

# The Support and Family Education (SAFE) Program: Mental Health Facts for Families

Michelle D. Sherman, Ph.D.

## ***Introduction by the column editors:***

Although more than half of adults who have a serious and persistent mental illness live with their families (1), less than 10 percent of families of outpatients with schizophrenia receive support or education (2). Such services fail to be provided despite the fact that family participation in well-designed psychoeducational programs has been documented as reducing relapse and readmission rates, improving involvement and adherence to treatment (3,4), and producing positive outcomes for caregivers, including improved morale, better knowledge of mental illness, enhanced feelings of empowerment, and reduced worry and displeasure about their loved ones (5,6). Moreover, the vast majority of mental health providers believe that educating families about mental illness and its treatment is very important (7). Why, then, do so few clinicians commit the requisite time and energy to providing these effective and much appreciated services?

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*Dr. Sherman is director of the family mental health program at the Oklahoma City Veterans Affairs Medical Center and is also affiliated with the South Central Mental Illness Research, Education, and Clinical Center (MIRECC) and the department of psychiatry and behavioral sciences at the University of Oklahoma Medical Center. Send correspondence to her at 921 North-east 13th Street (116A), Oklahoma City, Oklahoma 73104-5028 (e-mail, michelle.sherman@med.va.gov). Robert Paul Liberman, M.D., and Alex Kopelowicz, M.D., are editors of this column.*

There are four sources of obstacles to the adoption of a psychosocial treatment innovation such as family psychoeducation. The obstacles stem from the psychoeducational program itself (for example, its unfamiliarity and conflicts with the existing treatment ideology); the clinicians (lack of training, experience, and competence in functioning as “teachers” with families); the host agency or institution (countervailing priorities and lack of administrative support); and the process of dissemination (lack of knowledgeable consultants or enthusiastic “champions” or advocates for family psychoeducation and lack of user-friendly curricula or program manuals). These obstacles can be overcome when practitioners and family members work together as stakeholders in the benefits that accrue from ongoing psychoeducation (8).

In this month’s column, Michelle Sherman, Ph.D., presents the family psychoeducation program she created at the Oklahoma City Veterans Affairs (VA) Medical Center. Dr. Sherman describes how she tailored the intervention to the VA population, thus generating the support not only of the clients and their families but also of her fellow clinicians and the VA administration. Her work demonstrates that when mental health clinicians devote time, energy, and expertise to supporting and educating caregivers, significant benefits emerge for both clients and their families.

The Support and Family Education (SAFE) Program: Mental Health Facts for Families is a 14-session family psychoeducational curriculum created in a Department of Veterans Affairs (VA) setting (9). A 90-minute workshop is provided once a month, and participants can attend whenever they wish. The program has six major goals: to teach caregivers about the symptoms and course of mental illness; to afford family members the opportunity to ask questions about psychiatric disorders and treatment options; to reduce the stigma of mental illness by providing a forum in which to discuss concerns and obtain support from peers; to publicize the availability of mental health services at the medical center; to help family members understand the importance of early intervention for their loved one and of open, timely communication with providers; and to link family members with opportunities for support both at the medical center and through community resources, including the local affiliate of the National Alliance for the Mentally Ill (NAMI).

The SAFE program has several distinct features. First, in contrast with programs that target a specific mental illness, the SAFE program is not diagnosis specific. Family members with quite different home environments and relationships with clients can apply the information provided to their specific situations and learn from each other. Second, the program includes one session that focuses specifically on posttraumatic stress disorder (PTSD), a common diagnosis in the veteran population and an often neglected comorbid diagnosis among other clients,

### ***Workshop sessions in the SAFE program***

What causes mental illness?  
What can I do when my family member is depressed?  
What can I do when my family member is angry or violent?  
Communication tips for family members  
Limit setting and boundaries with family members  
How can I take care of myself as a caregiver?  
Rights and responsibilities of clients, family members, and professionals  
What do we tell our children, friends, and other relatives about mental illness?  
Stress-busting tips for family members  
What to do when your help is turned away  
Dos and don'ts in helping your family member  
Tips to help make the holiday season pleasant  
Posttraumatic stress disorder and its impact on the family  
Schizophrenia and its impact on the family

including those with schizophrenia. Although other psychoeducational programs may offer information about anxiety disorders, the specific challenges surrounding PTSD in the family have been ignored.

