



EVIDENCE-BASED  
PRACTICES

**KIT**

Knowledge Informing Transformation

# Building Your Program

# Family Psychoeducation



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)





# Building Your Program

# Family Psychoeducation

## Acknowledgments

This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the New Hampshire-Dartmouth Psychiatric Research Center under contract number 280-00-8049 and Westat under contract number 270-03-6005, with SAMHSA, U.S. Department of Health and Human Services (HHS). Neal Brown, M.P.A., and Crystal Blyler, Ph.D., served as the Government Project Officers.

## Disclaimer

The views, opinions, and content of this publication are those of the authors and contributors and do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), SAMHSA, or HHS.

## Public Domain Notice

All material appearing in this document is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization from the Office of Communications, SAMHSA, HHS.

## Electronic Access and Copies of Publication

This publication may be downloaded or ordered at <http://www.samhsa.gov/shin>. Or, please call SAMHSA's Health Information Network at **1-877-SAMHSA-7** (1-877-726-4727) (English and Español).

## Recommended Citation

Substance Abuse and Mental Health Services Administration. *Family Psychoeducation: Building Your Program*. HHS Pub. No. SMA-09-4422, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

### Originating Office

**Center for Mental Health Services**  
**Substance Abuse and Mental Health Services Administration**  
**1 Choke Cherry Road**  
**Rockville, MD 20857**

HHS Publication No. SMA-09-4422  
Printed 2009

## Building Your Program

*Building Your Program* is intended to help mental health authorities, agency administrators, and family intervention coordinators think through and develop the structure of Family Psychoeducation programs. The first part of this booklet gives you background information about the evidence-based model. This section is followed by specific information about your role in implementing and sustaining your program. Although you will work closely together to build your program, for ease, we separated tips into two sections:

- *Tips for Mental Health Authorities; and*
- *Tips for Agency Administrators and Family Intervention Coordinators.*

In preparing this information, we could think of no one better to advise you than people who have worked successfully with Family Psychoeducation programs. Therefore, we based the information in this booklet on the experience of veteran family intervention coordinators and administrators.

# Family Psychoeducation

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Family Psychoeducation KIT that includes a DVD, CD-ROM, and seven booklets:

**How to Use the Evidence-Based Practices KITs**

**Getting Started with Evidence-Based Practices**

**Building Your Program**

**Training Frontline Staff**

**Evaluating Your Program**

**The Evidence**

**Using Multimedia to Introduce Your EBP**



## **What's in *Building Your Program***

What Is Family Psychoeducation? . . . . .	1
Tips for Mental Health Authorities . . . . .	9
Tips for Agency Administrators and Family Intervention Coordinators . . . . .	19

# **Family Psychoeducation**



## Building Your Program

### What Is Family Psychoeducation?

Family Psychoeducation (FPE) is an approach for partnering with consumers and families to treat serious mental illnesses. FPE practitioners develop a working alliance with consumers and families.

The term *psychoeducation* can be misleading. While FPE includes many working elements, it is not family therapy. Instead, it is nearly the opposite. In family therapy, the family itself is the object of treatment. But in the FPE approach, the illness is the object of treatment, not the family. The goal is that practitioners, consumers, and families work together to support recovery.

Serious mental illnesses such as schizophrenia, bipolar disorder, and major depression are widely accepted in the medical field as illnesses with well-established symptoms and treatment. As with other disorders such as diabetes or hypertension, it is both honest and useful to give people practical information about their mental illnesses, how common they are, and how they can manage them.



Many consumers and families report that this information is helpful because it lets them know that they are not alone and it empowers them to participate fully in the recovery process. Similarly, research shows that consumer outcomes improve if families receive information and support (Dixon et al., 2001). For this reason, a number of family psychoeducation programs have been developed over the past two decades.

Models differ in their format (whether they use a multifamily or single-family format); duration of treatment; consumer participation; and location. Research shows that the critical ingredients of effective FPE include the following (Dixon et al., 2001):

- Education about serious mental illnesses;
- Information resources, especially during periods of crises;
- Skills training and ongoing guidance about managing mental illnesses;
- Problem solving; and
- Social and emotional support.

## The phases of Family Psychoeducation

FPE services are provided in three phases:

- Joining sessions;
- An educational workshop; and
- Ongoing FPE sessions.

### Joining sessions

Initially, FPE practitioners meet with consumers and their respective family members in introductory meetings called joining sessions. The purpose of these sessions is to learn about their experiences with mental illnesses, their strengths and resources, and their goals for treatment.

FPE practitioners engage consumers and families in a working alliance by showing respect, building trust, and offering concrete help. This working alliance is the foundation of FPE services. Joining sessions are considered the first phase of the FPE program.

## Educational workshop

In the second phase of the FPE program, FPE practitioners offer a 1-day educational workshop. The workshop is based on a standardized educational curriculum to meet the distinct educational needs of family members.

FPE practitioners also respond to the individual needs of consumers and families throughout the FPE program by providing information and resources. To keep consumers and families engaged in the FPE program, it is important to tailor education to meet consumer and family needs, especially in times of crisis.

## Ongoing Family Psychoeducation sessions

After completing the joining sessions and 1-day workshop, FPE practitioners ask consumers and families to attend ongoing FPE sessions. When possible, practitioners offer ongoing FPE sessions in a multifamily group format. Consumers and families who attend multifamily groups benefit by connecting with others who have similar experiences. The peer support and mutual aid provided in the group builds social support networks for consumers and families who are often socially isolated.

Ongoing FPE sessions focus on current issues that consumers and families face and address them through a structured problem-solving approach. This approach helps consumers and families make gains in working toward consumers' personal recovery goals.

FPE is not a short-term intervention. Studies show that offering fewer than 10 sessions does not produce the same positive outcomes (Cuijpers, 1999). We currently recommend providing FPE for 9 months or more.

In summary, FPE practitioners provide information about mental illnesses and help consumers and families enhance their problem-solving, communication, and coping skills. When provided in the multifamily group format, ongoing FPE sessions also help consumers and families develop social supports.

## Practice principles

FPE is based on a core set of practice principles. These principles form the foundation of the evidence-based practice and guide practitioners in delivering effective FPE services.

## Practice Principles

<b>Principle 1:</b> <b>Consumers define who <i>family</i> is.</b>	In FPE, the term family includes anyone consumers identify as being supportive in the recovery process. For FPE to work, consumers must identify supportive people they would like to involve in the FPE program. Some consumers may choose a relative. Others may identify a friend, employer, colleague, counselor, or other supportive person.
<b>Principle 2:</b> <b>The practitioner-consumer-family alliance is essential.</b>	Consumers and families have often responded to serious mental illnesses with great resolve and resilience. FPE recognizes consumer and family strengths, experience, and expertise in living with serious mental illnesses.  FPE is based on a consumer-family-practitioner alliance. When forming alliances with consumers and families, FPE practitioners emphasize that consumers and families are not to blame for serious mental illnesses. FPE practitioners partner with consumers and families to better understand consumers and support their personal recovery goals.
<b>Principle 3:</b> <b>Education and resources help families support consumers' personal recovery goals.</b>	Consumers benefit when family members are educated about mental illnesses. Educated families are better able to identify symptoms, recognize warning signs of relapse, support treatment goals, and promote recovery. Provide information resources to consumers and families, especially during times of acute psychiatric episodes or crisis.
<b>Principle 4:</b> <b>Consumers and families who receive ongoing guidance and skills training are better able to manage mental illnesses.</b>	Consumers and families experience stress in many forms in response to mental illnesses. Practical issues such as obtaining services and managing symptoms daily are stressors. Learning techniques to reduce stress and improve communication and coping skills can strengthen family relationships and promote recovery. Learning how to recognize precipitating factors and prodromal symptoms can help prevent relapses. For more information, see <i>Training Frontline Staff</i> in this KIT.
<b>Principle 5:</b> <b>Problem solving helps consumers and families define and address current issues.</b>	Using a structured problem-solving approach helps consumers and families break complicated issues into small, manageable steps that they may more easily address. This approach helps consumers take steps toward achieving their personal recovery goals.
<b>Principle 6:</b> <b>Social and emotional support validates experiences and facilitates problem solving.</b>	FPE allows consumers and families to share their experiences and feelings. Social and emotional support lets consumers and families know that they are not alone. Participants in FPE often find relief when they openly discuss and problem-solve the issues that they face.

