# Implementing Psychoeducational Interventions in Italy for Patients With Schizophrenia and Their Families

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***Objective:*** **This study explored the feasibility of providing psychoeducational interventions for persons with schizophrenia and their families.** ***Methods:*** **The study was carried out in 23 Italian mental health centers. Two professionals from each center attended three monthly training sessions on psychoeducational interventions. After the training, each professional provided informative sessions on schizophrenia to five families of service users with schizophrenia, which consisted of three meetings with each family on clinical aspects of schizophrenia, drug treatments, and detection of early signs of relapse. Each professional then provided the intervention to families for six months.** ***Results:*** **Thirty-eight of the 46 participants completed the training course, and 34 provided the intervention to 71 families. Twenty-nine of the 34 provided the entire intervention to the families and five of the 34 held only informative sessions on schizophrenia. Ninety-one percent of the participants who completed the study reported difficulties in integrating the intervention with their other work responsibilities, and 96 percent acknowledged the positive effect that the intervention had on the center's relationship with patients with schizophrenia and their families.** ***Conclusions:*** **These results support the idea that it is possible to introduce psychoeducational interventions in mental health services after a relatively brief period of training and supervision. (*Psychiatric Services* 57:266–269, 2006)**

In the past 25 years, family psychoeducational interventions have been developed to improve the clinical and social outcomes of persons with schizophrenia and to meet their relatives' needs for support and information (1). Several randomized controlled trials and meta-analyses have provided evidence that these interventions reduce psychotic relapses twofold at two years, have a positive effect on family relationships, and reduce the overall costs of care (1,2).

Although the use of psychoeducational interventions for the treatment of schizophrenia is recommended by several guidelines (3–5), their availability in clinical practice is scarce (6,7) and their effectiveness is poorly documented (8–10).

In Western Europe up to 15 percent of the families of persons with schizophrenia receive psychoeducational interventions (11), and in the United States, 10 percent (12). In Italy, one of the countries with the longest experience in community mental health care, 80 percent of families of consumers with schizophrenia are in regular contact with mental health services. However, only 8 percent receive psychoeducational interventions (13).

Studies aimed at implementing supportive treatments for families in clinical practice report that after a training course 7 to 27 percent of the staff who were trained apply these treatments in clinical work. Furthermore, a mean of 1.4 to 1.7 families per trainee received these treatments (7,14).

Available data demonstrate that the main obstacles to the dissemination of psychoeducational interventions in routine conditions are related to the organization of mental health services (14) and the limited availability of training and supervision (7). In addition, staff dynamics—such as resistance to the introduction of new treatments (15) and the fact that mental health professionals are exposed more to drug literature than to psychoeducation literature—can negatively influence the use of these interventions in clinical practice (12). On the other hand, consensus building, promotion of positive staff attitudes toward psychosocial interventions, and economic incentives have been found to be critical factors to a successful dissemination (6).

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A study funded by the European Commission and coordinated by the department of psychiatry at the University of Naples SUN explored the effect of staff training programs in six European countries on the implementation and effectiveness of a family psychoeducational intervention for schizophrenia (10). The study found differences between the countries in the difficulties in implementing the intervention, which were related mainly to the level of collaboration among professionals, the allowance of working time to run the intervention, and the compliance of the service users' families. The study also found statistically significant improvements at one year in the treated patients' symptoms and disability and in their relatives' burden and coping strategies.

Here we report the preliminary results of a study carried out in 23 Italian mental health centers to explore the feasibility of providing psychoeducational intervention programs in routine conditions by trained professionals to persons with schizophrenia and their families.

## Methods

Twenty-nine Italian mental health centers were randomly selected to participate in a previous study on the burden of family members of patients with schizophrenia (13). These centers were also invited to take part in the study presented here if they did not have any personnel who had previously received formal training in psychoeducational interventions, could allocate two professionals to this study, and did not adopt a therapeutic approach that contrasted with the cognitive-behavioral model. The study was approved by the ethical committee of Italy's National Health Institute.

In each center, one psychiatrist or psychologist and one professional with a different role were selected to be trained in the family psychoeducational intervention developed by Falloon (2). The training consists of assessing individual and family needs; providing informative sessions to patients and their families on schizophrenia, its treatments, and early signs of relapse; and training families in communication skills and problem-solving skills.

The training course included three monthly modules that lasted 2.5 days each (20 hours per module). Participants were trained in how to provide the intervention with guidelines, demonstrative audios, role-playing scenarios, and exercises developed in a previous study (10).

In the intervals between the modules, participants were asked to perform home exercises for each component of the intervention with the support of their own relatives, the staff, and consumers' families. For example, participants' relatives could assist with home exercises on communication skills and consumers' families could assist by giving the participant experience in providing informative sessions. Exercises were revised in each subsequent module on the basis of participants' feedback. After the first module, participants were asked to run a two-hour workshop informing their colleagues about the study at their centers. After the second module, participants were asked to select five families of patients with schizophrenia who had been receiving psychiatric treatment at the local mental health center for at least six months. It was suggested that the participants should avoid choosing families for whom "nothing has ever worked before." Eligible families and patients were asked for their informed consent to participate in the study with the understanding that they would be randomly selected to receive the intervention immediately (three families per participant) or six months later (two families per participant).

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After participants completed the three training modules, they were asked to start the intervention with the first group of families. After the patient and his or her family were assessed, informative sessions were scheduled. These informative sessions consisted of three meetings with each family on clinical aspects of schizophrenia, drug treatments, and detection of early signs of relapse. Participants were then invited to hold three sessions a month that lasted for one hour each for six months for each family. The frequency and location of family sessions were decided on a case-by-case basis, with the participant's working time and caseload and the family's needs taken into account.