Third, in contrast with many programs that are led by trained volunteer family members, the SAFE program is facilitated by mental health professionals. Although peer education can be effective and economical, professionals usually have broader knowledge, better group facilitation skills, and greater institutional support. Fourth, a psychiatrist attends part of every workshop to answer questions about medications. Finally, in contrast with the time-limited nature of many family curriculums, the SAFE program is offered on an ongoing basis and families may attend as frequently as they think they need to.

Publicity for the program is an important, ongoing, and time-consuming task that is accomplished by posting monthly flyers throughout the hospital; distributing pamphlets to clients' families on admission to the inpatient psychiatric unit; adding a blurb announcing the next workshop on all appointment letters from the outpatient mental health clinic (which averages 18,000 appointments per year); making regular presentations in various mental health programs and groups; and publishing articles in the newsletters of state psychological and psychiatric associations and veterans' organizations and on VA Web sites.

### **Workshop format**

Each 90-minute workshop has three sections: group discussion and support, a didactic presentation, and a question-and-answer period with a psychiatrist. Caregivers are given a participant notebook at their first workshop session, which contains useful newsletters, pamphlets, and lists of resources, including diagnosis-specific books, Web sites, and community resources such as NAMI. Family members may also borrow books or videos from the SAFE program's resource library.

At the beginning of every workshop, caregivers complete an information form (created by and available from the author) that assesses their experiences in the past month regarding confidence in dealing with the client's mental illness, the number of days the caregiver had difficulty coping with the client's behavior, the level of the caregiver's distress about the client's well-being, the caregiver's understanding of mental illness and knowledge of VA treatment resources, and the caregiver's ability to take good care of him- or herself. In addition, participants indicate the percentage of mental health appointments that the client attended in the previous two years. This information is used by the workshop leaders to individualize and address personal concerns during the sessions.

Each session begins with a review of goals of the program and confidentiality issues. Given that caregiving is often an unappreciated, difficult, and

lonely job, each participant's dedication to his or her ill relative is affirmed. Because the participants' presence at the workshop signifies a desire to know more about how to help their loved ones, the caregivers are genuinely acknowledged for their commitment. Next, family members have an opportunity to introduce themselves, including their reason for attending the session. Participants often use this time to update the group on their current challenges and successes.

A 30- to 45-minute didactic presentation and discussion follows the group support period. Each session has a specific topic; the titles of the sessions are listed in the accompanying box. Detailed lesson plans for each session include ready-to-present text containing didactic information on the session's topic, group activities such as role plays, discussion questions, videotape clips, and handouts. For example, the lesson plan for the session on the causes of mental illness includes ways to stimulate a group discussion of the common myths surrounding mental illness, a presentation of the biopsychosocial and diathesis-stress models, and a viewing of a brief videotape on the biological contributions to mental illness.

Participants next have an opportunity to ask a psychiatrist questions about medications. The psychiatrist does not give any specific advice or recommendations but answers questions about such issues as the purpose of specific drugs, common side effects, and possible drug interactions.

A representative from the local NAMI affiliate frequently attends the sessions. She describes the mission and activities of NAMI, addresses advocacy issues, and publicizes community events. The sessions close with the completion of evaluation forms and the distribution of small gifts—for example, candles, bookmarks, and journals—to signify the leaders' appreciation of the participants' commitment to their ill relatives.

Because client involvement in family psychoeducation can inhibit the educational process for families (10), clients are not invited to the SAFE workshops. Consequently, family members can freely share their struggles and concerns without worrying about possibly

offending their loved ones. Clients receive their own psychoeducation in each of the VA medical center's mental health treatment programs.

