



Can a carer (peer) led psycho-education programme improve mental health carers wellbeing, reduce burden, & enrich empowerment 'A service evaluation study'

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3 **Can a carer (peer) led psychoeducation programme improve mental health**
4 **carers wellbeing, reduce burden, & enrich empowerment 'A service evaluation**
5 **study'**
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8 **Abstract**
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11 **Purpose:** Carers of people with mental health problems present with high levels of
12 burden, poor mental wellbeing and feelings of disempowerment by mental health
13 services. The aim of this study was to establish whether providing a
14 psychoeducation skills programme for carers would lead to an improvement of
15 mental wellbeing, reduce the levels of burden that carers sometimes feel in caring for
16 someone with mental illness, and also to increase empowerment. This paper
17 provides a service evaluation study of an innovative carer led psychoeducational
18 intervention that was undertaken.
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23 **Design/ Methodology/ Approach:** This programme was initiated and led by a carer
24 who had themselves experienced a lack of service provision to support carers and
25 families in understanding and caring for a relative with severe and enduring mental
26 health diagnoses. A model of co-production was adopted with the carer who led this
27 initiative working closely with an occupational therapist and consultant psychologist
28 in its development and delivery. Data was collected to measure the impact of the
29 training at 5 different time points. The measures employed to measure outcomes
30 were the Warwick- Edinburgh Mental Well-Being Scale (WEMWEBS), the Burden
31 Assessment Scale (BAS) and Family Empowerment Scale (FES).
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36 **Findings:** Results indicated improved well-being, reduced burden and increased
37 family empowerment in carers who completed this peer led carer initiative
38 psychoeducational programme.
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42 **Research Limitations/ Implications:** This service evaluation study was conducted
43 in a single site and in the site in which it was developed. The carer consultant who
44 led this evaluation and development of the intervention was also the peer worker
45 who delivered the interventions. Hence, we are unable to ascertain if the results
46 reported are unique to the individual peer worker. The transferability of this
47 programme and generalisability of the result should therefore be treated with caution
48 and further replication of this model and research is required. This would be
49 beneficial to be conducted in an alternative site from where it was developed,
50 delivered by different facilitators and include a control group.
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55 **Practical Implications:** The evidence from this study indicates that carers are able
56 and willing to attend a group psychoeducational programme. The high number of
57 referrals to the programme in a relatively short timeframe, indicates that there is
58 significant demand for such a service. Implementation of the programme is relatively
59 straight forward. The key challenges for practical implementation are to have the
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3 right carer to lead and deliver the programme, and the right support system in place
4 for them (financial and supervision). Co-production also is not without challenges,
5 the peer worker and occupational staff need to ensure mutually valued and
6 respected working relationship develop.
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10 **Originality Value:** This is the first evaluation of the impact of a carer led
11 psychoeducation intervention for carers of people with mental health difficulties in
12 secondary mental health services.
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15 **Key Words** Mental Health, Personality Disorder, Carers, Peer worker,
16 Psychoeducation.
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19 **Paper Type** Service Evaluation Study
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21 22 **Introduction**