In the year after the three training modules, participants attended four supervision meetings on family work (eight hours each), in which their difficulties were addressed in small groups with the problem-solving approach. Furthermore, they received tutorial support monthly by phone for their work with recruited families.

At the first and the last supervision meeting, the benefits and difficulties experienced by participants in the use of the intervention were assessed with use of the Family Intervention Schedule (10).

## Results

Twenty-three of the 29 centers (79 percent) participated in the study. The other six centers did not meet the selection criteria for various reasons: one of the centers had staff who had been trained previously in the intervention, four centers did not have any

personnel to dedicate to the project, and one center adopted a different therapeutic approach.

Forty-six professionals participated in the first training module. Eight participants (17 percent) from four mental health services did not complete the course because they found the program too demanding.

The 38 professionals who completed the basic course were from 19 different centers. They had a mean±SD age of 42.8±7.2 years. Twenty-six (68 percent) were male, 16 (42 percent) were single, eight (21 percent) had a professional degree, nine (24 percent) had a university diploma (three-year degree in nursing or rehabilitation), and 21 (55 percent) had a university degree (four- to six-year degree in medicine, sociology, or psychology). Fifteen (39 percent) of the participants were psychiatrists, 11 (29 percent) were nurses, five (13 percent) were psychologists, four (11 percent) were rehabilitation therapists, and three (8 percent) were social workers. The participants had been working in mental health for a mean of 11.7±7.7 years.

A total of 91 families of service users with schizophrenia were selected and randomly assigned to receive the intervention immediately (54 families) or in six months (37 families). Ten of these families did not receive the intervention because some professionals dropped out of the study, and another ten did not receive the intervention because they themselves dropped out. After the families were recruited for the study, four professionals (11 percent) from two centers left the study before providing any part of the intervention. Discontinuance was due to the trainee's problems (one case) and organizational difficulties of the centers (three cases).

Thirty-four professionals (89 percent) from 17 centers started to provide the psychoeducational family intervention to 71 families of service users with schizophrenia (4.2 families per center). Five participants (13 percent) from three services dropped out of the study during the intervention period: one professional moved to another center, two did not have enough time to provide the intervention, and two had considerable difficulties in integrating the intervention with other workloads. Data on treated families are available from the authors.

The availability of time to run the intervention was reported as the main difficulty by 26 of 33 participants (79 percent) at the first supervision meeting and by 17 of 23 (74 percent) at the last one. Substantial difficulties in integrating the intervention with other work responsibilities were reported by 29 of 34 participants (85 percent) at the first supervision meeting and by 21 of 23 (91 percent) at the last one. Finally, a lack of familiarity with cognitive-behavioral techniques was reported by ten of 33 (30 percent) at the first supervision meeting and by one of 23 (4 percent) at the last one.

*Our findings emphasize the need to consider aspects such as redistribution of caseloads, staff incentives, and acknowledgment of professional competencies in implementing psychoeducational interventions.*

Twenty-two of 23 participants (96 percent) acknowledged that the intervention had a positive effect on the relationship between the center and the service users and their families, and 13 of 23 (57 percent) reported feeling more competent in their own work.

## Discussion

This is the first Italian study to systematically evaluate the possibility of disseminating a psychoeducational intervention in Italian mental health centers for persons with schizophrenia and for their families.

Eighty-nine percent of trainees ran informative sessions on schizophrenia, and 76 percent provided the informative session and the intervention for at least six months to two to five families. These results demonstrate higher adherence to the training program than the rates of 7 to 27 percent that were previously reported in the literature (7,14). The higher participation rate found in our study is probably related to several variables, such as the fact that in Italy consumers' families are generally in regular contact with the local mental health service (13) and the modular structure of the training program, which included home exercises.

Participants started to provide the intervention to 71 families in 17 centers. The mean number of families treated in our study (2.1 per trainee) is higher than that previously reported in the literature (1.4 to 1.7 per trainee) (14). This difference was probably due to the fact that our program included regular supervision meetings, in which the professionals had the opportunity to compare their experiences and devise common strategies by using a problem-solving approach to deal with organizational and family work difficulties (7). Also, our program split the sample of eligible families into two groups and suggested that the participants should not select "difficult" families in order to avoid a commitment that would be too demanding for trainees who had little experience in psychoeducational techniques.

Twelve of the 46 participants did not complete the training course or left the study soon after, although their interest in the program was supported by the fact that they completed the family recruitment phase. Furthermore, consistent with previous findings (6,10,12,14), difficulties in integrating family interventions with other work commitments were reported by a majority of participants. These findings emphasize the need to

consider aspects such as redistribution of caseloads, incentives for the staff, and acknowledgment of professional competencies in the implementation process.

The study design did not allow us to detect variables influencing staff's compliance with the program. However, our experience in the field suggests that trainees' beliefs about the clinical utility of these interventions influence their compliance in the implementation process. For this reason, professionals' attitudes toward family interventions should be considered in their selection as trainees, especially when a limited number of staff can be trained.

Ninety-six percent of the participants reported a significant improvement in their relationships with consumers' families, and 56 percent felt more confident in their work. It is likely that this perception is related to their having learned cognitive-behavioral techniques and to changes in the roles of the nonmedical professionals who participated in this study, in which they moved from a passive role to becoming actively involved in providing an intervention to persons with schizophrenia and their families.

## Conclusions

The results of this study support the idea that it is possible to introduce psychoeducational interventions in routine clinical settings after a relatively brief period of training and supervision. However, it is common that after the completion of research, the enthusiasm of the staff decreases when support is lacking. The combined efforts of trainers, clinicians, and policy makers are needed to facilitate the use of these interventions over time.


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