References


From Research to Clinical Practice:
Dissemination of New York State’s Family Psychoeducation Project

William R. McFarlane, M.D.
Edward Dunne, Ph.D.
Ellen Lukens, M.P.H., M.S.W.
Margaret Newmark, M.S.W.
Joanne McLaughlin-Toran, M.P.A.
Susan Deakins, M.D.
Bonnie Horen, M.A.

The New York Family Support Demonstration Project was begun in 1984 to translate the results of research on family psychoeducation in the treatment of schizophrenia into general practice. Goals were to compare experimentally a single-family psychoeducation model with a multiple-family group format, to replicate successful outcomes in ordinary clinical settings, and to train agency clinicians in the model. A total of 172 schizophrenic patients and their families from six sites across the state were followed for two years. Relapse rates comparable to those in more narrowly focused research studies were obtained in ordinary clinical settings. Patients in the multiple-family format had substantially lower risk of relapse than patients in single-family treatment. Over the next three years, the multiple-family approach was successfully disseminated across the state using a strategy based on five central assumptions of the psychoeducational model.

In its recent plan to improve mental health services, the National Advisory Mental Health Council asked investigators to translate their research into practice by disseminating...
their findings to service providers (1). The council plan calls for integrating the flow of information from research into the broad range of mental health services to improve the care system. It focuses special attention on clinicians, citing their historical difficulty with keeping abreast of research developments. It also recommends examining the merits of existing models of information dissemination and developing and evaluating new ones.

This paper reports on the New York Family Support Demonstration Project, which set out to translate the findings of research on family psychoeducational methodologies into general clinical practice in a public mental health system. The background and goals of the project are described, and the methods and results of the research study are summarized. The family psychoeducation model was disseminated to clinicians and administrators across the state. The dissemination strategy, which was based on central assumptions of the model, is described.

Background
When the family support project began in 1984, theories about the biological basis for schizophrenia were gaining wider support and recognition (2–4). The psychoeducational model builds on these theories, defining schizophrenia as a brain disorder sensitive to the social environment (5–9). Treatment is seen as bimodal, influencing both the disease, through medication, and the social environment, through techniques that deliberately reduce stimulation and complexity to tolerable levels (10–12).

The results of experimental trials of family psychoeducation methods for treating schizophrenia have been remarkably encouraging. Outcome studies by Goldstein (13), Leff (14–16), Falloon and Pederson (17), Hogarty and associates (18), Tarrier and colleagues (19), and McFarlane (20) reported that relapse rates of medicated versus unmedicated patients in many drug maintenance studies (21–23).

Although psychoeducational interventions appear to be successful, these studies were conducted under special circumstances and not in ordinary clinical settings. They involved small, carefully selected samples that were treated or supervised by the investigators themselves at research institutes. As such, these approaches fit Bachrach's definition (24,25) of a model program, which may mean that their outcomes are inherently nongeneralizable (26).

Furthermore, family psychoeducation satisfies only one of Rogers' criteria (27,28) for an innovation that is likely to be diffused rapidly. Although it clearly offers a major relative advantage, it is not compatible with many clinicians' theoretical training; it is more complex than standard individual treatment, at least initially; it is not particularly amenable to trials; and the outcomes, by design, emerge over the long term and are not readily observable. Thus a significant question remains unanswered: are these models effective where they are most needed, in public psychiatric hospitals and clinics using available personnel?

The New York Family Support Demonstration Project was initiated in 1984 as a policy initiative of the New York State Office of Mental Health with the support of the New York State Alliance for the Mentally Ill. It was an outgrowth of an earlier recommendation by a state-sponsored task force of professionals and family advocates to involve families in treatment planning and rehabilitation. At that time the first author was conducting a pilot study (20) of various forms of multiple-family groups, reflecting a suggestion made in several literature reviews that such groups deserved empirical evaluation (29–31). The pilot study found that psychoeducational multiple-family groups were more effective over four years in preventing relapse than was single-family psychoeducation (20).

The Family Support Demonstration Project combined several goals. The first was to demonstrate that reported outcome in studies of psychoeducation could be replicated in a variety of ordinary clinical settings using regular staff as the service providers. Another goal was to compare experimentally psychoeducation delivered in a single-family format to the same interventions in a multiple-family group format. The final goal was to train the research project's clinicians as supervisors and teachers of the model within their own agencies and geographic regions. The model of intervention to be taught by these new supervisors was to be determined by the outcome of the experimental trial.

