FAMILY PSYCHOEDUCATION
Fidelity Workbook

November 2010

Acknowledgements:

This document is the product of a collaborative effort between the Michigan Department of Community Health and the Family Psychoeducation Steering Committee, a sub-committee of the Practice Improvement Steering Committee. This is a living document enriched by the experiences of consumers, families, staff and administrators involved in the implementation, sustainability and fidelity of the Family Psychoeducation Evidence Based Model. The collaborative also wants to acknowledge the local Family Psychoeducation Coordinators. With special thanks to the Certification, Sustainability and Fidelity Sub-committee members.

This workbook is meant to assist facilitators trained in Family Psychoeducation (FPE) to monitor fidelity to the model. After initial FPE Facilitator training, 12 months of monthly supervision is provided to your team. During this time, it is suggested that you complete the fidelity checklist after each JOINING session, your WORKSHOP, and after each PROBLEM SOLVING GROUP for the entire year. These forms can be reviewed at your monthly supervision meeting.

Once the 12 month supervision has ended, it is strongly suggested that these checklists are utilized at least once a quarter for PROBLEM SOLVING SESSIONS in order to be sure your FPE team is on track and following the key aspects of the FPE model.

Two years after a facilitator is certified, they will be asked to attend a recertification or booster day long Learning Collaborative or to go on and complete ADVANCED FACILITATOR training in order to continue utilizing billing codes for FPE. It would be useful for facilitators to have an idea of how they have been delivering the model and any difficulties or successes can be shared at this recertification session.

If your team is audited by the Department of Community Health or other governing bodies, it will be in your best interest to be able to pull out your folder of competency checklists or fidelity rating scales to display your efforts to follow the model.

Attachments include:

Appendix A: Competency Checklists for Joining, Workshop, and Problem Solving Groups for individual FPE Facilitators or teams

Appendix B: SAMHSA FPE Toolkit Fidelity monitoring tools for use with individual FPE teams or to look at overall FPE implementation progress for your location

Appendix A:

Competency Checklists for Joining, Workshop, and Problem Solving Groups for individual FPE Facilitators or teams

Competency Checklist for MFG Clinicians
Problem-Solving Meetings of the
Multifamily Psycho-education Group

Clinicians ________________ **Date of Session** ________________

Session Number ________________ **Date of Rating** ________________

Circle One: Videotape Audiotape Self monitor/Discussion

Coding Key: ✓ = appropriately included **O** = optionally omitted **NA** = not applicable

Initial Socialization

____ 1. The meeting began with 10-15 minutes of social conversation.

____ 2. The clinician introduced a topic of conversation.

____ 3. There was balanced participation among group members.

____ 4. Quiet members were encouraged to participate.

____ 5. Group members were encouraged to talk to each other directly without side conversations.

____ 6. The clinician redirected side conversations.

____ 7. The content was light with a place for humor.

____ 8. Comments about the illness or criticisms/ complaints about the consumer were deflected, ignored or reframed.

____ 9. The group started on time.

____ 10. The clinician reminded the group members of the structure of the group (for the first 2-3 months).

____ 11. The clinicians shared relevant, social information about themselves.

Go Around

____ 1. The clinician started the go-around with the family who solved a problem in the previous session.

____ 2. The clinician reviewed the implementation of the plan with the family.

____ 3. The clinician praised the family for their efforts.

____ 4. Praise was given for an alternative solutions tried by the family

____ 5. The clinician pointed out specific suggestions made by other family members and thanks them for their participation

____ 6. Factors that might have been overlooked if the solution and plan was unsuccessful were reviewed.

____ 7. The clinician took responsibility for any failed solutions.

____ 8. An alternative solution was suggested if necessary.

____ 9. The clinician checked in with each member of the family.

____ 10. The clinician inquired about pertinent areas of significance.

____ 11. The clinician probed for more information when responses were general.

____ 12. Appropriate biological information was shared with the family.

____ 13. The Family Guidelines were reinforced or integrated into the clinician comments.

____ 14. The clinician offered to intervene directly with the treatment system when appropriate.

____ 15. The family was asked to observe a situation and contact the clinician before the next meeting if the situation persists, if appropriate.

