Training Health Professionals to Conduct Family Education for Families of Patients with First-Episode Psychosis: Adherence to Protocol

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Objective: The implementation of family psychoeducation at the service delivery level is not without difficulty. Few mental health professionals receive special training to work with families especially in Iran. The aim of the present study was to evaluate the effectiveness of training health professionals in terms of their adherence to protocol.
Method: Eight professionals (general practitioners, nurses and social workers) participated in a training program for health professionals as part of the Roozbeh First-Episode Psychosis Program (RooF) to conduct family psychoeducation. Training included a 3-day- workshop and 12 supervision sessions during the course of the implementation of the psychoeducation program. The family psychoeducation sessions (multiple-family group or single-family home-based) were tape-recorded. Transcripts of the audiotaped sessions were analyzed based on the content of the manual and were scored accordingly.
Results: Twenty-four recorded sessions were analyzed in terms of the adherence to protocol, the number of questions and the time for each session. The overall rating showed a 72% adherence to the protocol. Multiple-family group sessions had a higher rate compared to the single-family home-based family psychoeducation sessions (79% to 69%) as well as the time spent and questions asked. The rate of adherence to the protocol of conducting the family psychoeducation sessions had not changed over time .
Conclusion: Considering the amount of time taken for training and supervision, the level of adherence to the protocol was satisfactory. Tape recording sessions and regular supervision would be beneficial following specialized training. Further research is needed to tailor the amount of training and supervision required for professionals to conduct family psychoeducation programs in different settings.

Key words: *Family Psychoeducation, Guideline adherence, Health education, In-services training, Psychotic Disorders, Professional education, Staff development,*

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Working with families of patients with a mental illness has proven to be effective in reducing the relapse rate for these patients and the distress level of their families (1- 2). However, despite this significant research and policy development, implementation of family work at the service delivery level is rarely available and not without difficulty for a number of reasons (3- 4). In addition to limited resources, one main reason is that few mental health professionals have specific skills for working with families (5- 6). On the other hand, despite the growing interest in the assessment of program implementation, little is known about the best way to evaluate whether a particular program has been implemented for the intended service to a minimally acceptable level (7).

The extent to which clinicians can implement empirically validated therapies with adequate fidelity is a crucial factor in treatment programs (8).

There has been a rapid growth of clinical guidelines and training manuals for clinical practices (9). The issue of adherence to these guidelines and manuals is important in terms of quality of the care. Another important consideration is the fact that with our limited resources in the mental health services in Iran, finding the minimum amount of training and supervision required to ensure adherence is also very important.

The aim of the present study was to evaluate the effectiveness of training health professionals in terms of their adherence to a family psychoeducation manual for families of patients with first-episode psychosis.

Materials and Methods

The method used in this study was the evaluation of a training program based on a descriptive analysis. Eight health professionals (general practitioners, nurses and social workers) participated in a training program to conduct family psychoeducation as part of the Roozbeh First-Episode Psychosis Program (RooF). RooF is an integrated service for patients with first-episode psychosis at Roozbeh hospital (10). The integrated service is delivered in two models. The first model consists of outpatient visits augmented by telephone follow-ups. The other comprised of follow-up home visits by a team of trained general practitioners, psychiatric nurses and social workers. Families of patients in the first model (outpatient visits with telephone follow-ups) participated in multiple-family group psychoeducational sessions at the hospital (four to eight families formed one group). Families of patients in the second model (home visits by a team) participated in single-family psychoeducational sessions at homes. Details of each model, and methods used are described elsewhere (11- 12).

Training included a 3-day- workshop and 12 supervision sessions during the course of the program. Supervision consisted of 2–hour- group supervision sessions during which different topics were discussed. Training and supervision were administered by one of the authors (Y.M) who had training and was experienced in the field of family psychoeducation. The contents of supervision sessions were based on the challenges or areas of concern expressed by the team. Different topics related to family psychoeducation for families of patients with first episode of psychosis were presented and discussed by the supervisor and the group participants. Audiotapes of the family psychoeducation sessions were also analyzed and discussed during these sessions .

