Brief report

Psychoeducation: priorities of service users and service providers

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Abstract

Objectives: The objective of this study was to ascertain the topics patients and mental health professionals thought should be covered in a psychoeducation programme at a day hospital.

Methods: Patients at the psychiatric day hospital and mental health professionals were invited to complete the study questionnaire. Replies from 101 participants were analysed.

Results: The patients and mental health professionals generally agreed regarding the topics to be covered in the eight-week psychoeducation programme. Patients tended to score 'suicide' as more important than did the mental health professionals.

Conclusions: Patients in a day hospital setting and mental health professionals share similar concerns about what information needs to be imparted about the patients' illnesses. However, suicide is seen by patients as a more important topic in such a setting.

Key words: Psychoeducation; Psychiatric day hospital; Mental illness; Suicide.

Introduction

The National Institute for Health and Clinical Excellence (NICE)[1] defines psychoeducation as 'any structured group or individual programme that addresses an illness from a multidimensional viewpoint, including familial, social, biological and pharmacological perspectives, as well as providing service users and carers with information, support and management strategies'.

The American Psychiatric Association[2] recommends psychoeducation as a standard treatment programme for individuals with psychotic disorders. The National Institute for Health and Clinical Excellence[1] recommends that health professionals provide accessible information about mental illnesses and their treatments to service users and their carers. In contrast, a European Expert Panel on the Contemporary Treatment of Schizophrenia argued that the systematic provision of information is an essential part of good practices in the care of patients with schizophrenia and for their carers, both as a method of treatment and for ethical reasons.[3]

In many respects, psychiatric day hospitals provide an ideal location for the establishment of psychoeducational programmes. An emphasis on psychosocial interventions, as well as physical treatments, tends to be particularly pronounced in such settings.[4] Feldmann et al[5] reported that psychoeducation had effect on modifying rehospitalisation rates for patients with schizophrenia when given during their early psychosis. Many patients attending day hospitals are in such an early stage of the illness.

In planning the establishment of an appropriate psychoeducation programme for the local day hospital, the authors encountered a relative dearth of literature regarding what topics patients would like to see covered, as opposed to what mental health professionals feel should be covered. This study was conducted to address this issue.

Method

Participants

The study was conducted in the psychiatric day hospital at University Hospital Galway, which provides general adult psychiatric services. Included in the study were patients attending the day hospital over the two-month study period who all consented to fill out the questionnaire. The members of the psychiatric multidisciplinary team surveyed were either working at the day hospital or the adjacent acute unit. To increase the numbers of psychiatrists responding, the questionnaire was also distributed to psychiatric trainees attending the local MRCPsych teaching programme.

Questionnaire development

A pilot list of 23 suggested topics was composed initially by the authors (CC, MR). The questionnaire asked each respondent to score how important they felt it was for each topic to be covered in an eight-week psychoeducation programme for day hospital attendees. This was scored using a 5-point Likert scale (from 1 = 'unimportant' to 5 = 'very important'). This pilot was conducted with 10 patients and 10 staff. The pilot questionnaire invited respondents to suggest other possible topics.

As a result of the pilot, a list of 30 topics was composed, covering topics such as anxiety, diet, stigma, and hospitalisation (questionnaire available on request). The questionnaire was given to 55 patients, 36 psychiatric doctors and 41 psychiatric nurses/other multidisciplinary team members (MDTM). Frequent reminders to the participants were given to enhance the response rate.

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Table 1: Eight most highly scoring topics for each group

Rank	Doctors	Nurses/Other MDTM	Patients
1	Compliance with medications	Compliance with medications	Suicide
2	Anxiety	Early signs of relapse	Support systems
3	Stress	Causes and prevention of relapse	Anxiety
4	Early signs of relapse	Stress	Psychotherapy and counselling
5	Causes and prevention of relapse	Implication of illness for family	Early signs of relapse
6	Alcohol and illicit drugs	Support systems	Compliance with medications
7	Support systems	Side effects of medication	Stress
8	Side effects of medications	Suicide	Alcohol and illicit drugs

MDTM: Multidisciplinary team member

Since an eight-week rolling psychoeducation series was planned (based upon the typical turnover of attending patients), it was decided to list the top eight most highly scoring topics from each of the three responding groups: patients, doctors and nurses/other MDTM (based on mean scores given for each topic). To derive the final schedule of topics from these three lists, it was decided beforehand to select the topics based on the following criteria: topics appearing in more than one list, topics that could logically be combined and discussed in one session and topics that appeared near the top of any list.

Using these criteria, the authors decided the final list of eight topics by consensus. The resulting psychoeducational programme consisted of eight weekly 45-minute sessions with a 15-20-minute presentation and followed by group discussions and questions and answers. This was run as an 'open group' at the day hospital, so that patients could decide to attend or not during any given week. This course was conducted by one of the authors (MA).

Results

Response rate

The numbers of questionnaires distributed to and completed by each of the three groups is as follows:

- 30/36 psychiatric doctors responded (83.3%)
- 30/41 psychiatric nurses and other MDTM responded (73.2%)
- 41/55 patients responded (74.5%).

