



Review / Meta-analyses

Interventions for involuntary psychiatric inpatients: A systematic review



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ABSTRACT

Background: Observational research has found that involuntary treatment provides limited benefits in terms of long-term clinical outcomes. Our aim was to review literature on existing interventions in order to identify helpful approaches to improve outcomes of involuntary treatment.

Methods: This systematic review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement guidelines. Seven databases (AMED, PsycINFO, Embase Classic, Embase 1974–2017, CINAHL, MEDLINE, and BNI) were searched and the results were analysed in a narrative synthesis.

Results: Nineteen papers describing fourteen different interventions were included. Using narrative synthesis the interventions were summarised into three categories: a) structured patient-centred care planning; b) specialist therapeutic interventions; c) systemic changes to hospital practice. The methodologies used and outcomes assessed were heterogeneous. Most studies were of low quality, although five interventions were tested in randomised controlled trials (RCTs). Preliminary evidence supports structured patient-centred care planning interventions have an effect on long-term outcomes (such as readmission), and that specialist therapeutic interventions and systemic changes to hospital practice have an effect on reducing the use of coercive measures on wards.

Conclusions: This review shows that it is possible to conduct rigorous intervention-testing studies in involuntary patients, including RCTs. Yet, the overall evidence is limited. Structured patient-centred care planning interventions show promise for the improvement of long-term outcomes and should be further evaluated.

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1. Introduction

The most recent United Nations' convention on the rights of people with disabilities raised growing concerns about providing treatment in the absence of consent [1,2]. Historically the problematic ethical nature of involuntary treatment has been justified based on the principle of beneficence, by which subjecting people to involuntary treatment is in their best interest, and a clear benefit is expected [3]. Currently, involuntary treatment has different aims across countries and happens under different circumstances, but the ethical basis underlying its existence and

continued practice is at least in part the same, i.e. to manage risk to self and others and to avoid a significant deterioration of patients' mental health [4–6]. Yet, observational studies found that although involuntarily treated patients improve enough to be discharged based on the country's regulations (for example presenting a reduced risk to themselves and/or others) they show limited benefits in terms of long-term clinical improvement, a deterioration of social functioning and high readmission rates within the following year [7,8]. Additionally, involuntary treatment is experienced as distressing and disempowering and might negatively impact future relationships with mental health services [9–11].

Rates of involuntary treatment have been increasing in numerous European countries [12]. Sometimes involuntary treatment is the only option for providing treatment to highly vulnerable and distressed patients [13,14]. Despite the important place it holds in psychiatric practice, there has been relatively limited experimental research to inform practices, which appear to be largely based on traditions rather than on evidence [15].

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Hence, novel and systematically developed interventions to improve the outcomes of involuntary treatment are required.

With this review, we aimed to systematically appraise the available literature to identify helpful approaches to improve outcomes of involuntary treatment.

Our specific research questions are:

- a) What interventions have been studied with involuntary inpatients?
- b) Which study designs were used to assess their outcome(s) and which interventions showed evidence of benefit?

2. Methods

This systematic review was conducted according to the PRISMA guidelines (Appendix 1) [16]. We searched published and grey literature on involuntary inpatients in order to identify all interventions offered before discharge from involuntary care and their outcomes. The protocol for this review was preregistered on PROSPERO (CRD42017060418).

2.1. Search strategy

We searched the following databases: AMED, PsycINFO, Embase Classic, Embase 1974–2017, CINAHL, MEDLINE, and BNI. Grey literature was searched using Google Scholar and Open Grey. Additional studies were identified through hand-searching reference lists from relevant texts. Articles from inception to December 21st 2017 were included in our search. The searches were re-run on May 30th 2018 and none of the additional papers identified met the inclusion criteria. For the full search strategy see supplementary material.

