

Psychoeducation: psychiatry and family members essay sample

[Psychology](#)



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Nowadays, and that the future of family work for those with psychoses will be heavily informed by the future of psycho education. However, like many analogous terms (Such as psychoanalysis, or family therapy itself), psycho education today is an Umbrella word, under which several different ways of practicing are hosted.

1) Purpose and Rationale

1/a Rational For Choosing This Topic

Family psycho education is an evidence-based practice that has been shown to reduce relapse rates and facilitate recovery of persons who have Schizophrenia. A core set of characteristics of effective family psycho Education programs has been developed, including the provision of Emotional support, education, resources during periods of crisis, and Problem-solving skills. Unfortunately, the use of family psycho education in routine practice in Jordan has been limited. Barriers at the level of the Consumer and his or her family members, the clinician and the Administrator and the mental health authority reflect the existence of Attitudinal, knowledge-based, practical, and systemic obstacles to Implementation.

Family psycho education dissemination efforts that have been successful to date have built consensus at all levels, including among consumers and Their family members; have provided ample training, technical assistance, And supervision to clinical staff; and have maintained a long-term Perspective.

1/b Purpose of This Paper

Is to achieve the best possible outcome for the patient through
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Collaborative treatment and management, and to alleviate the suffering
Of the family members by supporting them in their efforts to aid the
Recovery of the person diagnosed with schizophrenia.

2/key Words

(Psycho education, family psycho education, multiple group psycho
Education, single family psycho education, mental illness, schizophrenia,
Case management, nursing professional).

2/b Research Types

Qualitative, Quantitative and Triangulation, But the almost was Quantitative .

3/c Databases

(Science Direct, Ebsco, Pub med, Ovid, Google Scholar, American Psychiatric
Association (APA), Substance Abuse and Mental Health Services
Administration (SAMHSA), National Institute for Health and Clinical
Excellence (NICE)).

3) Literature Review and Critical Appraisal

MAJOR THEMES

1) important of psychoeducation:

The patients and their families primary problems are disturbances in
relationships with others, decrease in activities, inability to care for self,
inability to fulfill marital and family roles, and job loss or hindrance to finding
a job, so they are not contented with only receiving general information
about their, illness and treatment, but they also express a need for practical

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recommendations for coping with the symptoms of their illness. it was determined that patients with schizophrenia and their relatives have the greatest need for health education on the subjects of general information about schizophrenia, coping with symptoms of schizophrenia, and communication and social relationships. (Gümüş, 2008).

it is a descriptive study, data collected by a questioner, sample was set randomly, sample size was 80, the Health educational needs Form's validity and reliability be tested in a larger sample for further research, These results are consistent with previous research findings In other related studies it was determined that patients and patients' relatives have the greatest need for education about general information about schizophrenia and coping strategies for general problems.

Another study that support psychoeducation:

(Chien, et . al. 2003) 48 caregivers from two psychiatric outpatient clinics were allocated randomly to an experimental or a control group (mutual support and usual outpatient care) Subjects randomized to the experimental group received a 3- month program of group mutual support as well as routine psychiatric outpatient services. The findings of this study demonstrate that: family caregivers in the mutual support group experienced a significant reduction in family burden in relation to caring for their relative with schizophrenia and a significant improvement in family functioning during the 3-month follow-up period, when compared with control. the feedback of participants in the experimental group: They felt less guilty and frustrated than previously and reported a heightened

understanding of their patient relative's illness and condition Consistent with findings of research studies which is demonstrated a significant decrease in the patients' length of psychiatric hospital stay for the experimental group over the follow-up period, compared with control group, the sample size was small when compared with the patient population in Hong Kong and it was recruited from only two outpatient clinics in one geographical region of Hong Kong. And the short follow-up period following completion of the group intervention (3 month).

Summary: (psychoeducatoin plays a major role in enhancing schizophrenic patient and their families status , facilitate coping strategies and problem solving).

2)expressed emotions&Psychoeducation

(Moxon . A, Ronan . K, 2008) explore family members' knowledge about schizophrenia and expressed emotion (EE), as well as awareness of their current coping strategies, by conducting a brief educational intervention designed to overcome methodological shortcomings of past studies. People with schizophrenia were recruited into the study along with family members. Relatives and patients were randomly allocated to a treatment group or a waitlist control group. They found that knowledge increased significantly after the intervention and was maintained at a three-month follow-up. The control condition reflected no changes in knowledge. Other results showed that both relatives' and patients' EE ratings significantly decreased from pretest to posttest. Changes in total EE scores improved after treatment by over twice the magnitude compared to the control condition. All gains were

maintained at the three-month follow-up, with continuing improvement seen in family members attitudes. sample size was 39 which reduced the power of statistical tests.