____ 16. The issue was identified as a possible problem solving for the meeting.

____ 17. The clinicians "debriefed" each family situation between families and summarized key issues.

____ 18. The Go-Around was completed in 20-25 minutes.

____ 19. The clinician's voice tone was low key, supportive and nonjudgmental throughout the Go-around.

____ 20. The clinician redirected interruptions from other group members.

____ 21. Everyone was thanked for their participation.

Problem/Issue Identification

____ 1. The clinicians openly discussed which problem needed to be worked on in this session.

____ 2. There was an attempt to rotate the problem-solving among the families.

____ 3. Attention was given to factors leading to relapse and issues having to do with the next steps in recovery when considering a problem-solving.

____ 4. Consideration was given to the immediacy of the problem/issue.

____ 5. The clinician offered to meet with the family outside of group if a crisis was presented.

____ 6. A problem solving was not done with a family attending for the first time.

____ 7. The definition of the problem/issue was narrowed so that it leads to a practical solution.

____ 8. The clinician acquired agreement on issue definition from all family members.

Problem Solving

____ 1. A problem solving process was facilitated utilizing the 6-step problem-solving model.

____ 2. In the early sessions the families were reminded of the problem-solving steps and guidelines.

____ 3. The clinicians rotated their roles; one lead the group through the six-step process while the other ensured group participation.

____ 4. Clinicians contributed solutions and accepted all solutions to the problem.

____ 5. Clinicians used a brainstorming format for solution generation; deferring evaluation of ideas to discussion of advantages/disadvantages.

____ 6. Six to eight solutions were generated before moving on to discussing the advantages and disadvantages.

____ 7. The advantages then disadvantages to each solution were explored.

____ 8. A solution was identified that the family feels best suits their situation.

____ 9. The solution was broken done into manageable, specific steps.

____ 10. A copy of the problem solving is given to the family.

____ 11. A recorder documented the information.

Closing Socialization

____ 1. The group spent five minutes socializing.

____ 2. The content was again light and positive.

Competency Checklist for MFG Clinicians
Joining Sessions and Family Workshop
Multifamily Psycho-education Group Treatment

Clinicians ______________ **Date of Session** ______________

Session ______________ **Date of Rating** ______________

Circle One: Videotape Audiotape Self monitor/Discussion

Coding Key: ✓ = appropriately included **O** = optionally omitted **NA** = not applicable

Session I

____ 1. The clinician socialized with the family for 15 minutes.

____ 2. The clinician presented self as a colleague and an advocate.

____ 3. The clinician shared relevant personal information about self.

____ 4. The consumer's history was reviewed.

____ 5. Early warning signs were identified.

____ 6. Symptoms of the illness were identified.

____ 7. The clinician explained the basic structure of the multifamily group experience and what the family can expect.

____ 8. Emphasis was placed on the concept that the family is not to blame.

____ 9. The clinician shared relevant information about the illness.

____ 10. The session ended with 5 minutes of socialization.

Session 2

____ 1. The clinician socialized with the family for 15 minutes.

____ 2. Exploration of the family's social network and resources occurred.

____ 3. The clinician identified family and consumer strengths.

____ 4. A genogram or sociogram was used in the session.

____ 5. The session ended with 5 minutes of socialization.

Session 3

____ 1. The clinician socialized with the family for 15 minutes.

____ 2. The clinician facilitated a discussion about the family and consumer's short-term goals.

____ 3. The clinician facilitated a discussion about the family and consumer's long-term goals.

____ 4. The clinician answered questions and provided information about the upcoming Family workshop.

____ 5. Inquires were made regarding the family's experience with groups and any concerns they may have about groups.

____ 6. The clinician asked the family for information regarding their past experiences with the mental health system of care.

____ 7. A discussion occurred regarding the consumer and family's response to living with and/or around the illness.

____ 8. The session ended with 5 minutes of socialization.

Multifamily Workshop

____ 1. The workshop was structured in a classroom atmosphere.

____ 2. Information about the nature, etiology, course and outcomes of schizophrenia was presented.

____ 3. Information about the nature, etiology, course and outcomes of bipolar disorder, addiction, or other pertinent material for the audience was presented.

