Schizophrenia is a severe and chronic disease characterized by lack of insight and poor adherence to treatment. Psychoeducation is a group intervention to share knowledge with patients, their relatives, and clinicians, about psychiatric symptoms, coping to relapse, effects by medication, and social support. Such an intervention contributes to decrease relapse or readmission and gain patients’ insight, adherence, and some well-being (Jun et al., 2011; Morimoto et al., 2017).

In our facility, we provide psychoeducation group program which consists of three sessions; 1) symptoms of schizophrenia and coping to relapse, 2) effects and side effects of medication, 3) social services and recovery. Our program are held once a week, taken about fifty minutes. Two to eight patients participate in program with psychiatrist, nurses, psychologist, social worker, and pharmacist. Patients with schizophrenia accounts for 60% of our acute psychiatric wards but only few patients attend our program. We thought that we could not provide our program to appropriate patients.

Purpose:
The purpose of this study is to show the characteristics between participants and non-participants in our psychoeducation group program in acute psychiatric ward.

Methods:
Subjects:
745 patients with schizophrenia who were admitted to two acute psychiatric wards in our hospital during from April 2015 to July 2017.

Data Collections:
We collected information about age, agreement to admission, duration of hospitalization, physical complications, admission history within recent one year, insight, medication adherence, visit interruption, discharge destination, family support, family living together, Clinical Global Impressions-Severity Scale (CGI-S), Clinical Global Impressions-Improvement Scale (CGI-I), and Global Assessment of Functioning (GAF). CGI is an observer-rated scale which measures illness severity and global improvement or change. CGI is 7-points scale and rated by a psychiatrist. CGI-S’s question is “Considering your total clinical experience with this particular population, how mentally ill is the patient at this time”. A psychiatrist rates a range from 1 (normal) through to 7
(among the most extremely ill patients). CGI-I’s question is “Rate total improvement whether or not, in your judgement, it is due entirely drug treatment. Compared to his condition at admission to the project, how much has he changed?”. CGI-I scores range from 1 (very much improved) through to 7 (very much worse). GAF is scored by psychiatrist consider social, occupational and psychological function. It rates how serious a mental illness may be, and measures how much a patients illness affect his/her daily life on a scale of 0 to 100. It is divided 10 sections, higher score means patients can be adapted to daily activities.

Analysis:
The data were analyzed by using The Mann-Whitney U test and chi-square test to compare between participants and non-participants. For the analysis we used the Statistical Package for Social Sciences (SPSS) version 21.

Ethical considerations
Personal data were managed anonymously to protect personal information before data analysis.

Results:
A total of 331 (44.4%) were analyzed whose data has no loss. The average age was 44.8 (SD=14.4), duration of hospitalization was 62.6 days (SD=42.6), 14 (4.2%) had physical complications, and 106 (32.0%) had admission history within recent one year. 66 (19.9%) were lack of insight at the time of the admission, 90 (27.2%) had a history of visit interruption, 147 (44.4%) did not take medicine regularly. All patients were back to their home, 300 (90.6%) had family support, 94 (28.4%) had some problem with their family living together. Mean CGI-S was 5.18 (SD=1.00), CGI-I was 2.23 (SD=0.87), GAF at the time of admission was 25.69 (SD=11.75), GAF at the time of discharge was 46.73 (SD=14.50).

89 (26.9%) joined our program more than one session, and 38 (11.5%) joined all of three sessions. The number of patients who had no admission history within recent one year was 30 out of 38 in participant group, and this was larger than non-participant group (p<.10). A rate of participation was higher in younger patients (age<50, 29.8%) than older patients (age>50, 13.6%) (p<.05). Patients had milder symptoms (rated less than 4 by CGI-S) were more attend to a program than patients had severely symptoms (rated more than 5 by CGI-S) (p<.10). No difference was found in the rate of participation by lack of insights, medication adherence, visit interruption, and admission history within recent one year. The duration of hospitalization of subjects who participated in program was longer (Me=70.8 days) than subjects who did not participate in it (Me=59.6 days).

