developing the parenting skills of the individual, and appropriately providing their children with education and support without pathologizing them.

9. How poverty, violence, trauma, immigration, racism and racial disparities affect and inform family beliefs and practices.

10. How illness related events affect the functioning of all family members.

11. Trauma connected to illness related events, e.g. violence, victimization, disappearance of a family member, iatrogenic events (treatment-caused problems).

12. Legal and emotional issues regarding confidentiality when dealing with family members.

13. The place of peer/family resources such as national and local support groups, on-line support groups, etc. in supporting those in recovery and their families.

14. Relationship of families to larger systems, e.g. schools, work, health care systems, government agencies.

15. An appreciation for the differences in types of interventions to determine what is best for a particular family and community setting.

SKILLS

1. Effectively negotiate with individuals with illness about whom to include in their treatment and recovery process, while following HIPAA and state confidentiality laws and procedures. Effectively invite family members to collaborate, keeping appropriate confidentiality. Connect appropriately with others in the individual's social support circle and service providers.

2. Demonstrate the ability to conduct a family interview, and complete an assessment and formulation that includes family factors. Operational family interview skills include:

    a. Meet with significant family members. Be able to present a rationale to individuals and family members to include families in the recovery process, especially when they are unsure about the process or have a history of difficult relationships with previous mental health providers.

b. Negotiate effectively with the individual about whom to involve in their care and what information can be discussed, balancing the need for family involvement with appropriate confidentiality.

c. Foster a therapeutic alliance with all family members by instilling feelings of trust, openness and rapport. If appropriate, consider the uses of appropriate and relevant self-disclosure to build trust and respect if one has had mental illness in one's own family.

d. Gather an appropriate history of both the individual and the family, as well as an understanding of current difficulties, family dynamics, and current strengths and resources.

e. Develop a description of the issues, or formulation if appropriate, that can be conveyed to the individual and family and used as a basis for treatment planning.

f. Effectively discuss with family how poverty, violence trauma, immigration, racism and racial disparities affect and inform the family's life.

3. Develop a plan for family connection to resources or services, both professional and peer, in the community. This plan might include anything from occasional check-ins, to support groups, to family therapy.

4. Conduct a family consultation and family education workshop. Conduct or participate in a family psychoeducation group or workshop.

5. Be familiar with family therapy techniques, enough to refer appropriately. This should include some experience in the use of basic family therapy skills, such as teaching problem solving and communications techniques that are helpful in families with an ill family member.

6. Consider and learn to use, when appropriate, alternatives to standard office meetings. For example, phone sessions and videoconferencing are becoming more commonly used strategies when families have transportation issues, and home visits, when possible, are a helpful window into the individual and the family's context.

7. Locate and work effectively with interpreters for non- English speaking families.

WEBSITES AND LINKAGES FOR ADULT AND/OR CHILDREN OF THE MENTALLY ILL:

The following websites have major resource lists that could be used by anyone wanting references. Each of these websites has an extensive list of resources for professionals and families.

- www.psych.org (American Psychiatric Association: works to advance the profession and promote the highest quality care for patients and their families.)

- www.apa.org (American Psychological Association: is a scientific and professional organization that represents psychologists in the United States).

- www.paplc.org (Pennsylvania Psychiatric Leadership Council: a change agent working to increase public service psychiatry in the state of Pennsylvania.)

- www.NAMI.org (National Alliance on Mental Illness: grassroots mental health organization dedicated to building better lives for millions)

- www.namipamainline.org (National Alliance on Mental Illness, Main Line Affiliate)
- www.frnfamilies.org (Family Resource Network: for family members/significant people, professionals and others supporting someone with a behavioral health disorder. Included are links to Philadelphia, Pennsylvania, National, and Military resources)
- www.mentalhealthpartnerships.org/program-objects/2017/5/12educational-family-support-groups (Mental Health Mental Health Partnerships, formerly Mental Health Association of Southeastern PA: for examples of educational family support groups and workshops.)

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