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Research Paper

Twelve months effect of self-referral to inpatient treatment on patient activation, recovery, symptoms and functioning: A randomized controlled study☆

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ABSTRACT

Objective: To investigate the effect of having a contract for self-referral to inpatient treatment (SRIT) in patients with severe mental disorders.
Methods: A randomized controlled trial with 53 adult patients; 26 participants received a SRIT contract, which they could use to refer themselves into a Community Mental Health Centre up to five days for each referral without contacting a doctor in advance. Outcomes were assessed after 12 months with the self-report questionnaires Patient Activation Measure (PAM-13), Recovery Assessment Scale (RAS), and the Behavior and Symptom Identification Scale (BASIS-32) and analyzed using linear mixed and regression models.
Results: There was no significant effect on PAM-13 (estimated mean difference (emd) −0.41, 95% CI (CI):-7.49–6.67), nor on the RAS (emd 0.02, CI:-0.27–0.31) or BASIS-32 (0.09, CI:-0.28–0.45). An exploratory post hoc analysis showed effect of SRIT in those with low PAM below ≤47 ($p = 0.049$).
Conclusion: There were no group differences after 12 months, but both groups maintained their baseline levels.
Practice implications: SRIT contracts can be recommended as it supports the rights to self-determination, promote user participation in decision-making in own treatment without any indication of adverse effects.
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1. Introduction

Shared decision making and the right to self-determination are important ethical aspects in mental health services [1,2]. Such aspects are not well implemented in mental health services at present [3]. Thus, there is a need for service models offering patients to be empowered as decision-makers [4,5], get involved as active partners [6] and participate in treatment decisions [7].

Patient activation is defined as knowledge, skills and confidence in managing one's own health [8]. Being active and engaged has been associated with improved health outcomes and positive experience with care, and better coping skills and recovery [9]. Conversely, patients with low levels of activation may be too

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overwhelmed to manage their own health, and have low confidence and insufficient problem-solving skills [10]. Regaining authority through being self-empowered with support is required for re-establishing and stabilizing the hope of recovery [11]. Participation in decisions empowers individuals and promotes their personal recovery [12]. Personal recovery is defined as a process of "changing one's attitudes, values, feelings, goals, skills, and/or roles" for "living a satisfying, hopeful and contributing life", even while living with a disease [13]. Such recovery requires that persons with severe mental disorders establish a meaningful life through taking more control over their lives in spite of their disorders [14]. In addition to improved personal confidence and willingness to ask for help, there is focus on goal and success orientation, reliance on others and avoiding domination by symptoms [15].

People with severe mental disorders occasionally need treatment from inpatient services in phases with increased symptoms and crises [16]. A flexible, safe and predictable support from the services will facilitate the patients' coping in those phases [17]. Self-referral to inpatient treatment (SRIT) might be one way to obtain that [18]. SRIT has recently been implemented in several Community Mental health Centers (CMHC) in Norway [19–26]. This intervention is based on legislation regarding patients' rights [27], personalized care planning [28] and shared decision making [29]. SRIT seems to be a flexible model adapted to patients' needs [23]. A recent systematic review of published reports on SRIT found only qualitative and observational studies [18]. However, two recent randomized controlled trials, evaluated the effect of SRIT. Both studies and the present study are parts of a larger study investigating the effect of introducing SRIT. One study found no effect of SRIT in re-admissions, inpatients days, and coercion after 12 months [22]. The other study found no effects on patient activation and recovery after 4 months [21]. It would therefore be important to investigate the effect of SRIT after 12 months regarding activation, recovery, mental health symptoms and functioning. Such information has not been reported.

Objectives: The main aim was to assess the effect of a SRIT contract on the primary outcome patient activation (PAM-13). The secondary outcomes were recovery (RAS) and behavior and symptoms identification (BASIS-32) after 12 months compared to those who received treatment as usual (TAU).

2. Methods

2.1. Trial design

An open parallel-group randomized, and controlled trial (RCT) was conducted at a CMHC in central Norway. The inclusion period was between May 2010 and December 2012.

The project had one user representative in the management group and two user researchers in the research group. The trial was registered at clinicaltrials.gov (NCT01133587).

2.2. Settings

The catchment area for the CMHC in Central Norway is 94,000 inhabitants.

2.3. Participants

The main inclusion criteria were adults clinically diagnosed with schizophrenia or bipolar disorder. Some had several diagnoses and comorbid drug addiction. The drug use should be relatively under control. They needed to have had previous contact with the CMHC rehabilitation unit, and to have had continued long-term primary and specialist healthcare outpatients consultations. The exclusion criteria were severe substance abuse problems or self-destructive behavior, inability to consent, or being unable to use SRIT as intended. An interdisciplinary team at the CMHC decided who was eligible for the study.

The recruitment took place by informing patients and staff both orally and in writing. The participants either volunteered themselves or were recommended by their therapists. All participants had to be approved by a specialist in psychiatry. They could either be inpatient or outpatient before they were included into the study, but they needed to be discharged the same day or within a few days. Thirty-three (62.3%) participants (18 in SRIT, 15 in TAU) were included and randomized while they were inpatients, and they stayed for an average of 13.6 days.

2.4. Intervention

The purpose of a SRIT contract was to increase user participation and to offer patients with worsening symptoms easy access to inpatient treatment without the need to contact the doctor. All participants in this study received exemplified information about how to use SRIT prior to inclusion (e.g. structure during the day, or experienced warning signs and worsening symptoms of their mental disorder). All were encouraged to establish an individual plan, as all patients with severe mental disorders have a right to have [30]. Participants were informed that if they were randomized to TAU, a SRIT contract would be offered after one year if they still fulfilled the inclusion criteria. The guidance in how to use the contract was repeated to each SRIT participant after randomization. The participants were encouraged to discuss their warning signs and what they could do to reduce them with their therapist.

SRIT participants could self-refer to the rehabilitation section between Mondays and Friday between 8:00 a.m. and 8:00 p.m. for up to five days. If they wanted to stay over the weekend, they had to contact the unit before 3:30 p.m. on Friday. A minimum of 14 days between each stay was enforced, which was done to avoid capacity problems and based on procedures from the first study in Norway [19]. Participants were invited to follow the units' usual rules and structure. All SRIT patients had a consultation with a specialist nurse in psychiatry after referral who documented in the health record on the basis of the consultation. Consultations with a doctor or psychologist were not planned, but could be arranged. Their medication plans should normally not be changed during the stay, but changes were possible under doctors' instruction. All patients could be admitted to the CMHC or hospitals by a doctor following normal procedures. Participants randomized to TAU followed usual procedures if they needed hospitalization.

2.5. Outcomes

The outcomes were assessed at baseline and after 12 months. A few participants completed the surveys at home. The rest completed the self-report questionnaires at the CMHC by themselves. A few needed assistance to complete the scales.

2.5.1. Primary outcome

The primary outcome Patient Activation Measure (PAM-13) is the most frequently used measure of activation in health care [7]. It measures both patient's beliefs about their ability to self-manage and their confidence to take action [7]. The translated [31] and validated Norwegian PAM-13 was used [31,32]. PAM-13 is a 13-item, self-report questionnaire measuring knowledge, skills and confidence in managing one's health, which is scored on a four-point Likert scale from 1 = strongly disagree to 4 = strongly agree, additionally 0 = not applicable [8,33]. The PAM-13 raw scores (sum score) were converted into a theoretical range of 0–100 [33] and can be divided into four levels where 1 = may not yet believe

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