Conclusion:
Firstly, the characteristics of between participants and non- participants in our program were subjects’ age and severity of illness. Participants in our program were younger (age<50), and with milder symptoms (rated less than 4 by CGI-S) than non-participants. Their mentally state were better than non-participants. Our program is program, participants need to tell their personal experience and conditions in program, and to share their stories with other participants. So, patients are required to understand contents in program and to communicate with others and clinicians. We thought participants could attend a program because they had not severe symptoms and kept cognitive function enough to understand program. To offer our program to patients with
severe mental state, we might need to consider to be appropriate their personal condition.

Secondly, we found a service gap. The rate of participation by lack of insight, medication adherence, visit interruption, and admission history within recent one year were not different between participants and non-participants. We thought that we should provide a program to patients have such these characteristics, but we could not deliver it to them. Patients with schizophrenia have a deficit of self-awareness, so they have difficulty to understand their situation objectively (Ng, et al., 2015). Patients may not to recognize a necessity of a program, though clinicians recognize it. Furthermore, patients may not know the existence of a program itself. So we should assess patients’ needs to their further life, and inform them of a program, and tell them necessity to get insight and enhance adherence to treatment.

Thirdly, duration of hospitalization of participants was longer (Me = 70.8 days) than non-participants (Me = 59.6 days). Furthermore, number of patients joined in all of three sessions (n=38) were less than patients joined least one session (n=89). In Japan, duration of hospitalization in psychiatric wards is more than 300 days, so we are demanded to shorten it. In case of our facility, average duration of hospitalization was about 60-70 days. It is important for clinicians to find out the time to approach to patients, since durations of hospitalization in psychiatric ward are shortening.

Limitations:
We could not analyze patients’ attitude to program in this study. Motivation impairments are one of some feature of schizophrenia (David et al., 2009), so our results may be reflected their negative attitude or refusal to program. We should consider patients’ attitude in a further study.

Title:
Difficulties of Psychoeducation Group Program for in-Patients With Schizophrenia in Acute Psychiatric Ward

Keywords:
psychoeducation, schizophrenia and service gap

References:
Abstract Summary:
We have provided psychoeducation program to in-patients with schizophrenia in acute psychiatric ward, but participants were fewer than we expected. Participants were young and had milder symptoms than non-participants, but insight and adherence did not differ significantly among them.

Content Outline:
1. Introduction
Schizophrenia is a severe and chronic disease characterized by lack of insight and poor adherence to treatment. To prevent relapse, psychoeducation is delivered to patients. Psychoeducation is a group intervention to share knowledge with patients, their relatives, and clinicians, about psychiatric symptoms, copings to relapse, effects by medication, and social support.
Patients with schizophrenia accounts for 60% of our acute psychiatric wards but only few patients attend our program. We thought that we could not provide our program to appropriate patients.
2. Objective
We studied to show the characteristics between participants and non-participants in our psychoeducation group program in acute psychiatric ward.

3. Methods
Subjects were 745 patients with schizophrenia who were admitted to two acute psychiatric wards in our hospital.
We collected information about age, agreement to admission, duration of hospitalization, physical complications, admission history within recent one year, insight, medication adherence, visit interruption, discharge destination, family support, family living together, Clinical Global Impressions-Severity Scale (CGI-S), Clinical Global Impressions-Improvement Scale (CGI-I), and Global Assessment of Functioning (GAF).

4. Results
A total of 331 (44.4%) were analyzed whose data has no loss.
89 (26.9%) joined our program more than one session, and 38 (11.5%) joined all of three sessions.
A rate of participation was higher in younger patients (age<50, 29.8%) than older patients (age>50, 13.6%) (p<.05).
Patients had milder symptoms (rated less than 4 by CGI-S) were more attend to a program than patients had severely symptoms (rated more than 5 by CGI-S) (p<.10).

5. Conclusion
The characteristics of between participants and non-participants in our program were subjects’ age and severity of illness. Participants in our program were younger (age<50), and with milder symptoms (rated less than 4 by CGI-S) than non-participants. We thought participants could attend a program because they had not severe symptoms and kept cognitive function enough to understand program. To offer our program to patients with severe mental state, we might need to consider to be appropriate their personal condition.
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