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Special points of interest:

- This should take no longer than 1 hour to prepare
- First time you undertake a journal club in this way it may be a bit nerve-wracking

but….

- It should be fun to conduct and attend
- It should begin and end on the practical day-to-day clinical situation

Inside this guide:

Psychoeducation for schizophrenia - THE LEADERS GUIDE

Produced by the Editorial base of the Cochrane Schizophrenia Group
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from
Xia J, Merinder LB, Belgamwar MR. Psychoeducation for schizophrenia. Cochrane Database of Systematic Reviews 2002, Issue 2. Art. No.: CD002831. DOI: 10.1002/14651858.CD002831.

Background explanation

Thank you for giving this guide a go. The idea behind this is to make things easier for you when you lead the journal club.

Journal clubs are often difficult to conduct and far removed from clinical life. Even if the leaders do prepare well, those turning up may be more in need of lunch, coffee or a social time than practical academic stimulation and the implicit pressure to read a difficult paper.

This suggested design is an attempt to allow for those needs, whilst getting the very best out of the session.

This journal club design should really help those attending see that this research may have some clinical value.

What you will need to do is:

- ☑ Have a good read of this
- ☑ Then read the review to which this is attached.
- ☑ Distribute the review to those attending well before the club
- ☑ Make more copies for those turning up on spec
- ☑ Do not really expect many to have read the review

PRINTING GUIDE

Pages 1-4 - one copy for you

Pages 5-6 - one copy for each participant - distributed at **start** of journal club

Page 7– one copy for each participant distributed at **end** of journal club

Page 8 - one copy for you to collate feedback

Full review for everyone

Try to find a colour printer that does double sided printing

The three parts

Part 1. Set the clinical scene (5 mins)

Be clear, but really make the participants feel the pressure of the situation...just like you would in clinical life

Part 2. Critical appraisal of the review (20 mins)

Get participants to list what is needed from the review before managers arrive, get them to talk, split into groups—with a feeling of urgency.

Part 3. Use of evidence in clinical life (20 mins)

Having distilled the evidence use role play to see how the participants would use what they have learned in everyday life.

Part 1.1 Setting the scene – Manager meeting

Introduce participants in the journal club to their scenario

Cutbacks are coming.

You lead a multidisciplinary team and you have been asked to see if delivery of information to patients with schizophrenia can be made more efficient.

You have to attend the managers meeting and know that you will be asked to justify the form of the education you give to patients regarding serious mental illness.

Currently this is in the form of one-to-one meetings with health care professionals, service users and/or their family.

Questions for participants:

Q 1. What do you think the managers may ask?

A 1. [Suggestion] "Well, doc, what is the most efficient way of delivering the psychoeducation?"

Q 2. What do you think they mean by 'efficient'?

A 2. ***List*** the suggestions from participants as these are what the managers will come back to in the role play

Q 3. What do you think service user will ask?

A 3. Again, list answers.

Part 1.2 Setting the scene – the Journal club

Complicate the scenario by adding the need to attend this journal club

Knowing you are due to see the managers in less than an hour you are nevertheless compelled to attend journal club.

You have not had time to read the paper and need some lunch.

By a stroke of luck the paper for discussion focuses on the value of psychoeducation.

Questions for participants:

Q 1. If you had not had this paper fall into your lap where might you have gone for reliable information?

A 1. There are now lots of answers to this - The Cochrane Library, Clinical Evidence, NICE Technology Appraisals.

Anything that has a **reproducible method** by which results are obtained.

Part 2.1 Critical appraisal of the review

For every review there are only three important questions to ask:

1. Are the results valid?

2. What *are* the results?

3. Are the results applicable to Patient?

You now have only 20 mins to get participants though this large review. To do this quickly is not easy, especially as many will not have read the paper in preparation.

Suggestion: Ask participants what salient facts they want to know - especially considering their tight time-scale.