Research phase
The research study was conducted at six sites across the state of New York in public hospitals and clinics representing standard conditions in mental health services for severely mentally ill persons. Five were state psychiatric centers, and the sixth was an inner-city municipal general hospital with a psychiatric unit. The hospitals included three that served various socioeconomic groups in New York City, one hospital in a small city, one suburban hospital, and one in a rural setting. With one exception, the interventions were carried out in the outpatient clinics operated by these facilities. A brief summary of the research study is included here; a full report will be available shortly.

A total of 172 patients consecutively admitted to the sites' inpatient facilities were recruited over a two-year period (September 1985 to June 1987) of treatment and observation. Patients included were those with a DSM-III-R diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder who had no outright addiction and a minimum of ten hours per week of family contact before inpatient admission. They and their families were randomly assigned to psychoeducational treatment in a single- or a multiple-family group format. In either modality, patients and their families were engaged in separate preliminary sessions; each patient was seen alone for at least three sessions, as was his or her family. After intensive education about schizophrenia for the families alone, patients and families
met together once every two weeks for two years, either as a single family or in a multiple-family group. The multiple-family meetings followed a prescribed clinical protocol (32). A period of socializing opened and closed each session. Clinicians, families, and patients were expected to share pleasant recent experiences and achievements and talk about common interests. The initial period was followed by a review of developments in the illness during the past two weeks; then one problem was identified and subjected to a formal problem-solving procedure patterned on an approach developed by Falloon and Liberman (33). Problems were defined, as broad a range of solutions as possible was proposed, and a final solution was selected for trial during the next two weeks. The family clinicians served as case managers and were available between meetings for consultations and emergencies. The site's study psychiatrist monitored medication.

Each multiple-family group consisted of six families and two co-leaders. Two or three such groups met at each site. Single-family clinicians were assigned nine families each. The clinicians worked on the project in addition to their regular caseloads.

Using this design, relapse rates for patients treated in the single-family approach that were comparable to those in the previous psychoeducation studies described above were obtained in ordinary clinical settings. A stronger main effect was achieved by the multiple-family group approach. The 83 patients treated in the multiple-family format had a one-year relapse rate of 15.7 percent and a two-year cumulative rate of 27.7 percent. The 89 patients seen in single-family treatment had a one-year relapse rate of 28.1 percent and a two-year cumulative relapse rate of 41.6 percent (Cox's proportional hazard model, \( \beta/\text{standard error} = 1.86; p = .06 \), with medication compliance entered as a covariate). The risk of relapse by patients in the multiple-family format was 61 percent of the risk of relapse by patients in single-family treatment (Cox's regression model coefficient = .49). Given these findings, which replicated the findings of the pilot study, later staff training focused on multiple-family group treatment.

Dissemination phase
The project staff consisted of a director, an administrator, and supervisors at the central project headquarters and a site director and four to seven clinician-supervisors at each of the six sites. They viewed the research component as the first part of a longer-term implementation and dissemination strategy. The initial intensive clinical staff training greatly helped to dispel any blaming attitudes toward the families among the clinicians, which addressed the incompatibility between the model and the clinicians' previous training. The rigor imposed by the research protocol helped the clinicians learn and implement the model as precisely as possible. As a result, by the conclusion of the outcome study, these experienced clinicians were ready to be trained in the model as supervisors.

The problem of disseminating these new principles into existing systems was addressed in a manner similar to that described by Fairweather (34), who demonstrated that an effective dissemination program requires simultaneous work with both administrative and clinical personnel. The training effort consisted of a one-day orientation for administrators and senior clinicians, a three-day intensive clinical training workshop for primary clinicians, and at least one year of monthly, three- to four-hour supervision groups involving from eight to 15 experienced clinician trainees. Training began in the spring of 1989 and continued through July 1992.

We attempted to go beyond the Fairweather strategy by developing distinct approaches for direct service providers and for administrators. The approaches were isomorphic with the interventions made on the clinical level with families. These strategies were based on five central assumptions of the psychoeducational model (10). First, success in promoting change in behavior and attitudes requires the establishment of a cooperative, collegial, nonjudgmental relationship between all parties. Second, education about schizophrenia supplemented with continued family support and guidance is necessary to improve patient status and prognosis. Third, difficulties in making or maintaining changes are a consequence of ignorance and isolation rather than family dysfunction or psychopathology. Fourth, problematic situations are best handled by breaking the problem into its components and solving them in a stepwise fashion. Five, support comes from a network of well-informed and like-thinking people. Each of these assumptions were implemented in a specific way.