Another study was conducted the subjects were patients with schizophrenia who lived with high-expressed emotion (EE) families and were at high risk of relapse. A total of 30 patients whose families underwent psychoeducation and intensive family sessions or psychoeducation and subsequent support were regarded as the psychoeducation group. A high-EE group without family psychoeducation made up of 24 patients was used as a control group. The mean outpatient medical cost, duration of hospitalization, inpatient medical cost, and total medical cost during the follow-up period were compared between the psychoeducation group and the control group they found that mean inpatient medical cost was ¥270 000 in the psychoeducation group and ¥470 000 in the control group. The mean total medical costs were ¥500 000 in the psychoeducation group and ¥710 000 in the control group. The cost in the psychoeducation group was significantly lower than the control group by Mann-Whitney U-test. The proportion of patients with a total medical cost greater than the median value was 23% in the psychoeducation group and 54% in the control group with a significant difference (Mino, et al., 2007).

patients in the intervention group were treated during 1994-1997, and those in the control group during 1991-1992. This discrepancy might cause differences in medical costs and the cost analysis was limited to the medical

cost. Since the medical cost is a part of the direct cost, the evaluation of indirect costs as well as other direct costs is also needed.

Summary: (Changes in total EE scores improved after treatment and after psychoeducation).

3) Ways to conduct psychoeducation and follow up with patients and their families: a) Structured psychoeducation booklet or package: After reviewing a multiple psychoeducation packages, we found this package as the most appropriate one, because it comprehensive, applicable in the unit and with patients and their families, the package briefly: begins with providing information to family members about schizophrenia, and how it affects the persons thoughts, emotions and behavior. A detailed account of symptoms is provided. Disturbances in sensory perception and their effects on the behavior of the patient are explained. The family receives information about the possible causal factors. The family is informed about factors that influence the occurrence of schizophrenia, including genetics, neurochemistry, biological factors, life stressors and interpersonal and social factors. The family and patient are educated about the treatment in detail. This component includes information about medication, its side effects and how these can be dealt with, likely benefits of the medicine, adherence to treatment, the importance of follow-up and information regarding prognosis. The intervention emphasizes the role the family can play in helping the patient to stay well. The intervention assists the families to improve their communication skills.

Another important component of psychoeducation is to address the emotional upset in family members. A therapist helps family members to normalize the negative emotional responses by providing information regarding these issues. One of the important aspects of the education package was to address family concerns and highlight their role in patient recovery and rehabilitation, which in turn will reduce the burden on family members. Family members were encouraged to address their own needs and to resume their former personal and social interests, which is imperative for their own mental health.

This package was used to examine the impact of psychoeducation on the burden of schizophrenia on the family in a randomized controlled trial in a study by (Nasr, and Kausar, 2009). A total of 108 patients with schizophrenia and their family members from the outpatient department of a teaching hospital in Lahore, Pakistan were randomized. Both groups received psychotropic drugs but one group received psychoeducation in addition. Family burden was assessed at the time of recruitment and at 6 months post-intervention, and there was significant reduction in burden at post-intervention assessment in the psychoeducation group based on intention to treat analysis. It is applicable, the sample size is good. This package developed as a model by another author but it hasn't been used previously.

b) Using the cellular phone:

(Price, 2007) schizophrenic clients and their family members were grateful for having been able to contact a professional (with whom they had at least a limited relationship) when problems or questions arose by using the

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cellular phone, it was a pilot study (posttest only) for a group of 13 participant (7 experimental group and 6 control group), small size sample, Although this was a pilot project with no expected statistical significance, the data were analyzed to examine the appropriateness of the variables used in the study, Fisher's Exact Test was used to measure the significance of the differences in categorical variables. And the result shows grateful for having been able to contact a professional by clients and family members. Most of other related article support followed psychoeducation without any significance to using telephone.

c) Shortand long term interviews:

in both state and trait anxiety on the State-Trait Anxiety Inventory for schizophrenic patients families members were significantly lower after psychoeducational intervention (interviews) than before intervention (interviews), In addition, subjective burden and distress reported by the family significantly decreased on the subscales for family confusion resulting from a lack of knowledge of the illness and anxiety about the future, subjective burden and depression resulting from the patient's illness, and difficulties in the relatives' relationships with the patient (YAMAGUCHI , et al , 2006)., it is pre test- post test experiment The subjects were 46 (small sample size) relatives of clients with schizophrenia who attended three or four sessions of psychoeducation others related article support the following with patient families through intervention.

