

Chapter 6

Examples of Effective Community Services and Training in Family Psychoeducation

Attitudes of patients with schizophrenia that were consistent with an orientation toward recovery were significantly and positively related to participation in family psychoeducation and optimal pharmacotherapy (Lieberman & Koppelowicz, 2005).

Chapter two outlined the definition, character and models of evidence-based family work. In this chapter we bring you a number of examples of services and training that adhere to the principles of these models and that are up and running, working effectively in the community. This is a small sample of a large number of operating programmes. We have selected these examples as highly representative of services providing evidence-based programmes, as well as services together with their evidence-based training. These are placed in random order in the chapter.

The Washtenaw Community Health Organization, Michigan, U.S.A.

Jeff Capobianco

The Washtenaw Community Health Organization (WCHO) is a public, not-for-profit organization. It is an agency charged with coordinating \$86 million in services, and contracting for those services, to be provided to mental health service consumers in a four-county region near Ann Arbor, Michigan, U.S.

Washtenaw County Community Supports and Treatment Services (CSTS) began implementation of the Family Psychoeducation model in 2000 and established two multifamily groups following McFarlane's model early in 2001. A critical component of this implementation included involving family members from the local branch of the National Alliance for Mental Illness (NAMI) - the U.S. self help organization. The WCHO has worked closely with NAMI since the mid-nineties to improve services for family members. This included developing a newsletter, FPE groups and a family education program called Family Education, Support and Training (FEST). This program curriculum included material from the NAMI Family to Family Education Program and the Families in Action programs. It is overseen/coordinated by a consumer. The eleven week program for family members is facilitated by consumers, family members and mental health professionals. The tri-facilitator approach has been particularly effective in bringing these three perspectives on mental illness to the training and to build relationships between the groups. The FEST has been running twice a year since 1999. It

has been recognized nationally and internationally for its work and continues to be funded by the WCHO.

When Family Psychoeducation groups (FPE) were to be implemented there we assured NAMI members that these would not replace the Family to Family education course. It was decided to train NAMI members in the FPE model alongside our staff. Trained family members helped facilitate the FPE groups, further strengthening the Washtenaw CHO relationship with NAMI family members. Since that time we have found families are eager to make use of the program. NAMI has been particularly helpful in funnelling families to these services.

Multifamily Psychoeducation Groups (MFG)

A 2005 evaluation of our MFG groups found a significant reduction in pre-post-hospitalization rates for those who attended at least seven months of FPE services. Table One shows cost savings from a reduction in Crisis Residential Services (CRS) and Table Two shows similar savings from a reduction in psychiatric hospitalizations. Year before/after first FPE meeting and Year before/after seventh FPE meeting is used to show the ‘dose’ effect of seven meetings and to mitigate possible self-selection bias – people who choose to attend MFG are motivated to improve and it might be this motivation that results in improvement, not the treatment. The results show that although this does impact the results, particularly with the Assertive Community Treatment (ACT) Clients, there is still a significant reduction in costs due to the FPE services themselves.

Table 1

Reduction in Crisis Residential Services					
Crisis Residential Service Costs	Year Prior to first FPE meeting	Year after first FPE meeting	Year before 7th FPE meeting	Year after 7th FPE meeting	
ALL 50 Clients	\$27,750	\$24,500	\$49,000	\$11,750	
34 Young Adult Clients	\$14,750	\$19,000	\$29,750	\$3,000	
16 Assertive Community Treatment Clients	\$13,000	\$5,500	\$19,250	\$8,750	

Table 2

Reduction in Psychiatric Hospitalizations				
Psychiatric Hospitalization costs	Year Prior to first FPE meeting	Year after first FPE meeting	Year before 7th FPE meeting	Year after 7 th FPE meeting
ALL 50 Clients	\$223,020	\$49,560	\$283,790	\$50,740
34 Young Adult Clients	\$83,190	\$44,840	\$122,130	\$21,240

16 ACT Clients	\$139,830	\$4,720	\$161,660	\$29,500
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Table Two shows that the 34 young adults had a \$100K drop in costs comparing hospital days before and after the seventh meeting (actual effect of FPE), but only a \$40K drop in costs comparing hospital days before and after the first meeting (effect of motivation). Act Clients showed more of a reduction in cost after the first meeting, indicating that the major effect was due to motivation of the selected clients.

Overall, in the Year prior to the first FPE meeting, total CRS and hospital costs for the 50 identified consumers were \$27.8K and \$223K. After the seventh meeting, total CRS and hospital costs dropped to \$11.8K (42% reduction) and \$50.7K (23% reduction) respectively.

We currently have fourteen FPE groups operating in the WCHO affiliation.

First Break Multifamily Psychoeducation Group

In addition to the Community Mental Health based MFG groups we have a first episode group for people who do not meet criteria for our services. In Michigan you must have at least one psychiatric hospitalization prior to entering Community Mental Health (CMH) services. We did not wish to wait for a psychiatric hospitalization so we started this group.

Success of the Multifamily Model

The model has had a positive influence on the quality of life of consumers and their family members. Below are two examples of the impact of this model.

Example 1:

JH is the mother of one of our clients and she has had difficulty coping with her son's illness, in part because JH's mother also has a mental illness. JH reported feeling helpless, particularly since her sister and ex-husband frequently have sabotaged her son's treatment. Her son has had significant suicidal ideation and some assaultive behavior. Unfortunately, when he would have an exacerbation, she would withdraw and let others petition (arrange for involuntary treatment of) her son. Further, her son would have to become severely psychotic before he would get treatment. JH attended an MFPG with her son over the course of several years. She is grateful for the help, and is much more assertive in intervening on her son's behalf (particularly with JH's sister). Further, she is intervening at the first sign of a change in her son's condition, which prevents her son from becoming severely ill. This, in turn, has reduced the suicidal and aggressive behavior he exhibits when he is severely ill. JH. feels safer around her son, is more in control, and clearly understands her responsibilities. She has joined NAMI and is a strong advocate on her son's and mother's behalf.

Example 2:

Mr and Mrs. W have two sons having treatment of schizophrenia. Both sons lived at home. Their parents had a difficult time coping with the behaviors and the sense of guilt that they may have passed on schizophrenia to their two sons. One of the sons would destroy property when symptoms escalated, leading to an unsafe environment. Neither of the sons had much insight into their need for treatment, and neither had accepted much responsibility to take their medications or to work. Both parents and both sons have been attending multi-family groups regularly for several years. Mr. and Mrs. W have made great strides in understanding schizophrenia, and understanding their role in their sons' recovery. Both of their sons are now working part time, and their adherence to their medication has improved. There is much less tension in the house, and the home is much safer. There have been no more episodes of property destruction and the sons get help with their medication doses at the first indication of exacerbation.

As of this writing, 35 participants and 68 of their family members have taken part in the first episode group. Eighty-three percent of the participants have not been hospitalized since joining the group. Ninety-six percent of the participants were able to use their insurance to cover both the service and the pharmacy costs, significantly reducing the operating cost by over \$20,000.

Challenges to Provision of Services

The primary challenge we have found in implementing family services is the degree to which staff need to change the way they are currently providing services. Family psychoeducation requires that staff receive extensive training and supervision. As staff are not typically familiar with working with family members a degree of anxiety has been found about how to interact with families. Youth and inexperience may be one of the reasons that some staff do not feel comfortable.

At the beginning, mental health professionals, including psychiatrists, were quite wedded to the lines, "we can't speak with you without formal permission from your family member". Since the development of FPE groups, families are now seen not as outsiders to the treatment but rather critical to the success of the treatment. While we must always honor a consumer's request not to release information to family members - and in some situations this is necessary - we can still encourage consumers to join a FPE group with or without their family with the hope of eventually seeing the usefulness of having their family involved. Consumers who do not themselves wish to attend can still consent for their family to do so.

We are working on a "Family Welcoming Policy" for all our mental health and addictions workers. It will detail the importance of engaging and supporting family members.

Funding and Support for the Program

In Michigan we have been successful in getting FPE funded. The state department of health received federal grant money to disperse to agencies willing to implement FPE.

The requirement to receive the funding was a formal implementation plan and budget. Additionally, a state-wide learning collaborative was developed, as well as a list-serve to support staff implementing the model. The University of Michigan School of Social Work was contracted to provide a formal evaluation of the state roll out and Dr. William McFarlane and his staff provide **biannual** training and monthly supervision to implementation sites. Within a year and a half we had sixty family psychoeducation groups operating in Michigan.

Partnerships to Support Funding

We have worked with the state to develop billing codes that are recognized by the federal government as billable under Medicaid and Medicare. Third party insurance providers have also allowed us to bill for the FPE services. Integration of mental health, substance abuse and physical health services is a primary focus of the WCHO and the state of Michigan. We are currently working to blend the funding for substance abuse and mental health services and have already begun providing mental health, substance abuse and physical health services in our clinics. We also provide general practitioners with psychiatrist and social work staff at their sites to support treatment of patients that traditionally would only have been served at a Community Mental Health (CMH) Clinic.

