# Appendix B Evidence tables

# Critical appraisal and findings tables

## Critical appraisal table

## Table reporting impact study

## Review Question 4: How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?

Goldberg S, Bradshaw L, Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial (NIHR TEAM trial). BMJ: British Medical Journal 347: f4132

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes.<br>Suitable patients were identified on the acute medical admission unit and were randomly allocated between the specialist unit and standard care. Randomised patients were subsequently approached to take part in the study. This approach was necessary so that patients could be moved from the admission unit to wards at any time of day or day of the week at the pace required for the efficient operation of the hospital | **Follow-up**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>MMHU: 199 of 310 were followed up (rest declined)<br>• **Comparison dropouts**<br>Standard care – 199 of 290 patients agreed to be followed up, rest declined.<br>**Groups comparable on intervention completion?**<br>• N/A<br>**Missing outcome data**<br>• Intervention missing outcome data<br>• Comparison missing outcome data<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Unclear/unknown risk of | **Did the study have an appropriate length to follow-up?**<br>• Yes. Given the primary outcome measure was only 90 days<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of detection bias effect.**<br>• Unclear | For our purposes, it is difficult to separate the effect of the whole episode from the admissions aspect. The intervention – the specialist ward offering physical and mental health support – is not well described, although we are told it featured staff with experience and understanding of dementia, so difficult to generalise results. Method of allocation generated some mismatch in samples at baseline. The method of allocation (as the authors note) could have introduced bias. It was not possible to blind investigators as the patients were on different wards.<br>The control arm (TAU) could be a general or a geriatric ward (see study | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>To some extent, but we are only interested in ADMISSIONS, and the effect of the inpatient stay is really the key intervention (not described).<br>**Are the outcomes relevant?**<br>• Yes, to some extent<br>**External validity**<br>• +<br>Not exactly on topic, as the admission merges with |

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|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| while enabling enough time for patients to be recruited ethically.<br>**Adequate concealment of allocation?**<br>• Unclear<br>**Comparable groups at baseline?**<br>• Yes<br>Groups were generally well matched, but there was some mismatch at baseline in certain key variables (previous residence in care home 28% vs 21%, presence of delirium 53% vs 62%, history of hip fracture 14% v 7%, or hemiparesis 4% v 10%).<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk | bias<br>**Likely direction of attrition bias effect**<br>• Unclear | **Do conclusions match findings?**<br>• Yes | design column, left). | the inpatient care – and we have very little detail of how the specialist unit functioned or what it offered. |

Goldberg S, Bradshaw L, Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial (NIHR TEAM trial). BMJ: British Medical Journal 347: f4132

| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
| • Unclear<br>**Did both groups receive equal treatment (apart from the intervention)?**<br>• No<br>The median length of the index stay was 11 days (interquartile range 5–22) in each group. Of the participants randomised to standard care, 204/290 (70%) were managed on geriatric medical wards and 86 (30%) on general medical wards. There were significant ($p<0.05$) differences between the specialist unit and standard care on 42/132 intervention process items, including more comprehensive assessment of mental state, function, collateral history, statement of a clear medical diagnosis, drug review, rehabilitation therapy, discussion with family | | | | |

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|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| carers, and referral to community rehabilitation and mental health services.<br>**Were the participants receiving care and support kept 'blind' to how the intervention was allocated?**<br>• No. As they were on different wards – 1 a specialist ward for people with dementia or delirium – not possible that staff were blind to allocation.<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• Unclear<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>The authors note that the main weakness was the compromise in trial design that could have introduced | | | | |

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|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| bias. Recruiting participants after randomisation led to mismatches at baseline for some ‘prognostically important variables’, which were adjusted for in the statistical analyses. This resulted in differences between unadjusted and adjusted estimates of the intervention effect and the possibility of residual confounding. | | | | |

## Findings table

## Table reporting impact study

## Review Question 4: How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?

| Goldberg S, Bradshaw L, Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial (NIHR TEAM trial). BMJ: British Medical Journal 347: 13–13 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Relevance to RQ**<br>• RQ 4) ADMISSION.<br>• RQ 7) DEMENTIA.<br>See link with RQ on admissions and effect size info.<br>**Study aim**<br>• Some specialist delirium units or combined medical and mental health units have been established but there is a lack of robust evaluations. The authors developed a specialist medical and mental health unit for older people with suspected dementia or delirium as a model of best practice and evaluated it in an RCT. Their hypothesis was that the unit would improve outcomes, experience, and satisfaction compared with standard care.<br>**Source of funding** | **Participants**<br>• Older people<br>• People with dementia<br>• Carers/family members of people with MH conditions<br>**Sample characteristics**<br>• Sample age<br>Over 65, median age 85<br>• Level of need/diagnosis<br>‘Participants identified by physicians in the admissions unit as being “confused”. This term used as there is significant overlap between delirium and dementia in this population, presentation to emergency care is usually with undifferentiated confusion as opposed to a specific diagnosis’ (p2).<br>**Sample size**<br>• Comparison numbers<br>290 standard medical ward.<br>• Intervention number<br>310 in specialist MH unit<br>• Sample size<br>600 older people randomised<br>Intervention | **Outcomes (quantitative)**<br>• Quality of life<br>Primary outcome: number of days spent at home over the 90 days after randomisation.<br>• Satisfaction<br>Secondary outcomes: structured non-participant observations to ascertain patients’ experiences; satisfaction of family carers with hospital care.<br>• Service outcomes<br>Number of days spent at home (reflects fewer days in hospital).<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>‘Patients randomised to the specialist unit had a significantly higher quality of hospital experience. They were more often in a positive mood or engaged (median 79% v 68%, equivalent to an additional 40 minutes per six hour observation), active (82% v 74%), or engaged in social interactions (47% v 39%) and less often in a negative mood (11% v 20%). They experienced more staff interactions that met psychological and emotional needs (“personal enhancers”). Noise levels were lower on the specialist unit, but disruptive vocalisation was more common’ (p4).<br>**• RQ2 Carers’ views**<br>‘Family carers of patients randomised to the | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>To some extent, but we are only interested in ADMISSIONS, and the effect of the inpatient stay is really the key intervention (not described).<br>**Are the outcomes relevant?**<br>• Yes<br>To some extent.<br>**External validity**<br>• + |

Goldberg S, Bradshaw L, Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial (NIHR TEAM trial). BMJ: British Medical Journal 347: 13–13

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| • Government<br>NIHR.<br>**Country**<br>• UK | • List interventions of interest specialist medical and mental health unit (MMHU) compared with standard care | specialist unit were significantly more satisfied with overall care, nutrition, dignity and respect, the needs of confused patients being met, and discharge arrangements. Most carers were very or mostly satisfied, but there was a tail of severe dissatisfaction in both groups, which was about twice as frequent in standard care' (p4).<br>• **RQ4 Admissions**<br>Reflected in other narrative/effect findings. | Not exactly on topic, as the admission merges with the inpatient care – and we have very little detail of how the specialist unit functioned or what it offered. |

## Critical appraisal tables

## Table reporting views studies

## Review Question 4: How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?

Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology. 40: 160–6

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Cross-sectional study<br>**Objectives of study clearly stated?**<br>• Yes<br>**Relevance to our review question(s)?**<br>• Yes.<br>As we are interested in service users' perceptions and experience of admission.<br>**Clearly specified and appropriate research design?**<br>• Yes<br>**Subjects recruited in acceptable way?**<br>• Unclear. Had a very high response rate (important to validity of findings) of 80%, but this could itself be a dependent on a feeling of coercion! Researchers did make it clear that they were independent of treatment teams (but it could be that perceived coercion is | **Measurements and outcomes clear?**<br>• Yes<br>**Measurements valid?**<br>• Yes<br>**Setting for data collection justified?**<br>• Yes<br>On ward, needed to be soon after admission.<br>**All important outcomes and results considered?**<br>• Yes | **Tables/graphs adequately labelled and understandable?**<br>• Yes<br>**Appropriate choice and use of statistical methods?**<br>• Yes<br>**In-depth description of the analysis process?**<br>• Yes<br>**Are sufficient data presented to support the findings?**<br>• Yes<br>**Results discussed in relation to existing knowledge on the subject and study objectives?**<br>• Partly<br>Comments on practice (team clearly are clinicians) are especially valuable and support findings.<br>**Results can be generalised?**<br>• Yes<br>**Do conclusions match findings?**<br>• Yes | Sample is a little small and limited to 1 site. | **Internal validity**<br>• +<br>Sample is a little small and limited to 1 site.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>Those admitted to hospital from community.<br>**Is the intervention clearly relevant to RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology. 40: 160–6

| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
| understated).<br>**Sample representative of defined population?**<br>• Yes. All admissions were approached | | | | |

Campbell J (2008) Stakeholders' views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32

| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
| **Methodology**<br>• Mixed methods<br>**Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?**<br>• Yes<br>**Is the process for analysing qualitative data relevant to address the research question?**<br>• Unclear. Not described<br>**Is appropriate** | **Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?**<br>• No – no info on survey responses or letters, or how they were decided upon<br>**Is the sample representative of the population under study?**<br>• Unclear<br>Unclear for all aspects of the study – not reported | **Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?**<br>• No<br>Not really mix of methods but there is triangulation.<br>**Is the integration of qualitative and quantitative data (or results) relevant to address the research question?**<br>• Partly | This study has very low response rates to the survey of legal practitioners (30 of 300 contacted) and to its request by letter to hospital managers (asking for details of information given to detained patients).<br>Could have been assessed as qualitative data, but would have done poorly there also due to lack of methodological detail. The study was conducted in Northern Ireland, where mental health law is | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?** |

<table>
<tr><td colspan="5">Campbell J (2008) Stakeholders’ views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32</td></tr>
<tr><td><b>Study design (qualitative)</b></td><td><b>Study design (quantitative)</b></td><td><b>Mixed methods component</b></td><td><b>Limitations</b></td><td><b>Overall assessment</b></td></tr>
<tr><td><b>consideration given to how findings relate to the context, such as the setting, in which the data were collected?</b><br>• Partly<br>Probably for necessary brevity, there is little explanation of how people were recruited to focus groups, etc.<br><b>Is appropriate consideration given to how findings relate to researchers’ influence; e.g., though their interactions with participants?</b><br>• Unclear<br>Not known (e.g. where and when inpatients’ trajectories the focus groups took place).</td><td><b>Are measurements appropriate (clear origin, or validity known, or standard instrument)?</b><br>• N/A<br><b>Is there an acceptable response rate (60% or above)?</b><br>• No</td><td>There does seem to be broad agreement from the different data sources, but methods are poorly reported.<br><b>Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?</b><br>• No</td><td>different to that of England.</td><td>• Yes<br><b>Overall assessment of external validity</b><br>• +<br>Unclear if this relates to England of 2015 but the issues raised, especially lack of information and support to appeal to MHRT, may well do so.</td></tr>
</table>

| Chinn D, Hall I, Ali A, et al. (2011) Psychiatric in-patients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60 |
|---|

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study - Interviews<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible But the scope is not well described: i.e. with the small sample, we have no idea how many specialist units they were living in.<br>**Is the context clearly described?**<br>• Unclear. Not clear how many specialist units the 17 participants lived in (as a broad guide to representativeness).<br>**Study approved by ethics committee?**<br>• No. It was decided to follow good ethical approaches (e.g. recruitment and consent is described) but not submit to an REC as considered a user consultation to support service development.<br>**How clear and coherent is the reporting of** | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate. Appropriate in that it was from 26 OAP people (but 9 could not be interviewed and it is unclear if their experience was different). Difficult to see how, as this was intended as a whole population funded as OAPs in these Boroughs, how it could have been improved.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Somewhat reliable. It is not very clear what the content of the semi-structured interview outline was. The themes identified in the findings may not fully reflect the study's introduced aims and scope. | **Are the data 'rich'?**<br>• Mixed<br>**Is the analysis reliable?**<br>• Somewhat reliable Thematic, recorded interviews undertaken by 5 people using coding programme.<br>**Are the findings convincing?**<br>• Somewhat convincing<br>**Are the conclusions adequate?**<br>• Adequate. On the basis of limited information. | Small sample, but people with intellectual disability are more likely than those without to be placed in specialist out of area units.<br>Content of semi-structured interview (prompts) is not clear. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant Small sample, but important group to consider. |

Chinn D, Hall I, Ali A, et al. (2011) Psychiatric in-patients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| | **ethics?**<br>• Not stated | **Is the role of the researcher clearly described?**<br>• Not described | | | |

Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Cross-sectional study<br>**Objectives of study clearly stated?**<br>• Yes<br>**Relevance to our review question(s)?**<br>• Yes<br>**Clearly specified and appropriate research design?**<br>• Partly<br>**Subjects recruited in acceptable way?**<br>• Yes | **Measurements and outcomes clear?**<br>• Yes<br>Structured measures at admission: within 1 week. Encounter (inc. satisfaction). Insight (into psychosis). Social Behaviour Scale at discharge: 3 months afterwards. Verona Service Satisfaction Scale CAN (Camberwell Assessment of Need).<br>**Measurements valid?**<br>• Partly. As authors state, | **Tables/graphs adequately labelled and understandable?**<br>• Yes<br>**Appropriate choice and use of statistical methods?**<br>• Yes. Basic, SPSS count, small numbers.<br>**In-depth description of the analysis process?**<br>• No<br>Unnecessary.<br>**Are sufficient data presented to support the findings?**<br>• Partly<br>Samples are relatively small for | Validity of scales for different ethnic populations may be an issue.<br>This is a very old study (16 years since publication).<br>There are therefore issues around generalisation – not least as the data relates to 1995–6. For example, most of the Asian sample was not born in UK – this will have changed. | **Internal validity**<br>• +<br>As far as it goes!<br>**Is the setting similar to the UK?**<br>• Yes<br>But not the UK of 2016.<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to RQ?**<br>• Yes<br>**Are the outcomes relevant?** |

Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| Consecutive admissions and discharges of people who met criteria for inclusion.<br>**Sample representative of defined population?**<br>• Unclear<br>But Birmingham is an ethnically diverse and relatively deprived population, and the sample appears to reflect that. | there are always questions about the validity of scales for different ethnic populations (some of whom did not speak English but were interviewed by bilingual researchers). Some of the measures, such as the Social Behaviour Scale, report higher levels of hostility, violence and lack of insight – this does not specifically speak to our RQs (and the same measures were not repeated at discharge), though it may explain higher use of police and coercion in admission process.<br>**Setting for data collection justified?**<br>• Yes<br>Inpatient units, admitting and discharging.<br>**All important outcomes and results considered?** | structured measures.<br>**Results discussed in relation to existing knowledge on the subject and study objectives?**<br>• Partly<br>This is a local study, and its findings are not inconsistent with those of others.<br>**Results can be generalised?**<br>• Partly<br>Some issues around generalisation – not least as the data relates to 1995–6. For example, most of the Asian sample was not born in the UK – this will have changed.<br>**Do conclusions match findings?**<br>• Yes<br>Conclusions restate the findings. | Although the data is presented as integrated, it was supplemented by case notes (unclear whether patients' accounts took precedence over casenotes), and the SBS was completed by a clinician. | • Unclear<br>Dated. Also (inevitably) determined by the measures used.<br>**External validity**<br>• -<br>Unclear, because the data is so old, and the samples small. It is to be hoped that services have improved, e.g. in supporting Black and Asian service users. |

Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| | • Partly<br>For the scope of the paper, yes, although the admission measures are dominated by structured ‘practitioner’ driven measures of pathology, while the CAN used at discharge is much more focused on the SUs’ views of the support received and thus possibly more informative for our purposes. | | | |

Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>SERVICE USERS<br>The nature of the inquiry sought detail about some very | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>Participants were recruited from 2 areas in the UK (1 a large county, the other an inner-city area). Service user | **Are the data ‘rich’?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable. Initially, data from interviews with several participants were checked for levels of agreement. High | Study was well conducted but sample was small. Only 7 service providers agreed to take part in focus groups. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

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|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | personal experiences, so individual interviews were chosen as the most appropriate method for this part of the study.<br>SERVICE PROVIDERS<br>Focus groups with providers were employed to enable in-depth discussion of their experiences and views.<br>**Is the context clearly described?**<br>• Clear<br>Participants (users, carers and providers) were recruited from 2 areas in the UK – 1 a large county including urban and rural areas, the other an inner-city area. Both used mainstream, and 1 occasionally specialist, mental health services. | participants were identified via providers in intellectual disability services. Sample of 26 service users admitted to mainstream inpatient mental health services for duration of at least 1 week during the previous 2 years were identified. Overall, 42% (n=11) of service users who fitted the inclusion criteria took part or chose for their carer to take part. Only 2 service users declined completely. Nine (35%) were judged too unstable or ill to participate and 4 could not be recruited within the study's timescale. Total of 22 out of 26 (i.e. 85%) responded to invitation to take part.<br>**How well was the data collection carried out?**<br>• Appropriately. After | levels of agreement were found. Results were analysed on a case by case basis, as opposed to comparing results across different groups of participants, which means that each case is about 1 person's admission experience, often from the viewpoint of several people. Focus group data were analysed separately with the purpose of identifying common themes among service provider experiences and views. Both interviews and focus groups were recorded and transcribed verbatim and analysed thematically in accordance with the principles and processes of interpretative phenomenological | | |

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|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | for people with intellectual disabilities. Seven service providers took part in focus groups; all of them were members of specialist community intellectual disability teams.<br>Study approved by ethics committee?<br>• Yes. The study was granted ethical approval by an NHS research ethics committee<br>How clear and coherent is the reporting of ethics?<br>• Not stated | consent was obtained, service users were given the option to be interviewed on their own or accompanied by a relative or nurse who was familiar to them. Where service users wanted to be interviewed on their own, they were asked for permission to interview their carers separately. If agreed, researchers contacted the carer by telephone and explained the nature of the study and information was sent to those who wanted to take part. All interviews were digitally recorded and based either in participants' own homes or at a day centre and lasted between 30 and 90 mins. Invitations were sent to all learning disability and mental health staff through the participating trusts' email | analysis (Smith 2003; Willig 2001). Results were discussed stage by stage by all the 3 researchers and grouped according to themes. These themes were repeatedly reworked to make sure that they reflected the wording and meanings drawn from the raw data.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | | |

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|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | | lists. Semi-structured interview schedules were designed and topics were divided into 3 broad sections covering events leading up to the admission, the admission itself and reflections on the experience after discharge. Open-ended questions were used in interviews and designed to allow for a general level of consistency in topics covered across all the interviews. The focus group guide asked service providers about their experiences of local mainstream admissions, factors that help and hinder their practice, and the impact of joint service agreements on service provision.<br>**Were the methods reliable?**<br>• Reliable. Service users | | | |

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|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | | were given various options to participate in interviews, either independently, or accompanied by a carers or trusted professional. Interview methods seemed appropriate and allowed them to express their views and experiences quite openly. Interviews were bolstered by the findings from focus group discussions with providers. Where users did not want to, they asked for carers to stand in as proxy in interviews.<br>**Is the role of the researcher clearly described?**<br>• Not described | | | |

| Farrelly S, Brown G, Rose D, et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. Social Psychiatry and Psychiatric Epidemiology 49: 1609–17 |
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| Farrelly S, Brown G, Rose D, et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. Social Psychiatry and Psychiatric Epidemiology 49: 1609–17 | | | | | |
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| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>Especially as part of RCT (where baseline characteristics of groups would be comparable).<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>via RCT<br>**How well was the data collection carried out?**<br>• Appropriately<br>Via JCP participants.<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Clearly described<br>This is not an encounter with researchers as much as between service users, JCP facilitator and care staff. | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>To ensure representativeness of the sample, statistical comparisons made between those who completed JCP and those who did not (this was part of a larger RCT), including those who were randomised to JCP but did not complete one (22%). Inductive thematic analysis was used, and a coding framework compiled from the first 50 JCPs (reviewed line by line, and capturing service user language). Constant comparison techniques were used to test categories, and higher order categories | The paper is rigorous and useful, but adherence to, and impact of, plans is not 'tested' for use in actual admissions (though it may be in the RCT to be reviewed subsequently for RQ6). | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant<br>Treatment options/choices are reported, but they are out of scope, and the main choice of SUs in their JCPs is not to be admitted. |

| Farrelly S, Brown G, Rose D, et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. Social Psychiatry and Psychiatric Epidemiology 49: 1609–17 | | | | | |
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| | | | developed. The framework was QA'ed by a third author, and independent dual analyses of 20% were carried out and discrepancies discussed. The final higher level categorisation has used service user quotes.<br>**Are the findings convincing?**<br>• Convincing<br>Convincing for this group, which represents a reasonably large sample across 4 localities, but within the sample, there is considerable variation (as would be expected of individuals).<br>**Are the conclusions adequate?**<br>• Adequate | | |

Hooff S van den, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. Scandinavian Journal of Caring Sciences 28: 425–34

| Research aims | Study design/theoretical approach | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Study aim**<br>• To explore the literature on patients' and professionals' perspectives on involuntary admission The main question of this review is: 'Which quality themes are reported by patients and professionals during involuntary admission?' (p426).<br>**Country**<br>• Range of countries England, Ireland, New Zealand, Austria, Denmark, Norway, Sweden, US. | **Methodology**<br>• Systematic review<br>Systematic search of published literature in peer-reviewed journals.<br>**Clearly focused question?**<br>• Yes<br>Relevance to our RQ(s)?<br>• Unclear<br>Exploratory qualitative synthesis. Still addresses the RQ in part.<br>**Inclusion of relevant individual studies?**<br>• Yes. All studies had to have the patient or health care professional's perspective of coercion during involuntary admission or the evaluation of the admission process as central focus.<br>**Rigorous literature search?**<br>• Partly rigorous. Five different databases were searched: Academic Search Elite, Cinahl, Medline, PubMed and Social Science Journals. Search strategy and use of key words was fairly limited.<br>**Study quality assessed and reported?** | **Adequate description of methodology?**<br>• Partly adequate<br>Both authors identified and explored the emerging themes together until consensus was reached.<br>**Do conclusions match findings?**<br>• Partly | Although this has been included and assessed as a systematic review of qualitative literature, it is not clear that the 22 studies were assessed for quality, so it may be only a literature review.<br>Only 2 papers were from England. | **Overall assessment of internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Partly<br>The review contained 2 papers from England. Other papers were from Ireland, Australia and Sweden which have similar healthcare systems to the UK.<br>**A clear focus on transition between inpatient MH setting and community or care home setting?**<br>• Yes<br>**Are the population groups relevant?**<br>• Yes<br>**Relevant to social care outcomes?**<br>• Unclear<br>**Does the review have a UK perspective?** |

| Hooff S van den, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. Scandinavian Journal of Caring Sciences 28: 425–34 | | | | |
|---|---|---|---|---|
| **Research aims** | **Study design/theoretical approach** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | • Unclear<br>The 22 included articles are analysed and broken down into components but the authors do not mention quality assessment. | | | • Unclear<br>**Overall assessment of external validity**<br>• + |

| Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric in-patients: a case-control study. Journal of Affective Disorders 144: 123–8 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Case-control study<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>Not directly relevant to admission itself, but clearly of great importance in that it appears to illustrate a poor and remediable understanding of risk of suicide at admission – and 'admission' may be understood to include the first | **Same exclusion criteria?**<br>• Adequately addressed<br>**Participation rate for each group?**<br>• Cases<br>Data was available on 120 cases.<br>• Controls<br>Data was available on 107 of the controls (89%).<br>**Comparison of participants?**<br>• Well covered<br>**Cases clearly defined?**<br>• Well covered<br>**Distinguishing of cases from controls?** | **Statistical analysis**<br>• CI provided<br>See effect sizes for Cis.<br>**Do conclusions match findings?**<br>• Yes | It is a stated limitation of the study that retrospective data collection from clinicians could be flawed because they knew of the subsequent outcome of suicide. | **Overall assessment of internal validity**<br>• ++<br>Limitations include matching only on date, clinicians not being blind to suicide, and exact timing of admission and death not known. Also, open verdicts assumed to be suicides.<br>**Is the setting similar to the UK?**<br>• Yes<br>England.<br>**Is there a clear focus on population of interest?** |

| Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric in-patients: a case-control study. Journal of Affective Disorders 144: 123–8 | | | | |
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| **Study design** | **Theoretical approach** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| 3 days of arrival on ward.<br>**Question appropriate and focused?**<br>• Adequately addressed<br>**Comparable populations?**<br>• Adequately addressed. Matching of controls on date alone may not be very rigorous – some variation (but it is shown in tables and is not significantly associated). | • Well covered<br>**Measures to prevent knowledge of primary exposure?**<br>• Adequately addressed<br>It is a stated limitation of the study that retrospective data collection from clinicians could be flawed because they knew of the subsequent outcome of suicide.<br>**Exposure status**<br>• Adequately addressed<br>**Confounding factors**<br>• Adequately addressed | | | • Yes<br>**Is the intervention in scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>See limitations to internal validity. |

| Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Research 187: 275–82 | | | | |
|---|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Mixed methods<br>**Are the sources of qualitative data (archives, | **Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the** | **Is the mixed-methods research design relevant to address the qualitative and quantitative research** | Sample size is too small at 1-month follow-up for convincing statistical | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?** |

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| **documents, informants, observations) relevant to address the research question?**<br>• Yes<br>**Is the process for analysing qualitative data relevant to address the RQ?**<br>• Yes<br>**Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?**<br>• Unclear<br>Nine acute wards in 2 hospitals in East London – no more information given about the context or particulars of the hospitals.<br>**Is appropriate consideration given to how findings relate to researchers' influence; e.g., though their interactions with participants?**<br>• Partly<br>Researchers are described | **mixed-methods question)?**<br>• Partly<br>Sample size of 58 people at 1-month follow-up has limited statistical power to detect significant associations.<br>**Is the sample representative of the population under study?**<br>• Yes. 'All eligible patients and study participants were compared at baseline on age, gender and diagnosis to assess the representativeness of the participating sample' (p276).<br>**Are measurements appropriate (clear origin, or validity known, or standard instrument)?**<br>• Yes<br>McArthur Perceived Coercion Scale (MPCS) widely used and validated.<br>**Is there an acceptable response rate (60% or above)?**<br>• Yes<br>Eight out of 91 people who felt coerced did not complete baseline measures. A further 25 (out of 83 who completed baseline interview) (30%) were lost to follow-up at 1 month. | **questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?**<br>• Partly<br>**Is the integration of qualitative and quantitative data (or results) relevant to address the RQ?**<br>• Yes<br>**Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?**<br>• Partly | data: qualitative data is more thorough and convincing. | • Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• N/A<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• ++ |

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| as being ‘independent from the patients’ care’ (p276) – no more information given. | | | | |

| Katsakou C, Rose D, Amos T, et al. (2012) Psychiatric patients’ views on why their involuntary hospitalisation was right or wrong: a qualitative study. Social Psychiatry And Psychiatric Epidemiology 47: 1169–79 | | | | | |
|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Not sure. A little unclear how the sample was recruited (after screening for diverse inclusion), and where the interviews took place.<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>Appropriate to get a diverse stratified sample – not necessarily representative.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Clearly described. Including user involvement at all stages. | **Are the data ‘rich’?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>Grounded theory, thematic analysis, inter-rater reliability assessed, etc.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | Some lack of clarity about how the sample was recruited and data collected. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

| Manktelow R, Hughes, P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland. British Journal of Social Work 32: 44–61 | | | | |
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| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Mixed methods<br>**Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?**<br>• Yes<br>**Is the process for analysing qualitative data relevant to address the research question?**<br>• Yes<br>**Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?**<br>• Yes<br>Focus groups were arranged through community groups.<br>**Is appropriate** | **Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?**<br>• Yes<br>**Is the sample representative of the population under study?**<br>• Yes. Survey was of all ASWs, 84% responded.<br>**Are measurements appropriate (clear origin, or validity known, or standard instrument)?**<br>• Yes.<br>Factual questions, piloted before use.<br>**Is there an acceptable response rate (60% or above)?**<br>• Yes<br>84%. | **Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?**<br>• Yes<br>**Is the integration of qualitative and quantitative data (or results) relevant to address the RQ?**<br>• Yes. Strong coincidence in findings.<br>**Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?** | The major limitation to external validity and generalisability is the age of the study, and the fact that it is governed by different NI procedures. In UK today, ASWs have been replaced by AMHPs and relatives did not have the powers they had in NI. | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Unclear<br>Age and difference in legislation and process are problematic.<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>The major limitation to external validity and generalisability is the age of the study, and the fact that |

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| **consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?**<br>• Unclear |  | • Yes |  | it is governed by different NI procedures. In UK today, ASWs have been replaced by AMHPs and relatives did not use the powers they had in NI. |

| Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9 |  |  |  |  |  |
|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>Specially designed, 17-item, non-standardised interview schedule.<br>**Is the study clear in what it seeks to do?**<br>• Clear. The main areas explored in the interview were service users' views about why they had been admitted, perceptions about their current problems, what they thought they would gain from the admission and how | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear. The study setting was all 4 acute admission wards in 1 mental health foundation trust in the West Midlands over 8 months in 2009. All those admitted during that period had spent at least 2 weeks on the ward following admission and whom | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>The 44 participants were 18 men and 26 women, ranging in age from 18 to 71 years (mean age 41 years). This was broadly in keeping with the gender distribution on admission wards in which the study was carried out in the previous 5 years (58% women and 42% men). | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | Study is limited to 1 mental health foundation trust. Not clear whether the question designed for the study allowed full scope for expression. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
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| the admission would help them in the future. | staff considered were eligible to be interviewed were invited to participate and 44 accepted (response rate of 49%).<br>**Study approved by ethics committee?**<br>• Yes<br>Ethical permission to undertake the study was granted and all stages of the study were conducted in accordance with ethical governance.<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **How well was the data collection carried out?**<br>• Appropriately. A pilot study was undertaken with 6 service users. This helped improve the design (e.g. fewer questions, and better sequencing, sensitive prompts) to elicit richer responses. Careful reading and re-reading of the transcripts led to the identification of 3 categories of participant. All interviews were audio-taped and transcribed verbatim by the first author.<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Unclear | | | |

Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>Good range of teams in local authorities (both hospital and community-based) which were selected on account of their vastly different sectioning rates. Interpersonal contact between researcher and the patients and professionals involved in the assessments kept to a minimum.<br>**Study approved by ethics committee?**<br>• Not stated | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Data only collected by 1 method.<br>**Is the role of the researcher clearly described?**<br>• Clearly described<br>Researcher adopted role of ‘complete observer’ while conducting fieldwork. | **Are the data ‘rich’?**<br>• Rich<br>**Is the analysis reliable?**<br>• Somewhat reliable<br>However, principle researcher fed back observations to the multidisciplinary team throughout process to create hypotheses.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | Published in 2003 which reduces its relevance to present practice. The ASW role no longer exists in this capacity. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant<br>The paper was published in 2003 which largely reduces its relevance. |

Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| | **How clear and coherent is the reporting of ethics?**<br>• Not stated | | | | |

Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & Social Care in the Community 21: 509–18