Remind them that managers meeting is now in about 20 mins.

You should be able to fit most of the suggestions supplied by participants into the three categories of question outlined above.

Read 2.2 as this give more detail of the issues that will, in some shape or form, be supplied by the participants.

If they are not lively—give them a hand.

Do not panic. Bright journal club attendees will come up with all the answers—your job is to help focus their efforts and categorise their answers.

Do not be worried by silence.

Take time to read and think about the review - this is the only time-consuming bit

LIST 1:

1.

2.

3.

4.

5.

List 2:

1.

2.

3.

4.

5.

Participants will think of most of the issues - you just need to catch them and write them on a board or flip chart

Part 2.2 The three parts of appraising a review

1. Are the results valid?

There is no point looking at the result if they are clearly not valid.

a. Did the review address a clearly focused issue?

Did the review describe the population studied, intervention given, outcomes considered?

b. Did the authors select the right sort of studies for the review?

The right studies would address the review's question, have an adequate study design

c. Do you think the important, relevant studies were included?

Look for which bibliographic databases were used, personal contact with experts, search for unpublished as well as published studies, search for non-English language studies

d. Did the review's authors do enough to assess the quality of the included studies?

Did they use description of randomization, a rating scale?

2. What *are* the results?

a. Were the results similar from study to study?

Are the results of all included studies clearly displayed?

Are the results from different studies similar?

If not, are the reasons for variations between studies discussed?

b. What is the overall result of the review?

Is there a clinical bottom-line?

What is it?

What is the numerical result?

c. How precise are the results?

Is there a confidence interval?

3. Can I use the results to help the meeting?

a. Can I apply the results to my service users?

Is my client group so different from those in the trial that the results don't apply?

b. Should I apply the results to my service users?

How great would the benefit of therapy be for these people?

Is the intervention consistent with my clients' values and preferences?

Were all the clinically important outcomes considered?

Are the benefits worth the harms and costs?

Part 2.3 Doing the appraisal

Having managed the interactive session with the participants - acquiring the three questions that need to be addressed by those appraising a review and some idea of how to answer each of those questions - now divide the room into three.

Apportion one of the questions per group and ask each group to get a feel for the whole review (1 min) but to focus on answering their particular question for the rest of the participants (5 mins or so).

Encourage talking to each other.

Move round the room to help the groups if they seem to need it.

Have your copy of the review marked up with where they may look for answers -although in a good review it should be obvious.

Stop the flow after about 10 minutes and ask each group to report in turn.

Do Group 1 really think that the review uses valid methods? Why?

After the first group's report you may want to ask everyone to vote whether to proceed or not.
If they agree to proceed —see if you can **get Group 2 to give you the clinical bottom line.**

We suggest that the Graph providing data for 'Global impression: 1. Not clinically improved – for people with treatment resistant illnesses' best fits Patient's request of information about getting 'better'.