## How we know that Family Psychoeducation is effective

FPE is based on research that shows that consumers and families who participated in the components of the evidence-based model had 20 to 50 percent fewer relapses and rehospitalizations than those who received standard individual services over 2 years (Penn & Mueser, 1996; Dixon & Lehman, 1995; Lam, Knipers, & Leff, 1993; Falloon et al., 1999). Those at the higher end of this range participated for more than 3 months.

Studies also show that FPE improved family well-being (Dixon et al., 2001). Families reported a greater knowledge of serious mental illnesses; a decrease in feeling confused, stressed, and isolated; and reduced medical illnesses and use of medical care (Dyck, Hendryx, Short, Voss, & McFarlane, 2002).

FPE has been found to increase consumers' participation in vocational rehabilitation programs (Falloon & Pederson, 1985). Studies have shown employment rate gains of two to four times baseline levels, when combined with evidence-based practice Supported Employment (McFarlane, Dushay, Stastny, Deakins, & Link, 1996; McFarlane et al., 1995; McFarlane et al., 2000).

Based on this significant evidence, treatment guidelines recommend involving families in the treatment process by offering the critical ingredients outlined in this evidence-based model (Lehman & Steinwachs, 1998; American Psychiatric Association, 1997; Weiden, Scheifler, McEvoy, Allen, & Ross., 1999).

## Who benefits most from Family Psychoeducation?

The greatest amount of research has shown benefits for consumers with schizophrenic disorders and their families (Dixon et al., 2001). Studies also show promising results for the following illnesses:

- **Bipolar disorder**—(Clarkin, Carpenter, Hull, Wilner, & Glick, 1998; Miklowitz & Goldstein, 1997; Moltz, 1993; Parikh et al., 1997; Miklowitz et al., 2000; Simoneau, Miklowitz, Richards, Saleem, & George, 1999);
- **Major depression**—(Simoneau et al., 1999; Emanuels-Zuurveen & Emmelkamp, 1997; Leff et al., 2000);
- **Obsessive-compulsive disorder**—(Van Noppen, 1999); and
- **Borderline personality disorder**—(Gunderson, Berkowitz, & Ruizsancho., 1997).

Studies show that the effectiveness of FPE does not differ depending on consumers' age, gender, education-level, or severity of illness.

This model has also been adapted and used effectively with a number of ethnic groups in a variety of settings in the United States. Studies have also been conducted in the following countries:

- **England**—(Leff, Kuipers, Berkowitz, & Sturgeon, 1985; Leff et al., 1990; Tarrier et al., 1989);
- **Spain**—(Muela Martinez & Godoy Garcia, 2001; Montero, Gomez-Beneyto, Ruiz, Puche, & Adam, 1992; Tomaras et al., 2000);
- **Germany**—(Wiedemann et al., 2001); and
- **China**—(Xiong et al., 1994; Zhang, Wan, Li, & Phillips, 1994).

Although more replications are desirable, all the evidence to date suggests that the positive effects of FPE generalize to nearly all major cultural populations: British, American, Australian, African American, Spanish or Latino, Scandinavian or Northern European, Chinese, and Japanese. However, anecdotally we know that culture and language pose significant barriers to providing FPE in some populations and, in any case, require culturally sensitive adaptations that must be further explored empirically.

### Is Family Psychoeducation for the family's benefit or for the consumer's?

FPE is for both consumers and families. The goal is to support recovery from serious mental illnesses. The evidence-based model asks family members to help in that effort. Though it is designed to achieve clinical outcomes and recovery goals for consumers, beneficial effects have been found for families as well.

### What if consumers do not have family or do not want their families involved?

In FPE, the term *family* includes anyone consumers identify as being supportive in the recovery process. The broad definition emphasizes that consumers choose whether to involve family and whom to involve. FPE helps consumers develop or enhance their support networks.

The evidence-based model has been found to work well with consumers who are disengaged from their families and have difficult treatment histories. Joining sessions give practitioners the opportunity to help consumers engage family members again in a constructive and supportive manner.

Research shows that practitioners often ask consumers for permission to involve their family members *during a crisis* (Marshall & Solomon, 2003). Asking for family involvement at this time may raise suspicions for some consumers. Consequently, they may be more reluctant to identify supportive people. For this reason, modify your intake and assessment procedures so that consumers are routinely told about the FPE program and are periodically asked if they would like to involve someone supportive in their treatment. For more detail, see *Set up referral procedures* under *Tips for Agency Administrators and Family Intervention Coordinators* in this booklet.

If consumers do not wish to involve family members in their treatment, FPE practitioners should respect their decision. If consumers do not give permission to share confidential information with their families, FPE practitioners may still respond to families' questions and concerns. Even the strictest interpretation of confidentiality policies does not prohibit receiving information from families or giving them general information about serious mental illnesses and agency services (Bogart & Solomon, 1999; Zippel, Langle, Spaniol, & Fisher, 1997).

If families want to learn more about serious mental illnesses, FPE practitioners should direct them to local family organizations such as the National Alliance on Mental Illness (NAMI). Consumers who are not interested in FPE may benefit from other education and skills training programs that are targeted specifically to consumers such as Illness Management and Recovery. For more information, see the *Illness Management and Recovery KIT*.

## Where should Family Psychoeducation be provided?

The FPE multifamily group model was first developed in a partial hospital setting. Nearly all of the controlled research on effectiveness has been conducted in outpatient clinics and community mental health centers. The extent to which FPE can be successfully adapted to other types of agencies is unknown.

FPE has been successfully implemented in both urban and rural settings, as well as in mid-sized cities and suburbs. For more information, see *The Evidence in this KIT*.

## Is it cost effective?

Implementing an FPE program has initial costs related to training and program development. However, studies show a low cost-benefit ratio related to savings from reduced hospital admissions, hospital days, and crisis intervention contacts (McFarlane, Dixon, Lukens, & Lucksted, 2003).

Cost-benefit ratios vary by state. For example, in New York, for every \$1 in costs for FPE provided in a multifamily group format, a \$34 savings in hospital costs occurred during the second year of treatment (McFarlane, 2002). In a hospital setting in Maine, an average net savings occurred of \$4,300 per consumer each year over 2 years. Ratios of \$1 spent for this service to \$10 in saved hospitalization costs were routinely achieved.

Non-fiscal savings are achieved as complaints from families about services decrease and family support for the agency and the mental health authority grows. In many communities, this has translated into political support for funding for expanded and improved services.



## Building Your Program

### Tips for Mental Health Authorities

Successfully implementing evidence-based practices requires the leadership and involvement of mental health authorities. This section discusses why mental health authorities should be involved in implementing Family Psychoeducation and the types of activities that mental health authorities typically undertake.

---

### Why should you be interested in Family Psychoeducation?

The Family Psychoeducation (FPE) KIT gives public mental health authorities a unique opportunity to improve clinical services for adults with serious mental illnesses. Research has shown that FPE has a consistent, positive impact on the

lives of consumers and their families. The FPE KIT gives you information and guidance for implementing this evidence-based practice in a comprehensive and easy-to-use format.