Summary: (there is multiple ways to conduct psychoeducation but we choose 3 of them as a most appropriate and applicable : structured psychoeducation

booklet or package, Short and long term interviews and Using the cellular phone). 4) Relapse prevention in relation to psychoeducation

(Nasr , and Kausar , 2009) examine efficacy of psycho educational interventions, in relapse prevention in patients with Schizophrenia in Pakistan, Between Group Design and Open label trial of psychoeducation versus treatment as usual, 108 patients with schizophrenia and their family members were recruited and randomly allocated to two groups. One group received psycho education and the other group was getting treatment as usual but did not receive psycho education. Patients were rated on PANSS scale before and after the delivery of family psycho educational intervention.

They found that Relapse rate in psycho education was lower (5. 8%) compared with control group (35. 7%) at six month follow up. Their symptoms were significantly less severe on PANSS.

So we can conclude that Combining family psycho educational intervention with routine treatment has proved efficacious for patients with schizophrenia

.

This study lacks the information about emotional climate within the family and the support given to the Key care giver by the other members of the family. The assessment and treatment was provided by one Person who can be a source of bias in the study.

Another study was conducted on 150 patients with schizophrenia over 15 centers in Italy. The experimental group was treated with drug therapy, traditional psychosocial and psychoeducation for the patients and their

families, while the control group received traditional psychosocial and drug intervention over 1 year, they found The experimental group showed a significant statistical improvement ($p < 0, 05$) in almost all the scales that have been assessed , Significant was the reduction of the number of hospitalizations and of days of hospital stay. So psychoeducational intervention with schizophrenic patients and their families can reduce the occurrence of relapse. (Agulia , et al , 2007). Sample size was good for an experimental design. (Motlova , et al , 2006) assessed the influence of a short-term, clinically based, and professionally led family psychoeducation program on a 1-year relapse rate , A total of 120 patients were recruited upon discharge from two psychiatric hospitals in Prague: (1) Site A (N=86), where family psychoeducation is offered to all patients with schizophrenia, and (2) Site B (N=34), where no such program was offered . they suggest that family psychoeducation should be supplemented early in the course of the illness to achieve favorable treatment outcomes and minimize adverse health and the social consequences of schizophrenia. 120 participant is good sample size for this study (over 1 year).

Summary: (there is a strong relation between patient and family psychoeducation and relapse prevention in schizophrenic patient.

3/ b Clinical Significance

First of all, FPE increase patients' knowledge and understanding of their illness and

Treatment. So that can help people with schizophrenia to cope more effectively with

Their illness and supporting them in overcoming and managing their emotional

Response of grief and loss From Other Hand, even implementing an FPE program has initial costs related to training and program development. Studies show a low cost-benefit ratio related to Savings from reduced hospital admissions, hospital days, and crisis intervention Contacts on the long run. Beside that the FPE gives public mental health authorities a unique opportunity to improve clinical services for adults with serious mental illnesses in Jordan. Research has shown that FPE has a consistent, positive impact on The lives of consumers and their families.

4) Summary and Conclusions

4/a Application in Clinical Area

First FPE program include the following:

- 1) Education about serious mental illnesses.
- 2) Information resources, especially during periods of crises.
- 3) Skills training and ongoing guidance about managing mental illnesses.
- 4) Problem solving; and Social and emotional support.

PHASES OF (FPE)

NOTE

We most frequently use Consumers in this program. Consumers are people

who are Living with serious mental illnesses and who use professional mental health services.

1) JOINING SESSIONS

Initially, FPE practitioners meet with consumers and their respective family members In introductory meetings called joining sessions. The purpose of these sessions is to Learn about their experiences with mental illnesses, their strengths and resources, and Their goals for treatment.

FPE practitioners engage consumers and families in a working alliance by showing Respect, building trust, and offering concrete help. This working alliance is the Foundation of FPE services. Joining sessions are considered the first phase of the FPE Program, beside that it consist of three major joining sessions. Tasks for Joining Session 1

1) Socialize.

2) Review a present (or past) acute psychiatric episode.

3) Identify precipitating events.

4) Explore prodromal signs and symptoms.

5) Review family experiences in providing support and validate their experience as

Normal human responses.

6) Identify consumer and family strengths and coping strategies that have been

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Successful .

7) Identify coping strategies that have not been helpful.

