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Review

Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review



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ABSTRACT

Background: A central question for the organisation of mental health care is whether the same clinicians should be responsible for a patient's care across inpatient and outpatient settings (continuity of care) or if there should be separate teams (specialisation). Current reforms in Europe are inconsistent on which to favour, and are based on little research evidence. This review is the first systematic appraisal of the existing evidence comparing continuity of care and specialisation across inpatient and outpatient mental health care.

Method: A systematic search for studies of any design comparing mental health care systems based on continuity or specialisation of care was performed. Differences in clinical, social and cost-effective outcomes, and the views and experiences of patients and staff were assessed using narrative synthesis.

Results: Seventeen studies met the inclusion criteria. All studies had methodological shortcomings, but findings point towards reduced length and number of hospitalisations, and faster or more flexible transitions between services in continuity systems. Survey and qualitative findings suggest advantages of both systems, whilst patients and staff appear to prefer a continuity system.

Conclusion: The evidence base suggests better outcomes and stakeholder preferences for continuity of care systems, but the quality of existing studies is insufficient to draw definitive conclusions. Higher quality comparative studies across various settings and population groups are urgently needed.

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1. Introduction

Optimal organisation of the mental health care system is important and should be informed by research evidence [42]. A mental health care system refers to all the treatment programmes for a target group in a given area and the coordination between these programmes [6]. One key component of mental health care systems concerns whether mental health care should be organised with continuous treatment teams across inpatient and outpatient settings or separate specialised teams within each of the two settings. A central area of ongoing debate in policy-making on mental health care systems is which of the organisational models, i.e. continuity or specialisation, is more effective [5,23]. Reflecting these alternative organisations of care, mental health care systems can focus either on continuity of care (here

termed continuity systems) or specialisation (here termed specialisation systems).

Currently, there are inconsistent reforms taking place throughout a number of countries regarding which model to adopt. For example, in the United Kingdom (UK) various services have recently switched from a traditional continuity system where the same consultant psychiatrist provides care for a patient across inpatient and outpatient settings, to a specialisation system where separate consultants are responsible for inpatient and outpatient care [5,34]. In other countries, such as Germany [4], there are initiatives to shift from separate specialised services to continuity across inpatient and outpatient settings. These conflicting reforms occurring throughout the world are based on little, if any, evidence on their benefits to patient care [5,23] and to date, there has been no systematic appraisal of the evidence regarding which system is more favourable. A synthesis of the evidence base regarding continuity and specialisation systems of mental health care is needed to inform the debate on which system to favour.

The aim of this systematic review was to identify studies comparing outcomes of continuity and specialisation systems of adult mental health care and synthesize their findings.

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2. Method

A protocol-driven systematic review was conducted following recommended guidelines [13,28,32].

2.1. Inclusion and exclusion criteria

We included any studies which compared continuity and specialisation systems of adult mental health care. A continuity system was defined as one where care was provided by the same clinicians across inpatient and outpatient services. In order to meet this definition, there had to be continuous clinical responsibility across treatment settings (e.g. simply maintaining contact following referral, or interventions to facilitate the transition between separate inpatient and outpatient services did not meet this definition). A specialisation system was defined as one where care was provided by different clinicians in inpatient and outpatient services, and the transition between services was coordinated through a network of regulated referrals.

We included studies focusing on general adult mental health care services. This included studies with adult psychiatric patients or health care staff (both clinicians and non-clinical staff members). We did not include studies focusing on services for eating disorders or substance use disorders as often these are separate to general mental health care. We only included studies if they contained primary data on clinical, social, or cost-effectiveness outcomes of the two systems, or on the experiences or opinions of staff and patients. Due to the difficulty of relying solely on randomized controlled trials (RCT) in health care systems research [12], we included studies of any design – experimental, quasi-experimental, surveys, and qualitative studies.

Studies were excluded from the review if they assessed services outside adult mental health care (e.g. the integration of mental health with primary care or substance misuse services). Individual articles were also excluded if they did not contain primary data or if they only presented replicated data available in another primary paper.

