Family Psychoeducation

Evidence-based practice

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…an opportunity for practitioners, consumers, and families to better understand and overcome the symptoms of mental illness, while maintaining hope.

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Why Focus on FPE?

- **People want information to help them better understand the illness process.**

- **Consumers generally want and need the support of their families.**

- **Families usually want to be a part of the consumer's recovery.**

- **People want to develop skills to get back into the mainstream of life.**

Positive Outcomes from FPE

- **The consumer _and_ family work together towards recovery.**

- **Can be as beneficial in the recovery of schizophrenia and severe mood disorders as medication.**
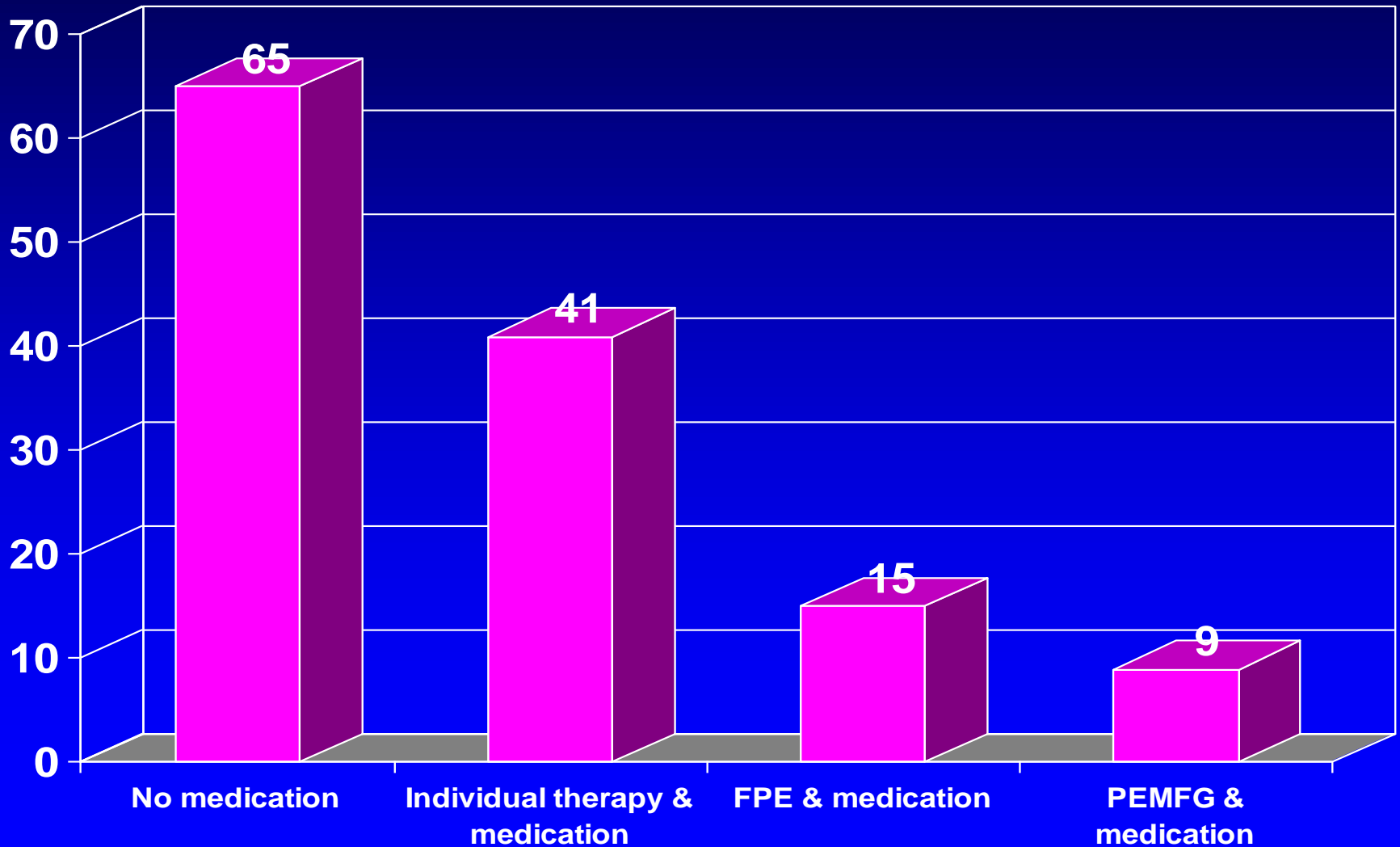
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Research with Family Psychoeducation

- **This treatment is an elaboration of models developed by Anderson, Falloon, McFarlane, Goldstein and others.**

- **Outcome studies report a reduction in annual relapse rates for medicated, community-based people of as much as 50% by using a variety of educational, supportive, and behavioral techniques.**

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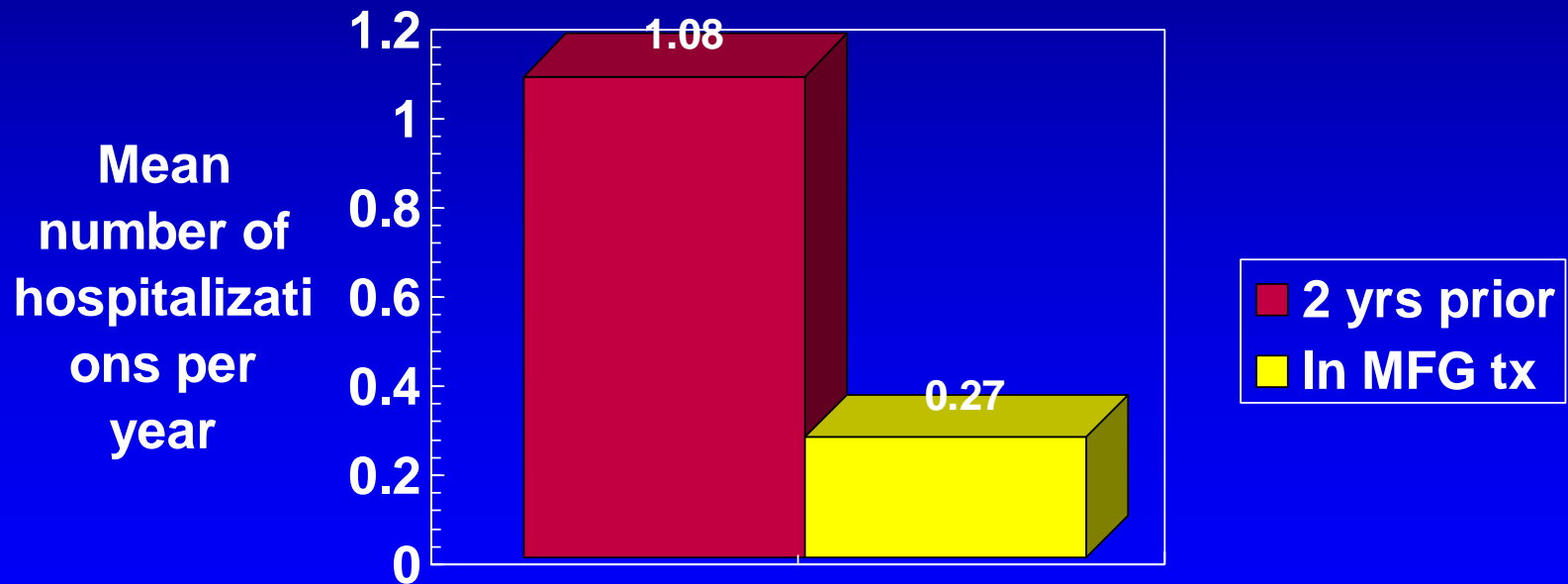William R. McFarlane, MD

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Research with Family Psychoeducation

- **Functioning in the community improves steadily, especially for employment.**

- **Family members have less stress, improved coping skills, greater satisfaction with caretaking and fewer physical illnesses over time.**

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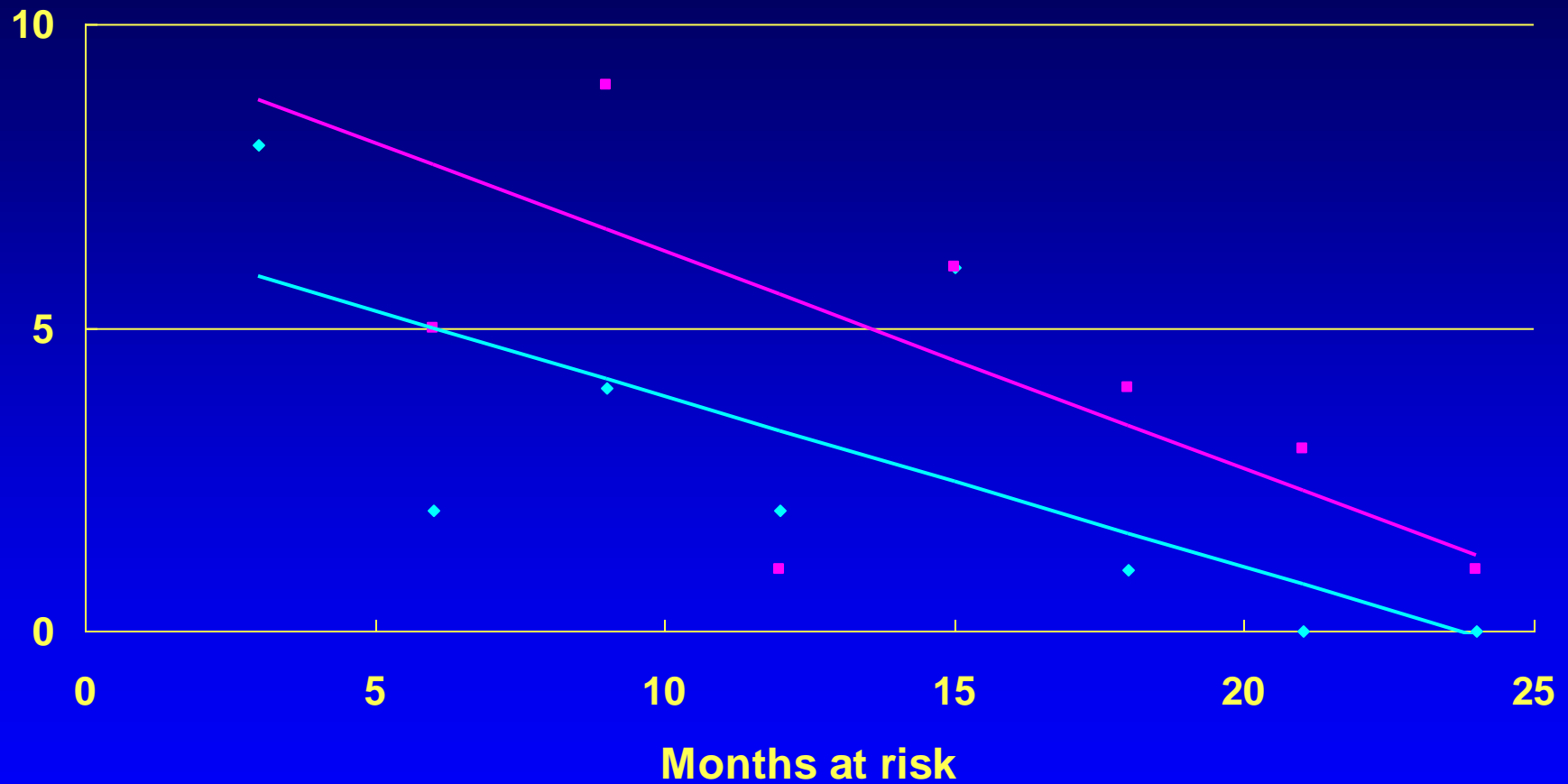Evidence-Based Practices

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Relapse outcomes in clinical trials

Hospitalizations before vs. during treatment

Mean number of hospitalizations per year

- 1.08 — 2 yrs prior
- 0.27 — In MFG tx

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Risk for relapse over two years

# of relapses

Months at risk

N: MFG=83; SFT=89

♦ MFG ■ SFT —— Linear (MFG) —— Linear (SFT)
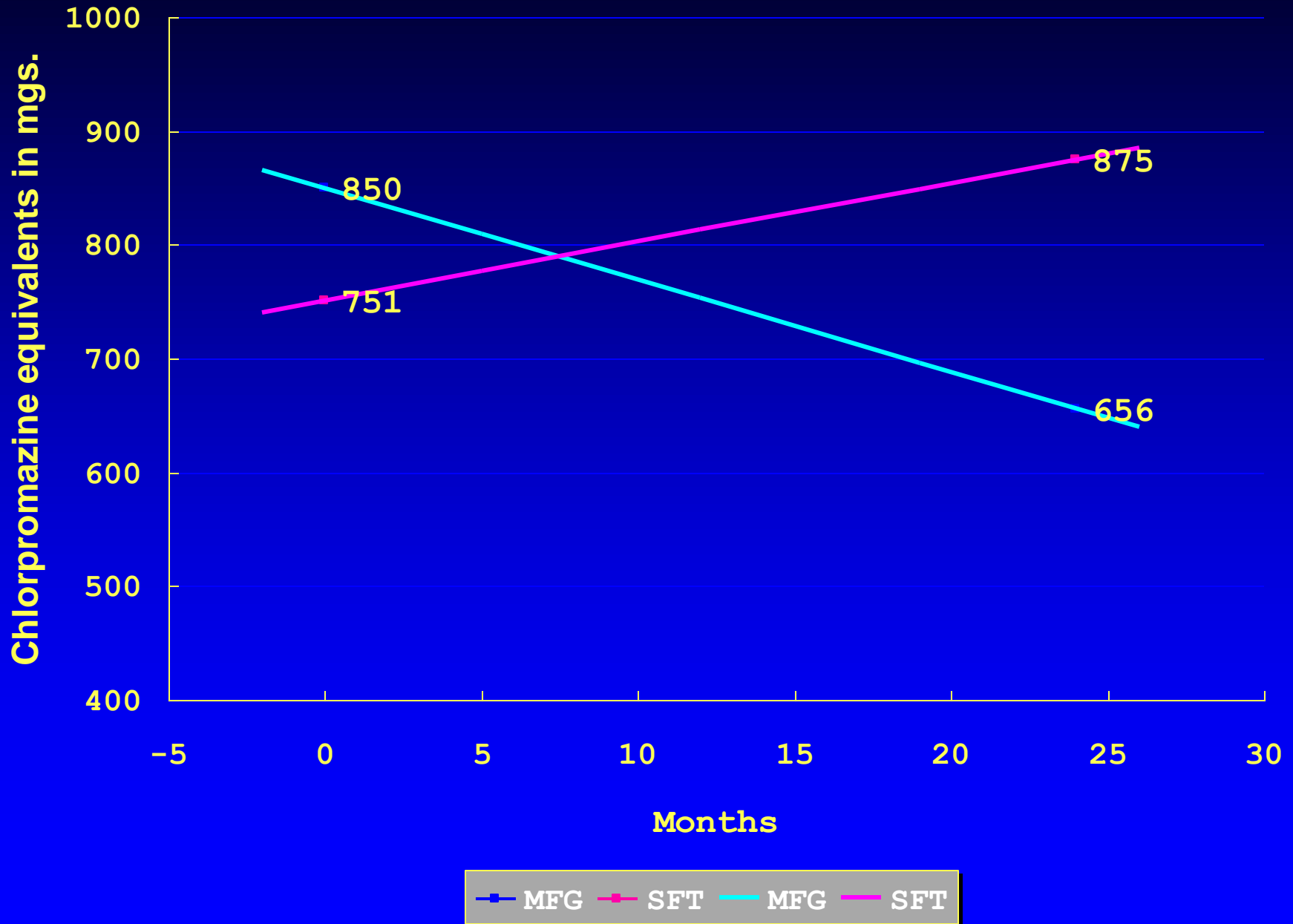
Risk factors and treatment type:
Effects on two-year relapse rates

Cumulative two-year relapse rate (%)