Provision of Training

Psychiatry residents rotate through our community mental health clinics. The residents receive training in family based interventions. Additionally we are working with the University of Michigan School of Social Work, Dean of Curriculum to develop Evidence Based Practice classes in their Master in Social Work curriculum. Currently Masters of Social Work students can take classes specifically in family psychoeducation. WCHO staff often assist in the teaching of these classes.

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First Episode Psychosis Program (FEPP): Toronto Centre for Addiction and Mental Health (CAMH), Toronto, Canada

Sabrina Baker

The Centre for Addiction and Mental Health (CAMH) launched a family-centred care initiative within all of its clinical programs in 2003 to improve the care and support that CAMH provides to family members and to improve the quality of life of relatives who receive care at CAMH. The family worker is the representative for the Schizophrenia Division on the steering committee for this initiative. The initiative is involved in helping staff to develop expert knowledge in this area

The Toronto First Episode Psychosis Program (FEPP) is also part of the Schizophrenia Division at CAMH and serves a catchment area of approximately 3 million people in the Toronto region. FEPP is a major resource for early identification and treatment of psychotic illness.

The FEPP program offers a wide range of interdependent components such as a high risk research clinic, an early psychosis unit, an eighteen-bed inpatient unit, ambulatory clinics and a home intervention team. Each provides assessment, follow-up, clinical case management, and specialized intervention.

The Learning Advocacy Recreation Network (LEARN) offers a broad menu of recovery focused services designed to meet the specific educational, vocational, social and support needs of first episode patients and their families and includes a specialized family worker. The outpatient clinic provides consultation and on-going follow-up for client and families for up to three years.

The Family Program

The family program of the First Episode Psychosis Program (FEPP) is an integral part of a comprehensive multi-level integrated program. The recovery framework is designed to address the needs of families based on the stage of recovery of the individual being treated. This model was developed in the Calgary Early Psychosis Program and was expanded for use in Toronto. The client and family-centred approach aims to promote optimal recovery and wellness to people with psychosis and their family members.

The model has four stages:

1. managing the crisis;
2. initial stabilization and facilitating recovery
3. consolidating the gains
4. prolonged recovery

Each stage has specific interventions and clear goals as defined by Addington et al. (2005). The families may work with the different programs within FEPP in order to promote recovery in their family members and to minimize disruption to family life by helping to create an environment that is as stress free as possible for everyone. This is accomplished by:

- Reducing personal stress for family members
- Reducing the risk of secondary morbidity for family members
- Educating family members about the illness
- Teaching strategies for coping.
- Providing family with more intensive family intervention

The family program recognises that families can have a significant impact on the recovery of their relatives following the onset of a first episode of psychosis. Families clearly have needs of their own and have a right to education, support and understanding in their own right. The family model is based on the belief that

families are resilient and have the capacity to navigate through the barriers that they may face in taking part in their relative's recovery and ensuring that the rest of the family continues to flourish.

Family members may need their own period of recovery and adjustment and are encouraged to keep healthy through stress management and coping techniques. This type of program is Family Education as described in Chapter 2.

The Benefits to Family Caregivers

Family work is tailored to meet the family's needs throughout the phases of illness. During the assessment stage family members can provide valuable information about the person's symptoms, and premorbid functioning. Family carers learn about the illness, treatment options, and expectations about recovery by working with the treatment team. They benefit from venting their feelings, expressing their stories in a safe environment and addressing their concerns. Throughout treatment families can receive support and education during sessions with the treatment team to participate in their relative's recovery and to take care of themselves. Individual family counseling and family group-work interventions as well as mutual support groups also address these issues.

Challenging Situations

During the later stage of recovery, other problems in the family that are not related to and may have pre-dated the onset of psychosis (such as marital conflict, problems with other siblings, mental health and or addiction issues) are addressed as the need arises. LEARN has a designated specialized family worker who has the capacity to do this type of work. Various modalities of treatment may be employed such as individual, couple, family and/or group counseling. People are also referred to the local family organizations when families require ongoing support because our groups are time limited.

Many families who report having no previous knowledge or experience in dealing with psychosis say that family services have been invaluable to them in helping them to navigate uncharted waters. They report :

- Reduced anxiety;
- Reduced isolation;
- Better understanding of symptoms and behaviours;
- A greater sense of control over their situations.

Family Education Course

The Family Psychosis Education group and the Taking Care of Caregiver group consisting of eight sessions in total, offered four times a year, and is always filled to capacity. Each family is offered two places in a group and each group consists of 12-16 family members. A parallel psychosis education group is offered to the person with psychosis. Families say that it is easier to express their feelings without their relative who has psychosis in the group. The Taking Care of Caregiver group encourages family members to find a balance between supporting their recovering relative and finding time to take care of themselves.

When families experience extreme distress or conflict or when their relative is slow to recover, families are referred to the specialized family worker for more intensive work. The relative with psychosis is invited to take part in these sessions as needed.

Program Strengths

A sign of the program's growth and maturity has been reflected in the many requests from across Canada and from abroad to learn more about how family support is offered at LEARN. Training in family work is provided for new staff and students. Alumni family members are routinely recruited to speak at workshops and family psychosis education groups sharing their wisdom and experience with other family members and giving hope to others who are at an earlier stage in their relative's recovery.

The program is tailored to individual needs. From our experience, most families are eager to make use of the services that are offered to them. Clinicians engage with family members at every stage of recovery.

Cultural Differences

Families who come from different countries and have different cultures can receive service in different languages through use of interpreters. Some families want to preserve their anonymity and have stated that they would prefer not to be in a group where families are from the same culture or home country as themselves. We have been able to accommodate their wishes and respect their feelings. Many times, a discussion about stigma ensues which is useful to the family.

Challenges to Provision of Services

The introduction of health sector privacy legislation in Ontario has heightened everyone's awareness of privacy rights and maintaining confidentiality. Clinicians who may be interested in supporting families express concern about violating Ontario's Privacy Legislation if they share information with families. In response to these concerns, staff members have stated that they need more education about privacy issues in order to feel more comfortable about working with families (see Chapter 9).

There is insufficient supervision for professionals who are doing this type of work and many staff feel inadequately prepared to do family-centred care and family work. All staff on the FEPP have had introductory training to family work and have had the privilege of hearing families' stories in an educational format. There are insufficient financial resources for printed materials and for translations that are needed to accommodate Toronto's multicultural population.

When clients and their family are discharged from the FEPP, families are often dismayed to find a lack of services available to them compared with the early intervention team. Since the family initiative is on the strategic plan of CAMH, we expect that there will be a proliferation of family services across all the areas of schizophrenia treatment, but this is yet to be implemented.

Response of Mental Health Professionals

Senior management have been supportive of family-centred care. Social work has been the most supportive of family-centred care and by and large has more expertise in family work. There is more support than resistance.

University of Toronto psychiatry residents rotate through the FEPP program and have the option of taking a six-month course of 15 – 20 seminars that cover the family intervention

literature, uses interactive techniques and generally prepares residents to work with families.

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Multi-Family Group Work in Stavanger and Oslo, Norway

Anne Fjell

As part of a treatment and research project for early intervention for psychosis in Norway and Denmark, called the TIPS project (1997 - 2000), clinicians were trained to be leaders of a multi-family psychoeducation group program for the patients included in this project.

The research aim in the TIPS project was “to test in a multi-centre trial whether reducing duration of untreated psychosis (DUP) would improve the prognosis or long time course and outcome for first episode non-affective functional psychosis, compared to areas without a program for reducing DUP.” In order to offer all patients the same treatment, all patients were followed for two years by a treatment protocol. The treatment offered to the patients in all sites was medication, weekly individual supportive therapy and biweekly multi-family psychoeducation.

In order to succeed in the implementation of family work, the following core requirements are needed: targeted training, ongoing supervision and organizational support (Fadden et al, 1997). Thus the TIPS project arranged for both training and supervision and ongoing information in the project sites to ensure that all patients and their families should get the same offer and to prepare for the successful implementation of the family program in the project.

Since that time more than 160 groups have been initiated in Norway (Fjell et al, 2007), and in Denmark more than 50. The conditions for gradually implementing this family work model are based on:

- Administrative support and encouragement;
- Training and supervision in the method;
- Needs-based groups;
- Confronting beliefs about the family’s responsibility for the illness;
- Confronting beliefs about confidentiality;
- The enthusiasm from professionals after learning family-friendly treatment skills

The last is continually confirmed by the positive feedback from the group members.

Details of the Program

The training program for group leaders was located in two of the project sites and was scheduled for ten days. The training is elaborated in the McFarlane (2002) manual. The training and supervision tasks were done by assigned clinicians.