2.2. Search strategy

We identified studies by conducting an electronic search of 5 bibliographic databases (Medline, PsycINFO, Embase, the Cochrane Libraries, and Web of Science) from inception using both controlled vocabulary and free text terms. There were no restrictions on the date of publication or language. The free text search consisted of various descriptors for continuity or specialisation (e.g. “continu* of” OR speciali* OR integrated OR functional* OR fragment*) which needed to appear adjacent to systems descriptors (e.g. system* OR organisation OR care OR responsibility*). This enabled us to capture terms such as “continuity of care”, “specialisation systems”, “functional organisation” etc. This was then combined with mental health service descriptors (e.g. “mental health services/” OR psychiatr*). The full search strategy can be found in the supplemental material (Supplement 1). The latest search was conducted on 22nd April 2014. We also conducted a grey literature search using Google Scholar, SIGLE, and ProQuest. Bibliographies of included articles and relevant reviews were hand searched and their citations tracked to identify additional articles. We also contacted the first authors of included studies to supplement the search and to resolve any ambiguity on study details.

Titles and abstracts were screened by two reviewers, with 25% double rated to confirm consistency. All potentially relevant full text articles were independently screened by both reviewers to determine eligibility and disagreement was resolved by discussion and consensus.

2.3. Data extraction and quality assessment

Data were extracted for each study independently by two reviewers using a standardized form, with differences resolved by consensus. Data were extracted on the study design, setting, participant characteristics, details of the systems (including the type of services, staff roles, treatments available), and the details and results of all outcome measures.

Internal validity of comparative studies was assessed using a standardised tool adapted from the Cochrane Effective Practice and Organisation of Care (EPOC) group’s risk of bias criteria [8]. Due to the lack of randomized trials on this topic, the items for randomization and allocation concealment were omitted. The tool was adapted to include an assessment of topic-specific confounders and differences in treatment between intervention groups. Each study was assessed as either high, low, or unclear risk on nine criteria: baseline differences in outcome measurement, baseline differences in topic-specific confounders, treatment differences, incomplete outcome data, outcome assessment (one item for service contact data and one for other clinical/social/quality outcomes), contamination, selective reporting, and other bias (e.g. design specific issues, number of clusters, sample size). The topic-specific confounders considered by the reviewers to be important in the patient outcome studies were participant demographics (age, gender, ethnicity, socioeconomic status, employment status, education background) and clinical characteristics (symptom levels, number of previous admissions, time since first contact, diagnosis). For studies assessing staff outcomes, the confounders assessed were age, profession, and years in service. The treatment differences item considered any differences between the groups in intensity of inpatient and outpatient treatments and the presence of additional co-occurring interventions that may have biased the results.

Surveys and qualitative studies were assessed as high, low or unclear risk in terms of sampling bias (e.g. representativeness of the population, response rate) and response bias (e.g. leading questions, biased instructions, social desirability). Each study was independently assessed by two reviewers. Disagreements were resolved either by consensus or by a third reviewer adjudicating in the case of ongoing disagreement.

2.4. Data analysis

As per protocol, we planned to conduct a meta-analysis of quantitative outcomes comparing continuity systems and specialisation systems where a sufficient number of high quality homogenous studies existed, but this was not the case due to variations in methodology, interventions, and outcomes. Instead, results were synthesized following the narrative synthesis guidance for systematic reviews [32]. First, we conducted a preliminary synthesis using tabulation and textual descriptions to summarise study characteristics, risk of bias, and the main findings. Studies were organised according to design and the main findings grouped under similar outcomes. The direction of effect across studies was compared for each outcome and, where possible, proportional differences or standardized mean differences were calculated. Where conflicting findings existed, extra emphasis was given to studies meeting the EPOC group’s criteria for acceptable study design in healthcare systems research (RCT; non-randomized controlled trial, NRT; controlled before and after study, CBA; interrupted time series) [9]. We then interrogated the findings by exploring relationships within and between studies to identify any potential moderator variables that may explain the main effects of studies. This included variations by sub-groups of participants, study setting, treatment characteristics, and methodology. The robustness of the final synthesis was assessed through critical reflection on the quality of the available evidence, the review

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