Doctoral Dissertation

博士論文

Intervention Study for Promoting Partnership between Self-Help Groups and Professionals

— Group-Randomized Trial for Groups of Families with the Mentally Ill —

セルフヘルプ・グループと専門職とのパートナーシップ促進のための介入研究

— 精神障害者の家族会を対象としたグループ無作為化試験による有効性の検討 —

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CONTENTS

INTRODUCTION 1

METHODS 3

Design 3

Conceptual framework 3

Ethics 4

Subjects and Procedures 5

Intervention program 6

Variables 8

Statistical analysis 10

RESULTS 11

Member subjects 11

Characteristics of the experimental and control groups 12

Program implementation 13

Effects of the intervention 14

Control of groups 15

Process evaluation 15

DISCUSSION 15

Significance of the study 15

Effects of the intervention 16

Applicability in practice 19

Limitations and perspectives 19

CONCLUSIONS 21

ACKNOWLEDGEMENTS

REFERENCES

FIGURES

TABLES

APPENDIX

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INTRODUCTION

Self-help groups are voluntary associations composed of persons who share a common problem. The number of self-help groups and members has been growing in many countries (Humphreys & Rappaport, 1994; Kessler, Mickelson, & Zhao, 1997; Kichbusch & Hatch, 1983). Also, the effectiveness of self-help groups has been shown in many outcome studies (Gould & Clum, 1993; Kyouyz & Humphreys, 1997). Thus, self-help groups have become an important element in health and health services (Jacobs & Goodman, 1989; Norcross, 2000), as a resource replaced for non-existent service (Adams, 1990; Gartner, 1997). This background necessitates studies of the relationship between self-help groups and professionals (Stewart, Bank, Crossman, & Poel, 1994). Many of the studies on the relationship have focused on the roles of professionals, or the mutual attitudes of professionals and members (Kurtz, 1997). The results were that most of the professionals and members have mutually positive attitudes and have been working together (Katz, 1993; Stewart, 1990b; Wilson, 1993). In order to establish a positive working relationship, several studies have indicated that a model guiding the establishment of the relationship is necessary (Auslander & Auslander, 1988; Wollert, Knight, & Levy, 1980).

As a desirable relationship model between self-help groups and professionals, several researchers have suggested a consultation model (Auslander & Auslander, 1988; Wollert et al., 1980), a shared leadership model (Gartner, 1997; Yoak & Chesler, 1985), and a partnership model (Katz, 1993; Miller, 1985; Srinivasan, 2000; Stewart et al., 1994). In particular, the partnership between lay people and professionals has been recognized as one of the essential subjects in the 21st century (Clark, 1997; Coulter, 1999; NHS Executive, 1996). Stewart (1990a) indicated that the partnership between self-help groups and professionals is an interdependent alliance characterized by cooperation, collegiality, balanced responsibilities, mutual respect, equality of status, shared decision making, and linkage functions. The partnership model is different from the consultation and the shared leadership models in terms of the following

characteristics. First, the partnership model allows for regular and frequent contact with no time limitation (Miller, 1985), whereas the consultation model is limited (Caplan, 1970). Second, the partnership model has dynamism to adapt flexibly to the situation of each partner (Stewart et al., 1994; Towle & Godolphin, 1999), whereas the shared leadership model always demands both self-help groups and professionals to share leadership, no matter what the circumstances are. For these reasons, the author has supported the partnership model.

Self-help groups of families with the mentally ill have addressed members to reduce the feelings of guilt and self-blame (Medvene, 1989b; Kurtz, 1997), to alleviate caregiver burdens (Cook, Heller, & Pickett-Schenk, 1999), to increase comfort in parent-child relationships (Medvene, 1989a), to acquire knowledge and information about mental illness (Norton, Wandersman, & Goldman, 1993), and to help families cope (Gidron, Guterman, & Hartmen, 1990; Norton et al, 1993). ZENKAREN, which is an acronym for the National Federation of Families with the Mentally Ill in Japan, was initiated in 1965 as the sole nationwide self-help organization for families with the mentally ill. The number of local groups belonging to the organization was 1,643 as of March 2001 (ZENKAREN, 2001), and has been growing year by year. The purposes of the local groups are to provide emotional support for families, to educate families about mental illness, to lobby for more services, and to raise public awareness for persons with mental illness. Most local groups were initiated and have been supported by professionals (Kageyama, Kanagawa, Oshima, & Oketani, 2000), in part because of local professionals' public responsibility to support self-help groups in the mental health and welfare fields (Ministry of Health and Welfare, 1997). In view of these backgrounds, it is appropriate to apply the partnership model to the relationship between local groups of families with the mentally ill and professionals in Japan.

Wollert et al. (1980) and Auslander & Auslander (1988) have conducted intervention studies, which applied the consultation model to self-help groups and professionals, in order to examine a desirable relationship between the parties. In these studies, professionals were involved with the self-help groups as consultants experimentally, with the result of positive effects for both the self-help groups (Wollert

et al., 1980) and professionals (Auslander & Auslander, 1988). Although Stewart et al. (1994) proposed strategies for promoting partnership between self-help groups and professionals based on their research findings, to my knowledge, no intervention study has applied the partnership model to self-help groups and professionals. In addition, to my knowledge, the effects of a program for promoting a positive working relationship have never been assessed in a randomized controlled trial.

The purpose of this study was to examine the effects of a program for promoting partnership, which was based on the partnership model proposed by Stewart et al. (1994), among local self-help groups of families with the mentally ill and professionals in Japan.

METHODS

Design

This study was an intervention study of family group "units" randomly assigned to intervention conditions. The group randomization design was chosen because of the very nature of this intervention, which promotes partnership between family groups and professionals. The study involved three types of subjects; family groups which were units of group randomization, members who belong to the groups, and professionals who were involved with the groups. With regard to the analysis, the author used a method based on an individual as unit of analysis, in addition to a method based on a group as a unit.

The term of the intervention was 6 months. The subjects were assessed twice at the baseline just before the intervention started and at 6 months just after the intervention. Time schedules in the experimental group and the control group over the intervention period are shown in Figure 1.

Conceptual framework

The conceptual framework of this study, which is shown in Figure 2, was

based on literature on self-help groups and discussions with local groups of families with the mentally ill. The author understood family groups based on the ecological framework proposed by Maton (1989): community-level, organizational-level, and individual-level. At the individual-level, furthermore, individual members were understood both in the nature of group involvement and in terms of personal characteristics. Promoting partnership between family groups and professionals would have some benefits for both the family groups and professionals (Comstock & Mohamoud, 1989; Stewart et al., 1994). Those benefits are shown in the figure. The benefits assessed in this study are marked with an asterisk.

Ethics

Tebes & Kraemer (1991) indicated that randomized controlled trials should not be applied to self-help groups without consideration of the unique complexities of self-help research. In addition to the general issues based on the Declaration of Helsinki (World Medical Association, 1997), this study had ethical considerations regarding the unique issues of the relationship between self-help groups and professionals (Lavoie, Farquharson, & Kennedy, 1994). With regard to the general issues, informed consent was obtained, and the control group was assured of almost the same intervention after the intervention period. With regard to the unique issues, the author took into account two points related to the nature of the self-help groups. First, in order to respect autonomy, integrity, and group culture, the author never invaded the right of self-determinations of both the groups and members (Lavoie et al., 1994), nor controlled the intervention tightly because these actions might lead to distortion of the nature of the self-help groups (Powell, 1993), and confirmed that the involvement of professionals did not contribute to losing control of the groups. Second, in order to respect confidentiality, the researcher did not obtain access to individual data such as name, address, or telephone number.

The author discussed ethical issues of this study adequately with staff of ZENKAREN, especially, with regard to how to identify members and how to record activities in the meetings. Through the discussion, for instance, the following methods

of recording activities in the meetings were decided. Those were that all records of the meetings must be in writing without operating a tape recorder, the researcher must not write the members' name in order not to publicly identify individuals, and the researcher should obtain informed consent before recording. With due ethical consideration, the author obtained the approval of the board of directors of ZENKAREN.

Subjects and Procedures

The study involved three types of subjects; family groups, members who belong to the groups, and professionals who were involved with the groups.

Family group subjects and professional subjects. Eligible criteria of the family groups were: 1) an affiliate of ZENKAREN (meaning that a leader is a family, even if only a leader on paper); 2) a community-based group; 3) frequency of meetings of one or more per month (taken from another survey); 4) in the Kanto area (the Capital and its neighboring prefectures). Two groups, which were the subjects of a preliminary study for this study, were excluded. Professional subjects were those who have public responsibility for supporting community-based self-help groups for families of the mentally ill. Most of professional subjects were public health nurses with formal qualifications or social workers with education in social welfare. In addition, the author included clerks of the administrative welfare department among professional subjects, because they have public responsibility to support self-help groups for families of persons with disabilities.

To respect the right of self-determinations by groups, the author first informed the family group subjects of this study. If the group wished to participate in this study, next, the professionals who were listed by the group were informed. Of the 127 eligible groups, 2 were excluded, 80 responded and 61 wished to participate in the intervention (see Figure 3). The groups, which one or more professionals wished to participate in the study, were 24 groups. The 24 groups were randomly assigned to either an experimental group or a control group. Twelve family groups and 15 professionals made up the experimental group, and 12 family groups and 14 professionals made up

the control group.

Member subjects. Members were informed of this study in a meeting before the intervention or by mail and made an independent choice from the groups which had already consented to participation in this study. After the intervention period, both questionnaires at baseline and at 6 months were matched by demographic data of the member and member's relative with mental illness. Such a matching method has been used among anonymous self-help groups (e.g., Koren, DeChillo, & Friesen, 1992). Of the matched data, members who satisfied all of the following eligible criteria were member subjects in this study: 1) attending 5 or more of a total of 7 meetings over the intervention period; 2) belonging to the groups for one or more years at baseline. Family members whose relatives with mental illness had already died were excluded from the study samples.

Intervention program

A semi-structured program for promoting the partnership, which was based on the strategies in the partnership model between self-help groups and professionals proposed by Stewart et al. (1994), was developed for this intervention. Stewart et al. proposed the following strategies: communication development; credibility enhancement; trust building; role and goal clarification; education; and clearinghouse (as a promoter of the partnership). Three of these strategies were selected as components of this program: communication development; role and goal clarification; and education. The reasons for selecting these were that communication would develop credibility and trust between the parties, and also, in Japan, clearinghouses are scarce and do not provide direct support, which the promoter should do, for local groups. Therefore, in this program, the author had the intention of making the professionals the promoters of the partnership and not the clearinghouses.