## How can mental health authorities support Family Psychoeducation?

As you read about FPE, you may think that it sounds great but unaffordable. We want to challenge that notion because mental health systems with limited resources are in the process of implementing FPE programs system-wide. These systems have visionaries who recognized the benefits of providing this evidence-based practice and who persisted in overcoming challenges. We hope you are that visionary for your system.

Implementing this evidence-based model takes a consolidated effort by agency staff, mental health authorities, consumers, and families. However, for this initiative to be successful, mental health authorities must lead and be involved in developing FPE programs in local communities.

### Be Involved in Family Psychoeducation

- Step 1** **Create a vision** by clearly articulating evidence-based practice principles and goals. Designate a staff person to oversee your FPE initiative.
- Step 2** **Form advisory groups** to build support, plan, and provide feedback for your FPE initiative.
- Step 3** **Establish program standards** that support implementation. Make adherence to those standards part of licensing criteria.
- Step 4** **Address financial issues** and align incentives to support implementation.
- Step 5** **Develop a training structure** tailored to the needs of different stakeholders.
- Step 6** **Monitor fidelity and outcomes** to maintain and sustain program effectiveness.

## Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur for the following reasons:

- One administration starts an initiative and another with a different vision and priorities subsequently assumes leadership.
- The model wasn't clearly understood from its inception.
- The staff drifted back to doing things in a way that was more familiar and comfortable.

Articulating the vision that providing FPE helps families and consumers recover from mental illnesses is essential for successfully implementing an FPE program. Place the FPE initiative in the context of the larger recovery paradigm. Talk about how FPE programs help agencies fulfill their mission—assisting consumers in their recovery process.

To ensure that your vision is clearly communicated, designate a staff person who has experience with the evidence-based model to oversee your FPE initiative. Some mental health authorities designate an office or staff with whom agencies may consult throughout the process of building and sustaining their FPE programs. Designated staff may also have oversight responsibility for FPE programs across the state.

## Form advisory groups

You can ensure that the FPE model is implemented appropriately if you contractually mandate that stakeholder advisory groups guide the implementation initiative. Your FPE initiative can benefit in many ways from an advisory group. Among other things, an advisory group can help you do the following:

- Build internal and external support;
- Increase program visibility; and
- Seek advice about ongoing planning efforts.

Consider forming both local and state-level advisory groups. State-level advisory groups may include the following members:

- Representatives of state agencies that would be invested in the initiative;
- Leadership from implementing agencies; and
- Representatives from consumer and family advocacy organizations.

Local advisory groups can serve as liaisons between the community and agencies that are implementing FPE programs. Community stakeholders who have an interest in the success of FPE programs include the following:

- Local consumer organizations;
- Local family organizations;
- Agency administrators; and
- FPE practitioners.

---

## Facilitating your advisory group

From the beginning, lead your advisory groups in understanding and articulating what FPE is and how it is going to be developed in your mental health system. For training materials that you can use to help stakeholders develop a basic understanding of FPE, see *Using Multimedia to Introduce Your EBP* in this KIT.

Advisory groups should continue to meet well after you have established your FPE program. We suggest that they meet about once a month for the first year, once every 2 months for the second year, and quarterly for the third year. In the second and third years, advisory groups may help FPE programs sustain high fidelity by assisting with fidelity evaluations and outcomes monitoring or translating evaluation data into steps for continuous quality improvement. For more information about the role of advisory groups, see *Getting Started with EBPs* in this KIT.

---

## Planning your Family Psychoeducation initiative

With a vision firmly in place, the process of unfolding FPE programs across the service system can begin. Carefully planning this process will help ensure a successful outcome. Implementing FPE programs first in pilot or demonstration sites may be useful. Working with pilot sites can help you manage problems as they arise and also give constituents the opportunity to see that the evidence-based model works. Multiple pilot sites are preferable to just one. When only one site is used, idiosyncratic things can happen that misrepresent the model. In contrast, when mental health authorities do a system-wide rollout, it is difficult to adequately train all FPE program staff. In that case, system problems that may have been resolved easily on a smaller scale with a few FPE programs can cause havoc.

## Establish program standards

Studies of agencies that have tried to replicate evidence-based practices have found that agencies that did not achieve positive outcomes failed to implement all of the components of the evidence-based model (Becker et al., 2001; Bond & Salyers, 2004). As a mental health authority, you can ensure that the system has incentives to implement the evidence-based model as outlined in the FPE Fidelity Scale (see *Monitor fidelity and outcomes* below). Attention to aligning these incentives in a positive way (such as attaching financial incentives to achieving improved outcomes) is vital to successfully implementing FPE programs.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern these areas:

- Admission and discharge;
- Staffing;
- Service components;
- Program organization and communication;
- Consumer medical records;
- Consumer rights; and
- Supervision and program evaluation.

Support FPE implementation by explicitly referring to the evidence-based model in licensing standards and other program review documents (for example, grant applications, contracts, and requests for proposals). Review current administrative rules and regulations to identify any barriers to implementing programs. Work closely with agency administrators to ensure that state-level policies support high-fidelity practice.

## Definition of FPE Services

The following language has been used to reimburse FPE services in Maine.

Covered services include Family Psychoeducation provided in multifamily groups and in single-family sessions. Covered services include Family Psychoeducation as defined under program elements, provided to related and non-related care-takers, as well as to the eligible person. Covered services may be provided to the participating people with or without the eligible person being present, if all other program requirements and elements are being provided.

Program elements of the covered services include joining sessions, usually involving eligible Medicaid recipients and their family member, who may meet separately or together, depending on clinical condition and other considerations to be determined by the eligible provider. These sessions focus on exploring the following:

- Precipitants of current and/or past acute episodes of illness;
- Prodromal signs and symptoms;
- Coping strategies and strengths;
- Family and social supports;
- Grief and mourning in relation to the illness; and
- Treatment goals and planning.

There may be three or more joining sessions, as early in the course of an episode or illness as possible.

Educational workshops involve identified family members and, at the determination of the practitioners leading the workshop, eligible Medicaid recipients. These workshops offer extensive information about the biological, psychological, and social aspects of mental illnesses; the nature, effects, and side effects of psychiatric treatments; what families can do to help recovery and prevent relapse; and guidelines for managing mental illnesses.

Ongoing Family Psychoeducation sessions occur biweekly in a multifamily or single-family format, usually with the eligible Medicaid recipient present. These sessions follow an empirically tested format and focus on solving problems that interfere with treatment, illness and symptom management, and coping skills. Case management may also be provided during these sessions.

## Address financial issues

Each state is different. Typically, FPE programs are funded by a combination of state mental health dollars, Medicaid, and private insurance. Funding approaches that have been used in some states include the following:

- Reallocating some psychosocial or psychotherapy services for FPE services;
- Adopting a case-rate approach where the agency is reimbursed monthly for each consumer to cover bundled direct and indirect costs; or
- Seeking Medicaid reimbursement.

In some states, Medicaid authorities support funding for FPE because emergency room visits and hospital admission costs are greatly reduced. The following chart is an example of how FPE has been defined for the purpose of Medicaid reimbursement.

## Develop a training structure

Agencies who implement evidence-based practices are often challenged in their efforts because people misunderstand the model or because they lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of FPE.

We encourage you to support agency administrators in their efforts to develop a training structure for implementing FPE. The training plan should include basic training for key community stakeholders including the following:

- Consumers;
- Families;
- Mental health authority representatives; and
- Staff from key community organizations.

The training plan should also include basic training for staff at all levels within participating agencies and intensive training for FPE practitioners (staff who are designated to provide FPE services).

Some mental health authorities develop a few FPE programs at a time so that staff from the first FPE program can help train those in newly developed programs. Generally, it takes about a year for staff to feel confident providing the evidence-based model, but this can vary depending on how much structural change is needed. FPE practitioners who are reluctant to accept new models can take longer to change.