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24 The purpose of psychoeducation is to increase knowledge, insight and
25 understanding of mental health and treatment. Psychoeducation for carers of people
26 with mental health difficulties has a growing body of research to support its
27 effectiveness (Cuijpers, 1999; Cassidy et al., 2001). Psychoeducation with carers of
28 people with mental ill health is thought to improve compliance with treatment and
29 reduce relapse (Sin et al., 2017). This project aimed to build on the existing
30 evidence, although it should be noted that there is a dearth of literature sharing carer
31 led initiatives. The aim of the project was to see if a feasible, practical and effective
32 model of a carer led psychoeducation and skills training programme could be
33 delivered successfully to carers of a family member with a variety of mental health
34 diagnosis. Participants additionally had to have family members whom were in
35 contact with secondary mental health services. This service evaluation was
36 conducted in a single site Northwest NHS Trust in England.
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43 This initiative was developed to support and educate carers of a family members
44 who had mental health difficulties including psychosis, personality disorder and who
45 were in treatment with community mental health teams, inpatient hospital admissions
46 or who were frequent attenders to accident and emergency. The principle outcome
47 was to ascertain whether psychoeducation can improve the mental wellbeing of
48 carers and reduce carer burden (McFarlane et al., 2003; 2012). Carers often report
49 feelings of isolation within the healthcare system due to lack of information around
50 diagnosis, financial difficulties, a sense of hopelessness and a system that can
51 stigmatise carers (Buteau, Dawkins, & Hoffman, 2008).
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56 A structured training programme has been developed by Hoffman & Fruzetti (2005)
57 called 'Family Connections'. Family Connections is a twelve-week manualised
58 education program for relatives of persons with borderline personality disorder
59 (BPD). The program provided (a) current information and research on mental illness,
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(b) coping skills, (c) family skills, and (d) opportunities to build a support network for family members. Using principles from Dialectical Behaviour Therapy family members are taught to be less judgemental, less critical and enabled to develop more effective interpersonal / communication skills (Gunderson and Hoffman, 2005).

Family interventions for psychosis have demonstrated reduced relapse rates for people with psychosis (Pilling et al., 2002). These programmes involve working with the service user and family together with the focus on improving the interaction and reducing high expressed emotions that can sometimes arise in families where somebody has psychosis (Barrowclough & Tarrier, 1997).

The programme developed and evaluated here 'Training, Education and Support' (TES) programme was however developed using the principles highlighted in the Family Connections programme (Hoffman & Fruzzetti, 2005). This training went beyond support and aimed to train carers in skills that enabled them to support family members who have difficulties with managing relationships and emotions more effectively (Gunderson & Hoffman, 2005). This programme however differs from that of family interventions in psychosis (Barrowclough & Tarrier, 1997) as it does not include both service user and carers. Having carer only groups enabled peer support networks to develop but also allowed for openness of discussion to raise self-awareness via the development of knowledge and skills. The training package was open to carers, family members of people who have array of mental health needs and was not restricted to those who had a psychosis or borderline personality disorder.

Project background

This programme was developed by a lived experience carer. The carer initially starting his journey by gaining a seat on the Trust board as a carer representative. This led to the carer being asked to join a team of occupational specialists and lived experience patients in the delivery of the nationally recognised personality disorder training (knowledge and understanding framework, KUF). The KUF training was an innovative co-produced and co-delivered model of training including both occupational experts and lived experience experts. The carer was one of the first carers to be trained nationally to deliver this training. Involvement in the KUF then led to the development of a bespoke locally developed carer intervention called CRISPS (Carers Require Information to Support Personality Symptoms). The educational initiatives described were driven by the development of an educational capabilities framework (National Institute for Mental Health in England NIMHE, 2003a) and the key policy document 'personality disorder, 'no longer a diagnosis of exclusion' (NIMHE, 2003b). The CRISPS programme was a carer led two-session awareness programme. From this training it emerged that the carers and families who took part felt they needed more skills in understanding the difficulties in living with personality disorder. The TES programme we evaluate in this paper was

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3 therefore subsequently developed. The content of this psychoeducational
4 intervention was led and developed in collaboration with a carer consultant, clinical
5 psychologist and occupational therapist. This co-production is also mirrored in its
6 delivery as the programme was led by a carer consultant and supported by a health
7 professional.
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11 A business case to take this forward, following conversations with commissioners
12 was submitted and subsequently a CQUIN (commissioning for quality and
13 innovation) was agreed to pilot the programme as an intervention. As part of this
14 CQUIN an agreement to audit and review the impact of the programme was agreed.
15 This led to contact with the Trusts Research and Audit Service who following
16 conversation reached the conclusion that this was not research but instead was a
17 service evaluation study, hence ethical approval was not required. The results and
18 overview of the data was shared with commissioners which has led to the carer
19 gaining a substantive NHS position as a 'Highly Specialised Peer Worker'. The data
20 and an analysis of the result are outlined within this paper.
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25 Why a Carer Programme?