____ 4. Information about medications and current treatment was presented.

____ 5. Information about management of the illness was presented.

____ 6. Information regarding common reactions was presented.

____ 7. The Family Guidelines were presented.

____ 8. The problem solving method was presented.

____ 9. Specific questions were answered.

____ 10. Handouts were included and given to families.

____ 11. The clinicians' manner was collegial, open and encouraged questions from family members.

____ 12. The clinicians acted as hosts, hostesses during the breaks assisting families in feeling comfortable.

Appendix B:

SAMHSA FPE Toolkit

Fidelity monitoring tools for use with individual FPE teams or to look at overall FPE implementation progress for your location

Family Psychoeducation Fidelity Scale

Criteria	Ratings / Anchors 1	2	3	4	5
1. Family intervention coordinator: Designated clinical administrator who performs the following tasks: ■ Establishes, monitors, and automates family intake and engagement procedures ■ Assigns potential FPE consumers to FPE practitioners ■ Monitors and adjusts FPE practitioner caseloads ■ Arranges for training new FPE practitioners and continuing education of existing FPE staff ■ Supervises FPE staff	Agency does not have a designated staff member OR Cannot rate due to no fit.	Agency has a designated staff member who performs 1 or 2 of the tasks.	Agency has a designated staff member who performs 3 of the tasks.	Agency has a designated staff member who performs 4 of the tasks.	Agency has a designated staff member who performs all tasks.
2. Session frequency: Families and consumers participate biweekly in FPE sessions.	< Every 3 months OR Cannot rate due to no fit.	Every 3 months	Every 2 months	Monthly	At least twice a month
3. Long-term FPE: Families and consumers are provided with long-term FPE; specifically, at least one family member per consumer participates in FPE sessions for at least 9 months.	Most families and consumers receive less than 6 months of FPE sessions OR Cannot rate due to no fit.	Most families and consumers receive 6–7 months of FPE sessions.	Most families and consumers receive 7–8 months of FPE sessions.	Most families and consumers receive 8–9 months of FPE sessions.	More than 90% of families and consumers receive at least 9 months of FPE sessions.
4. Quality of practitioner-consumer-family alliance FPE practitioners engage family members and consumers with warmth, empathy, acceptance, and attention to each individual's needs and desires.	High dropout rate OR Cannot rate due to no fit.	Sources indicate that alliance is often poor, leading to high dropout rate.	MSources indicate alliance is inconsistent or barely adequate, leading to moderate dropout rate. OR Information is inconsistent	Sources indicate a fairly strong alliance.	Sources consistently indicate a strong alliance.
5. Detailed family reaction: FPE practitioners identify and specify the family's reaction to their relative's mental illnesses.	There is consistent evidence for less than 33% of involved families.	There is consistent evidence for 33–49% of involved families.	There is consistent evidence for 50–64% of involved families.	There is consistent evidence for 65–79% of involved families.	There is consistent evidence for 80% or more of involved families.
6. Precipitating factors: FPE practitioners, consumers, and families identify and specify precipitating factors for the consumers' mental illnesses.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33-49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.
7. Prodromal signs and symptoms: FPE practitioners, consumers, and families identify and specify prodromal signs and symptoms of the consumer's mental illnesses.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33–49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.

Family Psychoeducation Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
8.	**Coping strategies:** FPE practitioners identify, describe, clarify, and teach coping strategies.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33–49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.
9.	**Educational curriculum:** FPE practitioners use a standardized curriculum to teach families about mental illnesses. The curriculum covers six topics: ■ Psychobiology of the specific mental illness; ■ Diagnosis; ■ Treatment and rehabilitation; ■ Impact of mental illness on the family; ■ Relapse prevention; and ■ Family guidelines.	Less than 33% of involved families receive a standardized educational curriculum, no standardized educational curriculum exists, OR Only 1–2 topics are covered	33–49% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 3 topics are covered.	50–64% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 4–5 topics are covered.	65–79% of involved families receive a standardized educational curriculum covering all 6 topics.	80% or more of involved families receive a standardized educational curriculum covering all 6 topics.
10.	**Multimedia education:** Consumers and family members are given educational materials about mental illnesses in several formats (for example, paper, video, and Web sites).	Less than 33% of families and consumers receive educational materials OR Cannot rate due to no fit.	33–49% of families and consumers receive educational materials OR Materials are given in only 1 format.	50–64% of families and consumers receive educational materials OR Materials are given in only 2 formats.	65–79% of families and consumers receive educational materials in all 3 formats.	80% or more of families and consumers receive educational materials in all 3 formats.
11.	**Structured group sessions:** FPE practitioners follow a structured procedure that includes the following: ■ Beginning socialization; ■ Review progress from last session's action plan; ■ Go-round; ■ Selection of a single problem; ■ Structured problem solving; and ■ Ending with socialization.	Groups include 2 or fewer components.	Groups include 3 of the 6 components.	Groups include 4 of the 6 components.	Groups include 5 of the 6 components.	Groups include all 6 components.