Legend: MFG (cyan), SFT (magenta)
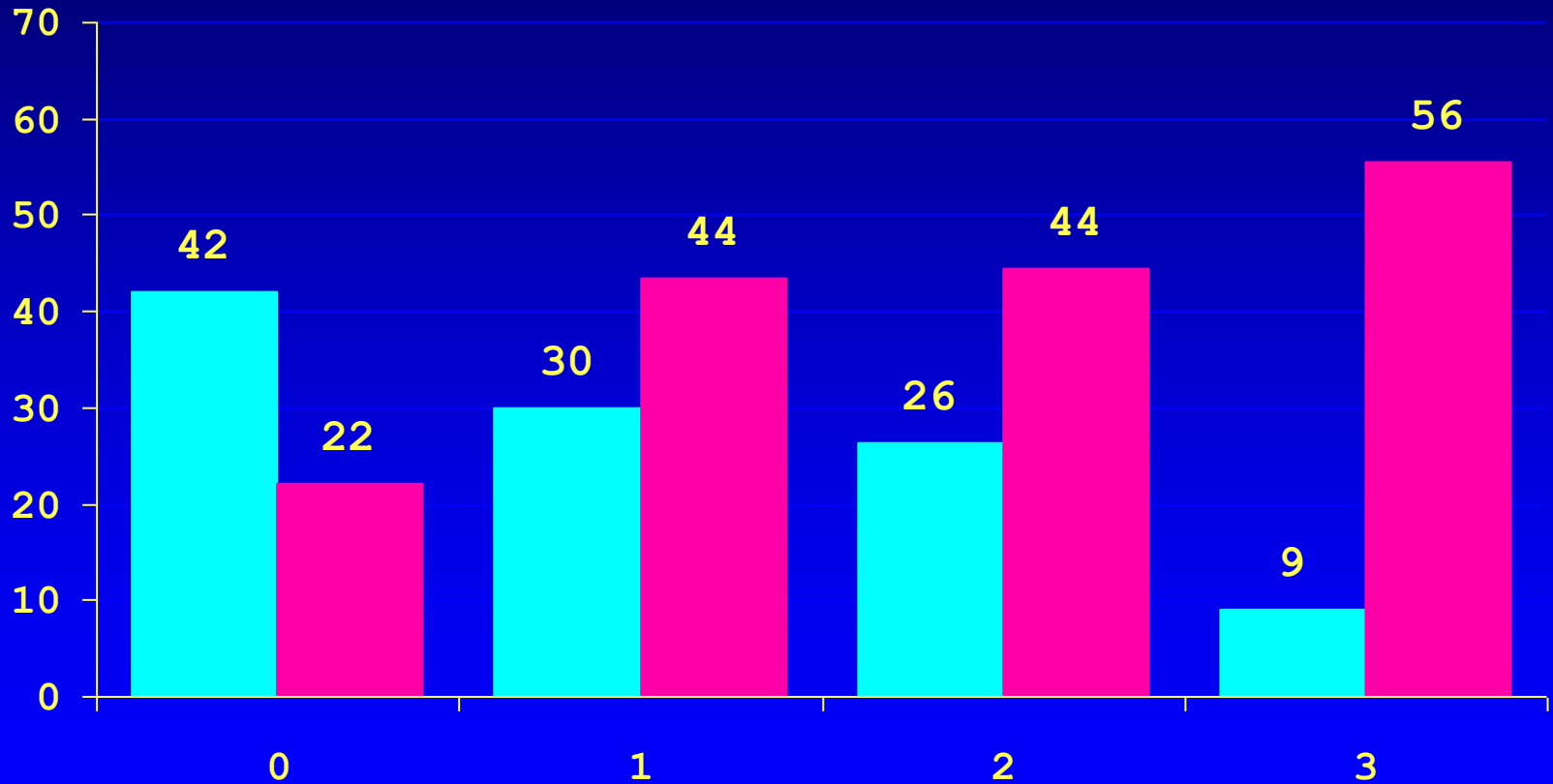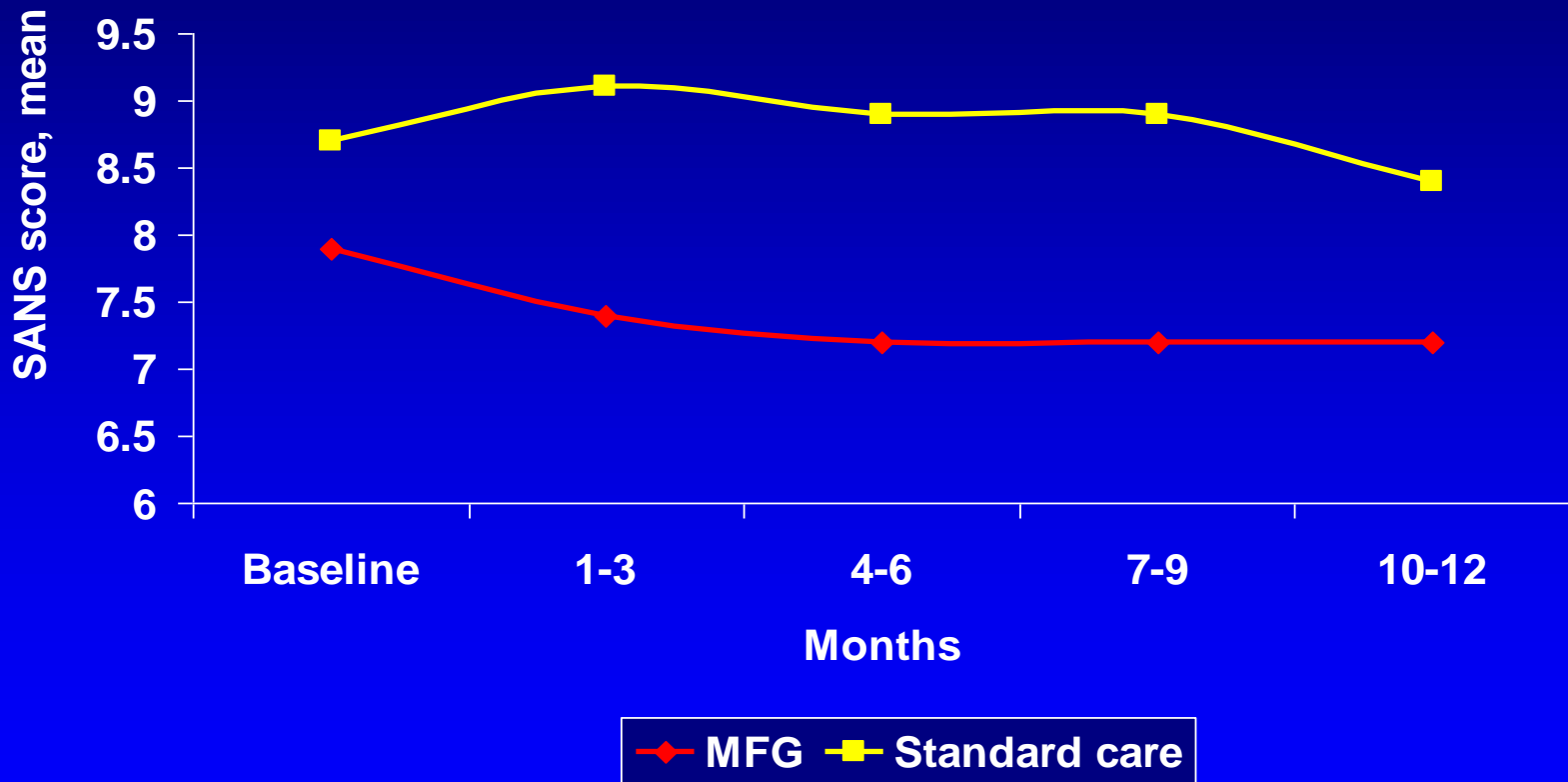
Number of factors, any combination: High EE, high BPRS, white race

Risk factors = high BPRS, high EE, white race

Negative symptom outcomes: MFGs vs standard care

MFG vs SC: p<.05, all f/u time points

Dyck, et al., 2000

Process and functional outcomes

Participation in MFGs	Patients: Full: 56% Partial: 40%	Families: Full: 88% Partial: 12%
Working at present	Full time: 28%	Part time: 24%
Substance abuse	At start: %28	Present: %12

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Family influences on work

Modeling

Information

Encouragement

Buffering

Guidance

Adjusting expectations

Ancillary support

Cueing

Personal connections

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Rehabilitation effects of multifamily groups

- **Reducing family confusion and tension**

- **Tuning and ratification of goals**

- **Coordinating efforts of family, team, consumer and employer**

- **Developing informal job leads and contacts**

- **Cheerleading and guidance in early phases of working**

- **Ongoing problem-solving**

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Work Outcome

Employed at baseline   **Employed at 2 years**

17.3%   **29.3%**

(p=.001)

Gain in % employed

PEMFG   16%

PESFT   8%

(n.s.)

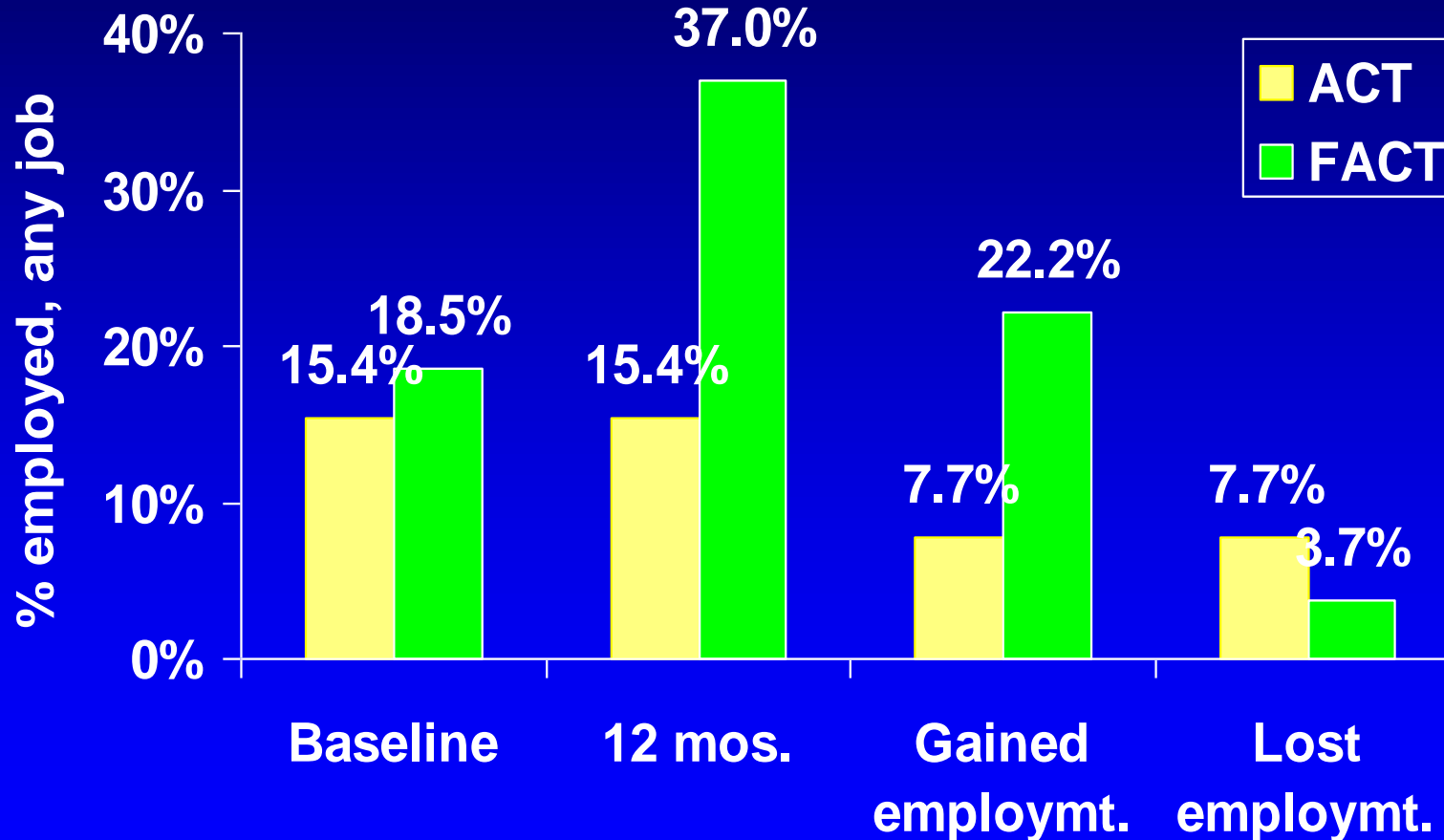Evidence-Based Practices

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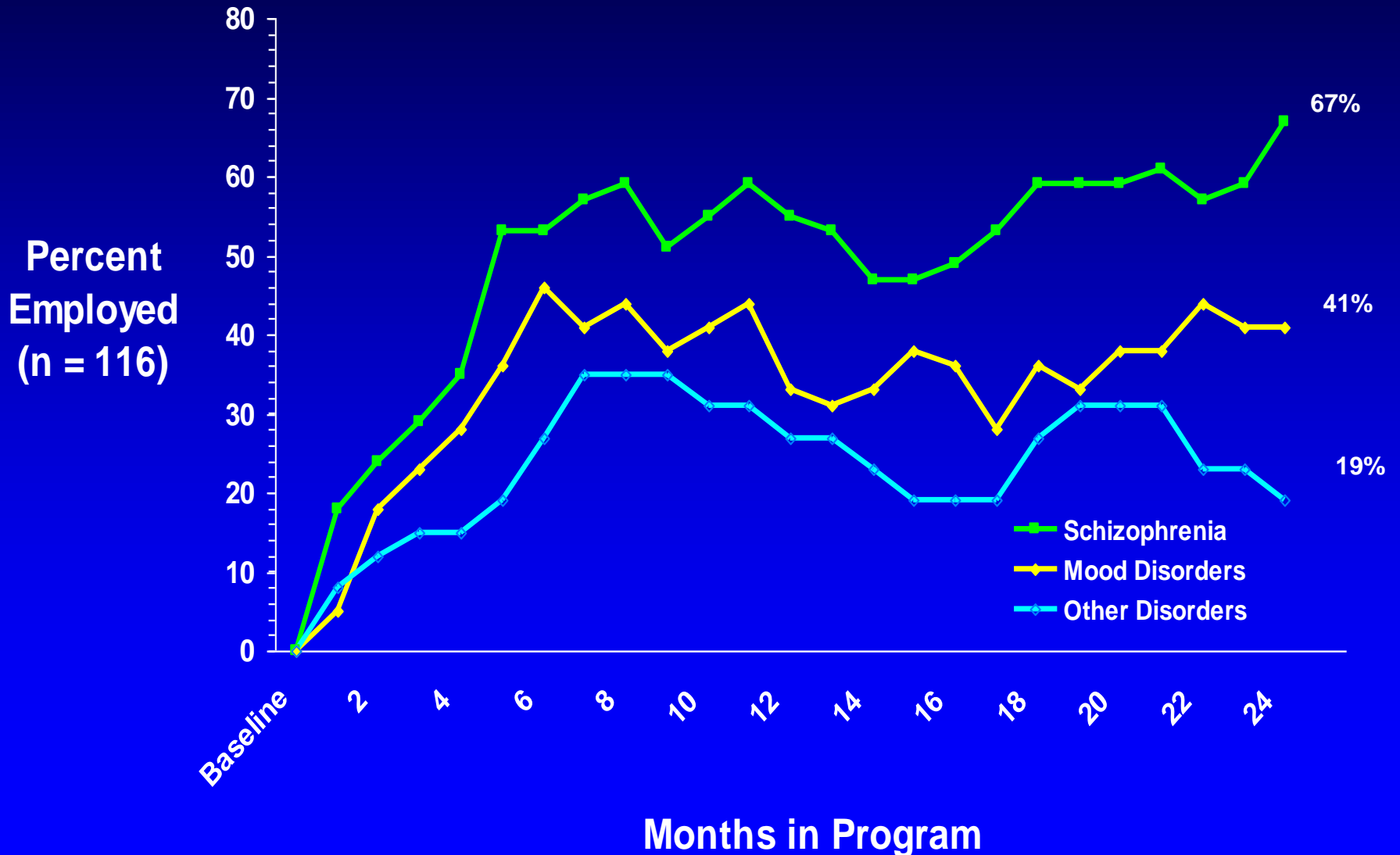# Family-aided Assertive Community Treatment (FACT):
A clinical and employment intervention

- Psychoeducational multifamily groups
- Clinical case management using ACT principles and methods
- Integrated, multidisciplinary teams
- Supported employment
- MH Employers' Consortium
- Cognitive assessments used in job accommodation

Employment rate in FACT combined with supported employment, by diagnosis

Percent Employed (n = 116)

Months in Program

Schizophrenia — 67%
Mood Disorders — 41%
Other Disorders — 19%

What is Family Psychoeducation?

An approach designed to:

- **help families and consumers better understand mental illness while working together towards recovery.**

- **recognize the family's important role in recovery.**

- **help clinicians see markedly better outcomes for consumers and families.**

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Central assumptions of the psychoeducational model

Success in promoting change in behavior and attitude requires:

- **the establishment of a cooperative, collegial, non-judgmental relationship among all parties**
- **education supplemented with continued support and guidance**
- **breaking problems into their components and solving them in a step-wise fashion**
- **support from a network of well-informed and like-thinking people**

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Principles of
Family Psychoeducation - I

- **Has roots in the clinical care system**

- **Assumes that reduction of symptoms and successful recovery reduces family burden**

- **Involves key members of care and social support systems, e.g. family, caseworkers**

- **Provides skills training to improve coping strategies**

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Principles of Family Psychoeducation - II

- **Capacity to achieve clinical goals in the absence of consumer.**

- **Long-term perspective to treatment and recovery.**

- **Higher costs than self-help or education alone, but markedly lower cost/benefit ratio than standard care ($1/$14-34).**

- **Need to re-train professionals and case managers in non-blaming paradigms.**

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The History of Multifamily Groups

- **originated 30+ years ago in a NY hospital**

- **families were offered education in a group format without consumers**

- **consumers wanted to join**

- **hospital staff noticed significant improvements, e.g., increased social skills and interest in treatment amongst consumers, improved family involvement and communication**

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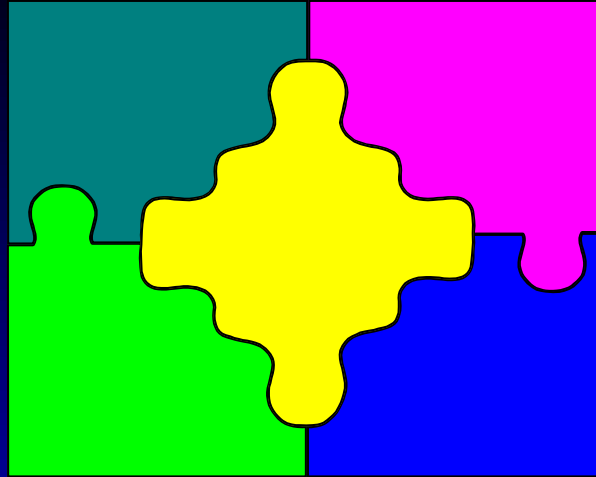
Today, FPE is offered in select locations throughout the U.S. and in countries such as Norway, Denmark, England, Australia, China, Japan, Holland and Canada. Training is generally offered through state agencies or university programs.

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Evidence-based benefits for participants

- **promotes understanding of illness**
- **promotes development of skills**
- **reduces family burden**
- **reduces relapse and rehospitalization**
- **encourages community re-integration, especially work and earnings**
- **promotes socialization and the formation of friendships in the group setting**

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Practitioners have found...

- **renewed interest in work**

- **increased job satisfaction**

- **improved ability to help families and consumers deal with issues in early stages**

- **families and consumers take more control of recovery and feel more empowered**

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Who can benefit from FPE?