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Mixed<br>The broad aim was to evaluate the implementation of the MHCT Act by exploring the experiences and perceptions of those who are subjected to it as well as professionals and advocates working with it. A previous paper (Ridley et al. | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>In order to gain an understanding of compulsion under the Act from service users' and professionals' perspectives interviews were felt to be the best design. Qualitative approach allows flexibility and is more likely to capture the variation in views which have previously | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>Letters originally posted to approximately 600 people, and then a second mailing followed in order to recruit sample of 49 people. Potentially bias as respondents would require a fixed address in order to participate.<br>**How well was the** | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable. The whole team (8 peer researchers and 5 professional researchers, 1 of whom had mental health service experience) read through the transcripts to determine key topics and to collectively create a coding framework. Then 2 researchers coded all transcripts before the whole team reconvened to look at the results.<br>**Are the findings convincing?** | This study reflects provisions in Scotland, so may not be entirely relevant. The response rate was very low, so unclear whether accounts are representative. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• A bit relevant |

| Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & Social Care in the Community 21: 509–18 | | | | | |
|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| 2010) explores the carers' viewpoints. | been found to have huge variation.<br>**Is the context clearly described?**<br>• Clear<br>Interviews took place in a time and location that suited the participant. A peer reviewer was present at all interviews who explained that they had experience as a mental health service user.<br>**Study approved by ethics committee?**<br>• Yes<br>University of Central Lancashire's Faculty of Health Research Ethics Committee and that of the State Hospital.<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Only 1 method of data collection, but the questions for semi-structured interviews (at stage 1 and 2) comprehensively address the 10 key points of the Act.<br>**Is the role of the researcher clearly described?**<br>• Clearly described | • Convincing<br>**Are the conclusions adequate?**<br>• Adequate | | |

Scior K, Longo S (2005) In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Not stated<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>Given the intention to compare generic and specialist units.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Not described | **Are the data 'rich'?**<br>• Rich<br>Not a lot is presented in terms of quotes, but there are also summary tables.<br>**Is the analysis reliable?**<br>• Reliable<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | This is a relatively small sample across a large population (10 inpatient units), but appears to convey well some important general principles. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>It is a relatively small sample across a large population (10 inpatient units), but appears to convey well some important general principles.<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant<br>The transition elements are intertwined with the entire inpatient experience. |

Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Cross-sectional study<br>**Objectives of study clearly stated?** | **Measurements and outcomes clear?**<br>• Yes<br>**Measurements valid?** | **Tables/graphs adequately labelled and understandable?**<br>• Yes<br>**Appropriate choice and use of** | There is no clarity around precisely who the therapeutic relationship assessed | **Internal validity**<br>• +<br>**Is the setting similar to the UK?** |

| Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| • Yes<br>**Relevance to our review question(s)?**<br>• Yes<br>Experience of admission.<br>**Clearly specified and appropriate research design?**<br>• Yes<br>**Subjects recruited in acceptable way?**<br>• Yes<br>**Sample representative of defined population?**<br>• Partly.<br>One of the study limitations is that 22% of those approached were excluded, and a further 15% declined to take part. The study took place in Oxford, which may not be generally representative of MH patient populations. | • Yes<br>Used the MacArthur Admission Experience Survey (AES), which consists of 14 items that require a patient's true or false response to statements about being admitted to the hospital, including perceived coercion, negative pressure and procedural justice. The Helping Alliance Scale is a measure of therapeutic relationship (adapted for hospital ward) examining whether and how much the patient feels understood by their clinician and whether goals have been agreed between them. Global Assessment of Functioning was used to measure overall functioning in respect of mental health.<br>**Setting for data collection justified?**<br>• Yes<br>On ward, as followed admissions.<br>**All important outcomes and results considered?** | **statistical methods?**<br>• Yes<br>**In-depth description of the analysis process?**<br>• Yes<br>**Are sufficient data presented to support the findings?**<br>• Yes<br>**Results discussed in relation to existing knowledge on the subject and study objectives?**<br>• Yes<br>**Results can be generalised?**<br>• Partly<br>See reservations re. representativeness of sample.<br>**Do conclusions match findings?**<br>• Yes | concerns, although as the measure (Helping Alliance Scale) is adapted for use on the ward, the implication is that it is with hospital staff (rather than the person organising admission).<br>The study took place in 1 setting, though on 5 acute wards. | • Yes<br>Oxford, UK.<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| | • Yes<br>In relation to the aims of study. | | | |

Smith V, Chouliara Z, Morris P, et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: a qualitative study from adult patients' perspectives. Journal of Health Psychology doi:10.1177/1359105313520336

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Appropriate. But from a single specialist inpatient unit.<br>**How well was the data collection carried out?**<br>• Appropriately<br>Private, recorded interviews with fully informed and consented subjects. All recruits, however, came from a single specialist inpatient unit, so may not be entirely representative.<br>Were the methods reliable?<br>• Reliable. The framework drawn up after the first interviews was critiqued by | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>Inductive, thematic analysis, with plentiful use of respondent validation.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | The reported data is not strictly limited to admissions, but the importance of transition for this population has meant it is worth including (and in findings for discharge question). | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant<br>The issues on transitions are particularly striking for this group (as they might be, e.g., with substance misuse or other addictive behaviours), and although they 'merge' with treatment, it has seemed worthwhile including the study. |

Smith V, Chouliara Z, Morris P, et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: a qualitative study from adult patients' perspectives. Journal of Health Psychology doi:10.1177/1359105313520336

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| | | a group of 4 women who were like, but were not, study participants. A reflexive approach to data collection was taken, with the CI keeping a diary. Respondent validation of data analysis was carried out with all interviews.<br>Is the role of the researcher clearly described?<br>• Clearly described. Yes, potential overlap of clinical and research staff discussed and avoided. | | | |

Valenti E, Giacco D, Katasakou C, et al. (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6

| Study design | Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?** | **How defensible/rigorous is the research design/methodology?**<br>• Defensible | **Was the sampling carried out in an appropriate way?**<br>• Not sure.<br>As secondary data | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>All interviews were audio- | Staff may have had a different perspective, but this is implied and not demonstrated. It is difficult to distinguish | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++ |

| Valenti E, Giacco D, Katasakou C, et al. (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6 | | | | | |
|---|---|---|---|---|---|
| **Study design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| • Clear | **Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Clear<br>Patient perspective is clear, but assumptions are made about staff perspectives. | was used for the sampling frame, it is not quite clear how the sample was identified.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Not described | recorded and transcribed verbatim. Thematic analysis framework was drafted; open, axial and selective coding was used and 2 researchers (including a service-user researcher) developed a coding frame capturing the emerging themes, which were further discussed and refined. Inter-rater reliability was discussed in 2 stages.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | (especially as interviews are post-discharge) between experience of admission and of whole hospital episode. | **Relevance to the MH transitions guideline**<br>• Highly relevant |

## Findings tables

## Table reporting views studies

## Review Question 4: How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?

| Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology 40: 160–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Cross-sectional study<br>Interviews with 100 of 118 people consecutively admitted to psychiatric ward – at admission (77% within 72 hours, 90% within a week), and again pre-discharge. Structured measures of experience and perceived coercion were used. Supplemented by case records (post-discharge) to track outcomes (for average follow up of 10 months). This | **Participants**<br>• Adults (no specified age) with MH conditions<br>• People subject to the MHA (involuntary admission)<br>**Sample characteristics**<br>• Sex<br>55 male (55%).<br>• Ethnicity<br>67% white, 21% black.<br>• Sample age<br>Mean age 39.<br>• Level of need/diagnosis<br>40 schizophrenia, 33 affective disorder, 12 PD. | **Outcomes (quantitative)**<br>• Satisfaction<br>• Service outcomes<br>**Findings – narrative**<br>• **RQ4 Admissions**<br>**Coercion**<br>15 patients (15 %) believed their admission status at the time of interview was involuntary (or 'sectioned'), 81 (81%) believed it was voluntary or 'informal' (though in fact 15 of these were formally detained), and 4 did not know.<br>29 of the 66 cases who correctly believed they had voluntary status (44%) believed they would be detained if they tried to leave hospital and a further | Internal validity<br>• +<br>Is the setting similar to the UK?<br>• Yes<br>Is there a clear focus on population of interest?<br>• Yes<br>Is the intervention clearly relevant to RQ(s)?<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes |

| Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology 40: 160–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| is a single cohort study, but assessed as cross-sectional study (views and experiences) because is closest fit.<br>Relevance to RQ<br>• RQ 4) ADMISSION<br>• RQ 6) REDUCING READMISSIONS<br>This is only a single cohort study, so can only identify associations with readmission (following from perceived coercion at admission).<br>**Study aim**<br>• To study patient perceptions of coercion (not necessarily under MHA) in a sample of patients admitted to psychiatric hospital in inner London, hypothesising that non-whites may feel more coerced, and that perceived coercion may be associated with poor engagement with follow-up care after discharge | **Sample size**<br>• 100<br>**Intervention**<br>• Admission | 15 (23%) were unsure whether they would be allowed to leave if they wished. Only 22 (33%) thought they would could choose to leave hospital.<br>As expected, none of the patients believing they were free to leave were rated as perceiving high coercion, 5 of the 15 (33%) who were unsure and 14 of the 29 (48%) who believed they would be detained were rated as perceiving high coercion (z=4.3, p<0.005, test for trend).<br>MHA was used to admit 19 patients, but a further 39 were detained later (e.g. after initially agreeing to voluntary admission).<br>**Objective coercion**<br>‘Three types of objective coercion were considered: the legal status of the patient, police involvement in admission, and any other aspects of admission to hospital which involved the overt threat or use of force’ (p162).<br>Police were involved in 24 cases and in 12 cases restraint or forced entry was used. Physical restraint, forcible medication or the use of seclusion were classified (by researchers) as experience of direct threat or actual use of force.<br>**Effect of perceived coercion on engagement with services after discharge**<br>Within (average) 10 month follow-up, ‘Perceived coercion was not a significant independent predictor | **External validity**<br>• + |

Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology 40: 160–6

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Source of funding**<br>• Government<br>DH.<br>• **Country**<br>UK. | | of any of the outcome variables at follow-up' (p163) (including time out of contact and readmissions).<br>**Conclusions**<br>Use of MHA is highly associated with perception of coercion, but the study suggests that patients admitted 'voluntarily' also feel coerced, and may be uncertain of where they stand if they try to leave. This suggests their information needs are unmet. 'It is, in fact, the case that the threshold for detaining a patient in hospital is reduced once informal admission has been accepted, both because section 5 of the Act allows the immediate detention of a patient for up to 72h on the basis of a single professional opinion, and because, once a patient is in hospital, staff are likely to feel a greater degree of responsibility for controlling perceived risk than they would in the community' (authors, p166). There was no association shown between perceived coercion at admission and failure to comply with follow-up care offered. | |

Campbell J (2008) Stakeholders' views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|

| Campbell J (2008) Stakeholders’ views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Mixed methods<br>Study is almost entirely qualitative interviews and focus groups, except for:<br>1. A survey of legal practitioners (300 in NI), to which only 30 responded (7 saying they did not practise in this area).<br>2. A letter to hospital managers requesting information given to patients about legal rights in relation to detention. Four responded.<br>**Relevance to RQ**<br>• RQ 4) Admission.<br>**Study aim**<br>• ‘To explore the nature and quality of information and legal advocacy services available to service users and their carers during and after compulsory admission to psychiatric hospital’ (p220)<br>**Source of funding** | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Adults who had been detained (4 focus groups)<br>• Carers/family members of people with MH conditions<br>Family members of people detained (1 focus group).<br>• Professionals/practitioners:<br>Interviews with 4 lawyers practising in this area, and 1 legal tribunal member.<br>• Administrators, commissioners, managers:<br>Total 3 managers of VS services trying to support patient advocacy and information needs. Letters sent to 9 hospital managers for info on what they provided; 4 responded.<br>• People subject to the MHA (involuntary admission)<br>[Info] All service users involved had been detained.<br>**Sample characteristics**<br>• Not reported<br>**Sample size** | **Outcomes (qualitative)**<br>• What can be improved<br>Information on how to appeal made readily available and accessible to all patients and to frontline carers (who may act as a buffer). Carers and patients commented on the shoddy nature of the MHRT report, despite the comprehensive (inc. social worker) reports they are given in evidence. MHA detentions of this kind may conflict with HRA (and are likely to have changed since this study).<br>• Experiences described<br>**Findings RQ4 admission**<br>**Experience of compulsory admission**<br>Family members at this time in NI had ability to substitute for ASW and detain the patient with GP involvement. Some carers felt pushed into this and regretted it – ‘I felt that I had ‘put him away. It is much better that this should be done by someone like an ASW who can then take the blame’ (mother, p224). May not have realised how difficult it was to overturn the detention.<br>Patients were denied dignity, explanations, information and legal advocacy. Some patients did not know they were detained: she was going ‘… with my family for the weekend. I was in the car park with my family leaving and a nurse came out and pulled me in, saying I was detained. This was in front of my | **Internal validity**<br>• +<br>Really doesn’t deserve this methodologically, but this is probably because of brevity of reporting. Could have been assessed as qualitative data, but would have done poorly there also due to lack of methodological detail. However, findings are convincing (within context of the time and place).<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes** |

| Campbell J (2008) Stakeholders' views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| • Not reported<br>**Country**<br>• UK<br>Northern Ireland. As the legislation is slightly different, the DE will focus on the more general issues. | • 44 users (who had been detained) and carers (categories not split) 4 lawyers, 1 MHRT legal member, 3 managers of advocacy services (23 solicitors surveyed; 4 of 12 hospital managers sent a letter gave some response).<br>**Intervention**<br>• Interest here is in the information and support on appeal to MHRTs made available to service users, carers and (indirectly) providers of MH services (nurses, doctors, social workers). | children and family she was saying I was detained' (p224).<br>**Information and advice following detention**<br>Health professionals, esp. frontline staff, brushed off people's questions about appeal or complaint ('Don't be silly, you don't need a solicitor' p225). People could be detained for long periods with no idea of their rights: 1 carer questioned the psychiatrist after 2 years and the detained relative was then told she was no longer detained. Staff did not know if or where there might be further information.<br>Burden of proof rests with RMO to justify detention – staff may feel pressured NOT to give patient or carer information. This role seemed to fall to junior staff. Only 1 hospital manager could provide comprehensive information (sent to CI). Five service users and 7 carers had experienced MHRT, 1 woman after extensive ECT, which the tribunal stopped: by chance, she was informed by a junior social worker. p226. Some carers felt that the tribunal should be more aware of carers' views and the patients' community circumstances (which the MHRT cannot insist be improved).<br>**Lawyers' views**<br>MHRTs can be adversarial, and the medical members have conflicting aims. May be difficult to challenge the RMO on his turf. A worrying pattern | **relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>Unclear if this relates to England of 2016 – but the issues raised, especially lack of information and support to appeal to MHRT, may well do so. |

| Campbell J (2008) Stakeholders’ views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | identified was the common withdrawal of detention as the MHRT was about to happen – suggesting the RMO could not justify it. Training in this area is not widespread among solicitors and could be improved.<br>**Findings: RQ 5 discharge**<br>Because appeal to an MHRT precedes discharge, the findings documented in RQ4 section may have some relevance to discharge – but in the scope of this study, discharge had not taken place. | |

| Chinn D, Hall I, Ali A (2011) Psychiatric inpatients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>Interviews<br>**Relevance to RQ**<br>**• RQ 4) Admission**<br>This does concern admissions, but some of the data reported will concern post-admission experience. Emphasis is on the outcomes of out-of-area | Participants<br>• Adults (no specified age) with MH conditions<br>• Learning disability<br>All 17<br>• People subject to the MHA (involuntary admission).<br>Three quarters had been detained under mental health act legislation.<br>• People placed out of area<br>All 17 participants, average 40 | **Findings – narrative**<br>**• RQ4 Admissions**<br>**Reasons for admission**<br>Many informants felt they were in the unit for punishment, more than therapy, possibly related to actual or alleged aggression - and some would have preferred to be in prison, where there was at least a finite ‘sentence’. There were negative remarks about medication and some mention of appreciating opportunities to talk.<br>**Social relationships and activities** | As far as can be ascertained from the paper, how well was the study conducted?<br>• +<br>Relevance to the MH transition guideline<br>• Somewhat relevant |

Chinn D, Hall I, Ali A (2011) Psychiatric inpatients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| placement (study suggests up to a third of people with ID and MH needs are OOP). Over 80% of placements are in independent sector (not NHS).<br>**Study aim**<br>• The context concerns care for people with IDs and MH problems (particularly where individuals were said to have 'challenging behaviour'). Three London Boroughs identified, 26 people who had been placed out of area (mean distance 49 miles from home) to consider their rarely heard perspectives. This study aimed to document 'the views of individuals placed in out of area facilities about their experiences of the care being provided as part of a service user consultation exercise' (p52).<br>**Source of funding**<br>• NHS Trust(s) | miles from home.<br>**Sample characteristics**<br>• Sex<br>13 of the 17 were male.<br>• Ethnicity<br>Half had white British backgrounds, and the rest came from a variety of ethnic minority communities.<br>• Sample age<br>Average age 34.<br>• Level of need/diagnosis<br>80% of interviewees were described as having a mild learning disability (no info on MH issues).<br>**Sample size**<br>• 17 (as 9 of the 26 were considered unable to take part by their RMOs)<br>**Intervention**<br>• List interventions of interest<br>Out of area placement. | Some expressed fear of other residents, some extreme boredom. There were reports of poor relations with particular staff: 'Experiences participants found particularly demeaning were: being verbally belittled by sarcasm, being called names, such as "idiot" or "nutcase"; being kept waiting for basic needs to be met for no apparent reason (some mentioned staff being preoccupied with paperwork or staff meetings); being treated unjustly or unfairly in comparison to other patients; being threatened and intimidated by staff. Participants used strong and vivid language – "worse than a dog"; "like a piece of shit on their shoes" – to describe feelings of being treated as less than human by staff. A number described what they perceived as punitive treatment by staff' (p55).<br>Positive allusions to staff were rarer. (THESE EXTRACTS ARE INCLUDED HERE TO ILLUSTRATE POOR ACCESS TO FAMILIAL RELATIONSHIPS: OAPS may be more dependent on staff.)<br>'Staff also mediated contact with friends and family outside the unit. Participants often had to ask permission to use the telephone to talk to relatives, and staff controlled the frequency and timing of visits to see family members' (p56).<br>**Being out of home community**<br>Residents commented on inability to use their first | |

| Chinn D, Hall I, Ali A (2011) Psychiatric inpatients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| E. London NHS Foundation Trust.<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• Experiences described. See narrative findings RQ4. | | (and family) languages, and engage in culturally familiar activities: 'I have to speak English all the time. I used to speak Bengali loads of times when I was in London. But I don't do that [now] because nobody speaks it here' (Amir, resident, p56). This is an important point as they came from very ethnically diverse East London areas.<br>Most said they would like to be closer to family and friends, or to local amenities (shopping centre, sports facilities) they knew and had enjoyed; 4 of the participants mentioned conflict and abusive relationships with family members. Some relatives, especially if old or infirm, could not visit, and residents did not mention any ability to leave the unit. 'How are you feeling about that, that you couldn't visit your family?' (interviewer); 'A bit upset, inside, hurt inside, hurt inside, heart, heartbroken inside' (William p56). | |

| Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |

| Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Cross-sectional study<br>**Relevance to RQs**<br>**• RQ 4) Admission**<br>**• RQ 5) Discharge**<br>**Study aim**<br>• To compare pathways into the psychiatric hospital (admission) and the provision of inpatient and aftercare for Asian, black and white patients with non-affective psychoses. (For our purposes, only the admission and post-discharge experience is relevant.)<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>Four inpatient units in Birmingham | **Participants**<br>• Adolescents with MH conditions<br>Age range 16–60.<br>• Adults (no specified age) with MH conditions<br>Age range 16–60.<br>• People subject to the MHA (involuntary admission)<br>**Sample characteristics**<br>• Sex<br>Over 50% male in all groups (22–29 of 40) except white patients discharged (16 of 40 male).<br>• Ethnicity<br>Equal proportions of Asian, black and white. All Asians significantly more likely to be born outside UK and be married.<br>• Socioeconomic position<br>Similar socioeconomic positions across all groups.<br>• Previous admissions<br>Admissions sample: no admission within previous month.<br>Discharge sample: inpatient for at least 6 months. Most patients reported 1 or more previous admissions. | **Outcomes (quantitative)**<br>• Admissions under MHA<br>Asian and black patients more likely to be compulsorily admitted and to not see themselves as having psychiatric needs, and had lower levels of satisfaction.<br>• Satisfaction<br>**Findings – narrative**<br>**• RQ4 Admissions**<br>At admission black patients were rated significantly more highly on Destructive Behaviour, Hostility, Inappropriate Sexual Behaviour and Incoherent Speech.<br>Asian patients were rated more frequently rated as having Socially Unacceptable Habits while white patients scored more highly on Depression and Panic Attacks and Phobias<br>"Over half the black patients had some police involvement in the period leading to hospitalisation and a similar proportion were brought to hospital by the police. They were less likely to be accompanied by family or friends and more likely to be detained compulsorily. Asian patients, like black patients, followed a more circuitous route than white patients, with greater levels of police contact.<br>Levels of involvement of mental health staff were similar across ethnic groups. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• -<br>Unclear, because the data is so old, and the samples small. It is to be hoped that services have improved, e.g., in supporting black and Asian service users. |

| Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | **Sample size**<br>• Researchers aimed to recruit the first 120 admissions who met the inclusion criteria, and the first 140 discharges (ditto), to the 4 participating inpatient units between April 95–Jan 96 (so quite old data). They were to be 40 in each of the racial groups (Asian, black and white). There is therefore an overlap of 64 people in the groups at different time points (i.e. some will be in both samples), therefore total sample is 216 people.<br>**Intervention**<br>• Admissions and discharges | Asian and black patients were less likely to perceive themselves as having a mental health problem and expressed greater dissatisfaction with the admission process (see Table 3). While the majority of white patients felt that they needed to come to a psychiatric hospital, this applied to only one-third of Asian and black patients (see Table 3)' (p486).<br>Black patients most likely to be sectioned, confined to ward, and in intensive care (after admission). Asian patients most likely to be visited by friends and family.<br>• **RQ5 Discharge**<br>Post-discharge (3 months) examination of need:<br>'Five main areas of unmet need (experienced by 20% or more patients) were identified on the CAN:<br>- daytime activities (n=16 Asian, n=10 black and n=8 white),<br>- psychological distress (n=7 Asian, n=7 black and n=13 white),<br>- company (n=16 Asian, n=11 black and n =9 white),<br>- information about their condition (n=12 Asian, n=21 black and n=14 white)<br>- welfare benefits (n=15 Asian, n=14 black and n=5 white).<br>However, only the latter differed significantly by ethnic group, Asian and black patients being more | |

Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| | | likely than white patients to complain of unmet need regarding welfare benefits (P < 0.05)' (p488).<br>In terms of measures of continued support and engagement after discharge, black patients were significantly less likely to have seen their GP since discharge, and were more likely to have discontinued medication (against medical advice), although most patients were on medication, and few had any psychological support. Most patients had a key worker, and three-quarters had seen a psychiatrist since discharge. Readmission was low for all groups. | |

Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>• **RQ 4) Admission**<br>**Study aim**<br>• The study aimed to firstly examine how service users with intellectual disabilities, | **Participants**<br>• People with a learning disability<br>• Carers/family members of people with MH conditions<br>• Professionals/practitioners<br>**Sample characteristics**<br>• Disability<br>• Ethnicity<br>To maintain anonymity, the | The results represent a mainly negative account of inpatient admissions for people with intellectual disabilities to mainstream mental health services. While the admission was often seen as providing much needed respite for carers, and providing good basic care during crisis for service users, generally there was a negative picture of life on the ward. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transition guideline**<br>• Somewhat relevant |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| their carers and service providers perceive mainstream inpatient mental health services, and secondly, to what extent their accounts are in line with key policy objectives.<br>**Country**<br>• UK<br>**Source of funding**<br>• Not reported<br>**Outcomes 1 (qualitative)**<br>•What works well<br>• Experiences described<br>**Outcomes 2 (quantitative)**<br>• Clinical outcome<br>• Satisfaction<br>• Service outcomes | ethnicity of participants from black and minority ethnic groups was not revealed.<br>• Sample age<br>All service users were aged between 30 and 55 years.<br>• Level of need/diagnosis<br>With exception of 1 case that was not specified, rest of sample of 11 presented with schizophrenia (1 paranoid sch.) or mood disorder.<br>• Socioeconomic position<br>Living alone, with family or in supported accommodation prior to the admission.<br>**Sample size**<br>• Sample size<br>Overall, 42% (n=11) of service users who fitted the inclusion criteria took part or chose for their carer to take part. Seven service providers took part in focus groups. | **Key themes from interviews**<br>**Respite**<br>In all except 1 of the cases, at least some feature of the admission was perceived as providing respite, either for the person with intellectual disability or more frequently the carer, e.g. the receipt of ‘good basic care’, i.e. a warm bed, suitable food and a sense of containment. Service users said the physical accessibility of staff helped them to feel supported, as did access to other patients who were also seen as a source of support. Some informal carers were put in touch with other services during the admission.<br>**Disempowerment**<br>In all but 1 case, the inpatient experience was seen as disempowering, e.g. enforced compliance, such as being told that they either had to admit themselves voluntarily or face being sectioned under the Mental Health Act. Some said they were not even told why they were being taken to hospital. Often treatment was seen to be characterised by the principle that compliance was synonymous with recovery; for many this meant adhering to medication regimes.<br>Service users were reluctant to complain about anything for fear of attracting negative attention.<br>**A daunting environment**<br>About half of the respondents reported examples of | |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | violence committed by other service users against ward property, staff and patients. Illicit drug use and theft of personal belongings were also cited. Carers viewed the ward as ‘depressing’, ‘intimidating’ or ‘frightening’ and counter to promoting recovery.<br>**Lack of ‘real’ treatment**<br>Participants said that treatment options were limited and mainly focused on medication, with very little therapeutic options.<br>‘For the 2 weeks she was in there she spent the majority of the time in her room just talking to herself, wandering around the room and that was it. I can’t say they did any more than that for her because they didn’t’ (C3).<br>Half of the participants felt well informed by ward staff. Ward reviews were seen as especially helpful, mainly as information was communicated directly by medical staff.<br>‘The meetings with the doctors and then the social workers I have to say were good. The doctors did actually explain as much as they could to me, or as much as they understood’ (C3).<br>But for many there was a striking absence of information-sharing, including about medication, rules and procedures on the ward. Carers found it difficult to know who to liaise with and often felt left out.<br>**Inclusive versus excluding care: having a voice** | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | **versus not feeling heard**<br>Some service users felt listened to by staff, and carers felt consulted at meetings, especially with regard to treatment, but other users and carers felt the opposite, e.g. some felt that had to ‘fight’ with staff to be heard.<br>**The impact of having an intellectual disability**<br>Participants felt that having an intellectual disability complicated the whole admission experience.<br>**A barrier to access**<br>The search for help was fraught with difficulty, often manifest in a lack of knowledge in the areas of mental health and intellectual disability by staff in primary care and accident and emergency services. It was also felt that staff in mental health services were often hesitant about assessing someone with an intellectual disability.<br>**Neglect**<br>A striking issue for many participants was that ward staff did not accommodate or properly understand a person’s intellectual disability. Some carers said that their loved ones were discharged without satisfactory assessment and that individual needs were not properly addressed. In general, it was overwhelmingly felt by users and carers that individuals with intellectual disabilities were seen as different both by professionals and other inpatients. | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | **Results: focus groups with providers**<br>Service providers said there were clear challenges as well as some examples of good practice and joint working between mental health and intellectual disability services. Communication was a major issue in terms of communication needs arising from the person’s intellectual disability and poor communication between different agencies. Eight themes emerged from the focus groups as below.<br>• Lack of joint working<br>This was seen as a key theme in terms of the failure by intellectual disability and mental health services to work together.<br>• Confusion over roles and responsibilities<br>Different opinions of the roles and respective responsibilities of intellectual disability and mental health services during admission included not knowing who should conduct assessments and provide support on a day-to-day basis and during leave from the ward, and confusion about whose role it is to draw up a care plan under the Care Programme Approach. Confusion about roles seemed to be complicated by a lack of communication between them.<br>• Awareness of different pressures and resources<br>Participants were very aware about the various demands faced by intellectual disability and mental | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | health services.<br>‘In learning disability our staffing levels are much higher, people do get good 1-to-1 support. That isn’t available in a ward setting.’<br>• ‘We’ve got one of yours’<br>There was a sense of conflict between intellectual disability and mental health services, described in terms of clients who ‘belonged’ to a particular service as opposed to different services having complimentary roles to address the individual’s needs.<br>• Everything is attributed to the intellectual disability<br>Within the context of trying to secure help from mainstream services, participants often spoke about their frustration where staff blamed all problems on a person’s intellectual disability, known as ‘diagnostic overshadowing’ (Mason and Scior 2004; Reiss and Syzszko 1983). ‘The doctor kept saying “he’s got learning disabilities, what do you expect?” (in response to nurse’s efforts to focus mental health staff on depressive episodes).<br>• What it means to have an intellectual disability<br>Respondents voiced their concern about what they saw as a very narrow understanding by staff in mainstream inpatient settings about the implications of intellectual disabilities, e.g. failure to take account of additional support needs. | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | • Different ethos<br>Participants described a different ethos in the 2 services, describing a lack of a person-centred approach in inpatient mental health services.<br>• Limited impact of policies<br>There was a general view that awareness and commitment to policies and agreements aimed at improving joint working seemed significant among managers compared to staff directly involved in providing support to individuals. Participants emphasised continually that success stories were ‘down to individual relationships that may have developed over time. It’s about who you know.’ | |

| Farrelly S, Brown G, Rose D, et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. Social Psychiatry and Psychiatric Epidemiology 49: 1609–17 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Study aim**<br>• To analyse the content – what service users want – of joint crisis plans made as part of a multi-site RCT of JCPs | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample characteristics**<br>• Sex: 51% male<br>• Ethnicity: White 63%, Black 23%, other 13% | **Outcomes (qualitative)**<br>• What can be improved<br>JCPs are analysed according to 2 categories: ‘The first category “delivery of care” – addresses the manner in which treatment was delivered and includes aspects of interpersonal interaction/communication and the availability of | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transition guideline** |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| (CRIMSON trial) compared with TAU for people with psychotic disorders<br>**Source of funding**<br>• Funding councils<br>MRC.<br>**Country**<br>• UK<br>Four MH trusts, 1 rural.<br>**Outcomes 1 (qualitative)**<br>• What can be improved<br>Joint crisis plans (JCPs) are analysed according to 2 categories: 'The first category "delivery of care" – addresses the manner in which treatment was delivered and includes aspects of interpersonal interaction/communication and the availability of services. The second category describes the particular treatments/interventions that service users' would/would not like in a crisis situation (e.g., medication and home | • Sample age<br>Mean age 40<br>• Level of need/diagnosis<br>Diagnosis of a psychotic disorder, and contact with a CMHT, and not an inpatient. Note: the respondents are randomised to the treatment (JCP) arm of the trial.<br>• Previous admissions<br>Admission within the past 2 years<br>**Sample size**<br>• Sample size<br>221 JCPs were analysed<br>**Intervention**<br>• List interventions of interest<br>JCP. This specifically requires involvement of the treatment team and a facilitator (unlike other advance statements). Method is then to encourage both user empowerment and shared decision-making between stakeholders within a meeting – but service users' views are recorded verbatim (source of analysis). The JCP has a structured 'menu' through which options and preferences are raised | services. The second category describes the particular treatments/interventions that service users' would/would not like in a crisis situation (e.g., medication and home treatment team)' (p1611).<br>**Findings**<br>There were 4 major themes around all delivery of treatment: 'Treat me with respect'; 'understanding what is illness, and what is not'; 'continuity/consistency/clarity'; and 'control and involvement' (p1611). Treating with respect included areas such as explaining what was felt to be wrong, how medication might help, and any home treatment team making appointments to visit (rather than expecting the person to stay in all day and arriving when it suited them). Understanding what illness is and what it is not relates to knowing the person.<br>Although admission had been problematic in some way for most of the sample, and there was strong support for being supported to stay at home, or staging interventions with hospitalisation as a last resort, there were also people who felt rapid hospitalisation was essential when particular symptoms were apparent. There was support for enabling other approaches and activities – e.g. yoga, talking therapies, or having a sympathetic and familiar person outside the family to talk to – but also for avoiding or using particular medication.<br>Many of the sample found hospitalisation | • Somewhat relevant |