Collegial relationships. Beliefs that families cause schizophrenia persisted in many state and local institutions. To incorporate psychoeducation, these long-established attitudes about schizophrenia needed to be changed because the psychoeducation model calls for a collegial relationship between clinician and family. The ability to engage families, maintain their enthusiasm, and dispel some of the negative self-images produced by stigma depends on an alliance based on mutual respect. Developing a collegial attitude toward families was among the more difficult tasks for clinicians; it was in this aspect that psychoeducation was least compatible with existing approaches to families.

Project supervisors modeled a collegial attitude by treating the clinician-trainees as colleagues whose input into refining the model and solving the problems of implementation was valued and utilized. Supervisors deliberately promoted an atmosphere of collaboration, acceptance, and affinity in all training and supervisory sessions with clinicians. They began and ended each supervisory session with a period of socializing about issues other than the project, a technique elaborated by Anderson and associates (10). In this way they worked to discard the more traditional supervisor-supervisee reserve while encouraging the clinicians to discard their customary reserve with families.

A similar relationship was established on the administrative level. Local administrators were included
in decision making from the beginning, consulted about problems related to the conduct of the project at their own and other sites, and invited to participate in training sessions. The same strategy was then used to maintain a collegial relationship with the cadre of new supervisors as a way of helping them foster similar relationship styles with both their own trainees and the administrators of the services in which they were training.

Education. The family psychoeducation model emphasizes educating families about schizophrenia so they can participate in the recovery and rehabilitation process from an informed position. In addition to conducting formal workshops for families, clinicians were trained to respond to many situations by providing education and updated information. Whenever applicable, they referred to guidelines for the management of the illness drawn from the clinical and basic sciences (10).

Applying this strategy to the task of establishing a cadre of proficient clinicians and supervisors, the project staff followed the training workshops with periodic updates about developments in the psychobiology of schizophrenia. Providing a detailed body of information to families and clinicians greatly reduced the perceived complexity of treatment and rehabilitation.

Formal training of clinicians included basic information about the biological and psychosocial aspects of schizophrenia, summaries of current psychoeducational studies, descriptions of families' attitudes toward the provider system, and concrete solutions to problems in implementation. Training also involved practice in each of the clinicians' tasks by group role-playing.

Initially, the project supervisors did all the training, but on completion of the research study, the site clinicians were trained as supervisors. As they began conducting clinician training workshops, project supervisors participated as guest presenters. As new findings about schizophrenia became available, they were distributed throughout the system to increase the quality of information available to everyone, from administrators to consumers.

At the organizational level, as many people as possible were informed about the project through hospitalwide grand rounds presentations and day-long executive sessions for administrators. As a result, the administrators understood the basic principles of the intervention and could offer knowledgeable and reasonable assistance when clinicians sought help with barriers to implementation. To ensure an extra layer of support and further dissemination, site research directors, who were mainly responsible for the technical aspects of gathering data and monitoring research protocols, were also trained and given administrative support by the staff at the project headquarters.

Staff of the New York State Office of Mental Health provided support by reminding local administrators of their family-inclusion policies and by providing technical and funding support. Finally, key persons throughout the state received quarterly progress reports for the duration of the project in an effort to disseminate information systemwide. The continued education and support given to administrators appeared to overcome barriers to initial implementation.

Assumption of least pathology.

In the psychoeducational model, clinicians are taught to view families as attempting to uphold the best interests of the patient even when they appear to be interfering with the recovery process. This assumption of least pathology, a key to successfully engaging families, was also applied to trainees and institutions. Therefore, both clinicians and institutions were given the benefit of the doubt; it was assumed that they valued family involvement in patients' treatment but were inhibited by the novelty of the necessary skills and by lack of knowledge, funds, and personnel.

To increase the acceptance of this perspective, neither clinicians nor institutions were labeled as uncooperative. Instead, a history of failed attempts to engage families was interpreted as a sign of good intentions, which could now be coupled with a new method of family intervention that was more effective in engaging families and in treating schizophrenia. In this way, it became possible to nurture the facility's positive inclinations in a blame-free atmosphere. Project trainers and administrative staff offered to assist in solving any problems that the introduction of a new perspective on schizophrenia and new clinical methods might create within the institution.

