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Three prevention studies ongoing in Germany and Switzerland enrolling psychiatric patients at high risk for violence and compulsory hospitalization: Comparing aims, designs and methods

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ABSTRACT

Over the past decades, reductions of hospital beds and lengths of stay in general psychiatry are opposed to increases in detention cases and times in forensic psychiatric institutions. These developments raise the issue of trans-institutionalization of patient subgroups, whose particular needs of support are less accommodated by rationalized general psychiatry. While forensic psychiatric aftercare with a focus on risk assessment and assertive treatment has been largely established, preventive care of high-risk psychiatric patients to avert delinquency, compulsory hospitalization, or forensic courses has not yet been developed. Three outpatient studies addressing these issues have been conceptualized independently and were initiated in Germany and Switzerland. All three have similar study endpoints regarding incidence of violence, delinquency, compulsory hospitalization, and forensific sequelae. However, designs and methods differ with regard to inclusion criteria, assessment methods, foci of interventions, modes of delivering care, degrees of assertiveness, and times of follow-up. By the time of study completions, it can be expected that the joined information from all three studies will allow for a comprehensive appraisal of preventive treatment strategies and approaches in high-risk patients. In this paper, the study designs and methods of the three trials are outlined.

Contents

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1. Introduction

Over the past 40 years, reforms in general psychiatry have induced marked deinstitutionalization in favor of social and community-based psychiatric care in many countries (Kramp & Gabrielsen, 2009). Additionally, rationalizations in hospital services have led to reductions of hospital beds and lengths of stay (Doenisch-Seidel et al., 2007; Schanda, Stompe, & Ortwein-Swoboda, 2010) At the same time, there is an apparent tendency of a subgroup of severely ill psychiatric patients to be discharged into the community despite persistently high symptom load, low levels of social functioning, and proneness to violence (Hodgins, Mueller-Isberner, & Allaire, 2006; Schanda et al., 2010). These developments coincide with a continuous rise of detention cases and times in forensic psychiatric institutions (Schanda et al., 2010). While the interrelation of opposing general and forensic psychiatric developments is likely to be multidimensional, possibly involving independent, e.g., justiciable factors (Schanda et al., 2010), the critical issue of trans-institutionalization has been raised (Habermeyer, Wolff, Gillner, Strohm, & Kutscher, 2010). A subgroup of severely mentally ill patients, among them schizophrenia patients with complex problems reaching from treatment resistance to noncompliance and comorbidities, does not seem to be sufficiently reached by general-psychiatric services. As a consequence, these patients tend to enter unfavorable courses of illness and are, thus, more prone to precarity and delinquency (Kutscher, Schiffer, & Seifert, 2009). They carry an increased risk of becoming forensic cases or, prior to that, become the subject of involuntary hospitalizations in general psychiatry. Being hospitalized against their will bears the risk of further worsening these patients' attitudes to treatment and psychiatric services in general. It may lead to a deleterious circle of treatment discontinuation and involuntary readmission (Jaeger et al., 2013).

To counteract such developments, and to better reach the severely mentally ill in the community, intensified ways of delivering social and psychiatric care have been initiated. On the one hand, there are treatment approaches on a voluntary basis, such as intensive case management (ICM; Dieterich, Irving, Park, & Marshall, 2011) and assertive community treatment regimes (ACT; Lambert et al., 2010; Brugha et al., 2012). On the other hand, there are compulsory outpatient commitments that are issued by legal orders at the point of discharge from involuntary hospital treatment (Burns et al., 2013; Steadman et al., 2001; Swartz et al., 2001). Dieterich et al. concluded in their meta-analysis of 24 trials that ICM, comprising small caseloads and high intensity therapeutic input, reduced hospitalization and increased retention in care of the severely mentally ill, when compared to standard community care. ICM was, however, not associated with a change in contacts with the legal system. Interestingly, the more ICM was adherent to the ACT model, the better it was at decreasing time in hospital. According to Lambert et al. key features of ACT are a multidisciplinary team approach with a small client/staff ratio, high-frequent treatment contacts with 60–70% of interventions provided in the community setting, a "no drop-out policy", and a 24 h a day availability including crisis intervention. When using this regime in patients with schizophrenia spectrum disorders, they found that ACT, as compared to standard community care, was associated with a reduced rate and time to service disengagement and with larger improvements of symptoms, illness severity, global functioning, quality of life, and client satisfaction. Brugha et al. (2012) found in their survey on the outcome of assertive outreach (AO) across England that, under AO, the time spent in hospital decreased. Furthermore, the effectiveness of joint crisis plans for people with psychosis has been evaluated in several controlled trials. While results clearly suggested improvement of therapeutic relationships, conflicting results have been reported as to their potential to reduce compulsory hospitalization (Henderson et al., 2004; Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002; Thornicroft et al., 2013).

The outcomes of compulsory outpatient approaches appear less favorable: An outpatient commitment program conducted in New York showed no significant difference of the court-ordered group regarding psychiatric rehospitalization (Steadman et al., 2001). In an outpatient commitment trial conducted in North Carolina, control and outpatient commitment groups also did not differ significantly regarding hospital outcomes. However, it is interesting to note that in patients with psychoses, outpatient commitment reduced hospital admissions when combined with a higher intensity of outpatient treatment (Swartz et al., 1999, 2001). In a large outpatient commitment study in the State of New York, Phelan et al. (2010) studied different endpoints not only in schizophrenia patients, but also in people with schizoaffective disorder, bipolar disorder, and major depression. They found positive effects of assisted outpatient treatment on several self-reported items, among them serious violent behavior, suicide risk, and social functioning, and attributed them to the enhanced service package and not to legal coercion per se. However, a very recent comparison of community treatment orders (CTOs) vs. "leave of absence under Section 17 of the Act" following involuntary hospitalizations again yielded negative results: Despite more than three-fold increased time spent under community care in the CTO group vs. the Section 17 group, rates of readmission, time spent in hospital, clinical and social outcomes were unchanged (Burns et al., 2013).

The convergence of evidence in the above studies suggests, but does not prove, that intensifying outpatient care delivery to the subgroup of difficult-to-reach severely mentally ill patients may be effective in reducing rehospitalization. Evidence appears equivocal between studies regarding the improvement of clinical symptoms, but more concordant for improving social functioning (Lambert et al., 2010; Phelan et al., 2010). Outpatient treatments in this clientele seem to work better if they are voluntary rather than compulsory, and if they include enhanced service features like multi-professional case-management, home treatment, out of hours services. It is unclear, however, which particular treatment modality or combination is effective, and whether treatment effects apply to the total of the severely mentally ill or to certain subgroups. There is also no firm knowledge, whether the above