Family Psychoeducation Fidelity Scale

Criteria	Ratings / Anchors				
	1	2	3	4	5
12. Structured problem-solving: FPE practitioners use a standardized approach to help consumers and families with problem solving, which includes the following: ■ Define the problem; ■ Generate solutions; ■ Discuss the advantages and disadvantages of each solution; ■ Choose the best solution; ■ Form an action plan; and ■ Review the action plan.	No more than 2 of 6 components of the structured problem-solving are used.	3 of 6 components of the structured problem-solving are used.	4 of 6 components of the structured problem-solving are used.	5 of 6 components of the structured problem-solving are used.	All 6 components of the structured problem-solving are used.
13. Stage-wise provision of services: FPE services are provided in the following: ■ Engagement; ■ 3 or more joining sessions; ■ Educational workshop; and ■ Multifamily group.	Families and consumers begin multifamily groups with minimal or no engagement, no joining sessions, or no education.	Engagement is minimal and only 1 joining session is completed before entry into the multifamily group. Education is delayed or absent.	Engagement and 2 joining sessions are completed before entry into the multifamily group. Education is delayed or absent.	Most steps are done in order; however, families enter multifamily groups before 3 joining sessions are completed or education is provided.	Engagement, all 3 joining sessions, and education are completed before entry into the multifamily group.
14. Assertive engagement and outreach: 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.	FPE practitioners do not engage potential consumers and family members.	FPE practitioners engage potential consumers and family members only once as part of initial engagement.	FPE practitioners engage potential consumers and family members 2 times as part of initial engagement.	FPE practitioners assertively engage some potential consumers and family members using all necessary means on a time-limited basis.	FPE practitioners assertively engage all potential consumers and family members using all necessary contact means on an ongoing basis. FPE practitioners demonstrate tolerance of different levels of readiness using gentle encouragement.

Score Sheet: Family Psychoeducation Fidelity Scale

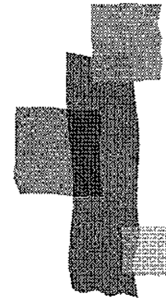
Date of visit ____/____/____

Agency name ____________________

Assessors' names ____________________ ____________________

		Assessor 1	Assessor 2	Consensus
1	Family intervention coordinator			
2	Session frequency			
3	Long-term FPE			
4	Quality of practitioner-consumer-family alliance			
5	Detailed family reaction			
6	Precipitating factors			
7	Prodromal signs and symptoms			
8	Coping strategies			
9	Educational curriculum			
10	Multimedia education			
11	Structured group sessions			
12	Structured problem-solving			
13	Stage-wise provision of services			
14	Assertive engagement and outreach			
	Total score			
	Items not rated			

62-70 = Good implementation
52-61 = Fair implementation
51 and below = Not evidence-based practice



Evaluating Your Program

Appendix D: Family Psychoeducation Fidelity Scale Protocol

Family Psychoeducation Fidelity Scale Protocol

This protocol explains how to rate each item on the FPE Fidelity Scale. In particular, it provides the following:

- A definition and rationale for each fidelity item. These items have been derived from comprehensive, evidence-based literature.
- A list of data sources most appropriate for each fidelity item (for example, chart review, family intervention coordinator interview, FPE practitioners, consumers, or families). When appropriate, a set of probe questions is provided to help you elicit the critical information needed to code the item. These questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.
- Decision rules that will help score each item correctly. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

1. Family intervention coordinator

Definition: One clinical administrator is designated to oversee the FPE program for a substantial portion of the job (time depends on size of program). This person's role includes activities such as the following:

- Establishing, monitoring, and automating family intake and engagement procedures;
- Assigning potential FPE consumers to FPE practitioners;
- Monitoring and adjusting FPE practitioners' caseloads;
- Arranging for training of new staff and continuing education of existing FPE staff;
- Supervising FPE practitioners.

Rationale: Delivery of services to families must be subject to accountability and tracking. One effective way for agencies to monitor the delivery of family services is to create a position of family intervention coordinator, who would also serve as the contact person for FPE services, facilitate communication between staff and families, and supervise FPE practitioners.