Communication development strategies develop and improve exchanges of information and knowledge between the members and professionals such that each respects and understands the language of the other (Stewart et al., 1994). In this program, the professionals participated in the meetings regularly once a month in order

to develop communication over the intervention period.

Role and goal clarification strategies involve input from both parties which elucidates and negotiates respective roles and establishes aims that respect each other's interests (Stewart et al., 1994). In this program, the members and professionals discussed the roles and goals in the meetings in order to clarify them two or more times. If they did not understand each other or did not develop positive attitudes, discussions on resolving the issues involved were necessary to clarify the roles and goals. The author described these discussions as *the preceding discussions* in this program. The main themes were explanations about the professionals' working, the members' valuable experiences in the group, and expression attitudes toward each other. Next, the members and professionals discussed to clarify the roles and goals of the family groups and professionals. The author described these discussions as *the main discussions* in this program. The main themes were what the group should be, and what roles the group members and professionals expected of each other. The discussions regarding the shared goals focused on the goals of family groups, because imbalances of power between the self-help groups and professionals have been identified as barriers to promoting the partnership (Cohen, 1998; Wilson, 1993). The contents of these discussions have already been assessed with the members of two family groups in the preliminary study, and all the members have reported these discussions as being effective.

Educational strategies help the professionals to change their attitude, increase information or knowledge, and develop skills (Stewart et al., 1994). In this program, the professionals attended at a seminar for two days using the guidelines. The guidelines were drawn up and were authorized by ZENKAREN. They included basic principles and essential knowledge for when the professionals interacted with the family groups.

The term of the intervention was 6 months from September 2000 to March 2001, because in Japan some professionals often change working locations in April every year. The author played the role of the researcher. The researcher gave instructions in program implementation to professional subjects. Professional subjects

followed the guidelines and instructions by the researcher. Concrete roles of the researcher were education for the professionals in a seminar, formal and informal advice for the professionals, observations and records of every meeting, and monitoring professional support inside and outside of the meetings.

In the control group, over the intervention period, the professionals interacted with the family groups the same as before the intervention started.

Variables

Organizational-level of family groups. The number of members was counted.

Individual-level of family groups. Group appraisal by members was assessed using the Group Appraisal Scale. This is a 10-item self-rating scale to assess the member's appraisal of the personal benefits that they have received from the group involvement and their satisfaction with the group in general (Maton, 1988). The scale consists of two subscales: the Group Satisfaction Scale and the Group Benefit Scale. Each item ranges from 1 (*not at all accurate*) to 5 (*completely accurate*), with high scores indicating higher appraisal. The validity and reliability of the original have been shown (Maton, 1988). In this study, a modified Japanese version translated by the author was used. Cronbach's alpha coefficients for this study were .80 and .77. Confirmatory factor analysis showed that the Goodness of Fit Index was .90.

Satisfaction with the professional services for family groups was assessed using the Client Satisfaction Questionnaire (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). This is an 8-item self-rating scale to measure consumer satisfaction in health and human service systems. Each item ranges from 1 to 4, with higher scores indicating higher satisfaction. The validity and reliability of the original (Larsen et al., 1979; Nyguyen, Attkisson, & Stegner, 1983) and a Japanese translated version (Tachimori & Ito, 1999) have been shown. In this study, a modified Japanese version translated by the author was used. Cronbach's alpha coefficient for this study was .90. Principle component analysis showed that the first component accounted for 58.3% of the total variance.

Empowerment of the families was assessed using the Family Empowerment Scale. This is a 34-item self-rating scale to assess empowerment in parents and other family caretakers whose children have emotional disabilities (Koren et al., 1992). The scale measures three levels of empowerment (Family, Service System, and Community/Political) and a total score. Each item ranges from 1(*not true at all*) to 5 (*very true*), with higher scores indicating greater empowerment. The validity and reliability of the original have been shown (Koren et al., 1992; Yatchmenoff, Koren, Friesen, Gordon, & Kinney, 1998). In this study, a modified Japanese version translated by the author was used. Cronbach's alpha coefficients for this study were .78, .80, .82, and .91, respectively. Test-retest reliability coefficients of the subscales ranged from .73 to .92, when measured in another survey among members of family groups with mentally ill patients in Japan. In addition to a dimension composed of three subscales, the conceptual framework of the scale includes the other dimension, which reflects the expression of empowerment as attitude, knowledge, and behavior. Confirmatory factor analysis based on the conceptual framework showed that the Goodness of Fit Index was .75.

Self-esteem of the families was assessed using the Self-Esteem Scale developed by Rosenberg (1965). This is a 10-item self-rating Guttman scale to assess self-esteem. It yields a 7-point scale with lower scores indicating higher self-esteem. The validity and reliability of the original have been shown (Rosenberg, 1965). In this study, a Japanese translated version (Hoshino, 1970) was used. Cronbach's alpha coefficient for this study was .52.

Professionals. Professional knowledge and skills were assessed using the Knowledge and Skills Subscale from the Social Worker Empowerment Scale (Frans, 1993). This is a 9-item self-rating scale to assess empowerment about knowledge and skills of social work practitioners. Each item ranges from 1 (*strongly agree*) to 5 (*strongly disagree*), with higher scores indicating greater empowerment. The validity and reliability of the original have been shown (Frans, 1993). In this study, a modified Japanese version translated by the author was used. Cronbach's alpha coefficient for this study was .87. Principle component analysis showed that the first component

accounted for 51.9% of the total variance.

Control of groups. The author confirmed that the involvement of professionals did not contribute to losing control of the groups, using an item: "Group members lose control of the group if professionals are involved" (Lotery & Jacobs, 1994). This item was converted into a 5 points scale from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating greater loss of control of the groups.

Process evaluation. Process evaluation was conducted in conjunction with an outcome evaluation. The program implementation was assessed from three aspects: additional time of the professionals' participation in the meetings, time of discussions to clarify the roles and goals between the family groups and professionals, and professional support related to the program outside of the meetings.

With regard to appropriateness of the modified Japanese version scales translated by the author, the equivalence of the Japanese version to the original was ascertained by back-translation.

Statistical analysis

First, the demographic data and baseline scores of subjects were tested to assess comparability between the experimental group and the control group. Regarding the community-level and organizational-level of family groups, *t* test, chi-square test, or Fisher's exact test was used. This study was of a group randomization design allocating randomly intact groups. Therefore, regarding the individual-level of family groups and professionals, mixed model analysis of variance or generalized estimating equations with family groups as a random effect, which took into account the extra component of variation due to the nested design (Donner, Brown, & Brasher, 1989), was used.

Second, main effects of the intervention on each of the outcome variables were assessed using analysis of covariance (ANCOVA) or mixed model ANCOVA to test whether there was any difference between the experimental group and the control group, after adjusting for the baseline scores, and demographic data with significant difference between the groups.

Third, interactions of the intervention by the baseline scores were analyzed by adding the interaction to the analysis of main effect. A statistically significant interaction means that the intervention has different effects according to the baseline score. When a statistic showed a significant interaction, the subjects were divided into two groups on the median of the baseline score. Thus, an interaction of the intervention by the two groups was analyzed once again.

Also, the program implementation was assessed using Pearson correlation to examine the relationships between the process variables of the program and the outcome variables. The outcome variables were used as a summary statistic for each family group.

All of the data analyses were conducted using SAS version 6.12.

RESULTS

Member subjects

In addition to the family group subjects and professional subjects, member subjects were identified after the intervention period as shown in Figure 3.

In the experimental group, at baseline, 203 members were informed of this study, and 168 members responded and provided their questionnaires. Twelve members did not complete the questionnaires for reasons that 7 did not know about the group activities, and 5 included missing data. Of the 168 members, 156 members completed them. At 6 months, 199 members were informed of this study, and 167 members responded and provided their questionnaires. Twelve members did not complete the questionnaires for reasons that 6 did not know about the group activities and 6 included missing data. Of the 167 members, 155 members completed them.

Of 156 questionnaires at baseline and 155 at 6 months, 96 matched both questionnaires. Of the 96 members, 20 were excluded for reasons that 16 had attended less than 5 meetings, and 7 had belonged to the group for less than one year (some overlapped). Accordingly, 76 satisfied all the eligible criteria.

In the control group, at baseline, 219 members were informed of this study, and 174 members responded and provided their questionnaires. Eight members did not complete the questionnaires for reasons that 6 did not know about the group activities and 2 included missing data. Of the 174 members, 166 completed them. At 6 months, 179 members were informed of this study, and 149 responded and provided their questionnaires. Eleven members did not complete the questionnaires for reasons that 5 did not know about the group activities, 5 included missing data, and 1 wrote inaccurate demographic data. Of the 149 members, 138 members completed them.

Of 166 questionnaires at baseline and 138 at 6 months, 103 matched both questionnaires. Of the 103 members, 30 were excluded for reasons that 19 had attended less than 5 meetings, 12 had belonged to the group for less than one year, and 1 because her relative with mental illness had died (some overlapped). Accordingly, 73 satisfied all the eligible criteria.

The average number of member subjects per group was 6.2 members. The average number of times which member subjects attended the meetings over the intervention period was 6.5 times of a total of 7 times. The average number of all the members who attend a meeting was 12.1 members per group. That of the member subjects was 5.8 members per group.

Characteristics of the experimental and control groups

The community-level and organizational-level demographic variables of the family groups did not differ significantly between the experimental and control groups, with the exception of a younger leader in the experimental group (see Table 1). Therefore, this was controlled for in the multivariate analysis of the outcome of organizational-level. The demographic variables of member subjects, which were the individual-level of the family groups, did not differ significantly between the groups (see Table 2). The demographic variables of the professionals did not differ significantly between the groups, with the exception of a higher rate of having had education about the family groups in the experimental group (see Table 3). Therefore, this was controlled for in the multivariate analysis of the outcome of professionals.

The outcome variables of the family groups and professionals did not differ significantly between the groups (see Table 4).

Program implementation

Free participating professionals. Sixteen professionals participated in addition to 15 professional subjects in the experimental group, because of requests from both the family groups and professionals. The professional subjects participated regularly in the meetings of family groups, attended at a seminar, and promoted partnership with the family groups. The additional professionals were free to participate in the meetings of family groups and attend at a seminar. Therefore, the effects of the intervention on free participating professionals were not assessed. Of the 16 free participating professionals, 9 were public health nurses, 4 were social workers, and 3 were clerks of the administrative welfare department.