8) Socialize.

Tasks for Joining Session 2

1) Socialize.

2) Explore feelings and reactions to having a mental illness or a relative with a

mental illness.

3) Identify consumers' social support network.

4) Construct a genogram or family tree.

5) Review past experiences with the mental health system.

6) Convey basic information about the consumer's specific mental illness.

7) Socialize.

Tasks for Joining Session 3

1) Socialize.

2) Identify personal strengths, hobbies, interests.

3) Identify short- and long-term goals.

4) Introduce the next phases of the FPE program.

5) Socialize.

2) EDUCATIONAL WORKSHOP.

In the second phase of the FPE program, FPE practitioners offer a 1-day educational Workshop, The workshop is based on a standardized educational curriculum to meet The distinct educational needs of family members.

FPE practitioners also respond to the individual needs of consumers and families Throughout the FPE program by providing information and resources. to keep Consumers and families engaged in the FPE program, it is important to tailor Education to meet consumer and family needs, especially in times of crisis. 3) ONGOING SESSIONS

After completing the joining sessions and 1-day workshop, FPE practitioners ask Consumers and families to attend ongoing FPE sessions. When possible, practitioners Offer ongoing FPE sessions in a multifamily group format. Consumers and families Who attend multifamily groups benefit by connecting with others who have similar Experiences. The peer support and mutual aid provided in the group builds social Support networks for consumers and families who are often socially isolated. Ongoing FPE sessions focus on current issues that consumers and families face and Address them through a structured problem-solving approach. This approach helps Consumers and families make gains in working toward consumers' personal recovery Goals.

FPE is not a short-term intervention. Studies show that offering fewer than 10 Sessions does not produce the same positive outcomes. We currently

recommend Providing FPE for 9 months or more. In summary, FPE practitioners provide information about mental illnesses and help Consumers and families enhance their problem-solving, communication, and coping Skills. When provided in the multifamily group format, ongoing FPE sessions also Help consumers and families develop social supports.

In general, single-family formats tend to be used for the following:

- 1) Consumers and families with strong social support networks.
- 2) Consumers and families who exhibit unusual resilience or strong coping skills; or
- 3) Consumers who respond positively to medications.

Multifamily groups tend to be used for the following: :

- 1) Consumers who are experiencing their first episode with mental illness.
- 2) Consumers who are not responding well to medication and treatment.
- 3) Consumers who are experiencing complicating issues such as other medical illnesses .
- 4) Families experiencing high stress.
- 5) Families who have separated from their relative with mental illness; and Families who have been through divorce.

Characteristics of a Family Psycho education Program

Family intervention coordinator

A designated clinical administrator oversees the FPE program and performs specific Tasks

Session frequency

Consumers and families participate every 2 weeks in FPE sessions . Long-term FPE

Consumers and families are provided with long-term FPE. At least one family Member for each consumer participates in FPE sessions for at least 9 months. Quality of practitioner-consumer-family alliance FPE

Practitioners (staff) engage consumers and family members with warmth, empathy, Acceptance, and attention to individual needs and desires.

Detailed family reaction FPE

Practitioners identify and specify families' reaction to their relative's mental illness . Precipitating factors FPE

Practitioners, consumers, and families identify and specify precipitating factors for Consumers mental illnesses.

Prodromal signs and symptoms

FPE practitioners, consumers, and families identify and specify prodromal signs and

Symptoms of consumers' mental illnesses.

Coping strategies

FPE practitioners identify, describe, clarify, and teach coping strategies.

Educational curriculum FPE

Practitioners use a standardized curriculum to teach families about mental illnesses

. Multimedia education

Consumers and family members receive educational materials about mental illnesses

in several formats (for example, paper, video, and Web sites).

Structured group sessions

FPE practitioners follow a structured procedure in conducting multifamily group

Sessions.

Structured problem solving FPE

Practitioners use a standardized approach to help consumers and families with

Problem solving.

Stage-wise provision of services FPE

Services are provided in the following order:

- 1) Engagement.
- 2) Three or more joining sessions.
- 3) The educational workshop; and
- 4) Multifamily group sessions.

Assertive engagement and outreach FPE

Practitioners assertively engage all potential consumers and family members by Phone, by mail, or in person (in the agency or in the community) on an ongoing basis.

. Practice Principles of the program

Principle 1: Consumers define who family is.