It may take 2 to 3 years for an agency to become sufficiently proficient in the evidence-based model before it can assume the added responsibility of training other agencies' FPE practitioners. Agencies that have become training sites indicate that involving their staff in training staff from new FPE programs reinforces the practice principles and their knowledge of the evidence-based model.

---

## Choose your trainer

Intensive training plans for FPE practitioners may be designed in several different ways. The first decision is related to who will conduct the training. The family intervention coordinator (a staff member who is designated to oversee FPE programs) may facilitate the initial training for FPE practitioners by using the training tools in *Training Frontline Staff* in this KIT.

Some mental health authorities choose to hire external trainers to train practitioners across the state. Other mental health authorities have established training centers or enhanced existing education and training centers that offer education, training, and ongoing consultation or supervision.

One successful strategy for training FPE practitioners entails having new FPE practitioners visit an existing, well-functioning, high-fidelity FPE program to observe how the program works. New FPE practitioners will benefit most from this visit if they have a basic understanding of the FPE model.

Once trained, family intervention coordinators and practitioners will be able to use the tools in *Using Multimedia to Introduce Your EBP* in this KIT to provide basic training to key stakeholders.

---

## Offer ongoing training and consultation

Throughout the first year of your FPE program, participating agencies should offer intermittent booster training sessions to FPE practitioners. After the first year, consider establishing an annual statewide conference on the evidence-based model.

Routine onsite and telephone consultation is also important, particularly for family intervention coordinators, since leading an FPE program requires a complex set of administrative and clinical skills. For example, family intervention coordinators provide clinical supervision, which may require a shift in thinking from how services were traditionally provided. Family intervention coordinators have administrative responsibilities such as preparing administrative reports, developing policies and procedures, and hiring.

Perhaps more important, family intervention coordinators are responsible for ensuring that the FPE program operates with fidelity to the evidence-based model, including ensuring the quality and content of practitioner-consumer-family interactions (See *Monitor fidelity and outcomes* on the next page). It is very difficult for any family intervention coordinator to grasp everything that has to be learned in a brief time. Also, understanding what must be done and translating that understanding into action are different and equally difficult. Strong daily leadership is essential to ensure that the FPE model is faithfully carried out.



For at least the first year after a new program has started, family intervention coordinators need someone who is experienced in the evidence-based model to give ongoing consultation on organizational and clinical issues. Consultation ranges from advice on how to integrate evidence-based practice principles into the agency's policies and procedures to consulting on cases. A state- or county-wide coordinator who is experienced with the evidence-based model can also help new FPE programs through ongoing contact, assessment, and troubleshooting.

### Monitor fidelity and outcomes

Providing FPE involves incorporating a new program into the service delivery system. The best way to protect your investment is to make certain that agencies actually provide services that positively affect the lives of consumers on an ongoing basis.

**Programs that adhere more closely to the evidence-based model are more effective than those that do not follow the model.** Adhering to the model is called *fidelity*.

The FPE Fidelity Scale measures how well programs follow key elements of the evidence-based model. Research tells us that the higher an agency scores on a fidelity scale, the greater the likelihood that the agency will achieve the favorable outcomes (Becker et al., 2001; Bond & Salyers, 2004). For this reason, it is important to monitor both fidelity and outcomes.

As a central part of the initial planning process, you must address how you will monitor the fidelity and outcomes of FPE programs. Too many excellent initiatives began with enthusiastic support but floundered at the end of a year because they did not plan how they would maintain the program. Monitoring fidelity and outcomes on an ongoing basis is a good way to ensure that your FPE programs will continue to grow and develop. For more information about monitoring fidelity and outcomes, see *Evaluating Your Program* in this KIT.

Consider developing routine supervision and evaluations of FPE programs. If state or county-level monitoring is not possible, use strategies (for example, rules, contracts, financial incentives) to support fidelity and outcomes monitoring on the local level or within individual agencies.

For the characteristics of an FPE program that would have a perfect score on the FPE Fidelity Scale, see the next page. For the entire FPE Fidelity Scale, see *Evaluating Your Program* in this KIT.

## Characteristics of a Family Psychoeducation Program That Would Have a Perfect Score on the FPE Fidelity Scale

<b>Family intervention coordinator</b>	A designated clinical administrator oversees the FPE program and performs specific tasks.
<b>Session frequency</b>	Consumers and families participate every 2 weeks in FPE sessions.
<b>Long-term FPE</b>	Consumers and families are provided with long-term FPE. At least one family member for each consumer participates in FPE sessions for at least 9 months.
<b>Quality of practitioner-consumer-family alliance</b>	FPE practitioners engage consumers and family members with warmth, empathy, acceptance, and attention to individual needs and desires.
<b>Detailed family reaction</b>	FPE practitioners identify and specify families' reaction to their relative's mental illness.
<b>Precipitating factors</b>	FPE practitioners, consumers, and families identify and specify precipitating factors for consumers' mental illnesses.
<b>Prodromal signs and symptoms</b>	FPE practitioners, consumers, and families identify and specify prodromal signs and symptoms of consumers' mental illnesses.
<b>Coping strategies</b>	FPE practitioners identify, describe, clarify, and teach coping strategies.
<b>Educational curriculum</b>	FPE practitioners use a standardized curriculum to teach families about mental illnesses.
<b>Multimedia education</b>	Consumers and family members receive educational materials about mental illnesses in several formats (for example, paper, video, and Web sites).
<b>Structured group sessions</b>	FPE practitioners follow a structured procedure in conducting multifamily group sessions.
<b>Structured problem solving</b>	FPE practitioners use a standardized approach to help consumers and families with problem solving.
<b>Stage-wise provision of services</b>	FPE services are provided in the following order: <ul style="list-style-type: none"> <li>■ Engagement;</li> <li>■ Three or more joining sessions;</li> <li>■ The educational workshop; and</li> <li>■ Multifamily group sessions.</li> </ul>
<b>Assertive engagement and outreach</b>	FPE practitioners assertively engage all potential consumers and family members by phone, by mail, or in person (in the agency or in the community) on an ongoing basis.





## Building Your Program

### Tips for Agency Administrators and Family Intervention Coordinators

Whether your agency is interested in enhancing an existing program or developing a new program, you will need a broad range of activities to successfully implement Family Psychoeducation. This section outlines the range of implementation activities in which agency administrators and family intervention coordinators are often involved.

#### Recruit your staff

Family Psychoeducation (FPE) programs typically consist of two or more practitioners and a family intervention coordinator. Broadly speaking, you can consider agency staff who are involved in providing FPE as a team, including the family intervention coordinator, FPE practitioners, and the agency director.

#### Choose a family intervention coordinator

It is important to hire or designate a leader for your FPE program. We suggest that FPE leaders (called *family intervention coordinators*) are full-time employees whose time is completely dedicated to the FPE program.



Family intervention coordinators are often mid-level managers who have the authority to make or suggest administrative changes within the agency. Successful family intervention coordinators have authority and both administrative and clinical skills.

As part of their administrative responsibilities, they undertake the following tasks:

- Develop and monitor FPE policies and procedures such as the intake and engagement process;
- Assign potential FPE consumers to FPE practitioners;
- Monitor and adjust FPE practitioner caseloads; and
- Arrange for training new FPE practitioners and continuing education of existing FPE staff.

Along with the agency director, family intervention coordinators are often responsible for hiring FPE practitioners, monitoring the program's fidelity to the FPE model, and overseeing other quality control and financial mechanisms.

As part of their clinical responsibilities, family intervention coordinators provide weekly group supervision and individual supervision as needed. During supervisory sessions, family intervention coordinators give FPE practitioners program feedback. They also act as a liaison with other agency coordinators and key stakeholders to maintain support for the FPE program.