Professionals' participation in the meetings. As shown in Table 5, before the intervention, the mean rates of professionals' participating in the meetings were 62.9 percent in the experimental group and 55.0 percent in the control group. Over the intervention period, the mean rates were 100.0 percent in the experimental group and 53.6 percent in the control group. Thus, the professionals in the experimental group participated in the meetings for more time than in usual support. The average time which the professionals participated in the meetings for the program, in addition to usual care before the intervention started, was 350.4 minutes. The average number of professionals who participate in the meetings was 2.0 in the experimental group and 0.5 in the control group.

Discussions to clarify the roles and goals. The average number of times, which the members and professionals discussed in order to clarify the roles and goals between the family groups and professionals, was 3.4 times. Also, the total average time required for the discussions was 227.3 minutes, that of *the preceding discussions* was 64.7 minutes, and that of *the main discussions* was 162.6 minutes.

Professional support outside of the meetings. With regard to the average number of times which professionals supported the family groups outside of the

meetings, support related to this program was 5.6 times, and usual support was 26.1 times (SD=12.7).

Effects of the intervention

Main effects of the intervention. With regard to the organizational-level of the family groups, ANCOVA showed that the number of members in the experimental group was significantly more than the control group (see Table 6). With regard to the individual-level of the family groups, the mixed model ANCOVA showed that the CSQ-8 in the experimental group was significantly higher than the control group. Also, with an alpha level of .10, the Service System score and the total score of the Family Empowerment Scale in the experimental group were higher than the control group. There were no significant differences between the experimental and control groups in the other outcome variables of the individual-level of family groups. With regard to the Knowledge and Skills Subscale of the professionals, the mixed model ANCOVA showed no significant difference between the groups.

Interactions of the intervention by the baseline scores. With regard to the organizational-level of the family groups, ANCOVA showed that there was no significant interaction of the intervention by the baseline scores (see Table 7). With regard to the individual-level of the family groups, the mixed model ANCOVA showed that only the CSQ-8 had a significant interaction of the intervention by the baseline score. The author divided the subjects into two groups on the median of the baseline score, and showed each change in the CSQ-8 between at baseline and at 6 months (see Figure 4). The mixed model ANCOVA, which analyzed interaction, showed that the intervention had a significant effect on only those subjects with lower baseline CSQ-8. With regard to the Knowledge and Skills Subscale of the professionals, the mixed model ANCOVA showed that there was a significant interaction of the intervention by the baseline score. The author divided the subjects into two groups on the median of the baseline score, and showed each change in the Knowledge and Skills Subscale at baseline and at 6 months (see Figure 5). The mixed model ANCOVA, which analyzed interaction, showed that the intervention had a significant effect on only those subjects

with lower baseline scores of the Knowledge and Skills Subscale. In addition, the author explored the characteristics of those subjects with lower baseline scores on the Knowledge and Skills Subscale. As a result, the average duration of their supporting the family group subjects before the intervention started was 0.43 years. This was significantly shorter than the average duration of 2.07 years for those with higher baseline scores on the Knowledge and Skills Subscale ($p<0.001$).

Control of groups

The mixed model ANCOVA, which controlled the baseline score and accounted for between-family group variation, showed that there was no significant main effect of the intervention (F=0.36, p= .56), and showed no significant interaction of the intervention by the baseline score (F=0.00, p= .94) on whether the groups were able to maintain control.

Process evaluation

Pearson correlations between the program variables and the outcome variables showed the following. There were significantly positive correlations between the length of time that professionals participated additionally in the meetings and the increase in the CSQ-8 or the Service System score of the Family Empowerment Scale (see Table 8).

DISCUSSION

Significance of the study

This study demonstrated the effects of a program for promoting partnership between local self-help groups of families with the mentally ill and professionals in Japan. To my knowledge, this is the first report on a randomized controlled trial of a program for promoting a positive working relationship between self-help groups and professionals. There have been only a few true experimental studies among actual

community-based self-help groups because of the limitations occurred when an experimental design is applied to self-help groups (Kurtz, 1997; Humphreys & Rappaport, 1994; Powell, 1993; Tabes & Kaemer, 1991). This study could be conducted with consideration for the unique complexities of self-help research.

Effects of the intervention

This intervention had some effects on the family groups. Those were increase in members, more satisfaction with professional services for family groups, and higher Service System score and total score of the Family Empowerment Scale (with an alpha level of .01).

The finding, which the intervention had a significant increase in members, is consistent with previous reports that professional interactions contributed to increasing new members of self-help groups (Kurtz, 1997; Wilson, 1995). Kurtz (1997) indicated that recruiting the membership is the most important and stressful issue which self-help group leaders face, because the groups cannot remain in existence without new members. In this intervention, the increase in members was recognized as shared goals of the family groups and professionals among 5 of 12 family groups in the experimental group. Wilson (1995) indicated that linking people with self-help groups is the most effective way in which professionals can help the groups. The number of members might increase with each role of members and professionals, such as making leaflets about group activities by members and referral by professionals.

When professionals support self-help groups, professionals must ensure that groups have a real choice of accepting support or not (Wilson, 1995). In short, on a program for promoting a positive relationship between self-help groups and professionals, professionals should respect members' acceptance and satisfaction. This intervention had a significant effect on the CSQ-8, particularly on those members with lower CSQ-8 at baseline. This finding was consistent with the previous report (Stewart et al., 1994), which most members of self-help groups believed that the partnership was desirable. Also, this finding means that members were satisfied with the program, in particular with members who had not been satisfied with professional involvement.

There was a positive correlation between the increase in the CSQ-8 and length of the time that the professionals participated additionally in the meetings. It is suggested that members desired professionals' participation in the meetings. Thus, the program was enough to be accepted and satisfied by members of family groups.

With an alpha level of .10, the intervention had significant effects on the Service System score and the total score of the Family Empowerment Scale. Also there was a positive correlation between the length of the time that professionals participated additionally in the meetings and the increase in the Service System score. The Service System score primarily involves the family's activities working with the professionals and agencies to obtain services that are needed by their relative with mental illness (Koren et al., 1992). Through communication with professionals over the intervention period, members may acquire abilities to negotiate with the professionals about the services received by their relative.

On the other hand, the intervention did not have significant effects on members' group appraisal, the Family score and the Community/Political score of the Family Empowerment Scale, and self-esteem.

There is one possible reason why the intervention did not have a significant effect on the Group Appraisal Scale. That is that the term of this intervention was not sufficient to have a significant effect on perceived group appraisal. Most members had little concern about the group activities at baseline. Through the discussions to clarify the roles and goals of the family groups and professionals, critical thinking about the group activities, which are necessary for solving problems (Nickerson, 1985), may have grown among members. In contrast, most goals of the family groups were not attained within 6 months, even though the goals were clarified. Therefore, a longer intervention may be necessary for members to attain their goals and to appraise their group activities more highly.

In terms of the Self-Esteem Scale, the intervention did not have a significant effect. However, the scores were lower at 6 months, which means a higher self-esteem, than at baseline in both the experimental group and control group. The member subjects were regular attendees in the meetings. This is consistent with the previous

report that more intense participation contributes to better outcomes (Kurtz, 1997). Also, the intervention did not have a significant effect on the Family score and the Community/Political score of the Family Empowerment Scale. Wollert et al. (1980) reported that the atmosphere in meetings of a self-help group was warmer with professional support. If the groups function effectively with professional support, the members will gain more benefits related to the nature of the family groups such as empowerment (Gidron, Gutterman, & Hartman, 1989; Kurtz, 1997; Segal, Silverman, & Temkin, 1993) and self-esteem (Katz, 1993), rather than a goal of psychotherapy or treatment aiming at a reduction of psychological symptoms (Kurtz, 1997; Powell, 1993). A longer intervention will help to make the family groups function effectively.

With regard to the professionals, on the Knowledge and Skills Subscale of Social Worker Empowerment Scale, the intervention showed a significant interaction with the baseline score, indicating that the program had an effect only on those professionals with lower scores at baseline. Also, those professionals with lower scores at baseline have not had enough experience to support family group subjects, even if they have accumulated experience as professionals. After the intervention period, those professionals with lower scores at baseline gave their impression of the intervention that they became more understanding of the family groups and gained confidence in their ability to support the family groups. Thus, professionals who have little knowledge and skill in supporting family groups, and those who have not had enough experience in supporting the family group subjects, may gain knowledge and skill through basic education with guidelines, participation in the meetings, and discussions with members. This finding is consistent with a previous report that involving self-help groups and members in professional training regarding self-help groups potentially empowered professionals, thus making it more likely to produce an effective partnership (Meissen, Mason, & Gleason, 1991). Also, the finding suggests that the program empowers professionals who lack knowledge and experience in supporting family groups, despite the short-term intervention. Also, this change in the professionals could be demonstrated in only an intervention study.

Furthermore, the intervention, which has the effects mentioned above, did not

contribute to losing control of the groups. However, Katz (1993) indicated that group members might welcome professional help but be afraid of losing control of what they have worked so hard to build. Whenever professionals promote partnership between self-help groups and themselves, they must evaluate whether their own interaction with the groups contributes to losing control of the groups or not.

Given these findings, the program for promoting partnership between self-help groups and professionals can be effective for both self-help groups of families with the mentally ill and professionals involved with the groups.

Applicability in practice

The program is applicable generally in practice because of the following. First, the subjects of this intervention were true community-based self-help groups of families with the mentally ill, and professionals who work in the truly practical fields. Second, there were broad varieties of family groups and professionals. Third, the intervention could be conducted within a normal budget. Finally, if professionals use the guidelines, they will be able to conduct the program. ZENKAREN will distribute the guidelines to all municipalities over the country. However, the intervention was conducted with support of the researcher, in particular, with advices from the researcher when professionals could not find a solution to a problem even if they used the guidelines. It is necessary to build up a system to advise professionals who have such problems.

Limitations and perspectives

This study has some limitations. First, the intervention was conducted on a variety of relationships. On the one hand some of the professionals had never participated in the group meetings, but on the other hand some of professionals had already participated regularly in the group meetings. It was not clear on which relationships between the parties the program had effects on. Second, the program included three components. Despite the fact that process evaluation was conducted, the effectiveness of each component could only be clarified by additional studies. Third,

because this study included members who attend regularly, the member subjects are not necessarily representative of all members of the family group subjects. However, the author could not find another ways of sampling members, because members of self-help groups are free to attend in the meeting and researcher should not handle it (Adams, 1990; Luke, Robert, & Rappaport, 1993). Forth, family groups and professionals were not blinded as to the group assignment. However, a double blind to family groups and professionals is not feasible because of ethical issues. Finally, the modified Japanese versions of the original scales used in the study require further examination of the validity and reliability.