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| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| treatment team)' (p1611). | and discussed.<br>NOTE: some of the material recorded here is out of scope: e.g. which medications are preferred, inpatient treatment, even preference for not being admitted (as then no admission takes place). However, JCP has direct relevance to admissions processes. | problematic, making them feel 'bored, heavily medicated and trapped' (p1614), but only 8% (18/221) refused admission in their JCPs (half of these in any circumstances, and half in relation to particular wards or as an involuntary patient). | |

Hooff S van den, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. Scandinavian Journal of Caring Sciences 28: 425–34

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Systematic review<br>Systematic search of published literature in peer-reviewed journals.<br>**Relevance to RQ**<br>**• RQ 1) Service user views**<br>**• RQ 3) Practitioners' views**<br>**• RQ 4) Admission**<br>**Do all studies fulfil inclusion criteria?**<br>• No. 6 out of 22 papers | **Participants**<br>• People subject to the MHA (involuntary admission)<br>• Professionals<br>Sample size<br>• Systematic reviews: number of studies, 22 included studies | **Findings – narrative**<br>**• RQ1 Service user views**<br>Inside perspective of the patient<br>'The two most commonly mentioned negative experiences reported by patients were powerlessness and humiliation.' (p427)<br>• Powerlessness<br>Powerlessness consisted of not being understood, being ignored, feeling helpless or insecure. Patients received a treatment they had not agreed to.<br>They felt that they were not being listened to.<br>'Patients felt out of control during their hospitalisation | **Overall assessment of internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Partly<br>The review contained 2 papers from England. Other papers were from Ireland, Australia, Sweden which have similar healthcare systems to the UK. |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| were published between before 1999 (earliest 1995)<br>**Study aim**<br>• To explore the literature on patients' and professionals' perspectives on involuntary admission. The main question of this review is: 'Which quality themes are reported by patients and professionals during involuntary admission?' (p.426).<br>Source of funding<br>• Other:<br>Inholland University of Applied Sciences, the Netherlands<br>**Country**<br>• Range of countries Austria, Denmark, England, Ireland, New Zealand, Norway, Sweden, US.<br>**Outcomes (qualitative)**<br>• Experiences described | | due to not receiving sufficient information and not being involved in decisions' (p430).<br>• Humiliation<br>Patients felt that they were not treated as human beings or that they were not perceived as having the same human value as a healthy person (p.430).<br>'Being dependent on healthcare professionals and health care increased experiences of vulnerability. Patients felt like an inferior kind of human being' (p431).<br>They were not involved in decision making and this made them feel their needs were not satisfied and the process was meaningless; this caused feelings of disrespect and helplessness (p431).<br>• Patients' positive experiences<br>Patients reported positive experiences when they felt they were guarded and seen. Patients wanted to feel safe, protected and cared for (p431). These feelings enhanced respect – an important primary ethical principle.<br>• The outside perspective on the patient<br>Other literature measured themes which were important during admission. Themes that played a major role in this category were pressure, loss of autonomy and procedural justice.<br>• Pressure | **A clear focus on transition between inpatient MH setting and community or care home setting?**<br>• Yes<br>**Are the population groups relevant?**<br>• Yes<br>**Relevant to social care outcomes?**<br>• Unclear<br>**Does the review have a UK perspective?**<br>• Unclear<br>**Overall assessment of external validity**<br>• + |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
|  |  | ‘Negative pressure consisted, for example, of treats, giving orders, deception and show of force. Positive pressure consisted of persuasion, promises, inducements, asking for a preference and using words to encourage individuals to make the “right” choice’ (p431).<br>• Loss of autonomy<br>Described as a loss of liberty, limited possibilities of moving and being dominated by others (p431).<br>• Procedural justice<br>‘Procedural justice concerns the fairness and the transparency of the processes by which decisions are made. For patients, this means that their voice is heard and that they have the opportunity to express, explain and participate in the admission decision themselves’ (p431).<br>‘Considerable clinical skills are required to initiate aspects of procedural justice, to reconcile these situations and ameliorate perception of coercion. A great need mentioned is the identification of effective interpersonal communication and the teaching of these methods to all professionals who are liable to be involved in the admission process’ (p431).<br>One study explained: ‘the challenge is to try to extend to all patients, at the time of their admission, a demonstration in word and action that they are persons with opinions, desires, rights and dignity’ |  |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | (Hiday 1997). Professionals should minimise patients' feelings of coercion by a good explanation of the rationale for admission (Bonsack 2005). O'Donoghue (2011) suggests that the majority of patients reflect positively on their involuntary admission if they have greater insight into their illness (p431).<br>• **RQ 3 Practitioners' views**<br>• The inside perspective of the professional<br>Themes in this category were: being stressed, being satisfied and connectedness.<br>'Just three articles taught us something about the feelings, motives and attitudes of frustrations of the professional during involuntary admission' (p431).<br>Jepsen (2010) described that GPs were stressed and frustrated due to the uncertainty about what was going to happen, the time-consuming procedure and the fact that they had repeatedly admitted patients who never seemed to benefit from the admissions (p431).<br>Satisfaction and connectedness were positive experiences voiced by professionals.<br>Although this was in an older paper (Anderson 1995) clinicians pointed out 'the importance of being flexible and individualising the process according to patients' needs and tolerance' (p431).<br>• The outside perspective on the professional<br>Within literature describing the outside perspective of | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | the professional, admission criteria come to the fore, e.g. the diagnostic and legal criteria. Additionally dangerousness, risk of harm and violence to others are criteria to take into account (p431).<br>• **RQ 4 Admission**<br>See RQ1 (service users) and RQ 3 (professionals) respectively for views on compulsory admission.<br>Findings show that most experiences of patients can be traced back to 1 core experience that makes the difference:<br>'Am I being listened to?' If patients experience genuinely listening, they feel more respected as a human being and less emotionally abandoned. The challenge for professional carers is to explicitly pay attention and really listen empathically to patients' struggles while at the same time make the decision to admit the patient' (p433). | |

| Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric in-patients: a case-control study. Journal of Affective Disorders 144: 123–8 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |

| Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric in-patients: a case-control study. Journal of Affective Disorders 144: 123–8 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Case-control study<br>**Relevance to RQ**<br>**• RQ 4) Admission**<br>How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?<br>**Study aim**<br>• To identify characteristics, including risk factors, for suicide among inpatients within the first week of admission to a psychiatric ward. (Previous studies have not isolated cases of early suicide.)<br>**Source of funding**<br>• Government<br>NPSA<br>**Country**<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample characteristics**<br>• Sample age<br>Adults 65 and over were excluded from the study (as old age is thought to involve different triggers of suicide).<br>• Level of need/diagnosis<br>All suicides who died within 7 days of admission to inpatient MH care (matched on admission date to 107 new admissions of people who did not commit suicide).<br>**Sample size**<br>• Comparison numbers<br>107 controls matched on admission date.<br>• Intervention number<br>107 suicides admitted within past 7 days.<br>**Intervention**<br>• List interventions of interest<br>N/A. Focus is on suicide as an outcome of admission process. Note that people recorded as suicides and 'open verdicts' were | **Findings – narrative**<br>**• RQ4 Admissions**<br>The first few days of admission for people with specific characteristics (including recent adverse events, previous self-harm, and acute, but perhaps only recently diagnosed) mental illness, especially if male, are a time of acute suicide risk. Most suicides happen off the wards, with patients having absconded or on leave. More rigorous risk assessment and greater vigilance, and possibly less distressing ward environment, may lessen the risk. Staff should be aware of these statistical findings. | **Overall assessment of internal validity?**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric in-patients: a case-control study. Journal of Affective Disorders 144: 123–8

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Outcomes (qualitative)**<br>• what can be improved<br>To reduce suicides within first week of admissions. | included in the suicide sample. | | |

Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Research 187: 275–82

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Mixed methods<br>Quantitative and qualitative.<br>**Relevance to RQ**<br>**• RQ 1) Service user views**<br>**• RQ 4) Admission.**<br>**Study aim**<br>• 'To investigate whether specific socio-demographic and clinical characteristics are associated with perceptions of coercion at admission among legally voluntary patients. To examine whether voluntary patients who feel coerced | **Participants**<br>• Adults (no specified age) with MH conditions<br>• People NOT subject to the MHA (voluntary admission)<br>**Sample size**<br>• Sample size<br>270 participants completed the quantitative part of the study (rating perceived coercion using the McArthur Perceived Coercion Scale (MPCS)); 36 participants were interviewed.<br>**Intervention**<br>• Legally voluntary admission | **Outcomes (quantitative)**<br>• Satisfaction<br>**Findings – narrative**<br>**• RQ4 Admissions**<br>• Hospital treatment not effective/need for alternative treatment<br>The majority of patients who felt coerced (91%) believed that they needed help for their mental health problem(s). However, they felt that alternative treatments to hospital admission would be more beneficial. Those who felt coerced described hospital care as unhelpful, or harmful, on account of being confined and kept away from their families, having no privacy, and feeling scared by other patients.<br>They described hospital as a place where they were contained and given medication rather than as a | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• N/A<br>**Are the outcomes relevant?** |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| into admission continue to feel coerced during hospital treatment. To identify factors associated with feelings of coercion during treatment, and to explore what experiences – in the view of the patients – lead to feelings of coercion both at admission and during treatment.' (p275/276).<br>**Source of funding**<br>• Government<br>European Commission.<br>**Country**<br>• UK<br>**Outcomes 1 (qualitative)**<br>• what can be improved<br>• experiences described | | therapeutic environment:<br>'I needed some sort of treatment, but I don't think to be locked up for 5 weeks is some sort of treatment' (participant 3).<br>• Not participating sufficiently in the admission and treatment process<br>91 percent of coerced patients believed that they did not have control over their admission and treatment:<br>'I didn't really decide, they decided for me … I thought that if I didn't say yes then I would be sectioned, so really I did feel coerced … it certainly didn't feel like I had a choice, so I got angry' (participant 15) (p278).<br>'They didn't really tell me what was going on, they just sort of left me there … then they said to me that I couldn't just go … hey said that they would take me in a cab, to this hospital to see my doctor for 20 minutes and then go straight home in a cab again. So I didn't really know where I was, in terms of a hospital ... When I came here they said your bed's ready, and gave me pyjamas! I was like what, you know, I'm only here for 20 minutes, it was like all a big mistake!' (participant 22) (p280).<br>'It was like we were backed into a corner, my mum almost had to convince him to let me come in on the Saturday because otherwise he wanted me to come in then and there, that day, that night, so I hadn't no | • Yes<br>**Overall assessment of external validity**<br>• ++ |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | choice and obviously I didn't want to be sectioned you know, because that's going to be stuck with me for ever. So there was no choices like, we had no discussion, I was adamant that I didn't want to come in, but I didn't want to be sectioned, so I had no choice about it whatsoever' (participant 9) (p280).<br>'I mean my big problem is my lack of self-esteem that's where all my problems come from, and to be locked in hospital like that just exacerbates that problem, fuels all the insecurities I have, um, it seems like I had no power or control over what happens to myself, um which is precisely the sort of reason why I took an overdose in the first place' (participant 30) (p280).<br>• Not feeling respected/cared for<br>Even when information was presented to them, people who perceived coercion did not feel that they had adequate time to reflect on it, resulting in their hospital admission:<br>'I was scared, feeling like I don't want to go and half of me wanted to go, but everything happened so quickly that day, that I didn't have time to say anything … I just thought that I got pushed into doing it, it wasn't like I was asked for my consent, that was the whole problem … In a way I wanted to face up to my problems … but I felt really intimidated, pressured into going' (participant 2) (p278/279). | |

Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Research 187: 275–82

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | Over half (57%) of patients felt that the staff involved in their admission and treatment did not care about them and were often rude and abrupt.<br>‘There’s a whole team there and they don’t listen to you; they TELL you … it just made me feel like I wasn’t human and nobody actually took my point of view into consideration’ (participant 32) (p279).<br>‘They are too professional and everything they’ve told me I don’t understand, ‘cause there’s too many long words in there, and I feel embarrassed and shy, I feel demolished, I feel like an idiot asking them’ (participant 28) (p279).<br>• Experiences not leading to perceived coercion<br>Mirroring the previous findings patients who did not feel coerced believed that they needed hospital treatment, that they were included in the admission and treatment process, and that they felt respected and cared for.<br>Those who did not feel coerced perceived that hospitalisation offered them the intensive treatment they needed and helped them recover in a place of safety.<br>‘I was feeling that people were following me, watching my every move. To me, the only safe place I felt was the psychiatric hospital’ (participant 1) (p279).<br>• Participating in the admission and treatment | |

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| Research aims | Population | Findings | Quality assessment |
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|  |  | process<br>‘They do talk to me and explain why I’m getting these things happening to me. I’m grateful, they’ve diagnosed me and told me what tablets they give me’ (participant 4) (p280).<br>‘The duty psychiatrist spent like about an hour with me, asking various questions and then he started to advise me on what he thought was the best course of action for me. He sort of told me what he thought was the initial kick off of the problem, but as we got chatting and talking more came out, and he seemed to think that there was something more deep-seated in the problem. So he then advised me basically to come in here, until they can work out some sort of programme for me … and I followed his advice. It was entirely my choice’ (participant 29) (p280).<br>All patients who did not feel coerced believed that they either asked to be admitted themselves or were actively involved in their admission and treatment process.<br>‘The mental health team said they’d visit me at home sometimes, but I thought it was better to come to hospital. The psychiatrist said that they couldn’t do a lot for me unless I went to hospital. They were willing to do home visits … but I thought it wasn’t enough support’ (participant 14) (p279).<br>• Feeling respected/ cared for |  |

| Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Research 187: 275–82 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | 85% of patients who did not feel coerced appreciated the staff's involvement in their admission and treatment.<br>'When you go through a dreadful breakdown, all you really crave for is somewhere safe and someone to understand and to just accept you, and, to actually treat me with dignity and just treat me as if I was my normal ... and here I've been treated very, very nicely' (participant 1). | |

| Katsakou C, Rose D, Amos T, et al. (2012) Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: A qualitative study. Social Psychiatry And Psychiatric Epidemiology 47: 1169–79 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Study aim**<br>• 'To explore involuntary patients' retrospective views on why their hospitalisation was right or wrong' (p1169, (abstract).<br>**Source of funding**<br>• Government<br>DH.<br>**Country** | **Participants**<br>• Adolescents with MH conditions<br>• People subject to the MHA (involuntary admission)<br>**Sample characteristics**<br>• Sex: 58% male<br>• Ethnicity: 63% white, 24% black, 10% Asian, 3% other<br>• Sample age: mean age 37.7 (+/- SD 10.2)<br>• Level of need/diagnosis<br>All had been admitted involuntarily: 49% psychosis, 36% | **Findings – narrative**<br>**• RQ4 Admissions**<br>28 patients were generally positive about IA (involuntary admission); 19 negative about IA (7 of whom had reflected on the necessity but decided it was wrong); and 12 were ambivalent. Some had changed their minds over time.<br>Of whole sample:<br>90% had felt unwell or at risk at admission. Experience to back this included taking an overdose, dramatic mood changes (distress, feeling frantic or elated), risky behaviour, and recognising themselves | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transition guideline**<br>• Highly relevant |

| Katsakou C, Rose D, Amos T, et al. (2012) Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: A qualitative study. Social Psychiatry And Psychiatric Epidemiology 47: 1169–79 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| • UK<br>22 hospitals in England.<br>**Outcomes (qualitative)**<br>• Experiences described | affective disorder, 15% other<br>• Previous admissions<br>79% had been hospitalised in past at least once<br>**Sample size**<br>• Sample size<br>59 of 69 asked agreed to be interviewed (from 22 hospitals). Patients interviewed between 3 months and 1 year after index admission, and always after discharge. Sample was purposive to reflect response to question applied 3 months after admission: 'Today, do you find it right or wrong that you were involuntarily admitted?' (p1170).<br>Respondents stratified into positive (yes), negative (no) and ambivalent, and this, as well as other characteristics (gender, ethnicity, etc.) was used to get an inclusive sample.<br>**Intervention**<br>• Involuntary admission | as being aggressive or argumentative. A minority of the 59 (32% of the negative group) did not experience this sense.<br>92% felt out of control during hospitalisation: this entailed not being informed or involved in decision to section, their rights or treatment alternatives. 'They never told me why I was sectioned, it's like taking you and locking you up, never telling you why you are being locked up! I felt like a prisoner!' (participant 38, 'negative' group) (p1172–3). Many of this group recalled coercion, restraint and forced medication.<br>63% felt the need to avert risk and feel safe in hospital: this included most of the positive group, but others also recognised the 'need' for help with social welfare and housing.<br>53% felt the need for non-coercive treatment: although 89% of negative view holders believed they needed help, they did not see the need for such intensive and coercive treatment. 'I've had this mental illness for years. So I know I've had it all my life, but I prefer to do it within the bounds of my family, not in a hospital … I realise that I needed help, but I would have preferred to have gone to my General Practitioner (GP), and say alter my medicine. Not be kept in hospital against my will' (participant 31, 'negative' group) (p1173).<br>42% felt an 'unjust infringement in autonomy': 74% of patients with negative view found the involuntary | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | admission had meant a huge and unnecessarily harsh interruption in their lives.<br>'I certainly didn't need to be sectioned. I was very anxious to get home, to find out where my dog was and to get my business running and get myself back on my feet … I have lost so much money through being sectioned … I lost all the trade over Christmas' (participant 40, 'negative' group) (p1174).<br>In conclusion, though most involuntary patients recognised the need for some help, and felt unwell, it was the forced and coercive aspects of admission, and the failure to consider alternative options, that they objected to. | |

| Manktelow R, Hughes, P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland. British Journal of Social Work 32: 44– 61 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Mixed methods<br>**Relevance to RQ**<br>• **RQ 1) Service user views**<br>• **RQ 2) Carers' views**<br>• **RQ 4) Admission**<br>GDG3 wanted ASW practice | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Carers/family members of people with MH conditions<br>• Professionals/practitioners ASWs | **Findings – narrative**<br>• **RQ4 Admissions**<br>Findings from ASWs reflected their difficulties in making an application for admission to hospital for an assessment (which was required in NI if the nearest relative objected); difficulties in contacting and consulting other professionals, difficulties in | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Unclear<br>Age and difference in legislation and process |

| Manktelow R, Hughes, P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland. British Journal of Social Work 32: 44– 61 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| included, but the mental health law is a little different in NI. However, ASW practice has in common the 'conflicting' tasks of detaining the patient and appearing to advocate for them and the least restrictive alternative (which rarely exists).<br>**Study aim**<br>• To explore the practice of ASWs in NI from the different perspectives of stakeholders, using survey data from ASWs, focus groups with users, carers and interviews with MH service managers<br>**Source of funding**<br>• Government<br>DHSS in NI.<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• Experiences described | Two-thirds of ASWs were women and over 50% aged 40–49. Two-thirds worked in field/community. and 14% in hospital settings.<br>**Sample size**<br>• Sample size<br>Survey included 243 ASWs (84% of total) 2 focus groups included 17 service users, 12 of whom had been sectioned by ASW (1–5 times). A third FG included 13 people with LD and MH problems. Five mothers and 1 sister caring for a person who had experienced ASW detention formed a further focus group. (These 2 categories recruited through voluntary sector advocacy groups.) (MH managers from 11 community and MH Trusts interviewed, but reported in another paper.)<br>**Intervention**<br>• List interventions of interest<br>Detention by ASW. | interviewing the person in a suitable manner and in forming a judgement.<br>74% had completed an application in past 2 years, a third had completed more than 10, and 10% 20 or more. More than half said the main difficulty in conducting the assessment arose from the person being too disturbed to engage, but a quarter also described concern for their own personal safety and another quarter use of drugs and alcohol as impediments.<br>Only 14% of ASWs said the GP was present in 80–100% of interviews, and 41% reported difficulty in contacting the GP. In NI, if a relative objects, as second ASW must be present. The GP presence is not mandatory, but ASWs reported wanting help in forming a judgement; 68% of experienced ASWs had at some time decided not to proceed to apply, but 40% had applied when the patient agreed to go voluntarily, usually because they though s/he might have a change of heart, or a history of absconding.<br>Arranging police protection, and appropriate transport, was other difficulties evidenced in the survey: 36% had been involved in MHR tribunals, and most had found it difficult to work within a health/social care/legal environment.<br>ASWs were also required to complete a social circumstances report within 14 days when a person was admitted by a relative. This often concerned out | are problematic.<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>The major limitation to external validity and generalisability is the age of the study, and the fact that it is governed by different NI procedures. In UK today, ASWs have been replaced by AMHPs and relatives did not have the powers they had in NI. |

| Manktelow R, Hughes, P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland. British Journal of Social Work 32: 44– 61 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | of hours work (so conflicted with their daily caseload requirements), required collaboration with relatives, GPs and others which was difficult to arrange, and might (some felt) have little influence.<br>**Findings from users**<br>Reported different levels of understanding of the ASWs' role, but many felt 'the ASW tried to help' and 'waited with me for 2 hours until I decided I needed to go to hospital' (p455).<br>Most users expressed concern about the nearest relative's ability to get them 'put out of the way' (p456), and some suggested an advocate other than ASW was needed (as conflict of interests there). Some felt that this power of the relative interfered with their subsequent relationship. Some felt ASWs did not explain the situation adequately, while others felt they did make efforts to explain and involve the person. A lack of community alternatives to admission was recognised by users. Although ASWs said they usually came with and waited at the hospital with the person until they were medically examined, none of the users recalled this, and many said they were left alone for 2 hours or more, frightened and with no information or support. The service user that recalled being given information about rights to appeal said it was a complicated form, difficult to understand.<br>**Carers:** Carers felt strongly they should not have the | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | responsibility of having to sign the application, but were often forced to do so out of concern for their loved one. It was difficult to get a GP opinion, and even then, the GP said if you don't sign, you will wait a long time for an ASW to arrive. Carers wanted to be consulted, but not to make the final decision. ASWs played a role also in negotiating the return of the person to the home, but relatives felt very conflicted and guilty when they knew it could not work - they felt they should have a SW to advocate for their views. Again, carers deplored the lack of alternatives to hospital admission.<br>**Summary:** Remarkable consistency across accounts. (Note that the arrangement whereby relatives can have a person compulsorily admitted, or where an ASW can do so without support from a clinician, may no longer apply in NI.) | |

| Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |

| Nolan P, Bradley E, Brimblecombe N (2011) Service users’ beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>- Qualitative study<br>Specially designed, 17-item, non-standardised interview schedule.<br>**Relevance to RQ**<br>**- RQ 1) Service user views**<br>**- RQ 4) Admission**<br>**Study aim**<br>- The aim was to understand the beliefs respondents held prior to and during their admission to an inpatient setting and how these influenced their views of the experience of being in acute inpatient care and the decisions they made.<br>**Source of funding**<br>- Not reported<br>**Country**<br>- UK<br>**Outcomes (qualitative)**<br>- What works well<br>- Experiences described | **Participants**<br>- Adults (no specified age) with MH conditions<br>- Older people<br>- People subject to the MHA (involuntary admission)<br>- People NOT subject to the MHA (voluntary admission)<br>**Sample characteristics**<br>- Sample age<br>18 to 71 years (mean age 41 years).<br>- Previous admissions<br>The participants varied in terms of their previous contact with mental health services: 22 had no previous admissions, 5 had 1, 8 had 2, 4 had 4, 2 had 8, 1 had 15, 1 had 27 and 1 had 33.<br>**Sample size**<br>- 44 respondents (18 men and 26 women) | **Findings – narrative**<br>**- RQ1 Service user views and RQ 4 Admission**<br>Continued contact with mental health services may shape people’s beliefs either positively or negatively. The study found that participants’ beliefs on admission fell into 3 categories, positive, negative and uncertain.<br>- Positive beliefs<br>In this category the consensus was that more could be done for patients in hospital than could be done elsewhere. This belief was reinforced by confidence from previous admission experiences for some who had connected with good and kind mental health staff and other patients experiencing similar issues, and recognition that admission would provide the best opportunity to rest. A woman with 3 previous admissions recalled:<br>‘I felt so safe that I would readily comply with whatever was recommended. Perhaps, I was too compliant but at the time I was not in a position to analyse what was happening and I believed others knew more about me than I knew myself’ (p145).<br>Six participants said they were told that admission was the fastest way to get well. Eight said that they believed their mental health problems had had a harmful effect on their families and valued the respite that admission offered family members: | **As far as can be ascertained from the paper, how well was the study conducted?**<br>- +<br>**Relevance to the MH transition guideline**<br>- Highly relevant |

| Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | 'I know now that I must have been a real worry to my wife and two children. What makes it worse is that I cannot be sure about what happened. I feel the live in fear of it happening again' (male with 3 previous admissions) (p145).<br>A quarter of the participants thought that admission provided a chance to have a proper assessment of their condition and offered the most suitable treatment than was available in primary care.<br>• Negative beliefs<br>12 respondents expressed unhappiness about being admitted, thinking that it was not in their best interests. A woman with 5 previous admissions said that every time she informed community staff that she was feeling well, admission was always the first option offered, so she had thought about not providing an honest assessment of her mental health.<br>Negative beliefs were also reinforced by staff that were pessimistic, poor listeners and had little time to engage with service users. Four women resolutely believed that they would never be well again, despite the best efforts of staff. Their positive expectations of previous admissions had not been realised and now they felt cynical about interventions.<br>• Neutral/uncertain beliefs about admission<br>About 11 participants said that they had no firm beliefs about the value or otherwise of admission and | |

| Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute in-patient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | were not able to decide whether it was the right course of action. Some saw admission as an offer of help, but also worried that it might be detrimental being with people who were more ill than themselves. Six women with more than 2 previous admissions stated that the benefit they received from being on the ward was outweighed by anxiety about what would happen to them after discharge in terms of having to return to the pressures at home.<br>The authors conclude that these findings suggest that service users can be helped to reconsider their beliefs through genuine, consistent and empathic relationships, thereby improving the outcomes of admission. | |

| Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>**• RQ 3) Practitioners' views**<br>**• RQ 4) Admission.**<br>**Study aim**<br>• To describe some of the | **Participants**<br>• Professionals<br>• People subject to the MHA (involuntary admission)<br>**Sample size**<br>• Fieldwork was conducted on 5 teams: 2 hospital-based social work teams in outer London, 2 | **Outcomes (quantitative)**<br>• Perceived coercion therapeutic relationship with staff (1 or more)<br>**Findings – narrative**<br>**• RQ4 Admissions**<br>Non clinical and extra-legal factors that may influence the outcome of an MHA assessment. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transition guideline**<br>• Somewhat relevant |

Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
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| non-clinical and extra-legal influences which affect the process and outcome of commitment decisions<br>**Source of funding**<br>• Government<br>Department of Health.<br>**Country**<br>• UK<br>Two London boroughs.<br>**Outcomes 1 (qualitative)**<br>• Experiences described | community mental health teams (CMHTs) and an out-of-hours emergency team in inner London. In-depth follow-up interviews with 4 of the 20 candidate patients and 1 carer (the others refused involvement, were too unwell or could not be traced).<br>**Intervention**<br>• The unit of analysis was the Mental Health Act assessment, as made under Part II of the Act.<br>**Follow-up OR time of interview**<br>• Time until follow-up interview not specified | How the team organise MHA assessments.<br>Notable differences in how the teams were organised were identified to affect MHA assessments.<br>A larger hospital-based team in outer London operated a 24-hour crisis service. A crisis assessment, carried out during a visit from the crisis team, was not an MHA assessment: the aim was to explore if one was necessary. In this way practitioners were encouraged to explore other alternatives before calling for a MHA assessment.<br>In contrast, the inner London CMHT team (CMHT A) carried out assessments using an integrated health and social services duty team. Urgent referrals were processed during weekdays. The CMHT had one of the highest sectioning rates in the country and was exceptionally busy. The researcher identified that it was not unusual for 3 MHA assessments to be happening at the same time. The approach to MHA assessments, consequently, was more ‘pragmatic’ (p124).<br>One ASW pointed out the pressure they were under:<br>‘The way they do things in [outer London] is all very well, but have you seen the number of referrals we get?’ (p124).<br>• Resource constraints<br>Social workers in the inner London CMHT did not perceive compulsory admission as a ‘bad outcome’ | Published in 2003 which reduces its relevance to present practice. The ASW role no longer exists in this capacity. |

| Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | (p124). They reported feeling unable to rely on community resources; lack of access to comprehensive services meant caring for a borderline client in the community was more risky.<br>The perceived lack of alternatives to inpatient care, and bed shortages, were seen to have a large influence on practice.<br>• Support of 'the team'<br>'I'm much more likely to take a risk [and not section somebody] if I know that I've got the team behind me. [And how would you know you've got that?] Well say with personality disorder we've talked a lot about it as a team and have developed clear guidelines' (approved social worker, inner London) (p125).<br>With support from a team (or a smaller team within a team; e.g. a psychiatrist and a community psychiatric nurse) a care plan can be developed, instead of detaining under the MHA. However, this may fall apart if they go on leave:<br>'What happens is that we work to keep people in the community, but often when I or [the consultant] go on holiday, you come back and find they've been sectioned by somebody else' (community psychiatric nurse, inner London) (p125).<br>The professional's knowledge of the person with mental health problems is key. An approved social worker from inner London commented: 'the best form | |

| Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | of risk assessment is getting to know the client really well. It's a mixture of the two things – as you get to know a client better, you know you might be able to do, say, family dynamic work instead of them being sectioned.' (p125).<br>• Variations in local operational norms<br>Level of peer support was found to be variable within and between professional groups.<br>Informal peer evaluation, such as discussing MHA assessments after they've taken place, is an important way to ensure that other options have been considered before committing patients.<br>• Perceptions of conditions on the admission ward<br>If professionals view the psychiatric ward they are sending someone to negatively then that also has a subtly but pervasive influence on their decision to commit someone.<br>'I'm not one of those who thinks you shouldn't section people, but it does help if you know the ward you're sending them to is good' (p126).<br>Class can also influence decisions<br>'In fact I'm more embarrassed dealing with upper-middle class people locally, if I have to say "Look, I'm sorry this is the best we have to offer". It's different for rough sleepers who may actually have better living conditions on the wards. So yes, there are big class implications' (approved social worker, inner | |

| Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal Of Mental Health 12: 119–30 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | London) (p126).<br>Assessment decisions directly affect the ward population.<br>• Chance<br>Everyday contingency factors – interpreters being booked for the wrong language, lack of phone reception - affect not only the process of assessment, but sometimes also its outcome.<br>Delays to the response of the referral mean that ‘emergency’ or ‘crisis’ may pass.<br>**Conclusion**<br>Factors which are likely to lower the threshold for compulsory admission:<br>- high work pressure and resource constraints which lead to a ‘getting the job done’ pragmatism, and a lack of alternatives to inpatient care (p128).<br>Factors which are likely to increase the compulsory admission threshold:<br>- team support in decisions to care for someone in the community; team processes which encourage compulsory admission to be seen as a ‘last resort’ option (such as being asked by peers in a non-threatening way to justify decisions); high bed occupancy rates and concerns about quality of local acute psychiatric wards. | |

| Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & Social Care In The Community 21: 509–18 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>**• RQ 1) Service user views**<br>**• RQ 4) Admission**<br>**• RQ 5) Discharge**<br>**• RQ 6) Reducing readmissions**<br>**Study aim**<br>• To explore the experiences and views of a sample of individuals who had been treated under the Mental Health (Care & Treatment*) (Scotland) Act 2003. *MHCT<br>**Source of funding**<br>• Government<br>Scottish Government.<br>**Country**<br>• UK<br>Scotland | **Participants**<br>• People subject to the MHA (involuntary admission)<br>Note, all participants had experience of compulsory measures under the MHCT Act<br>**Sample characteristics**<br>• Sex<br>67% male 33% female.<br>• Sample age<br>Mean years 40.5 years<br>• Level of need/diagnosis<br>8% had learning disabilities and/or autistic spectrum condition.<br>**Sample size**<br>• 49 service users with experience of compulsion under the MHCT Act (33 carers and 38 health and social care professionals and advocates also made up the sample, but their results are not reported here). Of those interviewed 15 service users were detained in psychiatric hospital (including intensive psychiatric care units). | **Findings – narrative**<br>**• RQ4 Admissions**<br>'Coercion was generally unwelcome. 42% judged compulsion to have been "completely unnecessary". Nonetheless, over half (52%) of the 39 people interviewed at Stage 2 reflected that compulsion had been the "right thing" for them at the time, a 'necessary evil' (p513).<br>Some participants held conflicting views about the experience, essentially viewing compulsory treatment negatively but with identifiable beneficial aspects:<br>'Well it could stop me from getting into any more trouble than I already got myself into. Somehow, it kept me stable … there would have been better ways of dealing with it, much better ways of dealing with it than hospitalisation' (male, G, hospital CTO) (p513).<br>• Compulsory treatment<br>As part of the application for compulsion, the MHO prepares a care plan drawn up in collaboration with service users, carers and other relevant services. Those interviewed had only a vague idea of what a care plan is or should contain. Care plans equated with professionals' checklists to ensure treatment compliance:<br>'I do have a care plan but I dinnae ken what's in it … when I came out of hospital … there was an A4 sheet saying, "continue taking your medication", and | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transition guideline**<br>• A bit relevant |

| Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & Social Care In The Community 21: 509–18 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | "continue to see Dr B", and "see your CPN". So I presume that's what they mean by an aftercare plan?' (female, F, short term order) (p514).<br>The ethos of the MHCT Act and its underpinning principles emphasise a person-centred and holistic approach, however treatment under compulsion is largely equated with drug therapies.<br>• **RQ5 Discharge**<br>'On the whole, participants reported poor planning and lack of involvement in hospital discharge, especially those leaving acute wards ... Assumptions were made about the capacity of relatives to assume or resume care once the person left hospital, particularly when carers had been regular visitors, though they often did not receive advice or information about how to care for someone after a period of acute illness. In contrast, there were some positive experiences including for one individual a phased return to the community, spending a few nights in his new community flat before moving out permanently' (p515). | |

| Scior K, Longo S (2005) In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |

| Scior K, Longo S (2005) In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>• **RQ 4) Admission**<br>**Study aim**<br>• To study the experiences of people with learning disabilities and mental health problems, and that of their carers, on admission to and treatment in psychiatric hospitals, comparing experience on both generic psychiatric wards and on specialist psychiatric wards for people with LDs.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• What can be improved<br>• Experiences described | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Learning disability<br>• Carers/family members of people with MH conditions<br>• People subject to the MHA (involuntary admission)<br>• People NOT subject to the MHA (voluntary admission)<br>**Sample characteristics**<br>• Level of need/diagnosis<br>17 had schizophrenia, 6 schizoaffective disorders, 3 mood disorders.<br>**Sample size**<br>• 29 service users<br>14 on generic wards, with 15–25 beds, 50% of whom were admitted under MHA; 15 on specialist LD assessment and treatment units, 6 of whom were admitted under MHA, rest voluntary; 10 carers of users admitted to each setting (20 in total).<br>Intervention<br>• Generic vs specialist LD | **Findings – narrative**<br>• **RQ4 Admissions**<br>**Service users**<br>The responses from SUs about admission were often related to the environment and social network they were admitted into e.g for some, admission was a respite and offered more social alternatives (to home): 'I saw lots of people there. I talked to the nurses. I liked their drinks and food and everything. I wish I was back there again' (GenSU11) (p25). Within the generic ward, SUs appeared to find more (a wider range) of patients they could talk to (consistent with the fact that the specialist units had a significant proportion of people with challenging behaviour). On the other hand, SUs found the staff on generic units less attentive, interested or even present.<br>Users of generic settings felt more vulnerable and disempowered and experienced less freedom.<br>**For carers**<br>Carers reported feeling very frustrated when trying to get assessment for admission, with disputes about who was responsible and poor support from professionals (inc. GP). Carers of people in general hospital did not trust staff to understand, support or protect their loved one: they sometimes felt even medication was too freely used to keep the person | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>Is a relatively small sample across a large population (10 inpatient units), but appears to convey well some important general principles.<br>**Relevance to the MH transition guideline**<br>• Somewhat relevant |

| Scior K, Longo S (2005) In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | psychiatric wards | quiet.<br>Carers felt more involved in specialist units, and more ‘welcome’ to visit and help the person, and to be involved in discussion of care and treatment:<br>‘When we arrived they sat us down and explained everything. They explained to X that if she was going to behave like in the old placement, they would have to restrain her … The only thing that I found difficult to accept was that they had to restrain her. But it had to be done. And they were very supportive of her’ (SpC8) (p27). However, there were concerns here too that drugs were used for sedative purposes.<br>Some carers also noted that, perhaps unexpectedly, their loved one enjoyed the ward environment and sociability.<br>‘She liked the social interaction. After she left she was always ringing the hospital to speak to some of the clients and staff. I think it [the admission] was helpful because it took her away from home for a while and gave her a new experience, meeting new people’ (GenC12) (p28).<br>In terms of assessment at admission and in the early days of the stay, carers felt that in the generalist ward, insufficient attention was made to the daily physical needs they had supported (e.g. help to dress, ensuring the person ate all their food), and this was exacerbated by staff’s lack of involvement of | |

Scior K, Longo S (2005) In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | carers. There was also a tendency noted in generalist settings to attribute LD patterns of behaviour to mental illness. | |

Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Cross-sectional study<br>**Relevance to RQ**<br>• **RQ 4) Admission**<br>**Study aim**<br>• To investigate the relationship (if any) between therapeutic relationship (with whom is not quite clear!) and perceived coercion during psychiatric admission.<br>**Source of funding**<br>• Other<br>Oxford University scholarship.<br>**Country**<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>• People subject to the MHA (involuntary admission)<br>36 of the 164 patients were involuntarily admitted.<br>• People NOT subject to the MHA (voluntary admission)<br>128 of the 164 patients were not involuntarily admitted.<br>Sample characteristics<br>• Sex<br>94 male, 70 female.<br>• Ethnicity<br>145 white, 19 non-white.<br>• Level of need/diagnosis<br>All needed admission to 1 of 5 acute adult wards at 2 psychiatric hospitals in Oxford, England. | **Outcomes (quantitative)**<br>• Perceived coercion<br>Therapeutic relationship with staff (1 or more)<br>**Findings – narrative**<br>**• RQ4 Admissions**<br>Although perceived coercion was also associated with involuntary admission, the logistic regression analysis suggested that the quality of therapeutic staff relationships modified the perception of coercion, even among involuntary patients. Hospital admission was seen as more coercive when patients viewed the admitted clinician negatively.<br>Other studies have suggested that involuntary admission causes poor relationships, but this study suggests that we cannot take for granted that involuntary admission will enhance perceived coercion (i.e. through causality). Improving therapeutic relationships can mitigate perceived coercion, and may have an impact on patients’ | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | • Previous admissions<br>113 of the 164 had been admitted before.<br>**Sample size**<br>• 164 consecutive admissions to the designated 5 wards<br>**Intervention**<br>• Perceived coercion during admission | experience of treatment, adherence to treatment and even outcomes. | |

| Smith V, Chouliara Z, Morris P, et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: a qualitative study from adult patients' perspectives. The Journal of Health Psychology | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>**• RQ 1) Service user views**<br>**• RQ 4) Admission**<br>**• RQ 5) Discharge**<br>**Study aim**<br>• To explore the experience of ADULT women undergoing specialist inpatient treatment for Anorexia Nervosa<br>NB: have extracted aspects | **Participants**<br>• Adolescents with MH conditions<br>• Adults (no specified age) with MH conditions<br>**Sample characteristics**<br>• Sex<br>All 21 were female (as there were too few males to provide valid contrast or representation).<br>• Sample age<br>18-41 years. Most research in this field concentrates on adolescents and may include the whole range of EDs, so this is felt to be an | **Findings – narrative**<br>**• RQ4 Admissions**<br>Admission to the unit was experienced as a 'handing over of control' of an illness which had governed the lives of the interviewees. This could be experienced as a relief or as a threat to personal safety and integrity.<br>'You don't have to control it anymore and you can give over that control … it feels as if you are in that stage where you can't make any decisions … so it is nice to have other people take over' (participant 17) (p)5.<br>'It was very scary thinking if I come into treatment I | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transition guideline**<br>• Somewhat relevant |

| Smith V, Chouliara Z, Morris P, et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: a qualitative study from adult patients' perspectives. The Journal of Health Psychology | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| relevant to transitions (both).<br>**Source of funding**<br>• Other<br>Was not funded – authors state this.<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• experiences described | unusual study.<br>• Previous admissions<br>13 had at least 1 previous admission, and 8 had had none.<br>Sample size<br>• 21 (of 31 eligible to take part) | have to hand over all control the eating disorder gave me. That made me feel very unsafe' (participant 3) (p5).<br>While interviewees realised the need for control – over food behaviours, meals, eating etc – it contravened their 'coping strategies', which were associated with control. Some felt they needed to be more 'in the loop', more involved in treatment review meetings.<br>Many commented on the stress of transition from home:<br>'I had gone from a stress-free home, you are just living with your illness … Then I came in here … I had a headache for the whole first week because it was so much' (participant 11) (p6).<br>Although these feelings arose during admission, they triggered great anxiety about discharge (see discharge narrative findings).<br>Interviewees also commented on the quality of staff/patient relationships (variable), the value of being (supported to) separate themselves from the illness which took up so much of their energies and capacities as they recovered, and the positive and negative aspects of having peer support from other patients (as this might easily reaffirm negative eating behaviour, competitive body comparisons, etc).<br>• **RQ5 Discharge** | |

| Smith V, Chouliara Z, Morris P, et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: a qualitative study from adult patients' perspectives. The Journal of Health Psychology | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | • Transitions<br>As in narrative findings on admission, the loss of control over condition, life and coping, triggered great anxiety about future discharge (see admission narrative findings).<br>'You become dependent on it … you feel it is your safe place almost. I am almost afraid to be here now because I have become quite attached' (participant 6) (p6).<br>• Loss of control and relapse was anticipated at discharge<br>'You go from being an inpatient in here to going out and maybe seeing someone once a week … there is very little support out there …' (participant 1).<br>'I worry about going home full time … I hear this voice saying … it will be you and me again' (Participant 3) (both p6). | |

| Valenti E, Giacco D, Katasakou C (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |

Valenti E, Giacco D, Katasakou C (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Relevance to RQ**<br>• **RQ 4) Admission**.<br>**Study aim**<br>• To explore the views of people admitted involuntarily into psychiatric hospitals to determine what values matter to them in this situation, where moral and ethical judgements take precedence.<br>**Source of funding**<br>• Government<br>DH funded the work on which this was based.<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• experiences described | **Participants**<br>• Adults (no specified age) with MH conditions<br>• People subject to the MHA (involuntary admission)<br>**Sample characteristics**<br>• Sex<br>25 female (42%), 34 male (58%).<br>• Ethnicity<br>63% white, 24% black, 10% Asian, 3% other<br>• Sample age<br>37.7 (SD 10.2)<br>• Level of need/diagnosis<br>49% schizophrenia, 36% affective disorder, 15% other; 70% had been hospitalised in the past. All admitted under s2-4 of MHA.<br>**Sample size**<br>• 59 people, discharged with 'index' admission between 3 and 12 months previously (mean length of stay this admission 68 days (SD 58.9) from 22 hospitals.<br>Intervention<br>• Involuntary admission | **Findings – narrative**<br>• **RQ4 Admissions**<br>Throughout findings – i.e. the reported experiences of patients – it is mostly impossible to distinguish whether they relate to admission or inpatient stay, but as most patients talked about themselves as being in need of a safe place, it is likely that their experience is of 'the whole package'. (Some may well have been taken off of section during stay – the range of length of stay was very variable.) Themes from the patients as follows.<br>• Lack of control and freedom<br>Lack of control over decision making on treatment and sense that their rights were violated (92% reported this); 41% felt they were 'overpowered' by staff and treated 'paternalistically': 'Well, it's the way the staff … they sort of overpower you … they tell you what to do all the time' (participant 2, male, aged 24).<br>'As soon as you get in there they give you medication … and basically if you refuse too many times they put you in what they call the lock, the proper lock-up' (participant 31, male, aged 42) (p834).<br>Not being free to go out or to do things (e.g. not having books or computer) was a considerable burden for 54%. 56% reported a lack of information on involuntary hospitalisation and treatment, but 17% | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>**Relevance to the MH transition guideline**<br>• Highly relevant |

| Valenti E, Giacco D, Katasakou C (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | said they had had some involvement in decision making on treatment.<br>• Recognition of risk and need for treatment<br>86% agreed they had been unwell on admission, with most agreeing they had needed treatment and 27% needing a place of safety; 56% agreed they had been a risk to self or others, including their children.<br>• Lack of respect among staff<br>Considering the quality of staff, respect, including willingness to listen to the patient, emerged as an important value. ‘I found out that sometimes they ignored you, they weren’t really listening to what you were saying, they didn’t sort of like treat you with respect. I didn’t think it was respect, some of them the way spoke to you’ (participant 5, female, aged 42) (p834).<br>Restriction of freedom on the ward, and (by implication) dependence on staff, was associated with labelling and stigma from staff by 36% of interviewees. ‘You’re on your guard all times … when it got quiet, that was when I had a huge panic attack, and I just woke up in just urine. I had wet myself, because I’d passed out, and I was knocking the door asking if I could have some water. Look, please can I have some water, and … a slightly sort of bully [responded] ‘oh leave her, she’s only faking it anyway’ (participant 40, female, aged 41) (p834). | |

| Valenti E, Giacco D, Katasakou C (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | • **Conclusion**<br>Patient values of freedom, safety and respect may well conflict with staff values (though these were not demonstrated) of ‘life and health’ (p835). | |

## Critical appraisal tables

## Tables reporting impact studies

## Review Question 5: What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

| Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Is the study clear in what it seeks to do?**<br>• Mixed<br>Does not demonstrate the appropriate adherence to | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• No<br>The control group was not assessed for MH status at | **Did the study have an appropriate length to follow-up?**<br>• No<br>Ideally the follow-up would have extended beyond the period of TCM being | Methodology, including recruitment, is poorly described.<br>The main outcome is service use (and costs of these), and there is no reporting of effect size. On secondary | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of** |

| Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| RCT methods – seems mainly to want to demonstrate that funding the service is worthwhile.<br>**Study aim**<br>• To investigate differences in quality indicators for patients receiving transitional case management at discharge from psychiatric inpatient unit (included mental health status, patient and carer satisfaction and costs caused by utilisation of ED and readmissions to inpatient care).<br>**Country**<br>• USA<br>**Relevance to our review question(s)?**<br>• Mixed.<br>Discharge and also RR, but the model may be of more interest than the findings.<br>**Appropriate randomisation?**<br>• Unclear<br>Not clear how the sample was | follow-up, nor for satisfaction.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• Unclear<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• Unclear<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>Likely direction of performance bias effect.<br>• Unclear<br>**Were all groups followed up for an equal length of time?**<br>• Unclear<br>No indication given that the intervention group were not fully assessed on MH measures at follow-up (controls were not)<br>**Dropout numbers** | delivered (and to both groups).<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>Used validated MH appraisal tools. Cost outcomes less certain - unclear how calculated.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Unclear<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias | outcomes such as mental health improvement, the control group were only assessed at baseline.<br>Consequently, as the authors state, improvements in mental health cannot be attributed to the intervention.<br>The study appears too motivated to demonstrate that the cost of the service was recouped through reduction in time spent in hospital.<br>Only those on the intervention were surveyed for satisfaction (by post, only 27% response rate). | **interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

Chiverton P, Tortoretti D, LaForest M, et al.  (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53

| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
|---|---|---|---|---|
| selected from this 28-bed unit. ‘Block randomisation’ (p49) not described.<br>**Adequate concealment of allocation?**<br>• Unclear<br>**Comparable groups at baseline?**<br>• Unclear<br>They say so, but no comparative info is offered.<br>**Selection bias appraisal**<br>• High risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear | • Intervention drop-outs<br>None stated.<br>• Comparison drop-outs<br>None stated.<br>**Groups comparable on intervention completion?**<br>• Unclear<br>Controls not followed up, except through hospital admissions records.<br>**Missing outcome data**<br>• Intervention: missing outcome data<br>Patient and carer satisfaction on a very limited sample. No indication that intervention group did not comply with MH ratings.<br>**• Comparator missing outcome data**<br>None taken except hospital records.<br>**Groups comparable on available data?**<br>• Unclear<br>**Attrition bias appraisal** | **Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Yes<br>Conclusions are really about cost. | | |

Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53

| Study design | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| | • Unclear/unknown risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | | | |

De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58

| Study design | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate the impact of an intensive case management 12-month follow-up of adults being discharged from psychiatric inpatient wards deemed (on past history) to be at high risk of suicide<br>**Country**<br>• Australia<br>**Is the study clear in what it seeks to do?** | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>Note that many ‘left’ services and that the telephone component suffered heavy loss in the ICM group.<br>**Were the participants receiving care and support kept ‘blind’ to how the intervention(s) were allocated?**<br>• Unclear | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>Given that this is a transient group, 12 months was ambitious.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?** | Main limitations are the very small sample size, and high rates of attrition. Also lack of clarity on randomisation method and aspects of methods such as blinding. | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes** |

| De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Clear<br>**Relevance to our RQs?**<br>• Yes<br>**Appropriate randomisation?**<br>• Unclear<br>**Adequate concealment of allocation?**<br>• Unclear<br>**Comparable groups at baseline?**<br>• Yes. No significant differences in age; age when first attempted suicide, history of admission, length of index admissions.<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear | **Were individuals who administered the care and support kept ‘blind’ to the intervention allocation?**<br>• Unclear<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias effect**<br>• Unclear<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>16 appear to have dropped out – became uncontactable – during the early period (not stated at what point of ICM). At completion at 12 months, 14 were left (of 30) in the ICM group.<br>• Comparison drop-outs<br>At completion at 12 months, 8 were left (of 30) in the TAU group. Reasons for drop out not | • Yes<br>**Were investigators kept ‘blind’ to participants’ exposure to the intervention?**<br>• Unclear<br>**Were investigators kept ‘blind’ to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• High risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Yes<br>That ICM ‘may be beneficial in assisting the post-discharge phase of high-risk psychiatric patients’ (abstract). Not a very useful conclusion. | | **relevant?**<br>• Yes<br>**External validity**<br>• + |

| De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | given.<br>**Groups comparable on intervention completion?**<br>• No<br>**Missing outcome data**<br>• Intervention missing outcome data<br>This paper is very unclear on how many people are assessed at 6 months (e.g Table 5), though it is clear that full data is only available at 12 months for 14 and 8 patients respectively (table 6).<br>**Comparator missing outcome data**<br>See above.<br>**Groups comparable on available data?**<br>• Unclear<br>**Attrition bias appraisal**<br>• High risk of bias (also A5)<br>**Likely direction of attrition bias effect**<br>• Unclear | | | |

Dixon L, Goldberg R, Iannone V et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8

| Study design | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess the effectiveness of a brief 3-month critical time intervention (B-CTI) in improving continuity of care when people (veterans) are discharged from inpatient psychiatric treatment.<br>**Country**<br>• USA<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Unclear<br>Random assignment – method not described.<br>**Adequate concealment of allocation?**<br>• Yes<br>Neither patients or providers could be blinded, but | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias effect**<br>• Unclear<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dro-outs | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear | Methods (recruitment randomisation) are not very clearly reported.<br>It is not entirely clear who delivers the intervention, whether they are hospital- or community-based, and whether the person loses contact with the person 3 months after discharge. | **Internal validity**<br>• +<br>This could have been a ++ if methods, e.g. of randomisation, had been a bit clearer.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Dixon L, Goldberg R, Iannone V et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| investigators were.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>Recruitment is from 4 inpatient units, but it is not very well described.<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear | 116 of the 135 enrolled in the study received 3 month evaluations – 55 in IC and 61 in control group. All had notes reviewed at 6 months.<br>• Comparison dropouts: 116 of the 135 enrolled in the study received 3-month evaluations – 55 in IC and 61 in control group. All had notes reviewed at 6 months.<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Missing outcome data**<br>• Intervention missing outcome data<br>116 of the 135 enrolled in the study received 3-month evaluations – 55 in IC and 61 in control group. All had notes reviewed at 6 months.<br>• Comparator missing outcome data<br>116 of the 135 enrolled in the study received 3-month evaluations – 55 in IC and 61 in | **Do conclusions match findings?**<br>• Yes | | |

| Dixon L, Goldberg R, Iannone V et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8 | | | | |
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| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | control group. All had notes reviewed at 6 months.<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | | | |

| Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate the effectiveness of trans diagnostic internet-based maintenance treatment (TIMT) when compared to | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>The intervention and control group did not differ in TAU received (outpatient psychotherapy, standardised | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes | **Self-report of outcomes**<br>Heterogeneous sample of mental health inpatients, mostly diagnosed with affective, anxiety, stress and somatoform disorders. People with psychotic disorders were excluded. | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?** |

Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56

| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
|---|---|---|---|---|
| treatment as usual (TAU)<br>**Country**<br>• Germany<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• Yes<br>Conducted by blinded administrative staff not otherwise involved in study.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias | group maintenance therapy, anti-depressant medication). However, participants in the intervention group were less likely to take sedatives (p<0.001).<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>Dropped out before first web session n=9 (4.5%) 3 months | **Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>HEALTH-49 self-report instrument used widely in the German healthcare system. Symptom Checklist German versions.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Yes | | • Yes<br>Although people with psychotic disorders were not included.<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56 | | | | |
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| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | follow-up; discontinued intervention n=31 (15.5%); 12 months follow-up n=12<br>• Comparison dropouts<br>Data not provided by 3 months n=30 (15%) 12 months n=54 (22%).<br>**Groups comparable on intervention completion?**<br>• No<br>**Missing outcome data**<br>• Intervention<br>Lost to follow up at 12 months n=69 (34.5%).<br>• Comparison<br>Lost to follow up at 12 months n=54 (22%).<br>**Groups comparable on available data?**<br>• Yes<br>Intention to treat analysis used.<br>**Attrition bias appraisal**<br>• Low risk of bias | | | |

Forchuk C, MacClure SK, Van Beers M, et al.  (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and ‘no fixed address’. Journal of Psychiatric Mental Health Nursing 15: 569–75

| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
|---|---|---|---|---|
| **Methodology**<br>• Pilot RCT using a cluster design<br>**Study aim**<br>• To develop and test an intervention to prevent homelessness associated with discharge directly to no fixed address.<br>**Country**<br>• Ontario, Canada<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes. Participants selected an envelope with their allocation inside.<br>**Adequate concealment of allocation?**<br>• Yes<br>**Comparable groups at baseline?**<br>• Yes. No statistically | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept ‘blind’ to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept ‘blind’ to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>No drop outs.<br>**Groups comparable on** | **Did the study have an appropriate length to follow-up?**<br>• No<br>Six months is very short to measure this outcome – however this is a pilot study.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept ‘blind’ to participants’ exposure to the intervention?**<br>• Unclear<br>**Were investigators kept ‘blind’ to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal** | Very small sample size (as pilot).<br>Results are not presented transparently, i.e no tables presenting results, just narrative.<br>Some of the inclusion/exclusion criteria for the population of study (such as no recent history of substance abuse, and only including those with a stable source of income, with no further definition of what this means) considerably limit the generalisability of the study.<br>Study highlights problems within current system (in terms of people at risk of being homeless being discharged without any support or advocacy provided by housing services). | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• - |

| Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'. Journal of Psychiatric Mental Health Nursing 15: 569–75 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| significant differences between groups at baseline.<br>**Selection bias appraisal**<br>• Low risk of bias | **intervention completion?**<br>• Yes<br>**Missing outcome data**<br>• Intervention missing outcome data<br>Information on primary outcome (housing status) was obtained from all 14 participants.<br>• Comparison missing outcome data<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias | • Unclear/unknown risk of bias<br>**Do conclusions match findings?**<br>• Partly | | |

| Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim** | **Did the comparison groups receive the same care and support apart from the intervention/s studied?** | **Did the study have an appropriate length to follow-up?**<br>• Unclear | Very small samples, time frame insufficient, use of self-report bias, a very low threshold of statistical | **Internal validity**<br>• -<br>**Is the setting similar** |

| Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27 | | | | |
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| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • To implement a pilot RCT to consider effectiveness of a transitional care model (TCM) with people transferring from psychiatric hospital to home, who also have a physical health condition.<br>**Country**<br>• US<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• No<br>**Comparable groups at baseline?**<br>• Unclear<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk | • Unclear<br>As practitioners knew who was in which group, TAU discharge planning may have been adapted.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• High risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts: 18 patients in IG were analysed up to 12 weeks (of 20)<br>• Comparison dropouts:17 | Follow-up did not extend beyond intervention period<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear<br>Self report used on service use – was said to be unreliable in some cases.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• No<br>**Detection bias appraisal**<br>• High risk of bias<br>**Likely direction of detection bias effect** | significance is used. Only 1 nurse practitioner was running the intervention – unclear how well (and reduces possible sample size). Lack of blinding seemed to permit multiple changes in TAU by practitioners (and research data collectors). | **to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27

| Study design | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Direction of bias effect**<br>• Unclear | patients from CG were followed up to 12 weeks<br>**Groups comparable on intervention completion?**<br>• Unclear. Too small to generalise<br>**Missing outcome data**<br>• Intervention missing outcome data<br>Not reported<br>• Comparator missing outcome data<br>Not reported<br>**Groups comparable on available data?**<br>• Unclear<br>**Attrition bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | • Unclear<br>**Do conclusions match findings?**<br>• No<br>Conclusion is that more staff with different specialties – social workers, more NPs and peer support workers – are needed to maximise impact of such a service. This is unproven. | | |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–19 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess the effectiveness of a Critical Time Intervention (CTI) model in reducing homelessness for persons with severe mental illness who were discharged from inpatient psychiatric treatment facilities.<br>**Country**<br>• New York, US<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• Yes. The administrator who oversaw randomisation process was not blind to treatment status during | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes. All patients received basic discharge planning services and access to psychiatric treatment. After discharge, participants in both conditions received a range of usual community-based services, depending on the individual's needs, preferences and living situation. In addition to the above, the experimental group received 9 months of CTI.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?** | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Yes | Some participants assigned to the CTI group did not receive all components of the intervention.<br>One of the key points of the CTI model is that workers establish a working relationship with the client prior to their discharge to the community. Previously, 3 points of contact has been established as the threshold which is minimally sufficient for this purpose; 42 participants (56%) received 3 or more such contacts while 35 (44%) received 2 or fewer contacts.<br>This was most often a result of having limited time between randomisation and discharge. Originally the plan was to recruit people as hospital inpatients, but in response to policy changes people were recruited while in transitions residence. | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–19 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| allocation but was not involved in any other part of the study.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias | • No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>19 dropouts 11 refused and 8 lost.<br>• Comparison dropouts<br>14 drop outs 7 refused, 5 lost, 2 deceased.<br>**Groups comparable on intervention completion?**<br>• Unclear<br>75% of the CTI group completed the 18-month follow-up 80% of the control group completed the 18-month follow-up.<br>Complete follow up data were obtained for significantly more males than females (85% of males vs 58% of females). Those with a substance | | | |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–19 | | | | |
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| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | dependence diagnosis were more likely to complete follow-up (91% of substance dependant vs 61% of non-substance dependent).<br>**Missing outcome data**<br>• Intervention missing outcome data same as dropout<br>• Comparison missing outcome data; same as dropout<br>**Groups comparable on available data?**<br>• Yes<br>Multiple imputation procedures were carried out to verify findings in light of missing data, including intention to treat (ITT) comparison testing.<br>**Attrition bias appraisal**<br>• Low risk of bias | | | |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To test 3 hypotheses (final 1 most important?) in letter contacts to people at risk of suicide (following depressive or suicidal motive for hospitalisation): sense of isolation of person at risk of suicide would be reduced by some ‘connection’; contact must make no demands on recipient; systematic programme would help prevent suicide in this group if they refuse assistance from MH services.<br>**Country**<br>• US<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>**Were the participants receiving care and support kept ‘blind’ to how the intervention/s were allocated?**<br>• Yes<br>**Were individuals who administered the care and support kept ‘blind’ to the intervention allocation?**<br>• Yes<br>**Performance bias appraisal**<br>• Low risk of bias<br>**Likely direction of performance bias effect**<br>• Unclear<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>None except those dying. | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept ‘blind’ to participants’ exposure to the intervention?**<br>• Unclear<br>**Were investigators kept ‘blind’ to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match** | It is not clear what systematic differences might exist between those accepting or not accepting formal therapy (which may be important as suicide rates are higher in those in treatment). Little is known about the characteristics of the groups at baseline. | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>Generalisability is marked down: (a) because not enough is known about the 3 groups to focus intervention on likely respondents; (b) the data is quite old, and does not, for example, |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| Though not described.<br>**Adequate concealment of allocation?**<br>• N/A<br>Does not appear that subjects knew they were in a study.<br>**Comparable groups at baseline?**<br>• Unclear<br>Only age and sex is given – not, e.g., diagnosis<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Was selection bias present?**<br>• Low risk of bias<br>Authors treated contact group as initiated throughout study so any effect might be minimised. However, there may be some systematic bias in those who refuse further treatment after discharge.<br>**Direction of bias effect**<br>• Unclear<br>Possibly in favour of intervention. | • Comparison dropouts<br>None except those dying.<br>**Groups comparable on intervention completion?**<br>• N/A<br>**Missing outcome data**<br>• Intervention missing outcome data<br>None as main data and outcome is death.<br>• Comparison missing outcome data<br>None as main data and outcome is death.<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | **findings?**<br>• Yes | | use modern means of communication. |

| Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: A pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate a novel aspect of discharge, improving communication with GPs to facilitate patient engagement with primary care services<br>**Country**<br>• UK<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>Computerised.<br>**Adequate concealment of allocation?**<br>• Unclear<br>Researchers but not patients (after randomisation) or | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• No<br>Liaison with 19 patients in TAU group took place on clinical grounds. Calls to general practice took place in 86% of cases in intervention group, but the GP could not always be spoken to (not stated).<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias | **Did the study have an appropriate length to follow-up?**<br>• Unclear<br>The immediate concern was rating post-discharge effect on symptoms – so 1 month is reasonable; 6 months is relatively short for readmissions data.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>As far as health records can be reliable.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes | This study has suggested some benefits to patients discharged to primary care in that the intervention group encouraged people to make (significantly) more use of GP services, which appear to be associated with a trend to fewer admissions.<br>But the study is small, the intervention is not dramatically different from usual practice, and it may not be possible to implement this in practice when many GPs and psychiatrists consider it a potential additional burden on resources. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>But the study is small, the intervention is not dramatically different from TAU and the findings are not significant. However, |

| Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: A pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| clinicians by implication were blinded to allocation.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>Uncertain whether appropriate characteristics were matched.<br>**Direction of bias effect**<br>• Unclear | **Likely direction of performance bias effect**<br>• Unclear<br>**Were all groups followed up for an equal length of time?**<br>• Yes. But not necessarily successfully.<br>**Dropout numbers**<br>• Patients completed questionnaires at discharge (baseline) including symptom identification (BASIS-32) and HADS. One month post-discharge, repeated by post (requiring return in SAE). Comparative assessment repeated at 6 months, to assess readmission rates and time to readmission within the 6/12 period; efficient transfer of discharge info to GP, speed and frequency of contact between patients and primary care and continuation of medication.<br>• **Groups comparable on intervention completion?** | **Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Partly<br>Perhaps more strongly stated that results justify. | | this is consistent with study results that might be generalisable. |

Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: A pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15

| Study design | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
|  | • Yes<br>**Missing outcome data**<br>•Nos completing questionnaire at discharge: 132 (79%) of in and 133 (76%) of TAU group; at 1 month 106 (63%) in novel group and 111 (64%) in TAU group.<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear |  |  |  |

Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal Of The Association Of European Psychiatrists 30: 258–70

| Study design/theoretical approach | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|

| Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal Of The Association Of European Psychiatrists 30: 258–70 | | | | |
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| **Study aim**<br>• To systematically appraise evidence comparing continuity of care vs specialisation across inpatient and outpatient MH settings. To be included, there has to be more than a follow-up appointment with consultant: needs to be ‘continuous clinical responsibility across treatment settings’.<br>**Country**<br>• Range of countries<br>Australia, Germany, Italy, Netherlands, New Zealand, Norway, Sweden, UK, USA. | **Methodology**<br>• Systematic appraisal using narrative synthesis<br>**Clearly focused question?**<br>• Yes<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Inclusion of relevant individual studies?**<br>• Somewhat relevant<br>**Rigorous literature search?**<br>• Partly rigorous<br>Five bibliographic databases were searched and grey literature.<br>**Study quality assessed and reported?**<br>• Yes | **Adequate description of methodology?**<br>• Yes<br>Do conclusions match findings?<br>• Yes | Findings need to be interpreted with extreme caution for various reasons.<br>- The inclusion of all study designs regardless of their robustness or quality. A lot of the studies had high risk of bias within them, and some of them (uncontrolled before and after studies and cohort studies) would not have met our own inclusion criteria.<br>- The wide variation in the terms used to describe the 2 systems means that eligible studies may have been missed.<br>- Narrative synthesis as opposed to meta-analysis also increases potential sources of bias.<br>-There was a tendency for novel systems to show positive results regardless of which system was being implemented, possibly as a result of novel systems being more intensive. Such | **Overall assessment of internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Partly<br>**A clear focus on transition between inpatient MH setting and community or care home setting?**<br>• Yes<br>**Are the population groups relevant?**<br>• Somewhat<br>**Relevant to social care outcomes?**<br>• Yes<br>**Does the review have a UK perspective?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal Of The Association Of European Psychiatrists 30: 258–70 | | | | |
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| | | | validity raises concerns about what is causing the positive effect. | |

| Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences 20: 181–92 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To test the effect of a needs-oriented discharge planning intervention on the number and duration of psychiatric inpatient treatment episodes (primary), as well as on outpatient service use, needs, psychopathology, depression and quality of life (secondary).<br>**Country**<br>• Germany<br>Five psychiatric hospitals. | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?** | There is little information on contextual factors – e.g. what constitutes 'usual care' for the control group. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• No<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes** |

| Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences 20: 181–92 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• Yes. Conducted by independent unit.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias | **Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>Attrition total (loss between T0 and T3) was 26%, and attrition was highest for the early (14% between T0 and T1), but much lower for the later assessments (4% between T1 and T2, and 10% between T2 and T3 respectively), and attrition rates did not differ by allcation.<br>• Comparison drop-outs<br>See above.<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias | • Unclear<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Yes | | **relevant?**<br>• Unclear<br>**External validity**<br>• + |

| Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess whether adding a telephone care management protocol to usual aftercare improved the outcomes of veterans in the year after they were discharged from residential treatment for PTSD.<br>**Country**<br>• US<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Mixed<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• Yes<br>Efron randomisation by someone | **Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?**<br>• Yes. Followed up at 4 months and 12 months. | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear<br>Self-report used in questionnaire form.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?** | This study was limited to patients who sought intensive residential treatment in the VA health care system, where aftercare was readily available. Telephone case monitoring might function differently in other treatment environments. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• + |

| Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| blind to participant's treatment histories.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias | **Dropout numbers**<br>• Intervention dropouts<br>At 4 months telephone care: 20 discontinued intervention 4 deceased.<br>• Comparison dropouts<br>TAU; 15 discontinued participation 3 deceased.<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Missing outcome data**<br>• Intervention missing outcome data<br>Did not return 4-month survey n=113.<br>Did not return 12-month survey n=131.<br>• Compar. missing outcome data<br>Did not return 4-month survey n=108.<br>Did not return 12-month survey n=126.<br>**Groups comparable on available data?**<br>• Yes. Intention to treat | • No<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match findings?**<br>• Yes | | |

Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20

| Study design/ theoretical approach | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| | analysis conducted, and similar numbers returned survey from each group: telephone completed either 4-month or 12-month survey, 75% (n=310) TAU completed either 4-month or 12-month survey, 77% (n=328).<br>**Attrition bias appraisal**<br>• Low risk of bias | | | |

Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5

| Study design/ theoretical approach | Theoretical approach & data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To study the effect of a brief motivational interviewing intervention on outpatient treatment adherence among psychiatric and dually diagnosed inpatients.<br>**Country**<br>• US | **Comparable groups at baseline?**<br>• Yes<br>There were no significant differences between the 2 groups on pre-treatment levels of motivation, nor were there statistically significant differences between the 2 groups regarding the | **Did the study have an appropriate length to follow-up?**<br>• Unclear<br>The study aimed to only assess attendance at first admission, but there is a need for longer follow-up of outcomes to assess effectiveness of | No formal attention control group used to rule out possibility that positive effect of the intervention group could have resulted from extra attention given, as opposed to the motivational interviewing technique itself. The same therapist who conducted | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes |

| Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| Two inner-city private, not-for-profit hospitals.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes. Random number tables.<br>**Adequate concealment of allocation?**<br>• No | proportions of patients referred to the different outpatient sites ([chi]2=3.94, df=3, p=.268).<br>Selection bias appraisal<br>• Unclear/unknown risk of bias<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Were all groups followed up for an equal length of time?** | motivational interviewing.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Unclear<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match findings?**<br>• Yes | the change assessment also assigned the allocations to the control or intervention groups using the random number table. Follow-up of outcomes did not go beyond attendance of the first aftercare appointment – longer-term outcomes needed. Funding not stated. | **Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5 | | | | |
|---|---|---|---|---|
| **Study design/ theoretical approach** | **Theoretical approach & data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | • Yes<br>Research assistants and onsite personnel checked databases to verify first aftercare appointment attendance.<br>**Dropout numbers**<br>• Intervention dropouts<br>None.<br>• Comparison dropouts<br>None.<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Missing outcome data**<br>• Intervention missing outcome data<br>None.<br>• Comparison missing outcome data<br>None.<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias | | | |

## Findings tables

## Tables reporting impact studies

## Review Question 5: What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

| Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To investigate differences in quality indicators for patients receiving transitional case management at discharge from psychiatric inpatient unit (included mental health status, patient and carer satisfaction and costs caused by utilisation of ED and readmissions to inpatient care).<br>**Source of funding**<br>• University of Rochester Medical Centre<br>**Country**<br>• USA | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Carers/family members of people with MH conditions<br>**Sample size**<br>• Intervention number:121<br>• Comparison numbers: 122<br>• Sample size: 243<br>**Sample characteristics**<br>• Sex<br>Male: 68% of total sample (n=165)<br>• Sample age<br>Mean age 56, range 19–95<br>• Level of need/diagnosis<br>Of total sample, 65% had affective disorder, 18% schizophrenia, 6% dementia.<br>**Intervention**<br>• The intervention trialled is transitional case management provided by (trained) inpatient | **Outcomes 1 (qualitative)**<br>• What works well<br>Satisfaction survey with likert scales developed for patients and carers – only for intervention group.<br>• What can be improved<br>Satisfaction survey with likert scales developed for patients and carers – only for intervention group.<br>**Outcomes 2 (quant)**<br>• Clinical outcome<br>• Service outcomes<br>• Costs of service use measured (at 10 weeks post-discharge)<br>**Costs**<br>• Patterns of service use<br>• RQ 5 - Discharge<br>**Findings – effect sizes**<br>• Between discharge and end of the project, those in the intervention group showed some improvement on the Beck Depression Inventory (p=.0001), but those in TAU group were not measured<br>But the authors do say in discussion that this therefore cannot be attributed to the intervention. No effect size was | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes |

| Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | psychiatric nurses to people discharged from the unit for up to 3 months. 'Case management is a purposeful interaction coordinated among multiple providers ... with the intention of meeting the client's needs (p47). Nursing actions included a minimum of 3 home (or care home) visits and 5 telephone contacts, based on patient need. Care plans designed for the project included medical stability, medication adherence, symptoms sufficiently controlled to maintain discharge, sleep, suicide risk and violence potential reduced, attendance of outpatient services. Nurses provided education to patient and family on how to implement the plan of care. Examples of admission avoidance were arranging food for a family when the parent had no money and would have sought admission. The nurse care managers would also visit those readmitted and redesign discharge plan. | given. Nine patients in the intervention group and 16 patients in TAU were readmitted during 10 weeks (for a total of 181 days costing $125,000 for the int. group, and a total of 408 days costing $320,000 for the TAU group). One patient in int. group, and 18 in the control group were seen in emergency dept. during the 10 weeks. Taking into account the case management cost ($234 pp), the intervention group still showed savings of over $175,000 in 10 weeks. Surveys (27% of intervention group sample responded) showed 96% of these were very pleased with the services received. 95% of Carers were very pleased. TAU group not surveyed.<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>In relation to the intervention (transitional case management for 3 months post discharge), there was evidence of mental health improvement (on BDI but not on MMSE), high patient and carer satisfaction and fewer readmissions and ED use within the 10 weeks from discharge. However, this is not a very rigorous study, and no comparative ratings were made on the first 2 outcomes above – TAU patients' records were investigated only for service use, so the other findings cannot be attributed to TCM. This is described as a 'demonstration project' and seeks to demonstrate it is worthwhile funding this service. | **External validity**<br>• + |

Chiverton P, Tortoretti D, LaForest M, et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | **Follow-up OR time of interview**<br>• All measured on mental health at discharge, BUT it appears that only the int. group were measured again, at discharge from the case management intervention. Patients and their carers from the intervention group had satisfaction survey (posted): 27% only responded. Costs measured at 10 weeks, i.e. cost of service, readmissions and ED visits. | | |

De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate the impact of an intensive case management 12-month follow-up of adults being discharged from psychiatric inpatient wards | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 30<br>• Comparison number: 30<br>• Sample size: 60<br>**Sample characteristics**<br>• Sex | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Quality of life WHOQOL-BREF<br>• Satisfaction<br>• Service outcomes<br>**Findings – effect sizes**<br>• This is a very small study with high attrition rates, so these reported findings are condensed | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of** |

| De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| deemed (on past history) to be at high risk of suicide.<br>**Source of funding**<br>• Government<br>**Country**<br>• Australia | Males only (higher suicide rate).<br>• Sample age<br>18+.<br>ICM group 34 (24-59).<br>TAU group 37 (19-62).<br>• Level of need/diagnosis<br>Had a current admission at the local psychiatric ward due to severe suicidal ideation and/or attempt as reason for hospitalisation.<br>• Previous admissions<br>At least 1.<br>**Intervention**<br>• Intensive case management for 1 year including: weekly face-to-face sessions with CM, at home where appropriate; focus on problem-solving, improving help-seeking behaviour; empowering clients to function in community (e.g. accommodation and work); having same case manager throughout; access to telephone counselling service, consisting of 2 calls per week from trained counsellors. Other features include small | 'Levels of depression (BDI) improved significantly among ICM participants over the first six months of treatment [t(13)=3.82, p<.01)] and over the entire treatment period [t(13)=3.94, p <.01] …A significant drop in suicide ideation scores was observed from 7.50 at six months post-discharge to 4.43 at the end of the treatment in the ICM group [t(13)=2.26, p<.05] … Quality of life improved from discharge to 12 months in the ICM group [t(13)=2.30, p<.05]. This was characterised by significant improvements in Physical Health over the treatment period [t(13)=2.17, p<.05] and in Psychological Quality of Life in the first six months post-discharge [t(13)= 2.19, p<.05] and the 12-month period [t(13)=2.40, p <.05]. Furthermore, ICM participants reported improvements in general quality of life [t(13)=2.74, p <.05] and satisfaction with health [t(13)=2.39, p <.05] over the 12-month treatment period' (p54–5).<br>'At six months post-discharge, ICM participants reported significantly higher scores than TAU participants on the subscales of Bond [t(19)=6.22, p <.01], Partnership [t(19)=2.97, p <.01], and Confidence [t(19)=4.56, p <.001]. At 12 months post-discharge, ICM participants again reported significantly higher scores for Bond [t(19)=3.69, p <.01] and Confidence [t(19)=4.10, p <.01] ... At (12 months post discharge) participants' perceptions of the community mental health services they were engaged in were gathered, using a modified version of the Verona Service Satisfaction Scale (VSSS). Participants in the ICM group had greater | **interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| | caseloads, and emphasis on skills-building and empowerment; linkage and brokerage with other services; 14 participants in ICM group who completed had average of 49.75 weeks (range 23–62). Telephone appointments averaged 20, since it was decided to stop service after 5 appointments were missed by an individual. TAU patients were eligible to receive standard case management as well as GP and other psychiatric services (but no telephone counselling).<br>**Follow-up OR time of interview**<br>• Baseline, and 6 and 12 months after discharge | satisfaction with the services they received in comparison to participants in the TAU group. This was in terms of overall satisfaction, professionals’ skills & behaviour, and efficacy, but a trend was noted also for (better) information and access’ (p55).<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>There were no suicides in either group. Levels of depression (BDI) and hopelessness improved significantly over the first 6 months, and levels of suicidal ideation dropped at 6 and 122 months in the ICM. Quality of life – physical, psychological and general improved over the 12 months in the ICM group. At 12 months after discharge, 12 people (86%) were still in contact with case manager, and only 2 (25%) of treatment group (receiving standard case management) were. Therapist-client relationships were significantly better on the Bond sub-scales at 6 and 12 months in the ICM group, and satisfaction with services (overall, professional skills, information, access and efficacy) were all significantly higher for ICM clients. | |

Dixon L, Goldberg R, Iannone V, et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess the effectiveness of a brief 3-month critical time intervention (B-CTI) in improving continuity of care when people (veterans) are discharged from inpatient psychiatric treatment.<br>**Source of funding**<br>• Government<br>Dept. of Veteran Affairs.<br>**Country**<br>• USA | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 64<br>• Comparison numbers: 71<br>• Sample size: 135<br>**Sample characteristics**<br>• Sex<br>58 in int group male (veterans).<br>64 in control group male.<br>• Sample age<br>Eligible if 18–70.<br>Mean age overall 48 years, mean age in int. group 47, 49 in control group (SDs given).<br>• Level of need/diagnosis<br>50 of 135 total schizophrenia or psychotic illness (33% IG, 41% CG); rest had major depression/mood disorders.<br>**Intervention**<br>• Brief critical time intervention (B-CTI). This is a brief 3-month intervention to integrate people discharged from psychiatric inpatient care into community-based care, social support and other services (based on a longer | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Quality of life<br>QOLI, a 33 item scale, used.<br>• Satisfaction<br>• Service outcomes<br>**Findings – effect sizes**<br>• Significant effect sizes<br>Participants in the B-CTI group reported receiving more help in making and keeping appointments for mental healthcare: difference 7.15 @ 95 CI, 2.99–17.14, df 1, p=<.001.<br>Participants in the B-CTI group reported receiving more help in making and keeping appointments for medical health care: difference 6.93 @ 95% CI, 3.04–15.78, df 1, p=<.001.<br>Small differences in favour of B-CTI in making family contact (p=.003) and community connections (p=.006), and receiving information on prescribed medications p=.012). (Full details given, but uncertain what is clinically significant as we do not know the scales.)<br>Compared with controls, the IG had significantly fewer days between discharge and first MH appointment: 3.5 vs 15 days (medians): 2.73 @ 95% CI, 1.80–4.15, df 1, p=<.001.<br>A greater proportion of IG had 1 or more such appointments within 30 and 180 days (both given), and a greater number overall during that time (20.8 vs 10.08, effect size 3.24@ 95% CI 1.58–2.91, df 1, p=<.001).<br>Within the QOLI, IG members described significantly higher levels of satisfaction with legal and safety issues (5.30 +/-1.5 | **Internal validity**<br>• +<br>(This could have been a ++ if methods, e.g. of randomisation, had been a bit clearer.)<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Dixon L, Goldberg R, Iannone V, et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | intervention). The intervention is delivered by a trained nursing or social work practitioner (unclear if inpatient practitioner, although it does start with meeting up before discharge, to establish rapport, develop goals, identify barriers and plan case management. Overall aims are to bridge the transition and facilitate engagement with community-based services. Systems coordination and psychiatric stabilisation, together with 2–3 other targets (from a list of 7 other possible, including life skills training, practical needs assistance) are selected. The B-CTI clinician conducts home visits after discharge (mean of 4.95 visits in first 30 days; 12.67 throughout 3 months – SDs were given). Fidelity to the model was rated independently.<br>**Follow-up OR time of interview**<br>• Patient reported data collected at baseline and 3 months later (including satisfaction with | vs 4.72 +/- 1.5, p+.026) and greater frequency of social contact (2.92 +/- 1.15 vs 2.40+/- 1.08, p=.013).<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>Overall satisfaction with services did not differ, participants in the B-CTI group reported receiving more help in making and keeping medical and mental health appointments, making family contact and community connections, and receiving information on prescribed medications.<br>Compared with controls, those receiving the intervention had significantly fewer days between discharge and their first outpatient appointment, and a greater proportion had 1 or more such appointments within 30 and 180 days, and a greater number overall during that time. Using the quality of life tool, members described significantly higher levels of satisfaction with legal and safety issues and greater frequency of social contacts. Their experience also reflected receiving significantly more help in making and keeping healthcare appointments (for mental and physical disorders).<br>The study suggests that B-CTI targeted at point of inpatient discharge can help promote continuity of care. Changes to mental health were not identified, but patients did appear to have more contact with community health services, which is a definition of continuity of care. | |

Dixon L, Goldberg R, Iannone V, et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services 60: 451–8

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
|  | services). Chart reviews from health records collected at 6 months post-discharge. |  |  |

Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56

<table>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Quality assessment</th></tr>
<tr>
<td><b>Methodology</b><br>• RCT<br><b>Study aim</b><br>• To evaluate the effectiveness of transdiagnostic internet-based maintenance treatment (TIMT) when compared to treatment as usual (TAU)<br><b>Country</b><br>• Germany<br><b>Intervention</b><br>• Treatment as usual</td>
<td><b>Participants</b><br>• Adults with MH conditions<br><b>Inclusion criteria</b><br>• At least 18 years old<br>• Met criteria for a mental disorder according to ICD-10 -spoke German fluently<br>• Had basic reading and writing skills<br>• Had access to a computer with as internet connection (internet literacy was not a prerequisite as training was available)<br><b>Exclusion criteria</b><br>• A psychotic diagnosis</td>
<td>Reliable change, remission and recovery of participants' general psychopathological symptom (GPS) severity at<br><b>Follow-ups</b><br>D=deteriorated S=stabilised<br>t2= discharge from inpatient treatment.<br>t3=3 months follow-up.<br>t4=12 months follow-up.
<table>
<tr><th>GPS</th><th colspan="2">TIMT+TAU</th><th colspan="2">TAU</th><th>X²</th><th>p</th></tr>
<tr><td></td><td>D</td><td>S</td><td>D</td><td>S</td><td></td><td></td></tr>
<tr><td>T2-T3</td><td>9 (5.2)</td><td>164 (94.8)</td><td>31 (18.24)</td><td>139 (81.7)</td><td>14.14</td><td><0.001</td></tr>
</table>
</td>
<td><b>Internal validity</b><br>• ++<br><b>Is the setting similar to the UK?</b><br>• Unclear<br><b>Is there a clear focus on population of interest?</b><br>• Yes<br>Although the population does not include</td>
</tr>
</table>

<table>
<tr><td colspan="4">Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56</td></tr>
<tr><td>**Research aims**</td><td>**Population**</td><td>**Findings**</td><td>**Quality assessment**</td></tr>
<tr>
<td>(TAU)<br>Following inpatient treatment, all participants had unstructured access to outpatient psychotherapy and standardised outpatient group-based face-to-face maintenance treatment.<br>TIMT + TAU (intervention)<br>In addition to TAU the TIMT group had a 12-week TIMT. The main focus was to support patients in continual use of the skills acquired during inpatient treatment. TIMT works to help patients to identify activities which they found helpful and systematically integrate them into their daily routines.<br>There are 5 core components:<br>1) Generation of a personal development</td>
<td>• Acute alcohol or substance dependence<br>• Significant risk of suicide<br>**Sample size**<br>• Intervention n=200<br>TAU n=200.<br>Total n=400.<br>**Sample characteristics**<br>• Sex<br>Female (%):<br>Intervention 147 (73.5).<br>TAU 151 (75.5).<br>• Ethnicity<br>Nationality: German(%)<br>Intervention 199 (99)<br>TAU 194 (97)<br>• Sample age<br>Age (mean SD), years<br>Intervention 45 (8.88)<br>TAU 45 (9.80)<br>• Level of need/diagnosis<br>F30-F39 mood (affective) disorders<br>Intervention 108 (54)<br>TAU 113 (56.5)<br>F40-F48 neurotic, stress-related and somatoform disorders<br>Intervention 84 (42.49)</td>
<td>
<table>
<tr><td>T2-T4</td><td>15 (11.45)</td><td>116 (88.55)</td><td>43 (29.45)</td><td>103 (70.55)</td><td>13.52</td><td><0.001</td></tr>
</table>
Remission at follow-up
<table>
<tr><th>GPS</th><th>TIMT+TAU</th><th>TAU</th><th>X²</th><th>p</th></tr>
<tr><td>T2-T3</td><td>95 (55.23)</td><td>72(42.35)</td><td>5.68</td><td>0.02</td></tr>
<tr><td>T2-T4</td><td>74(56.48)</td><td>54(36.98)</td><td>8.43</td><td>0.004</td></tr>
</table>
Recovery at follow-up
<table>
<tr><th>GPS</th><th>TIMT+TAU</th><th>TAU</th><th>X²</th><th>p</th></tr>
<tr><td>T2-T3</td><td></td><td></td><td></td><td></td></tr>
<tr><td>T2-T4</td><td>61 (46.56)</td><td>49 (33.56)</td><td>0.09</td><td>0.003</td></tr>
</table>
**These are just primary outcome findings. Please refer to original paper for extensive outcome findings tables.<br>**Findings – narrative**<br>The TIMT + TAU group was superior to the TAU-only group with regard to differences in change of general psychopathological symptom severity from discharge to 3-</td>
<td>people with psychotic disorders.<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +</td>
</tr>
</table>

Ebert D, Tarnowski T, Gollwitzer M, et al. (2013) A transdiagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82: 246–56

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| plan. This process takes place during the last 10 days of inpatient treatment. TIMT participants complete 3 face-to-face sessions of standardised goal setting and action planning. Participants develop a plan which includes: highly relevant personal goals they want to achieve during the intervention phase; implementation intentions, including details on how, and when they will achieve these goals, barriers they are likely to encounter, and how they plan to cope with these challenges. 2) Structured web diary. Participants evaluate the realisation of their personal goals on a weekly basis, and set specific goals for the next week. | TAU 68 (34)<br>F50-F59 behavioural syndromes associated with physiological disturbances and physical factors<br>Intervention 2 (0.5)<br>TAU 8 (4)<br>F60-F69 disorders of adult personality and behaviour<br>Intervention 3 (1.5)<br>TAU 4 (2)<br>Other<br>Intervention 3 (1.5)<br>TAU 7 (3.5)<br>**Remission at discharge**<br>Intervention 94 (47)<br>TAU 93 (46.5)<br><br>**Follow-up OR time of interview**<br>• t1= beginning of inpatient treatment; t2= discharge from inpatient treatment; t3=3 months follow-up; t4=12 months follow-up. | and 12-month follow-up. Those in the intervention group also showed less frequent symptom deteriorations and were more often in remission/recovery than controls.<br>Significantly more patients of the intervention group were in remission at each follow-up than in the TAU-only group. Intervention patients were 68% more likely to be remitted at 3-month follow-up than TAU-only patients (odds ratio=1.68), and they were more likely to be in remission at 12-month follow-up (odds ratio=2.21).<br>After having achieved remission, significantly more intervention participants were still remitted at 12-month follow-up and achieved recovery compared to TAU-only patients. Intervention participants were 73% more likely to be recovered at 12-month follow-up than TAU-only patients (odds ratio = 1.73). | |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| 3) Online peer support group. Sub-groups consisting of 3 to 6 people are asked to give asynchronous online feedback to each other on their web diaries.<br>4) Coach support. Weekly asynchronous written online feedback from a therapist regarding patient's web diaries.<br>5) TIMT includes weekly monitoring of psychopathological symptoms. | | | |

| Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'. Journal of Psychiatric Mental Health Nursing 15: 569–75 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Pilot RCT using a cluster | **Participants**<br>• Adults (no specified age) with | **Outcomes 2 (quant)**<br>• Satisfaction with housing | **Internal validity**<br>• + |

Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and ‘no fixed address’. Journal of Psychiatric Mental Health Nursing 15: 569–75

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| design<br>**Study aim**<br>• To develop and test an intervention to prevent homelessness associated with discharge directly to no fixed address.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• Ontario, Canada<br>**Intervention**<br>• Assistance and advocacy in finding affordable housing, a community housing advocate from the Canadian Mental Health Association (CMHA) came to the ward immediately. Normally, because of high caseload and backlog, only around half of referred patients are discharged before the housing advocate can see them. A streamlined process of obtaining community start-up funds to cover first and | MH conditions<br>Persons aged 18–75 with a diagnosis of serious mental illness who had no address to go to after hospitalisation.<br>- A secured source of income (NB this is not defined in any more detail in the paper).<br>- The ability to live independently as assessed at admission.<br>- Length of hospitalisation less than 12 months.<br>- Interest in private sector housing.<br>**Exclusion criteria**<br>• Refusing treatment recommendations against medical advice discharge<br>• Recent history of drug or alcohol abuse within the past 3 months<br>• History of violence<br>**Sample size**<br>• Intervention n=7<br>Control n=7<br>Total n=14<br>**Sample characteristics** | • Housing status<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>All individuals in the intervention group attained independent housing prior to, or within 2 days of discharge and maintained housing when interviewed at the 3- and 6-month period. All but 1 individual in the control group did not attain housing and remained homeless at the 3- and 6-month period (Pearson c2, fisher exact, p<0.001). The exception joined the sex trade to avoid homelessness’ (p573).<br>The results of the pilot were so dramatic that it was deemed inappropriate to keep randomising to the control group and plans were made to start routinely implementing the intervention. | **Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>Are the outcomes relevant?<br>• Unclear<br>External validity<br>• - |

| Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'. Journal of Psychiatric Mental Health Nursing 15: 569–75 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | Q**uality assessment** |
| last months' rent, to attempt to have this available in a day. | • Sex<br>Female<br>Intervention n=3 Control n=2<br>Male<br>Intervention n=4 Control n=5<br>• Sample age<br>Mean years (SD)<br>Intervention: 35 (15.2)<br>Control: 31 (13.4)<br>Range<br>Intervention: 21–63<br>Control: 18–52<br>• Level of need/diagnosis<br>Primary diagnosis (self-reported).<br>Schizophrenia.<br>Intervention: 3 Control: 2.<br>Mood disorder intervention<br>Intervention : 4 Control: 2.<br>Anxiety disorder<br>Intervention: 2 Control: 0.<br>Other<br>Intervention: 1 Control: 0.<br>• Previous admissions<br>Length of admission (weeks)<br>Mean (SD) | | |

Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'. Journal of Psychiatric Mental Health Nursing 15: 569–75

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| | Intervention: 3.36 (5.6) Control: 1.67 (0.7)<br>Follow-up or time of interview<br>• 3 and 6 months. | | |

Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| **Methodology**<br>• RCT<br>Study aim<br>• To implement a pilot RCT to consider effectiveness of a transitional care model (TCM) with people transferring from psychiatric hospital to home, who also have a physical health condition.<br>**Source of funding**<br>• Voluntary/charity<br>**Country** | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 20 initially<br>• Comparison numbers: 20 initially<br>• Sample size: 40 in total<br>**Sample characteristics**<br>• Sex: 50% male in CG, 55% male in IG<br>• Ethnicity<br>About 45% in each group were African-American.<br>• Sample age<br>45.8 in CG; 44.1 in IG.<br>• Level of need/diagnosis | **Outcomes 2 (quant)**<br>• Quality of Life<br>• Service Outcomes<br>All – whether emergency or rehospitalisations, were assessed from self-report at 6- and 12-week interviews.<br>**Findings – effect sizes**<br>• HRQOL<br>'Both groups' scores indicate moderate disability at baseline, and for most domains, an increase of 5 or more points from baseline to 12 weeks (domains that improved ≥ 5 points were physical functioning, role limitation, bodily pain, and emotional role limitation (Table 3). The control group had higher (but not statistically significant) average baseline scores than the intervention group on physical functioning, general health, and social functioning. The intervention group showed clinically significant improvement in their | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?** |

| Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | Q**uality assessment** |
| • US | Selected for prominence in sample: psychiatric condition (some have more than 1): 65% in CG, 50% in IG, major depression; 40% and 30% schizoaffective disorder; 25% and 10 BPD; 10% and 25% schizophrenia.<br>Medical condition (may be more than 1): 40% and 60 % endocrine condition (including diabetes); 55% and 40% hypertension; 30% and 10% reflux disease (partial reporting here).<br>• Socioeconomic position<br>Education and income show that short education, being on low income, and single were dominant features in both groups.<br>**Intervention**<br>• IG received TAU plus the care of a psychiatric nurse practitioner (NP) for 90 days post discharge. The NP visited patient in hospital, and at home within 24 hours of discharge, and was then available to patient 24/7 via email and phone. NP focused on managing | general health scores over the 12-week study whereas the control group did not. Both groups had higher mental health subscale scores at 12 weeks' (p320).<br>No significant differences (say at p=.01) were demonstrated.<br>On continuity of care:<br>'One half or less of the participants in both groups had provider appointments documented on the discharge plan. Of the documented provider appointments at discharge, significantly fewer members of the intervention group were assigned a mental health or medical specialist provider appointment than the control group (p<.055)' (p320).<br>Few primary care appointments were included in any discharge plans, although post-discharge hospital appointments were scheduled for 100% of participants. It was unclear if appointments were attended (as no consent from patients to check was sought).<br>Service utilisation<br>'The intervention group had statistically significant higher mean use of rehospitalization (56.6%) compared with the control group (23.5%; p=.025). Notably, the control group had no medical hospitalizations whereas 22.2% of the intervention group had medical hospitalizations (p=.042). The intervention group showed a slightly lower use of the emergency department (ED) for psychiatric (5.6%) and medical (22.2%) problems compared with the control group (5.9% and 29.4%, respectively), but these differences were | • Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | risk of decline, problem behaviours, assessing and managing physical symptoms and preventing functional decline, promoting adherence to therapy and helping case managers understand integrated mental and physical care approach. She could also prescribe (refills, generally).<br>**Follow-up OR time of interview**<br>• Six and 12 weeks after discharge (NP service spanned 12 weeks or 90 days). | not statistically significant. Reasons for rehospitalization and emergency room use included unstable housing (33%); conflicts in relations with family, friends, or residential staff (35%); lack of insurance or treatment (22%); substance use (44%); psychiatric symptoms (65%); and medical problems (25%).' (p322–3).<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>Both groups showed some improvement in HRQOL, including in MH aspects, over the 12 weeks of the study, and the intervention group (the authors' suggest, but not convincingly) showed 'clinically significant improvement' in general health scores over the study.<br>The intervention group had significantly higher use of rehospitalisation (56%) compared with control group (23.5%); 22% of IG had hospitalisations for medical care, compared with none in the CG. The IG showed a slightly lower, non-significant use of the emergency department for psychiatric and medical problems.<br>It appears that the intervention increased readmissions – especially for medical care (non-psychiatric), though the numbers are too small to be conclusive. The limitations of a single nurse practitioner (NP) working alone suggest that potential benefits could not be realised, though there may be evidence here that better surveillance, especially of physical health, led to more hospitalisation. This may of course be a positive outcome (and the study did not set out to | |

Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | demonstrate reduction in hospitalisation). Authors conclude that a team approach (including physical health specialists and a social worker) would be more beneficial. | |

Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–9

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess the effectiveness of a critical time intervention (CTI) model in reducing homelessness for persons with severe mental illness who were discharged from inpatient psychiatric treatment facilities.<br>**Linked studies**<br>The following 4 studies reported on the same CTI trial (these papers will not be reported on as individual | **Participants**<br>• Adults (no specified age) with MH conditions<br>- People who had a diagnosis of a psychotic disorder and were homeless at the index hospitalisation or who had experienced an episode of homelessness 18 months preceding admission.<br>- Recruited from transitional residencies located on the grounds of 2 state operated psychiatric hospitals in New York City. | **Outcomes (quantitative)**<br>• Homelessness (number of nights spent homeless and as binary outcome)<br>• Continuity of care<br>• Hospital readmission<br>**Findings – effect sizes**<br>• Total number of homeless nights for each group during the final 3 observation intervals.<br>CTI: 6 nights, control: 20 nights.<br>Poisson regression model adjusting for baseline homelessness, this difference was statistically significant at the p<.001 level.<br>Owing to a change in policy not all members of the experimental group received 3 or more pre-discharge | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?** |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| papers, but any additional outcome data are reported alongside Herman DB, Conover S, Gorroochurn P et al. (2011).<br>• Baumgartner J and Herman D (2012) Community integration of formerly homeless men and women with severe mental illness after hospital discharge (exploratory study with data from only 95 of 150 participants). The analysis did not follow usual analysis standards for RCTs so it could not be included in this review.<br>•Tomita A and Herman DB (2012) The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge (for reducing readmission outcomes).<br>•Tomita A, Lukens EP, Herman DB (2014) Mediation | Sample size<br>• Total n=150, control n=73<br>Intervention (CTI) n=77<br>Sample characteristics<br>• Sex<br>Female<br>Control (total=73) n=18 (25%)<br>CTI (total=77) n=25 (34%)<br>• Ethnicity<br>African American<br>Control (total=73) n=45 (62%)<br>Intervention (total=77) n=48 (62%)<br>Latino<br>Control (total=73) n=12 (16%)<br>Intervention (total=77) n=11 (14%)<br>White<br>Control (total=73) n=11 (15%)<br>Intervention (total=77) n=14 (18%)<br>• Sample age<br>18–29<br>Control (total=73) n=14 (19%)<br>Intervention (total=77) n=19 (25%) | contacts by the CTI worker (as planned). A 2-stage logistic model, with homelessness during the last 3 intervals as the outcome, group assignment as the instrument, and receipt of 3 or more pre-discharge contacts as the treatment, while again adjusting for baseline homelessness found that receipt of CTI with 3 or more pre-discharge contacts was associated with a statistically significant 10-fold reduction in the odds of homelessness compared to assignment to usual care (OR =0.10, 95% CI .03--.35).<br>The impact of the intervention on homelessness over the full 18-month follow-up period.<br>Logistic regression was used to model the impact of assignment to CTI on a dichotomous measure of homelessness over the 18 months, again controlling for baseline homelessness. The odds ratio for the CTI group was 0.28 (95% CI=0.78--1.02), indicating that assignment to CTI was associated with a substantial reduction in the odds of homelessness in comparison with assignment to usual care, although the result was at the borderline of statistical significance. The total number of homeless nights accrued by participants was examined in both groups. Among those assigned to CTI there were 1812 total homeless nights, while among those assigned to the control group, there were 2403 homeless nights. Using Poisson regression to control for baseline homelessness, this difference was statistically significant at the p<.001 | • Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| analysis of critical time intervention for persons living with serious mental illnesses: assessing the role of family relations in reducing psychiatric rehospitalisation.<br>•Tomita A, Herman DB (2015) The role of a critical time intervention on the experience of continuity of care among persons with severe mental illness after hospital discharge (for continuity of care outcomes).<br>**Source of funding**<br>• Government<br>research supported by NIMH grant<br>**Country**<br>• New York, US<br>**Intervention**<br>• CTI<br>Nine-month case management intervention delivered in 3 phases, each of which lasts around 3 months (see Table 1 below | 30-39<br>Control (total=73) n=26 (36%)<br>Intervention (total=77) n=25 (33%)<br>40-45<br>Control (total=73) n=17 (23%)<br>Intervention (total=77) n=19 (25%)<br>46+<br>Control (total=73) n=16 (22%)<br>Intervention (total=77) n=14 (18%)<br>• Diagnosis<br>Schizophrenia<br>Control (n=73) n=44 (60%)<br>Intervention (n=77) n=48 (62%)<br>Schizoaffective<br>Control (n=73) n=28 (38%)<br>Intervention (n=77) n=24 (31%)<br>Other<br>Control (n=73) n=1 (1%)<br>Intervention (n=77) n=5 (7%)<br>• Previous homeless episodes 1<br>Control (total n=73) n=13 (18%)<br>Intervention (total n=77) n=18 | level.<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>**Homelessness**<br>Among those with complete follow up data 3 out of 58 (5%) of subjects assigned to the CTI group experienced homelessness during the final 3 follow up intervals; 11 out of 59 (19%) of subjects assigned to the control group experienced homelessness during this period. Using logistic regression to model the impact of assignment to CTI on homelessness during the final 3 follow-up intervals the odds ratio for treatment assignment was OR = 0.22 (95%CI=.06--.88). Assignment to CTI was associated with a statistically significant 5-fold reduction in the odds of homelessness compared to assignment to usual care only.<br>**Continuity of care**<br>**Outcomes taken from** Tomita A, Herman DB (2015) The role of a critical time intervention on the experience of continuity of care among persons with severe mental illness after hospital discharge.<br>Perceived ease of access to care process: the results of the 9- and 18-month continuity of care (COC) assessments after hospital discharge show no difference in the mean and median COC ratings in perceived ease of access to care between the 2 groups. Stability of patient- | |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| for more information).<br>Phase 1 – Transition to the community focuses on providing intensive support and assessing the resources that exist for the transition of care to the community and to implement a transitions plan. The worker provides specialised support, actively encourages participants to communicate, or resume contact (when agreed to by the participant) with their family. Phase 2 – try out devoted to testing and adjusting systems of support that were developed during phase 1. By this stage, community providers will have assumed primary responsibility for delivering support and services so the CTI worker can concentrate on assessing the degree to which this support system is working as planned. Phase 3 | (24%)<br>2 to 4<br>Control (total n=73) n=37 (51%)<br>Intervention (total n=77) n=29 (39%)<br>5 to 9<br>Control (total n=73) n=12 (17%)<br>Intervention (total n=77) n=18 (24%)<br>10 or more<br>Control (total n=73) n=10 (14%)<br>Intervention (Total n=7&) n=10 (13%)<br>**Follow-up OR time of interview**<br>• Following discharge from the transitional residence, participants were interviewed every 6 weeks for 18 months. | service provider relationship: the proportion of study participants who experienced a change in their case manager/therapist was significantly lower in the CTI than the USO group at the 9-month assessment (USO, 41% vs. CTI, 23%; χ2=4.0, p ≤ 0.05), but not at 18 months. The Wilcoxon rank-sum test indicated that the median lengths of working relationships with the same psychiatrist (p ≤ 0.05) and case manager (p ≤ 0.05) were significantly higher for those assigned to the CTI than the USO group at 9 months (but not at 18 months) based on a statistically different distribution and ranking of the outcome. Severity of instability patient-service provider relationship: the participants assigned to CTI had a significantly lower median number of changes in their case manager/therapist at 18 months (USO, 2 vs CTI, 1; z=2.5, p ≤ 0.01), but not at 9 months, based on the Wilcoxon rank-sum test. The adjusted quintile regression analyses indicated that those assigned to CTI as a group had more favourable physician transition subscale ratings than did the USO group at the 9-month assessment (β=37.5, t=2.33, p=0.03), reflecting a more positive perception of dealing with changes in their treating psychiatrist. There was no significant difference between the groups in this outcome at 18 months. Continuity of care: 'Assignment to CTI was associated with a more favourable assessment of continuity across several domains, particularly during the first 9 months. Although improved COC ratings were observed in some measures over 18 months, these | |

| Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| – transfer of care focuses on completing the transfer of responsibility to community resources that will provide long-term support. The CTI worker reaffirms ongoing roles of support network members and develops and begins to set in motion plan for long-term goals (e.g employment, education). | | impacts were more limited. Several 9-month COC measures were significantly correlated with lower risk of homelessness and psychiatric rehospitalization at the study's endpoint, suggesting that some of the impact of CTI on reducing recurrent homelessness and psychiatric rehospitalization risk may be mediated by improved continuity.' (p67).<br>• **RQ6 Reducing readmissions**<br>**Taken from** Tomita and Herman (2012)<br>The impact of critical time intervention in reducing psychiatric rehospitalisation after hospital discharge. Psychiatric rehospitalisation was more frequent in the usual services group in all intervals apart from 1 (the 8th interval). Assignment to CTI was significantly associated with reduced odds of rehospitalisation during the final 3 observation intervals (odds ratio=.11; 95% CI=.01-.96. Control group=1508 rehospitalisations (at least 1 night of psychiatric rehospitalisation) CTI group=1183 rehospitalisations Both the proportion (27% vs 18%, z=2.09, p<.05) and frequency of rehospitalisation nights (49 versus 31; df=1; p<.05) above median and significantly higher for the usual services group. Housing stability was associated with a reduced likelihood of rehospitalisation (OR=.96; CI=.92-.99). | |

**Table 1** Phases and activities of critical time intervention (CTI) used in Herman et al. (2011)

| Phase | Transition | Try-out | Transfer of care |
|---|---|---|---|
| Timing | Months 1–3 | Months 4–6 | Months 7–9 |
| Purpose | Provide specialised support & implement transition plan | Facilitate and test client's problem-solving skills | Terminate CTI services with support network safely in place |
| Activities | • CTI worker makes home visits<br>• Accompanies clients to community providers<br>• Meets with caregivers<br>• Supplements the role of caregivers when necessary<br>• Gives support and advice to client and caregivers<br>• Mediates conflicts between client and caregivers | • CTI worker observes operation of support network<br>• Helps to modify network as necessary<br>• Intervenes when a crisis arises | • CTI worker reaffirms ongoing roles of support network members<br>• Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification)<br>• Holds party/meetings to symbolise transfer of care |
| Mean number of face-to-face contacts | 8 | 5 | 5 |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To test 3 hypotheses (final 1 most important?) in letter contacts to people at risk of suicide (following depressive or suicidal motive for hospitalisation): sense of isolation of person at risk of suicide would be reduced by some 'connection'; contact must make no demands on recipient; systematic programme would help prevent suicide in this group if they refuse assistance from MH services.<br>**Source of funding**<br>• Funding councils<br>NIMH Research.<br>**Country**<br>• US | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number<br>Contact group 389.<br>• Comparison numbers<br>Non-contact group 454.<br>• Sample size<br>843 participants were recruited and randomised to either contact or no contact. All had been part of a wider number of 3005 admissions between 1969 and 1974 to 9 inpatient facilities in San Francisco. All 3005 were interviewed prior to discharge for psychosocial evaluation; 30 days from discharge, a follow-up enquiry asked if they had accepted post-discharge therapy and continued it for 30 days. Those who declined or did not continue for 30 days were eligible for study: 843 patients were randomly assigned to either contact or non-contact. (A further group designated 'undetermined' | **Outcomes 2 (quant)**<br>• Clinical Outcome<br>**Findings – effect sizes**<br>• In the analysis, those accepting treatment were also used as a comparator. At 5 years, the contact group had the lowest rate of suicides of all 3 groups (treatment 6.2%; contact 3.9% and no contact 4.6%). Plotting the 3 groups (total 2782 after removing non-suicidal deaths), the greatest advantage for the contact group is within the first 2 years after the intervention began – i.e the years most associated with suicidal death. This is illustrated in a table showing the cumulative suicides in the 2 study groups.<br>The rates then converge at year 14 (6 years after cessation of the intervention).<br>At 15 years, the study groups have converged (treatment 8.2%; contact 6.4% and no contact 5.7%), except that the suicide rate among those in treatment continues to exceed those in the trial (which authors suggest may indicate particular severity of conditions).<br>Note that the reporting here follows that used in the paper.<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>Discharge intervention also attracted some qualitative replies which suggested the letters were well received, e.g (from p831–2): 'About 25 percent of the patients in the contact group expressed positive reactions in writing, such | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>Generalisability is marked down: (a) because not enough is known |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | were people who died within 30 days or who could not be located or did not respond to 3 enquiries about follow-up therapy – this group might have committed suicide, but were not followed up.)<br>**Sample characteristics**<br>• Sex<br>In contact (IG) group, 42% women; in no contact (CG) group, 46% women.<br>• Sample age<br>29% over 39 years in contact group, 28% over 39 years in non-contact group.<br>• Level of need/diagnosis<br>All included subjects had been hospitalised for depressive or suicidal symptoms: intervention started at discharge.<br>• Previous admissions<br>At least 1 admission, as sample recruited at discharge.<br>Intervention<br>• Intervention to contact group was a number of letters of concern, asking if the person was OK and inviting a response if they wanted | as “Thank you for your continued interest,” “It is a good feeling to know you are still interested,”... “After I threw the last letter out I wished I hadn’t, so I was glad to get this one,” “I really appreciate your persistence and concern,” ... “Your note gave me a warm, pleasant feeling. Just knowing someone cares means a lot,” ... and “You are the most persistent son of a bitch I’ve ever encountered, so you must really be sincere in your interest in me.”’<br>In the analysis, those accepting treatment were also used as a comparator. At 5 years, the contact group had the lowest rate of suicides of all 3 groups (treatment 6.2%; contact 3.9% and no contact 4.6%). Plotting the 3 groups (total 2,782 after removing non-suicidal deaths), the greatest advantage for the contact group is within the first 2 years after the intervention began – i.e. the years most associated with suicidal death. The rates then converge at year 14 (6 years after cessation of the intervention).<br>At 15 years, the study groups have converged (treatment 8.2%; contact 6.4% and no contact 5.7%), except that the suicide rate among those in treatment continues to exceed those in the trial. | about the 3 groups to focus intervention on likely respondents; (b) the data is quite old, and does not, e.g., use modern means of communication. |

| Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | one. They were personalised as far as possible, and worded differently, but made no demands for action or information from the patient. Contact letters were sent monthly for 4 months; then every 2 months for 8 months and then every 3 months for 4 years – in total, 24 contacts over 5 years. Although some were clearly no longer at the same address, and contacts ranged from 2–24, all those in initial contact group, including those accepting treatment during follow-up, were analysed as contact group (so any observable difference would be conservatively analysed). Deaths were confirmed through the official records.<br>**Follow-up OR time of interview**<br>• Follow-up is continuous<br>Results primarily show cumulative 5 and 15 year outcomes, but different intervals could be used. | | |

| | | | |
|---|---|---|---|
| Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: a pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15 | | | |
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate a novel aspect of discharge, improving communication with GPs to facilitate patient engagement with primary care services<br>**Linked study**<br>• Detail (name, date) of SR in which cited<br>Cited in SRs, Steffen (2009) and Shepperd (2013) (neither reviewed as SRs, not on topic)<br>**Source of funding**<br>• NHS Trust(s)<br>Country<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>Sample drawn from patients admitted to 3 acute psychiatric wards at hospital in Aberdeen during a 12 month period.<br>**Sample size**<br>• Intervention number: 168<br>• Comparison numbers: 175<br>• Sample size: 343 entered into trial – 168 to int group, 175 to TAU<br>**Sample characteristics**<br>• Sex: 52% male in each group<br>• Sample age: mean age 40/41<br>**Intervention**<br>• Discharge by the novel procedure involved the hospital doctor routinely phoning GP and informing them of discharge, and ideally discussing the patient. In addition, an appointment within 1 week of discharge was arranged. A copy of discharge summary was posted to GP, and patient given a copy to deliver to general practice asap. Conventional discharge did not | **Outcomes 1 (qualitative)**<br>• What works well<br>A sample of 16 GPs and 17 hospital psychiatrists were interviewed for views on novel approach.<br>**Outcomes 2 (quant)**<br>• Clinical outcome<br>• Service outcomes<br>**Findings – effect sizes**<br>• No significant differences between the 2 groups at baseline in symptoms: a slight higher median score among novel group on HADS observed at 1 month, but this was analysed to show it reflected more alcohol/opiate dependency at 1 month in intervention group.<br>There were no significant differences between the arrival of discharge info to GP between the groups (2 days).<br>The median number of GP appointments in the 6 months (apart from the initial 1) for MH related matters was significantly higher in int group (3.0 and 95% CI 1-5 versus 2.0 and 95%CI 0-4, p=0.016). A smaller proportion of intervention group patients attended at least 1 hospital appointment than was the case in TAU group (72 versus 82%, 95% CI for the different in proportions, p=0.032.<br>33 (19.6%) of novel discharge patients were readmitted in the 6 months following hospital discharge, vs 48 (27%) of conventional discharge patients (7.4%, 95% CI for proportions, p=0.09). The mean time to readmissions in the | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>But the study is small, the intervention is |

| Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: a pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | require hospital doctor to phone GP, and patients were asked to deliver discharge summary asap and make appt with GP themselves. Both groups had 7 day supply of medication.<br>**Follow-up OR time of interview**<br>• Patients completed questionnaires at discharge (baseline) including symptom identification (BASIS-32) and HADS. One month post-discharge, repeated by post (requiring return in SAE). A comparative assessment of mental health was repeated at 6 months, when there was also assessment of readmission rates and time to readmission within the 6/12 period, efficient transfer of discharge info to GP, speed and frequency of contact between patients and primary care and continuation of medication. Nos completing questionnaire at discharge: 132 (79%) of in and 133 (76%) of TAU group; at 1 month 106 (63%) in | novel group was 161 days (95% CI 153-169 days) compared with 153 days (95% CI 144-162) in the conventional group.<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>Despite small numbers and little that is statistically significant, trend seemed to be for novel intervention to be associated with more use of GPs and less use of hospital outpatient appts, and fewer readmissions.<br>Fidelity to the protocol was not automatic. Some psychiatrists felt a call to GP was necessary despite the patient being in TAU group. Phone calls to the GP concerning the intervention group took place in 124 (86%) of cases, and appointments with GP were made in 103 (72%) of cases in novel group. Interviews (with GPs and junior psychiatrists) showed that most psychiatrists saw an advantage in facilitating contact between primary and secondary care, but both psychiatrists and GPs felt this was not always necessary, was inconvenient, were difficult to implement, and took time they couldn't easily find. | not dramatically different from TAU and the findings are not significant. However, this is consistent with study results that might be generalisable. |

Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric in-patients back to primary care: a pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| | novel group and 111 (64%) in TAU group. | | |

Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal Of The Association Of European Psychiatrists. 30(2): 258-70.

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| **Methodology**<br>• Systematic review<br>Systematic appraisal using narrative synthesis.<br>**Systematic reviews ONLY: Do all studies fulfill inclusion criteria?**<br>• No. 17 unique studies: 4 out of date range: Mellsop 1997; Systema et al. 1997; 1996; Le Bas et al. 1998; Perris et al. 1985; 1 excluded on country: Juven-Wetzler et al. 2012 (Israel); 71% are inside our range. There is only 1 cluster NON-randomised trial: most are before and after or | **Participants**<br>• Adults with MH conditions<br>• Professionals/practitioners<br>• Systematic reviews: number of studies<br>21 articles (from 17 unique studies) were included in the review. No RCTS were identified; 13 non-randomised comparative studies which compared outcomes of continuity and specialist systems; 3 survey studies which investigated staff and patient views towards both systems; 1 Qualitative semi-structured interview study on staff views. | **Outcomes 2 (quant)**<br>• Satisfaction<br>• Service outcomes<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>Five out of 6 studies that measured the views of patients and staff reported preferences for continuity over specialisation systems.<br>Two non-randomised comparative studies found patients in continuity systems were more satisfied with their care and with their psychiatrist – although only significant in the latter with regards to being treated with respect and dignity.<br>**Qualitative findings**<br>Three UK survey studies and 1 UK semi-structured interview study also collected qualitative data on the views of patients and staff towards the 2 systems. They | **Overall assessment of internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Partly<br>**A clear focus on transition between inpatient MH setting and community or care home setting?**<br>• Yes<br>**Are the population** |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| qual/quant surveys.<br>**Study aim**<br>• To systematically appraise evidence comparing continuity of care vs specialisation across inpatient and outpatient MH settings. To be included, there has to be more than a follow-up appointment with consultant: needs to be 'continuous clinical responsibility across treatment settings.<br>**Source of funding**<br>• Other<br>No additional funding was required for this research.<br>**Country**<br>• Range of countries<br>Australia, Germany, Italy, Netherlands, New Zealand, Norway, Sweden, UK, USA. | **Follow-up OR time of interview**<br>• From 6 months to 42 months<br>Most average 12 months follow-up. | assessed participants' views on the change from a continuity to a specialisation system, and all found advantages to both systems.<br>Key benefits for a specialisation system were cited as:<br>The opportunity for a second opinion/perspective from another consultant; more dedicated and better inpatient care; shorter admissions and a faster discharge process; reduced consultant workload; improved specialisation and focused skills of staff; streamlining of Mental Health Act processes; improved access to doctors and specialist services; empowerment of nursing staff; and more supervision of junior doctors.<br>The main concerns regarding a change from a continuity to specialisation system included poor continuity of care and problems arranging care after hospital discharge; disagreement between staff; a communication gap; a breakdown in therapeutic relationship or familiarity; repetition of the patient's history and concerns; frequent changes to treatment plans; uncoordinated admissions and discharges; staff dissatisfaction and increased community workload; and deskilling of specialists.<br>A common finding was that key to the success of the specialisation system is communication and effective collaboration between separate teams.<br>• **RQ5 Discharge**<br>There are mixed findings regarding the number of | **groups relevant?**<br>• Somewhat<br>**Relevant to social care outcomes?**<br>• Yes<br>**Does the review have a UK perspective?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal Of The Association Of European Psychiatrists. 30(2): 258-70. | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | hospitalisations in the specialist and continuity systems, though the 2 higher quality studies that meet the EPOC group's study design criteria (a non-randomised trial and a controlled before/after study) both suggest favourable outcomes in a continuity system.<br>There is more consistent evidence from the included studies to suggest that continuity systems are associated with lower lengths of hospital stay. Some preliminary evidence, from studies not meeting the EPOC groups study design criteria (cohort, cross-sectional, before and after and survey studies) also suggest a continuity system has faster and more flexible transitions between services, and may be preferred by both patients and staff.<br>Little evidence currently exists regarding other clinical, social or cost-effectiveness outcomes, or regarding the benefits of each system across different population sub-groups or settings. | |

| Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences. 20: 181–92 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT | **Participants**<br>• Adults with MH conditions | **Outcomes 2 (quant)**<br>• Quality of Life | **Internal validity**<br>• + |

| Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences. 20: 181–92 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | Q**uality assessment** |
| **Study aim**<br>• To test the effect of a needs-oriented discharge planning intervention on the number and duration of psychiatric inpatient treatment episodes (primary), as well as on outpatient service use, needs, psychopathology, depression and quality of life (secondary).<br>**Source of funding**<br>• DFG<br>German Research Foundation.<br>**Country**<br>• Germany: 5 psychiatric hospitals.<br>**Intervention**<br>• Manualised needs-led discharge planning and monitoring intervention with 2 intertwined sessions administered at hospital | Aged 18-65 and currently receiving psychiatric inpatient care.<br>With a primary diagnosis of schizophrenia, bipolar affective disorder or major depressions.<br>With previous high utilisation of psychiatric inpatient care which was defined as during the 2 years prior to current inpatient treatment.<br>1) At least 2 admissions with a cumulative length of stay (LOS) exceeding 30 days or<br>2) At least 1 admission with a cumulative LOS of more than 50 days.<br>Exclusion criteria:<br>- primary diagnosis of substance abuse<br>- learning disability or organic mental disorder<br>- insufficient command of German language<br>- foreseeable inpatient or day psychiatric treatment (including | • Service outcomes<br>**Findings – effect sizes**<br>Service use outcomes<br>• Kind of service use n % Difference<br>Inpatient stays (at all)<br>Intervention 108 64.3<br>χ2(df=1)=0.17; p=0.68<br>Control 103 66.5<br>Outpatient visits (at all)<br>Intervention 165 98.2<br>χ2 (df=1)=1.3;<br>Control 149 96.1 p=0.25<br>** please refer to original paper for complete findings tables.<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>'Intention-to-treat analyses revealed no differences between intervention and control groups on neither | **Is the setting similar to the UK?**<br>• No<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• + |

| Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences. 20: 181–92 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| discharge and 3 months after.<br>Pre-discharge session: took place around 7 days before discharge. Participants were patient, inpatient clinician, carers if consented to by patient, and the intervention worker (IW). The IW had obtained the results of the needs assessment (using the Camberwell Assessment of Need). A structured discussion moderated by the IW on areas of need identified by the patient constituted the core part of the session. A standardised summary was entered into the NODPAM discharge plan that was signed by all participants. This plan had every single need discussed with a precise problem definition, objectives, timeframe of its achievement | rehabilitation) extending 7 days after discharge from psychiatric inpatient treatment.<br>**Sample size**<br>• Intervention n=241<br>Control n=250<br>Total n=491<br>**Sample characteristics**<br>• Sex<br>Male n (%)<br>Intervention 127 (52.7%), control 126 (50.4%)<br>• Sample age<br>Years, mean (SD)<br>Intervention: 41.2 (11.1), control: 41.4 (11.4)<br>• Level of need/diagnosis<br>Camberwell Assessment of Needs, CAN Mean (SD)<br>Intervention: 6.3 (2.7)<br>Control: 5.9 (2.7)<br>Manchester Short Assessment of Quality of Life, MANSA Mean (S.D) | primary nor secondary outcomes. This means that participants who received (or rather were intended to receive) the NODPAM intervention did not exhibit less inpatient service use during the follow-up period nor did they utilise more outpatient mental health services. They also had no superior "soft" outcome with regard to unmet need, psychopathology, depression and quality of life' (p186). | |

Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences. 20: 181–92

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| and the person(s) responsible for implementation. After discharge a version was sent to the treating outpatient clinician and to the patient. Both were instructed to discuss all relevant topics and to monitor progress of implementation at every aftercare appointment. Post-discharge session: 3 months after discharge, the discharge monitoring took place with patient, outpatient clinician, carer (if desired by patient) and IW. The session was based on current standardised needs assessment including the comparison with care needs at baseline ('needs development'). A resumé was drawn of the course, critical problem areas and implementation of the | Intervention: 4.4 (0.9)<br>Control: 4.5 (0.9)<br>• Previous admissions<br>Admissions during last 2 years<br>Mean (S.D)<br>Intervention: 2.9 (2.5)<br>Control: 2.8 (1.8)<br>Cumulated length of stay during last 2 years, days<br>Mean (S.D)<br>Intervention: 129.8 (91.2)<br>Control: 118.3 (81.4)<br>• Not reported<br>Work<br>Full-time, n(%)<br>Intervention: 39 (16.5%), control: 47 (19.0%)<br>Part-time<br>Intervention: 23 (9.7%), control: 31 (12.6%)<br>Unemployed<br>Intervention: 44 (18.6%), control: 46 (18.6%) | | |

Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences. 20: 181–92

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| discharge plan. Again the patient and clinician were asked to discuss and monitor implementation of the plan. | Not working<br>Intervention: 130 (55.1%), control: 123 (49.8%)<br>Follow-up or time of interview<br>• Four measurement points: baseline (T0, at hospital discharge), 3 months (T1), 6 months (T2) and 18 months (T3) thereafter. | | |

Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To assess whether adding a telephone care management protocol to usual aftercare improved the outcomes of veterans in the year after they were | **Participants**<br>• Adults with MH conditions Consecutive admissions to 5 VA residential PTSD treatment programmes.<br>**Exclusion criteria**<br>- cognitive impairment which precluded giving consent | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Quality of life subscale of the Veterans Affair Military Stress Treatment Assessment<br>• Service outcomes<br>**Findings – effect sizes**<br>• Clinical outcomes of participants in telephone care management or treatment as usual | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on** |