Sources of information: Before the site visit, determine whether the organization has someone who has a title of family intervention coordinator or its equivalent. During the fidelity visit, interview the agency director, family intervention coordinator, practitioners, consumers, and family members.

Item response coding: The agency director and family intervention coordinator are the primary sources of information for this item. If other sources do not report these responsibilities performed by the coordinator, then fidelity assessors should follow up with the agency director and family intervention coordinator with clarifying questions and documentation (at end of the fidelity visit day or in follow-up call). If the program does not have a designated position of family intervention coordinator (or an equivalent), code the item as "1." If the program has a designated staff member who performs all five tasks, code the item as "5."

Probe questions

For family intervention coordinators:

- "What is your role in the FPE program? How much time do you devote to this? What kinds of responsibilities do you have?" [Check who performs the tasks specified above.]
- "Can you explain intake procedures, monitoring, training schedule, and supervision schedule?"

For FPE practitioners:

- "What functions does the family intervention coordinator perform?"
- [Read list of five tasks listed above.] "Is anyone responsible for these tasks?"

For consumers and family members: "What functions does [family intervention coordinator's name] perform?"

2. Session frequency

Definition: Families and consumers participate at least in biweekly FPE sessions.

Rationale: It is presumed that families benefit more if sessions are offered regularly and predictably.

Sources of information: Chart review, roster of sessions, and interviews with family intervention coordinator, FPE practitioners, consumers, and family members.

Item response coding: The primary evidence for coding this item would be attendance rosters or a calendar of scheduled events, if such documents exist. The program should have some way of documenting the frequency of FPE sessions. If the documentation suggests that the organization provides at least biweekly FPE sessions, code the item as "5."

Probe questions

For family intervention coordinators:

- "How often are FPE sessions held for family members?"
- "Do you have attendance rosters, a calendar of events, or other documentation to verify this?"

For FPE practitioners:

- "How often are FPE sessions held for family members?"
- "Do you have attendance rosters, a calendar of events, or other documentation to verify this?"

For consumers and family members: "How often are FPE sessions held for family members?"

3. Long-term FPE

Definition: Families and consumers are provided with long-term FPE; specifically, at least one family member per consumer participates in FPE sessions for at least 9 months.

Rationale: In general, 9 months of biweekly equivalent FPE sessions are required for families and consumers to learn the necessary information and problem-solving skills. After completing the program, families and consumers may also benefit from booster sessions or support groups.

Sources of information: Chart review, roster of sessions, and interviews with the family intervention coordinator, FPE practitioners, consumers, and family members.

Item response coding: The primary evidence for coding this item would be a report containing the number of families and consumers completing FPE and how long they attended, records of duration of FPE groups, or attendance sheets. In the absence of written records, the assessment will depend on interviews. Excluding dropouts, if there is evidence that 90 percent or less of families receive at least 9 months of FPE sessions, code the item as "5."

Probe questions

For family intervention coordinators or FPE practitioners:

- "How long do family members attend FPE before they graduate?"
- "Do you have attendance rosters, a calendar of events, or other documentation to verify this?"

For consumers and family members:

- "How long have you attended FPE sessions?"
- "How long do you intend to attend?"

4. Quality of Practitioner-Consumer-Family Alliance

Definition: FPE practitioners engage family members and consumers with warmth, empathy, acceptance, and attention to each individual's needs and desires.

Rationale: When the alliance between practitioners, consumers, and families is poor, family members and consumers are less likely to participate fully or at all in FPE programs and, as a result, are less likely to benefit from FPE services.

Sources of information: Interviews with FPE practitioners, family members, and consumers. Observations of FPE sessions.

Item response coding: The primary source for rating this item is direct observation. This item requires clinical judgment and is based on the fidelity assessor's experience. Negative indicators would include comments in interviews, FPE sessions, or charts expressing judgmental or blaming attitudes. If sources consistently indicate a strong alliance for all FPE practitioners, code the item as "5."

Probe questions

For FPE practitioners:

- "How do you establish rapport or develop an alliance with family members and consumers?"
- "How would you rate or describe your alliance with [family and consumer's name]?" [Select one family and consumer with whom the practitioner works.]
- "Are there any family members or consumers with whom you feel your relationship is counterproductive or poor?"