The author did not conduct a follow-up assessment of the intervention. Because the partnership was characterized with continuous interaction, the author has been considered that not a follow-up assessment but a long-term intervention is necessary in future studies. Also, the author did not assess the community-level of family groups because the term of the intervention was short of 6 months. However, in previous reports, it has been indicated that the partnership between self-help groups and professionals provides some benefits as shown in Figure 1 (Humphreys & Ribisl, 1999; Penny, 1997; Srinivasan, 2000). In order to assess the effects of this program at the community-level, a long-term intervention is needed. Although this intervention did not have any effects on the Group Appraisal Scale, two subscales of the Family Empowerment Scale, and the Self-Esteem scale, a longer intervention may have effects on these measurements.

CONCLUSIONS

The purpose of this study was to examine the effects of a program for promoting partnership between self-help groups and professionals based on the partnership model proposed by Stewart et al., among local self-help groups of families with the mentally ill and professionals in Japan, in a group-randomized trial. The author assessed the effects of the program on the family groups, members who belong to the groups, and professionals involved with the groups.

As a result, the number of members in the experimental group increased more significantly than that of the control group. Also, the CSQ-8 in the experimental group was significantly higher than the control group. With an alpha level of .10, the Service System score and the total score of the Family Empowerment Scale in the experimental group were higher than the control group. Furthermore, the author explored the interactions of the intervention by the baseline scores, with the result that the program had significant effects on those members with lower baseline CSQ-8 scores and on those professionals with lower baseline scores of the Knowledge and Skills Subscale.

Given these findings, the program for promoting partnership between self-help groups and professionals can be effective for both self-help groups of families with the mentally ill and professionals involved with the groups.

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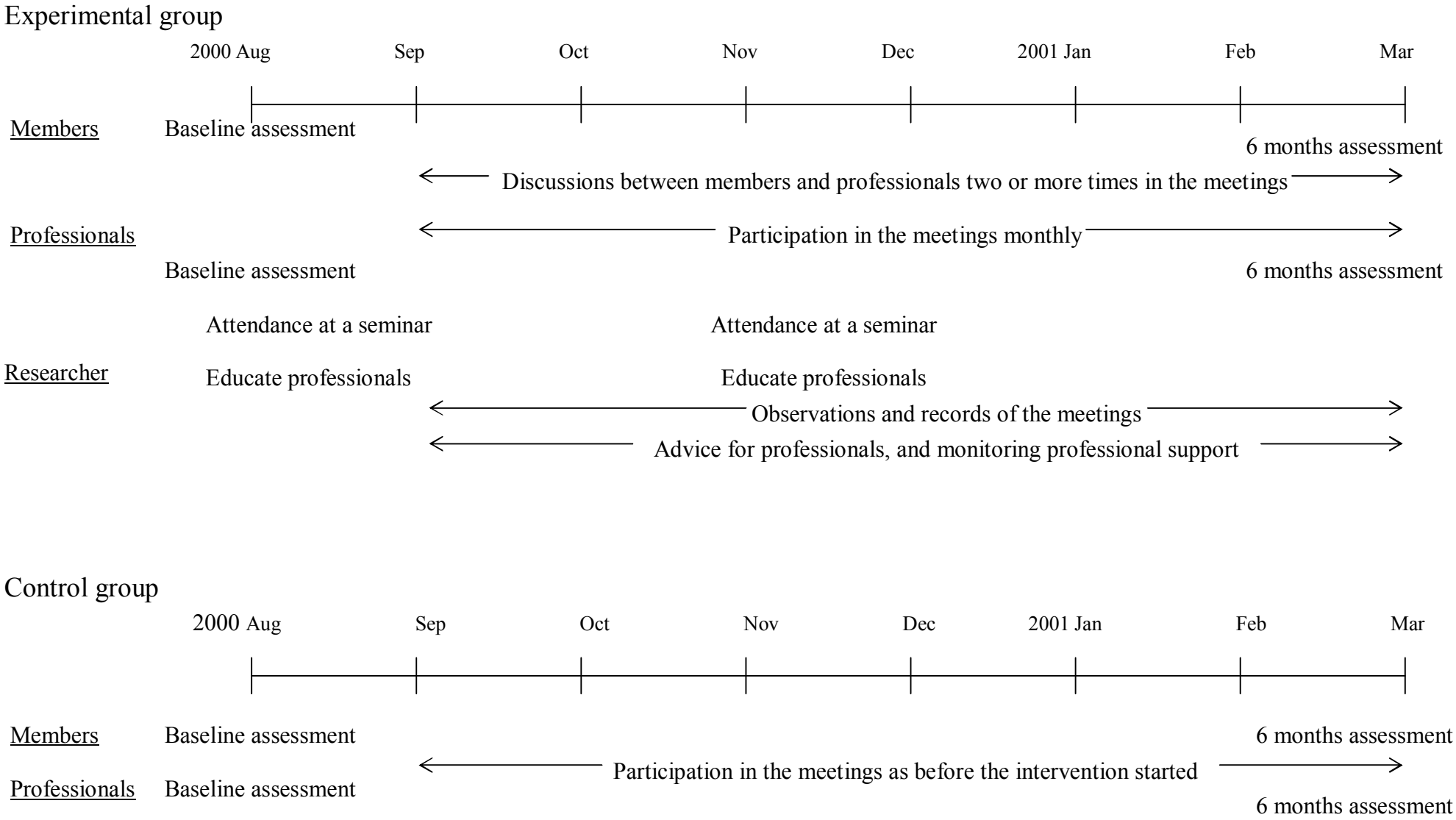


Figure1. Time schedules in the experimental group and the control group over the intervention period

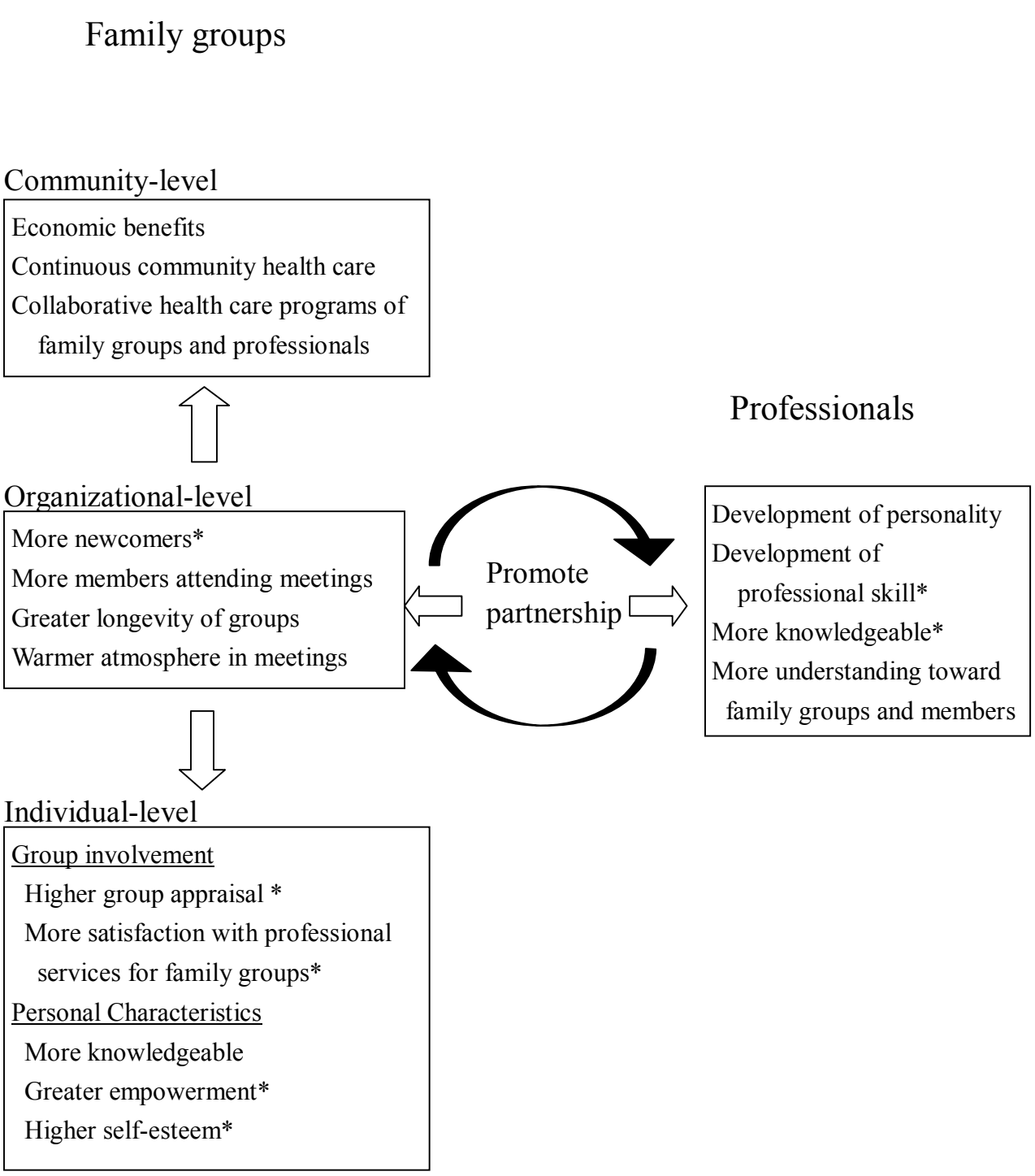


Figure 2. A conceptual framework of this study

Benefits, which promoting partnership might provide to family groups and professionals, are shown.

An asterisk indicates variables assessed in this study.