At the end of the project, training has continued and is now an integrated part of clinical training activity at the University Hospitals in Stavanger and Oslo. After fulfilling the training program and supervision during the group period, the group leaders are given a diploma.

The group leaders were trained to meet the following criteria:

- Help families and consumers better understand mental illness while working together towards recovery
- Recognize the family's important role in recovery
- Help clinicians see markedly better outcome for consumers and families

The manual used for the training in the TIPS project for MFPG had the following elements:

- *Joining sessions*
 - Engaging the patient and family members
- *Survival Skills Workshop (SSW)*
 - At the beginning, separate educational workshops are held for patients and family members
 - After one year group work, SSW for patients and relatives together
- *Multifamily group meetings had the following elements:*
 - Group period of two years
 - Biweekly meetings of 90 minutes
 - Group size of 5 patients; each patient was asked to bring three relatives
 - Two group leaders
 - The group program was designed around problem solving and communication training

In the TIPA project one extra session of education was added to the original manual after one year. This time the patients and family members were invited to the same workshop and they were asked what subject they wanted more information on. Quite often the group members asked for information about issues of drugs and psychosis, and also how family members could be supportive in the consumer's wish to be more independent.

The group-leader training began in 1997 with a two-day training course for all clinicians and research staff in the project at the beginning of the project. This presentation of the model to project staff was essential in order to inform them about the family work chosen in this project. William McFarlane was invited to Norway to teach his program and to act

as a core role model for future family workers. Following this initial training, a ten-day training program was set up.

The training program philosophy integrates understanding of illness with the multi-family model. The research foundation is based on expressed emotion (EE) and attention arousal studies, the understanding of the patients' limited tolerance for intensity, negativity, complexity and relationship disruption. The understanding of EE indicates that there are optimal social environments for schizophrenia including calm, benign, flexible and relatively simple, with known social structure and behavioural limits. The knowledge that this environmental intervention accommodates the underlying brain dysfunction is essential for clinicians in order to meet the needs of the adults with schizophrenia and their families.

The focus of the training is how to put this evidence-based treatment into practice. Thus the different interventions and elements were role-played in small groups to prepare the group leaders.

Qualifications for taking this training are

- professional psychiatric training of minimum three years,
- two years of experience in the treatment of psychosis,
- experiences in meeting with the families of the patients,
- recommendation by their administration.

The group leaders applying for this training are recruited from all clinical disciplines: psychiatrists, doctors, psychologists, psychiatric nurses and social workers. Clinicians from most parts of Norway are now applying for this training, as are colleagues from Denmark.

The 10-day training program had the following elements:

- concept of the illness and evidence based treatments,
- multi-family group manual including the communication rules and the problem solving section,
- signs of relapse,
- guidelines for family members,
- genogram and evaluation instruments.

An essential part of the role-plays is the modeling of the group leader role. A group leader has to have several roles: clinician, host, teacher and leader. These roles are to be combined in the group leader position in:

- setting group norms
- softening confrontations
- reformulating critical comments
- validating resources

- validating positive interactions
- supporting the problem solving in bringing up the patients perspective
- positive reframing and moderating strong familiar engagement
- keeping the structure and level of problem solving within patient's perspective

Communication skills are essential for group leaders in order to succeed in guiding the problem-solving process while keeping a clear focus on the patient's perspective. Thus the training of the communication rules has a strong focus on some core communication rules from Ian Falloon (1984), especially the "active listening" part. In the problem-solving process the group leaders are trained to pick up problem-solving issues by *first* asking the patient about his/hers experience (O'Brien M 2006). The group leader then thanks the patient for sharing his/hers experiences with the group and *then* asks the patient's family member:

Supervision

The supervision for group leaders after this training is scheduled regularly. The group leaders are asked: what is going well and if there is anything they think they could have done better. The supervisor also asks for fidelity to the training; if there are challenges in the problem solving and in following the structure for the group meetings.

In our experience the strongest challenge for the group leaders in the first phase of group work is following the time schedule for meetings. In order to shorten the time in the go-around, the group leaders need support from the supervisor to be active in asking questions about the patients functioning and risk of relapse. The group leaders will need continued support to use active listening instead of interpretation, to be open in their leadership, to share personal information and to validate the co-parenting activity in the group.

Another challenge for new group leaders is to focus on the patient's perspective and support the family members to do likewise.

Training Evaluation

After the training, the trainees evaluate the experience and share their thoughts about what they have accomplished within this training. Some of the trainees have reported:

- *"The MFG model supports me in bringing forward the family's competence and the needs of patients and families"*
- *"The training supported the understanding of the need for and the benefits of a structured method."*
- *"I have never earlier been trained personally in how to meet patients and families together."*
- *"This training has taught me the competence in effective communication with patients and families."*

- *“It is never too late; but I wish I had learned this 20 years earlier.”*

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Multifamily Psychoeducational Intervention – Enhancing other treatments - A Program at Ullevål University Hospital, Department of General Adult Psychiatry in Dikemark, Norway

Karin Kjonnoy and Liv Nilsen

In Norway, the Health Department has legislated four new laws that state that health services have an obligation to include and educate both the patient and their close family members. We have been doing psychoeducation and cognitive intervention full time for the past three years.

Our intervention focuses on coping strategies, reducing burden and preventing relapse. We include five to six patients and their chosen family members who participate in a group for approximately three years. We use the manual by McFarlane et al (2002).

In our experience, the most important factor in order to succeed is to invest heavily in engaging families during the “alliance period”. In order to create a therapeutic atmosphere all the participants need to develop trust and knowledge of the role of the therapists. The relationship between the participants and the therapists is the most important factor in succeeding with the intervention.

So far we have completed one 3-year group and the outcome is similar to that shown in published research. The patients who were recruited to our first group were suffering from severe mental illnesses and had been hospitalized for up to 15 years, mostly under compulsory treatment. Our study showed a reduction of controlling behaviour and criticism from the patients and the family members. Family members reported that participating has led to increased support, more knowledge, greater understanding of their relative’s illness and a reduction in felt burden. They experienced a significant improvement in communication skills, learning more positive ways of responding and reframing, thus reducing conflict.

Our study results showed that psychosocial functioning was improved immediately after the completion of the group and was even further improved at one year follow-up. None of the people who joined as inpatients are hospitalized as we speak. The three groups we are running at present have also shown symptom and functional improvement at the two year mark.

Example 1:

Ingrid, who had lived in a locked ward for many years had almost lost her ability to use the language coherently. During the three years we attended the group, she came to us once a week to improve communication skills. Today she lives in a rehabilitation centre with no locked doors. She is able to join conversations, and to describe what she wants for her future.

Example 2:

Hans was struggling with all daily life activities, especially nutrition. As a start he began to shop for food with help. Today he writes his own shopping list with a little prompting at meetings and phone calls. He is now able to go shopping by himself and to prepare a nice meal, even doing baking, although he thinks his kitchen is too small for that kind of activity.

After the groups finish we have kept in touch with those who want to, either by telephone or sometimes through meetings and booster sessions.

In the department of general adult psychiatry only a few inpatients are offered family treatment. However, those who get the opportunity are very willing to participate. All participants are in need of single-family meetings, individual sessions and phone calls. Some are in need of weekly sessions throughout the process; others may need weekly sessions during a difficult phase.

The obstacles we have encountered are mostly from ward personnel who have not yet realized that family intervention is as important as it turns out to be. Traditional treatment has not involved family and the health carers often lack education and competence in this area despite all reports and studies confirming the benefit. We offer education to personnel in order to reduce the resistance both inside the hospital and for students at various levels.

We find that the most supportive colleagues are newly educated personnel and those who have education skills in other types of family intervention. We have experienced very good cooperation with young psychologists with a thorough interest and understanding of cognitive therapy.

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Berkshire Family Work Services for individuals with psychosis and their families. England: Berkshire HealthCare NHS Foundation Trust

Nicki Moone and Jacqueline Sin

Since 2002, a network of “Family Work and Carers’ Education Services” has been established in Berkshire to represent an innovative approach: holistic, needs-orientated mental health services to its users and carers (Sin, Moone & Wellman 2003). This

network of services was initiated to fill the gaps in current service provision by targeting service users and their carers/ families as an holistic unit. In response to the ever-increasing calls for better services and the growing evidence of the benefits of families/ carers work especially using the psychoeducation model (NICE, 2002; Kuipers, Leff & Lam, 2002), we aimed to set up a network of inter-related services for carers and families putting theory into practice.

The Family Work Service initiated the establishment of the network, which developed further with the creation of the Carers’ Education Group and Social Club in 2003. The network brought the mental health trust, the local authority and the Princess Royal Trust Carers’ Centre, together to form seamless services. The partnership enhances the involvement of families/ carers across organizational boundaries and provides more choices of services and various different channels for access. Services ranged from social and supportive to educational input for carers, as well as structured problem-solving-therapeutic work for families. The network provides an invaluable link with the Psychosocial Interventions for Psychosis Programme (THORN-accredited which is regarded as gold-standard in the UK) to provide training and clinical practice opportunities. See Figure I and II for the outline of the network of services and the care pathway for families and carers (Figures replicated from Sin, Moone & Newell 2007).