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27 A quality standard for the provision of psychoeducation for carers and families was
28 highlighted in NICE guidance 88 (NICE, 2015). Higher family involvement has been
29 predictive of better outcomes (Mottaghypour & Bickerton, 2005) and this therefore
30 provided additional support and rationale for the development of this programme.
31 For many patients with mental health difficulties the crisis presentation is triggered by
32 relationship breakdowns. It is not uncommon for family, friends, carers to frequently
33 be themselves feel alone and there is nothing they can do and therefore a
34 psychiatric admission or more input is needed (Motlova et al., 2006). In some case's
35 this may be true but at other times it can be that a lack of understanding and skills at
36 managing people in distress can be facilitating and exacerbating the problem. Carers
37 are in themselves high attenders of health service care with often unexplained
38 medical symptoms and physical health difficulties that are associated with
39 psychological distress and feelings of alienation and distress (Shah, Wadoo & Latoo,
40 2010). The aim of this psychoeducation programme was to educate carers hence
41 reducing carer burden, enhancing well-being and empowering carers with greater
42 skill and knowledge.
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50 Why Carer Led?

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52 In recent years there has been an increased interest in mental health services in the
53 development of peer support roles for those individuals who had lived experience of
54 mental health difficulties. Peer based roles have been more widely used in
55 substance misuse and alcohol services and it is reported that these roles have
56 grown substantially within mental health services (Kilpatrick, Keeney & McCauley
57 2017). They explored if these roles were effective or merely tokenistic but cited
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clearly defined role and job specification being necessary in the implementation of this type of intervention to mitigate against this.

The rationale for having a carer led programme was that this could help with the engagement process and also provide the unique lived experience and sharing of what are often encountered complex challenges of being carer. Stigma for carers is still a significant problem and many models of mental health can put the family down as a cause for the person's problems, often not understanding the complex interactions that occur in families of people with mental health needs. Stigma for carers and family members of borderline personality disorder is particularly a problem (Kirtley et al., 2018).

Training Education and Support (TES)

The co-delivered programme comprised of up to 20, two-hour training sessions. The purpose of this study was to establish if the programme was able to have a positive impact on carer participant needs as measured by burden, well-being and empowerment. Carer participants were offered two educational awareness sessions based on either: Mental Health psychoeducation covering; Schizophrenia, Bi-Polar, Depression and Anxiety or Personality Disorder. Those who had a family member with co-morbidity could attend both awareness sessions. Following this they proceeded to attend five sessions of group-based learning, covering the following; 1. Invalidation 2. Validation 3. Improving Relationships 4. Coping with Emotions and 5. Managing Stressful Situations.

All sessions consisted of a power-point presentation outlining the different elements to be discussed, carers would also complete exercises within the session and also away from the session on their own experience so they can then relate to and understand how their family member experiences difficulties. The carers then progress to the final training and skills element, which is a twelve-module enhancing problem solving skills programme. Outcomes were measured at five different time points, which are indicated below (Table 1).

Table1 – The Training Programme Overview

Outcome Assessments Time Point 1	
Psychoeducation	Psychoeducation Session 1
	Psychoeducation Session 2
Outcome Assessments Time Point 2	
Family Skills Sessions	Family Skill 1 Invalidation
	Family Skill 2 Validation
	Family Skill 3 Improving Relationships
	Family Skill 4 Coping with Emotions
	Family Skill 5 Managing Stressful Situation
Outcome Assessment Time Point 3	
Problem Solving	Module 1 Understanding Mental Health Disorders.

