Family Psychoeducation

What is the practice?

Family psychoeducation (FPE) is an approach for partnering with consumers and families to treat serious mental illnesses by providing information and support. Information is provided via psychoeducation— in this approach the illness is the object of treatment, not the family dynamics. Practical information is provided about mental illnesses, how common they are, and how they can be managed. The goal is that practitioners, consumers, and families work together to support recovery.

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

- education about serious mental illnesses
- information resources, especially during periods of crises
- skills training and ongoing guidance about managing mental illnesses
- problem solving
- social and emotional support

FPE services are provided in three phases:

- joining sessions
- an educational workshop
- ongoing FPE sessions

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

Practice principles include:

- Consumers define who they consider family, as this may differ for each person.
- The practitioner-consumer-family alliance is essential.
- Education and resources help families support consumers' personal recovery goals.
- Consumers and families who receive ongoing guidance and skills training are better able to manage mental illnesses.
- Problem solving helps consumers and families define and address current issues.
- Social and emotional support validates experiences and facilitates problem solving.

What outcomes does this practice produce?

When practiced with fidelity, FPE can impact the following:

- Relapses and rehospitalizations
- Improved family well-being
- Increased consumer participation in vocational rehabilitation programs

What is the evidence for this practice?

As of 2004, there were more than 30 randomized clinical trials that demonstrated that psychoeducation programs reduce relapse, improve symptomatic recovery, and enhance psychosocial and family outcomes (Murray-Swank & Dixon, 2004). Specific studies have been conducted that show that consumers and families who participated in the components of the model had 20 to 50 percent fewer relapses and rehospitalizations than those who received standard individual services over two years (Penn & Mueser, 1996; Dixon & Lehman, 1995; Lam, Kuipers, & Leff, 1993; Falloon, 1999). Other studies also show that FPE improved family well-being (Dixon et al., 2001). Families reported a greater knowledge of serious mental illnesses; a decrease in feeling confused, stressed, and isolated; and reduced medical illnesses and use of medical care (Dyck, Hendryx, Short, Voss, & McFarlane, 2002). Based on this evidence, treatment guidelines recommend involving families in the treatment process by offering the critical ingredients outlined in this evidence-based model (Lehman, Steinwachs, & the Co-Investigators of the PORT Project, 1998; American Psychiatric Association, 1997; Weiden, Scheifler, McEvoy, Frances, & Ross, 1999).

How is this practice implemented?

In what contexts is this practice implemented (e.g., schools, clinical)?

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

What is the dosage of this practice (e.g., one-time training, six-week curriculum)?

At least three introductory meetings called “joining sessions” followed by a one-day educational workshop. After completing the joining sessions and one-day workshop, FPE practitioners ask consumers and families to attend ongoing FPE sessions. When possible, this is offered in a multifamily group format. Studies show that offering at least 10 sessions is ideal and that fewer than 10 sessions does not produce the same positive outcomes (Cuijpers, 1999). It is recommended that FPE be provided for 9 months or more.

How is the practice delivered (e.g., online, in-person)?

The program is delivered in-person, although during the pandemic, it could be adapted to virtual settings.

What infrastructure or readiness is needed to implement this practice (e.g., capacity for data analysis, individual full-time equivalent [FTE])?

A designated clinical administrator oversees the FPE program and performs specific tasks. At least one FPE practitioner is needed. Two practitioners co-leading sessions may be indicated based on number of participants.

For which population(s) can this practice be implemented?

For which population(s) is this best or promising practice (BPP) intended? Has it been adapted for diverse groups? If so, which ones?

FPE was developed for individuals with serious mental illnesses (SMIs) and serious and persistent mental illnesses (SPMIs) and their family members. It has not been adapted for diverse groups; however, the delivery of psychoeducation as an intervention is widely used in behavioral health settings.

For which populations is there evidence of effectiveness?

There is evidence of effectiveness for adults with SMI and SPMI.

With which specific populations has this practice been successfully implemented?
This approach has been successfully implemented with adults with SMI and SPMI.

For which populations, if any, is this practice NOT a good fit?
Individuals who behaviorally or cognitively are unable to benefit from participating in individual or group educational activities are not a good fit for FPE.

Who can implement this practice?

What expertise is needed to implement the practice?
It is helpful if practitioners of this evidence-based practice (EBP) have some experience working with adults with SMI/SPMI and/or family members. Knowledge of adult learning principles and skills training experience (e.g., Illness Management and Recovery training, psychiatric rehabilitation training) is also helpful.

What specific training or certification is required to implement the practice?
There is no specific training or certification required to implement the program; however, effective training and supervision of practitioners is essential. Most agencies would need to devise their own training program and/or obtain expert consultation from subject matter experts (SMEs).

What costs are associated with delivering this practice?

Cost varies depending on trainers selected. Note that the MHTTC Network can provide training on this BPP free of cost.

Does the practice have an associated fidelity assessment?

The Family Psychoeducation (FPE) Fidelity Scale was developed to measure implementation in the U.S. National Implementing Evidence-Based Practice Project (McHugo et al., 2007). It was established that FPE, with technical assistance, could be implemented to good fidelity within one year. The FPE scale has 14 items and is based on the core principles described by Dixon et al. (Dixon et al. 2001). It was initially designed to measure multifamily therapy (McFarlane et al., 2002); however, the scale is considered flexible enough to be used for other FPE approaches that share the same principles and methods, including single-family psychoeducation (Miklowitz et al., 2010).

What resources or references are useful for understanding/implementing the practice?

There is an FPE Fidelity Protocol developed as part of the SAMHSA EBP Toolkit Series that describes the recommended process for conducting fidelity reviews.

Where should you go for more information?

- Anderson, C., Hogarty, G., & Reiss, D. (1986). *Schizophrenia and the family*. Guilford Press.
- McFarlane, W. R. (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. Guilford Press.
- Substance Abuse and Mental Health Services Administration. Family psychoeducation evidence-based practices (EBP) toolkit. https://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4422

- Search for Family Psychoeducation in:
  - MHTTC Training and Events Calendar: https://mhttcnetwork.org/centers/global-mhttc/training-and-events-calendar
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Miklowitz, D. J., O'Brien, M. P., Schlosser, D.A., Zinberg, J. Z., De Silva, S., George, E. L., & Cannon, T. D. (2010). *Clinician's treatment manual for Family-Focused Therapy for Prodromal Youth (FFT-PY)*. Unpublished treatment manual.

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