The flexible approach allows carers to access one or all of the services available depending on individual needs. The feedback from carers to date reveal a positive and dynamic interface between various services. Some carers find it helpful to go to all services as they are congruent with one another, while others start with the more informal social club to gain knowledge and assurance of more services. Often because of the current pressures of care-giving, engagement with services may not be optimal, but families find it is reassuring to know that services will be available in the future.

Figure 1 – Care Pathway for carers of individuals with psychosis

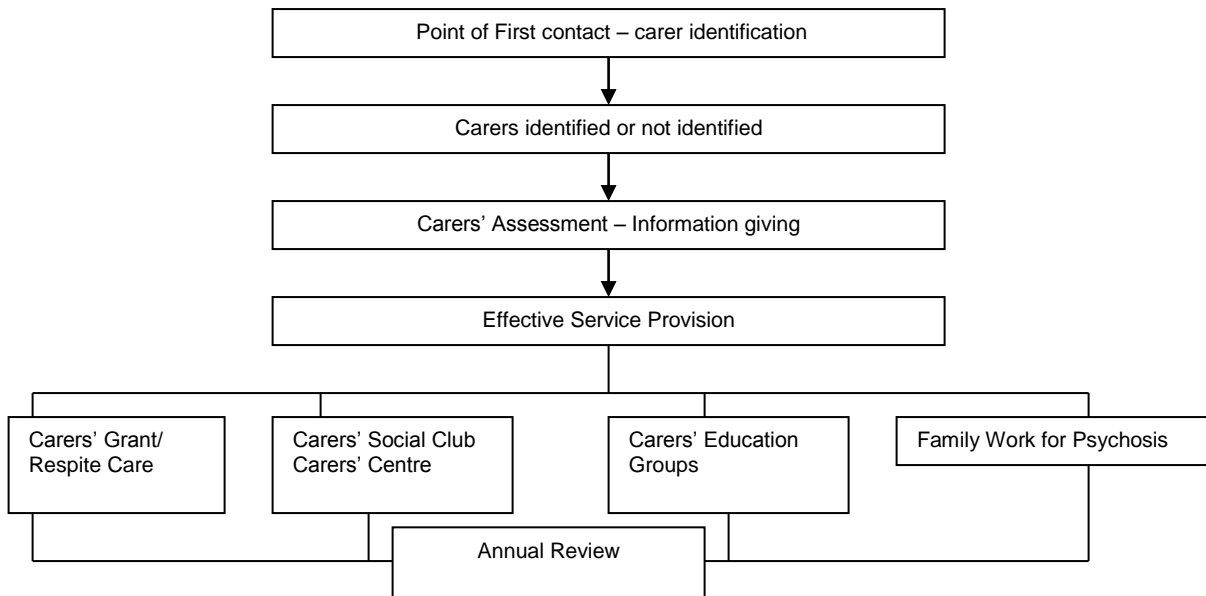


Figure 2 – Managed care framework for carers caring for someone with psychosis (adopted from IRIS, 2005)

<p>Step 1. Point of first contact</p> <ul style="list-style-type: none">▪ Within one week of presentation, carer(s) should be identified according to DoH (2001) definition: “people over the age of 16 who care or intend to care for a person except paid carers and/or volunteer workers. The carer does not have to be a relative or living with the person they care for.”▪ Carer(s) to be offered an assessment in his/her own rights▪ Initial contact should be at carer’s home if preferred
<p>Step 2. Interface with skilled assessment</p> <ul style="list-style-type: none">▪ Assessor being allocated and introduced to carers▪ Is the assessment collaborative?▪ Does the carer has an opportunity to “tell their story” and to give vent to their feelings (IRIS, 2005)▪ Information on local services and channels to access services introduced.
<p>Step 3. Effective service response</p> <ul style="list-style-type: none">▪ Assertive engagement with carers and families▪ All available services for carers introduced and assessed for appropriateness for carers▪ Is it carer-centred and community based?▪ Is there alternative service provider other than the statutory mental health services?▪ Is carer’s assessment and care plan being addressed and reviewed?▪ Carers are involved in service development, training professionals and recruitment of staff.

Different services within the network

Family Work Service

Family Work for Psychosis was the first service to be set up in Berkshire in 2002. The model of psychoeducation and collaboration underlines the theoretical approach we use in our family work services, which believes families and carers should be regarded as valuable resources in the treatment, maintenance and recovery of people with serious mental illness. Building upon these positive beliefs and attitudes, family work aims to improve family understanding of the illness and subsequently, improve coping. These aims are achieved through finding new ways of contending with problems, sharing information and education, and acknowledging the experience and knowledge that families have, and last but not least, by developing appropriate and constructive

communication. This intervention is always delivered in the families' households including the service users and other family members as much as possible. The delivery of the family work reflects the best evidence-based practice advocated by the NICE guidelines for management of schizophrenia (NICE 2002). It is underpinned by a psychoeducational model, and offers more than ten structured sessions over a period of not less than six months.

Carers' Education Group

The carers' education group borrowed largely from the psychoeducational family work model (Kuipers et al 2002) recommended by a series of ongoing research studies in this area. The major difference between the carers education group and the family work is the use of the group approach which draw carers with similar experiences, aiming to derive and mobilize the social support and mutual learning amongst carers themselves (McFarlane et al 1995). Since 2003, the group has been further developed and diversified to ensure different specific groups are run to match with carers' experiences and needs, considering the length and nature of their caring experiences. A template programme is illustrated in Figure 3.

Evaluation Process

Through the in-built audit mechanisms in the managed care framework for all carers and families (see Figs. 1 & 2), three key elements of carers' services are regularly monitored and evaluated:

- Identification of carers
- Comprehensive carers assessment & provision of education information
- Service provision in response to identified needs

Based upon the framework and its integral care pathway, a practice governance protocol incorporating keybenchmarks has been developed, for example, number and percentage of carers identified; number and percentage of carers receiving the information pack and an individualized education session within the standard duration.

The individual family interventions and carers' education groups have their own additional evaluative mechanism yielding objective information on the impact of interventions on:

- carers' perceived knowledge on illness by using Knowledge on Schizophrenia Illness – modified version (KASI , Barrowclough & Tarrier, 1995);
- carers' perception of management and coping by using Carers' Assessment of Managing Index (CAMI, Nolan et al. 1995);
- Carers' appraisal of the experience of caring for a mentally ill person by using the Experience of Caring Inventory (ECI, Szmukler et al. 1996);
- Carers' subjective feedback on the service through a semi-structured questionnaire.

Figure 3.

The Carers' Education Group Program over a Period of Six Months	
Sessions	Topics
One	Programme overview, ground rules & introduction
Two	Overview on psychosis: Aetiology, treatments, medication, Etc.
Three	Caring issues – what do they mean to you?
Four	Common problems in caring and how to tackle them
Five	The mental health system – getting through the maze
Six	Carers' assessments and practical help for carers
Seven	Communication skills within the family
Eight	The use of cannabis, alcohol and street drugs
Nine	Early warning signs and how to recognize these
Ten	Working towards recovery
Eleven	Future concerns – contingency planning
Twelve	Looking after yourselves and evaluation

A battery of evidence-based tools were administered, before clinical and post intervention work began, to collect targeted data. All data was analysed within the family intervention service audit protocol. The group sessions always ended with a questionnaire to ask for feedback and evaluation from the carers with a full evaluation exercise at the very end of the whole program. The qualitative feedback from carers has been significantly positive and has informed the expansion of the services over the last two years and modification of further development. A brief summary of some qualitative feedback from carers who graduated from the recent groups is outlined in. Figure 4.

Figure 4.

Carers' Feedback on General Satisfaction with the Carers' Education Groups
<ul style="list-style-type: none"> ▪ “Good informal support, understanding, supportive group” ▪ “It’s been useful having a framework, so the group does not become a sound off” ▪ “...Above all, the hope you instilled in my heart and for other patients and their carers” ▪ “Just a relief to know there are other people who understand”
Carers' feedback on content of the groups
<ul style="list-style-type: none"> ▪ “Very comprehensive and thorough” ▪ “Able to relate aspects of content to own experiences, it has been focused and carer-friendly” ▪ “Useful to learn about the illness and strategies to cope and what to look out for”
Suggestions to expand carers services from carers
<ul style="list-style-type: none"> ▪ “Involve siblings in a sibling group”

- “Start with glossary of terms”
- “More staff please so many more people can benefit from”

Training Practitioners to Work with Families/ Carers

The network of families/ carers services described above is part of a wider programme to develop and disseminate psychosocial intervention skills in the mental health workforce in Berkshire and to embed these skills in routine clinical practice. This project has involved some investment of new funds and some restructuring of existing services. This has been undertaken to ensure that conditions exist to maximize the likelihood that practitioners will be able to successfully practice their psychosocial intervention skills and receive appropriate supervision and managerial support.