And from **Group 3 get some feel of how applicable the findings are.**

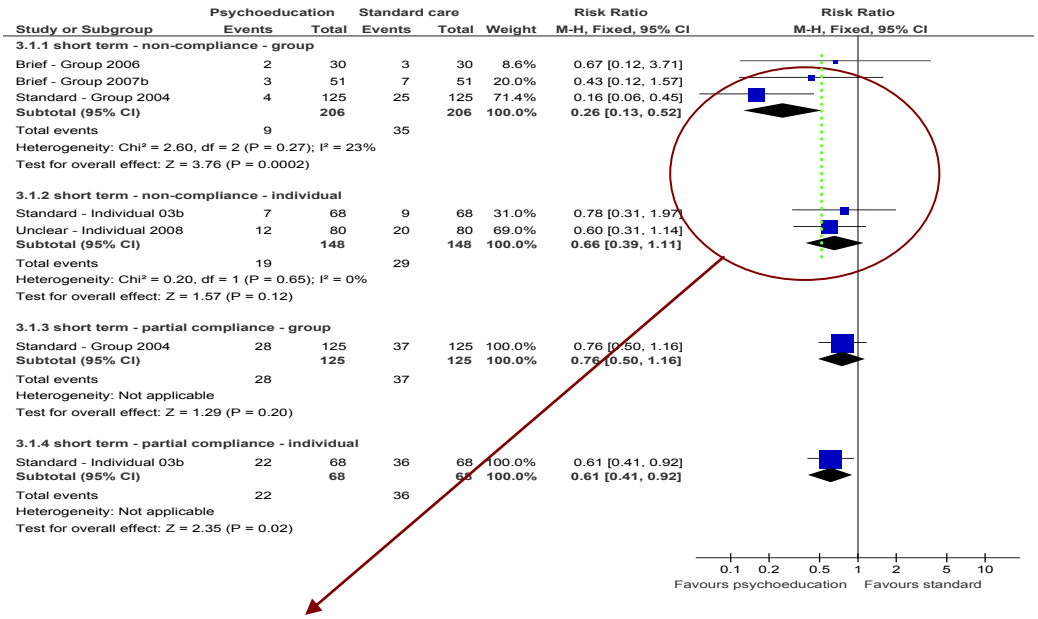
There is no point proceeding to the second question if journal club participants think the results are not valid

"Well, doc, what is the most efficient way of delivering the psychoeducation?"

Part 2.4 Interpret numerical outcomes

COMPARISON 3 SUBGROUP ANALYSIS 2. GROUP PSYCHOEDUCATION/INDIVIDUAL PSYCHOEDUCATION vs STANDARD CARE

Outcome 3.1 Compliance: 1a. With medication - binary outcomes



Outcome 3.1.1 are all the short term data on non-compliance with medication for the GROUP interventions- whether brief or longer. 3.1.2 is the same outcome but for where the treatment is given one-to-one. Look at the graph - the summary diamonds of each overlap (0.52 and 0.39) - and non-overlap means they are not really different. If anything GROUP may be better for reduction of non-compliance.

We have not pasted in the graphs for RELAPSE as an outcome - but it is no different.

Part 3. Managers meeting

This is the most important part of the journal club - the *practical application* of what knowledge you have gained.

This is one way of doing it.

Set out chairs in consultation style. Do not call for a volunteer - just nominate someone to be the clinician and you be the managers.

Make sure that the clinician feels they can have time to ask their [relieved for not being singled out] colleagues for help [remember - this has got to be a combination of practical and fun].

Back on page 2 there are suggestions for what managers may ask - use them.

"Well, Doc, what is the most efficient way of delivering the psychoeducation?"

See if they can put across in a supportive way the best evidence as they understand it.

There is no perfect way to do this - but perhaps something like this:

"The best evidence we have is from less than perfect trials - but we think there may be a way of delivering the same information in a way that will be more cost effective. A group approach may work just as well. We could audit our drug compliance and relapse rates for 6 months while we work out how to run the groups, then run the groups and see if this rate changes."

What do YOU mean by "efficient"? would be a good next question.

Again there is no right answer but think about how to put into words what the research outcome really means.

Perhaps - "Efficient probably means more cost efficient - and we do not have good data on costs. However, time of practitioners is a big factor in costs as is relapse. If we use these outcomes as proxies for 'efficient' then if we set up groups to be run by two people for 10 patients we could compare before and after setup-time and run-time."

As has been said - there is no right answer and all depends on personal style and situation. Your job is to encourage the best answer out of the clinician.

If it is going well there are other questions that you may ask - see side **Box 1**.

Box 1. Additional questions

☑ **What *are* the odds of patients getting better, Doc?**

You could be numerical here - but do you understand them yourselves? Can you put Relative Risk into words? Graph 1.18 - providing data on 'Global functioning' is a good one to use. Graph shows that there is no significant difference in the short term, but in the medium term between 3 months to one year, about 1 in 4 people do manage a conically significant improvement in Global functioning.