### Participation and evaluation

During the first three years of the SAFE program, 115 individuals attended the program. The number of participants per session ranged from four to 25 (mean $\pm$ SD=9 $\pm$ 4.3), with attendance steadily increasing over time. More than three-quarters of the participants were female, more than half were in their 40s and 50s, and almost all were Caucasian. Almost half were the clients' wives. The clients' diagnoses varied widely, including PTSD, major depression, bipolar disorder, and schizophrenia. Most of the participants' ill relatives had struggled with mental illness for many years, and almost half of the caregivers reported having extensive or all-day contact with their family member.

Of the 115 persons who attended the SAFE program during the first three years, almost two-thirds attended more than one session. Regular attendees attended an average of 6 $\pm$ 4.5 sessions. Barriers to regular attendance have included geographic distance, lack of transportation, and inclement weather. Even though the program is held only once a month and the composition of the group varies by session, participants quickly connect with one another, freely providing support both during and between sessions.

The participants who are also VA employees did not complete the monthly assessments; therefore, the following data include only the nonemployee caregivers (N=90). Pearson correlations were examined between the number of workshops attended and the other variables assessed at each session. The number of sessions attended was significantly correlated with understanding of mental illness ( $r=.34$ ,  $p<.01$ ,  $N=74$ ) and with awareness of VA resources ( $r=.51$ ,  $p<.001$ ,  $N=72$ ). Also, a strong positive relationship was found between the number of sessions attended and improvements in caregivers' ability to perform self-care activities ( $r=.42$ ,  $p=.02$ ,  $N=71$ ).

At the end of every session, the participants completed four 5-point Lik-

ert-scale items assessing their satisfaction with the workshop. The overall mean score was 18 $\pm$ 2.6 out of a possible 20 ( $N=314$ ). The participants also indicated that receiving handouts, talking to peers, and asking questions of doctors were especially helpful. The caregivers often expressed great appreciation for the availability of the program. For example, one caregiver stated, "I've been looking for a program for myself for five years in three different states, and this is the first one I've found!" Clinicians at the medical center have also responded positively to the program, indicating that caregivers who attend the SAFE program are more involved in the client's treatment.

### *Afterword by the column editors:*

Mental health treatment of persons with serious and persistent mental disorders will undoubtedly undergo major changes in the 21st century, and including families will be essential in providing comprehensive and effective care. Professionals' increasing commitment to involving families attests to the continuing shift by practitioners away from the anachronistic tendency of blaming and neglecting families toward viewing caregivers as potentially competent, supportive collaborators. When providers dedicate their time and expertise to educating caregivers, significant benefits ensue for clients, families, and practitioners.

One barrier to engaging caregivers in the treatment process is the dearth of relevant, effective, and easy-to-use educational materials. To overcome this obstacle, more than 130 copies of SAFE manuals have been distributed to VA networks across the country, facilitating the adoption of the program. In addition, the University of Oklahoma Information Technology Group created a Web site (<http://w3.ouhsc.edu/safeprogram>) that contains the entire manual. The site includes detailed outlines of the 14 sessions, specific publicity strategies for attracting family attendance, and a literature review attesting to the positive impact of educating families. The Web site has been available since December 2000 and has received more than 8,000 hits from 40 U.S. states and 30 countries.

Although some practitioners might

consider family psychoeducation in VA facilities as having limited appeal because of the alienation or separation of many veterans from their families, a more optimistic appraisal of the cost-effectiveness of psychoeducation would develop if practitioners and clinical managers grasped the full potential of this approach. Psychoeducation can be offered to a wider audience, including clients themselves, professional and paraprofessional staff who work in VA facilities, and operators and staff from community residential programs where many veterans with mental illness live. Furthermore, the practical and attractive format and curriculum of Dr. Sherman's program can be an effective vehicle for reaching out to many family members for whom more conventional efforts have failed. ♦

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