In FPE, the term family includes anyone consumers identify as being supportive in The recovery process. For FPE to work, consumers must identify supportive people They would like to involve in the FPE program. Some consumers may choose a Relative. Others may identify a friend, employer, colleague, counselor, or other

. Supportive person

. Principle 2: The practitioner-consumer-family alliance is essential

Consumers and families have often responded to serious mental illnesses with great Resolve and resilience. FPE recognizes consumer and family strengths, experience, And expertise in living with serious mental illnesses.

FPE is based on a consumer- Family-practitioner alliance. When forming alliances with consumers and families, FPE practitioners emphasize that consumers and families are not to blame for serious Mental illnesses. FPE

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practitioners partner with consumers and families to better understand consumers and support their personal recovery goals . Principle 3: Education and resources help families support consumers' personal Recovery goals

Consumers benefit when family members are educated about mental illnesses. Educated families are better able to identify symptoms, recognize warning signs of Relapse, support treatment goals, and promote recovery. Provide information Resources to consumers and families, especially during times of acute psychiatric Episodes or crisis

Principle 4: Consumers and families who receive ongoing guidance and skills Training is better able to manage mental illnesses

Consumers and families experience stress in many forms in response to mental illnesses. Practical issues such as obtaining services and managing symptoms daily Are stressors. Learning techniques to reduce stress and improve communication and Coping skills can strengthen family relationships and promote recovery. Learning How to recognize precipitating factors and prodromal symptoms can help prevent Relapses.

. Principle 5: Problem solving helps consumers and families define and address Current issues

Using a structured problem-solving approach helps consumers and families break Complicated issues into small, manageable steps that they may more easily address. This approach helps consumers take steps toward achieving their personal recovery Goals

. Principle 6: Social and emotional support validates experiences and facilitates Problem solving

FPE allows consumers and families to share their experiences and feelings.

Social And emotional support lets consumers and families know that they are not alone. Participants in FPE often find relief when they openly discussed problem-solve the Issues that they face.

What Policies and Procedures Should Cover

- 1) Admission and discharge criteria
- 2) Staffing criteria
- 3) Service components
- 4) Program organization and communication
- 5) Consumer records requirements
- 6) Consumers' rights
- 7) Program and team member performance evaluation

Determine the length of your sessions and program

FPE services are provided in three phases:

- 1) Joining sessions.
- 2) An educational workshop; and
- 3) Ongoing FPE sessions.

During the joining sessions in the first phase, FPE practitioners meet with each FPE Consumer and their respective family members at least three times for about 1 hour. You may hold joining sessions with consumers and their respective family members Together or meet separately with them. (That means you would conduct six or more Sessions instead of three or more.)

FPE practitioners base their decisions about offering joining sessions to consumers And family members jointly or separately on consumer and family preferences, Diagnosis, and illness characteristics. For information to help FPE practitioners make These decisions.

During the second phase of the FPE program, a 1-day educational workshop is Offered. Typically, the workshop is conducted solely with families—not with Consumers—to give families a chance to speak freely about their experiences and to Interact with others who are in similar situations.

Some agencies involve consumers in part of the workshop to ensure that they receive The same educational information as their families. Others offer this information to Consumers individually or in a separate consumer forum. Typically, this workshop is Offered only once to participants in the FPE program. You should offer it within 1 or 2 weeks after joining sessions are completed.

You may offer the last phase of the FPE program—ongoing FPE sessions—in either The single-family or multifamily group format. FPE multifamily groups consist of five to eight consumers and their respective family members. they meet every 2 weeks for 1½ hours. Two FPE practitioners co-facilitate the

group. In the single-family format, one FPE practitioner meets individually with consumers and their respective family members. Meetings are usually every 2 weeks for 1 hour.

Offer both single-family and multifamily sessions for 9 months and more.

Offer other core service components

Your FPE policies should also discuss how to assertively engage consumers and Families. Engaging consumers and families in FPE starts the moment that they are Referred to the program and continues throughout the program. FPE practitioners assertively engage consumers and family members by phone, by Mail, or in person (in the agency or in the community). To keep consumers and Families engaged in services, encourage FPE practitioners to routinely reassess the Issues that consumers and families are facing and offer services to meet their needs. FPE practitioners also keep consumers and family engaged in FPE services by Routinely offering educational materials tailored to their own needs. Policies and Procedures should encourage FPE practitioners to provide educational materials in Several formats (for example, paper, video, and Web sites).

Samples of Forms That Can Be Used In Documentation Process in FPE Program .

Appendix A: Joining Session 1, 2, 3 *

Appendix B: Educational Workshop *

Appendix C: Multifamily Group Problem Solving Worksheet*

(Attached in the end of these papers)*

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What if consumers do not have family or do not want their families involved?