- **Individuals with schizophrenia who are newly diagnosed or chronically ill**

- **adolescents and young adults with pre-psychotic symptoms**

- **there is growing evidence that the following people can also benefit:**

  - **individuals with mood disorders**

  - **consumers with OCD or borderline personality disorder**

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A brief introduction to the psychobiology of schizophrenia

"…the basic defect in schizophrenia consists of a low threshold for (mental) disorganization under increasing stimulus input."

Epstein and Coleman, 1970

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Symptoms Indicating Psychosis

- *Hallucinations*

Hearing voices or seeing visions

- *Delusions*

False beliefs or marked suspicions of others

- *Disorganized thinking*

Jumbled thoughts, difficulty concentrating

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# People with psychosis often experience:

- **Social withdrawal**

- **Odd, unusual behaviors**

- **Decreased motivation**

- **An inability to enjoy activities**

- **Mood swings**

- **Pervasive anxiety**

- **Disrupted sleep patterns and changes in appetite and eating**

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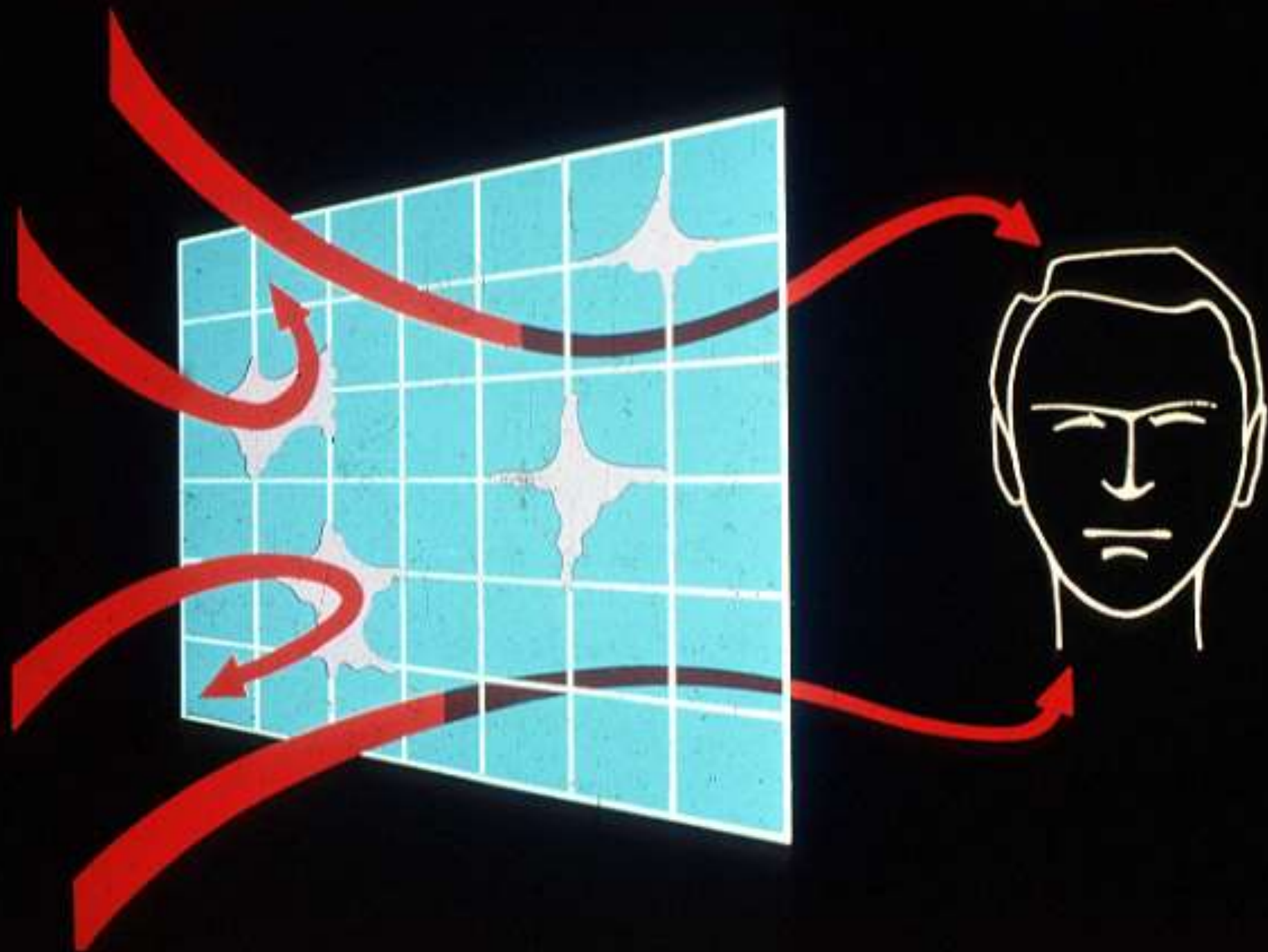# Psychosis is an unusual sensitivity to:

- Sensory stimulation

- Prolonged stress, strenuous demands

- Rapid change

- Complexity

- Social disruption

- Illicit drugs and alcohol

- Negative emotional experience

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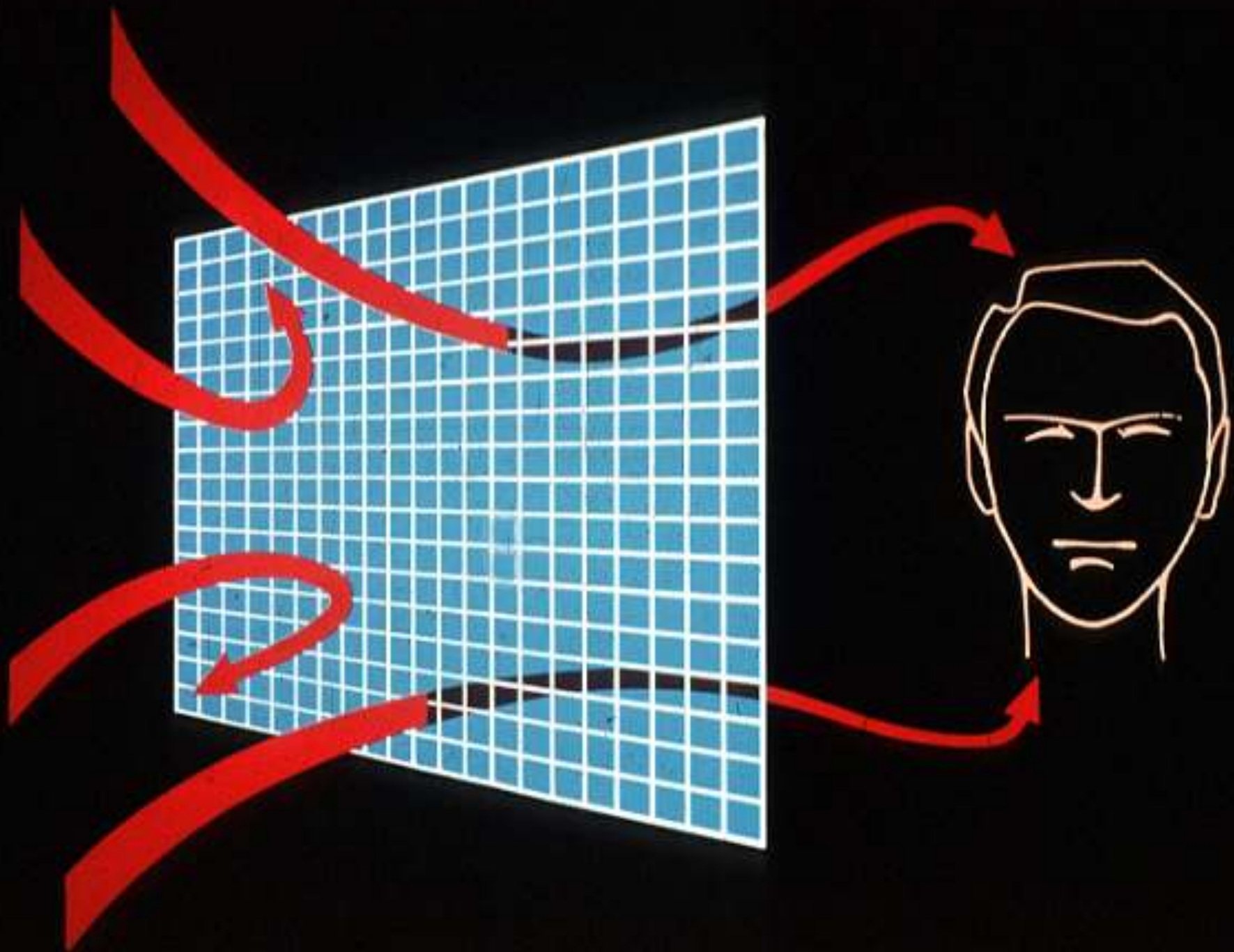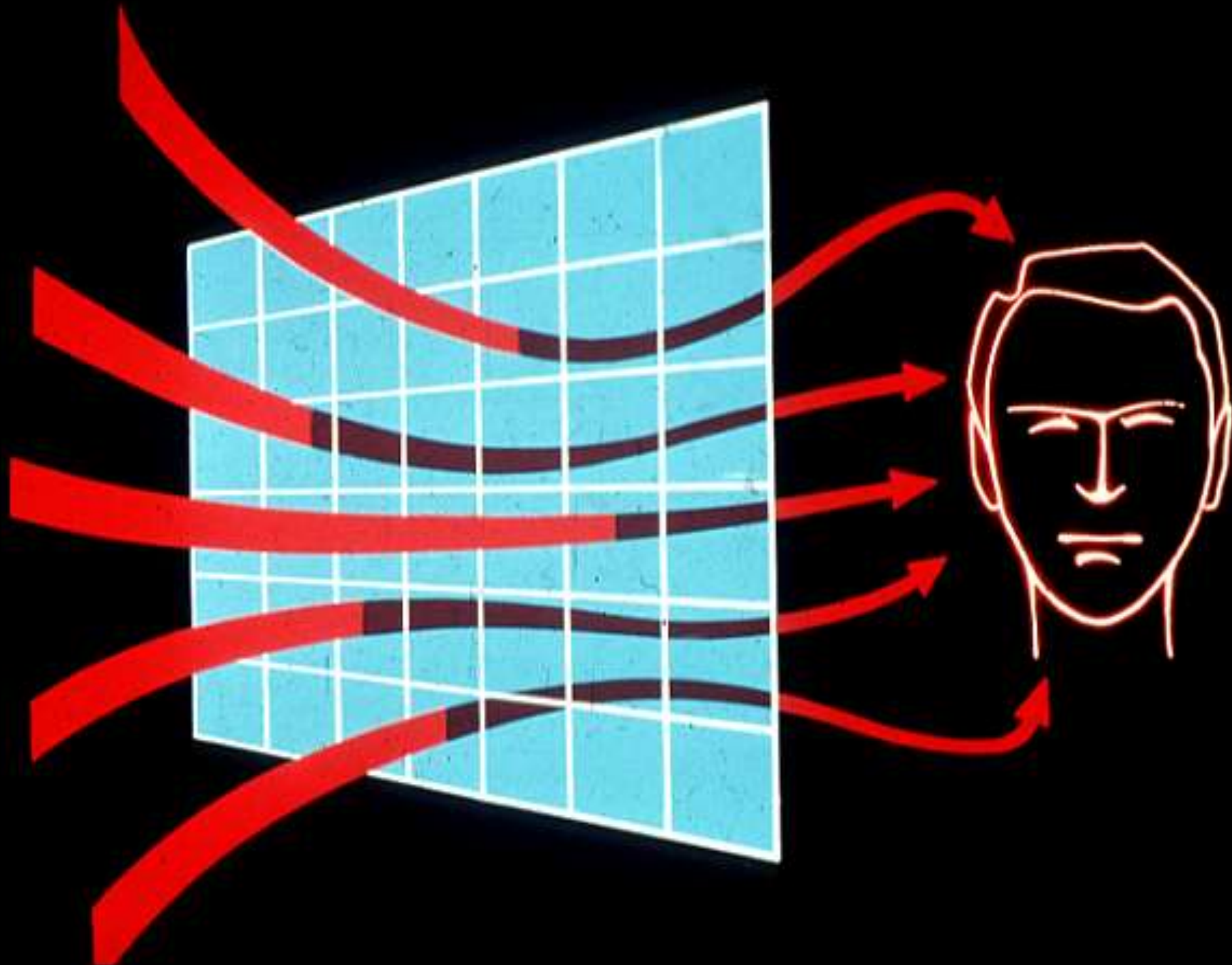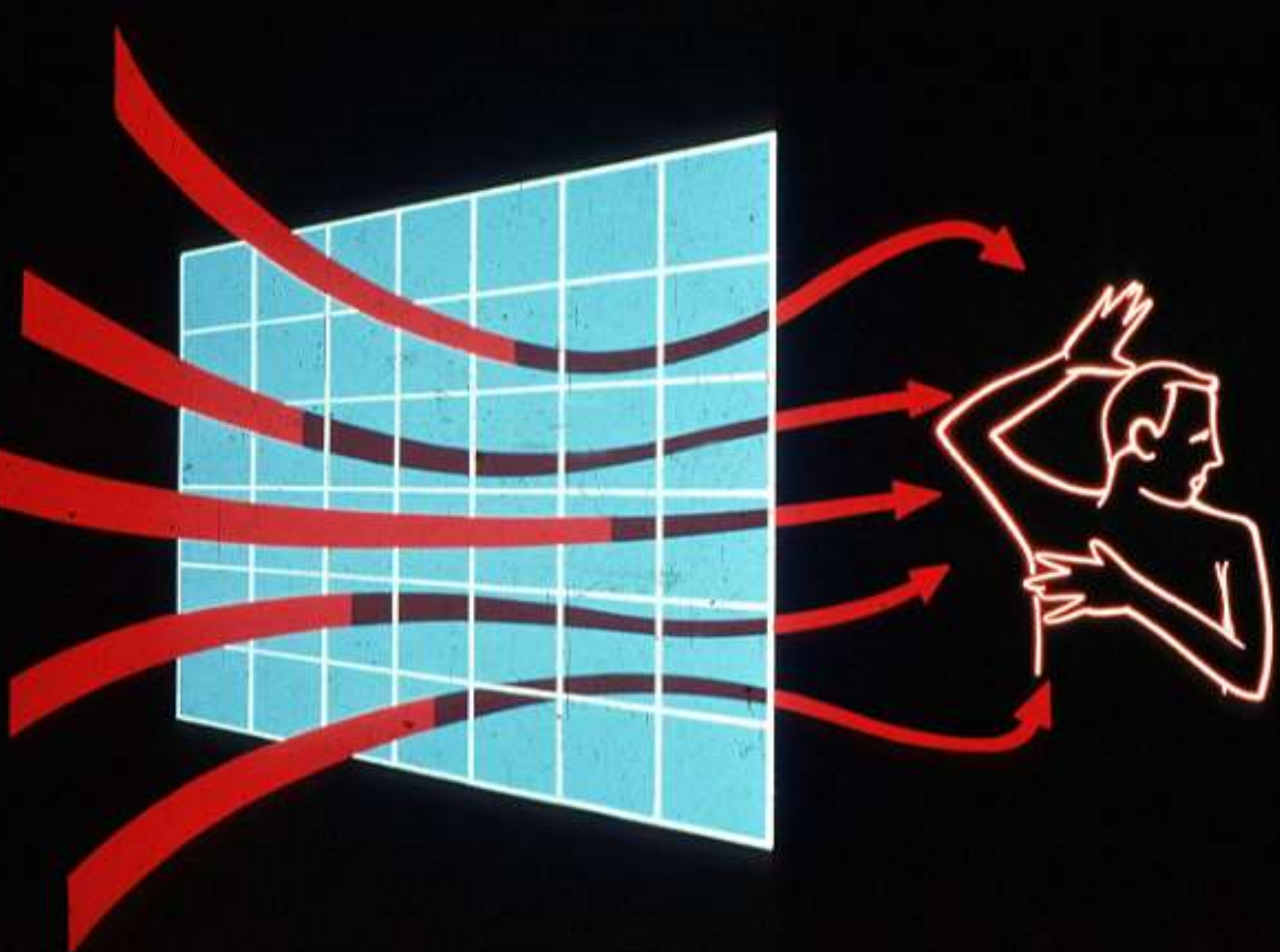
Altered Brain Function in Psychosis

- *Prefrontal cortex* activity lessens due to metabolic and structural changes
- The *limbic system*, which assists with attention and the integration of thoughts and feelings, becomes overactive
- Hypoactivity of the *cingulate cortex* creates emotional lability and disconnection of thoughts/feelings

