CAN A ''RELAPSE PREVENTION'' MODULE FACILITATE THE TRANSFER OF TRAINING?

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Abstract. The objective of this pilot study was to evaluate the relative effectiveness of two approaches to staff training. Multidisciplinary mental health staff, receiving a standard training programme ($N = 45$), were compared on multiple measures with an experimental group ($N = 11$), receiving a programme featuring a ''relapse prevention'' module. This module was designed to improve the transfer of the training. The staff receiving the relapse prevention module reported significantly greater generalization of the training. Participant variables, the delivery of the training and work environment factors did not appear to explain this favourable finding. It is concluded tentatively that a relapse prevention module shows promise as a facilitator of the transfer of training in psychosocial interventions for severe mental illness.

Keywords: Staff training, transfer of training.

Introduction

The training of multidisciplinary staff in effective interventions is increasingly emphasized as a necessary feature of modern mental health services (e.g. by the UK's Department of Health, 1998). Skill gaps in relation to such policy priorities as psychosocial interventions for severe mental illness are referred to as a ''critical challenge'' (Department of Health, 1999, p. 108). What is particularly challenging is to find ways to overcome the obstacles to the generalization of the training that mental health staff receive in evidence-based practice.

The generalization challenge has faced mental health practitioners for many years. A

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quarter of a century ago, Stokes and Baer (1977) reviewed 270 studies of staff training and noted that the majority fell into what they termed the ''train and hope'' category. By contrast, the evidence from the alternative studies indicated to them that generalization of training does not occur without some explicit programming. This is either of the work environment within which the training is to be employed, the member of staff, or both. Over the years various attempts have been made to meet the generalization challenge, including training in context (Milne, 1984), developing supportive environments (Corrigan & McCracken, 1995), maximizing learner involvement (Hesketh, 1997) and through ''relapse prevention'' training (Tziner, Haccoun, & Kadish, 1991). The latter authors summarized the objectives behind relapse prevention training as being to promote the transfer of training by ''immunizing'' learners against the environmental obstacles to generalization through heightened awareness, group problem-solving, realistic goal-setting and simulating the necessary coping skills. Tziner et al. (1991) reported favourable generalization outcomes for their relapse prevention module. Other researchers have similarly reported positive effects in a variety of human service organizations (e.g. Burke & Baldwin, 1999; Marx, 1986; Wexley & Baldwin, 1986). However, it appears that no studies have to date been reported from a mental health service, nor have studies controlled for some of the multiple confounds that arise in such complex settings. The present study is therefore original in that, firstly, it concerns the training (including a relapse prevention module) of mental health staff working in the National Health Service (NHS) in the UK. Secondly, three possible and major confounds were analysed: participant variables, the delivery of the training, and the extent to which the work environment represented a barrier to generalization.

Pilot study

Participants in the relapse prevention (experimental) group ($N = 11$) were mental health nurses, care managers, social workers, and an occupational therapist. Their average age was 37.27 (*SD* 5.95), and there were nine women and two men. Average length of time worked in the NHS or Social Services was 16.36 years (*SD* 6.59). The control group was made up of $N = 45$ staff from the same organizations and professions. For practical reasons, random allocation to the two groups was not possible. There was, however, a very similar demographic breakdown between the two groups in terms of their age (mean 37.9, *SD* 7.46), gender (69% were female), and time in post (mean 13.7 years; *SD* 9.48). All these staff completed questionnaires designed to measure their reactions to the training (Davis, Rawana, & Copponi, 1989), the barriers to generalization within their work environment (Corrigan, Kwartarini, & Pramana, 1992), and the degree to which generalization had occurred (Milne, Keegan, Westerman, & Dudley, 2000). This generalization questionnaire assessed the use of 13 PSI-related techniques before and after the PSI training, the approximate number of clients with whom these PSI approaches had been applied, a rating of any associated clinical impact, and a general rating of training transfer across behaviours, persons and responses. Test-retest reliability or the generalization questionnaire had been found to be good (Milne, Keegan, et al., 2000). In addition, the experimental group completed an ad hoc knowledge quiz, concerned with the relapse prevention approach, and the fidelity of the delivery of the training was coded using an observational instrument (Milne, Keegan et al., 2000). The relapse prevention quiz was administered immediately before and after the training, with a two month follow-up; the training reactions questionnaire was completed