Rankings of topics

The eight highest-scoring topics for each of the three responding groups are listed in *Table 1*.

Final topic list

From inspection of the results in *Table 1*, there were a number of topics that appeared in all three 'top eight' lists: compliance, support systems, stress and early signs of relapse. Given the content similarities of 'anxiety' and 'causes and prevention of relapse' with stress and signs of relapse, respectively, it was decided to combine these into two separate topics. Three other topics occurred on two of the three lists and were also included on the final topic list: suicide, alcohol and illicit drugs, and side effects of medication. Although 'psychotherapy and counselling' only appeared on the patient list, it was decided to include this on the final list given its relatively high scoring position. The only topic from *Table 1* that was not included in the final list was 'implications of illness for family' (nurse/other MDTM list). The final topic list is shown in *Table 2*.

Table 2: Final topic list for psychoeducation programme

- Compliance with medications
- Anxiety/stress
- Early signs, causes and prevention of relapse
- Support systems
- Suicide
- Alcohol and illicit drugs
- Side effects of medications
- Psychotherapy and counselling

Discussion

This study aimed to establish a psychoeducational session in a psychiatric day hospital setting, with an appropriate topic list for patients who have a range of diagnoses and who are in varying stages of their illness. The study also assessed what patients and health professionals wish to be covered.

From *Table 1*, it is notable how similar the lists of the eight most highly scored topics were among the three groups of respondents, though the rank ordering of these varied. It is reassuring to find that there is such a degree of agreement among the service users and service providers about the most important aspects of psychoeducation, such as compliance with medication.

The most striking difference, however, is surely the relative placing of the topic 'suicide' among the three groups. Patients scored this as the most important topic to be covered, while the nurse/other MDTM group scored it as eighth most important and it did not appear on the top eight topics of the doctors (it actually came ninth). It is worth noting that the difference between patients and all mental health professionals, as one group, regarding placing of the topic 'suicide' was statistically significant ($X^2 = 6.293$, p-value = 0.012).

This particular finding may reflect the sensitivity associated with the issue of suicide on the part of the mental health professionals. According to Thobaben,[6] healthcare providers often feel uncomfortable discussing suicide with their clients for different reasons. The subject is a taboo for some of them, and others may feel that they will alienate or humiliate clients. Mental health professionals need to be aware of their own biases that prevent them from dealing effectively with suicidal clients.[6]

Training healthcare professionals in order to increase their knowledge on the means of suicide prevention and educating patients to improve their compliance are highly beneficial.[7]

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Education and training of healthcare professionals has led to a significant reduction in suicide rates among depressed patients.[8] There is a need for protocols and training on how to address the issue of suicide in psychoeducational settings for mental health professionals.

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Roles of authors

- Mohamed Ahmed: Designer of questionnaire second draft and feedback form; data collector of main study; deliverer of psychoeducation sessions; writer of manuscript first draft; literature searcher.
- Michael Reilly: Originator of study design; study co-supervisor; collaborator on psychoeducation session content; data input; manuscript second draft corrector.
- Carol Cassidy: Designer of questionnaire first draft; data collector of pilot study; literature searcher.
- Laura Mannion: Study supervisor; manuscript third draft corrector.

Declaration of Interest: None.

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Review

Informed consent in psychiatric practice: where does the law now stand?

Peter Leonard

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Abstract

There is an established ethical and legal duty upon psychiatrists to obtain informed consent before treating a patient, although some exceptions do apply under Mental Health Legislation. The required standard for informed consent has been the subject of important case law in Ireland and other common law jurisdictions and this has caused some uncertainty for clinicians. The standard of informed consent can be viewed from the point of view of what the medical profession thinks is appropriate, or alternatively from the position of what a patient would reasonably expect to be told. These contrasting approaches are discussed in detail. A recent decision of the Irish Supreme Court establishes the 'patient-centred' standard for informed consent as the relevant standard in Irish law. The current legal position on informed consent is discussed in relation to common clinical scenarios in psychiatric practice.

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Introduction

It has long been established in law that healthcare interventions must be carried out with the consent of the patient.[1] Intervention without consent may amount to a breach of the patients unenumerated constitutional right[2] to bodily integrity[3] (an unenumerated right is not written in the Constitution but is established through case law), a criminal assault,[4] trespass[5] or professional negligence in the law of tort.[6]

This consent may be implied through our actions[7] or in situations of extreme urgency,[8] and it may be given expressly in verbal or written form. For consent to be valid it must be given voluntarily, by a person with legal capacity to consent (ie. an adult of sound mind), and finally it must be informed (the doctor has provided all information relevant to the decision).

The issue of decision-making capacity is crucial to receiving valid consent. It is commonly found in clinical practice that patients with, for example, dementia or intellectual disability may lack capacity to consent to treatment but fall outside of the remit of Mental Health Legislation because they do not meet the legal test for 'mental disorder'. In such cases there are limited options for substitute decision-making other than making the patient a Ward of Court. Contrary to common belief and practice, relatives do not have a legal entitlement to consent on behalf of an adult.

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