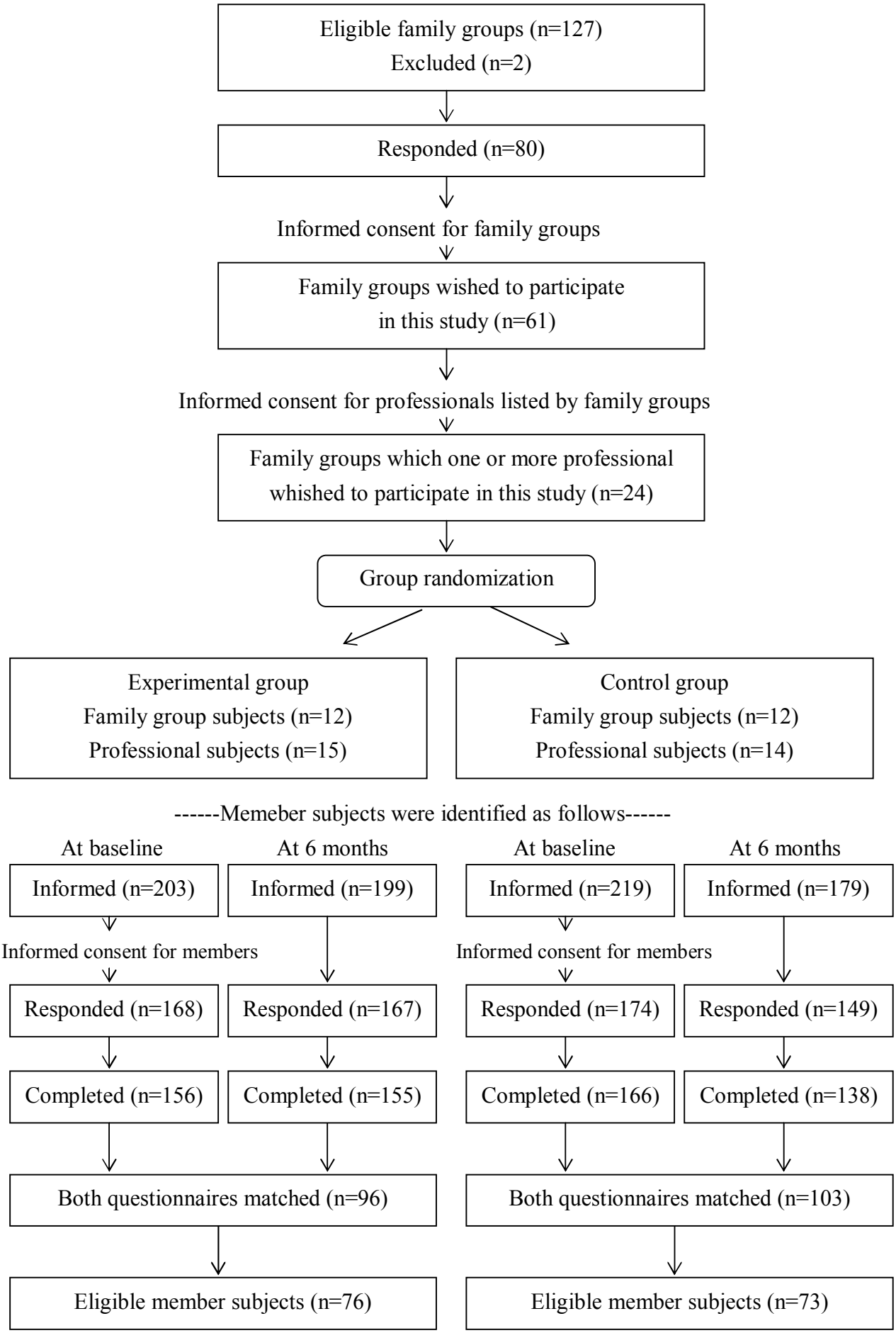
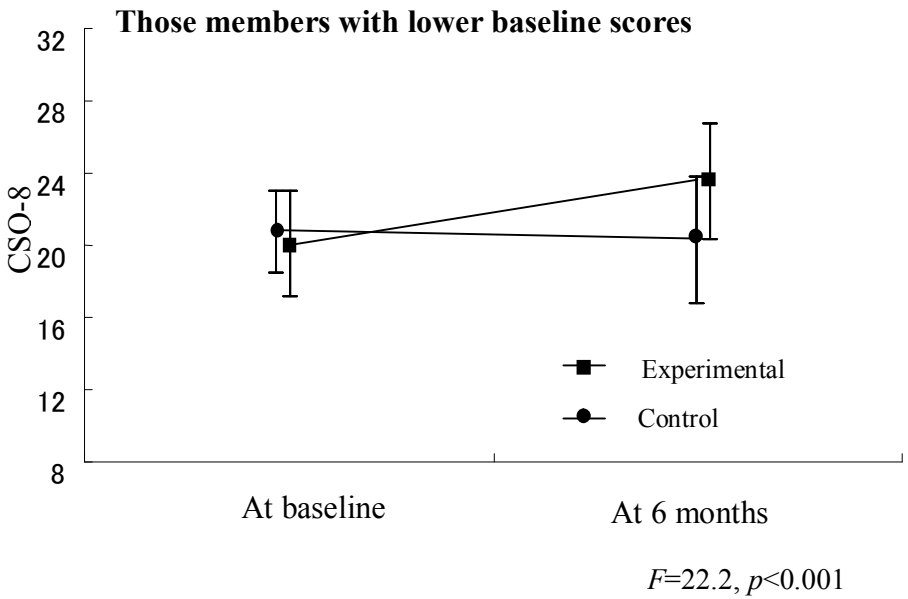


Figure3. Flow diagram of the study subjects: Family groups, professionals, and members



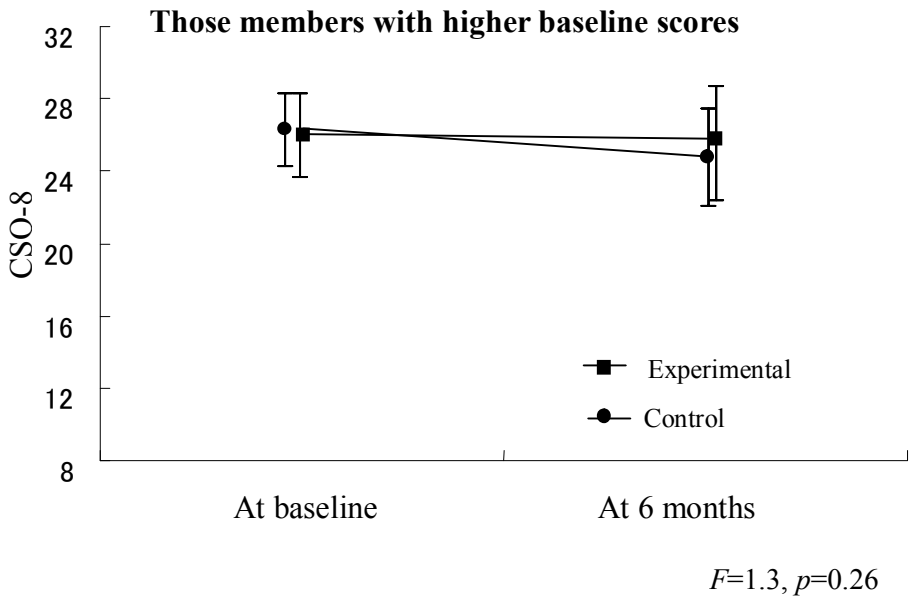


Figure4. Interaction of the intervention by the baseline score of CSQ-8

Member subjects were divided into two groups on the median of baseline score, and these figures show change of each group.

Vertical lines depict standard deviations of the means.

F statistics are in mixed model ANCOVA, with baseline score as covariate.

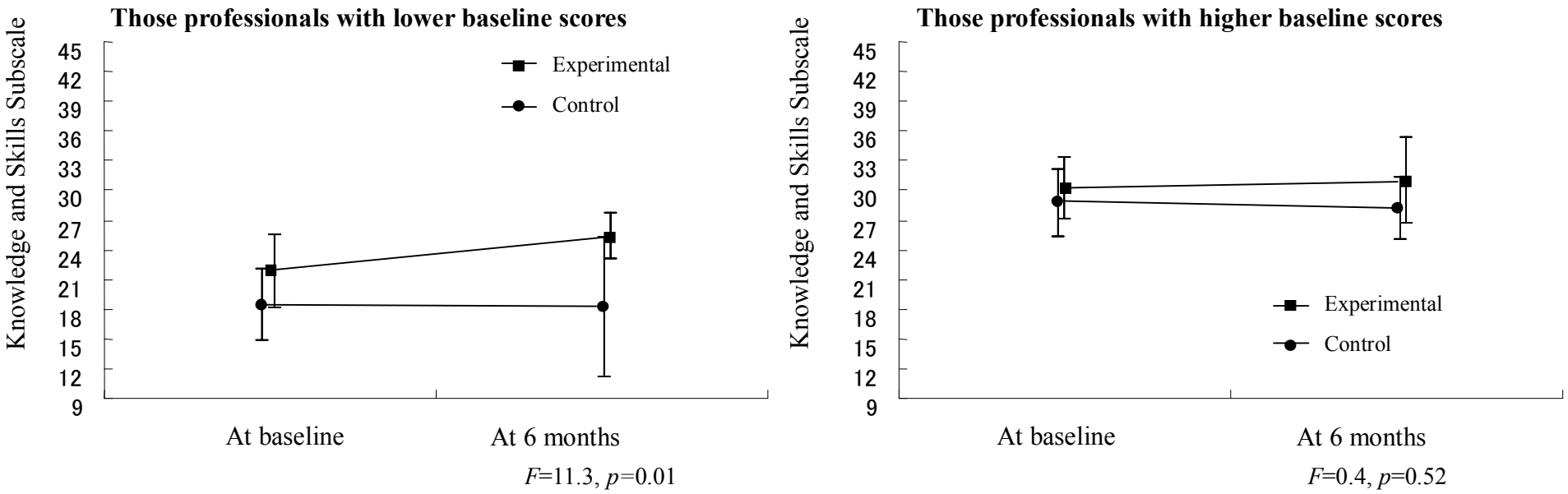


Figure5. Interaction of the intervention by the baseline score of the Knowledge and Skills Subscale

Professional subjects were divided into two groups on median of the baseline score, and these figure show change of each group.

Vertical lines depict standard deviations of the means.

F statistics are in mixed model ANCOVA, with baseline score and having had or not education about family groups as covariates.