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NORMAL/SCHIZO, CM 5, FRONT
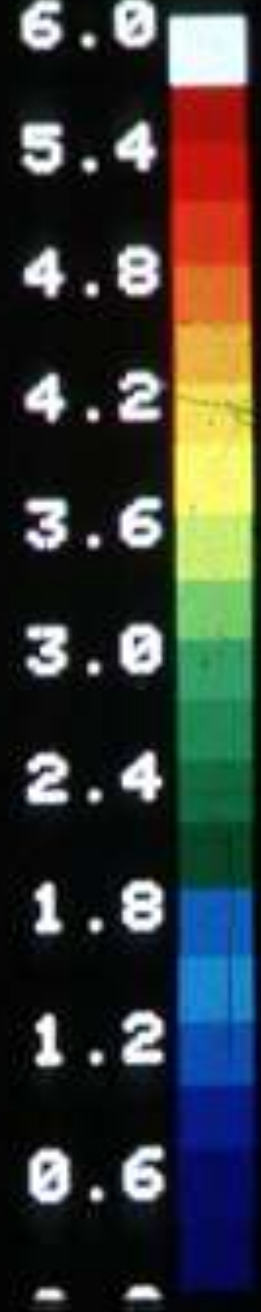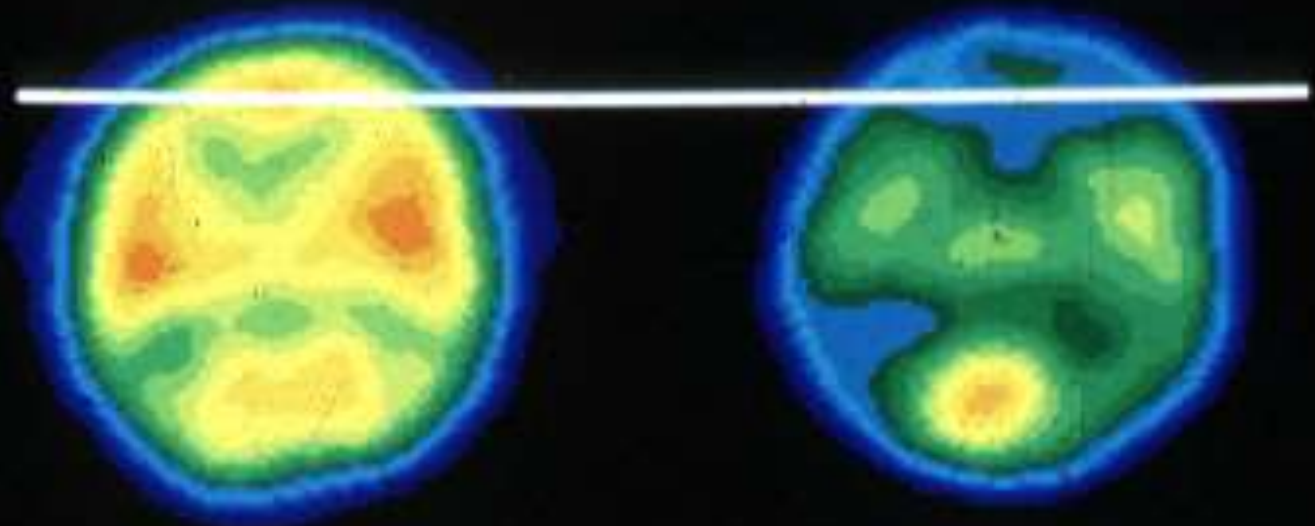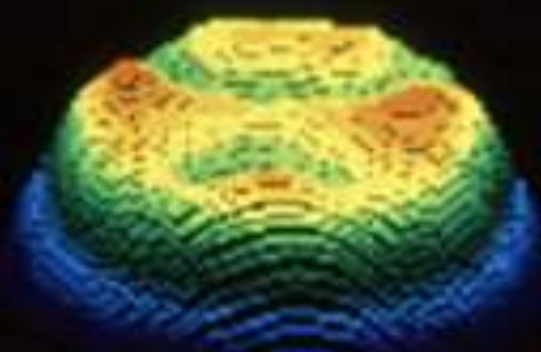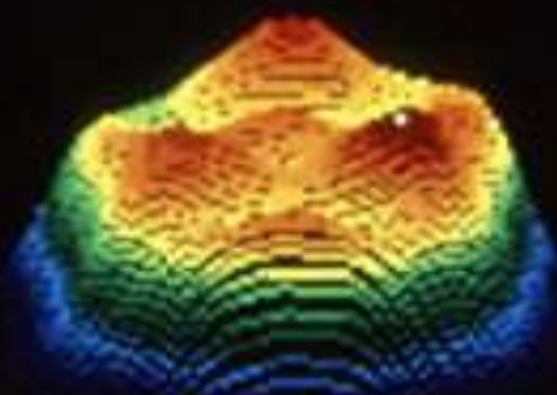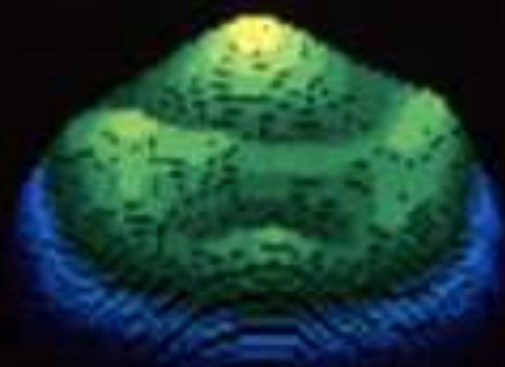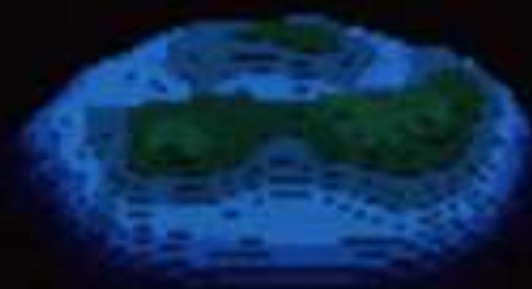
Dorsolateral prefrontal cortical activity in response to cognitive challenge
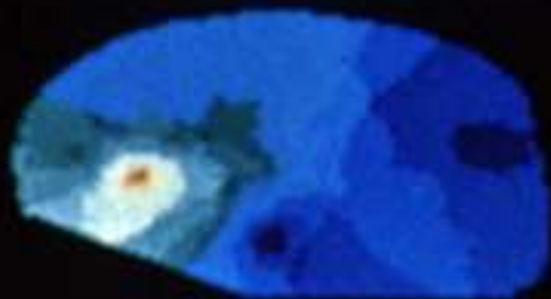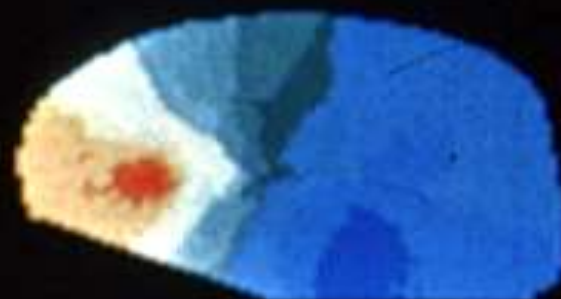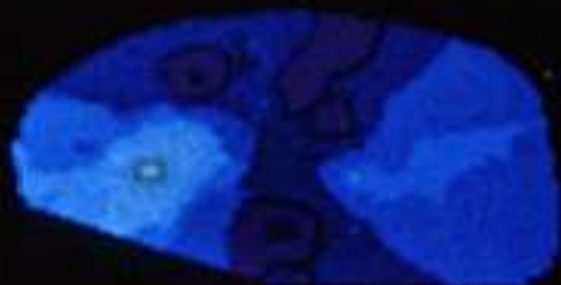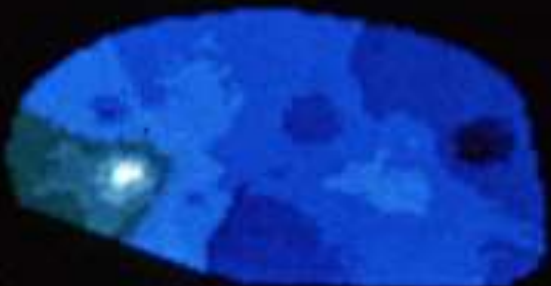
Prefrontal Cortex:
higher mental functions
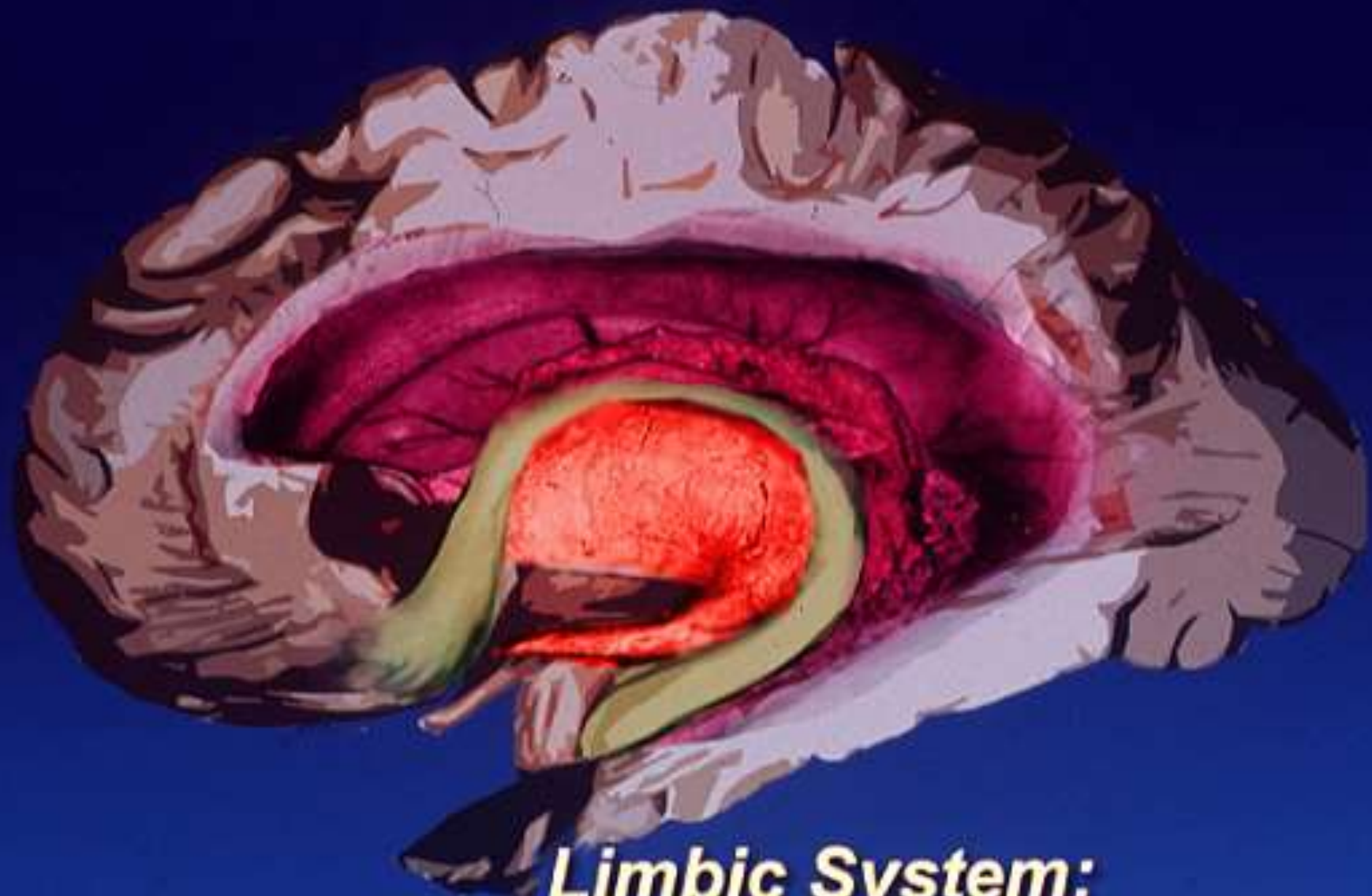
Limbic System: integration of thoughts and feelings

Temporal Lobe:
language, speech, and
hearing
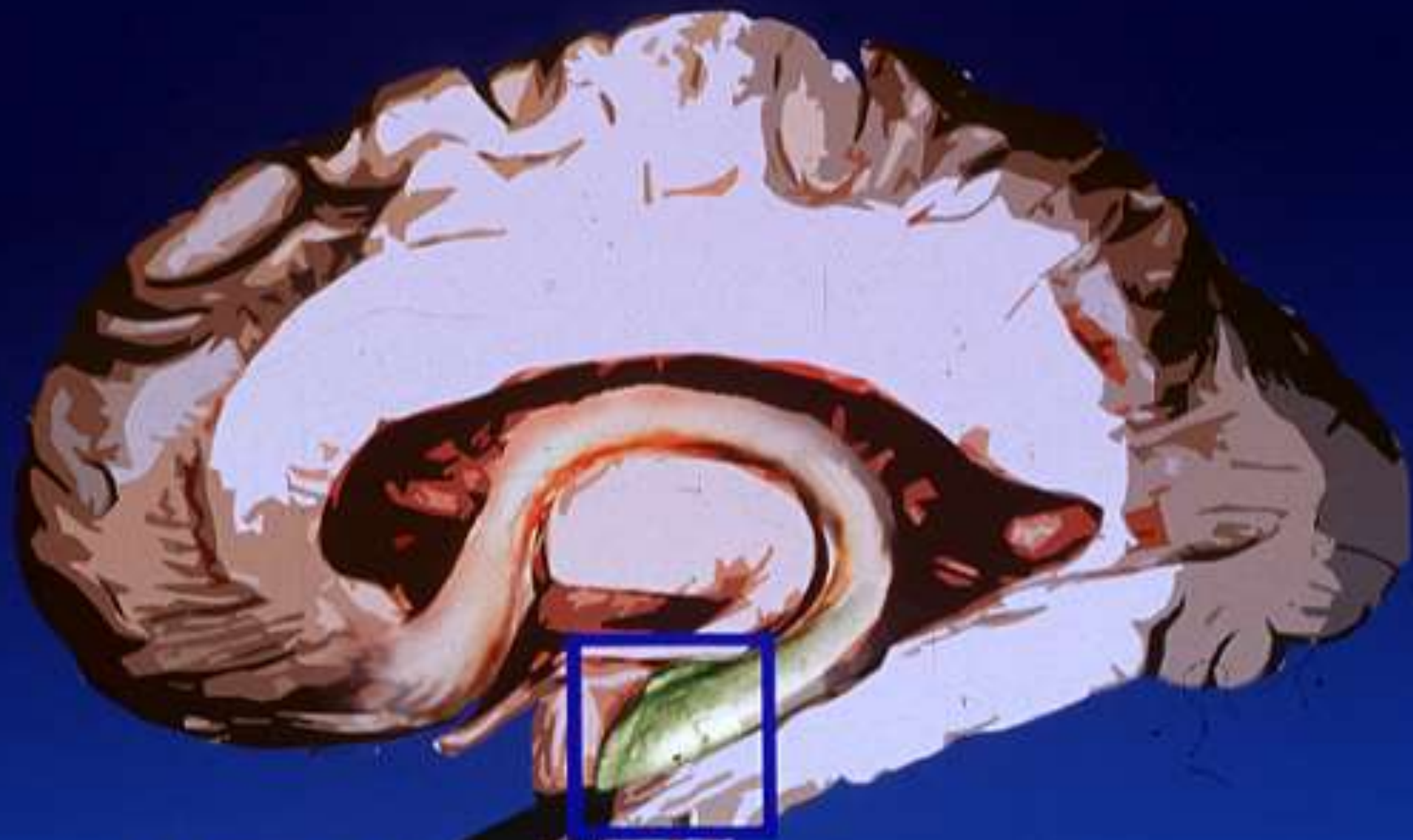
Hippocampus:
short-term memory and
attention