Sessions	Module 2	Supporting Recovery from a Mental Health Disorder.
	Module 3	Relapse Prevention.
	Module 4	Manage Symptoms & Behaviours of Mental Illness.
	Module 5	Communication & Problem-Solving Skills.
	Module 6	Barriers to Listening.
	Outcome Assessment Time Point 4	
	Module 7	Conflict Situations.
	Module 8	Stages of Change in Behaviour.
	Module 9	Impact of Mental Illness on the Family.
	Module 10	Effect of Mental Illness on different family Members.
	Module 11	Setting Boundaries & Limits.
	Module 12	Enhancing Relationships Within the Family.
Outcome Assessment Time Point 5		

On completion of the programme carers were offered a point of contact with the peer carer who led the programme, this post programme support was optional.

Method of delivery

The education and skills components of this programme are delivered by a peer support carer, who has lived experience of caring for a family member with mental health needs and an experienced mental health practitioner delivering interventions and education in group formats. The peer support carer provides ongoing support to carers once the programme has ended and if a relapse re-occurs for six months after the programme. A small number of carers have accessed this support mainly for reassurance in how they are coping with situations.

Inclusion Criteria

This was primarily for carers of a family member with a mental health diagnosis and who may also experience psychosis or personality disorder amongst others and who are in contact with the secondary mental health services recovery team, assessment team, home treatment team, inpatient care, or mental health liaison. Additionally some carers in the geographical trust footprint were referred by primary care psychotherapist and local carer centres. This ensured that family members whom are less involved in the patients care were not excluded from the opportunity to receive this intervention.

Exclusion Criteria

Exclusion criteria included any carers under the age of eighteen as this project was project was aligned to adult services. We also excluded involvement of carers if it was deemed to be clinically inappropriate to work with them or if NICE guidance would recommend alternative approaches.

Recruitment

Recruitment and involvement in this study took place between 22nd September 2014 to 26th June 2017. Carers were identified initially either by their family members engagement within mental health services, primary care psychological therapies services, or local carer centres. They were then offered an appointment with the peer support carer either face to face or telephone to explain what the programme entails.

Methodology

The carers attending the training completed three assessment questionnaires; these were the Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007), The Burden Assessment Scale (Reinhard et al., 1994) and the Family Empowerment Scale (Kageyama et al., 2016) (Table 2).

Table 2 Outcome Measures

Outcome Measure's	Description
The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)	Includes 14 statements relating to feeling and thoughts
The Burden Assessment Scale (BAS)	Includes 19 specific questions to assess the perceived burden of carers
Family Empowerment Scale (FEM)	Includes 27 items /self-report scale for carers

Carers were asked to complete the questionnaires at five different time points over the course of the programme (Table 1). The first set of questionnaires were completed before the awareness sessions, hence ascertaining baseline knowledge and understanding of different mental health diagnoses i.e. Schizophrenia, Bi-Polar, Depression, Anxiety, Personality Disorder. The second set of questionnaires were completed after the awareness sessions, hence on completion of the two educational awareness sessions based on either Schizophrenia, Bi-Polar, Depression, Anxiety or Personality Disorder. A further measure was taken on completion of the skills training programme component. Then finally carers completed the questionnaires at the halfway stage and at the end of the problem-solving modules. In total 166 carers were recruited to the programme. Sixty-three did not take a place on the programme and withdrew prior to commencing. Thirty-eight participants partially completed the programme dropping out after the mental health awareness sessions, as they opted as only wanting the awareness sessions, not the full programme. A further five participants only completed some of the programme due to their personal circumstances changing. In total sixty fully completed the programme and are reported within the results of this paper (Table 3).

Table 3 – Participant Programme Engagement

Total Carer Referrals	166
Carers who did not engage from start	63
Carers who attended awareness only	38

Carers who left due to personal reasons	5
Carers who completed the whole programme	60

In total the results of seven completed groups are reported within this paper. Five of the groups were made up of nine participants, one of eight participants and one of seven participants.