2.2. Inclusion/exclusion criteria

Studies were included if they contained a description of an intervention or practice used with adults receiving involuntary psychiatric inpatient care. Coercive measures (e.g. forced medication, restraint or seclusion) were not considered interventions. To be eligible, at least 50% of the study's sample needed be adults (aged 18–65) who were receiving involuntary inpatient treatment at the time of recruitment to the study. If the sample consisted of fewer than 50% inpatients, or fewer than 50% involuntary patients, the study was excluded. Other than excluding reviews and opinion pieces that were not based on a specified sample that met the inclusion criteria, no restrictions were applied to the research studies' designs, to be as inclusive as possible.

Papers that were not available in the Latin alphabet were excluded because unfortunately we had neither the linguistic capacity within the research team nor the resources for translation.

Studies whose participants' only psychiatric diagnosis was of substance-use problems or eating disorders were excluded. Involuntary treatment for people with these diagnoses can be differently regulated under different national legislations and sometimes carried out outside of psychiatric services. Comorbid substance use or eating disorders were included, as long as the primary reason for involuntary treatment was neither substance use nor an eating disorder.

2.3. Screening procedures

Screening was conducted by three authors in line with recommendations outlined by the Centre for Reviews and Dissemination [17]. An initial piloting phase of the inclusion and exclusion criteria was conducted by MC and TM to test, further

refine the inclusion criteria. One author (MC) screened all titles for eligibility, then a randomly selected subsample of 50% (using a random sequence generator) was independently screened by EB, and a further randomly selected subsample of 20% was independently screened by TM. Disagreements between authors on inclusion at title-screening were recorded and counted to assess inter-rater reliability. A high level of agreement was achieved: between MC and TM it was 96% and between MC and EB it was 92%. Disagreements were resolved by including texts if there was any indication they may be eligible from their titles. Full texts were obtained for the 383 texts whose titles and abstracts indicated they may meet the inclusion criteria, and the reference lists of relevant reviews were screened by MC and TM for additional texts. Disagreements between authors at full-text screening were resolved through discussion with the review team as a whole. If the percentage of involuntary patients in the sample was not stated in the paper, the authors were contacted by MC. Uncertainties and disagreements on inclusion were discussed and resolved by the authors. They included a psychiatrist and psychologist (SP), two psychiatrists (TM and DG) and two research psychologists (MC and EB).

2.4. Data extraction and quality assessment

Data were extracted using structured tables, including details on the sample, the study design and outcomes assessed. The intervention descriptions were also extracted for the narrative synthesis. The quality of the included papers was rated independently by MC, TM and EB using the McGill Mixed Method Appraisal Tool (MMAT) [18]. This tool is well-suited to the variety in designs and measures of the included studies, and has been found to be both reliable and efficient. Criteria against which quality is assessed depended on the type of methods studies used. Scores ranged on a five-point scale from 0 (no criterion met) to 4 (all criteria met). In studies with a mixed method design, both components were rated according to MMAT criteria, and the score of the weakest component was taken as the overall score of the study. Disagreements on quality ratings were resolved through discussion between raters and with DG.

2.5. Data analysis

As the articles found were highly heterogeneous in design and outcome, we used a narrative approach to synthesise the characteristics of the interventions. The narrative synthesis took place in two stages based on the guidelines set out by Popay and colleagues [19]. First an initial framework of criteria was developed to explore the interventions' commonalities and differences. These criteria included factors such as whether the intervention was an alternative or an addition to involuntary treatment, who was involved in delivering the intervention, what training they received, what expertise and role they had, the aim(s) of the intervention and the duration and frequency of sessions. These criteria were identified inductively: familiarisation with the descriptions of the interventions led to the formulation of the criteria. This process was carried out independently by two researchers (MC and TM), and through discussions among the entire research team a framework of criteria was developed and refined through an iterative process. The second stage of the analysis consisted of characterising each intervention based on the framework of criteria developed in the first stage. This allowed us to consider and explore the commonalities and differences between interventions in greater depth. Through discussion between the researchers, tables were drawn up to capture the essential elements for each of the interventions and interventions were categorised into groups

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