Table1. Characteristics of the community-level and the organizational-level of the family group subjects

Characteristics	Experimental n = 12(100.0%) mean±SD	Control n = 12(100.0%) mean±SD	*P* value
Community-level			
Population (thousand people)	245±188	161±44	0.16
Population density (thousand people / km^2)	5.4±4.8	7.5±5.5	0.34
Number of psychiatric hospitals (per 100,000 population)	1.0±1.1	0.6±0.5	0.28
Number of psychiatric clinics (per100,000 population)	3.2±3.5	2.9±3.2	0.81
Number of rehabilitation facilities for the mentally ill (per100,000 population)	3.5±2.7	2.8±1.7	0.45
Organizational-level			
Number of members	50.2±36.1	38.1±22.0	0.33
Number of committees	7.9±4.9	9.3±4.2	0.36
Sex of the leader			
Man	7(58.3)	7(58.3)	1.00
Woman	5(41.7)	5(41.7)	
Age of the leader (yrs)	65.1±7.6	70.7±4.4	0.04
Number of members' attending the meetings [a]	17.5±10.1	15.4±7.8	0.57
Social activities (have done the action in 1999)			
Public policy activities	8(66.7)	8(66.7)	1.00
Establishment and operation sheltered workshops	6(50.0)	7(58.3)	0.68
Official peer counseling	3(25.0)	7(58.3)	0.21
Charity bazaars and fundraising activities	10(83.3)	10(83.3)	1.00
Rate of professional's participating in the meeting (%) [a]	62.9±42.3	55.0±42.7	0.65

SD: standard deviation; NS: not significant.

Fisher's exact test: categorical data.

t test: continuous data.

[a] Data are from April to August in 2000.

Table2. Characteristics of the member subjects

Characteristics	Experimental n = 76(100.0%) mean±SD	Control n = 73(100.0%) mean±SD	*P* value
Group involvement			
Length of membership (yrs)	5.9±4.2	6.7±4.3	0.30
Role in the group (committee)	53(69.7)	47(64.4)	0.62
Personal characteristics			
Members			
Age (yrs)	63.6±8.3	65.0±7.6	0.26
Sex (woman)	61(80.3)	53(72.6)	0.53
Relation to person with mental ill (parent)	71(93.4)	67(91.8)	0.44
Persons with mental ill			
Age (yrs)	35.9±9.5	37.5±9.8	0.28
Sex (man)	57(75.0)	47(64.4)	0.79
Diagnosis (schizophrenia)	59(77.7)	66(90.4)	0.60
Length of the mental illness (yrs)	14.8±8.9	16.3±9.7	0.12
Treatment (outpatient treatment)	63(82.9)	66(90.4)	0.19

SD: standard deviation; NS: not significant.

Mixed model ANOVA: continuous data.

Generalized estimating equations: binary data.

Table3. Characteristics of professional subjects

Characteristics	Experimental n = 15(100.0%) mean±SD	Control n = 14(100.0%) mean±SD	*P* value
Sex (woman)	10(66.7)	10(71.4)	0.76
Discipline (public health nurse)	7(46.7)	8(57.2)	0.48
Discipline (social worker)	7(46.7)	5(35.7)	0.54
Discipline (clerk of welfare department)	1(6.6)	1(7.1)	0.94
Agency or department (related to public health)	13(86.7)	12(85.7)	0.93
Agency or department (related to public welfare)	2(13.3)	2(14.3)	0.93
Length of professional (yrs)	13.6±9.3	13.9±6.6	0.98
Length of professional in mental health fields (yrs)	10.2±9.6	8.7±7.1	0.83
Length of supporting the family group subject (yrs)	1.5±1.5	1.0±1.0	0.26
Length of supporting the other family groups (yrs)	4.0±6.9	2.6±5.0	0.51
Length of supporting the other self-help groups (yrs)	3.2±5.2	5.0±7.3	0.31
Education about family groups (have had)	8(53.3)	2(14.3)	0.05
Education about self-help groups (have had)	10(66.7)	6(42.9)	0.28

SD: standard deviation; NS: not significant.

Mixed model ANOVA: continuous data.

Generalized estimating equations: binary data.

Table4. Baseline scores of outcome variables

Categories (n= experimental/ control) Outcome variables (range)	Experimental mean (SD)	Control mean (SD)	*P* value
Family groups			
Organizational-level (n=12/12)			
Number of members	50.2(36.1)	38.1(22.0)	0.33
Individual-level (n=76/73)			
Group Appraisal Scale			
Group Satisfaction Scale (5-25)	15.7(3.4)	15.7(3.7)	0.91
Group Benefit Scale (5-25)	19.5(2.7)	19.4(3.2)	0.94
CSQ-8 (8-32)	22.4(4.0)	23.9(3.5)	0.16
Family Empowerment Scale			
Family (12-60)	42.6(6.6)	42.8(7.2)	0.97
Service System (12-60)	43.7(7.8)	44.0(8.1)	0.92
Community/Political (10-50)	34.6(7.0)	34.1(7.0)	0.52
Total Score (34-170)	120.8(18.5)	120.8(20.6)	0.82
Self-Esteem Scale (0-6)	2.2(1.4)	2.4(1.6)	0.36
Professionals (n=15/14)			
Knowledge and Skills Subscale (9-45)	26.9(5.2)	22.9(6.4)	0.14

SD: standard deviation; NS: not significant.

t test: number of members.

Mixed model ANOVA: the other variables.

Table5. Comparisons between the program implementation and usual support

		Experimental n =12		Control n =12	
		Usual support April-August	The program September-March	Usual support April-August	Usual support September-March
Rate of professionals' participating in the meetings					
0% (not at all)		3	0	3	3
1-99%		4	0	5	5
100% (every meeting for one time per month)		5	12	4	4
mean±SD(%)		62.9±42.3	100.0	55.0±42.7	53.6±40.5
Number of professionals' participating in the meetings	mean±SD	ND	2.0±1.0	ND	0.5±0.1
Additional time of professionals' participating in the meetings (min)	mean±SD	-	350.4±478.3	-	-
Number of times of the discussions	mean±SD	-	3.4±0.9	-	-
Total time of discussions to clarify the goals and roles (min)	mean±SD	-	227.3±80.5	-	-
The preceding discussions	mean±SD	-	64.7±50.7	-	-
The main discussions	mean±SD	-	162.6±68.2	-	-
Professional support related to the program outside of the meetings (number of times)	mean±SD	-	5.6±4.0	-	-

Dashes indicate no applicable data.

ND: no data measured.

Table6. Main effects of the intervention

Categories (n= experimental/ control) Outcome variables (range)	Experimental At 6 months LSmean (SE)	Control At 6 months LSmean (SE)	Effect *F* (*p*)
Family groups			
Organizational-level (n=12/12) [a]			
Number of members	47.2(1.0)	43.8(1.0)	5.38(0.03)
Individual-level (n=76/73) [b]			
Group Appraisal Scale			
Group Satisfaction Scale (5-25)	15.8(0.4)	15.4(0.4)	0.33 (0.58)
Group Benefit Scale (5-25)	19.0(0.2)	19.0(0.4)	0.00(1.00)
CSQ-8 (8-32)	24.8(0.2)	22.5(0.5)	15.59(0.0007)
Family Empowerment Scale			
Family (12-60)	44.2(0.4)	43.2(0.4)	2.44(0.15)
Service System (12-60)	45.2(0.6)	43.1(0.9)	3.55(0.08)
Community/Political (10-50)	35.5(0.4)	34.5(0.5)	2.37(0.13)
Total Score (34-170)	124.9(1.2)	121.0(1.5)	4.35(0.06)
Self-Esteem Scale (0-6)	2.0(0.1)	1.8(0.1)	0.69(0.43)
Professionals (n=15/14) [c]			
Knowledge and Skills Subscale (9-45)	27.1(1.0)	24.9(1.3)	2.03(0.17)

SE: standard error.

[a] *F* statistic in ANCOVA, with baseline score and age of the leader as covariates.

[b] *F* statistic in mixed model ANCOVA, with baseline score as covariate.

[c] *F* statistic in mixed model ANCOVA, with baseline score and having had or not education about family groups as covariates.

Table7. Interactions of the intervention by the baseline scores

Categories (n= experimental/ control) Outcome variables (range)	Experimental At 6 months LSmean (SE)	Control At 6 months LSmean (SE)	Effect Intervention *F* (*p*)	Effect Intervention ×baseline scores *F* (*p*)
Family groups				
Organizational-level (n=12/12) [a]				
Number of members	47.2(1.0)	43.9(1.0)	2.27(0.15)	0.06(0.80)
Individual-level (n=76/73) [b]				
Group Appraisal Scale				
Group Satisfaction Scale (5-25)	15.8(0.4)	15.4(0.4)	0.03(0.9)	0.00(1.0)
Group Benefit Scale (5-25)	19.0(0.3)	19.0(0.4)	1.53(0.2)	1.55(0.2)
CSQ-8 (8-32)	24.7(0.3)	22.3(0.5)	9.85(0.002)	5.96(0.02)
Family Empowerment Scale				
Family (12-60)	44.2(0.4)	43.2(0.4)	0.03(0.97)	0.01(0.93)
Service System (12-60)	45.2(0.6)	43.1(0.9)	1.44(0.23)	0.62(0.43)
Community/Political (10-50)	35.5(0.4)	34.5(0.5)	0.95(0.33)	0.53(0.47)
Total Score (34-170)	124.9(1.2)	121.0(1.5)	0.18(0.67)	0.0(0.98)
Self-Esteem Scale (0-6)	2.0(0.1)	1.8(0.1)	0.23(0.64)	0.99(0.32)
Professionals (n=15/14) [c]				
Knowledge and Skills Subscale (9-45)	27.7(0.8)	25.8(1.1)	13.00(0.007)	10.86(0.01)

SD: standard deviation.

[a] *F* statistic in ANCOVA, with baseline score and age of leader as covariates.

[b] *F* statistic in mixed model ANCOVA, with baseline score as covariate.

[c] *F* statistic in mixed model ANCOVA, with baseline score and having had or not education about family groups as covariates.

Table8. Correlations between the process variables of the program and the outcome variables in the experimental group

	Outcome variables (n=12)									
	Organizational- level	Individual-level								Professionals
Process variables (n=12)	Number of members	Group Satisfaction Scale	Group Benefit Scale	CSQ-8	Family Empowerment Scale: Family	Family Empowerment Scale: Service System	Family Empowerment Scale: Community/ Political	Family Empowerment Scale: Total Score	Self-Esteem Scale	Knowledge and Skills Subscale
Additional time of professionals' participating in the meetings (min)	- .333	.307	- .056	.705*	- .426	.722**	.223	.390	.397	- .094
Time of discussions to clarify the roles and goals (min)										
Total discussions	- .267	.242	- .357	.382	- .385	.206	.552	.249	.116	.131
The preceding discussions	- .334	.222	.155	.376	- .084	- .130	.125	- .050	.199	.241
The main discussions	- .066	.120	- .536	.171	- .392	.340	.558	.331	- .012	- .024
Professional support related to the program outside of the meetings (number of times)	- .167	.513	.240	.268	- .209	.106	.322	.142	.437	- .146

Pearson correlations; *P<0.05, **P<0.01.

