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Is psychoeducation routinely provided in the UK? Survey of community mental health teams

AIMS AND METHOD

The study aimed to assess the current provision of psychoeducation programmes for patients with mental illness in the UK. A postal questionnaire was sent randomly to 100 community mental health teams regarding the delivery and characteristics of psychoeducation programmes. Non-responders were

contacted via telephone after 8 weeks.

RESULTS

The response rate was 87%. Eight services provided group psychoeducation, 40 provided individual psychoeducation within the care programme approach, and 39 did not provide any psychoeducation programme.

CLINICAL IMPLICATIONS

Patients with mental illnesses have limited access to psychoeducation in routine care. Group programmes should perhaps be more widely implemented as a relatively low-cost intervention.

The existing literature on psychoeducation dates back to the early 1980s. The National Institute for Health and Clinical Excellence (NICE) (2006) defines psychoeducation as 'any structured group or individual programme that addresses an illness from a multi-dimensional viewpoint, including familial, social, biological and pharmacological perspectives, as well as providing service users and carers with information, support and management strategies'. Several randomised controlled trials have tested the effectiveness of psychoeducation in patients with schizophrenia and bipolar affective disorders. Studies on patients with bipolar affective disorder (Soares *et al*, 1997; Colom *et al*, 2004) show that overall such programmes are beneficial, but the systematic reviews on their effectiveness in patients with schizophrenia are more inconsistent. A Cochrane review (Pekkala & Merinder, 2002) suggests that the positive effects of psychoeducation in schizophrenia include improved symptom scores, reduction of relapse rates and/or rehospitalisation, better adherence, higher treatment satisfaction and better knowledge about the illness. Conversely, a recent meta-analysis on patients with psychotic disorders (Lincoln *et al*, 2007) found no significant effect of psychoeducation on symptoms scores, medication adherence and functioning, a small positive impact on knowledge, and a medium effect on relapse and rehospitalisation rates. A recent French multicentre trial tested a new psychoeducation programme in individuals with schizophrenia and failed to identify significant effects on relapse prevention or adherence (Chabannes *et al*, 2008).

Based on the available evidence, NICE recommended that structured psychological interventions should be considered for individuals with bipolar affective disorder. These interventions should normally consist of at least 16 sessions (over 6–9 months), and should include information about the illness, the importance of regular daily routine and sleep, and concordance with medication, help in detection of early warning signs, and strategies to prevent progression into full-blown episodes. The

National Institute for Health and Clinical Excellence has taken a more cautious approach regarding the use of psychoeducation in people with schizophrenia, only suggesting that health professionals should provide accessible information about schizophrenia and its treatment to service users and their carers (National Institute for Health and Clinical Excellence, 2006).

The American Psychiatric Association (2004) and the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN; 2006) take a stronger approach, recommending psychoeducation as a standard treatment programme for individuals with psychotic disorders. A European Expert Panel on the Contemporary Treatment of Schizophrenia argued that the systematic provision of information is an essential part of good practice in the care of patients with schizophrenia and their carers, both as a method of treatment and for ethical reasons (Altamura *et al*, 2000).

The aim of this survey was to assess the current provision of psychoeducation programmes for individuals with mental illness in the UK.

Method

We designed a brief questionnaire with 12 questions. It explored whether a community mental health team (CMHT) provides a psychoeducation programme and if so, how it is delivered. Questions addressed the setting (i.e. individual, open group or closed group), the inclusion/exclusion criteria, diagnostic groups, the length of the programme, the professional background of facilitators and their role in the patients' care, the use of a manual, involvement of carers, and evaluation of outcomes.

The questionnaire was sent to 100 randomly selected CMHTs identified using the information on adult community mental health services produced by Durham University (<http://www.dur.ac.uk/service.mapping/amh>). To achieve a random selection of teams and a sample size of 100, the questionnaire was posted to every eighth



team on the alphabetically ordered list. Non-responders were contacted via telephone after 8 weeks.

Results

After the initial postal survey, 23 CMHTs responded. Through telephone contacts we obtained information from a further 64 CMHTs, resulting in an overall response rate of 87%.

Thirty-nine CMHTs (45%) stated that they do not provide any psychoeducation programme. The most common reasons reported were financial constraints, workload and lack of expertise.

Of the 87 CMHTs, 48 (55%) reported that they provide some form of psychoeducation. Forty teams (46% of all responding teams) stated they provide individual programmes. However, none of these teams reported using a manual or having a pre-specified number of sessions.

Eight CMHTs (9%) reported delivering psychoeducation in small groups of six to ten patients. The number of sessions varied from 7 to 12. Four of these eight CMHTs included only patients with psychotic disorders and two programmes were exclusively for patients with anxiety and depressive disorders. One programme aimed at patients who wished to improve their literacy skills, and one team did not report on any inclusion or exclusion criteria. Three out of these eight group programmes were also attended by carers. The groups were facilitated by professionals with different backgrounds such as occupational therapists, community psychiatric nurses and support workers, students and – in one group – a psychiatrist. Five of these CMHTs used manuals for their psychoeducation programme, and six teams reported to have evaluated the outcomes of the programme.

Discussion

Almost half of the CMHTs we approached reported that they provide psychoeducation in individual settings, mainly as part of the care programme approach. It is possible that this figure may be lower than the actual number of teams providing what we would term 'psychoeducation' due to differing understandings of the meaning of the term among responders. Such delivery of information in individual settings may have some benefit. However, there is no research evidence as yet to back up the effectiveness of individual psychoeducation. Furthermore, it is more time-consuming than a group programme and does not have the advantages of group processes such as sharing of information, exchange of experiences and mutual support. Thus, as helpful as the provision of detailed information in individual settings may be, it should not replace a group programme based on research evidence and delivered by trained facilitators.

Less than 10% of CMHTs provided a psychoeducation programme in a group setting. Not surprisingly, the characteristics of the programmes varied. They were set up for different diagnostic groups, used different – if any – manuals, and were facilitated by professionals with

different backgrounds. Also, some programmes included carers, whereas others did not. Some standardisation of psychoeducation programmes may help support training, evaluation and further development.

Why is psychoeducation not more widely provided?

When asked why they did not provide psychoeducation, teams did not cite a lack of research evidence, but instead reported financial constraints and excessive workload as the main reasons. Limited financial and workforce capacity are non-specific reasons, and one might argue such reasons are always likely to be mentioned when justifying the absence of otherwise useful activities. In fact, group programmes are a relatively efficient use of resources and might even free up capacity. One can only speculate as to whether the fact that psychoeducation is not unequivocally recommended by NICE and was not included in any of the nationally defined targets in the past has prevented a wider implementation.

In summary, the survey showed that patients with mental illness have limited access to standardised psychoeducation programmes. New initiatives are needed to facilitate the provision, evaluation and further development of group psychoeducation programmes in routine care across community mental health services in the UK.

Declaration of interest

None.

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