The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

HIV Prevention in the Clubhouse

HIV prevalence among people with severe mental illness is roughly ten times the national average. Inpatient and outpatient workshops in clinical settings have improved knowledge, attitudes, and risk-reduction behaviors in this population.

This project took a successful manual-based HIV prevention intervention from the inpatient setting and adapted it to the clubhouse setting in the south Bronx in 2006 and 2007. Clubhouses are traditionally refuges from the medical model of health care, and education is a central pillar of clubhouse activities. The clubhouse can be an indispensable site for preventive health education in the community. This is the first report of a community-based HIV prevention program in the Bronx and the first such report from any clubhouse in the United States.

Accurate knowledge about HIV transmission is already at high levels. This workshop focused on building skills through hands-on, group, and role-play activities to reduce anxiety and improve decision making in real-life situations. Activities included practicing condom use and role playing various scenarios, such as discussing past risky behaviors with a new sexual partner, assertively negotiating condom use with a sexual partner, deflecting peer pressure to use alcohol and drugs, pursuing safe sex practices while intoxicated, and managing coercive situations.

Workshop sessions were advertised, coordinated, and facilitated by a family and social medicine resident with medical school experience working in the clubhouse setting. The clubhouse director collaborated on advertising at affiliated residential sites in the month leading up to each new round of the workshop. The director also attended some of the first workshop sessions to help integrate the workshop facilitator into the clubhouse community.

The south Bronx clubhouse is linked to five geographically disparate residential sites with a total clientele of roughly 360. During three offerings of the workshop over 18 months, 47 consumers participated, representing roughly 13% of the target population. The workshop was consistent with participation rates at other unrelated clubhouse activities.

The workshop initially consisted of ten weekly sessions with incentives that included public transportation passes, beverages, and condoms at each session. Classes were scheduled as a lead-in to weekly free clubhouse dinners. In order to improve attendance and decrease turnover, the workshop was reduced to six sessions, and a modest attendance prize was given at the final session. Through these interventions, average attendance increased from five to seven persons per session, and the average number of week-to-week returning participants jumped from three to six. After steady attendance improvements over three iterations, a fourth round offered within two months of the previous session failed to recruit participants, suggesting that the workshop would sustain semiannual repetition but not quarterly repetition.

With institutional review board approval from Montefiore Medical Center, we conducted anonymous surveys during the first and last sessions of each round of the workshop. Questions for the survey were borrowed from previously validated survey instruments in the domains of demographic characteristics, risk factor inventory, knowledge, self-efficacy, and customer satisfaction. Entrance and exit surveys were matched by mother's birth date, allowing preservation of anonymity. Transit passes with a value of $10 were given as an incentive to participants completing both the entrance and exit surveys. More than 40 surveys were completed, but only seven participants completed both the entrance and exit surveys. Respondents were mostly single, African American, and ages 25 to 49, with roughly an equal number of men and women. Despite promising trends in knowledge (from 68% to 80%) and self-efficacy (from 77% to 84%), the sample was too small to analyze.

Future directions for the project include expansion of the curriculum to include other preventive health topics such as nutrition. Success of the workshop at the clubhouse led to an invitation to train staff in HIV prevention at affiliated residential sites. The initial group that attended the workshops may not be the group most at risk, and expansion into the residential sites would therefore be vital. Links were established with Montefiore's medical school affiliate, Albert Einstein College of Medicine, in order to provide an ongoing, reliable source of workshop facilitators.

HIV is a serious yet neglected problem among people with severe mental illness. Clubhouses are an underutilized facility for preventive health education in the community. This intervention deserves further evaluation as a model for dissemination to clubhouses across the country.

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The Family Member Provider Outreach Program

Many benefits of family participation in evidence-based interventions for persons with serious psychiatric illnesses have been reported. The American Psychiatric Association's (APA's) 2004 best-practice guidelines for treatment of schizophrenia and the Schizophrenia Patient Outcomes Research Team (PORT) 2003 treatment recommendations urge the use of family services; in addition, APA's best-practice guidelines for bipolar disorder recommend family education. Unfortunately, many efforts to implement family-based services have resulted in disappointing numbers of involved families.

Evidence-based family interventions typically include an initial engagement phase, in which the clinician, not the consumer, assumes primary responsibility for inviting relatives to join the treatment team. We have developed a brief, manualized intervention, the Family Member Provider Outreach (FMPO) program, that orients consumers and relatives to the possibility of including families in treatment and encourages consumers to invite relatives to become involved in the consumer's care. FMPO is consistent with a recovery orientation in emphasizing consumer self-direction and empowerment. It incorporates an individualized and consumer-directed approach and is grounded in the belief that in most cases consumers can and should be responsible for deciding if and how their relatives should be involved in their treatment and for inviting them to participate should this be desired. The family member provider (FMP), who facilitates the intervention, is a relative of a person with serious psychiatric illness and has mental health professional training. This dual role helps the FMP to bridge the gap between the family, the consumer, and the care team. The FMP may or may not be a member of the consumer's specific mental health treatment team.

FMPO consists of two phases offered over approximately two months. Sessions are typically offered in the clinic, but they can be offered in the home.

In phase 1 consumers are offered two to three 45-minute individual sessions with the FMP. The FMP gets to know the consumer and uses motivational interviewing techniques (open-ended questions, values clarification tasks, and decisional balances) and behavioral strategies to help the consumer make deliberative decisions about involving the family in his or her care. The consumer also practices extending an invitation to relatives to join phase 2 of the intervention, should this be the consumer's decision. Potential obstacles to involvement are discussed for resolution. Consumers end phase 1 with a decision about whether to invite family to phase 2.

In phase 2 consumers' families are offered two to three 45-minute individual sessions with the FMP to help the family connect with the consumer's treatment team. The FMP uses motivational interviewing techniques to direct the conversation and provides basic information on psychiatric illness (including facts about the illness, medication, and relapse prevention). Families receive information about contacting the treatment team and solving potential problems (such as staff unavailability and concerns abut confidentiality). Families are also provided information on local support and educational groups. The consumer may or may not be present at these sessions.

From May 2005 to April 2006, we conducted a pilot of FMPO with 17 consumers receiving treatment at the Veterans Affairs (VA) Maryland Health Care system. Their families had not had contact with the treatment team for at least six months. Informed consent was obtained from participants, and all procedures were approved by the relevant institutional review boards. The FMP was a doctoral-level clinical psychologist completing a fellowship at the VA Maryland Health Care System who had a family member with serious psychiatric illness. Seventy-five percent of the participants were male, and 70% were African American. Their mean ±SD age was 48.8±7.1. Diagnoses included 11 consumers (65%) with schizophrenia or schizoaffective disorder, four (24%) with bipolar disorder, and two (11%) with major depression.

All clinician notes were reviewed to assess whether any mental health clinician had contact with the family, in person or via telephone, and whether the family attended monthly support groups at the VA facility during the six months after the intervention. After participation in FMPO phase 1, 13 of 17 (76%) consumers invited their families into phase 2 of the program. After completing the FMPO program, 11 of 17 families (65%) had contact with the treatment team and five of 17 (29%) attended at least one monthly support group at the VA facility.

Limitations to our findings were that our sample was small; we had only one FMP facilitator, so we were unable to establish the generalizability of our results to other providers; and we had data from only the active treatment group. Nevertheless, our data suggest that the FMPO program may be a gateway to developing successful collaborations with families of persons receiving mental health care for serious psychiatric illnesses. We are now evaluating the intervention in a randomized controlled trial.

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