Step-by-step solutions. The psychoeducational principles developed by Anderson and associates (10) and Falloon and colleagues (11) encourage the use of formal problem-solving techniques to minimize stress and distraction, temporarily lower expectations, and encourage optimism about finding solutions. In supervision, trainees were encouraged to apply this method to the administrative difficulties they encountered, thus gaining experience in using a step-by-step method not only with families but also with other service providers, such as the staff of day hospitals and community residences.

For example, guidelines such as "going slow" or "encouraging periods of social withdrawal" were occasionally at odds with local practice standards in the treatment of severe mental illness. The clinicians were taught to avoid conflict and confrontation by negotiating changes in treatment plans on a case-by-case basis. They relied on the improved functioning of these patients to argue for the advantages of embracing the entire model. By simplifying the process of innovation and making it more manageable, we hoped to deal with the complexity and compatibility barriers and make the model more amenable to trial.

A network of like-thinking people. Stigma and burden often isolate families dealing with chronic mental illness (35-40). Family psychoeducation responds by establishing links between families in similar circumstances. The multiple-family group format provides an opportunity for network building (41). Project staff also encouraged mutually supportive networks for the clinicians through conference calls and site visits. They
also promoted wider network building through twice-yearly off-site training programs.

This approach allowed everyone involved in the project to develop relationships, share experiences, and sharpen and broaden their clinical skills. It also served to counteract any feelings of isolation that involvement in a special project with a sometimes-controversial viewpoint might inadvertently have fostered. These social networks were useful in dealing with the compatibility issue, by making psychoeducation congruent with the preferences of many public-sector clinicians for more supportive and team-based work environments.

Outcome

Among the original project goals were training staff clinicians in a sophisticated technique and its implementation and training them to train other clinicians. Twenty-six clinicians completed two years of supervision in the model, of whom 16 went on to become supervisors and trainers, promoting active dissemination efforts at all of the six original sites. Four sites have produced a second generation of clinicians, and four have expanded their programs to train clinicians from state, county, and private-sector providers. Staff at the project headquarters went on to establish clinical programs at 15 additional sites, three of which are now capable of independent supervision.

Of the approximately 3,000 clinicians who attended introductory workshops and the 1,500 who received full initial training, more than 300 clinicians are using the model in various forms. More than 100 have completed a year of supervision.

Between July 1991 and July 1992, a total of 43 new multiple-family groups were established at 21 different sites. After the efficacy of the multiple-family format was documented, many of the project clinicians went on to explore this promising approach with patients with other diagnoses, especially patients with bipolar disorder, those who have been sexually abused, violent or long-term inpatients, and dual diagnosis patients. The approach has been used with families of Hispanic, African, and Native American descent and in nonfamily settings, such as community residences and inpatient units (42).

Discussion

Our experience corroborates Fairweather's conclusions (34) that successful system change requires simultaneous efforts at both the line-staff or program level and the agency or institutional-leadership level. Beyond that, however, we believe that a unified strategy—applying the principles of the psychoeducational model to all levels of the system—greatly improved the chances that our research findings would be translated into durable service programs. This dissemination methodology overcame the barriers to rapid adoption of innovation described earlier by Rogers (27), Fairweather (34), Backer (43), and others.

The strategy, of course, has its price. Dissemination and implementation of new technology in an existing service system require an initial expenditure of extra time, energy, money, and commitment to produce a clinically meaningful outcome at reduced cost.

The credibility of a treatment based on research conducted in ordinary nearby clinical settings facilitated change in the conceptual orientation and prevailing practice of clinician recruits and their administrators. We found that halo effects, seemingly inevitable in field trials of new treatments, can be judiciously exploited in making large-scale changes in clinical programs. Learning a rigorous research-based model bolstered the clinicians' adherence to the most critical clinical and logistical features while maintaining morale, sometimes against daunting odds. By focusing on schizophrenic disorders, a credible treatment alternative was offered for a limited number of patients in several facilities without threatening the philosophy of all their usual treatment programs.

Successful dissemination of positive outcomes from clinical research to ordinary clinical settings is more important in an age of scarce resources and increased demand. As service systems lose funding, innovative research leading to programs that reduce requirements for service will be eagerly sought. Yet even the most promising programs may not be fully implemented because of institutional and attitudinal factors. Strategies such as the one detailed here offer hope of a more successful transfer.

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