<table>
<tr><td colspan="4">Rosen CS, Tiet QQ, Harris AH, et al.  (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20</td></tr>
<tr><td><b>Research aims</b></td><td><b>Population</b></td><td><b>Findings</b></td><td><b>Overall quality assessment</b></td></tr>
<tr>
<td>discharged from residential treatment for post-traumatic stress disorder (PTSD).<br><b>Source of funding</b><br>• Government<br>Office of Research and Development, US Department of Veterans Affairs (VA), Veterans Health Administration. And VA Center for Health Care Evaluation and the VA Palo Alto Health Care System.<br><b>Country</b><br>• US<br><b>Intervention</b><br>• Treatment as usual group received standard referral to outpatient counsellors, psychiatrists, or both. Participants in telephone care management received standard referral plus biweekly telephone monitoring and support during the first 3 months after discharge. Telephone</td>
<td>- discharged in fewer than 15 days<br>- active duty military personnel were excluded because they receive aftercare outside the VA system.<br><b>Sample size</b><br>• Telephone care n=412<br>Treatment as usual n=425<br>Total n=837<br><b>Sample characteristics</b><br>• Sex<br>Female (%)<br>Telephone care n=357 (13)<br>Treatment as usual n=368 (13)<br>• Sample age<br>Age M (SD)<br>Telephone care 50.2 (0.62)<br>Treatment as usual 49.9 (0.86)<br>• Level of need/diagnosis<br>Co-occurring diagnosis (%)<br>Depression<br>Telephone care: 328 (80)<br>Treatment as usual: 349 (82)<br>Anxiety (other than PTSD)<br>Telephone care: 123 (30)<br>Treatment as usual: 135 (32)</td>
<td>At 4-months follow up
<table>
<tr><td>Score</td><td colspan="2">Telephone</td><td colspan="2">TAU</td><td>ES</td></tr>
<tr><td></td><td>M</td><td>SD</td><td>M</td><td>SD</td><td>d</td></tr>
<tr><td>PTSD (PCL score)</td><td>63.8</td><td>12.9</td><td>63.3</td><td>12.7</td><td>.04</td></tr>
<tr><td>Depression (CES-D)</td><td>37.7</td><td>10.1</td><td>37.2</td><td>10.8</td><td>.06</td></tr>
<tr><td>Quality of life</td><td>3.2</td><td>1.1</td><td>3.2</td><td>1.1</td><td>-0.3</td></tr>
</table>
At 12 months follow up
<table>
<tr><td>Score</td><td colspan="2">Telephone</td><td colspan="2">TAU</td><td>ES</td></tr>
<tr><td></td><td>M</td><td>SD</td><td>M</td><td>SD</td><td>d</td></tr>
<tr><td>PTSD (PCL score)</td><td>63.9</td><td>13.0</td><td>63.4</td><td>12.5</td><td>.04</td></tr>
<tr><td>Depression (CES-D)</td><td>38.0</td><td>10.1</td><td>38.4</td><td>10.4</td><td>-0.3</td></tr>
<tr><td>Quality of life</td><td>3.3</td><td>1.1</td><td>3.3</td><td>1.1</td><td>.00</td></tr>
</table>
*Quality of life measured by the 10-item quality of life subscale of the Veterans Affairs Military Stress Treatment Assessment. Possible scores range from 1 to 7, with</td>
<td><b>population of interest?</b><br>• Yes<br><b>Is the intervention clearly relevant to RQ(s)?</b><br>• Yes<br><b>Are the outcomes relevant?</b><br>• Unclear<br><b>External validity</b><br>• +</td>
</tr>
</table>

| Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| monitors briefly assessed the participant's outpatient treatment attendance; medication compliance; severity of symptoms; and coping related to PTSD, depression, and anger; substance use; suicidality; and risk of violence. | Substance use disorder<br>Telephone care: 224 (54)<br>Treatment as usual: 240 (57)<br>Schizophrenia<br>Telephone care: 20 (5)<br>Treatment as usual: 18 (4)<br>Bipolar<br>Telephone care: 49 (12)<br>Treatment as usual: 58 (14)<br>• Previous admissions<br>Outpatien.t mental health visits in prior year<br>Telephone care 35.0 (2.1)<br>Treatment as usual 38.6 (2.9)<br>Length of stay in residential programme<br>Telephone care 47.0 (1.2)<br>Treatment as usual 45.9 (1.7)<br>**Follow-up OR time of interview**<br>• Four months and 12 months follow-up | higher scores indicating greater satisfaction.<br>* Center for Epidemiological Studies Depression Scale (CES-D). Possible scores range from 0 to 60, with higher scores indicating more severe depression.<br>**Findings – narrative**<br>**• RQ5 Discharge**<br>Participants in the telephone care and treatment as usual groups showed similar outcomes on all clinical measures. Time to rehospitalisation did not differ by condition. Participants in both telephone monitoring and treatment as usual completed a mental health visit an average of once every 10 days in the year after discharge. | |

| Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To study the effect of a brief motivational interviewing intervention on outpatient treatment adherence among psychiatric and dually diagnosed inpatients.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• US<br>Two inner-city private, not-for-profit hospitals.<br>**Intervention**<br>• All patients were administered the University of Rhode Island Change Assessment Scale (URICA), a psychometrically sound instrument designed to measure readiness for, or stage of, change.<br>Standard treatment (ST).<br>ST patients received an | **Participants**<br>• Adults (no specified age) with MH conditions<br>Patients were psychiatric or dually diagnosed and were all on a voluntary status. Exclusion criteria – diagnosis of dementia or mental retardation – those who spoke no or little English – acutely psychotic, manic and/or hostile were initially excluded until their symptoms were reduced.<br>**Sample size**<br>• Control (ST only)=57<br>Intervention (ST + MI)=64<br>Total=121<br>**Sample characteristics**<br>• Sex<br>MALE<br>ST n=36 (63%)<br>ST +motivational Interview n=41 (64%)<br>• Sample age<br>ST=34.87 ±8.90<br>ST + MI=32.87 ±9.03<br>• Level of need/diagnosis | Outcomes<br>• Service outcomes<br>**Findings – narrative**<br>The proportion of patients who attended their first outpatient appointment was significantly higher for the ST+MI group than for the ST group (47% vs 21%; [chi]2=8.87, df=1, p<.01) overall, and for dually diagnosed patients (42% vs 16%; [chi]2=7.68, df=1, p<.01). Although more non-substance-abusing psychiatric patients in ST+MI attended their first appointment than did those in ST, this difference did not reach statistical significance (63% vs 42%; [chi]2=1.20, df=1, p=.274).<br>The study also assessed whether the 15-minute feedback session regarding the results of the URICA (given only to the ST+MI group) had an effect on attendance at inpatient activity (AT) and cognitive-behavioural therapy (CBT) group sessions during hospitalisation. Only non-dually diagnosed ST+MI patients showed a trend toward attending more CBT groups than those in ST (46% vs 17%, respectively; t=1.97, df=23, p=.061). Dually diagnosed patients in ST and ST+MI attended a comparable percentage of AT (64% vs 58%, respectively) and CBT groups (49% vs 44%, respectively) while hospitalised. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| intake assessment by a multidisciplinary team, resulting in an individualised treatment plan, which identified psychiatric, psychological, medical and social service needs. Although patients in ST were administered the URICA they were not given any feedback on the results.<br>Standard treatment plus motivational interviewing (ST+MI). Patients in this group received ST plus a 15-minute session of feedback on their change assessment scores at the beginning of their hospitalisation and 1-hour motivational interview 1 or 2 days before discharge. The hour-long motivational interview involved a more in-depth discussion regarding the patient's perception of his/her problem(s), and level of commitment to treatment | Dually diagnosed<br>ST n=45 (79%)<br>ST +MI n=48 (75%)<br>Psychotic disorder<br>ST n=16 (31%)<br>ST+MI n=21 (35%)<br>• Length of stay (days)<br>ST=12.98<br>ST+MI=15.39<br>**Follow-up**<br>• First aftercare appointment post-discharge | | |

| Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| after discharge. Therapists attempted to elicit, from patients, motivational statements suggesting a desire to take some responsibility for their continued treatment while also encouraging the patient to follow through on such statements. Therapists drew on the 5 principles of MI: a) express empathy; b) note discrepancies between current and desired behaviour; c) avoid argumentation; d) refrain from directly confronting resistance; and f) encourage self-efficacy, or the patient’s belief that he/she has the ability to change. | | | |

## Critical appraisal tables

## Table reporting views studies

## Review Question 5: What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

| Bennewith O, Evans J, Donovan J et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Overall assessment** |
| **Methodology**<br>• Mixed methods<br>1. DEVELOPMENT PHASE Qualitative interviews with 10 patients conducted to develop supportive letter based on a previous US model, but tailored to the needs of the intervention group in the study. Followed by questionnaire survey of two-thirds of inpatients in 4 psychiatric wards to further fine-tune intervention.<br>2. STATISTICAL DATA COLLECTION A. Information collected from intervention wards on the number of (1) psychiatric readmissions, and (2) emergency department attendances=general hospital admissions for self-harm, during the 12 months post-discharge. B. Data collected on all admissions and readmissions to wards A and B and other general adult acute inpatient psychiatric wards | **Are participants (organisations) recruited in a way that minimises selection bias?**<br>• No<br>This is a pilot study and the intervention was piloted on 3 wards located in 3 different psychiatric inpatient units in SW England. Ward A (a 23-bed unit) serving an inner city, ward B (a 19-bed unit) serving a suburban area and ward C (a 22-bed unit) serving a mixed urban/rural population.<br>**Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?**<br>• Partly<br>Data partly relevant to RQ6 on readmissions. The author states that for logistical reasons, ‘information was collected only for | **Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods question?**<br>• Yes<br>**Is the integration of qualitative and quantitative data (or results) relevant to address the research question?**<br>• Yes<br>**Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?**<br>• No | Internal validity<br>• +<br>The quantitative evaluation (RR outcome) is based on a spurious before/after comparison, even though the authors admit there have been other context/policy changes; and the qualitative aspect says little about who is recruited and why they may or may not be representative. The author acknowledges that the findings of this pilot study do not appear to warrant a full RCT to test the feasibility of this intervention. There are also difficulties of trialling an intervention where such a high proportion (72.2%) of the study group are either ineligible or do not complete the intervention, due to opt-out or readmission to hospital.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>The study tested the feasibility of |

| Bennewith O, Evans J, Donovan J et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Overall assessment** |
| (wards X, Y, and Z) at the same hospitals for the 12-month period prior to and during the pilot study. C. Data on the number of community mental health service contacts in the 12 months after discharge.<br>3. QUALITATIVE INTERVIEWS to assess participant views on the usefulness of supportive letters. Two descriptive accounts were produced at the mid and end points of the series of interviews.<br>**Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?**<br>• Partly<br>DEVELOPMENT PHASE<br>Qualitative interviews with 10 participants, who suggested that preferred modes of contact were by letter or telephone. Subsequent questionnaire | participants from intervention wards A and B on the number of (1) psychiatric readmissions, and (2) emergency department attendances/general hospital admissions for self-harm, during the 12 months after discharge. Anonymized data were collected on all admissions and readmissions to wards A and B and other general adult acute inpatient psychiatric wards (wards X, Y, and Z i.e. non-intervention wards) at the same hospitals for the 12-month period before and during the pilot study. Community mental health service contacts data in the 12 months after discharge were collected for a subset of participants (6 from each of wards A and B), to identify ‘existing levels of community support=frequency of contact with services, to assess the role of the letter-based contacts in the context of the patients’ overall care’.<br>**In the groups being compared** | | ‘supporting letters’ and is very context-specific. Wider applicability and outcome data will vary according to local circumstances and any changes in government policy.<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Bennewith O, Evans J, Donovan J et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Overall assessment** |
| survey of two-thirds (48/71, 67.6%) of inpatients on 4 psychiatric supported this. IN-DEPTH INTERVIEW PHASE Examining patient views and experiences of mental health, contact with services and experience of supportive letter (s); 13 participants (12.7% of those in receipt of the intervention) were interviewed 14 weeks (median 8 weeks, range 2 weeks–11 months) after the last study letter was received. Interviews relevant to RQ 1(b) – user views/exp of discharge. Note however, there is little information about who is recruited and why they may or may not be representative.<br>**Is the process for analysing qualitative data relevant to address the research question?**<br>• Yes<br>Extensive summaries of each interview were analysed using constant comparison – | **(exposed vs non-exposed; with intervention versus without; cases vs controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?**<br>• No<br>No description of participant data in the non-intervention wards and how differences are accounted for/controlled.<br>**Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?**<br>• Yes<br>As this was a pilot study to assess the feasibility of undertaking a large-scale trial to assess the usefulness of supportive letters, the researchers restricted data collection on readmission to only participants from intervention wards A and B. | | |

| Bennewith O, Evans J, Donovan J et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Overall assessment** |
| emerging themes and codes were compared within and across transcripts (Donovan and Sanders 2005; Miles and Huberman 1994).<br>**Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?**<br>• No<br>**Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?**<br>• No | | | |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| **Methodology**<br>• Survey<br>**Objectives of the** | **Research design clearly specified and appropriate?** | **Describes what was measured, how it was measured and the** | **Basic data adequately described?**<br>• Yes<br>**Results presented clearly,** | **Internal validity**<br>• -<br>This study has significant |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| **study clearly stated?**<br>• Yes<br>**Relevance to our RQ(s)?**<br>• Yes | • Partly<br>**Clear description of context?**<br>• Yes<br>**References made to original work if existing tool used?**<br>• N/A<br>**Reliability and validity of new tool reported?**<br>• N/A<br>**Survey population and sample frame clearly described?**<br>• Yes<br>**Representativeness of sample is described?**<br>• Partly<br>A list of patients subject to SCT was provided by Mental Health Act offices in the Merseyside area in November 2010 following local NHS trust approval. Population may not be representative but be biased towards those in | **outcomes?**<br>• Yes<br>The authors designed a structured interview based upon information in patient leaflets provided by a local mental health trust. The interview included 14 questions based upon 4 main themes: involvement in planning of SCT, quality of provided information, awareness of SCT process and legal rights and outcomes and satisfaction. The questions referred to 'CTO' (community treatment order) as this was the term the authors believed would be recognised by patients in the survey population.<br>**Measurements valid?**<br>• Yes<br>**Measurements reliable?**<br>• Yes<br>**Measurements reproducible?**<br>• Yes | **objectively and in enough detail for readers to make personal judgements?**<br>• Yes<br>**Results internally consistent?**<br>• Yes<br>**Data suitable for analysis?**<br>• Yes<br>**Clear description of data collection methods and analysis?**<br>• Yes<br>**Methods appropriate for the data?**<br>• Yes<br>A Likert scale was used for each interview question where 1=strongly disagree, 2=disagree, 3=neither agree or disagree, 4=agree and 5=strongly agree. Also each structured question was followed by an open-ended question to explore patient experience, beliefs and expectations related to the SCT process. Two authors conducted a face-to-face interview and survey in the patient's home – 1 to conduct the interview and the other to transcribe verbal responses. The length of each interview took 45–90 minutes. | limitations.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the review question?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | favour of SCT.<br>**Subject of study represents full spectrum of population of interest?**<br>• Partly<br>Primary diagnosis of participants and numbers as follows: schizophrenia (12), schizoaffective disorder (3), delusional disorder (1), mental disturbance due to drugs or alcohol (1). However low female and ethnic minority representation.<br>**Study large enough to achieve its objectives, sample size estimates performed?**<br>• No<br>**All subjects accounted for?**<br>• Yes<br>**All appropriate outcomes considered?**<br>• Yes<br>Key outcome – hospital | | **Statistics correctly performed and interpreted?**<br>• Yes<br>**Response rate calculation provided?**<br>• No<br>**Methods for handling missing data described?**<br>• No<br>**Difference between non-respondents and respondents described?**<br>• No<br>**Results discussed in relation to existing knowledge on subject and study objectives?**<br>• Yes<br>**Limitations of the study stated?**<br>• Yes<br>The authors state that a limitation of this study is that it is based upon a small sample size. The survey was conducted within 25 months of SCT being introduced in England and Wales and most patients had not been recalled to hospital. Those who were held considerably more negative views | |

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|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | readmission.<br>**Ethical approval obtained?**<br>• N/A<br>This was a service evaluation and as such the NHS trust waived the requirement for formal ethics approval. But an information sheet was developed clarifying the study aims and objectives and the voluntary nature of participation, as dictated by good practice.<br>**Measures for contacting non-responders?**<br>• No | | about SCT. The survey was retrospective and relied upon the ability of patients to recall events from up to 25 months ago. The bulk of questioning was about events that happened prior to discharge when a patient's cognitive function may have been poor due to acute or residual mental illness. There is likely to be significant recall bias in the study.<br>**Results can be generalised?**<br>• Partly<br>**Appropriate attempts made to establish 'reliability' and 'validity' of analysis?**<br>• No | |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | | |
|---|---|---|---|---|
| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | | |
|---|---|---|---|---|
| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews that included open questions and prompts.<br>**Is the study clear in what it seeks to do?**<br>• Clear | **How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>Semi-structured interview schedule which had open-ended questions and prompts was used flexibly in order to allow participants to determine direction of the interview. Data was coded and analysed thematically in accordance with the principles of interpretative phenomenological analysis (IPA).<br>**Is the context clearly described?**<br>• Unclear<br>All participants were white, British females. Participants were all from general adolescent psychiatric units (rather than specialised).<br>**Study approved by ethics committee?** | **Was the sampling carried out in an appropriate way?**<br>• Not sure<br>Haphazard sampling method! Participants were recruited either from past inpatient records from general adolescent units (6 of total sample) or via face–to-face contact with clinicians in adult inpatient eating disorder units (1 from sample); 50 participants were invited to take part in the study and 7 opted in. All had received treatment for AN in a general adolescent inpatient setting, and all had been discharged from inpatient care 2–5 years prior to the study.<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>Interviews were between 60 to 90 minutes and conducted | **Are the data 'rich'?**<br>• Rich<br>Is the analysis reliable?<br>• Reliable<br>Primary researcher shared random pages of the interview transcripts with fellow qualitative researchers and compared analyses. An audit trail (from original coding to clustering of themes) was conducted. Member checking was conducted to verify participants' understanding of themes.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>The author acknowledges that 1 of the limitations is the retrospective nature of the study which means that it may allow less accurate reports of experiences.<br>**Relevance to the MH** transitions guideline<br>• Highly relevant |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
|---|---|---|---|---|
| | • Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | at either the participants' home or at a local clinic.<br>**Were the methods reliable?**<br>• Somewhat reliable<br>**Is the role of the researcher clearly described?**<br>• Unclear | | |

Owen-Smith A, Bennewith O, Donovan J, et al. (2014) 'When you're in the hospital, you're in a sort of bubble.' Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60

| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?** | **How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly** | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>**How well was the data collection carried out?**<br>• Appropriately | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>Analytic procedures were enhanced by rigorous searching for 'negative cases,' | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>Although the |

| Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.‘ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60 | | | | |
|---|---|---|---|---|
| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| • Clear | **described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Not stated<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | In-depth interviews were conducted with service users (n=10) who had recently been discharged from psychiatric hospital. Sampling was undertaken purposively, and aimed for diversity in terms of age, gender, length of stay, primary diagnosis, and history of self-harm. Participants were recruited from 5 acute wards of 2 psychiatric hospitals, and access to service users was facilitated by senior nurses, who sent or gave information to potential informants shortly before or after they were discharged<br>**Were the methods reliable?**<br>• Reliable<br>Interviews took place in confidential settings on university or NHS premises, or at the informant’s home, and were undertaken by AOS (6), OB (2), and DG (2). A short topic guide was used to ensure some | where informants held particularly divergent views or whose experience did not follow standard patterns of events.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | conclusions that can be drawn from this study are limited by the small number of participants, this is a good quality study.<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.‘ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60

| **Study aims & suitability of design** | **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
|---|---|---|---|---|
| | | comparability between the interviews, and all interviews were digitally recorded and fully transcribed.<br>**Is the role of the researcher clearly described?**<br>• Clearly described | | |

Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45

| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
|---|---|---|---|---|
| **Methodology**<br>• Survey<br>The main study collected data from key players in the discharge process – including local authorities, health boards, hospital staff, community-based staff and patients. The | **Research design clearly specified and appropriate?**<br>• Yes<br>**Clear description of context?**<br>• Yes<br>**References made to original work if existing tool used?**<br>• Yes<br>**Reliability and validity of new tool reported?** | **Describes what was measured, how it was measured and the outcomes?**<br>• Yes<br>‘All patient assessments were completed face-to-face with each patient as part of a longer interview. The diagnosis information was obtained from the discharge record and was that recorded by the discharging | **Basic data adequately described?**<br>• Yes<br>**Results presented clearly, objectively and in enough detail for readers to make personal judgements?**<br>• Yes<br>**Results internally consistent?**<br>• Yes<br>**Data suitable for analysis?**<br>• Yes<br>**Clear description of data collection** | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the review question?**<br>• Yes |

| Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| study took place between April 1998 and December 1999. This paper draws only on the data relating to patients and community-based staff collected using the CAN between November 1998 and September 1999.<br>**Objectives of the study clearly stated?**<br>• Yes<br>**Relevance to our RQ(s)?**<br>• Mixed | • Yes. The CAN has been shown to be a reliable and valid assessment, with independent ratings from both service users and staff (Phelan et al. 1995).<br>**Survey population and sample frame clearly described?**<br>• Yes<br>‘A sample of patients discharged from acute psychiatric units was interviewed at 6 weeks post discharge. The sample was drawn from the discharge records (SMR04) returned to the Information and Statistics Division of the Scottish Executive. Eight health boards were chosen to reflect the urban/rural typology of Scotland. These represented half the annual discharges in Scotland in any 1 year. All patients discharged from each unit | psychiatrist, classified according to ICD-10 categories. Any diagnoses of schizophrenia, schizo-affective disorder, manic depression and puerperal psychosis were considered a psychotic diagnosis. All other diagnoses were considered non-psychotic. Staff assessments were completed with 98 personnel. When the patient had identified a key community support worker, the patient was asked to give their permission for the research team to obtain a CAN assessment from this staff member. In all cases permission was given and all staff members responded. These were completed on a separate occasion, usually over the telephone. The staff designations were as follows: 71 community psychiatric nurses, 12 day hospital nurses or other staff at day hospital, six social workers, | **methods and analysis?**<br>• Yes<br>**Methods appropriate for the data?**<br>• Yes<br>**Statistics correctly performed and interpreted?**<br>• Yes<br>**Response rate calculation provided?**<br>• N/A<br>**Methods for handling missing data described?**<br>• N/A<br>**Difference between non-respondents and respondents described?**<br>• Yes<br>**Results discussed in relation to existing knowledge on subject and study objectives?**<br>• Yes<br>**Limitations of the study stated?**<br>• Yes<br>**Results can be generalised?**<br>• Partly<br>Authors suggest this sample was not large enough, and the context/locality | This study was published in 2002 and based on 1999 data. So though CAN still being relevant, this study should be considered in the wider realm of more recent policy changes.<br>**Are the outcomes relevant?**<br>• Yes<br>The CAN seeks to identify needs rather than provide a detailed description and the views of both service users and staff is critical. CAN assesses need in 22 domains of daily living (including accommodation, food, looking after the home, self care, physical health, psychotic symptoms, psychological distress and safety of others).<br>**Overall assessment of external validity**<br>• + |

| Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | in the health board area over a specified time period, usually 2 months in each area, who met the criteria were invited take part in the study. Inclusion criteria were to be aged 18–65 and to have been an inpatient for over 1 week but less than 6 months'.<br>**Representativeness of sample is described?**<br>• No<br>**Subject of study represents full spectrum of population of interest?**<br>• Yes<br>**Study large enough to achieve its objectives, sample size estimates performed?**<br>• No<br>Authors say that this study sample is relatively small. Furthermore, that as it is locality-specific results may not be replicated in a similar manner elsewhere. | three voluntary sector case workers and six others'.<br>Measurements valid?<br>• Yes<br>Measurements reliable?<br>• Yes<br>Measurements reproducible?<br>• Yes | too specific to make generalisable statements.<br>**Appropriate attempts made to establish 'reliability' and 'validity' of analysis?**<br>• Yes<br>The CAN assesses need in 22 domains of daily living. For each of these domains, need is rated on a 3-point scale: 0 = 'no problem' (no need), 1= no/moderate problem because help is given (met need), 2 = 'serious problem' (unmet need). The distinction between these 3 ratings may be challenging to judge and care has to be taken to ensure accurate ratings are made by assessors. Patient and staff ratings may differ systematically. When a need is identified in any domain, further investigation of the help received (formal and informal) is carried out. The CAN Research Version 3.0 and accompanying manual was obtained from PRiSM for use in the study. | |

| Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45 | | | | |
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| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | **All subjects accounted for?**<br>• Yes<br>Authors describe why they think non-responders did not take part. The initial response rate was 46% of the 377 patients invited to take part, with 173 discharged patients interviewed at 6 weeks post-discharge. Comparisons were made of the non-responders and responders on key characteristics: gender, length of stay, referral to community support and diagnosis. A key difference was found in respect of diagnosis, where more patients with a non-psychotic diagnosis had responded than those with a diagnosis of a psychotic illness thus reflecting the challenges of involving the latter group in research. | | | |

| Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45 | | | | |
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| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | **All appropriate outcomes considered?**<br>• Yes<br>All 22 domains of the CAN were considered in the assessment of unmet and met need as identified by both patients and professionals.<br>**Ethical approval obtained?**<br>• Yes<br>Ethical approval for the study was granted by the Multi-Research Ethics Committee for Scotland and the 8 local research ethics committees of the individual health board areas.<br>**Measures for contacting non-responders?**<br>• Yes<br>Patients were invited to take in 2 ways: (1) when a patient was known to have contact with any community support | | | |

| Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45 | | | | |
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| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | services (statutory/voluntary), as described in the discharge record, this service was asked to support an invitation to the patient to take part in the study; (2) for a patient not known to have support from a community service, contact was by letter and a subsequent home visit from an interviewer at a prearranged time. In both scenarios if the patient was not in at the arranged time, 1 further attempt was made to establish contact before being classed as a non-responder. | | | |

## Findings tables

## Table reporting views studies

## Review Question 5: What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

| Bennewith O, Evans J, Donovan J, et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Mixed methods | **Participants**<br>• Adults with MH conditions | **Outcomes 1 (qualitative)** | **Internal validity**<br>• + |

| Bennewith O, Evans J, Donovan J, et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| 1. DEVELOPMENT PHASE Qualitative interviews with 10 patients conducted to develop supportive letter based on a previous US model, but tailored to the needs of the intervention group in the study. Followed by questionnaire survey of two-thirds of inpatients in 4 psychiatric wards to further fine-tune intervention.<br>2. STATISTICAL DATA COLLECTION A. Information collected from intervention wards on the number of (1) psychiatric readmissions, and (2) emergency department attendances=general hospital admissions for self-harm, during the 12 months post-discharge. B. Data collected on all admissions and | Mean age 37.8.<br>**Sample size**<br>• Sample of 102 participants across 3 wards broken down as follows received intervention:<br>Gender, n (%)<br>ward A ward B ward C<br>Male 26 (70.2) 23 (53.5)18 (81.8) Total: 67 (65.7)<br>Female 11 (29.7) 20 (46.5)4 (18.2) Total: 35 (34.3)<br>For logistical reasons data on the incidence of self-harm were only obtained for participants discharged from wards A and B. i.e. sample size=80.<br>**Sample characteristics**<br>• Sex<br>67 male; 35 female.<br>• Level of need/diagnosis<br>Participants with the following range of MH conditions:<br>. affective disorders<br>. schizophrenia & other psychoses<br>. personality disorders | • Experiences described<br>**Outcomes 2 (quant)**<br>• Clinical outcome<br>• Service outcomes<br>Costs<br>• No<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>The intervention was piloted on 3 psychiatric inpatient wards – on 2 wards a series of 8 letters were sent to patients over the 12 months and on the third ward 6 letters were sent over a 6 month period. A total of 102 patients discharged from the wards received at least 1 letter, but only 45 (44.1%) received the full series of letters.<br>Whilst some did express dissatisfaction with mental health services and post-discharge support, in general, participants appeared to be supported well following discharge and made reference to a number of services and professionals. As the study sample comprised mainly long-term service users, most knew of services and numbers to call in a crisis situation, so certain aspects (i.e. contact numbers/ information) of the supportive letter intervention were barely used.<br>'Because if you do get into trouble, because you've already been in the ward, you know the people to ring up … because like once you're admitted in, you work with the | The quantitative evaluation (RR outcome) is based on a spurious before/after comparison, even though the authors admit there have been other context/policy changes; and the qualitative aspect says little about who is recruited and why they may or may not be representative. The author acknowledges that the findings of this pilot study do not appear to warrant a full RCT to test the feasibility of this intervention. There are also difficulties of trialling an intervention where such a high |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| readmissions to wards A and B and other general adult acute inpatient psychiatric wards (wards X, Y, and Z) at the same hospitals for the 12-month period prior to and during the pilot study. C. Data on the number of community mental health service contacts in the 12 months after discharge. 3. QUALITATIVE INTERVIEWS To assess participant views on the usefulness of supportive letters. Two descriptive accounts were produced at the mid and end points of the series of interviews.<br>Study aim<br>• ‘The aim of the current pilot study was to assess the usefulness and feasibility of a contact-based intervention for people recently | . substance related disorders<br>. other.<br>**Intervention**<br>• The intervention (supportive letters) was piloted on 3 psychiatric inpatient wards<br>On 2 wards a series of 8 letters were sent to patients over the 12 months and on the third ward 6 letters were sent over a 6-month period. A total of 102 patients discharged from the wards received at least 1 letter, but only 45 (44.1%) received the full series of letters.<br>**Follow-up OR time of interview**<br>• N/A | crisis team and also your CPN [Community psychiatric nurse] is, sort of, you know they give you all the numbers and things anyway’(p8) (41 years, female).<br>Such participants felt that the intervention would be of more benefit to those new to the system (none of whom agreed to an interview) and those who did not have as much support as themselves.<br>Despite some interviewees finding the initial letters and support and advice leaflets helpful and reassuring, a regular theme was that after a while these felt too frequent, and could function as ‘a negative reminder of their hospitalization’.<br>‘To the first timers, yeah, and, you know, they come out and they’ve got nowhere to turn, and obviously the information could be vital for them. So I’m not denigrating the information, I think the information was great’ (p13) (38 years, male).<br>Some participants perceived the letters to be impersonal.<br>‘…To me, they suggested that you’d written a draft, it was printed off on the computer, and sent to everyone … If you’re looking for a way of reducing self-harm or suicide after a hospital admission you need to have a sense of love. Don’t you agree? You need to have this sense of actual human compassion instead of this computerized letter and a round robin of telephone numbers’ (p5) (36 years, male). | proportion (72.2%) of the study group are either ineligible or do not complete the intervention, due to opt-out or readmission to hospital.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>The study tested the feasibility of ‘supporting letters’ and is very context-specific. Wider applicability and outcome data will vary according to |