This network of family and carer services has close link with the BSc(Hons)/ HEDip Psychosocial Interventions for Psychosis Programme for post-qualifying mental health practitioners in the Thames Valley region. Within the programme, there is a compulsory module on Family Interventions. The Family Intervention (FI) module is also open for all Berkshire practitioners as a stand-alone module as the provision for such training outside of PSI training is limited. The FI training is very skill-focused. In addition to the 10 lecture days spread over 6 months, trainees have to practice skills learnt with families with keen clinical supervision. Families and carers are actively involved in the interviewing and training of mental health practitioners, running sessions such as: “Listening to the experts”, “Carers’ experiences of family work”.

Nicki Moone
Family Work Service, BHCT

Jacqueline Sin
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The Washington Institute for Mental Illness: Research and Training (WIMIRT), Spokane, Washington

Diane Norell and Dennis Dyck

WIMIRT, located at Washington State University was established in 1989 and represents an active collaboration between Washington State University, University of Washington, Washington State Department of Social and Health Services, Western and Eastern State Hospitals. The Institute is committed to improving mental health services in the state and nationally through high quality research and training.

NIMH Funded Research Study

In 1995, WIMIRT was awarded a National Institute of Mental Health grant to evaluate the effectiveness of Multifamily Group treatment (MFG) following McFarlane’s model. Persons with schizophrenia, who were relatively stable, living in the community and receiving outpatient services, and their families, were enrolled into MFG. We found that this significantly reduced hospital admissions without increasing outpatient staff time compared to standard outpatient care (Dyck et al., 2002). After three years, this same

group of persons with schizophrenia also required significantly fewer outpatient hours than those in the standard care group (McDonnell et al., 2003). We have found that in addition to decreasing adverse events such as hospitalization, MFG also reduces the deficit symptoms of schizophrenia which are predictive of community functioning (Dyck et al., 2000).

In addition to improving outcomes for persons with schizophrenia, MFGT reduces the psychological distress of family caregivers (Hazel et al., 2004). Finally, while the mechanisms of MFG effectiveness have not been conclusively researched, it is important to note that fidelity of clinicians to the model ensures positive outcomes for persons with schizophrenia (McDonnell et al., 2006), particularly for those participants with a high level of symptom severity.

Success Stories from the Study

Numerous examples of successful outcomes for consumers and families arose from the research study. The following are two examples:

Example 1:

Mr. and Mrs. A have a son who is a client of the local mental health care system for treatment of schizophrenia and substance abuse. The son lives independently and relies upon his family for financial and emotional support as well as practical support for meal planning, laundry, etc. The parents were spending significant time and money to support the son who periodically would destroy property at home when symptomatic or abuse substances which would result in being arrested and/or hospitalized. The son had lapses in understanding the value of medications and not using substances. All of this resulted in significant stress for the family resulting in serious arguing, tension and conflict. The family attended a multifamily group fairly regularly for two years. The parents learned a variety of practical strategies about how to more effectively manage the home environment, set clear limits and provide helpful support to their son. The result was a significant decrease in arguing and tension, decreased use of substances by the son and better medication compliance. Recently, the son enrolled in part time in a local community college beginning to take some next steps in his recovery. His parents are investing more of their time and resources in their own interests.

Example 2:

Mrs. B is the mother of a client of a local mental health provider agency who was very concerned about the persistent negative symptoms of her daughter. The daughter has a schizoaffective illness. She was sleeping up to 14 hours a day with very little energy to participate in even short term, small daily living tasks. Mrs. B indicated a fear that her daughter would be dependent upon her for the rest of her life, a notion that distressed the mother considerably. The daughter, age 28, was concerned as well, feeling guilty for having to rely so heavily upon her mother. The mother and daughter attended the family psychoeducation group for two years in which time the daughter slowly began to take interest in her own life increasing her activities systematically.

She began by participating in some regular daily exercise, then volunteering regularly each week, finding a part time job, then a full time job and eventually living independently. Mrs. B embraced the value of going slow and persistently supporting her daughter, while learning more about effective methods of managing schizophrenia.

Multifamily Psychoeducation Group Treatment

Due to the successful outcomes for families and consumers from the research study, MFG following the McFarlane model was introduced at two local mental health provider agencies in the Spokane, Washington area.

1) Family Service Spokane is a private non-profit mental health agency which offers counseling and case management to adults and children who are dealing with mental illness or mental health-related issues. One multifamily psychoeducation group is offered for adults with schizophrenia and their families. The group has been in operation for five years and is considered to be a core clinical component of service delivery. The group functions as an open-ended group with members periodically enrolling or completing the group. Most members continue in the group for a period of 2-4 years depending upon their needs. Other types of therapy are offered such as individual, family or group. Case management is also provided as necessary to meet client needs or to coordinate care with other service providers.

2) Spokane Mental Health is a non-profit organization that serves children, families, adults and elders throughout Spokane County. They provide comprehensive treatment and rehabilitation for those with mental illness and co-occurring disorders. Services include crisis response; individual, family and group therapy; case management and support; vocational rehabilitation; psychiatric and psychological services, medication management and consumer and family education. Spokane Mental Health was a research site for a National Institute of Mental Health funded study. Currently, the agency provides one family psychoeducation and support group for persons with schizophrenia and their families. The group operates as open-ended with members periodically enrolling or graduating from the group.

Family Education Workshops at Eastern State Hospital

After a number of clinical staff from one of the two state hospitals in Washington State were trained in MFG by William McFarlane, a decision was made to offer a quarterly family education day long workshop to families who have members hospitalized at the state hospital. This venture soon became so successful that the workshop is now offered to anyone interested in obtaining more information about the major mental illnesses of schizophrenia, bipolar and depression.

The emphasis on support and information for families remains the hallmark of the workshop, yet friends, patients from the hospital, clinical staff from facilities throughout eastern Washington, consumers from the community and others attend. The content of

the workshop includes information about the major mental illnesses, current treatments both medication and psychosocial, current research, common responses to illness, family guidelines for effective management and how to support a person in their recovery process. Local National Alliance for Mental Illness (NAMI) members also present on the benefits of joining NAMI. Because of the rural nature and vast referral area of the state hospital, this has been one way to offer education free of charge to families who may not have the opportunity to attend local family support groups.

Program Strengths

Consumers who have participated in either the research study or the community-provided treatment report that hospitalizations have decreased, negative symptoms of their illness have diminished, and methods have improved in managing symptoms. This has resulted in consumers' ability to take next steps in recovery and achieve some of the goals and dreams they have had for their lives. Qualitative interviews with a number of consumers have indicated an increased satisfaction with their lives, and increased sense of support from other family members as well as other members of the group, and a sense of being respected and valued.

Families report experiencing less emotional burden, diminished distress, improved management strategies and skills and a sense of pride in their family members' successes.

Clinicians who have facilitated MFG indicate a tremendous sense of satisfaction in the work, a new sense of hope that change and recovery is possible for persons with schizophrenia, and a paradigm shift in how they view families and persons with severe and persistent mental illness. They recognize the resource and value that families have to contribute to the team. It appears that the experience of partnering with families consistently over a long time period greatly contributes to a shift in thinking and attitude.

Program Obstacles

Family Involvement

One of the most significant obstacles to successful implementation of family psychoeducation is the initial inclusion of the family. There are a variety of reasons why this is a challenge in the public mental health system.

Some families report that they disengaged from their ill member due to the level of distress they have experienced, while others informed us that they were encouraged by professionals to disengage. Other families indicate that this type of intervention would have assisted them "years" ago, but they have now learned how to cope and feel that they are managing well enough.

Many consumers have moved here from other more rural areas to secure better housing options and thus live long distances from their families, making it difficult for families to engage in family psychoeducation.

One of the ways we have dealt with the obstacle of family inclusion is to include consumers who do not have family members participating or to invite the consumer to include someone who is "like family" to them. In the situation without a family member, we have witnessed other families "adopting" a consumer. Consumers have reported

feeling like they have a family through the group due to the natural support network that develops. We have also encouraged families to reconnect and reconsider the value of more involvement with their ill member, utilizing the MFG intervention as the means that may assist them and their member in facilitating this reconnection. With persistent conversation over time, we have found that families are interested in involvement and welcome the opportunity to re-engage.

Professional Attitudes

We have observed reluctance in the professional community to embrace the notion of family involvement. As is indicated in Michigan, case managers involved in the facilitation of MFG may feel inexperienced in working with families and thus find it uncomfortable initially. Even where clinical staff value working with families, we have observed that the system inadvertently creates barriers in the form of limiting time and resources for the staff involved in the intervention. Few rewards or incentives currently exist for staff. Far more disincentives exist that cause staff to feel that involvement in this innovation is a burden. The financial benefits of MFG need to be clearly understood and demonstrated to administrative personnel in order for incentives to be developed for staff. As well, staff need long term supervision by more senior staff in order to become comfortable and skilled in facilitating MFG.