Neurotransmitters

Dopamine
Serotonin
Noradrenalin
Glutamine

Effect of Prefrontal Dopamine Differentiation

Prefrontal Cortex

Limbic Sites

Brain Stem DA Neurons

Normal State

Prefrontal Cortex

Limbic Sites
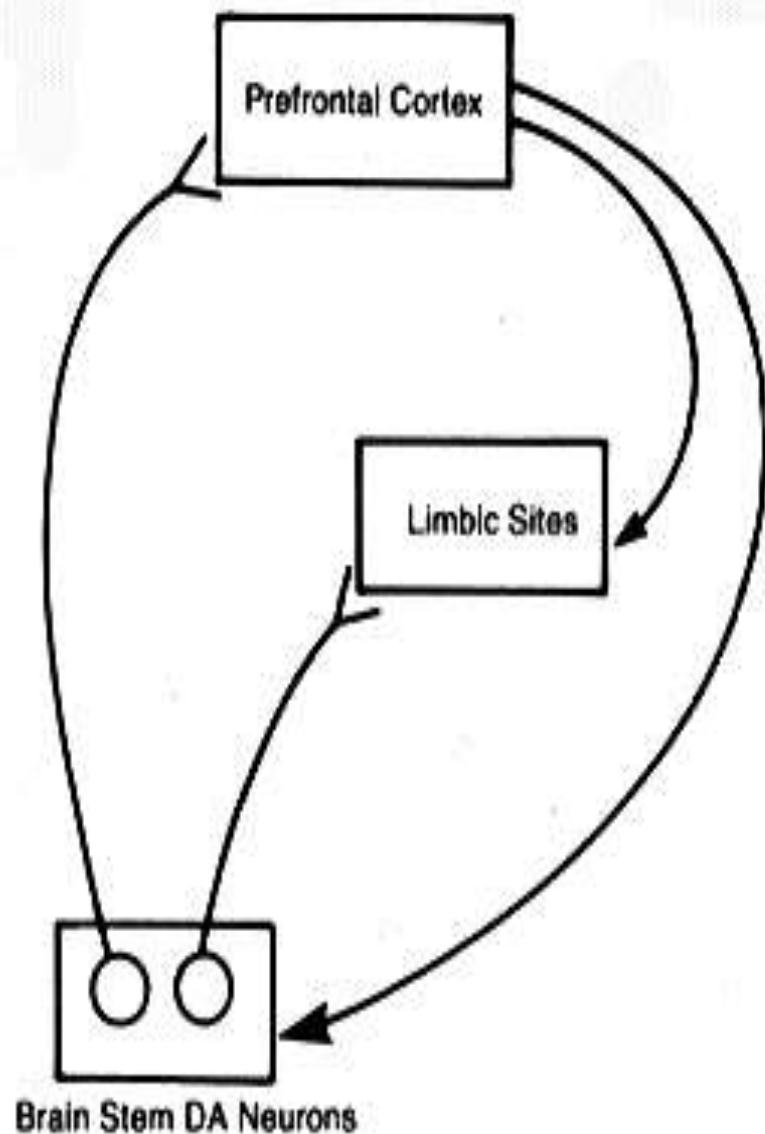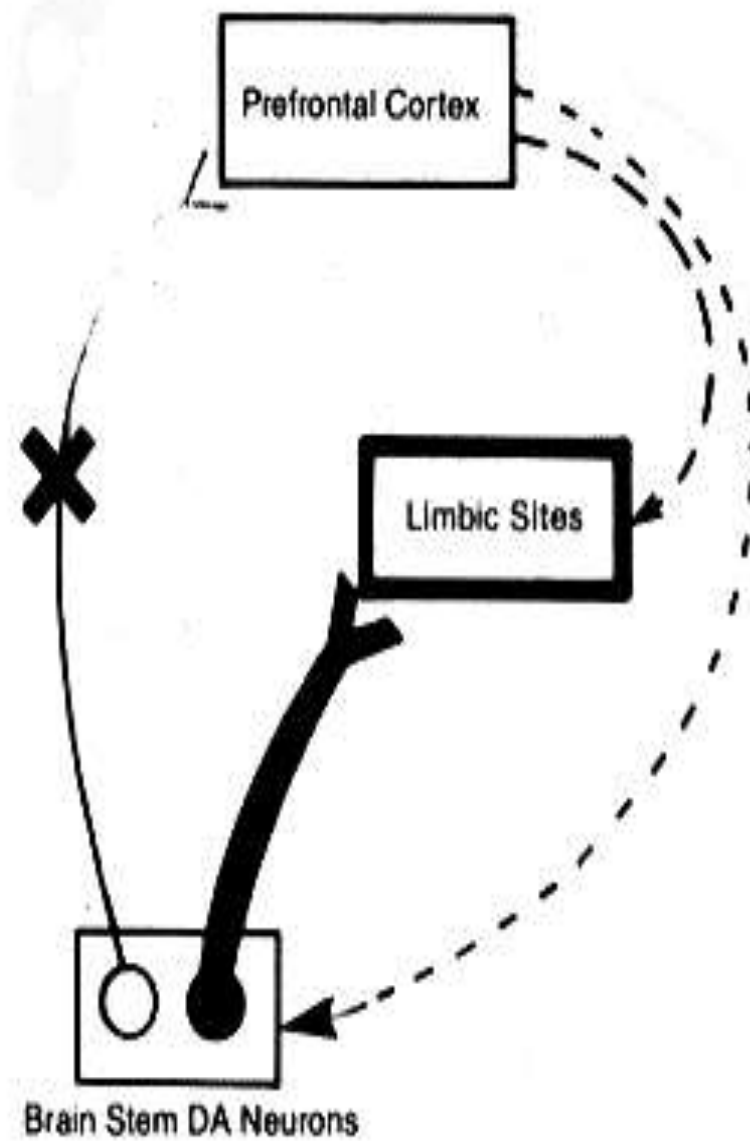
Brain Stem DA Neurons
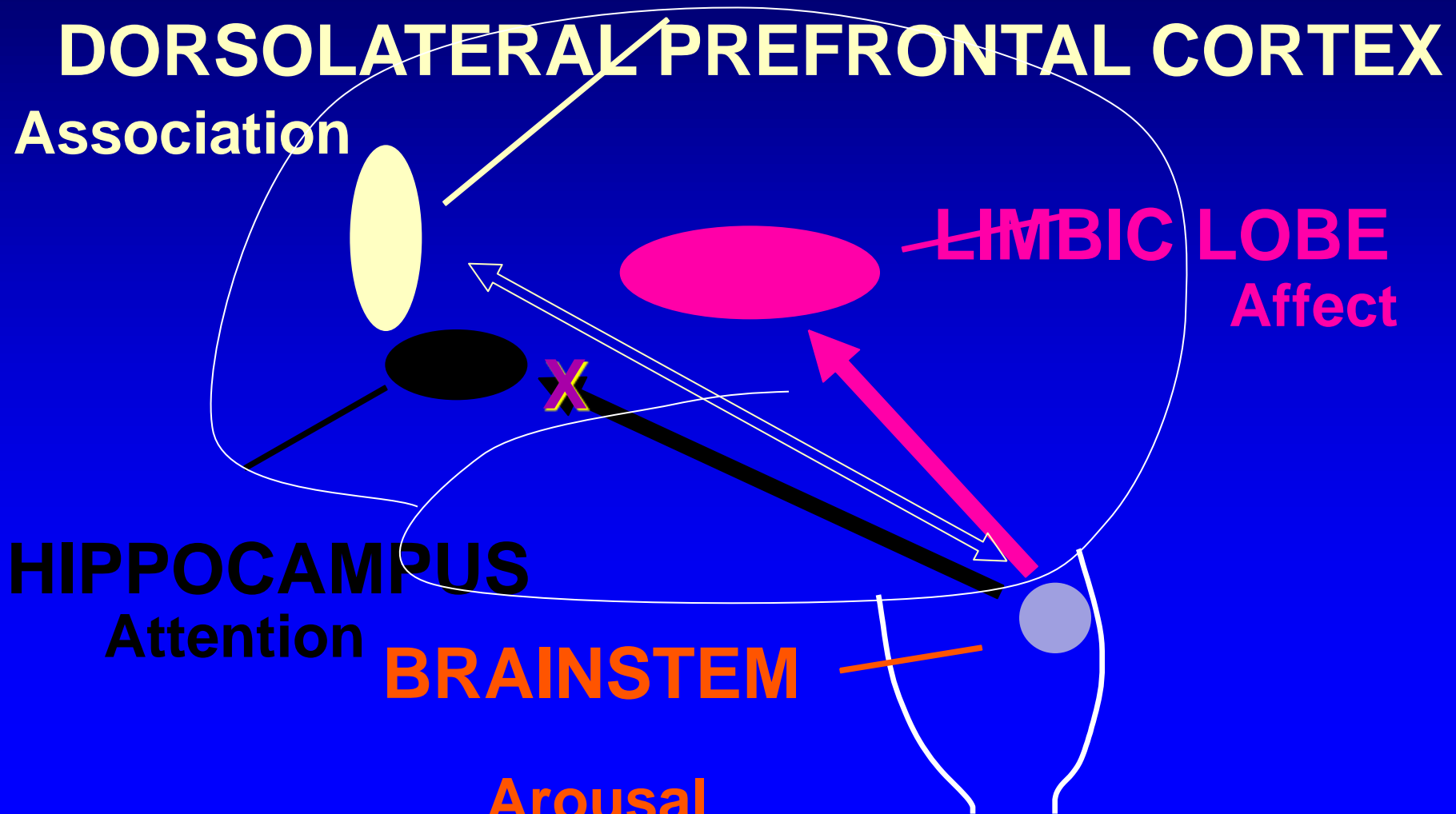
SCHIZOPHRENIA IN MONOZYGOTIC TWINS

Pair no. 2: 44 year old males
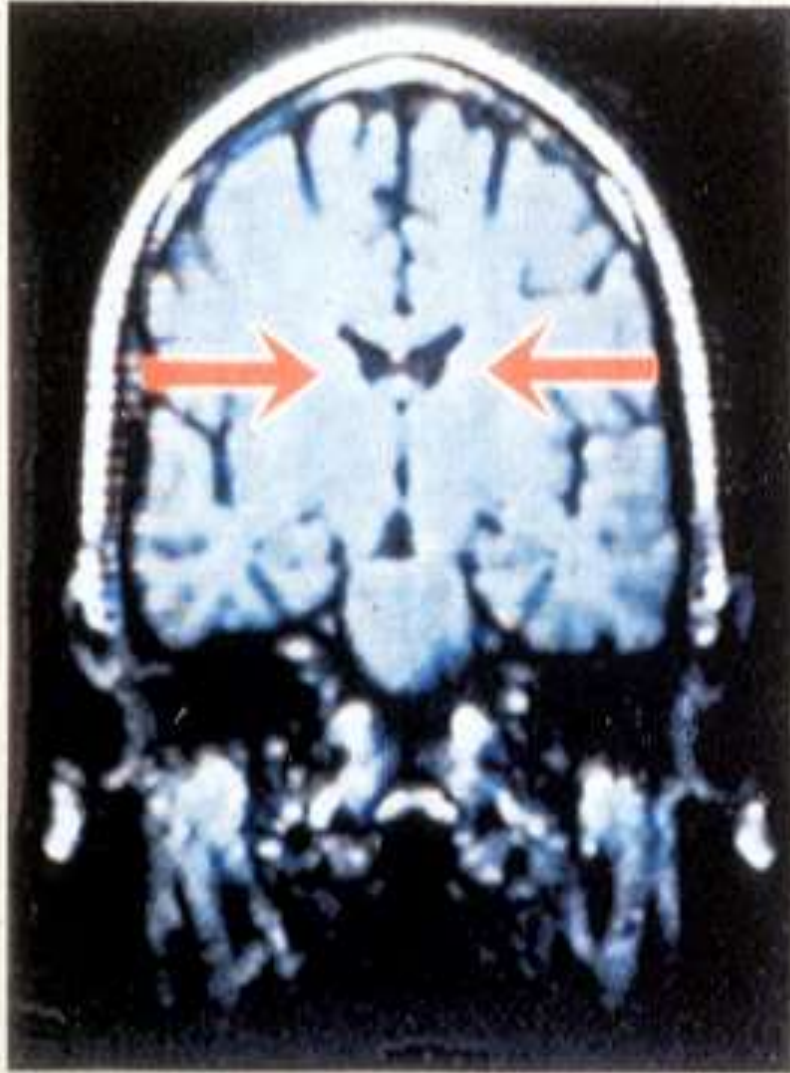
UNAFFECTED
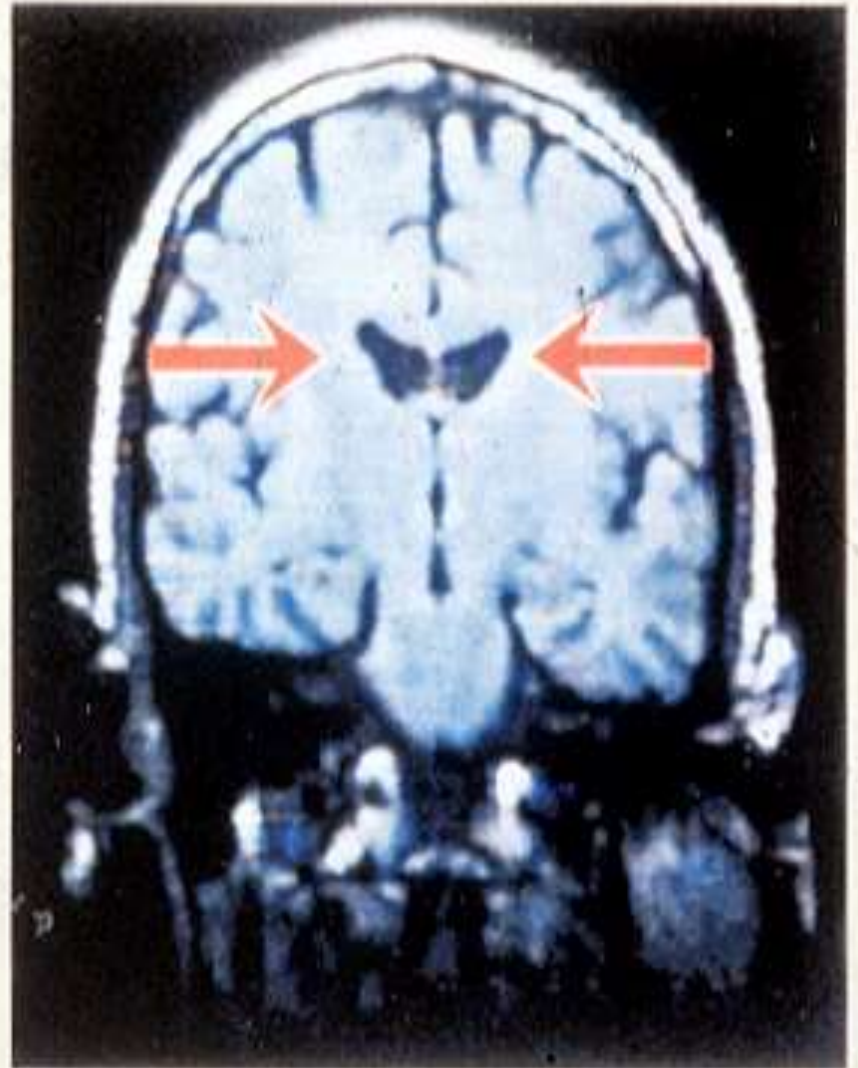
AFFECTED

Disorganization in Mania and Depression...

- **...may be similar to that for schizophrenia**
- **threshold may be raised by medication**
- **more social support and less stimulation + stress = higher threshold**

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Cortical metabolic activity in major depression
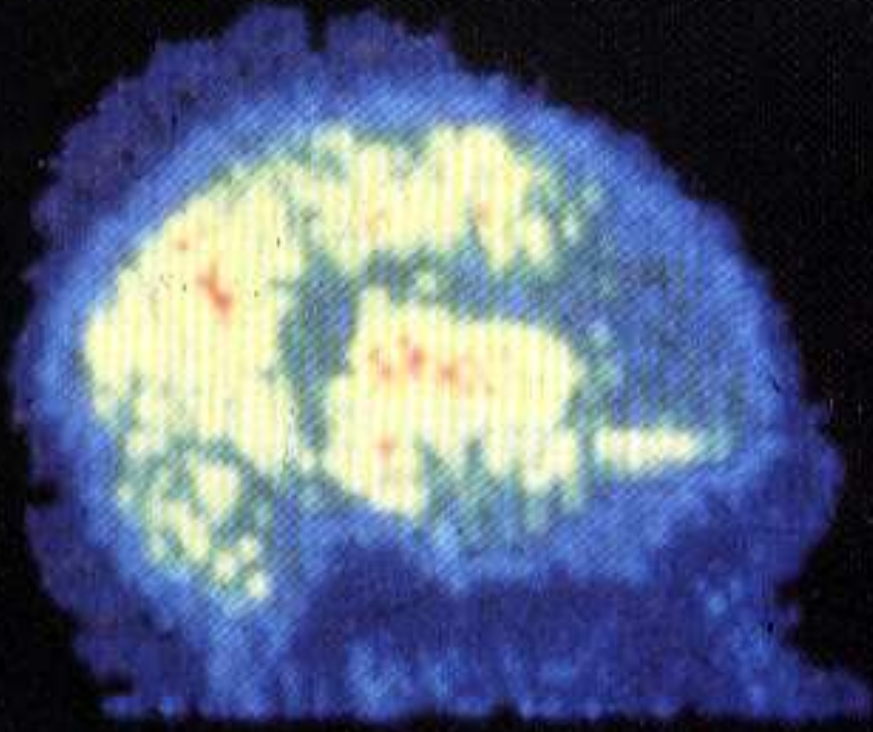
Before antidepressant medication
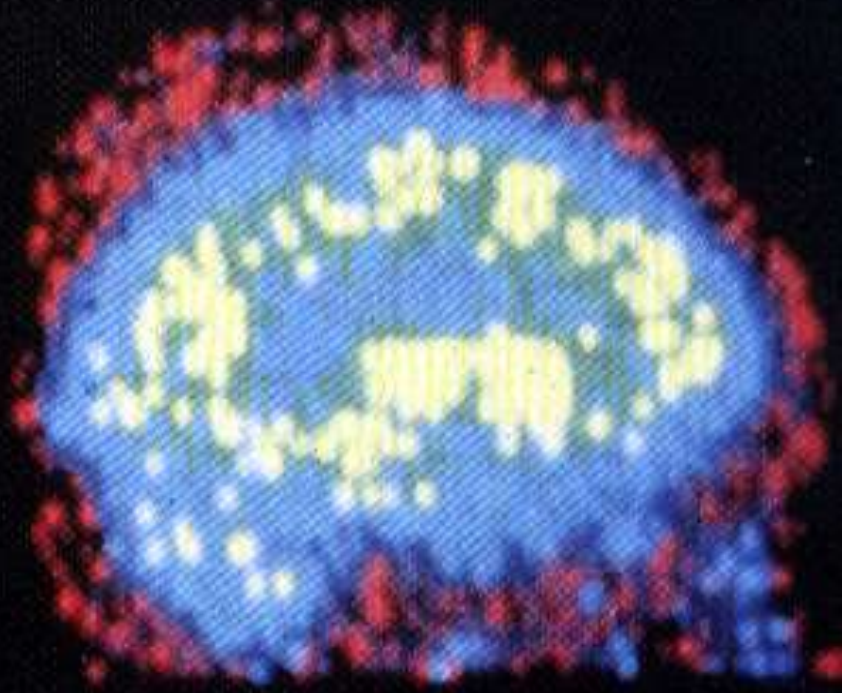
After antidepressant medication

Functions of the Prefrontal Cortex

- **establishing a cognitive set**

- **problem-solving**

- **planning**

- **attention**

- **initiative**

- **motivation**

- **integration of thought and affect**

- **mental liveliness**

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Interaction of attention and arousal

Optimal

Inattention

Distraction

Attention

Arousal

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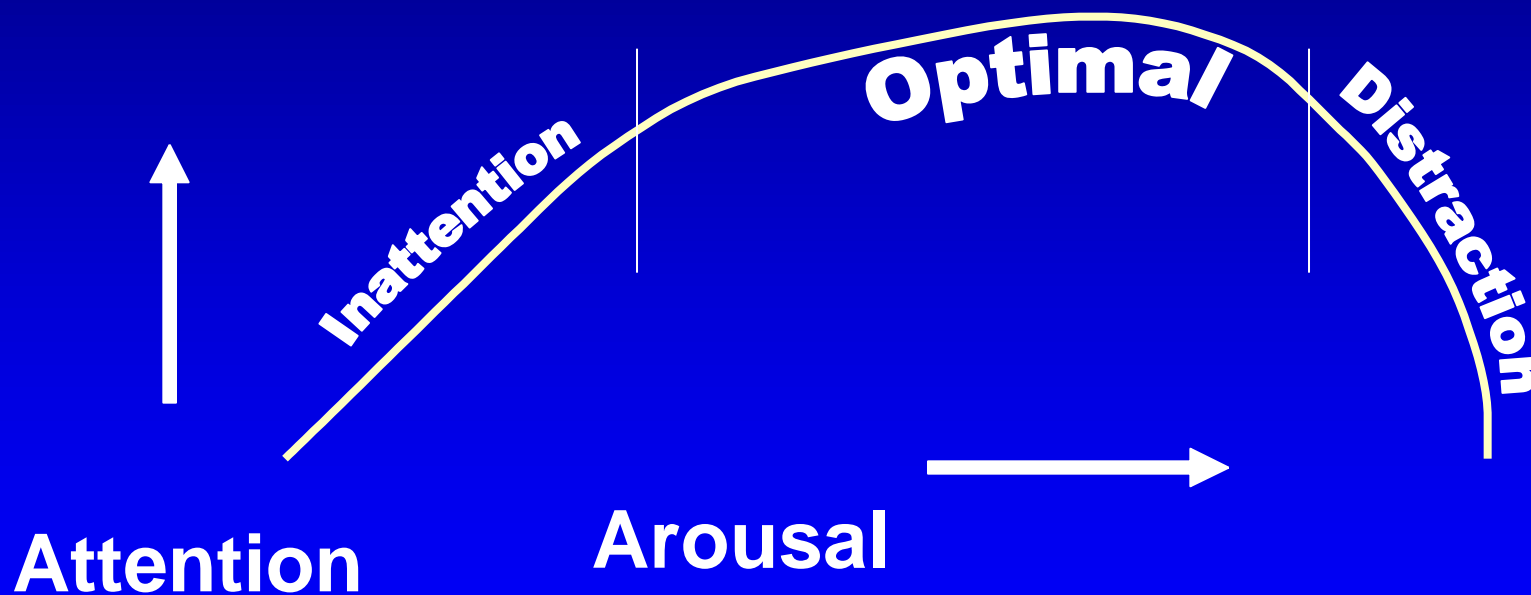
There is an optimum relationship between arousal and attention...