☑ **If we allow the psychoeducation programme to continue, how much of**

your salary would you put on patients avoiding relapse in the coming year?

Graph 1.7 is a good one to use to answer this question. Outcome data is in favour of psychoeducation in both medium terms of up to one year and long term of over one year - about 1 in 9 people receiving psychoeducation manage to avoid relapse in one year.

☑ **If we reduce the length of therapy to lower cost, would it jeopardise the overall effectiveness of the intervention?**

Result of subgroup analysis indicates that the effect of brief psychoeducation and standard psychoeducation are equivocal. Standard length psychoeducation seems slightly better at reducing relapse than brief psychoeducation, but the difference is not significant.

CATmaker

This can be part of a store of Critically Appraised Topics - see CATmaker online

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End on a positive note. Feedback how in a matter of minutes they have got though the bare bones of a big review, appraised and applied it—and, you hope, enjoyed doing it.

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Special points of interest:

- The idea of this is to lead you from the clinical situation, trough the research and back to the real-world clinical situation again
- You may or may not have read the paper - but even if you have not that does not mean that you cannot get something out of this

- Make sure you participate, and speak up - you will have to in the real clinic
- There is no perfect way of doing this - each person has an individual way of interacting and conveying information

Psychoeducation for schizophrenia - HANDOUT FOR PARTICIPANTS

Produced by the Editorial base of the Cochrane Schizophrenia Group
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Managers *will* arrive soon

What do you think managers may ask?

List:

1.

2.

3.

4.

5.

If you had not had this paper fall into your lap where might you have gone for reliable information?

What key points do you need to know to see if this review can help?*

1.

2.

3.

4.

5.

***managers arrive in 30 mins**

After discussion do you want to change the key points you need to know to see if this review can help?*

1.

2.

3.

***Managers arrive in 10 mins**

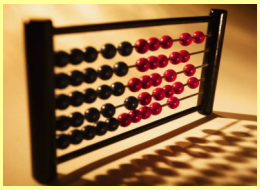
Can you extract numbers that will be useful to you and the managers?

Clue: focus on what you think managers may ask - main effects - graph 3.1.1a may be a good one to use

1. Can you put relative risk into words?

2. Are there any improvements *attributable* to use of Psychoeducation?

3. Can you interpret the numerical outcomes concerning relapse?



The arithmetic is not complicated

4. Can you compare the effectiveness of brief and group psychoeducation? Can you put relative risk into words

Managers arrive

Is there a good use of words you would want to use?

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Special points of interest:

- Best evidence suggests that clinically focused problem-based learning "has positive effects on physician competency" even long into the future. [1]

1. Koh GC, Khoo HE, Wong ML, Koh D. The effects of problem-based learning during medical school on physician competency: a systematic review. CMAJ 2008; 178(1):34-41. (free online)

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Psychoeducation for schizophrenia - PARTICIPANTS' CRIB SHEET

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Interpret numerical outcomes (Graph 3.1.1a)

Outcome 3.1.1 are all the short term data on non-compliance with medication for the GROUP interventions- whether brief or longer. 3.1.2 is the same outcome but for where the treatment is given one-to-one. Look at the graph - the summary diamonds of each overlap (0.52 and 0.39) - and non-overlap means they are not really different. If anything GROUP may be better for reduction of non-compliance.

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Thank you

This is one of 40 Cochrane Schizophrenia Group Guides for Journal Clubs

A full list is found on

http://szg.cochrane.org/journal-club

Psychoeducation for Schizophrenia - FEEDBACK

Date and place of journal club

1. How many attended?

About

2. What was the background of the people attending? (please tick)

Health care professionals

Consumers

Policymakers

Undergraduate

Postgraduate

Others

3. Marks out of ten compared with usual journal club

(10=much better, 5=same, 0 = much worse)

Free text feedback