Results

All sixty treatment completers engaged in the measuring of outcomes. Each of the three scales (Mental Health & Wellbeing, Burden Assessment and Family Empowerment) were completed by each individual at five different time points throughout the course. Only those who completed the programme (N=60) were included in this analysis and 70% were female and 30% were male. All participants to complete the programme also completed the evaluations at each of the timepoints outlined.

Patient Diagnosis

The identified diagnoses of the patients whom carers were supporting were varied as can be seen in Table 4. A majority of those who took part identified with their family member having a diagnosis of either borderline personality disorder or bi-polar disorder. A smaller sample identified their family member as having a depression or anxiety related disorder and a very small number identified schizophrenia as being the patient's diagnosis.

Table 4 – Patient Diagnosis

<i>Patient diagnosis</i>	%
BPD	45.0
Depression/anxiety	13.3
Bi-polar	31.7
Schizophrenia	3.3
BPD/anxiety	5.0
BPD/bi-polar	1.7
Total	100

The following (Table 5) displays the Mean (SD), *N* on each scale at the five different time points for each of the outcome measures used;

Table 5 – Outcome measure results at the five different timepoints.

Mental Health and Wellbeing Scale

Time point	Mean (SD)	N
1	40.83 (9.77)	60
2	44.35 (8.22)	60
3	45.85 (8.63)	60
4	47.47 (8.14)	60
5	49.42 (9.45)	60
Burden Assessment Scale		
Time point	Mean (SD)	N
1	46.08 (11.60)	60
2	39.63 (12.19)	60
3	37.63 (10.83)	60
4	36.48 (11.31)	60
5	34.28 (10.45)	60
Family Empowerment Scale		
Time point	Mean (SD)	N
1	80.20 (19.49)	60
2	85.15 (20.02)	60
3	88.63 (20.21)	60
4	90.28 (20.74)	60
5	96.17 (19.61)	60

Inferential Statistics

A one-way repeated measures ANOVA was used to ascertain if there was a significant difference somewhere among the scores on each scale between the five different time points. The ANOVA revealed that the mean scores on the Mental Health and Wellbeing Scale were statistically significantly different ($F(3.167, 186.846) = 21.840, p < 0.05$). In relation to the Burden Assessment Scale there was also a statistically significant difference ($F(3.214, 189.654) = 25.734, p < 0.05$). The mean scores on the Family Empowerment Scale were also statistically significantly different ($F(2.633, 155.363) = 16.998, p < 0.05$).

ANOVA however does not tell us between which specific time points the differences in scores were significant, just that there was an overall variance. In order to identify which means differed on each scale and at what time points, it is necessary to conduct further post-hoc tests. To ascertain where the specific significant differences occurred, a series of Bonferroni post hoc tests were performed, which allows us to make comparisons as to which of the mean scores differed between the five different time points.

Table 6 below show the p values generated from the post-hoc tests and indicate if there was a significant difference in individual's mean scores between each of the five time points on each of the scales. (* denotes significant at the <0.05 level)

Table 6 - Mental Health and Wellbeing Scale

Time point	1	2	3	4	5
1	-	0.03*	0.00*	0.00*	0.00*
2	-	-	.928	0.02*	0.00*
3	-	-	-	0.80	0.00*
4	-	-	-	-	0.09

Burden Assessment Scale

Time point	1	2	3	4	5
1	-	0.00*	0.00*	0.00*	0.00*
2	-	-	1.00	0.09	0.00*
3	-	-	-	1.00	0.00*
4	-	-	-	-	0.02*

Family Empowerment Scale

Time point	1	2	3	4	5
1	-	0.08	0.03*	0.03*	0.00*
2	-	-	1.00	0.25	0.00*
3	-	-	-	1.00	0.00*
4	-	-	-	-	0.00*

From the post hoc tests in relation to each scale the mean scores increased significantly between the time points indicated by the asterisks.