- **In order to pay attention, we need to be aroused on a sensory level.**

- **In a psychotic state, people are over-aroused, which makes it hard to pay attention…information is missed.**

- **With negative symptoms, a person is slow to register information and/or has poor attention.**

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Interaction between ongoing behaviors and cognition

- **encoding both internal and external cues**

- **realistic appraisal of the cues**

- **decision-making regarding both immediate and long-term goals**

- **remembering acceptable responses**

- **evaluating these or new responses**

- **carrying them out appropriately**

Expressed emotion and relapse

Total N= 128

Low EE — **13%**
- On med. — **12%**
- No med. — **15%**

High EE — **51%**
- **< 35 hrs.** — **28%**
  - On med. — **15%**
  - No med. — **42%**
- **> 35 hrs.** — **69%**
  - On med. — **53%**
  - No med. — **92%**

Low EE = 71
High EE = 57
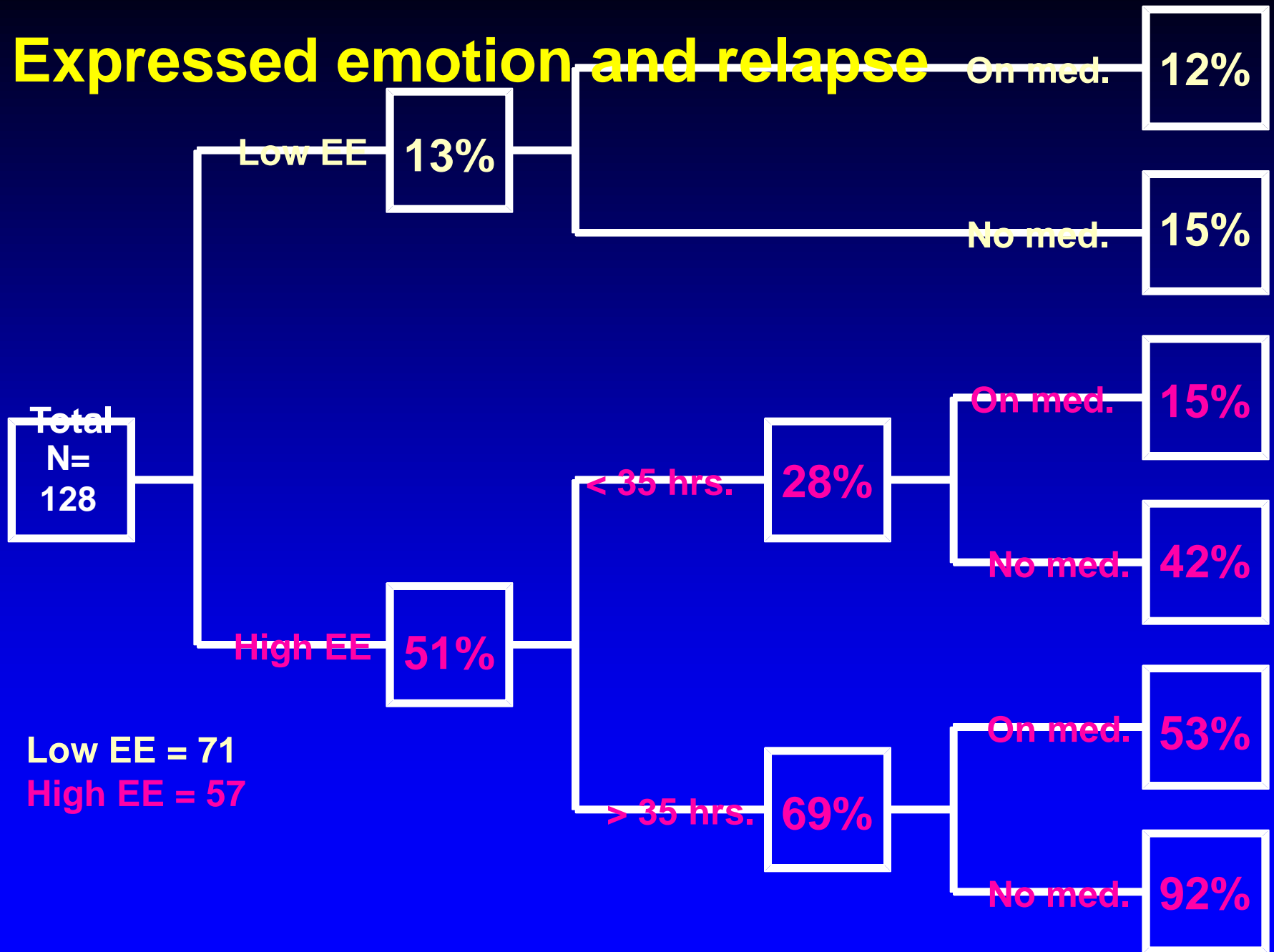
Effects of stress, in general populations

- **The positive effects of stress include**
  - growth
  - reprioritization of goals
  - increased self-esteem
  - expanded or strengthened networks;

Effects of stress, in general populations

- **The negative effects include, initially,**
  - **heightened arousal, anxiety and psychosis, then**
  - **withdrawal, apathy, depression and**
  - **diminished sense of self-worth and self-efficacy**

- **The absence of meaningful stimulation can be stressful as well; too little stress can lead to boredom and anergia**

Potential for Relapse in Schizophrenia

Positive Symptoms | Negative Symptoms

(Medication started)

Prodromal Episode 1 to 3 weeks

Acute Psychotic Episode 2 to 5 weeks

Post Episode 12 to 24 months
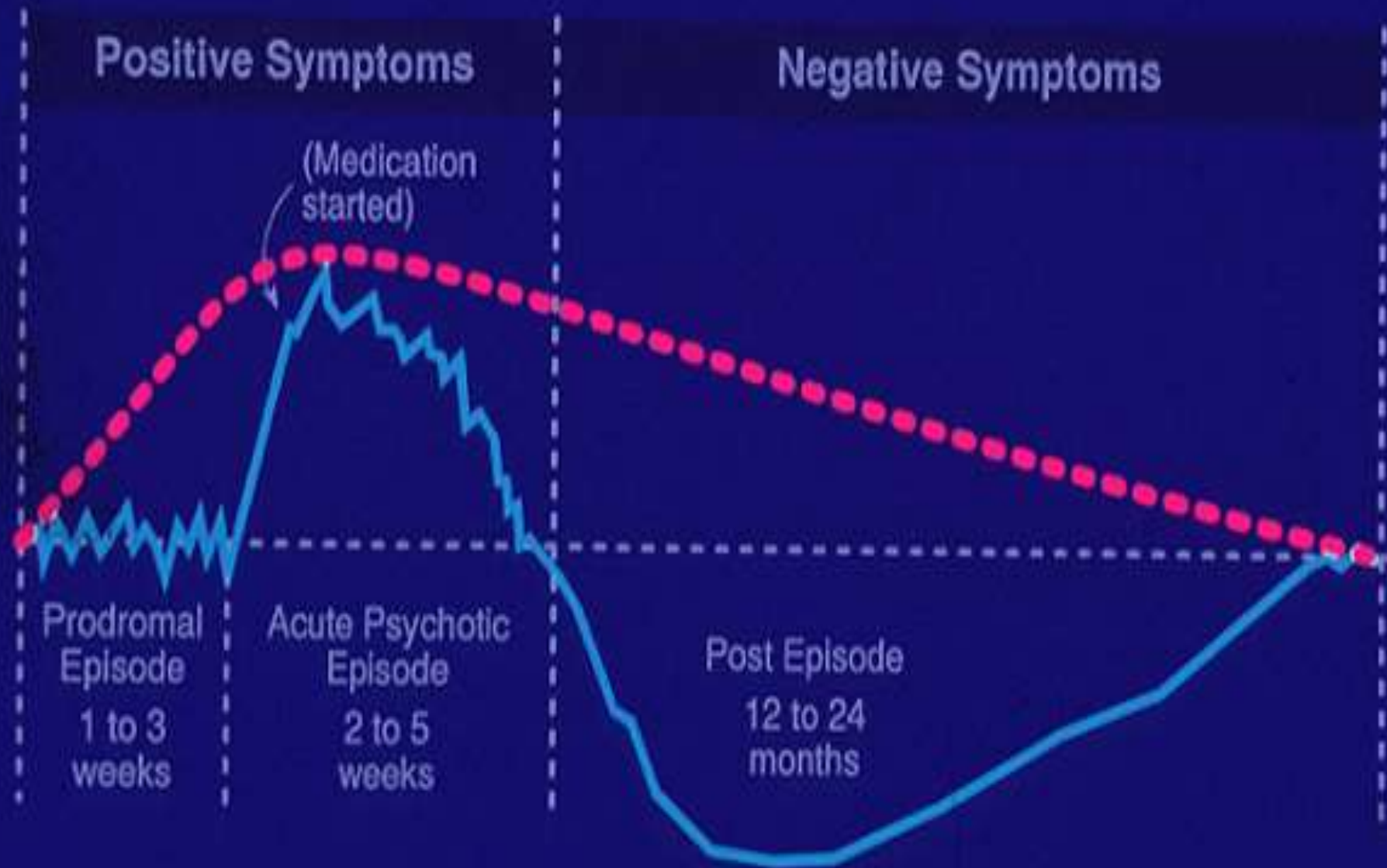
Dimensions of social support and networks

- **Four dimensions:**
  - **emotional (caring, trust, empathy),**
  - **instrumental (performing concrete tasks),**
  - **informational (imparting of knowledge and skills), and**
  - **appraisal or feedback support.**
- **Breier and Strauss include:**
  - **reciprocity of communication and caring (i.e. give-and-take between individuals),**
  - **material support,**
  - **constancy,**
  - **opportunity for ventilation,**
  - **social approval, and**
  - **integration**

Principles of interaction based on the psychobiology of schizophrenia

- **To compensate for difficulty in regulating arousal, the people closest to the susceptible person can create a relatively quiet, calm and emotionally warm environment.**

- **They can attempt to protect against sudden intrusions, confrontational conversations, arousing entertainment and simultaneous and multiple kinds of sensory input.**

Principles of interaction based on the psychobiology of schizophrenia

- To help with information processing difficulties, conversations can be shorter, less complex and focussed on everyday topics.

- Complexity in the environment and stressful life events will overwhelm cognitive capacities: these need to be protected against and buffered as much as possible.

Principles of interaction based on the psychobiology of schizophrenia

- **The optimal emotional tone is in the middle range, not intense and especially not negative, but also not overly distant, cold or rigid, like "Muzak".**

- **To compensate for delusions, family and friends can be encouraged to change the subject and not dwell on delusional ideas, but rather focus on less stressful topics.**

Principles of interaction based on the psychobiology of schizophrenia

- **Sensory overload can be avoided by these same means, and also by, for example, reducing background noise, keeping light levels moderate, and having only one conversation going at a time.**

Principles of interaction based on the psychobiology of schizophrenia

- **Negative symptoms can moderate with time, but not under conditions of high stress: rehabilitation should be carried out in small careful steps, using reductions in negative and positive symptoms as indicators of safety and success.**

Principles of interaction based on the psychobiology of schizophrenia

- **There is a biological and psychological relapse recovery process that cannot be accelerated without risking another relapse or at least stalling progress toward functional recovery; slow, careful and steady rehabilitation can achieve remarkable degrees of functional improvement without relapse.**

Principles of interaction based on the psychobiology of schizophrenia

- **Time is on the side of recovery, rather than an enemy that leads inevitably toward deterioration.**

- **Stresses and demands are taken seriously and steps toward recovery are paced to keep stress below the threshold for symptom exacerbation.**

Effects of social networks

- Family network size diminishes with length of illness.

- Network size for patients appeared to decrease in the period immediately following a first episode.

- Smaller network size at the time of first admission.

- Networks buffer stress and adverse events.

- Networks and families determine treatment compliance.

- Social support predicts relapse rate.

- Social support is associated with coping skills and burden.

Social networks, received family stigma and over-involvement:
In mothers of sons with schizophrenia
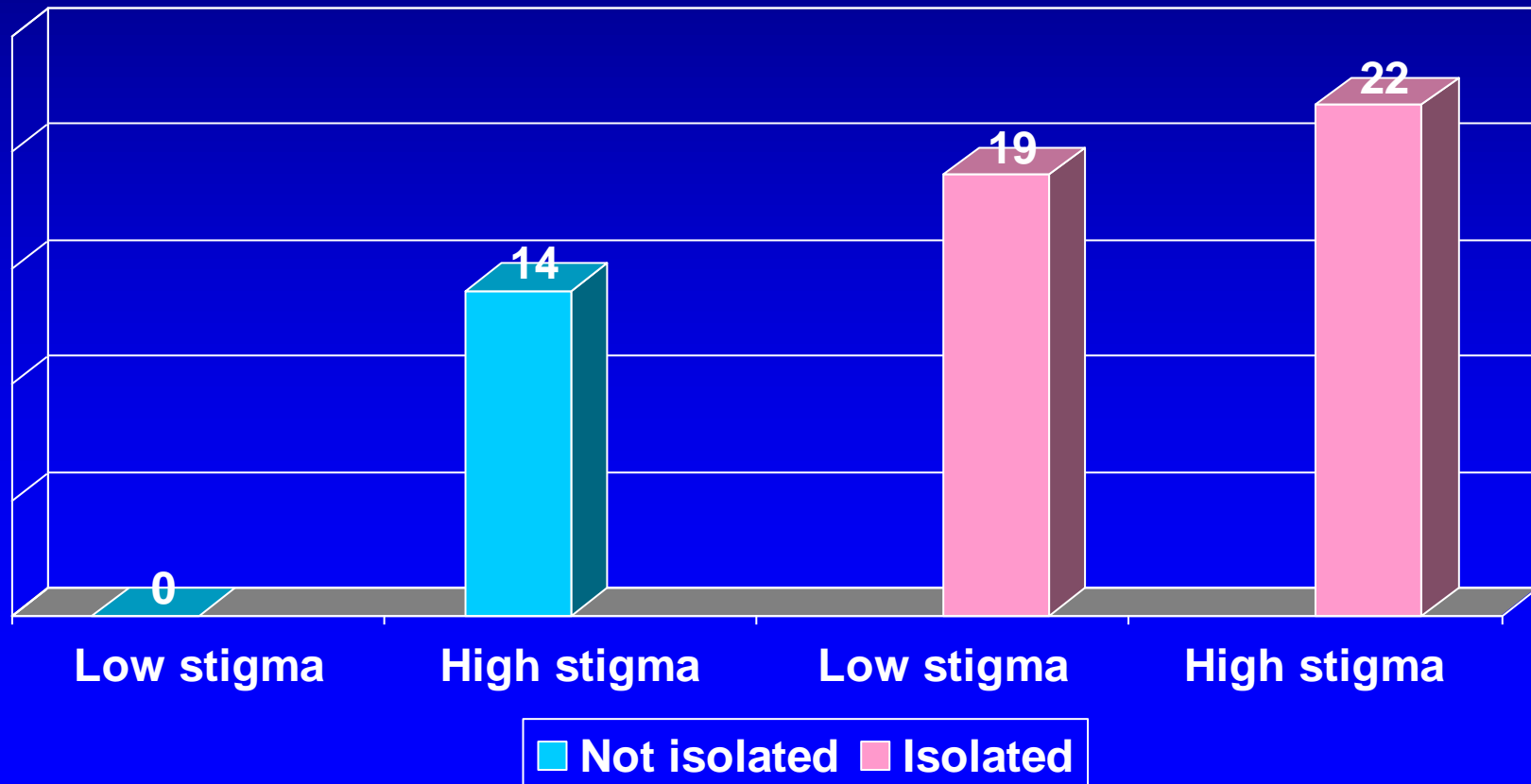
A Biosocial Model for Relapse

Stigma

Isolation
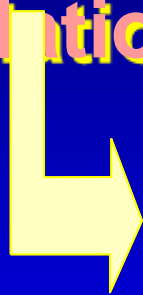
Negative Intensity
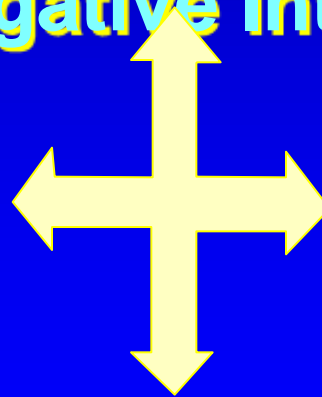
Arousal　　　**Distraction**