For family members and consumers:

- "How would you describe your relationship with [FPE practitioner's name]?"
- "Do you feel that [FPE practitioner's name] has worked to establish a good relationship with you? What has he or she done to connect with you? What has he or she done that makes it more difficult for you to work with him or her?"
- "What would you change about your working relationship with [FPE practitioner's name] to make it better?"

5. Detailed Family Reaction

Definition: FPE practitioners identify and specify the family's reaction to their relative's mental illnesses. Reactions are emotional and behavioral responses (note the distinction from coping strategies in Item 8).

Rationale: A core principle of FPE is to help family members achieve a basic understanding of serious mental illnesses as well as to resolve family conflict by listening and responding sensitively to each family's emotional distress related to having a relative with serious mental illnesses.

Sources of information: Chart review (especially treatment plan) and interviews with FPE practitioners, consumers, and families.

Item response coding: If documentation in the treatment plan and reports by FPE practitioners, consumers, and families corroborate that family reactions are identified and specified in joining sessions for 80 percent or more of involved families, code the item as "5."

Probe questions

For practitioners:

- "What sorts of issues do you discuss in joining sessions?"
- "Do you address how families react emotionally or behaviorally to their relatives' mental illnesses?"
- "What sorts of activities do you engage in to help them deal with their reactions?"
- Using a chart for a family member seen by the practitioner, ask the practitioner to explain the specifics.

For consumers and family members:

- "What sorts of issues did you discuss during the first couple of FPE sessions?"
- "Earlier in the FPE sessions, did you spend time discussing how you felt and reacted about the illness?"
- "Did the practitioner lead you in activities to help you deal with your feelings and reactions?"

6. Precipitating Factors

Definition: FPE practitioners, consumers, and families identify and specify precipitating factors for consumers' mental illnesses.

Rationale: Exploring factors that have precipitated relapse in the past is a crucial step to developing individualized relapse prevention and illness management strategies. Involving consumers and families as equal partners in planning and delivering treatment is a core principle of FPE.

Sources of information: Chart review (especially treatment plan) and interviews with FPE practitioners, consumers, and families.

Item response coding: If documentation in the treatment plan and reports by FPE practitioners, consumers, and families corroborate that precipitating factors are identified and specified in joining sessions for 80 percent or more of involved families and consumers, code the item as "5."

Probe questions

For FPE practitioners:

- "In joining sessions, do you discuss the precipitating factors of the illness with families and consumers?" [If *yes*, "Can you describe the process you use to discuss them? Can you show me examples?"]
- Using a chart, ask the FPE practitioner to explain the specifics.

For consumers and family members:

- "Earlier in the FPE sessions, did the FPE practitioner identify precipitating factors for [your or your relative's] illness?" [If *yes*, "Please give examples."]
- "Did you discuss how to respond to them once you notice these factors? Have you reviewed these strategies in later sessions?"

7. Prodromal Signs and Symptoms

Definition: FPE practitioners, consumers, and families identify and specify prodromal signs and symptoms of consumers' mental illnesses.

Rationale: Exploring consumers' prodromal signs and symptoms is another crucial step to developing individualized relapse prevention and illness management strategies. Involving consumers and families as equal partners in planning and delivering treatment is a core principle of FPE.

Sources of information: Chart review (especially treatment plan) and interviews with FPE practitioners, consumers, and families.

Item response coding: If documentation in the treatment plan and reports by FPE practitioners, consumers, and families corroborate that prodromal signs and symptoms are identified and specified in joining sessions for 80 percent or more of involved families, code the item as "5."

Probe questions

For FPE practitioners:

- "In joining sessions, do you identify prodromal symptoms with consumers and families?" [If *yes*, "Can you describe the process you use to identify them? Can you give an example?"]
- Using a chart, ask the practitioner to explain the specifics.

For consumers and family members:

- "Earlier in the FPE sessions, did the FPE practitioner discuss the signs that you (or your family member) may be becoming symptomatic?"
- "What sorts of things were suggested in your sessions for recognizing the early signs and symptoms of the illness? Please give examples. Have you reviewed these suggestions in later sessions?"

8. Coping Strategies

Definition: FPE practitioners identify, describe, clarify, and teach coping strategies. *Coping strategies* are intentional and thoughtful attempts to change behavior or symptoms related to mental illnesses (note the distinction from family reactions in Item 5).