The family psychoeducation program consisted of four sessions for families of patients with first-episode psychosis delivered in two different formats: multiple-family groups at the hospital or single-family sessions at home. For both models, the same manual was used (13). Two professionals conducted the family psychoeducation sessions at the hospital or at home. All the eight trained professionals were involved in conducting both family psychoeducation models. Professionals who conducted the family psychoeducation sessions explained the purpose of the tape recording for the family members, and ensured them of the confidentiality of information discussed during the sessions. Permission to tape the sessions was given by the family members who participated in the sessions. Both models of family psychoeducation sessions (multiple-family group at the hospital or single-family sessions at home) were tape-recorded. Tape recording sessions included the total time of each session lecture, discussions, as well as questions and answers. Professionals who conducted the sessions knew that during the supervision, they would receive feedback based on their presentations. Afterwards, a checklist was developed based on a list of the content of each session provided for the family psychoeducation manual. An independent evaluator, a psychologist (PhD student) analyzed the transcripts of sessions based on the checklist and scored accordingly. The total score was calculated based on a positive score for each topic which was presented during the session. The ratio for each model was calculated based on the total score received divided by the total possible score for that particular section outlined by the protocol. The percentage of the above ratio was calculated to determine the level of adherence to the protocol. The time spent for each session and the number of questions asked by family members during each session was also calculated**.**

Results

Twenty- four recorded family psychoeducation sessions were analyzed in terms of adherence to protocol, the number of questions asked by family members during the session and the time spent for each session. Table 1 demonstrates the items of the checklist based on the content of each session.

Figure 1 shows the result of the analysis of the transcripts of the sessions in each model based on the number of the topics/sections presented during each session divided by the total possible score for that particular session outlined by the protocol. The overall rating showed a 72% adherence to the protocol; multiple-family group sessions had a higher rate compared to single-family home-based sessions (79% vs. 69%). The introduction and conclusion sections of each session included the topics that were presented less frequently during the family psychoeducation sessions. Therefore, those sections showed the least adherence to the protocol.

The average time for multiple-family group sessions was 60 minutes compared to the 30 minutes sessions of home-based family psychoeducation .

The number of questions asked by the family members during each session also showed a higher number for multiple-family group sessions in contrast to the single-family psychoeducation sessions (an average of 6 questions compared to 2 questions).

The main difference in the two settings in terms of structure, besides the place and the number of participants, was the presence of patients during the single-family sessions conducted at home. Hence, single-family psychoeducation sessions at patients' homes included family members who were present as well as the patient.

Discussion

One of the main reasons professionals do not deliver family psychoeducation programs is the fact that their training does not adequately prepare them for such tasks (6, 14). In a research conducted in England, more than 70% of the professionals in mental health services