In relation to the Mental Health and Wellbeing Scale, although the scores increased between all the time points, 2-3, 3-4 and 4-5 were not significant. It is important to note however that the scores on the Mental Health and Wellbeing scale display that from time point 1 through to time point 5 the scores did increase at each point and were statistically significant. Why they did not increase between the other time

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3 points is unclear. But an increase in mental health and wellbeing is indicative of
4 positive outcomes.
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7 In relation to the Burden Assessment Scale, again, there was a decrease in the
8 mean scores from time point 1 – time point 5 overall, which is indicative of a positive
9 outcome and reduced burden. There was not a significant decrease in the mean
10 scores from 2-3, 2-4 and 3-4.
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13 On the family empowerment scale, again the significant increases indicated
14 increased reports of being empowered hence a positive outcome. The asterisks
15 indicate mean scores. Interesting that on this scale there is no significant increase in
16 scores from 1-2. Also there is no significant increase from time 2-3, 2-4 and 3-4.
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19 The overall message from the results is that the programme obviously had a positive
20 impact on all three aspects that were measured. The means all fell in a positive
21 direction, although a handful were close to but not statistically significantly different.
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24 **Limitations**

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27 This service evaluation study was conducted in one site and the site in which it was
28 developed. The carer consultant who led this evaluation and development of the
29 intervention was also the peer worker who delivered the interventions. What is not
30 known is, are the results unique to the individual peer worker. The transferability of
31 this programme and generalisability of the results should therefore be treated with
32 caution and further replication of this model and its delivery in another site with
33 different trainers, is therefore required. There were a disproportionate and increased
34 number of carers who identified their family member as having borderline personality
35 disorder and bipolar disorder, compared to other identified disorders. The results
36 analysed include programme completers only, and therefore we do not establish or
37 report why others dropped out after the mental health awareness stage or why a
38 third of participants chose not to engage in the skills and problem-solving
39 components. Hence the results presented within this paper may have been skewed,
40 as it could be assumed that those who complete the programme were by virtue of
41 their engagement inevitably going to report positive experiences. Conversely it could
42 be argued non-completers or those who chose not to complete the full programme
43 may have reported different experiences.
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51 The use of a waiting list control group to provide comparisons of the effect of the
52 intervention would have strengthened this study. If further replication studies testing
53 out the effectiveness of this study were carried out, this should be considered and
54 should therefore move beyond service evaluation into a powered research study.
55 Any replication study also should include different trainers to establish if the carer
56 who developed and delivered all training in this study is in fact the active ingredient
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3 or if the content of this intervention can be delivered with similar results by other
4 carer peer support workers, hence displaying the transferability of the intervention.
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7 **Discussion**