Rationale: Exploring coping strategies that have and have not worked is a crucial step to developing individualized relapse prevention and illness management strategies. Insight into patterns of ineffective interactions and behaviors is likely to motivate consumers and families toward desired change.

Sources of information: Chart review (especially treatment plan) and interviews with FPE practitioners, consumers, and families.

Item response coding: If documentation in the treatment plan and reports by FPE practitioners, consumers, and families corroborate that practitioners help 80 percent or more of involved families and consumers to identify, describe, clarify, and learn coping strategies in joining sessions, code the item as "5."

Probe questions

For FPE practitioners:

- "Do you identify coping strategies with consumers and families?" [If *yes*, "Can you describe the process you use?"]
- Using a chart, ask the FPE practitioner to explain the specifics.

For consumers and family members:

- "Have you discussed coping strategies? What sorts of things did you talk about?"
- "Did you discuss alternative ways of coping with [your or your relative's] illness?"

9. Educational Curriculum

Definition: FPE practitioners use a standardized curriculum to teach families about mental illnesses. The curriculum covers six topics:

- Psychobiology of the specific mental illness;
- Diagnosis;
- Treatment and rehabilitation;
- Impact of mental illness on the family;
- Relapse prevention; and
- Family guidelines.

Rationale: Effectively teaching families new information and skills requires structure and systematically using specific evidence-based techniques and strategies. Therefore, it is critical that an FPE program has a standardized educational curriculum that specifies what is taught and how it is taught.

Sources of information: Curriculum review, schedule of completed session, and interviews with family intervention coordinator, FPE practitioners, and families.

Item response coding: If 80 percent or more of involved families receive a standardized educational curriculum covering all six topics, code the item as "5."

Probe questions

For family intervention coordinators:

- "Does your program have a standardized educational curriculum?" [If *yes*, "May I have a copy for review? How was it developed?"]
- "How do you ensure that the curriculum is followed? Do you periodically evaluate and update the curriculum? Do you have a schedule of completed sessions and their content?"
- Ask about each area listed above and whether they are included.

For FPE practitioners:

- "Do you use a standardized educational curriculum?" [If *yes*, "Are there any areas you teach differently from the curriculum?"]
- "Do you have a schedule of completed sessions and their content?"
- Ask about each area listed above and whether they are included.

For family members:

- Have you attended a 1-day educational workshop? [If *yes*, "What topics were covered?"]
- Ask about each area listed above.
- "Did the FPE practitioners review these educational topic areas with you individually or in a group session?"

10. Multimedia Education

Definition: Consumers and family members are given educational materials about mental illnesses in several formats (for example, paper, video, and Web sites).

Rationale: Consumers and families benefit from receiving educational materials in a variety of formats. Some people may be more likely to watch a video or search a website than to read the same information in a document.

Sources of information: Review of educational materials and interviews with the family intervention coordinator, FPE practitioners, and families.

Item response coding: If educational materials are provided to families and consumers in all three formats, code the item as "5."

Probe questions

For family intervention coordinators and FPE practitioners:

- Ask to see the materials.
- "Do you provide educational materials to families and consumers? How many families and consumers on your caseload or in your FPE program have received educational materials?"
- "Can you give or show me examples or the types of materials that you give to families and consumers?"

For family members and consumers:

- What types of educational materials have you received through the FPE program?" [*If they suggest only written materials have been provided,* "Have you ever been offered or given videos, Web site addresses, or material in other formats?"

11. Structured Group Sessions

Definition: FPE practitioners adhere to a structured procedure that includes:

- Beginning socialization;
- Review the last session's action plan;
- Go-round;
- Selection of a single problem;
- Structured problem-solving; and
- Ending with socialization.

Rationale: Families and consumers benefit from structured sessions that follow a predictable pattern. FPE practitioners should establish a clear agenda, goals, and expectations for each FPE session.

Sources of information: Observation of FPE multifamily group sessions and interviews with family intervention coordinator, FPE practitioners, consumers, and families.

Item response coding: If FPE multifamily group sessions include all six components listed above, code the item as "5."

Probe questions

For family intervention coordinators and FPE practitioners:

- Can you describe the typical FPE multifamily group session?"

For consumers and family members:

- "Can you describe what you do at the beginning of each multifamily group session? In the middle? At the end?"
- "Does the FPE practitioner seem to have a structured approach to each session?"
- "Is it clear to you what will be accomplished in each session?"