Because family intervention coordinators must have an active role in setting up the structures and processes needed to support the FPE program, you should make the KIT available to candidates during the hiring process so they understand what they must do.

## Select the best Family Psychoeducation practitioners

FPE practitioners can come from a wide range of clinical backgrounds, including the following:

- Social work;
- Occupational therapy;
- Counseling;
- Case management;
- Nursing;
- Psychology; and
- Psychiatry.

In some carefully supervised situations, paraprofessionals working closely with a masters-level clinician have effectively conducted FPE sessions. However, some agencies have experienced difficulty being reimbursed for services provided by non-licensed staff. For this reason, review the regulations of FPE funding mechanisms when you make staffing decisions.

Success as an FPE practitioner appears to have less to do with academic credentials and more to do with personal style and philosophy. Positive, high-energy, and enthusiastic people who have a “can do” attitude tend to do well. We recommend recruiting FPE practitioners who understand serious mental illnesses, believe that consumers can live full and productive lives in the community, and believe that families can support the recovery process.

Effective FPE practitioners are warm, kind, and empathic. Good listening skills are important, including the ability to reflect back what consumers and families say and seek clarification when necessary. Good eye contact, a ready smile, and a good sense of humor are other helpful attributes that put people at ease.

Specific teaching and facilitation skills are also helpful. FPE practitioners must be able to structure sessions that follow a predictable pattern. They must also be able to establish clear objectives and expectations, set goals, and follow through on those goals.

Another important attribute for practitioners is the ability to take a *shaping* approach to increasing consumers' knowledge and skills. Shaping means that practitioners recognize that people often need a significant period of time to learn new information and skills. You must give consumers positive feedback for their efforts and acknowledge small successes along the way. Having a shaping attitude means that you acknowledge and value even very small steps and encourage consumers to achieve their personal goals.

In addition, FPE practitioners must be able to work both independently and as team members—providing cross-coverage for consumers and participating in group supervision.

### Requirements for FPE Practitioners

- Have specific knowledge of mental illnesses
- Be willing and able to actively involve consumers and families in making decisions about their own treatment and services
- Have strong clinical and rehabilitative skills
- Be warm, kind, positive, empathic people with good listening and teaching skills
- Be willing to work both independently and collaboratively as a team

---

### Reflect your community's cultural diversity

FPE teams should reflect the cultural diversity of the communities in which they operate. More important, FPE practitioners must be aware of and sensitive to cultural differences and consumer preferences. FPE teams should include bilingual practitioners as needed to reflect the cultural diversity of the communities in which they provide services. If bilingual staff are not available, you should provide translators as needed.

Having a balance of male and female FPE practitioners may also be helpful. In addition, your FPE program must have resources available to allow practitioners to work with consumers who have hearing and visual impairments.

---

### Consider these hiring tips

Thoroughly check references for job candidates. The best predictor of work performance is likely to be candidates' performance in previous jobs, particularly jobs that required some of the same skills and personal qualities that are desirable for FPE practitioners. The family intervention coordinator should talk to previous supervisors, ask in detail about candidates' previous work responsibilities and performance, and seek opinions about their capabilities.

Invite all candidates who are being seriously considered for employment to spend a half-day or more in your FPE program so that they can see practitioners at work firsthand. Candidates can then better evaluate how well they might fit in and will be able to make a more informed decision about taking the job.

This visit will also give FPE practitioners a chance to talk with and observe candidates. Ask them to offer their feedback during the hiring process. This type of screening may help you weed out people who may not be appropriate for your FPE program.

## Build support for your program

Developing a successful FPE program depends on the support and collaboration of a number of stakeholders. Internally, it is important that the director and staff across the agency understand and support implementing FPE. Your program is more likely to achieve high fidelity if the agency director is informed and involved in the implementation process from the start.

It is important that the agency director take the lead in promoting the FPE program and addressing any misconceptions. Articulate internal and public support for the FPE program by telling key stakeholders that consumers can recover from mental illnesses and families can support the recovery process. Inform key stakeholders that the core components of FPE are linked to positive consumer outcomes and emphasize the importance of your FPE program by demonstrating how practitioners help consumers get on with life beyond illness to achieve their personal recovery goals.

Once the agency director has articulated a clear vision for implementing the evidence-based model, continue to bolster internal support for your program by giving all agency staff basic information. For more information, see *Develop a training plan* later in this booklet.

### Form advisory committees

Forming a local advisory committee for your FPE program is an effective way to gain key stakeholders' support. Identify community stakeholders who have an interest in the success of your FPE program to serve on your committee. Committees often include the following people:

- Representatives from local consumer organizations;

- Members of local family organizations such as the National Alliance on Mental Illness (NAMI);
- Representatives from local mental health authority;
- Representatives from local mental health agencies;
- Key agency staff; and
- FPE practitioners.

To start, your mental health authority representatives or agency director should voice support for the FPE initiative. Next, provide basic training to help advisory group members understand the evidence-based model. Once established, advisory groups may help implement your program in a variety of ways. For more information, see *Getting Started with EBPs* in this KIT.

### Sustain support for your program

Building support for your FPE program should be an ongoing effort. Once your program is operational, find ways to recognize and reward the achievements of FPE practitioners and consumers. For example, organize meetings with key stakeholders during which consumers share their success stories and administrators highlight staff achievements.

Another option is to sponsor a banquet to celebrate your program's accomplishments with consumers, family members, policymakers, and agency staff members. Banquets are particularly helpful if a wide array of stakeholders (such as physicians, administrators, and key public officials) attend.

Your agency director and family intervention coordinator should meet regularly to review program evaluation data, discuss roadblocks, and plan ways to improve your FPE program. Building support from internal staff and key community stakeholders is essential to implementing an effective FPE program.

## Agency Directors Can Lead This Effort

- Articulate clear support for the FPE program to internal staff and key community stakeholders.
- Attend some FPE trainings, supervision, and advisory group meetings.
- Meet monthly with the family intervention coordinator to address roadblocks to providing FPE.
- Facilitate ongoing planning and program improvement efforts.
- Engage local and state mental health authority representatives.

## Develop effective policies and procedures

Starting a new FPE program means developing policies and procedures that support the activities of the FPE model.

### Develop admission and discharge criteria

Set up a process to identify consumers who are appropriate for your FPE program and acquaint referral sources with your procedures. Initially many agencies choose to offer FPE to consumers with schizophrenic disorders since the evidence for this model is strongest with this group. Once practitioners have provided FPE services to consumers with schizophrenic disorders and their families, it is relatively easy to modify your FPE program to provide services to consumers who have other diagnoses and their families. For more information on adapting FPE for specific diagnoses, see *The Evidence* in this KIT.

FPE is effective for a wide variety of consumers. No evidence suggests that consumers' race, gender, or age is related to consumer and families' ability to benefit from FPE. In addition, consumers may benefit from FPE regardless of how long they have experienced symptoms of their mental illnesses.

Some evidence shows that FPE is particularly beneficial for consumers and families with the following characteristics (McFarlane, 2002):

- Consumers who have recently experienced their first episode of mental illness or are early in the course of illness;
- Consumers who are experiencing acute psychiatric crisis;
- Consumers who experience frequent hospitalizations or prolonged unemployment;
- Consumers or families who have asked to learn more about serious mental illnesses;
- Families who have previously benefited from a family education program and want to learn how to better support their relative; or
- Families who are especially exasperated or confused about the illness.

### What Policies and Procedures Should Cover

- Admission and discharge criteria
- Staffing criteria
- Service components
- Program organization and communication
- Consumer records requirements
- Consumers' rights
- Program and team member performance evaluation

FPE is particularly effective in working with families and consumers who are early in the course of illness since most consumers and families report the most extreme distress during this time. Often in this early period, major rifts develop between consumers and families that may exacerbate symptoms and disability. FPE has prevented and often healed those rifts, as participants stop blaming themselves or one another and cooperate to help in the overall treatment and rehabilitation process. Consider targeting your FPE program to consumers based on these criteria.