Symptoms and Relapse

Risks for symptom exacerbation and relapse
Intensity, negativity and complexity

- **Critical comments**

- **Over-involvement**

- **Lack of warmth**

- **Crowding**

- **Excessive pressure to perform**

- **Interactions with conflict**

- **Multiple sources of input**

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High rate of change

- ## Excessive life events per unit of time

- ## Disruption of social supports

- ## Lack or loss of "bridging" cues

- ## Entry into a new context

- ## Multiple functional levels involved in compensating

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Risks for symptom exacerbation and relapse
Physical and chemical factors

- **Stimulants**

- **Hallucinogens**

- **Dependence on depressants**

- **Unknown environmental toxins**

- **Loud noises**

- **Distracting noises, echoes**

- **Bright lights**

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Relapse   vs.   Recovery

Biological vulnerability   ⟷   Medication

Substance abuse   ⟷   Abstinence

Conflict, confusion and exasperation   ⟷   Coping skills

Environmental stress   ⟷   Low stress environment

Core Elements of Psychoeducation

- **Joining**

- **Education**

- **Problem-solving**

- **Interactional change**

- **Structural change**

- **Multi-family contact**

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Therapeutic processes in multifamily groups

- **Stigma reversal**

- **Social network construction**

- **Communication improvement**

- **Crisis prevention**

- **Treatment adherence**

- **Anxiety and arousal reduction**

SOCIAL NETWORKS AND MULTIFAMILY GROUPS

COMMUNITY

EXTENDED FAMILY

F

E

PATIENT

A

B

C

D
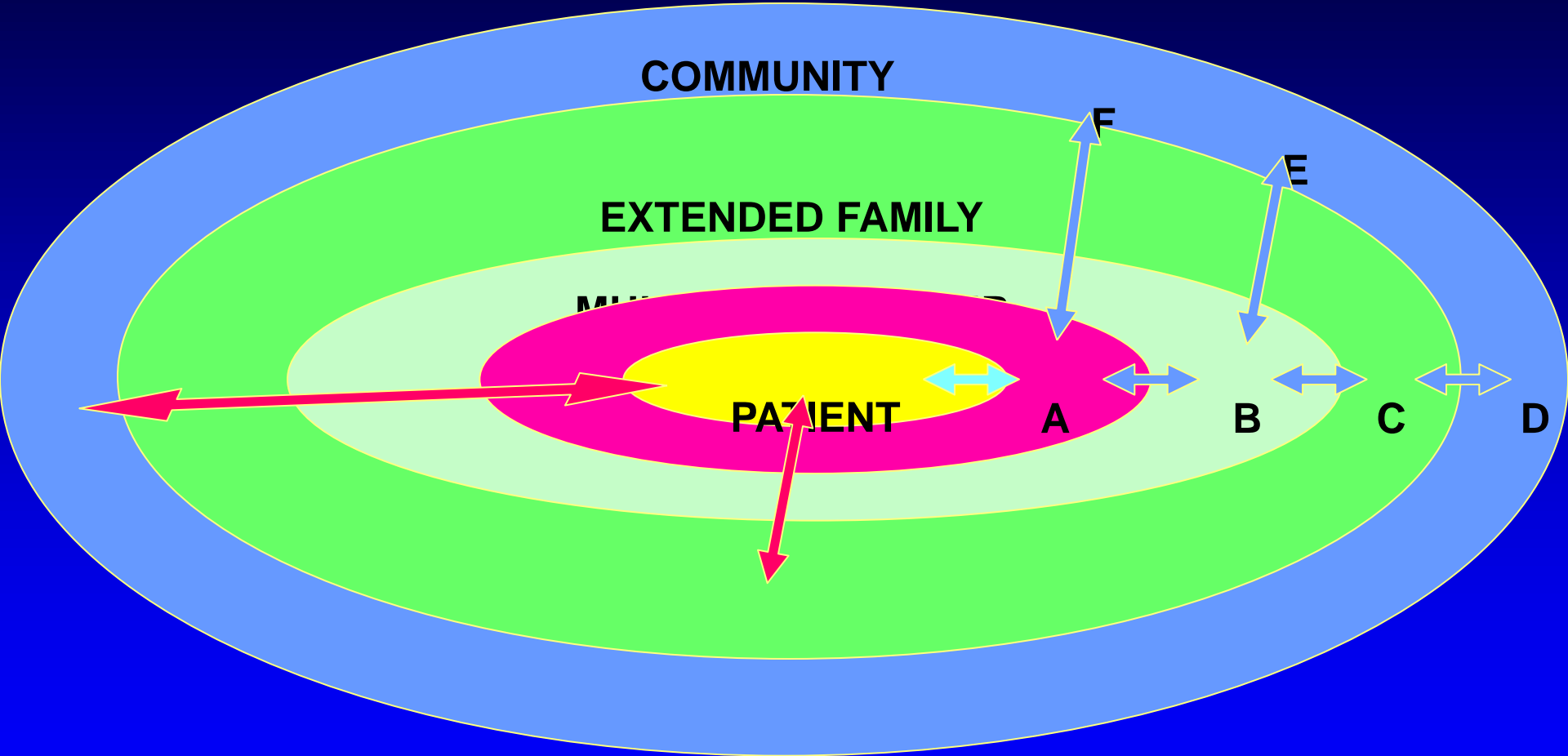
Multifamily group vs. single-family meetings

- **MFGs are more effective for cases with social isolation, high distress and poor response to prior treatment**

- **Some families prefer meeting with one practitioner for the entire time**

- **Some families want to hear what other families have done and need support**

- **Consumers and families may need the practitioner's guidance to decide**

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Stages of treatment in family psychoeducation

Joining

Family and patient separately 3-6 weeks

Educa-tional workshop

Families only 1 day

Ongoing sessions

Families and patients 1-4 years
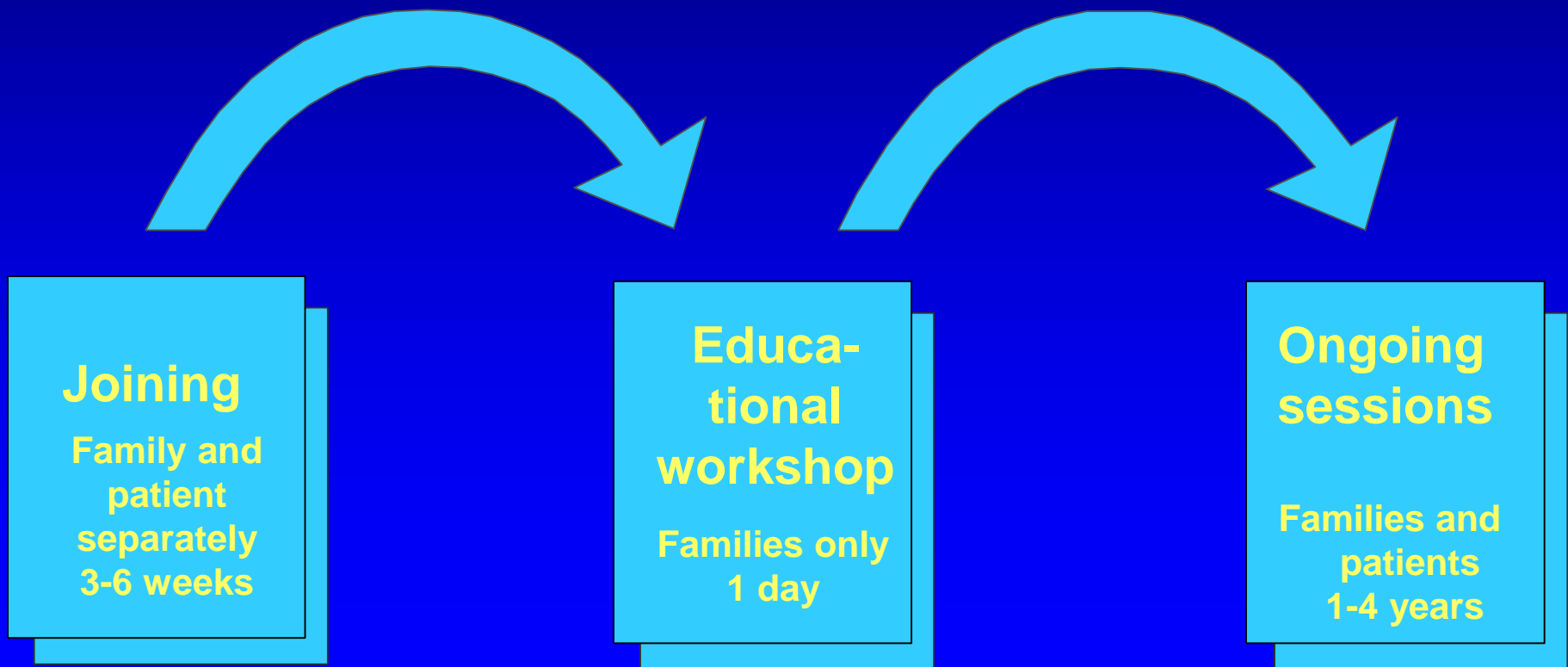
Elements of Joining

- **Exploration of precipitants**

- **Review of warning signs**

- **Reactions of family to illness**

- **Coping strategies**

- **Social supports**

- **Grieving**

- **Contract for treatment**

- **Preparation for multi-family group**

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What Happens During Joining?

- **discuss personal interests -- it's a good way to facilitate getting to know one another**

- **identify early warning signs of illness**

- **explore reactions to illness**

- **identify coping strategies**

- **review family social networks**

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What Happens During Joining?

- **identify characteristic precipitants for relapse ("triggers")**

- **investigate ways to reduce burden**

- **offer opportunities to explore feelings of loss and "what might have been"**

- **share "Family Guidelines' with consumers and family members**

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The Psychoeducation Workshop

An educational opportunity for families held after the joining sessions and prior to multifamily groups

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The first time that families and individuals "come together"

- **6 hours of illness education**
- **relaxed, friendly atmosphere**
- **co-leaders act as hosts**
- **questions and interactions encouraged**

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Classroom Format

- **Promotes comfort**
- **Families can interact without pressure**
- **Encourages learning**
- **Co-facilitators as educators**

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Educational Workshop Agenda

- **History and epidemiology**

- **Biology of illness**

- **Treatment: effects and side effects**

- **Family emotional reactions**

- **Family behavioral reactions**

- **Guidelines for coping**

- **Socializing**

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Guidelines for recovery-I
Creating an optimal social environment

- **Go slow**

- **Keep it cool**

- **Give `em space**

- **Set limits**

- **Ignore what you can't change**

- **Keep it simple**

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Guidelines for recovery-II
Creating an optimal social environment

- **Lower expectations, temporarily**

- **Follow doctor's orders**

- **Carry on business as usual**

- **No street drugs or alcohol**

- **Pick up on early warning signs**

- **Solve problems step-by- step**

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Identifying FPE Group Participants

- **consumers with similar diagnoses**

- **families in search of psycho-education and support**

- **people for whom this intervention would "make a difference" with relationships and life plans**

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Preparation for MFGs

- **remind people about date, time, and place of first meeting**

- **distribute list of meetings**

- **review format of first 2 meetings**

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Components of groups

- **two co-facilitators**
- **5-6 families with similar diagnoses**
- **meetings every other week for a minimum of 9 months, monthly thereafter**
- **families, consumers, and practitioners become partners**
- **on-going education about symptoms, medication, community life, work, etc.**
- **problem-solving format**

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The role of FPE facilitator

- **collaborate with families and consumers to separate illness from personality**

- **assume the role of educator and family partner and trainer-coach**

- **teach families and consumers to use the problem-solving method to deal with illness-related behaviors**

- **keep asking, "what's next?"**

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Group logistics

- **provide snacks**
- **consider a time of day and day of week that is not a hardship for participants**
- **maintain the same time and location**
- **offer telephone reminders and meeting schedules to reduce "no shows"**
- **provide a take-home action plan following problem-solving**

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The 1st and 2nd Groups

"Getting to know you"

- **co-facilitators model behavior**

- **share personal information**

- **culturally normative introductions**

- **begin to develop trust and understanding**

"Experience with mental illness"

- **co-facilitators model behavior**

- **personal stories of impact of M.I. are shared**

- **continue to build relationships**

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Structure of Sessions
Multifamily groups (MFG) and single-family treatment (SFT)

	MFG	SFT
1. Socializing with families and consumers	15 m.	10 m.
2. A Go-around, reviewing--	20 m.	15 m.

   a. The week's events
   b. Relevant biosocial information
   c. Applicable guidelines

	MFG	SFT
3. Selection of a single problem	5 m.	5 m.
4. Formal Problem-solving	45 m.	25 m.

   a. Problem definition
   b. Generation of possible solutions
   c. Weighing pros and cons of each
   d. Selection of preferred solution
   e. Delineation of tasks and implementation

	MFG	SFT
5. Socializing with families and consumers	5 m.	5 m.
Total:	**90 m.**	**60 m.**

"What ever became of the comity once deemed essential to civilized discourse?"

Characteristics of Problem-solving

- Borrowed from organizational management

- Offers benefit of multiple, new perspectives

- Complexity of method matches complexity of the situations

- Need to control affect and arousal

- Need to compensate for information-processing difficulties in some consumers and relatives

- Need to be organized and systematic

- Need to succeed and overcome failure

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Types of problem solving

- **Based on clinical experience and family guidelines**

- **Direct action and intervention by clinicians**

- **Problem is agreed upon by all family members**

- **Problem that is not agreed upon by all family members**

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Hierarchy for problem-solving

- **Medication compliance**

- **Street drug and alcohol use**

- **Life events**

- **Problems generated by other agencies**

- **Conflicts between family members**

- **Conflicts with family guidelines `**

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Problem-solving conflict

- **Validate all positions**

- **Define the problem as illness-based, to the degree that is reasonable**

- **Undertake a step-wise or sequential solution**

- **Look at consequences of each position in the conflict itself -- what are the advantages and disadvantages?**

- **Reframe motives of all concerned**

- **Support limit-setting**

Picking the Problem

- **don't ignore medication, safety or drug issues!**
- **simplify**
- **narrow**
- **concentrate on behavior**
- **focus on relapse risk**
- **avoid crisis issues too complex or risky for the group setting**

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Evidence-Based Practices
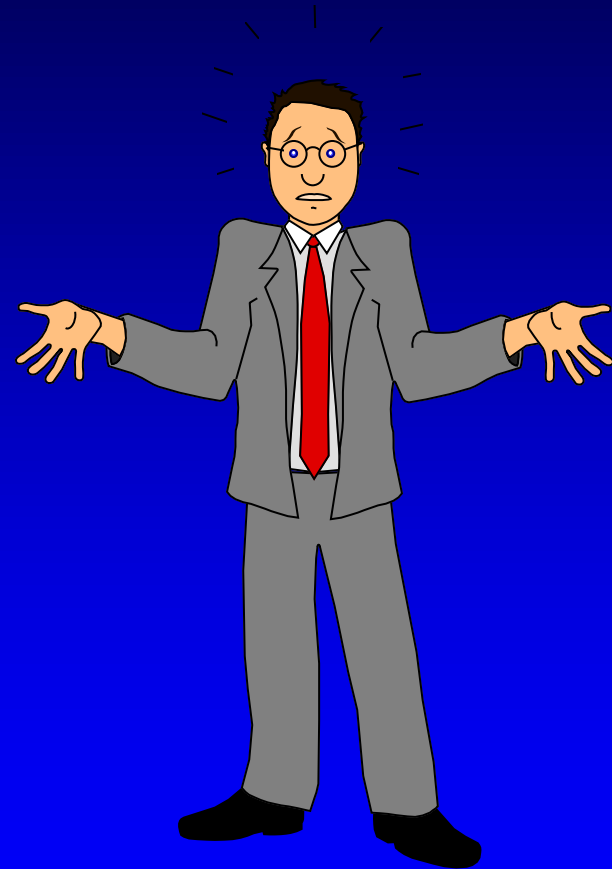
Brainstorming solutions

- **all members can contribute**

- **all suggestions are welcome**

- **no suggestion is analyzed or critiqued during brainstorming**

- **suggestions are limited to 10 - 12 ideas**

- **the person with the identified problem chooses 1 - 2 suggestions to try**

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Take action!

- **an action plan is developed for the chosen suggestion(s)**

- **tasks are identified and assigned**

- **consensus is achieved prior to leaving the meeting**

- **the plan is reviewed at the next meeting to determine success or the need for further problem-solving**

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Importance of "Chat"
before and after the group
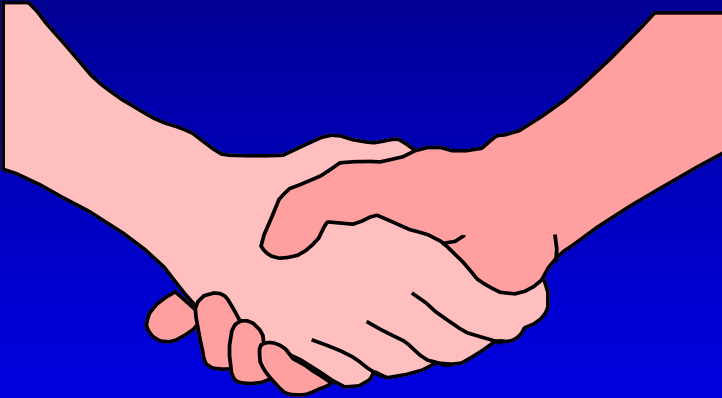
- **People with M.I. often forget how to initiate and join in conversation**

- **Reduces tension and anxiety**

- **Participants learn about one another**

- **Good way to learn what's going on in the community**

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FPE "Tools"

- **separate illness from personality**
- **identify problems**
- **prioritize steps**
- **develop actions**
- **delegate and distribute tasks**
- **explore multiple options rather than the same one!**

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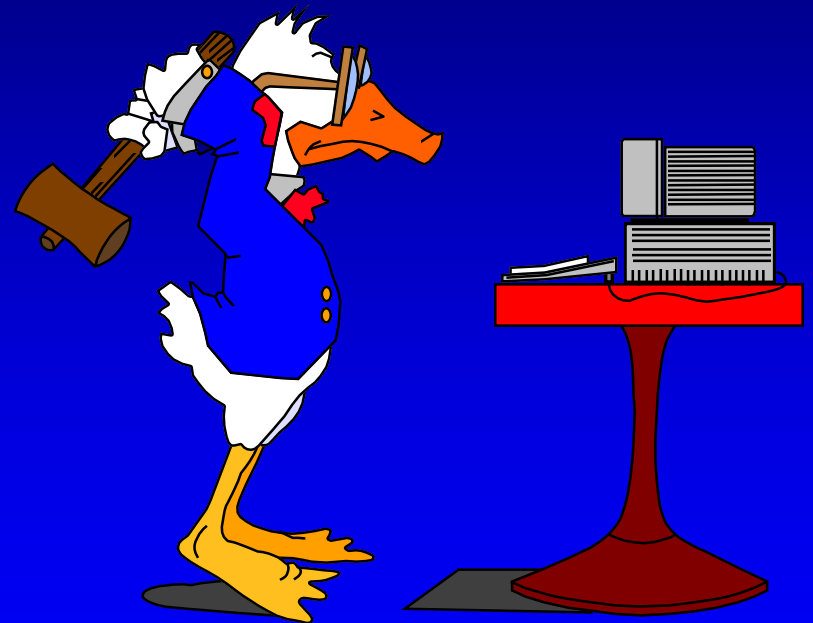
Where can FPE groups be held?