All outcome variables are differences between scores at baseline and at 6 months.

As outcome variables of the individual-level of family groups and professionals, a mean for each family group is calculated.

Appendix

Family Empowerment Scale

(Koren, P. E., DeChillo. N., & Friesen, B. J., 1992)

次の質問は、あなたが置かれている状況にどのように感じているかをお聞きするものです。それぞれの質問について、あなたにもっとも当てはまるものを選び、数字一つに○をつけてください。全部で 34 項目あります。すべての項目にお答え願います。

質問文の中の「私」とは、家族である「あなたご自身」のことです。「本人」とはあなたが支えている「障害者本人（当事者）」のことです。	いいえ	どちらかと言えばいいえ	どちらとも言えない	どちらかと言えばはい	はい
1）私には、本人が受けるすべての精神保健福祉サービスについて、良いか悪いか判断する権利があると思う	1	2	3	4	5
2）本人に問題がおきたとき、私はそれらの問題にかなりうまく対応している	1	2	3	4	5
3）私は地域の精神障害者の制度をよりよくするために、わずかでも協力できると思う	1	2	3	4	5
4）私は本人の回復を助ける自信がある	1	2	3	4	5
5）本人の受けている精神保健福祉サービスが足りないのではないかと心配になった場合、私はどういう手続きをとればよいか知っている	1	2	3	4	5
6）本人が必要とする精神保健福祉サービスについての私の意見を専門職（保健婦や相談員等）が理解しているかどうか確かめる	1	2	3	4	5
7）私は本人に問題がおこったとき、どう対応したらよいかわかっている	1	2	3	4	5
8）精神障害者の制度に関する重要な議案がまだ決まっていないとき、私は議員に連絡をとる	1	2	3	4	5
9）私の家族の生活が本人のために乱されることはないと感じる	1	2	3	4	5
10）私は精神障害者の制度がどのようなものかを理解している	1	2	3	4	5
11）私は、本人がどのような精神保健福祉サービスを必要としているか、よくわかっている	1	2	3	4	5
12）本人にとって必要な精神保健福祉サービスについて、私は関係機関や専門職（保健婦や相談員等）と話し合える	1	2	3	4	5
13）私は念のため、本人に関わっている専門職（保健婦や相談員等）に定期的に連絡をとっている	1	2	3	4	5
14）私は精神障害者の理想的な制度について、自分なりの考えを持っている	1	2	3	4	5
15）私は他の家族が必要としている精神保健福祉サービスを受けられるように手助けする	1	2	3	4	5

	いいえ	どちらかと言えばいいえ	どちらとも言えない	どちらかと言えばはい	はい
16）私は本人をよりよく理解するために、役立つ情報を集められる	1	2	3	4	5
17）私は他の家族と協力して、精神障害者の制度をよりよくすることができると思う	1	2	3	4	5
18）本人がどのような精神保健福祉サービスを必要としているかを決める上で、私の意見は専門職（保健婦や相談員等）の意見と同じくらい重要である	1	2	3	4	5
19）私は本人が受けている精神保健福祉サービスについて、関わっている専門職（保健婦や相談員等）に意見を言う	1	2	3	4	5
20）精神障害者の制度をよりよくしてもらうように、私は関係機関や行政の人たちに訴える	1	2	3	4	5
21）私は本人に問題がおこったとき、私自身でそれを解決できると思う	1	2	3	4	5
22）私は自分の意見を聞いてもらうために、関係機関の管理職や議員に会う方法を知っている	1	2	3	4	5
23）私は本人がどのような精神保健福祉サービスを必要としているか知っている	1	2	3	4	5
24）私は精神保健福祉法に定められている本人や家族の権利と義務を知っている	1	2	3	4	5
25）家族としての私の知識や経験は、精神障害者や家族を取り巻く状況をよくするのに役立つと思う	1	2	3	4	5
26）私の家族に問題がおきて助けが必要になったとき、私は他の人に助けを求められる	1	2	3	4	5
27）私は本人のよりよい回復のために新しい手だてを学ぶよう努めている	1	2	3	4	5
28）必要なときは、本人や家族のために率先して、私は利用できる方法や制度を探す	1	2	3	4	5
29）私は本人と接するとき、悪い面ばかりでなく良い面にも目を向けるようにしている	1	2	3	4	5
30）私は本人が利用できる精神保健福祉制度についてよく理解している	1	2	3	4	5
31）私は本人を巻き込む問題に直面したとき、私自身でどうしたらよいかを考え、それをおこなっている	1	2	3	4	5
32）専門職（保健婦や相談員等）は、私が本人のためにどのような精神保健福祉サービスを望んでいるかを直接（家族である）私にたずねるべきだ	1	2	3	4	5
33）　私は本人の病気についてよく理解している	1	2	3	4	5
34）　私は良い親（家族）だと思う	1	2	3	4	5

Self-Esteem Scale

(Rosenberg, M., 1965)

以下の文を読んで、あなたはどのようにお感じになりますか。
あなたの考えに最も近いものを選んで数字一つに〇をつけてください。

	大いにそう思う	ややそう思う	あまりそう思わない	全くそう思わない
1) 私はすべての点で自分に満足している	1	2	3	4
2) 私はときどき自分がまるでダメだと思う	1	2	3	4
3) 自分にはいくつかのとりえがあると思っている	1	2	3	4
4) 私はたいていの人がやれるくらいには物ごとができる	1	2	3	4
5) 私にはあまり得意に思うことがない	1	2	3	4
6) 私はときどき自分が役立たずだと感じる	1	2	3	4
7) 私は他人と同じくらい価値ある人だと思う	1	2	3	4
8) もう少し自分を尊敬できたならばと思う	1	2	3	4
9) どんなときも自分を失敗者だと思いがちだ	1	2	3	4
10) 私は自分に対して前向きの態度をとっている	1	2	3	4

Group Appraisal Scale

(Maton, K. I., 1988)

あなたが家族会に参加して感じていることについておうかがいします。
あてはまるもの一つに〇をつけてください。

	全くそうではない	そうではない	いくぶんそうである	その通りである	全くその通りである
1）家族会に関わることで、私は得ることがたくさんあった	1	2	3	4	5
2）家族会に参加してから、私の家族としての対応は、かなりよくなった	1	2	3	4	5
3）私は家族会に参加し始めてから、自分自身がいい方向に変わってきたと感じる	1	2	3	4	5
4）私の家族としての個人的な悩みは、家族会に参加しても期待していたほどには、解消されていない	1	2	3	4	5
5）私は、家族会活動に参加して、精神障害者の家族をめぐる問題についてかなり良く理解できるようになった	1	2	3	4	5

今の家族会について、あなたのご意見をおうかがいします。
あてはまるもの一つに〇をつけてください。

1）家族会のあり方については、大いに改善の余地がある	1	2	3	4	5
2）私は全体的に、家族会が会員を援助するやり方にとても満足している	1	2	3	4	5
3）この家族会は効果的な活動をするために、必要に応じて計画的に進められている	1	2	3	4	5
4）この家族会は、他の家族会と比べても、かなり良い方だと思う	1	2	3	4	5
5）この家族会は、私が描いている理想的な家族会のイメージ（像）に近い	1	2	3	4	5

CSQ-8

(Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen T. D., 1979)

専門職（保健婦・相談員・ワーカー）による支援について、おたずねします。
あてはまるもの一つに〇をつけてください。

1）家族会が受けた専門職による支援の質について、あなたはどのように評価しますか。
①とても良い　②良い　③まあまあ　④良くない

2）家族会が受けた専門職による支援は、あなたが期待していた通りのものですか。
①全く違う　②そうではない　③大体そうである　④全くその通りである

3）専門職による家族会への支援は、あなたが求めているものをどの程度満たしていますか。
①ほぼ全て満たす　②おおかた満たす　③あまり満たさない　④全く満たさない

4）もし他の家族会も、あなたの家族会が受けている支援と同じような支援を受けられるとしたら、それを他の家族会の人にすすめますか。
①絶対にすすめない　②たぶんすすめない　③たぶんすすめる　④絶対にすすめる

5）あなたは、家族会が専門職から受けた支援の量についてどのくらい満足していますか。
①全く不満　②やや不満　③ほぼ満足　④とても満足

6）家族会が専門職から受けた支援は、家族会が効果的に活動していく上で役立っていますか。
①たいへん役立つ　②いくぶん役立つ　③ぜんぜん役立たない　④逆効果だと思う

7）全体的に、家族会が専門職から受けた支援についてあなたはどのくらい満足していますか。
①とても満足　②ほぼ満足　③やや不満　④かなり不満

8）家族会がこれから先も、今専門職から支援されているのと同じように支援されることを、あなたは望みますか。
①絶対に望まない　②望まないと思う　③望むと思う　④必ず望む

Knowledge and Skills Subscale of Social Worker Empowerment Scale

(Frans, D. J., 1993)

あなたの家族会支援についてのお考えなどをお聞きします。
それぞれの質問について、最も近いものを選んで数字一つに〇をつけてください。

	全くそうではない	そうではない	どちらとも言えない	その通りである	全くその通りである
1）私は、家族会を支援しているときに起きる状況にどのように対応すればよいか、大体わかっている	1	2	3	4	5
2）私は、家族会を支援するために必要な教育を受けている	1	2	3	4	5
3）私は、家族会に関する多くの専門的な問題を解決するために、十分な情報を持っている	1	2	3	4	5
4）私は、家族会に関連するあらゆる問題を承知している	1	2	3	4	5
5）最近では、家族会を支援しているときに予期していなかった問題にぶつかることは滅多にない	1	2	3	4	5
6）私は家族会を支援するのに役立つ雑誌・本をよく読んでいる	1	2	3	4	5
7）私は、家族会をよりよく支援できるノウハウを獲得するために、研修などによく参加する	1	2	3	4	5
8）もし私が家族からの質問に答えられなくても、私はどこでその答えを得ることができるか、わかっている	1	2	3	4	5
9）私は、家族会に関する知識を豊富に持っていると、しばしば他の人に言われる	1	2	3	4	5