Training and Supervision

Clinicians who facilitate MFG at Family Service Spokane or Spokane Mental Health are trained individually or in small groups by staff from the Washington Institute or Spokane Mental Health. Staff receive ongoing supervision for a period of at least one year to ensure fidelity to the original model.

Professionals who have been trained to recognize the importance of considering environmental factors as well as client centered methods seem to be effective and demonstrate a sense of ease and understanding

Training Opportunity

Currently, The Washington Institute has developed a training program which is available to those who may be interested in developing the knowledge and skills in Macfarlane model MFG. The course offers:

- Sufficient training that will translate into the knowledge and skills needed for staff to implement a multi-family group in their organization
- Opportunities to practice skills through demonstration, video observations and discussion
- Consultation and supervision to clinical staff post training in order to increase skill level, competence and fidelity to the model
- The tuition includes 15 continuing education units. Post training consultation and supervision is available.

The Institute has trained clinical staff from many mental health agencies in the State of Washington over the past five years. Family psychoeducation is identified as an evidence-based practice in Washington State. Agencies are encouraged to develop family

psychoeducation programs. However, to date there are no mandatory training expectations related to family education for adults in the state of Washington.

Diane Norell, MSW, OTR/L, CPRP, Research Associate, Washington Institute for Mental Illness Research and Training, and Dennis Dyck, Ph.D., Director/ Vice Chancellor, Washington State University, Spokane

The Córdoba Association for Help for People with Schizophrenia and their Families (ACAPEF), Argentina

From a report by Raimundo Muscellini

An interesting mental health service that could be described as an NGO/ Civil Society partnership is ACAPEF a community initiative in Córdoba, Argentina. ACAPEF is part non-governmental organization, part professional service and has been operating since 1994. This forward thinking organization has melded together professional work with families, family to family support and patient rehabilitation. Close relationships between family representatives, concerned psychiatrists and associated mental health workers has lead to the development of a service that combines treatment and care with elements of family education and support, family psychoeducation and supportive employment. For over 10 years psychiatrist Dr. Raimundo Muscellini, psychologist, Maria Gabriela Contreras, and a committed family member, Hector Porfilio, have developed ACAPEF into a comprehensive program for the treatment of schizophrenia and related conditions, recognising the importance of both medical and psychosocial interventions.

ACAPEF provides comprehensive care, including medical treatment, therapy groups, assessments, consultations, educational public meetings and/or workshops, as well as psychosocial enterprises that have stimulated and encouraged members in their quest for recovery. Self esteem and community are the basis of ACAPEF support programs.

The group called Psychoeducational Group Therapy for Family Members operates for a 10 month period, giving emotional support and information much like many family education programmes elsewhere in the world. A second therapeutic group is based on the stress-vulnerability model of family work developed by Kuipers, Leff and Lam (see Chapter 2). In addition, there are weekly, two hour psychoeducation group for siblings as described below.

Run by Lic. Miguel Kusnierzewski the rationale for the programme is as follows: The intrusion of an illness as complicated as schizophrenia in the midst of a family provokes a deep alteration of family links; siblings are not exempt.

The psychoeducation group for siblings of persons with schizophrenia was formed in view of the diverse problems and the specificity of the fraternal link, that is different from the relationships parents have with the ill person.

Relationships established among siblings may be of all sorts. Siblings that have had to take charge of the family and the responsibility the treatment

requires, or friends and pals, even enemies, hypercritical or those who negate the illness.

This is due to a multiplicity of emotions felt by siblings, such as jealousy, competition for parental attention, fear and concern, as well as guilt because of the limitations of the sibling's illness while they lead a normal life.

It is for these reasons that it is so important to give psychoeducation to brothers and sisters, not only because it leads to an improvement in the quality of family life but also because they are a very important resource in the treatment of the patients:

Siblings have the possibility of maneuvering differently than parents. A sibling can accompany the person on outings, trips to the movies, going to parties, and assist him/her in taking his medications.

That is why it is necessary that they know about the disease, that they know how to treat their sibling and which is the best way to help them.

Work Modality: In the Psychoeducation Group meetings we work with active participation techniques with all the group members, with the coordination of a Licentiate in psychology, and sometimes psychology students acting as non-participant observers.

Diverse problems are presented and the opinion of the more experienced siblings is requested, but any group member may give an opinion; the coordinator will intervene if it is necessary to clarify something or establish the topics for conversation.

Functions of the Coordinator: To give information and clarification:

- To inform about what is scientifically known about the disease in simple easy terms.
- To inform about current scientific knowledge about treatment (psychopharmacology, psychotherapy, rehabilitation and psychoeducation)
- To report about attitudes and actions that must be adopted to improve quality of family life (with physicians, therapists, family, society, etc)
- Continually repeating the previous concepts and constant up-dating of same.
- At group level, stimulate the group to transcend the disease that gathered them, forming a group conscience and establishing links among the persons.

ACAPEF has also been able to develop their Well-being Clubhouse, which has initiated a number of activities. These include a radio program which airs on the University of Cordoba, a football club, and a recently opened small bakery in the community that has links with a local supermarket and is run by consumers with therapeutic companions. The clubhouse has also been the location for a postgraduate course associated with psychiatric practice. ACAPEF also develops literature, maintains a library, conducts recreational trips for members and more.

Dr. Raimundo Muscellini is Director of the psychiatry program at ACAPEF.

The Family Institute for Education, Practice and Research, New York State, United States

Thomas C. Jewel and Anne M. Smith

Family Psychoeducation Training and Implementation

In the Fall of 2002, the University of Rochester Medical Center's Department of Psychiatry and the New York State Office of Mental Health (NYSOMH), in collaboration with the Conference of Local Mental Hygiene Directors and the New York State Chapter of NAMI (the National Alliance for Mental Illness), partnered to establish the Family Institute for Education, Practice & Research. The Family Institute, funded by the NYSOMH, was created to establish a mechanism to teach mental health providers throughout New York State how to effectively provide family services to individuals with a mental illness and their families.

The first initiative undertaken by the Family Institute was to promote the routine use of evidence-based family services in community mental health settings by teaching providers to implement Multifamily Group Psychoeducation (MFGs). The initiative began with a series of seven family psychoeducation information forums for agency leadership across the state. These forums provided an opportunity for providers to learn about family psychoeducation, the establishment of the Family Institute, and the pending statewide rollout of this practice. In the Spring of 2003, the Family Institute developed and issued a Request for Proposals to providers across the state. After receiving 52 applications that represented over 75 agencies. The Family Institute selected a total of 17 applicants, which included a total of 37 sites. For each site, Family Institute staff delivered clinical and organizational consultation (including clinical supervision) to small implementation teams organized within each site for a period of eighteen months. It is noteworthy that two different consultation strategies were employed. Twenty sites received one on one consultation in which a single Family Institute consultant was assigned to work with a single agency. The other 17 sites were organized into four distinct Multi-Agency Group Collaboratives in which a single Family Institute consultant was assigned to work with a group of a minimum of four agencies simultaneously; these agencies were already part of an existing care coordination network (i.e., the Western New York Care Coordination Program).

Overview of Services Research Conducted by the Family Institute

The Family Institute has conducted ongoing services research by gathering data from multiple perspectives and sources to investigate factors related to the statewide implementation of family psychoeducation. It is hoped and expected that this research will help inform future statewide and national efforts to implement evidence-based family service innovations. It is important to note that this project was not intended as a study of the clinical impact of Multifamily Group Psychoeducation, which has been well established in previous efficacy and effectiveness studies for more than 25 years. Instead, the main purpose of our evaluation efforts was to investigate factors related to the relative effectiveness (or ineffectiveness) of our training and implementation activities. As such,

we designed the evaluation to help us answer important questions and gaps in the literature that are summarized as follows:

- How might a state proceed to successfully implement an evidence-base practice?
- What factors predict relative success or failure of implementation at a site, e.g. organizational context, staff, consultant, training process?
- What is the optimal level or strategy of consultation and/or technical assistance for a program/staff? Does it depend on the program setting or other characteristics?

Baseline data were collected during the initial engagement with each participating site and then at regular periods thereafter: quarterly for implementation milestones assessments, every 6 months for fidelity assessments, and every 12 months for administrative, staff and trainer assessments. See table 1 below for a summary of the administration timeline for each assessment tool utilized in the initiative.