- **In-patient units**
- **Partial hospital programs**
- **Out-patient settings**
- **ACT programs**
- **Group homes**
- **Nursing homes**
- **With NAMI chapter**

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Starting a FPE group

- **find a compatible co-facilitator**
- **attend a training and follow the manual**
- **explore your own motivation and enthusiasm since barriers will appear**
- **promote this model to your supervisor because you will need his/her support**
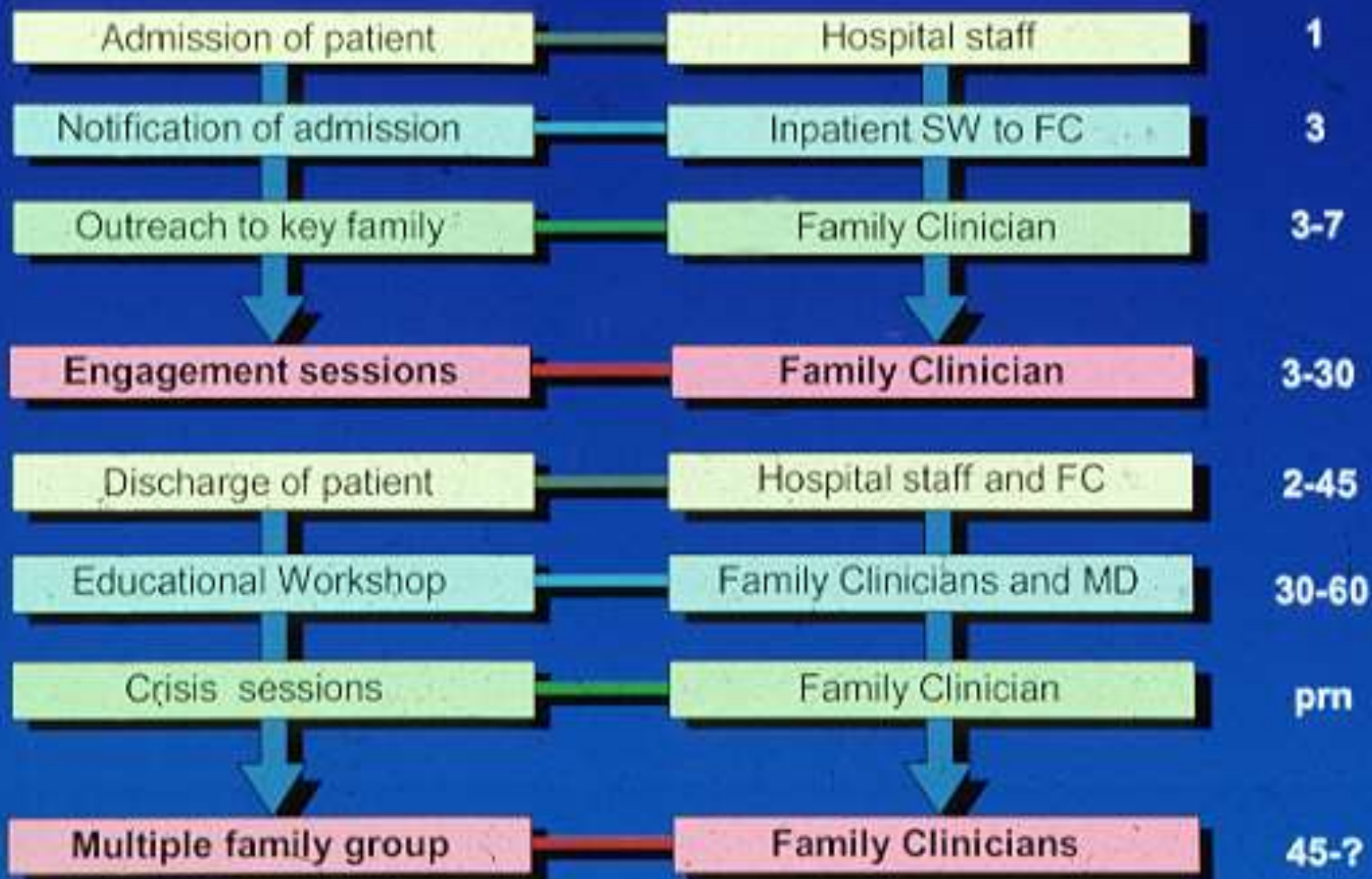- **adhere to the problem-solving format since this is not group process**

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Formation of Psychoeducational MFGs

Events	Staff	Days
Admission of patient	Hospital staff	1
Notification of admission	Inpatient SW to FC	3
Outreach to key family	Family Clinician	3-7
Engagement sessions	Family Clinician	3-30
Discharge of patient	Hospital staff and FC	2-45
Educational Workshop	Family Clinicians and MD	30-60
Crisis sessions	Family Clinician	prn
Multiple family group	Family Clinicians	45-?

Year One: Relapse Prevention

- **Engaging individual families**

- **Multifamily educational workshop**

- **Implementing family guidelines**

- **Reducing stigma and shame**

- **Lowering expectations**

- **Controlling rate of recovery**

- **Reducing intensity and exasperation**

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"I suppose one could say that stress is an inescapable part of the human condition."

Year Two: Rehabilitation

- **Gradually increasing responsibilities**

- **Moving one step at a time--the internal yardstick**

- **Monitoring encouragement from family members**

- **Establishing inter-family relationships**

- **Cross-parenting**

- **Focusing family interests outside family**

- **Restoring family's natural social network**

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"Young Kellerman has a lean-and-hungry look. But, of course, these days _everyone_ has a lean-and-hungry look."
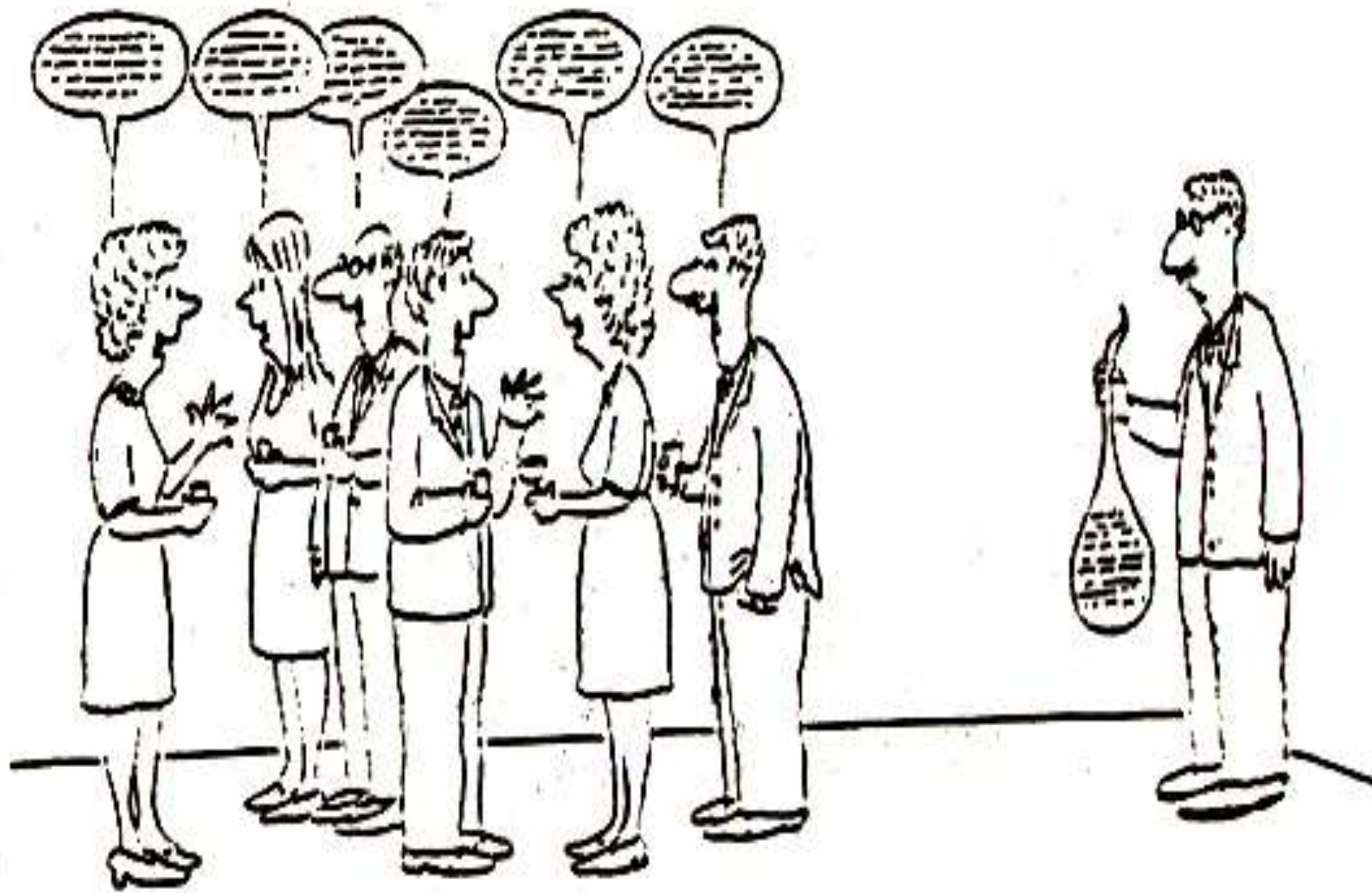
Year Three: Network Formation and Recovery

- **Validating group competency**

- **More socializing, less problem-solving**

- **Encouraging social contacts outside the group**

- **Shifting role of clinicians**

- **Converting to an advocacy group**

- **Converting to a vocational auxiliary**

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Better outcomes in family psychoeducation

- **Over 16 controlled clinical trials, comparing to standard outpatient treatment, have shown:**
  - **Much lower relapse rates and rehospitalization**
    - **Up to 75% reductions of rates in controls; minimally 50%**
  - **Increased employment**
    - **At least twice the number of consumers employed, and up to four times greater--over 50%employed after two years--when combined with supported employment**
  - **Reduced negative symptoms, in multifamily groups**
  - **Improved family relationships and reduced friction and family burden**
  - **Reduced medical illness**
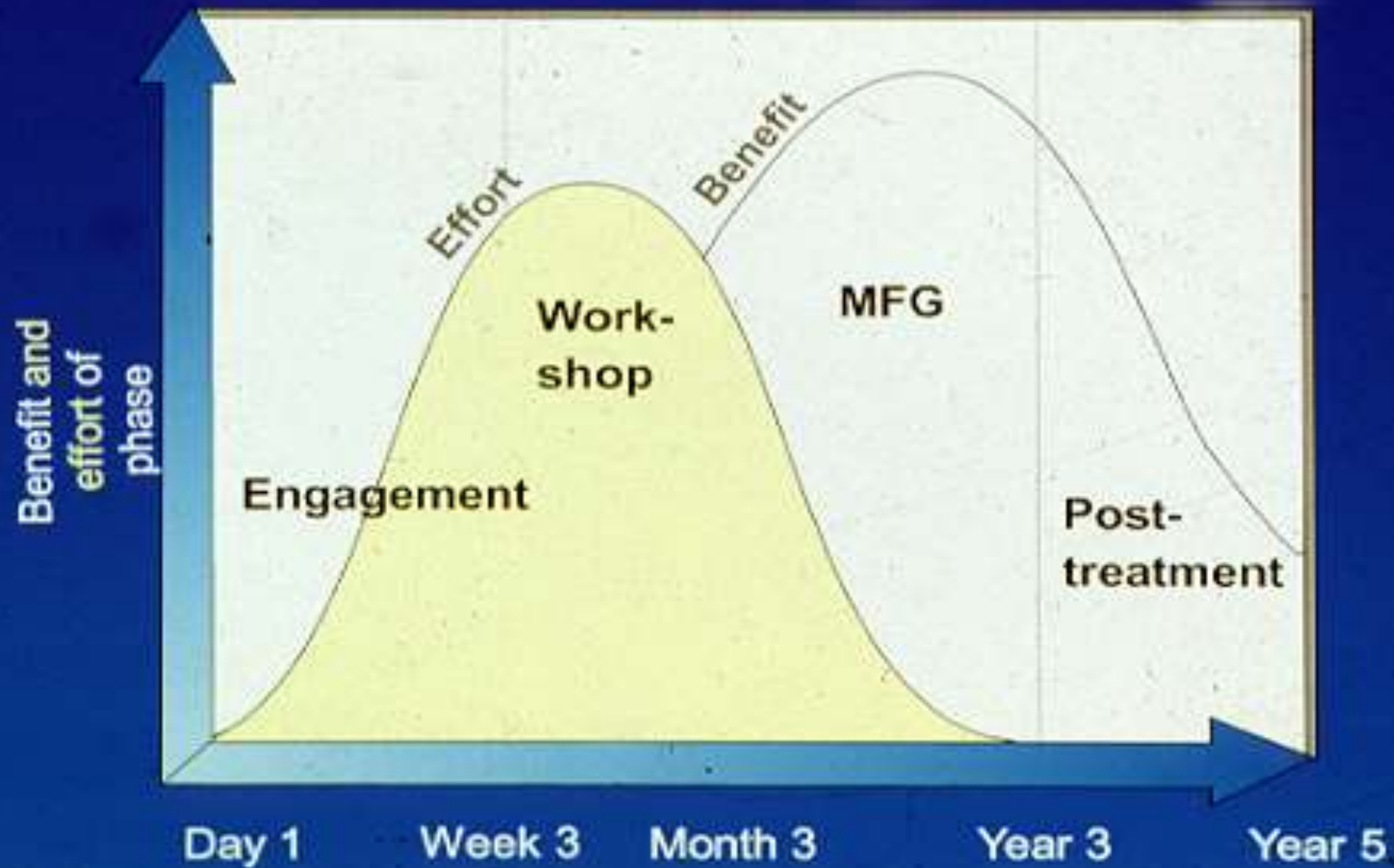   - **Doctor visits for family members decreased by over 50% in one year, in multifamily groups**

Cost-benefit ratios of PMFGs

Treatment	Hospital Costs /pt./yr.	Treatment costs	Net
Usual/prior	$6156	$300	$5836
Family PE	$1539	$300	$1239
Difference	($ saved per pt./yr.)		$4597

"*Incredible, but is it billable?*"

Benefits vs. effort over time

Voices from families and patients

Verbatim interviews of clinicians from the New York FPSP and summaries of the experience at one site

Disadvantages of family psychoeducation

- Costs are higher than self-help and may not borne by insurers in some states

- Requires some professionals to unlearn negative family paradigms from their training

- Requires lengthy, low intensity work

- Some results are abstract (e.g., remission, fewer relapses)

Influences on treatment adoption

- **Trainers**
  - **Familiarity with the model**
  - **"Well-taught" basic training exercises**
- **Content of training**
  - **Hearing about experiences of agencies and success stories of other MFGs**
  - **Also, successful local adaptations**
- **Format**
  - **Role playing was particularly useful**
  - **Visual material**
  - **Two-day workshop allowed time to process information**

Influences on treatment adoption

- **Enthusiasm**

  - **"Being part of a larger process"**

  - **Gained motivation and inspiration**

  - **"Great enthusiasm is contagious"**

    - **Came from trainers and others whose agencies had already implemented**

    - **Testimonials from staff and families at booster training sessions**

Influences on treatment adoption

- **Stated reasons for progress**

    - Belief in the model
        - Equally, staff effectiveness and outcomes
    - Grant support and free training
    - Depends upon the "drive, enthusiasm, and commitment of a determined individual"
        - Backed by a supportive administration
    - Skill and support of a trusted supervisor
        - Survey: "Use of outside consultants" most helpful item on survey (3.7/5)
    - Positive feedback processes
        - Success and positive outcomes beget further adoption, even between agencies

Influences on treatment adoption

- **Barriers**

    - **Shortage of agency resources, especially time and energy, sometimes money**
        - **Survey: "Intense work pressure on staff" highest rating for obstacle (3.7/5)**
        - **Next highest: "Staff demands too high already" (3.3/5)**
    - **Patient and/or family participation**
    - **Lack of staff and rapid turnover of previously trained staff**
    - **Staff burnout, unrelated to adoption process**
    - **Insufficient administrative support**

" I would entreat professionals not to be devastated by our illness and transmit this hopeless attitude to us.

I urge them never to lose hope; for we will not strive if we believe the effort is futile."

--Esso Leete, who has had schizophrenia for 20 years