専門職による家族会支援に関するガイドライン
（全国精神障害者家族会連合会発行）

目次

Ⅰ．ガイドラインの趣旨・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 1

Ⅱ．総論：家族会と家族会支援
１．家族会とは・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 2
２．家族会の現状と今後・・・・・・・・・・・・・・・・・・・・・・・・・・・ 3
３．専門職が家族会を支援することの意味・・・・・・・・・・・・・・・・・・・ 3
４．家族および障害者本人へのケアにおける家族会支援の位置づけ・・・・・ 5
５．専門職が抱える業務全般の中での家族会支援・・・・・・・・・・・・・・ 7
６．家族会支援の多様性・・・・・・・・・・・・・・・・・・・・・・・・・・・ 7

Ⅲ．総論：家族会と専門職の関係性
１．家族会と専門職の様々な関係・・・・・・・・・・・・・・・・・・・・・・ 8
２．家族会と専門職の理想的な関係・・・・・・・・・・・・・・・・・・・・・ 8
３．家族会と専門職がパートナーになるために・・・・・・・・・・・・・・・・ 9

Ⅳ．総論：家族会支援のすすめ方
１．家族会支援の流れ・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 11
２．家族会の活動とその評価・・・・・・・・・・・・・・・・・・・・・・・・ 12
３．家族会への支援方法の決め方：実践・・・・・・・・・・・・・・・・・・・ 21
付録・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 24

Ⅴ．各論：家族会支援の実際
１．　家族会支援の枠組み　・・・・・・・・・・・・・・・・・・・・・ 26
２．　家族会支援の実際　・・・・・・・・・・・・・・・・・・・・・・・ 28
Ａ．家族会の機能面への支援　・・・・・・・・・・・・・・・・・・ 28
Ｂ．家族会の組織面への支援　・・・・・・・・・・・・・・・・・・ 36
Ｃ．地域の関係機関・住民への働きかけ　・・・・・・・・・・・・・ 44
Ｄ．家族会の会員個人への支援　・・・・・・・・・・・・・・・・・ 46
付録　・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・ 49
付録１　入会案内
付録２　家族会の案内を載せている会報
付録３　家族の悩み･体験を綴った会報
付録４　例会の様子を詳しく書いた会報
付録５　低料第三種郵便申請書類

家族会会員と専門職の話し合いのテーマおよび進め方

（ガイドラインより抜粋）

３．家族会への支援方法の決め方：実践

家族会への支援方法は、基本的には家族会と専門職との話し合いで決めることをおすすめます。家族会との話し合いには、次の段階があると考えられます。

［第１段階］　家族会と専門職がお互いにパートナーになれるように態度を変える
［第２段階］　家族会の今後の方向性について話し合い、具体的な目標を決める
目標を達成するためにお互いにできることを具体的にする
［第３段階］　お互いに決めたことの進行状況について確認し、意見交換をする

次に、具体的にどのように進めていけばよいかグループワークのすすめ方を紹介しますので、参考にしてください。なお、ここでは専門職が司会をとる形のグループワークを紹介します。

［第１段階］　家族会と専門職がお互いにパートナーになれるように態度を変える

家族会と専門職がパートナーであるとき、①お互いのことをよく理解している、②お互いに信頼して尊敬している、③お互いに対等で平等である、④お互いに持ちつ持たれつの関係である、というような特徴があります。このような関係でない場合は、第１段階の話し合いをし、家族会と専門職がお互いにパートナーになれるように態度を変えてから、家族会への支援方法について話し合いましょう。もし、すでにパートナーになれるような関係であれば、第２段階から進んでも構いません。

次のような場合は特に第１段階の話し合いが必要です。

タイプＡ：お互いのことをよく知らないため、良い印象を持っていない

家族は、「専門職ってどんなことをしているのかわからない」、「保健婦さんは精神よりも赤ちゃんのほうを好んでいる」、「保健婦さんは精神のことをよく知らない人が多い」等と言います。

家族のこのような否定的な態度は、専門職や関係機関がどのような仕事をしているのか知らない、家族会や家族に何をしてくれるのかわからないという、お互いをよく知らないことが原因と考えられます。

このような場合、まず、専門職は、自分の仕事や自分が所属する機関の仕事について家族に説明し、家族会とパートナーでありたいという気持ちを積極的に示しましょう。そうすれば、家族会の専門職に対する態度は好意的なものに変わるでしょう。

タイプＢ：家族会が専門職に依存しており、家族が主体的でない

家族会が主体的でなく、専門職に家族会の運営や進行を任せていることがしばしばあります。

家族は、「専門職にすべてお任せします」と言い、専門職に何をして欲しいか訴えることがほとんどありません。

このような場合、まず、専門職は、家族が家族会の素晴らしさを認識できるように働きかけ、専門職も家族会に関わることで得ることがたくさんあるということを知らせましょう。そして、家族が専門職に意見を言うことを積極的に促しましょう。

［　テーマ設定とすすめ方　］

テーマ１：お互いのことを知ろう

家族に専門職の仕事や専門職が所属する機関の仕事について説明し、知ってもらいましょう。精神障害者に関連した事業の取り組み状況や家族会支援についての取り組み状況を説明しましょう。必ず、質疑応答の時間を取り、理解を深めましょう。

専門職も家族会のことをよく知らないことがあります。そのよう場合は、お互いのことを知ることに時間を割きましょう。

テーマ２：家族会の素晴らしさをあらためて認識しよう

「家族会に入ってよかったこと」について、家族に話してもらいましょう。家族が家族会に支えられて生きていることを再認識できるでしょう。家族会が素晴らしいことを専門職が認め、家族会の素晴らしさを家族が実感できるように伝えていきましょう。家族が自信をもてれば、専門職とパートナーになる自信もついてきます。

一人ずつ話していくと家族会の会員数が多い場合、この話題だけでかなり時間がかかるので、すすめ方に注意しましょう。

テーマ３：家族会と専門職は、持ちつ持たれつの関係であることを認識しましょう

「専門職が家族会に関わってよかったこと」をたくさん話しましょう。家族が専門職に意見を言ってもらうことが専門職のためになることを伝えましょう。家族にも「専門職と関わってよかったこと、感じたこと、嫌だったこと」などを話してもらいましょう。家族から出された意見に対して、専門職は説明して誤解を解くよう努力しましょう。

このテーマは、家族会が専門職と関わるために、重要なテーマです。ここにはある程度時間を割きましょう。

［第２段階］　家族会の今後の方向性について話し合い、具体的な目標を決める。
目標を達成するためにお互いにできることを具体的にする。

次は、家族会の今後の方向性について専門職と家族会が話し合いましょう。

［　グループワーク実施前の準備　］

グループワークでは、家族会と専門職で、家族会の今後の方向性について話し合います。そのために、専門職も家族も家族会の活動を評価し、今後の方向性について考えを持っておきましょう。

このような話題は、定例会よりも役員会で話すほうが適切な場合があります。あらかじめ役員会で話してもらい、ある程度意見をまとめて定例会の中で話し合ったほうがスムーズにいくかもしれません。また、会員の方にも前もってこのような話題を話すことを伝えておき、各自で考えておいてもらいましょう。（家族には付録を渡して考えてもらうとよいでしょう）

［　テーマ設定とすすめ方　］

テーマ１：家族会の今後の方向性について話しましょう

まず、家族に「どのような家族会にしていきたいか」というテーマで話してもらい、専門職も今の家族会の状況を見て、今後どのように活動したらよいと思っているかを言ってみましょう。専門職が家族会の目標を受け入れなければ、専門職として家族会を支援することはできないはずです。お互いに思っていることを言い合える関係が大切です。

テーマ２：家族会の具体的な目標をはっきりさせてもらいましょう

家族会の今後の方向性が大体見えてきたら、次に具体的にどのような活動をしていくかをはっきりさせるようにしましょう。具体性のない「なんとなくこうしたい」という目標は、実現しにくいものです。いつ、誰が、どのようにして、実行するか具体的に対策を考えていきましょう。

テーマ３：家族会と専門職がお互いにすることを決めておきましょう

そして、専門職としては、何ができるのか、家族会は何をするのかを具体的に決めておきましょう。このとき、専門職として何を支援できるか、いくつかの選択肢をあげて選ぶようにするとよいでしょう。専門職としてできることの限界も伝える必要があるでしょう。お互いに寄り添った中での妥協点を見つけていきましょう。

その場ですぐに答えられることは答え、答えられないことは次回までに専門職としてできることを考えておきましょう。家族にも次回までに考えておくことを伝えましょう。

［第３段階］お互いに決めたことの進行状況について確認し、意見交換をする

次の例会の時は、どこまでお互いに決めたことが実現しているか確認して、専門職も意見を言い、家族からも意見をもらいましょう。専門職から報告を受けたり、意見を求められると、家族は専門職が家族会と一緒になって活動してくれていることをより実感できるでしょう。

［　全体を通してグループワーク実施上の注意　］

１．　グループワーク開始前

・グループワークの目的を理解し、進行、専門職各々の役割について打ち合わせをしておきます。
・家族会の予定にあわせてグループワークにどのくらいの時間をとれるのか聞いておきます。その時間内で、家族会と専門職にとって話し合うことが必要なテーマはどれかを絞っておきましょう。
・会長や役員と簡単に打ち合わせをしておきましょう。話がでないときは会長などに口火をきってもらうようお願いしておくこともよいでしょう。

２．　グループワーク実施中

・話しやすい雰囲気作りに努めましょう。
・家族に話し合っているテーマを十分認識してもらえるよう工夫しましょう。例えば、毎回「○○さんは××についてどのように考えていますか」と聞く方法があります。
・発言がない場合は、司会者が口火を切って話したり、会長にお願いすることもできます。また、「右回りで一言ずつ話してもらいますので準備してください」と事前に発言してもらうことを伝えておくと心構えができます。
・グループワークの進行が目的からそれないように、軌道修正を行ないましょう。
・家族の発言をまとめ、伝えたい内容を全員が理解できる言葉や表現に変える工夫をしましょう。
・最後は、話し合った内容について感想を言ったり、話された内容をまとめて伝えましょう。

３．　グループワーク終了後

・グループワークの内容について目的を達成できたか、専門職間で話し合いましょう。
・次回のグループワークの進行、家族会へのフィードバックの方法について話し合いましょう。
・当日話し合った内容は、簡単にまとめて会員に配ったり、機関紙に載せてもらいましょう。