In FPE, the term family includes anyone consumers identify as being supportive in The recovery process. The broad definition emphasizes that consumers choose whether to involve family and whom to involve. FPE helps consumers develop or enhance their support networks.

The evidence-based model has been found to work well with consumers who are Disengaged from their families and have difficult treatment histories.

Joining sessions Give practitioners the opportunity to help consumers engage family members again

. In a constructive and supportive manner

Research shows that practitioners often ask consumers for permission to involve their Family members during a crisis. Asking for family involvement at this time may rise Suspicions for some consumers. Consequently, they may be more reluctant to identify supportive people. For this reason, modify your intake and assessment procedures so that consumers are routinely told about the FPE program and are periodically asked if they would like to involve someone supportive in their treatment.

If consumers do not wish to involve family members in their treatment, FPE Practitioners should respect their decision. If consumers do not give permission to Share confidential information with their families, FPE practitioners may still respond To families' questions and concerns. Even the strictest interpretation of confidentiality policies does not prohibit receiving information from families or giving them general information about serious mental illnesses and agency services. If families want to learn more about

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serious mental illnesses, FPE practitioners should Direct them to local family organizations. Consumers who are not interested in FPE May benefit from other education and skills training programs that are targeted Specifically to consumers such as Illness Illness Management and Recovery. 4/b facilitators of Application to Clinical Area

1) Connections and Collaboration Between the (unite) and outpatient clinics and Community mental health center such as (alhashemy clinics for mental health , our Steps society (non -profit society), to keep the better utilization and continuity of This program .

2) We can conduct FPE sessions in almost any location that is convenient for staff,

Consumers, and families. For example, in the unit, Or Consumers' family members'

Home.

3) Availability of an environment that is quiet, free of unnecessary distractions, and

Conducive to sharing and learning from one another.

4) Availability of social worker, phone line that will help in conducted with serves

Users after discharge and ensures the continuity of ongoing FPE sessions.

4/b Hinders of Application to Clinical Area

1) Probably the greatest barrier to implementation lies within the health system itself.

This can be happen when nurses staffs actually discontinue applied these principles and interventions on the long run.

2) Maybe the relatives are not always receptive to these Interventions and accepted

The invitation to attend relatives groups.

3) High rate for drop out from family therapy because of lack of interest and time,

Non-acceptance of the diagnosis and service users.

4) Low levels of contact between clinical staff and family members in public and Community-based settings may preclude the more substantial educational or support Interventions.

5) At the health-system level, pressures to focus on outcomes, cost-effectiveness, and Customer satisfaction seem in principle to favor the widespread adoption of family Information and support interventions.

However, other tenets of the current health Care environment—such as the emphasis on short-term cost savings, technical rather Than human-process-oriented remedies, and individual pathology—discourage Clinicians from providing such services,

6) Practical impediments such as transportation problems and competing demands for time and energy.

7) In addition, stigma is common— family members may not want to be identified with psychiatric facilities. They may feel uncomfortable revealing that there is psychiatric illness in their family and airing their problems in a public setting. 8) The lack of availability of family psycho education may reflect an under- appreciation on the part of mental health care providers of the utility and importance of this treatment approach.

9) Financial barriers are critical since specific costs are associated with starting new EBP programs and sustaining them.

4/ c Conclusions

The efficacy and effectiveness of family psycho education as an evidence-based

practice have been established. To date, the use of family psycho education in routine

clinical practice is alarmingly limited. Research has recently begun to develop

dissemination interventions targeted at the programmatic and organizational levels,

with some success. Ongoing research must continue to develop practical and low-

Cost strategies to introduce and sustain family psycho education in typical practice

Settings. Basic research that identifies the barriers to implementing family psycho

Education in various clinical settings is also needed—for example, the impact of

Clinicians' attitudes, geographic factors, funding, disconnection of patients from

Family members, and stigma—as well as the extent to which variations in these

Factors mediate the outcomes of educational interventions.

Dissemination could also be facilitated by further exploring the integration of family Psycho education with psychosocial interventions— such as assertive community Treatment, supported employment, and social skills training— and other evidence- Based cognitive-behavioral strategies for improving the treatment outcomes of Persons with schizophrenia.

NOTE :

*There is an Workshop, That will be Held in This Week on Tuesday (05/15) for 2 Hours , That Will Present The Utilization For Our Project Briefly. * The Presentation Material will Be Attached With These Papers.