Table 1

Summary of administration timeline for each assessment tool utilized in the initiative									
Name of Assessment Administered	Timeline of Administration in monthly increments								
	0	3	6	9	12	15	18	21	24
Staff Survey	X				X				X
Organizational/Administration Survey	X				X				X
Fidelity Assessment	X		X		X		X		X
Implementation Milestones Summary			X		X		X		X
Consultant Survey	X				X				X
Training Activities Documentation		X	X	X	X	X	X	X	X
Perceptions of Training and Consultation					X				X

Mental health professionals' views toward families – Conducting this evaluation has helped us, in retrospect, to gain a better understanding of the agency staff that participated in this training initiative. For example, findings illuminated the fact that staff members at baseline tended to hold some views that were inconsistent with the philosophy and ideology of the MFG intervention itself. For instance, the MFG intervention is based largely on scientific findings that espouse schizophrenia as a biological brain disorder, while debunking myths about family dynamics as causal factors. Based on staff responses to a measure called the Family Culpability Scale at baseline, it appears that large percentages of the staff trainees at baseline held views that were quite incompatible with the basic conceptual underpinnings of the family psychoeducation model. Specific examples include:

- Sixty-five percent (N = 136) AGREED with the statement, "Getting families to understand how their family dynamics have helped cause their relative's severe mental illness should be an aim of therapy."

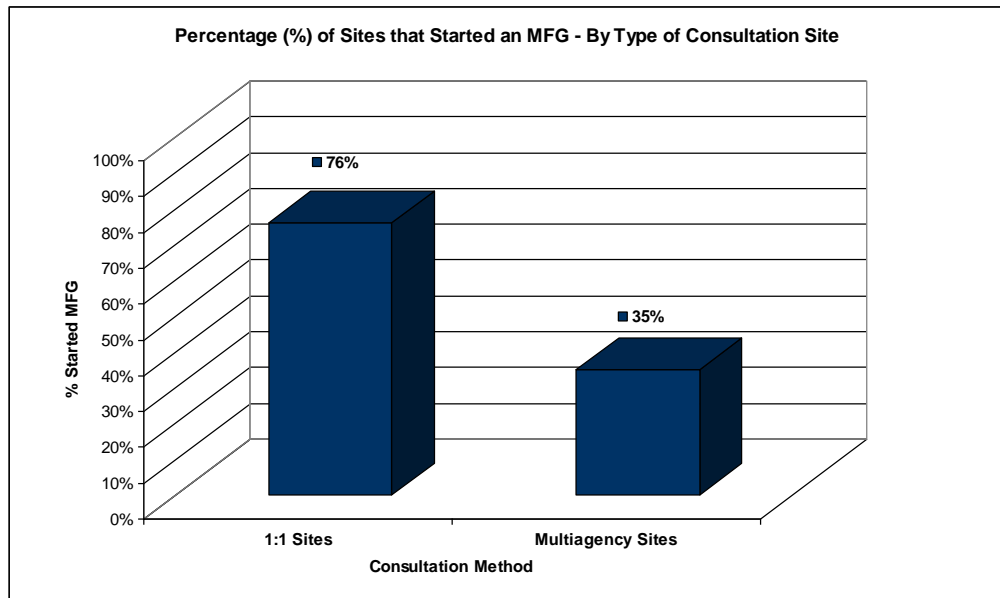
- Seventy-three percent (N = 152) DISGREED with the statement, "Therapists should inform relatives of clients with severe mental illness that their own behaviors or family dynamics did not help cause their relative's illness."

Nevertheless, despite beliefs such as these, agency staff attended training workshops and regularly met with Family Institute consultants for supervision with the expressed goal of establishing an MFG program at their agencies.

Success and Impact of Training Program

The project has been successful in that the majority of agencies have changed the way they do business by adding this important evidence-based practice to their service system, consistent with the President's New Freedom Commission Report (2003) recommendation that mental health care should be consumer- and family-driven. By the end of December 2005, 60% of the sites had started an MFG treatment program. More specifically, 76% of the one on one sites have established an MFG program, and 35% of the WCC Learning Collaborative sites had started an MFG. Forty percent of the sites had not yet started an MFG program, although only a relatively small number of sites (3) formally dropped out of the project, see Figure 1.

Figure 1. Percentage of Sites that Started an MFG by Type of Consultation Site



We also tracked the total number of MFGs that were started and the total number of consumers and family members who received family psychoeducation services as a result of this initiative. As summarized below, as of December 31, 2005, 137 consumers and 183 family members were served across a total of 28 multifamily groups. In terms of average numbers of participants per group, findings indicate approximately 11 members per group. It is noteworthy that the MFGs were started at these sites with minimal incentives for agency participation. Anecdotally, the staff, consumers and families involved with MFGs have widely reported that they value the service and expressed

wishes to see it continue. For example, one staff member who had been supervised conducting the intervention for two years sent an e-mail to the Family Institute in which she wrote:

“It has been a really interesting ride through the Multifamily course. The goal of this group was to help the individuals and their families solve problems, and the growth and progress made by everyone has been such an inspiration. The individuals who initially sat quietly and said very little now sit with their heads up and participate to some degree. The group has meshed very well and they are very supportive of each other. We accomplished our mission using the ‘flat’ triangle the Family Institute taught us to use -- it taught us that the individual, the family or support person, and the staff were all working together... on the same level. We as the group leaders were not only there to teach, but rather to initiate problem solving techniques and encourage them all to participate by sharing their ideas and suggestions or even their own experiences with a like situation. And two years later, after sharing many meals and ideas together, I think we accomplished just what we were supposed to do. I'm very proud to have been a part of the new found confidence that many individuals now have.”

Average Time to Implement Key Components of the MFG Intervention

One of our goals was to obtain a better understanding of the time it takes for an agency to implement family psychoeducation, given the current climate of increasing clinical productivity demands of staff, paperwork and documentation responsibilities, and the concept that agency staff is increasingly called upon to "do more with less". The Family Institute therefore collected information about the time that elapsed between site staff's attendance at an initial 2-day intensive training workshop until the time that key aspects of the MFG intervention (i.e., 1st Joining Session, Family Education Workshop, Multifamily Group) started. We found that, for those sites who successfully started an MFG, it took an average of 7.7 months from the initial training to the 1st Joining Session with a family; 11 months until the Family Education Workshop, and almost one full year (11.7 months) until implementation of the first Multifamily Group meeting. It is particularly noteworthy that there was a tremendous range in the amount of time it took for the sites to begin implementing this intervention model, see Table 2.

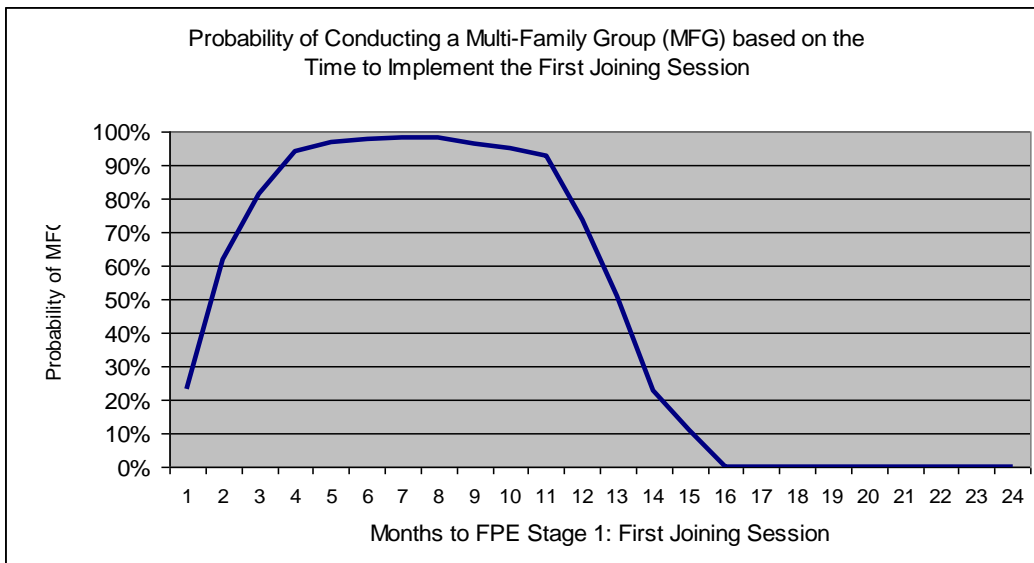
Table 2

Time to Implement Components of MFG After Training Workshop			
	Mean	SD	Range
Workshop to 1st Join	7.7 months	5.2 months	1-23 months
Workshop to Family Ed. Workshop	11 months	4.4 months	4.7-22.5 months
Workshop to MFG	11.7 months	4.6 months	5.7-22.8 months

Curvilinear Relationship Between Time Until First Joining & Probability of Starting MFG

We were also interested in better understanding the relationships between the time it took for a site to begin Joining and the likelihood that they would eventually start an MFG. Our interest was due to our anecdotal observations that if it took too long for an agency to begin the intervention, it seemed that momentum and focus on this implementation suffered considerably and sites eventually dropped out or were unsuccessful. As can be seen below in Figure 2, statistical analysis confirmed this, the probability that they will eventually start an MFG drastically decreases after 12 months. Interestingly, it also appears that sites who start to implement the intervention too soon (e.g., within the first 1-2 months) also have a decreased probability that they will successfully get an MFG established. It is likely that simply "jumping in" and trying to begin this intervention without a modest amount of careful planning, conversations with administration, identifying potential obstacles and solving basic implementation problems *prior* to implementation is a less than optimal way to proceed.