immediately following the training; the work environment barriers and the training-generalization questionnaires were administered over a two to three month follow-up period; and finally the observations of the training were conducted during the relapse prevention module for the experimental group and for a sample of the standard training modules for the control group (Milne, Keegan, et al., 2000). The training that all these staff received was an eight-day, in-service workshop on psychosocial interventions for severe mental illness, which is described in detail in Milne, Keegan et al., 2000. The relapse prevention module occupied one half day and was only undertaken by the experimental group, who had slightly reduced time on other topics to create the session. It followed the seven step model (Marx, 1986), which included 14 relapse prevention techniques identified by Marx (e.g. understanding the relapse process, creating an effective support network on the job, and expecting colleagues to be sceptical).[1] The results indicated that there were no significant between group differences in the staffs' reactions to the training they received ($T = 1.86$, $df = 1$; $p = .31$), nor in their perceptions of the barriers to the generalization of this training. The comparative observational data were also similar for both staff groups, indicating that the relapse prevention module had been delivered in the same ''experiential'' way as the standard modules. As expected, the experimental group achieved a significantly higher score on the relapse prevention quiz following training. This indicated that they had learnt the concepts and strategies of relapse prevention: their mean score at the pre-training assessment were 5.5 (*SD* 1.72), and following training 7.6 (*SD* 0.85), a significant improvement: ($T = 4.8$, $df = 9$, $p<.01$). This was maintained at the follow-up assessment. Crucially, the experimental group reported significantly greater generalization of the training across behaviours, persons and responses ($T = 9.6$, $df = 9$, $p<.01$) than did the controls. Their use of the PSI techniques was also significantly greater than for the control group ($T = 2.4$, $df = 12$; $p<.05$).

Conclusions

In summary, therefore, the findings of this pilot study suggest that the relapse prevention group transferred their training to a greater extent than did the control group. It would appear that this was not attributable to differences in the respective participants, the barriers perceived to be present to the generalization of training in the workplace, nor to variations in the way that the respective training programmes were delivered. The most likely explanation, therefore, appears to be that the relapse prevention training resulted in a significant learning effect and in turn to an enhanced transfer of training. Anecdotal evidence indicated that the staff in the experimental group perceived the relapse-prevention training as designed explicitly to help them overcome the transfer barriers, which may therefore have contributed a favourable motivational element to the technical aspect of relapse prevention (e.g. realistic goal-setting). Given our small experimental group sample and the non-random allocation to groups, it is clearly necessary to treat this favourable interpretation with caution. For instance, although the two groups were matched on the three demographic variables that we assessed, it is possible that they may have differed on other, potentially discriminating variables (e.g. motivation and attitudes). Also, the reliance upon self-report data to determine generalization is a concern. A clear possibility is that the respondents were aware of the

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[1.] A copy of the relapse prevention manual is available on request to the second author.

purpose of the assessment and were inclined to provide biased, socially-desirable responses. Against this possibility, parallel evaluations have indicated that self-reports were consistent with more objective data (i.e. a case note audit and archival sickness-absenteeism data: Milne, Gorenski, Westerman, Lock, & Keegan, 2000; Milne, Keegan, et al., 2000). Also, the ad hoc relapse prevention quiz requires psychometric development. Therefore, we conclude cautiously that this small-scale evaluation of the relative effectiveness of a relapse prevention module indicates its potential value in promoting the generalization of training. It merits further evaluation in relation to the ''critical challenge'' of transferring staff training in effective, evidence-based interventions within the mental health field to client care.

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