---

### Defining family

Participating in FPE is the consumers' choice. In FPE, the term *family* includes anyone consumers believe is supportive and would like to participate in FPE. For FPE to work, consumers must identify supportive people they would like to involve in the FPE program. Some consumers may choose a relative. Others may identify a friend, employer, colleague, counselor, or other supportive person.

---

### Set up referral procedures

Agency administrators and family intervention coordinators must also develop referral procedures. Modify intake forms to prompt agency staff to tell consumers who are new to the agency about the FPE program and elicit their interest in participating. Also include a section on your assessment or treatment planning forms that prompts similar questions so that practitioners routinely provide information about the FPE program.

Some agencies also encourage referrals through the following sources:

- Treatment team meetings;
- Internal or external service providers;
- Community presentations; or
- Consumer self-referrals.

Put your procedures into operation by identifying and educating referral sources about the FPE program. Procedures for advertising your FPE program will depend on your referral approach. For example, if your FPE program primarily depends on referrals from treatment team members and other internal service providers, routinely conduct agency-wide presentations to develop a basic understanding of your FPE program.

Consumers do not have to accept that they have a mental illness to be referred to the FPE program. FPE practitioners can effectively work with consumers even if they do not believe that they have a given diagnosis. Develop a process for explaining your FPE program to consumers in a way that helps them make an informed decision about accepting services.

---

### Review confidentiality policies

Confidentiality policies vary from state to state. In many states, policies do not specifically discuss releasing confidential information to family members of consumers with mental illnesses. As a result, practitioners may be reluctant to speak with family members or they may be confused about the types of information that they may share (Marshall & Solomon, 2003).

Review your agency's confidentiality policies. Find out if consumers must complete a Release of Information Form to give permission to share confidential information with their family members. If so, review your agency's current forms to see if they are appropriate for this purpose. For example, Release of Information Forms created solely for sharing information between agencies may be limited to 30, 60, or 90 days. Using these forms for your FPE program may cause undue burden on FPE practitioners who would be required to complete multiple forms for each consumer over the course of the program. In such cases, consider revising your forms to meet the needs of the FPE program. For resources to help you modify your Release of Information Forms, see *The Evidence* in this KIT.

## Establish staffing criteria

Your policies and procedures should also specify the staffing criteria for your program. Include clear and useful job descriptions in your staffing criteria. For job applicants, a good position description clarifies whether a particular position matches their skills and expectations.

Include the following in your job descriptions:

- Task-specific position descriptions;
- Main task categories; and
- Specific duties.

Clear job descriptions allow family intervention coordinators to effectively supervise new employees and also allow employees to focus on the basic elements of their jobs.

When offering FPE in the multifamily group format, designate two FPE practitioners to facilitate each group. The recommended size of a FPE multifamily group is five to eight consumers.

More information is provided above under *Recruiting your staff*.

## Discuss program organization and communication

Policies and procedures for your FPE program should include criteria for how the FPE program is organized and how practitioners communicate. To be effective, FPE practitioners must be able to work both independently and as team members, especially if they are providing FPE in the multifamily group format.

As team members, FPE practitioners should communicate regularly and provide cross-coverage for consumers. They should also attend weekly group supervisory meetings that the family intervention coordinator facilitates. These meetings give FPE practitioners the opportunity to discuss and problem-solve consumers' cases.

FPE practitioners should be part of a multidisciplinary treatment team. When working with treatment team members, FPE practitioners should model evidence-based practice treatment skills. Your policies should outline clear procedures for how FPE practitioners will communicate with multidisciplinary treatment team members. They should also coordinate services with other team members to ensure that treatment supports recovery goals.

## Offer Family Psychoeducation in both individual or group formats

Your policies should specify that ongoing FPE sessions may be provided either in the single-family or multifamily group format. The format that you choose depends on consumer and family preferences and needs.

In general, single-family formats tend to be used for the following:

- Consumers and families with strong social support networks;
- Consumers and families who exhibit unusual resilience or strong coping skills; or
- Consumers who respond positively to medications.

Multifamily groups tend to be used for the following:

- Consumers who are experiencing their first episode with mental illness;
- Consumers who are not responding well to medication and treatment;
- Consumers who are experiencing complicating issues such as other medical illnesses;
- Families experiencing high stress;
- Families who have separated from their relative with mental illness; and
- Families who have been through divorce.

Participating in the multifamily group format has other benefits for both consumers and their families. For example, the social stigma related to mental illnesses causes many consumers and families to feel socially isolated. FPE in a multifamily group format connects consumers and families to others who have had similar experiences. It gives them a forum for peer support and mutual aid by allowing participants to share solutions that have worked for them. For this reason, whenever possible, we recommend offering ongoing FPE services in a multifamily group format.

FPE practitioners commonly work in both multifamily or single-family group formats. For example, when multifamily group members are unable to attend specific group sessions, FPE practitioners may offer single-family sessions to accommodate scheduling difficulties.

For information for practitioners about providing FPE in both individual and group formats, see *Training Frontline Staff* in this KIT.

---

### Determine the length of your sessions and program

In your FPE policies and procedures, outline the length of FPE sessions and the program. FPE services are provided in three phases:

- Joining sessions;
- An educational workshop; and
- Ongoing FPE sessions.

During the joining sessions in the first phase, FPE practitioners meet with each FPE consumer and their respective family members at least three times for about 1 hour. You may hold joining sessions with consumers and their respective family members together or meet separately with them. (That means you would conduct six or more sessions instead of three or more.)

FPE practitioners base their decisions about offering joining sessions to consumers and family members jointly or separately on consumer and family preferences, diagnosis, and illness characteristics. For information to help FPE practitioners make these decisions, see *Training Frontline Staff* in this KIT.

During the second phase of the FPE program, a 1-day educational workshop is offered. Typically, the workshop is conducted solely with families—not with consumers—to give families a chance to speak freely about their experiences and to interact with others who are in similar situations.

Some agencies involve consumers in part of the workshop to ensure that they receive the same educational information as their families. Others offer this information to consumers individually or in a separate consumer forum. Typically, this workshop is offered only once to participants in the FPE program. You should offer it within 1 or 2 weeks after joining sessions are completed.

You may offer the last phase of the FPE program—ongoing FPE sessions—in either the single-family or multifamily group format. FPE multifamily groups consist of five to eight consumers and their respective family members. They meet every 2 weeks for 1½ hours. Two FPE practitioners co-facilitate the group.

In the single-family format, one FPE practitioner meets individually with consumers and their respective family members. Meetings are usually every 2 weeks for 1 hour. Offer both single-family and multifamily sessions for 9 months or more.

---

## Ensure stage-wise provision of services

In your policies and procedures specify that all three phases of the FPE program should be provided in order. Also, FPE practitioners should complete the first phases of the FPE program *in full* before offering the next.

Coordinating the timing of the phases requires some planning and organizing. If FPE occurs in the multifamily group format, the two FPE practitioners who will facilitate the group divide the responsibility for conducting joining sessions. For example, out of eight consumers and their respective family members, each practitioner would join with four. Offer the 1-day educational workshop within 1 to 2 weeks after joining sessions have been completed.

To achieve the stage-wise provision of services, set aside time for planning meetings during the first phase of the program. Begin the planning process by developing a list of potential consumer participants. When both FPE practitioners begin joining sessions simultaneously, it will be easier to coordinate the timing of the second and third phases. Include in your policies and procedures that FPE practitioners should meet weekly during this time period to ensure that you provide services in stages.