Figure 2



Fidelity Changes Over Time

Fidelity, or the degree to which a treatment adheres to specific implementation guidelines, has been shown to be an important factor in the impact of evidence-based practices. As can be seen in table 3 below, there were steady increases in the fidelity of MFG implementation at the sites over time, with the highest degree of fidelity reached at the 24-month follow-up period. This suggests that the clinical training and consultation does in fact lead to improvements in the fidelity of MFG implementation over time. However, it is also noteworthy that the scores fall short 100% fidelity. This is likely due to a number of factors, one of which may be the fact that consultants were taught to strike a balance between encouraging and supporting high levels of practice fidelity, while also maintaining a respectful stance toward agencies/clinicians and for some flexibility in the way they chose to implement the intervention and solve implementation problems at their site. Sites were "allowed" to make some adjustments and implement *slight variations* of the MFG model, while simultaneously encouraged to follow the key components of the intervention and avoid *major deviations* from the original MFG model.

Table 3

Family Psychoeducation Fidelity Scores Over Time (Possible Scores Range from 1 – 5 for Each Time Period)					
	Baseline	Post-Train	12 Mon	18 Mon	24 Mon
Mean (SD)	1.35 (.19)	1.81 (.46)	2.98 (.82)	3.39 (.85)	3.52 (.93)
Range	1 - 2	1 - 4	1 - 4	2 - 5	2 - 5

Development of Additional Resources to Address Challenges

The Family Institute team, in partnership with numerous collaborators and stakeholders, designed several resource materials that were needed to make the statewide implementation program as successful as possible. The following is a brief description of each of these tools:

Consultation/Site Visit Training Manual - A site visit manual was created by the Family Institute as a tool for consultants to use when working with each site's project coordinator and family service team. This instructional document guided the consultant through an entire family psychoeducation consultation procedure that consisted of 17 steps that the consultant could follow to ensure that each site understood the intervention and was actively making strides toward implementation.

Initial Engagement with Families and Consumers – It rapidly became clear that staff who wished to implement this model needed specific guidance about ways to have initial engagement conversations with consumers and their families. We developed several materials and handouts that focused on key issues such as: a) ways to identify consumers for participation depending on their current stage in the recovery process, b) skills for having the first conversation about MFGs with consumers, and c) tips for conducting a successful outreach phone call or other outreach contact with family members.

Billing & Reimbursement Manual - A Billing and Reimbursement Manual was developed in partnership with NYSOMH to help guide, inform and educate providers how to plan, deliver, and document family psychoeducation so that they may obtain reimbursement for these services under existing outpatient regulations. This manual helped the Family Institute team address a core issue of fiscal sustainability of this intervention for participants in this initiative.

Family Education Workshop Manual - A comprehensive Family Education Workshop Manual was developed as a toolkit to assist providers as they plan and prepare for the component of the MFG intervention called the Family Education Workshop. This aspect of the intervention consists of a 6-8 hour long workshop about mental illness that clinicians provide for clients and family members. Understandably, there was a considerable amount of anxiety and apprehension on the part of clinicians for this aspect of the intervention. This manual was created in response to clinicians' expressed wants/needs for a "how to" toolkit.

Family Guidelines Magnet - A key aspect of the MFG intervention involves the use of a core set of family guidelines that help the clinician teach family members and consumers a set of critical attitudes and skills to foster the successful treatment and recovery of people with mental illness. To help families and clinicians remember these guidelines, the Family Institute developed and purchased several hundred family guidelines magnets. These small magnets were created for the purpose of passing them out to clients and their family members at the multifamily group sessions. Anecdotally, while families and consumers appreciated these magnets, participating staff members also indicated that they thoroughly enjoyed being able to share these with the people in their groups.

Other Lessons Learned

In addition to the ongoing services research related to this initiative, anecdotally we learned a number of important lessons from the statewide implementation:

- Identifying a Project Coordinator at each agency and then supporting that person with social support and practical problem-solving support was integral to the success of the initiative.
- Agency leadership generally supported the implementation in the absence of fiscal incentives. We believe that this underscores the importance of engagement and ongoing contact with administrators to ensure buy-in.
- We believe that it was essential for agencies and staff members themselves to "own" the change and implementation process at their home sites. The Family Institute team adopted the stance that we were involved as supportive resources, and frequently observed to trainees that this was *their* implementation project (i.e., not the Family Institute's or the NYS Office of Mental Health's).
- Feedback from providers and other stakeholders suggested that it was important for New York State to designate and fund a technical assistance and resource center (i.e., The Family Institute) to support providers. Having a resource center

with staff who were experienced with the MFG model as well as with training and dissemination technologies, was effective in moving this initiative forward.

Unfortunately, MFG is also a difficult practice for agencies to implement and sustain, as evidenced by the paucity of family psychoeducation taking place across the country and in most NYS agencies that were not a part of this initiative. Unfortunately, even with training and implementation supports in place, some agencies did not successfully start an MFG.

URMC Department of Psychiatry – 3rd Year Residency Training Program in MFGs

The URMC Department of Psychiatry has a long-standing investment in the evaluation and dissemination of family psychoeducation interventions – an investment that dates back earlier than the statewide efforts described above. As part of this interest, family psychoeducation has been integrated into the training of psychiatric residents. Under the direction of J. Steven Lamberti, MD, all third-year psychiatric residents at the URMC Department of Psychiatry have received formal training in family psychoeducation since 1996. This training begins with a 6-week seminar series that reviews the impact of schizophrenia upon families, the history of family approaches to schizophrenia, and the origins of family psychoeducation interventions. This didactic experience is followed by a year-long clinical experience in which residents are paired with seasoned clinicians and gain experience co-leading a multifamily psychoeducation group. As 'hands on' participants in the group, residents learn all facets of the family psychoeducation process, including joining with families, utilizing family guidelines, teaching communication skills, facilitating problem solving, and facilitating social network formation. In addition, this year-long multifamily group training forum has provided observational opportunities for students in psychology, social work and nursing. A research evaluation is currently underway to assess the impact of this training experience upon residents' skill, knowledge and attitudes related to assisting families. While the evaluation has not been completed, it is noteworthy that the residents have consistently rated the family psychoeducation training experience very highly.

Alternatives to MFG Participation for Families: A Spectrum of Family Services

It is important to note that family members enter the mental health system in many different ways and often have their first direct contact with the system via mental health professionals. Although families of people with mental illness share certain essential needs, their specific needs and concerns are incredibly diverse. One important lesson we learned from the family psychoeducation initiative was that even with the time and resources allocated to the MFG initiative, penetration was generally low and many families and consumers were excluded when a single model of family psychoeducation was offered. In our experience, agencies spontaneously began to explore other approaches to involve families not tied exclusively to a particular model. They also examined their policies, procedures and expectations related to family involvement and asked for guidance on this matter.

Conclusion

The University of Rochester Medical Center's Department of Psychiatry and the New York State (NYS) Office of Mental Health, in collaboration with numerous partners such as NAMI-NYS, have explored ways to build upon the successes, challenges and lessons learned from the family psychoeducation initiative - so that all consumers and families may benefit from a service system that is family-oriented and includes a spectrum of treatment and community options. To meet the diverse needs of families, we are recommending that every agency in NYS be prepared to conduct at least one family consultation visit with every member whose loved one suffers from severe mental illness. Employing a consultation approach can be a useful way for consumers and families to identify and prioritize their needs, briefly deal with illness-related concerns, and make informed choices about the use of family service offerings in their geographic area. We are currently in the process of rolling out a second, multi-year initiative across New York State in which we are teaching providers to implement family consultation. Such a consultation approach, which will serve as the initial contact with families as well as the service platform by which families may access additional family services and supports (e.g., family psychoeducation), will allow for a flexible way for families to access a variety of supports that will help them assist their loved one's recovery.

Onsite Group Training, Consultation and Supervision

The Family Institute has several resources that may assist agencies as they prepare to learn, implement and conduct family psychoeducation and family consultation interventions. Training opportunities range from 1-2 hour presentations for awareness building and information dissemination, to 2-3 day training workshops in core family intervention practices as well as specialized skills with the ultimate goal of helping staff make practice changes. In addition, several Family Institute faculty members actively partner with McFarlane and colleagues at the University of Maine's Family Psychoeducation Institute to provide training, consultation and supervision for states and agencies. For additional information, you may contact:

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