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9 The positive findings from this service evaluation study can be seen to support the
10 view that a psychoeducational programme is able to positively improve the mental
11 wellbeing of carers and reduce carer burden, whilst also improving empowerment.
12 The highly encouraging results from analysis of the three outcome measurements
13 (mental health wellbeing, burden and empowerment) demonstrated that the
14 programme had a positive impact from baseline to end measurement for carers of
15 family members with mental health difficulties. The results also suggested that the
16 programme had a positive, incremental effect across each of the five, measured time
17 points. The post-programme support that is offered to participants could also ensure
18 that the impact of the programme is continuous and that improvements in
19 participant's mental health wellbeing, reduced burden and enriched empowerment
20 are not lost once the programme has ended.
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26 This is the first evaluation of the impact of a carer led psychoeducation intervention
27 for carers of people with mental health difficulties in secondary mental health
28 services. The evidence from this study indicates that carers will engage with and are
29 able to attend a carer peer led psychoeducational programme. The number of
30 referrals from the programme also indicates that there is significant demand for such
31 a service. Implementation of the programme is relatively straight forward. The key
32 challenges for practical implementation is have the right carer to lead and deliver the
33 programme, the right support system in place for them (financial and supervision).
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38 The results indicate that although almost half did not engage or only partially
39 engaged with the programme. A third of participants who partially completed the
40 programme leaving post psychoeducation group indicates that understanding of their
41 family members presenting condition is of great importance. However, we did not
42 explore why they chose to discontinue the programme prematurely. A larger
43 proportion however completed the full programme and therefore are indicative of
44 carer commitment to learn not just about the mental health problems but also to
45 explore their own skills to support and coping mechanism skills development. It
46 could however be argued that those who completed and who's results are analysed
47 here may have provided skewed data. As by completing the programme this could
48 be indicative of satisfaction with the programme.
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54 This model of carer peer psychoeducation programme does provide evidence that
55 with the correct structures and supportive systems in place, a co-delivered but peer
56 led carer initiative in mental health carer programmes should be embraced and
57 further developed and researched. The role of the peer carer roles however required
58 not just supportive and supervisory practice but also investment to ensure that
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3 financially these roles are embraced, funded and supported giving meaningful and
4 paid opportunities for people with lived experience of caring to share their expertise
5 and provide support to other people with similar experiences.
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9 What we do not know, as there was no follow up is the durability of the outcomes
10 reported. Training evaluations have indicated that once complete the effectiveness
11 can decline and that learning during the intervention or learning phase is always
12 going to show some impact (Health Foundation, 2012). The measures however
13 were not measuring knowledge generation but instead were measures of wellbeing,
14 burden and empowerment. We also do not know if this programme and its impact is
15 due to the delivery team, who also developed this programme and hence have had a
16 unique impact or whether the programme is transferable and has potential to show
17 similar results if delivered in a different locality with a different training team. It is
18 anticipated that a further evaluation and sharing of this programme in a different area
19 will be performed to establish its potential transferability and generalisability of the
20 findings reported here. Very low numbers of people with family members with
21 schizophrenia engaged in this training and the reasons for this unclear.
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27 **Conclusion**

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29 This is the first evaluation of the impact of a carer led psychoeducation intervention
30 for carers of people with mental health difficulties in secondary mental health service
31 and the positive results from the analysis of the three outcomes of improved mental
32 wellbeing, reduced burden and enriched empowerment indicate that peer carer
33 supported opportunities should be encouraged and supported. This project has
34 identified that peer developed and delivered programmes are well received by carers
35 of people with mental health difficulties. That psychoeducational component is in
36 highest demand and additional skills development are also welcomed and embraced
37 by carers of people with mental health difficulties. The peer carer delivering and
38 leading this process has been well received and this innovative programme has
39 displayed promising outcomes. The challenge now is in being able to further
40 replicate this in another locality, to establish if it's the training programme, the model
41 of delivery or the specific delivery contributors that have been responsible for the
42 results indicated. Implementation of the programme is relatively straightforward. The
43 key challenges for practical implementation is have the right carer to lead and deliver
44 the programme, the right support system in place for them financially and with
45 supervision.
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53 **Key components for the replication of this project**

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60 | 1. A Peer Worker (Carer background) will need to be identified alongside occupational expertise to support and deliver the programme in co-production however with the peer worker taking a non-tokenistic and leading role. Support structures and institutional buy in will be required. |
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2. There will be a requirement for support or time factored into the peer workers role to ensure the necessary administration duties are complete within the programme.
3. We strongly advocate that peer support workers should be valued and paid roles. Hence the development of a clear job description and personal specification for the training role is required.
4. Time will be required to develop an effective recruitment campaign, this may be via advertising and raising the profile of the project for carers. However furthermore the team supporting this project should ensure they also attend team meetings and spread the word to the practitioners on the front line of clinical practice.
5. Ongoing supervision of the peer worker by professionals supporting the project will be required.
6. Anyone interested in find out more about this initiative should make contact with the corresponding author who is willing to discuss and keen to provide train the trainer type opportunities for those wishing to replicate this work.

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