---

## Adjust practitioners' caseloads

In the first 3 months of implementing your FPE program, practitioners are involved in a number of activities including training activities and planning meetings. Consequently, initially they will have an increased workload.

To effectively implement FPE, reduce practitioners' caseload until the first two phases of the FPE program are completed. Once practitioners have completed their first joining sessions and 1-day educational workshop and your family intervention coordinator has developed procedures to routinely identify and refer consumers to the FPE program, workload demands will be substantially decreased. You can restore caseload size.

---

## Structure your Family Psychoeducation sessions

Policies and procedures for your FPE program should also outline the structure of FPE sessions. Following a prescribed structure helps FPE practitioners provide effective FPE services. Specifically, FPE practitioners complete a prescribed set of tasks for each joining session. The tasks are outlined in the sample Progress Notes on the next few pages.

In the second phase of the FPE program, FPE practitioners offer a 1-day educational workshop that follows a standardized educational curriculum. The structure of the workshop is also outlined in a sample Progress Note on the next few pages.

Ongoing FPE sessions follow a structured approach shown below:

Multifamily Group Session Agenda	
Socialize	15 minutes
Identify current issues—go-around	20 minutes
Select a single problem	5 minutes
Use structured problem solving	45 minutes
Socialize	5 minutes
<b>Total</b>	<b>90 minutes</b>

The structured problem-solving approach is also outlined in a sample Progress Note on the next few pages.

In your FPE policies and procedures, encourage practitioners to follow the suggested structure during each phase of the FPE program.

### Offer other core service components

Your FPE policies should also discuss how to assertively engage consumers and families. Engaging consumers and families in FPE starts the moment that they are referred to the program and continues throughout the program.

FPE practitioners assertively engage consumers and family members by phone, by mail, or in person (in the agency or in the community). To keep consumers and families engaged in services, encourage FPE practitioners to routinely reassess the issues that consumers and families are facing and offer services to meet their needs.

FPE practitioners also keep consumers and family engaged in FPE services by routinely offering educational materials tailored to their own needs. Policies and procedures should encourage FPE practitioners to provide educational materials in several formats (for example, paper, video, and Web sites).

### Document Family Psychoeducation services

Outline the policies and procedures for documenting FPE services. Instruct FPE practitioners to complete Progress Notes to document the following:

- Meeting the goals of each joining session;
- Providing a standardized educational curriculum to each FPE family participant; and
- Following the structured problem-solving approach during ongoing FPE services.

For sample Progress Notes tailored to each phase of the FPE program, see the next pages. For printable copies, see the CD-ROM for this KIT. We strongly encourage you to adapt these forms and incorporate them into your routine paperwork.

<b>Progress Note</b>		<b>Joining Session 1</b>	
Consumer's name:		Consumer's I.D. number:	
Family or other supporter's name:		Relationship to consumer:	
Family or other supporter's name:		Relationship to consumer:	
	Date	_____ / _____ / _____	Start time:
			Stop time:
Completed by:			
Past or present crisis:			
Precipitating events:			
Early warning signs:			

<b>Progress Note</b>	<b>Joining Session 1</b>
Family or other supporter's experience:	
Strengths and helpful coping skills:	
Past unsuccessful strategies or interventions:	
Action steps:	

<b>Progress Note</b>		<b>Joining Session 2</b>	
Consumer's name:		Consumer's I.D. number:	
Family or other supporter's name:		Relationship to consumer:	
Family or other supporter's name:		Relationship to consumer:	
	Date	_____ / _____ / _____	Start time:
			Stop time:
Completed by:			
Feelings or reactions to illness:			
Social support system:			
Genogram:			

<b>Progress Note</b>	<b>Joining Session 2</b>
<p>Past experiences with the mental health system:</p>	
<p>Educational information shared:</p>	
<p>Action steps:</p>	

Progress Note	Joining Session 3		
Consumer's name:		Consumer's I.D. number:	
Family or other supporter's name:		Relationship to consumer:	
Family or other supporter's name:		Relationship to consumer:	
	Date	_____ / _____ / _____	Start time:
			Stop time:
Completed by:			
Personal strengths (hobbies, interests, work, school, etc.):			
Short-term goals			
Long-term goals:			
Concerns about participating in the educational workshop or multifamily group:			





Progress Note		1-day Educational Workshop	
Consumer's name:		Consumer's I.D. number:	
Family or other supporter's name:		Relationship to consumer:	
Family or other supporter's name:		Relationship to consumer:	
	Date	_____ / _____ / _____	Start time:
			Stop time:
Completed by:			
Was the consumer present for the workshop?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In part <input type="checkbox"/> Attended a separate consumer forum <input type="checkbox"/> Received individual education		
Was the family member present for the workshop?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In part <input type="checkbox"/> Provided individual education		
Which of the following topics were presented?	<input type="checkbox"/> <b>Psychobiology of the specific mental illness</b> including basics of brain function and dysfunction and the potential causes of the mental illness <input type="checkbox"/> <b>Diagnosis</b> including symptoms and prognosis <input type="checkbox"/> <b>Treatment and rehabilitation</b> including an overview of the treatment options and how they promote effective coping and illness management strategies <input type="checkbox"/> <b>Impact of mental illness on the family</b> including how mental illnesses affect families as a whole <input type="checkbox"/> <b>Relapse prevention</b> including prodromal signs and symptoms and the role of stress in the precipitating episodes <input type="checkbox"/> <b>Family guidelines or recommended responses</b> to help families maintain a home environment that promotes relapse prevention		
In which of the following formats were educational materials presented?	<input type="checkbox"/> Handouts <input type="checkbox"/> Slides <input type="checkbox"/> Video <input type="checkbox"/> Web Sites <input type="checkbox"/> Other _____		





# Multifamily Group Problem Solving Worksheet

Consumer's name:		Consumer's I.D. number:	
Family or other supporter's name:		Relationship to consumer:	
Family or other supporter's name:		Relationship to consumer:	
Date	_____ / _____ / _____	Start time:	
		Stop time:	
Completed by:			
Step 1: Define the problem			
Step 2: Generate solutions			

# Multifamily Group Problem Solving Worksheet

Step 3: Discuss advantages and disadvantages	Possible solution	Advantages	Disadvantages
Step 4: Choose the best solution			
Step 5: Form an action plan			
Step 6: Review the action plan			

## Describe how to maintain consumer records

In the policies and procedures for your FPE program, describe how you will maintain consumers' records. You must keep records for each consumer and safeguard them against loss, tampering, and unauthorized use. The records should be consistent with requirements of organizations to whom you bill (e.g., the Centers for Medicaid and Medicare Services) or that accredit your agency (e.g., the Joint Commission on Accreditation of Rehabilitation Facilities, etc.).

If you are setting up a new recordkeeping system, you will need materials to create records (for example, binders and forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records.

Make sure that FPE practitioners are familiar with your policies and procedures for documenting and maintaining records. Supervise them in completing the required documentation and monitor that records are properly stored and protected.

### How Administrators and Family Intervention Coordinators Can Help Provide Recovery-Oriented Services

- Clearly explain consumer rights in FPE policies and procedures.
- Offer training on recovery principles and consumer rights to practitioners, consumers, and families.
- Hold community forums using the multimedia tools in this KIT.
- Involve consumers in local advisory groups.

## Discuss how to ensure consumers' rights

In the policies and procedures for your FPE program, discuss how you will ensure that consumers' rights are upheld. FPE practitioners should do the following:

- Be aware of the state and federal consumer rights requirements;
- Inform consumers of their rights in a meaningful way; and
- Help consumers exercise their rights.