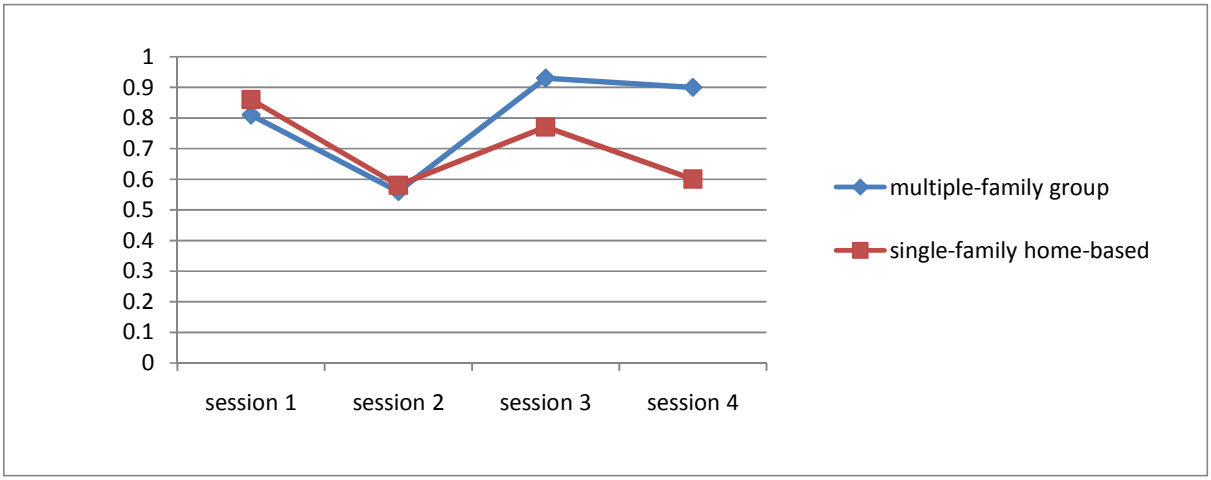

Figure 1. Comparing the two models based on the number of topics/sections presented during each session divided by the total possible score for that particular session outlined by the protocol

Table 1: Items of the checklist based on the content of each session of the familypsychoeducation manual

Session I: (total score 7)	**Session II: (total score 8)**
1. Introduction	1. Introduction
2. What is psychosis	2. Treatment
3. Symptoms	3. Medication
4. Different types of psychosis	4. Alcohol and substance abuse
5. Stress-vulnerability model	5. Noncompliance
6. Three phases of psychosis	6. Electroconvulsive therapy
7. Conclusions	7. Follow-up
	8. Conclusions
Session III: (total score 14)	**Session IV: (total score 5)**
1. Introduction	1. Introduction
2. Family members reactions to illness	2. Early warning signs
3. Revise expectations	3. Recovery
4. Create barriers to over stimulations	4. Problem solving exercise
5. Selectively ignore certain behaviors	5. Conclusions
6. Recognize signals for help	
7. Keep communication simple	
8. Support medical regime and use professionals	
9. Normalize the family routine	
10. Discussion on marriage	
11. Discussion on employment	
12. Discussion on education	
13. Discussion on travel	
14. Conclusions	

had not received any training during their education to provide intervention and psychoeducation to families of patients with psychiatric disorders (5). Therefore, adequate training in order to conduct psychoeducational program for families is crucial.

In Iran, with limited resources in mental health services, finding the necessary amount of training and supervision needed for professionals is quite important. In the present study, the rate of adherence to protocol in order to conduct the four sessions of family psychoeducation was satisfactory (average above 70%) (8- 9). In a training study for case managers, the rate of using different skills after training varied from 23% to 66% (9). One main issue stated in the literature concerning research on the rate of adherence to protocol or guidelines is the use of self-report measures for assessment which can affect the outcome (7). In this study, we have used the tape-recorder as a more objective assessment tool.

Family psychoeducation sessions conducted at home had less adherence rate compared to the multiple-family groups conducted at the hospital. This might be due to a number of factors. Cultural issues could play a part when team members go to the homes of the families. For example, they are treated more as guests when they visit. The home setting is less structured and patients are usually present at home during the sessions. Another factor that should be considered is that family education sessions at home are conducted only for one family. This is in contrast to the multiple-

family group sessions at the hospital which included four to eight families. This difference could have an effect on the rate of questions asked as well as the time spent for each session.

There are two possible explanations for the two sections that were presented less frequently by presenters: turning on the tape recorder after the team had already presented the introduction of a session and/or turning the tape recorder off before the conclusion of each session. Still, emphasis on giving an introduction for each session and ending each session with a conclusion require attention during the training of professionals. In general, psychoeducational sessions in hospitals offer services to a number of families at the same time; and sessions are conducted in a more structured environment and families could ask more questions. They also have an opportunity to listen to questions from other family members. In addition, the health professionals have the ability to follow the protocol more effectively.

As shown in this study, tape recording the sessions and regular supervision are beneficial following the specialized training and are highly recommended in other programs (14).

One main limitation of our study is using one rater to rate the transcripts of the sessions. Therefore, for future studies in this area the presence of at least two raters is recommended.

Further research is needed to tailor the amount of the training and supervision required for health professionals to conduct family psychoeducation programs in different settings. Differences due to cultural issues that could affect adherence should also be considered.

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