12. Structured Problem-Solving

Definition: FPE practitioners use a standardized approach to help consumers and families with problem-solving, which includes:

- Define the problem;
- Generate solutions;
- Discuss the advantages and disadvantages of each solution;
- Choose the best solutions;
- Form an action plan; and
- Review the action plan.

Rationale: Studies show that collaborative and structured problem-solving techniques involving setting realistic goals and priorities and breaking goals into small behavioral steps are effective in improving consumers' functioning and families' coping.

Sources of information: Observation of FPE multifamily group sessions and interviews with family intervention coordinator, FPE practitioners, consumers, and families.

Item response coding: If all six components of structured problem-solving were used, code the item as "5."

Probe questions

For family intervention coordinators and FPE practitioners:

- "Do you focus on problem-solving in multifamily groups?" [If *yes*, "What strategies do you use? Do you follow the same process during every session?"]
- Listen for the list of six components given above. If a component is omitted, probe for whether it is included.

For the family members and consumers:

- In the multifamily groups, do you discuss how to address problems that may arise?" [If *yes*, "What sorts of activities do you do in the sessions to work on problems you may be having? Do you ever generate plans of action? Is it a step-by-step procedure? Can you describe the steps?"]

13. Stage-Wise Provision of Services

Definition: FPE services are provided in the following order:

1. Engagement;
2. Three or more joining sessions;
3. Educational workshop; and
4. Multifamily group.

Rationale: FPE is most effective if all components of the evidence-based model are followed in order. Effective FPE programs ensure that consumers and families are well informed about the practice, establish a strong working alliance, receive a standardized educational curriculum, and develop clear treatment goals before entering into the multifamily group.

Sources of information: Chart review and interviews with family intervention coordinator, FPE practitioners, consumers, and families.

Item response coding: If sources corroborate that engagement, joining sessions, and the educational workshop are completed in a step-wise manner before entering into the multifamily group, code the item as "5."

Probe questions

For family intervention coordinators and FPE practitioners:

- "How do you engage consumers and families who would benefit from FPE?"
- "Do you provide joining sessions for consumers and families?" [If *yes*, "How many joining sessions has each consumer and family on your caseload had? What kind of topics do you cover in your joining sessions?"]
- "Did you offer a 1-day educational workshop? When was it offered? How many consumers and families attended? Did all the attendees complete three or more joining sessions before participating in the workshop?"
- "When did the multifamily group begin? Did all group participants complete three or more joining sessions and participate in the workshop before the group began?"

For consumers and family members:

- Ask if he or she has received each of the four services. Probe further about the timeframe and content of each service.
- "Did you feel that you had a good understanding of FPE before the multifamily group began?"

14. Assertive Engagement and Outreach

Definition: 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.

Rationale: All consumers and families who may benefit from FPE should be educated about the practice so that they can make informed decisions about participation. Effective FPE programs are flexible in meeting the needs of individual families and consumers and use a variety of means for reaching out to them. Assertive engagement and outreach is also crucial in overcoming barriers to participation such as stigma and hopelessness.

Sources of information: Chart review and interviews with family intervention coordinator, FPE practitioners, consumers, and families.

Item response coding: If FPE practitioners actively engage all potential consumers and family members through all necessary means on an ongoing basis, code the item as "5."

Probe questions

For family intervention coordinators and FPE practitioners:

- "How do you engage consumers and families who would benefit from FPE?"
- "How do you engage hard-to-reach consumers and family members? For example, some consumers may not have a phone number to contact. Or, you may not be able to reach some family members during your office hours because they work."
- "What would you do if a consumer or a family member told you he or she was not ready for FPE?"
- "What do you do with families who don't show up for treatment? What about families who drop out of treatment? How do you engage or re-engage these families?"

For consumers and family members:

- "How did you come to participate in this FPE program? Did the program do a good job in helping you understand FPE, explore your expectations about the program, and make an informed decision about participating?"
- "Have you ever felt discouraged or ambivalent about participating in FPE or stopped showing up for sessions?" [If yes, "What did the FPE practitioner do to re-engage you in FPE?"]
- "How do you feel about the availability of your FPE practitioner? Do you feel that your practitioner actively reaches out to you?" [If *yes*, "How does he or she do so?"]