Also, your policies and procedures should reflect the model's recovery orientation. Traditional services were developed with a biomedical approach to mental health treatment; they focus on reducing symptoms and preventing relapse. In contrast, the evidence-based model is based on the concept of *recovery*. In the recovery framework, the expectation is that consumers can have lives in which mental illnesses are not the driving factors. Recovery means more than maintaining people with mental illnesses in the community. Recovery-oriented services encourage consumers to define and fulfill their personal goals.

FPE practitioners must believe in and be true to the recovery principles in the evidence-based model. Be careful not to replicate those elements of traditional services that simply emphasize containing symptoms and complying with medication.

The value of consumer choice in service delivery and the importance of consumer perceptions must be infused in how you provide FPE. Most practitioners have never examined their own attitudes and behaviors about consumer recovery and uncritically accept many clinical traditions without paying attention to how disempowering these practices are for consumers.

In recovery-based services, establishing a trusting relationship is critical. Interactions with consumers should be based on mutuality and respect. Challenge FPE practitioners to listen to, understand, and respect consumers' perspectives and take into account consumers' reasons for noncompliance.

FPE practitioners should also focus on consumer-defined needs and preferences and accept consumer choice in service delivery. Providing services with a recovery orientation means that you support and empower consumers to achieve their individual goals.

### Develop procedures to evaluate program and staff performance

When it is properly implemented, FPE is associated with a variety of positive consumer and family outcomes. Evaluating the performance of your FPE program will help you provide high-quality services and assure stakeholders of your program's effective performance. Develop procedures to evaluate your program early using the guidelines in *Evaluating Your Program* in this KIT. Also, develop procedures for how you will supervise and evaluate your FPE team. To a large extent, clinical supervision is the process that will determine whether FPE staff understand and are consistently applying the evidence-based practices for family psychoeducation or whether further leadership, training, and accountability are required to meet this goal.

Family intervention coordinators should provide weekly group supervision to FPE practitioners. Group supervision should review all consumers involved in the FPE program and problem-solve ways to help them better meet their individual goals.

Family intervention coordinators also should provide individual, side-by-side supervision to achieve the following goals:

- Assess performance;
- Give feedback; and
- Model interventions.

Family intervention coordinators may schedule regular meetings with FPE practitioners to review specific cases. They should be regularly available to consult with FPE practitioners, as needed.

Some aspects of the FPE practitioner's job are hard to understand without seeing them done by an experienced FPE practitioner. Once family intervention coordinators thoroughly understand the evidence-based model, they should model aspects of the job—such as engagement or educational techniques—and directly coach them in their work. For training tools and recommendations, see *Training Frontline Staff* in this KIT.

If the FPE program is working with a consultant, the family intervention coordinator should involve the consultant in group supervision, treatment team meetings, and FPE multifamily group sessions. If the attendance of an outsider disrupts the group process, consider periodically videotaping sessions for purposes of supervision. Many new FPE programs have found that feedback from an external consultant is a crucial component for improving staff performance and the quality of their program as a whole.

## Develop a training plan

Developing an FPE team is a complex undertaking. Recruiting and retaining practitioners who know the FPE model or who know how to treat people with serious mental illnesses can be difficult. Agencies that have successfully implemented FPE indicate that offering one-time training for FPE practitioners is not enough. Instead, assess the knowledge level of key stakeholders (See *Evaluating Your Program* in this KIT) and develop a training plan.

Practitioners who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of FPE. This training will build support for your FPE program. Your staff will find that they are better able to generate referrals for their program, engage consumers, and provide effective treatment.

### What Should Your Training Plan Include?

- Basic training for staff at all levels across the agency.
- Basic training for key stakeholders, including consumers, families, mental health authorities, and members of key community organizations such as the National Alliance on Mental Illness (NAMI).
- Intensive training for FPE practitioners.

In addition to these internal basic training activities, consider organizing routine educational meetings for consumers, families, or other key stakeholders in the community where consumers who have received services through FPE programs share their experiences. These key stakeholders may hold misconceptions about the goals of the FPE program. It is important to correct false beliefs before they impede implementing the evidence-based model.

Next, consider how you will offer FPE staff intensive training to allow them to learn and master the evidence-based model. We suggest organizing a group training series that includes at least five half-day sessions. The FPE KIT includes *Training Frontline Staff*, which gives FPE practitioners in-depth information about the evidence-based model and skills for providing effective services to consumers. Family intervention coordinators may facilitate a structured group training using these materials.

Once FPE practitioners have a basic understanding of the model, they should visit an existing, well-functioning, high-fidelity FPE program to observe how FPE practitioners work with consumers, interact with one another, and collaborate in multidisciplinary treatment teams. Once trained, family intervention coordinators and practitioners will also be able to use the basic training materials in the KIT to conduct routine community workshops and inservice seminars. For materials to support basic training, see *Using Multimedia to Introduce Your EBP* in this KIT.

## Hire an external consultant and trainer

Establishing the initial processes that must be in place to provide quality services requires great attention to detail. Consequently, during the first 1 to 2 years after forming a new FPE program, many agencies have found it helpful to work with an experienced external consultant and trainer.

Consultants and family intervention coordinators often work together to ensure that the FPE program is structured appropriately. They integrate evidence-based practice principles into the agency's policies and tailor procedures to meet local needs.

Once the FPE program has been launched, it is important that you not allow FPE practitioners to revert to older and more familiar ways of doing things. External consultants and trainers who are experienced in running FPE programs can provide ongoing technical assistance, side-by-side supervision, and periodic booster training sessions. This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in maintaining adherence to the evidence-based practices.

## Select a location for your Family Psychoeducation program

You can conduct FPE sessions in almost any location that is convenient for practitioners, consumers, and families. For example, you could conduct joining sessions in the following locations:

- Your mental health agency;
- Consumers' homes; or
- Consumers' family members' home.

When selecting a location for the 1-day educational workshop and multifamily groups, consider the following:

- The number of participants;
- Type of multimedia you plan to use;
- Comfort and convenience of the location; and
- The ability to serve refreshments.

Regardless of the location, FPE practitioners should strive to create an environment that is quiet, free of unnecessary distractions, and conducive to sharing and learning from one another.

## Review your program budget and revenue sources

It is important that you understand the budget for your FPE program and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed.

### What are the costs?

The initial implementation costs are about \$250 per practitioner for recruitment, preparation, and associated costs for training. Other agency costs include agency administration time, planning meetings, supervision, consultation, and costs associated with reducing practitioner caseloads during the first two phases of the FPE program.

Ongoing FPE sessions in the multifamily group format require about 1 hour of staff effort per month for each consumer in addition to the time spent in group. Based on East Coast salary levels, when using a master's-level practitioner, the costs of providing ongoing FPE session in a multifamily group format is about \$350 per year, per consumer in staff time. Single-family format is roughly twice the cost per consumer.

The FPE budget should also include funds to cover the costs of refreshments for the 1-day educational workshop and multifamily groups, as well as multimedia educational materials.

### What are the revenue sources?

Financing mechanisms for FPE programs vary from state to state. Typically, FPE programs are funded by a combination of state mental health dollars, Medicaid, and other insurers.

In some mental health systems, programs receive a fixed rate for each consumer who receives services. In other systems, programs are only reimbursed based on the specific services provided. In that case, you should be familiar with how services must be tracked to capture billing from various funding streams. You will also need to know the billing process and billing codes.

Financial barriers can slow implementation. Be aware that over time the mission and activities of programs can become defined by the funding that supports them. Know the principles of the evidence-based model and be vigilant that funding opportunities support the model rather than shape and corrupt it. For useful ideas and strategies, consult with agencies and system administrators who have been successful in this area.

In summary, building an effective, well-functioning FPE program is a developmental process. We encourage you to periodically revisit the information in this KIT throughout the first year after you start your new program. We believe that these materials will take on a new meaning as the process of implementing an FPE program evolves.