Bennewith O, Evans J, Donovan J, et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives Of Suicide Research 18: 131–43

| Research aims | Population | Findings | Overall quality assessment |
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| discharged from inpatient psychiatric care in the UK'. The purpose was to assess if supportive letters sent by psychiatrists to high-risk patients in the period after hospital discharge result in a reduction in suicide. Participant views on the usefulness of the intervention (supportive letters sent to discharged patients) collected via qualitative interview 2.5–11 months following the index discharge. Questions included: previous experiences of mental health care and contact with mental health services since discharge; usefulness of the intervention; and the format, frequency, duration, source and stopping of the letters. Statistical data on | | There was some misunderstanding and questioning over not being able to contact the ward, despite the letters coming from there. Participant accounts demonstrate that the letters add little to the experience of post-discharge support.<br>• **RQ5 Discharge**<br>**Self-harm**<br>For logistical reasons data on the rate of self-harm were only obtained for patients discharged from wards A and B; 12 (15.0% 95% CI: 6% to 21%) of the 80 patients receiving the intervention on those wards attended a local emergency department for treatment after a self-harm incident in the 12 months after discharge; 8 (10%, 95% CI 3% to 17%) of these were admitted to a general hospital bed. One person who had not attended the emergency department for self-harm, died by suicide. Two persons self-harmed within 2 weeks of discharge, a further 8 within the first 6 months of discharge and 2 during the 6 to 12 months after discharge. Most (72.7%) of these participants were still receiving the letters at the time of self-harm.<br>• Community mental health contacts<br>Policy developments within the trust providing mental health services required that local crisis services initiated face-to-face contact with at least 70% of patients discharged from inpatient psychiatric care within 48 hours of discharge and 6 such contacts within the first 2 weeks post-discharge. 11 of the 12 individuals, for whom data on | local circumstances and any changes in government policy.<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| readmission, contact with mental health services, etc. also collected.<br>**Source of funding**<br>• Government<br>National Institute for Health Research (NIHR)<br>**Country**<br>• UK | | community mental health service contacts was recorded, had at least 2 follow-up contacts in the first week post-discharge. There was a mean number of 12 contacts (either face to- face or by telephone) during the first month after discharge. This number of contacts varied over the year after discharge and was lowest around 4 months after-inpatient discharge.<br>• **RQ6 Reducing readmissions**<br>Total 33 (41.3%) of the 80 intervention patients discharged from wards A and B were readmitted to a psychiatric ward within 12 months of the index discharge. There was no clear evidence of a reduction in readmissions to the pilot wards (A and B) compared with other (non-pilot) wards (X, Y and Z).<br>For example, on the first hospital site (wards A, X, and Y) there was a 0.4% (95% CI 22%–17%) increase in readmissions in the intervention period for participating ward A whereas readmissions fell by 2.6% (95% CI 20%–15%) and 11.4% (95% CI 4%–28%) on the non-pilot wards.<br>There was no obvious decline in psychiatric readmissions – while 41% of participants discharged from the intervention wards A and B during the intervention period were readmitted within 12 months, nationally between 1 April 2004 and 31 March 2005, this figure was 24.7% (Gunnell et al. 2008). | |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Survey (use 7. CA)<br>**Study aim**<br>• Aim of the study: This paper explores the views of patients subject to supervised community treatment (SCT) within 2 mental health teams in Merseyside.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• 17 patients<br>**Sample characteristics**<br>• Sex<br>Of the 17 patients who took part in the survey 14 (82 per cent) were male and 3 (18 per cent) female.<br>• Disability<br>In total, 12 (70.6 per cent) subjects had a primary diagnosis of schizophrenia, 3 (17.6 per cent) with schizoaffective disorder, 1 (5.9 per cent) with delusional disorder and 1 (5.9 per cent) with a mental and behavioural disorder secondary to alcohol.<br>• Ethnicity<br>White British.<br>• Sample age ranged from early 20s to mid-60s<br>**Intervention**<br>• Supervised community treatment. The mean duration of SCT was 15.6 months (range 2 | **Findings – narrative**<br>**• RQ1 Service user views**<br>Generally, there was mixed satisfaction with SCT. Some patients were positive (41 per cent, n=7), others were indifferent (12 per cent, n=2) and a proportion saw this as damaging to their life (47 per cent, n= 8). Two patients who had been recalled to hospital conveyed strong dissatisfaction with SCT. A common theme identified was an overall restriction of a patient's liberty and anxiety that he or she would be detained if they did not adhere to the conditions of SCT. One patient said 'The CTO restricts my liberty. The police can come to my flat whenever they want. They own my life. I've got no liberty' (p162).<br>Patients with positive responses included 'I believe that if I did relapse the doctor would be able to give me medication. I feel like a better person, more normal again' (p162).<br>**• RQ5 Discharge**<br>In total, 76 per cent of patients (n=13) agreed that starting SCT enabled earlier discharge from an inpatient unit. But, only 35 per cent (n=6) agreed that they were involved in the decision to begin SCT and 29 per cent (n=5) agreed that they were involved in planning the conditions of the SCT, handing over key decisions to the responsible clinician, reflected in statements such as:<br>'I had no say in the CTO' (p160). | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on the population of interest?**<br>• Yes<br>**Is there a clear focus on the review questions?**<br>• Yes<br>**Are the questions relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | months to 25 months). | ‘it’s not what I think, it’s what the psychiatrist says’ (p160).<br>‘I just got told I was going on it. I had no say in it and if I wasn’t going on it I wasn’t leaving hospital’ (p160).<br>‘They make up their minds and the conditions and I’ve just got to abide by them. When you’re in hospital you just agree to anything, don’t you?’ (p160).<br>There was a common misunderstanding that the patient must firmly abide by CTO to remain in the community, and there was a lack of awareness that recall was dependent on the ‘harm criteria’ (as set out in ‘Section 17E (1) (a) (b) – namely the consideration of risk to the patient’s own health or safety, or the safety of others’). The author posits that ‘the effectiveness of CTO may be thought to be based on a perception that is fallacious’.<br>A significant proportion of patients lacked the motivation or ability to understand the verbal and written information affecting their legal rights at the time it was given, usually immediately prior to hospital discharge.<br>A regular theme -support or indifference to CTO if it did not impact significantly on the patient’s life:<br>‘I’m quite pleased with it. It doesn’t infringe upon me too much’ (p161).<br>‘I wish I wasn’t on it. But it’s not too bad’ (p161).<br>‘It makes you attend your appointments more but it could put people in hospital who don’t need to be in hospital.‘ | |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | (p162)<br>• **RQ6 Reducing readmissions**<br>See reducing readmission RQ6 below. | |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews that included open questions and prompts.<br>**Study aim**<br>• To find out the views of young adults on the treatment they had received for anorexia nervosa whilst admitted to a general adolescent psychiatric unit. It also aimed to elicit participants' views | **Participants**<br>• Adolescents with MH conditions<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• 7<br>Sample characteristics<br>• Sex: all female<br>• Ethnicity<br>White British.<br>• Sample age<br>16–23 years old.<br>**Intervention**<br>• Admission and discharge from general adolescent psychiatric unit | **Costs**<br>• No<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>Control and collaboration. Several participants reported that on admission an initial taking away of their control over eating was helpful and relieving: 'I felt I had to. And that kind of helped me because it was like, "It's not my decision, I'm not eating cos I want to be well, I'm not eating cos I deserve to eat, I'm eating cos they're telling me to", and that kind of lessened the guilt. Which is what I felt I needed' (Sophie) (p382). Failure to take a holistic approach that included the needs of other family members, and prioritising emotional or psychological needs were all seen to be unhelpful. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>The author acknowledges that 1 of the limitations is the retrospective nature of the study which means that it may allow less accurate reports of experiences.<br>**Relevance to the** |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
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| regarding their admission and discharge.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>Not explicitly stated, but participants are all British and researchers are from UK institutions and they describe UK context of general adolescent psychiatric units. | (for treatment for anorexia nervosa).<br>**Follow-up OR time of interview**<br>• Participants had been discharged 2–5 years prior to the study. | 'Creating individualised, empowering and collaborative approaches to care, which encourage connections with the outside world and positive relationships with fellow inpatients, may serve to minimise some of the otherwise negative effects of hospitalisation. The findings also suggest that it is important to provide adequate preparation prior to discharge, rather than abrupt discharge following achievement of target weight' (p.386). With hindsight, many participants agreed on the importance of receiving a relatively high level of support from services following discharge, even though they may not have wanted continued contact at the time.<br>• **RQ4 Admission (Findings reported at GC 4)**<br>• **RQ5 Discharge**<br>Removal from normality vs connecting with the outside world<br>The majority of participants experienced a pervasive sense of being removed from the outside world upon admission. This brought with it a sense that their development was temporarily suspended.<br>This caused problems in terms of their emotional wellbeing and sense of self, and posed a challenge to subsequent readjustment to the 'real world' following discharge.<br>Many participants felt that they were actively discouraged from engaging in real-world activities – even those not linked to exercise or their eating disorder. This added to the feeling that life moved on for their peers while theirs | **MH transitions guideline**<br>• Highly relevant |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | remained stagnant:<br>'… but I was very aware that they were getting on with their lives, erm, they were doing their "A'" levels, they were gonna be going off to university at the end of the year, and that was really hard for me cos I had fears of everybody going … and I'd never catch up … it meant that I sort of stayed stuck because I didn't have much incentive to sort of move-on. I thought, well "this is it now"' (Sarah; 1 admission lasting 6 months) (p379).<br>Creating an 'informal environment' and promoting normal life was regarded as important.<br>Several people felt that a 'normal' activity outside of the unit would have helped their transition following discharge and also served as an incentive to get well. Similarly, after discharge the key to successful readjustment for many involved having incentives such as a college course, new friends or a job which provided a motivation to stay well and distracted focus away from eating difficulties.<br>**Contrasts in structure and support**<br>Participants frequently commented that the contrast between high levels of structure and support in the unit and the lack of structure and support in the outside world, proved problematic. This often led to high levels of dependency and painful emotions on discharge.<br>Abrupt transitions were experienced as scary whilst those planned in a gradual and collaborative manner were | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | experienced more positively:<br>'everything, was slowly introduced, so we decided that in x amount of weeks I was going to leave and … it was sort of … slowly done, instead of saying, this weekend you're going home, next weekend you're going to school, week after you're gonna leave, it was done slowly' (Katie; 2 admissions, total length 15 months) (p380).<br>Several people reported that it would have been helpful to have received ongoing psychological/ emotional support from the practitioner they saw while in hospital. However others preferred support provided by local services, discharge marking a 'fresh start'.<br>It was important that the level of support reflected the individual's stage of recovery.<br>'For example, Katie viewed the support she received initially as too superficial and infrequent, commenting that this may have contributed to her relapse. When nearing complete recovery, having someone at a distance, although sometimes viewed as irritating, was regarded as necessary and helpful' (p380).<br>**Preparing for discharge – handing back control**<br>Participants often felt they had little control over their lives whilst in inpatient care and thus appropriate preparation for discharge was essential.<br>'Several participants talked about helpful unit practices that | |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | enabled them to gradually build up their level of control, such as being given more freedom, having more control over decisions, and preparing one's own meals. In the absence of such careful preparation, participants often described finding the sudden availability of freedom following discharge unmanageable' (p383). | |

| Owen-Smith A, Bennewith O, Donovan J, et al. (2014) 'When you're in the hospital, you're in a sort of bubble.' Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Study aim**<br>• 'To investigate the lived experience of psychiatric discharge and explore service users' experiences following discharge'.<br>**Source of funding**<br>• Government<br>**Country** | **Participants**<br>• Adults with MH conditions<br>**Sample size**<br>• 54 service users asked to participate in the research, of whom 12 agreed, although 2 later withdrew because of deteriorating health, so 10 in sample. Purposively selected sample of service users (n=10) with a range of primary diagnoses, who had recently been discharged from psychiatric hospital recruited from | **Outcomes 1 (qualitative)**<br>• What works well<br>• What can be improved<br>• Experiences described<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>See RQ5.<br>**• RQ5 Discharge**<br>1) Attitudes to discharge and the immediate post-discharge period<br>Most participants felt their period of hospitalisation had been of benefit. They consisted of 3 main groups with regard to their attitude to being discharged. Three (service | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• ++<br>Although the conclusions that can be drawn from this study are limited by the small number of participants, this is a good quality study. |

| Owen-Smith A, Bennewith O, Donovan J, et al. (2014) 'When you're in the hospital, you're in a sort of bubble.' Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| • UK | 5 acute wards of 2 psychiatric hospitals. Access to service users was facilitated by senior nurses, who sent or gave information to potential informants shortly before or after they were discharged.<br>**Sample characteristics**<br>• Sex<br>Male 2, female 8<br>• Ethnicity<br>White 9, other 1<br>• Sample age<br>Age (years)<br><21=1<br>21–40=3<br>41–60=6<br>• Level of need/diagnosis<br>All had recently been discharged from psychiatric hospital, and lengths of stay had varied from 5 days to 4 months. For 4 informants this had included detentions under the Mental Health Act (Department of Health 1983), although only 2 of them had been admitted involuntarily, and for half this had been their first admission to a | user SU1, SU6, SU9) seemed unequivocally happy to have been discharged, and a further 3 (SU3, SU4, SU8) were pleased to have been discharged despite some ongoing anxieties about fitness to be out of hospital. The remaining 4 individuals had been disappointed to be discharged, and had not felt involved in the discharge decision.<br>All 4 informants who had not wanted to be discharged said they had had urges to harm themselves since discharge (2 had done so), and 3 reported experiencing suicidal feelings during this period. One had felt bad enough to check that she could still get access to a particular means for suicide.<br>'I said I hadn't felt like suicide since I've been home, [but] I think there's been twice when I've been back to the Internet … and I have re-looked at that [tricyclic] drug … I think it's like a safety net in a sense … not really having the idea that I want to kill myself, but knowing that it's there and it's accessible if I want it' (SU6) (p156).<br>2) Post discharge stressors<br>For some, problems that had existed prior to admission and re-emeged on discharge, and difficulties that had been prompted or worsened by their inpatient stay.<br>• Re-emergence of pre-existing stressors<br>Nearly all participants highlighted the safety offered by being in hospital, and for many 1 of the main advantages of hospitalisation had been their removal from unbearably | **Relevance to the MH transitions guideline**<br>• Highly relevant |

| Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.’ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | psychiatric ward. A range of primary diagnoses were reported, including a high proportion of personality disorders, and all subjects reported suffering from anxiety and depression regardless of whether this was recorded as their primary diagnosis. Seven reported a history of self-harm.<br>**Intervention**<br>• Psychiatric discharge | stressful situations. However, on discharge informants were often again exposed to these situations, and recurring problems included social isolation, financial difficulties, challenging familial relationships, childcare responsibilities, and dealing with everyday household responsibilities.<br>‘You’re quite mothered in hospital … you are literally just taken out of your environment, and quite sheltered. … [on discharge] you’re back in the real world, and having to deal with the real world again’ (SU4) (p156).<br>• Stressors prompted or exacerbated by inpatient stays<br>Participants talked about a number of difficulties that had arisen as a result of, or had been made worse by, their stays in psychiatric hospital. Ironically, the provision of constant availability of support and reassurance while in hospital often contributed to feelings of vulnerability following discharge, principally for those who lived alone.<br>‘It [the discharge] was hard to start off with … going through having someone I can talk to at any time to not having anybody … it is a shock to the system to suddenly have nobody around’ (SU9) (p157).<br>Participants also spoke about coming to terms with the change in their health status following their stay in hospital, and for some (particularly those for whom this had been their first inpatient stay) this seemed to have resulted in a change to their sense of personal identity. This was exacerbated by concerns over the social stigma attached to | |

Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.’ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| | | having been a psychiatric inpatient, and some were worried they would face discrimination on discharge.<br>Additionally, inpatient stays sometimes disrupted existing family relationships and social networks, making readjustment to home life more difficult.<br>‘[Coming home] felt weird … the kids are distant now, they’re not as loving’ (SU5) (p157).<br>Unmet expectations of care were also a key stressor for some following discharge.<br>‘Every hospital admission I’ve had … things have been promised in care plan meetings … and things never materialize. … It pisses me off, and I start getting really depressed again’ (SU10) (p157).<br>3) Factors affecting the impact of stressors<br>All participants identified helpful factors that had offset the impact of difficulties they had faced since discharge, including preparation for discharge while they were inpatients and support from within the non-statutory and statutory sectors following their return home.<br>• Preparation for discharge<br>Seven participants had had periods of home leave prior to discharge, and most had found this useful. However, 3 had found periods of leave unhelpful due to the continuous periods of readjustment. | |

<table>
<tr><td colspan="4">Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.’ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Overall quality assessment</th></tr>
<tr><td></td><td></td><td>Despite the commonality of the stressors faced following discharge, participants did not recall any efforts made by staff to prepare them for the psychological impact of being discharged.<br>• Support within the non-statutory sector<br>Familial support was identified by many as an important factor in helping them adjust to life outside of hospital, and many saw living alone as a risk factor for vulnerability after discharge.<br>‘Some days I just want to stay in bed all morning … if I was on my own … with no one to motivate me – that would sink [me] into a deep depression’ (SU1) (p157).<br>Wider networks of social support were generally of less significance, although ongoing relationships with other service users, were very important in helping manage their continuing symptoms of mental distress for some.<br>Half of the informants had accessed voluntary sector agencies for practical or emotional support.<br>• Support within the statutory sector<br>Most had no ongoing contact with the ward nursing team apart from a post discharge telephone call, which is now part of recommended post discharge care throughout England (National Confidential Inquiry 2006). There were mixed views about this lack of contact, with some feeling excluded by the sudden cessation of support, and others having no desire to maintain any ongoing links with ward</td><td></td></tr>
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Owen-Smith A, Bennewith O, Donovan J, et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.’ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| | | staff.<br>• Community mental health care<br>The most important source of post-discharge support within the statutory sector was community mental health services, and all had some links into this form of support, especially that provided by community psychiatric nurses (CPNs) or specialist social workers. Important aspects of the care provided included the regular contact with 1 professional, the flexibility to meet them at home, and attention to both clinical and social needs.<br>Some also received short daily visits from members of crisis teams immediately after discharge, but these were generally viewed as lacking clarity of purpose, which limited their usefulness. Additionally, 9 informants recollected being provided with a 24-hr crisis contact plan, which was generally felt to be reassuring, but there were concerns about the reliability of the service.<br>‘I had home intervention coming in to start off with, but they’d only stay, like, about 5, 10 min. So it seemed a bit pointless them coming round’ (SU9) (p158). | |

Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| **Methodology**<br>• Survey<br>The main study collected data from key players in the discharge process – including local authorities, health boards, hospital staff, community-based staff and patients. The study took place between April 1998 and December 1999. This paper draws only on the data relating to patients and community-based staff collected using the CAN between November 1998 and September 1999.<br>**Study aim**<br>• 'The aim of this paper is to report on the needs of patients discharged from acute psychiatric wards as assessed by the Camberwell Assessment of Need (CAN)'. The needs and unmet needs as assessed by both patients and mental health community staff on | **Participants**<br>• Adolescents with MH conditions<br>16–24 age group included with older age groups.<br>• Adults with MH conditions<br>Age range from 16 up.<br>• Professionals/practitioners<br>98 community staff identified as providing key support to 98 of the patient sample.<br>**Sample size**<br>• The sample consisted of 173 patients recently discharged from acute psychiatric units in 8 health board areas of Scotland and 98 community staff identified as providing key support to 98 of the patient sample.<br>Sample characteristics<br>• Sex<br>Gender % no<br>Male 43 75<br>Female 57 98<br>• Sample age<br>Age<br>Less than 25 years 8% n=14 25–44 years 56% n=96<br>45 years and older 36% n= 63<br>• Level of need/diagnosis | **Outcomes (quant)**<br>• Quality of life<br>• Social care outcome<br>• 22 CAN domains including accommodation, food, psychotic symptoms, psychological distress, physical health, transport, benefits and budgeting<br>Costs<br>• No<br>**Findings – narrative**<br>**• RQ1 Service user views**<br>**• RQ3 Practitioners' views**<br>**• RQ5 Discharge**<br>The mean number of needs identified by discharged patients was 5.8 (range 0–17). The mean number of unmet needs was 2.5 (range 0–11). Comparing the average levels of need and unmet need for the sample on key characteristics there were few differences. No significant differences were found with regard to gender, age, length of stay or admission number. However, a significant difference was found for diagnostic group: those patients with a diagnosis of a non-psychotic illness (n=112) reported higher levels of need than those patients with a diagnosis of a psychotic illness (n=61). This is true for both total need and unmet need.<br>• Patient-rated help received at 6 weeks post-discharge<br>Patients were in receipt of assistance in all need domains (Table 4). Only 3 patients who identified needs were without any help from formal or informal sources.<br>The importance of informal help to the group of patients is | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is there a clear focus on the review question(s)?**<br>• Yes<br>This study was published in 2002 and based on 1999 data. So though CAN still being relevant, this study should be considered in the wider realm of more recent policy changes.<br>**Are the questions relevant?**<br>• Yes<br>The CAN seeks to identify needs rather than provide a |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| the Camberwell Assessment of Need (CAN) are presented. By assessing needs of patients soon after discharge the authors aim to identify the key areas of need at this critical time. This will help assess how effective discharge policy and procedures have been in identifying and addressing patients' needs.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK | % No<br>Schizophrenia, including psychosis<br>9 33<br>Schizoaffective disorder<br>3 5<br>Bipolar disorder<br>13 22<br>Depressive disorder<br>44 76<br>Other<br>6 11<br>Personality disorder<br>11 19<br>Substance misuse<br>2 3<br>Unspecified disorder<br>2 4<br>Intervention<br>• Camberwell Assessment of Need (CAN). The CAN was developed by a group of psychiatrists and researchers at the Institute of Psychiatry (PRiSM). Mental health | shown in Table 4. Only 16 patients who identified needs were without any informal help. In the majority of domains, well over half the patients who identified a need were receiving some level of help from relatives or friends.<br>In the sample, only 15 patients were without any service support at 6 weeks after discharge. Table 1 shows the types of support received, with the majority having some outpatient contact and 60% of the sample having contact with a community psychiatric nurse. Of the patients with community support, one-quarter (40 patients) had contact with 1 service after discharge, while the majority (118) had contact with 2 or more services.<br>The satisfaction levels patients reported with the help they were receiving as recorded in each of the domain areas is shown in Table 4. On the whole there was a relatively high level of satisfaction with the help received, both formal and informal. Areas where the opposite is shown were information and benefits. Only 25% of patients were satisfied with the type of help and 26% satisfied with the amount of help with regard to information.<br>The needs of the population discharged from acute psychiatric units are perhaps more complex than first thought, with the non-psychotic group reporting a higher number of needs and a higher level of unmet need. It could be argued that patients overestimated their levels of need when involved in the assessments.<br>The needs assessment reported here shows that patient | detailed description and the views of both service users and staff is critical. CAN assesses need in 22 domains of daily living (including, accommodation, food, looking after the home, self-care, physical health, psychotic symptoms, psychological distress and safety of others).<br>**Overall assessment of external validity**<br>• + |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | experts and service users were consulted during the development of the instrument. It has been shown to be a reliable and valid assessment, with independent ratings from both service users and staff (Phelan et al .1995). | perceptions of need post-discharge are higher amongst those usually deemed as less severely ill. This is a time of vulnerability, indicating a need for service support in the initial period after discharge. More importantly, the staff ratings show that, even when non-psychotic patients have service support, the services appear less able to meet their needs than for patients with a diagnosis of psychotic illness.<br>The types of need repeatedly identified by the patients in the study have aspects in common with other studies. Need areas that stand out in this and other studies are psychological distress and psychotic symptoms; daytime activities and company; food and transport; budgeting and benefits. This important finding can help to highlight areas where services are failing to address needs, not only at discharge but at other points of contact with health services. These needs are being identified by mental health services users in a wide range of settings, inpatients, outpatients, day patients and those with a wide range of characteristics and illnesses. These findings are supported by the views of the community-based staff in this study, who identified a similar pattern of common needs in the sample.<br>Level of need identified by patients in each domain area of the CAN – all types of need – basic, health, social and services – were represented in the most commonly | |

Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| | | identified needs. The rank order of the first 5 most commonly identified needs was psychological distress (n=102), daytime activity (n=98), company (n=73), information about condition and treatment (n=71), and being able to obtain and prepare food (n=68). Psychotic symptoms were reported less often (n=64), as would be expected with the proportionally fewer patients with psychotic diagnoses in the sample, and accurately reflects the sample composition with regard to diagnostic group.<br>No areas of unmet need were reported by 27% of users. The most commonly identified unmet needs followed a similar pattern to total need: psychological distress (n=48), company (n=48), daytime activities (n=45) and information (n=36) were the 4 most commonly reported unmet needs. The fifth most common unmet need was benefits (n=33) which reflects the high level of unemployment found in the sample. Examining the proportion of total needs which were unmet for each domain, again a variety of types of need are represented:<br>• Benefits had the highest proportion of unmet need, with only 17% of those users who identified benefits as a need reported the need as being met due to the help given.<br>• Childcare had a high proportion of unmet need, with 70% of total need being reported as unmet.<br>• 66% of the sample who reported company as a need felt it to be unmet. | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | • Budgeting 57% of the sample reporting their need as unmet.<br>• 56% per cent reported their transport needs as unmet.<br>• Staff-rated needs at 6 weeks post-discharge<br>The mean number of total needs identified by staff was 5.6 (range 0–12). The mean number of unmet needs was 2.9 (range 0–9). Staff and patient average scores for total and unmet need did not differ significantly. No difference was found with regard to diagnostic group for mean total need; however, staff rated nonpsychotic patients as having higher unmet needs than the psychotic group.<br>Staff rated needs in all domain areas and, similarly to patients, the most commonly identified needs encompassed the range of types of need. The top 5 ranked needs were: daytime activities (n=67), psychological distress (n=59), company (n=57), psychotic symptoms (n=37) and obtaining and preparing food (n=36). Information about condition and treatment was just out of the top 5 (n = 29). Staff-rated unmet needs again had some common areas with total needs: company (n=31), psychological distress (n=30) and daytime activities (n=30). However, childcare (n=15) and safety for self (n=12) featured more commonly in staff ratings of unmet need.<br>Staff perceptions about which needs were met differed from the patients perceptions. In no domain did staff rate all the need as met: | |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | • Staff rated 97% of need for information about condition and treatment as met, as opposed to half of patients believing their need to be unmet.<br>• High levels of unmet need were shown in education, sexual expression and drugs, although overall low levels of needs were identified. | |

## Critical appraisal tables

## Tables reporting impact studies

## Review Question 6: What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | | |
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| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate the impact of acceptance and commitment therapy, delivered in 4 sessions pre-discharge, on rehospitalisation of patients with psychotic symptoms.<br>**Country**<br>• US<br>Single Nevada hospital.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Unclear<br>Unclear how this was done.<br>**Adequate concealment of allocation?**<br>• Unclear.<br>Inpatient staff and outpatient staff except case managers were said to be blind, and case managers were said to be blind to condition, but patients were | **Were all groups followed up for an equal length of time?**<br>• Yes. But not all were included in different measures, e.g. the analysis based on previous hospital admissions (compared to those during the 4-month follow-up period). Not all records were available.<br>**Dropout numbers**<br>• Intervention dropouts: 40 (less 5 excluded, see 2012 paper). However, p1132 suggests rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>• Comparison dropouts: 40 (less 5 excluded, see 2012 paper). However, p1132 suggests | **Did the study have an appropriate length to follow-up?**<br>• Unclear<br>Four months is a relatively short time to ascertain rate of re-admissions.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear. There were reported discrepancies in available data, but the authors did attempt to validate the findings by ‘objective’ records (e.g. readmissions, medication compliance).<br>**Were investigators kept ‘blind’ to participants’ exposure to the intervention?**<br>• Unclear<br>**Were investigators kept ‘blind’ to other important confounding factors?**<br>• Unclear | Those asked to take part were already taking part in psychoeducational sessions, which may distinguish them from the total patient population. Small sample sizes. There are minor discrepancies in numbers (dropouts, those with no prior local hospitalisation, those without records) - because the sample sizes are small, this may be a problem. Both groups had packages of services – before and after discharge – as TAU which could include individual psychotherapy, group rehabilitation, psychoeducation and assertive outreach services. Any 1 or combination of these might be responsible for | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes. Except that a wide range of psychological treatments appear to be available.<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | | |
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| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| likely to have known (during hospital episode).<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>Was selection bias present?<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes. But this is a potentially complex package of care interventions and case management which may themselves be responsible for the outcomes.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• Yes. It is said that only case managers knew the person was in a | rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>**Groups comparable on intervention completion?**<br>• Yes<br>Missing outcome data<br>• Intervention: 40 (less 5 excluded, see 2012 paper). However, p1132 suggests rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>• Comparison: 40 (less 5 excluded, see 2012 paper). However, p1132 suggests rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>**Groups comparable on available data?**<br>• Yes | There was potential for a number of factors to influence findings.<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Yes. Fairly cautious, i.e. recognising the limitations of the sample size. | the impact on rehospitalisation. | |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| trial, and not their 'condition'.<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias effect**<br>• Unclear | **Attrition bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | | | |

| Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial. Psychiatric Rehabilitation Journal 25: 28–34 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>OCTET is a non-blinded, parallel arm RCT.<br>**Study aim**<br>• To test the hypothesis that patients with a diagnosis of psychosis who are discharged from hospital on community treatment orders (CTOs) will have a lower rate of readmission than those discharged on Section 17 leave. | **Were all groups followed up for an equal length of time?**<br>• Yes<br>Both groups followed up at 12 months.<br>**Dropout numbers**<br>• Intervention dropouts: 1 withdrew on day 1, 41 not interviewed at 12 months (17 refused, | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>Hospital records used to | The number of protocol violations was high (42 violations in the CTO group and 46 in the section 17 group). This was because the trial was only lawful if each clinical decision after study randomisation was taken without reference to randomisation. Secondly, the setting up | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes |

Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial. Psychiatric Rehabilitation Journal 25: 28–34

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Country**<br>• UK<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>Random permuted blocks with lengths of 2, 4 and 6 and stratified for sex, schizophrenic diagnosis and duration of illness.<br>**Adequate concealment of allocation?**<br>• Yes. Assignments stored in opaque sealed envelopes by an independent researcher to the trial team.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Was selection bias present?**<br>• Low risk of bias<br>Did the comparison groups receive the same care and support apart from the | 10 did not attend, 8 not contactable, 2 inadequate English, 1 team refusal, 3 deceased)<br>42 in total.<br>• Comparison dropouts: 2 excluded on day 1 (1 already on a CTO, 1 on a section 17 too long), 51 not interviewed at 12 months (26 refused, 8 did not attend, 12 not contactable, 2 inadequate English, 2 deceased, 1 other reasons)<br>54 in total.<br>**Groups comparable on intervention completion?**<br>• Unclear. There were 11 more drop outs in the Section 17 group. 26 refused in Section 17 group (compared with 17 who refused in | determine readmission rates and length of time to readmission. Validated scales used for measuring social and clinical functioning.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• N/A<br>This would not have been possible (or legal).<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>Unlikely as measures are objective.<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Yes | of CTOs at recruitment to that arm can take days or weeks.<br>Thirdly, almost all the trusts were reorganising during the study, and patient care could be passed by a psychiatrist unfamiliar with the trial. (A sensitivity analysis to take account of these violations did not alter the findings.) | **Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• ++ |

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| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| intervention/s studied?<br>• Unclear. Treatment in the community very difficult to monitor. In terms of receiving CTO or Section 17 as assigned by the trial the authors reveal there were 42 violations of the protocol in the CTO group and 46 in the Section 17 group. These violations came about due to the legalities of the trial. Clinicians could not be encouraged to continue with initial randomised assignment if they did not deem it appropriate. Also finalisation of CTO could take days/weeks after the point of randomisation for the trial.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Low risk of bias<br>**Likely direction of performance bias effect** | CTO group).<br>**Missing outcome data**<br>• Intervention missing outcome data<br>As hospital records used no missing data on primary outcome (readmission).<br>• Comparison missing outcome data<br>**Groups comparable on available data?**<br>• Yes<br>Intention to treat analysis used.<br>**Attrition bias appraisal**<br>• Low risk of bias | | | |

| Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial. Psychiatric Rehabilitation Journal 25: 28–34 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Unclear | | | | |

| Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34 | | | | |
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| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To demonstrate the potential of a brief intensive transitional acute intervention for reducing admissions and the costs of admissions, delivered to people already admitted, or presenting to the ER and having been assessed and agreed as needing admission.<br>**Country**<br>• US | **Were all groups followed up for an equal length of time?**<br>• Yes<br>Collected at different timepoints, not all of which are reported.<br>**Dropout numbers**<br>• Intervention dropouts: 'Regional hospitalization data was available for 100% of participants. | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>Although not stated in paper (!) 1 year for readmissions seems reasonable<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?** | There were differences in the population entered into the study and the possible 244 consecutive admissions who might have taken part – e.g. 30 individuals who had more problematic conditions not approached at request of CMH team. These patients differed from participants in the study, 'with 55% longer | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>Unclear if the rural, poor area, the ER service and the participants are similar to those seen in England.<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention** |

| Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| Rural area with high levels of poverty.<br>**Appropriate randomisation?**<br>• Unclear<br>Unclear how done, but it was done after people were admitted or agreed following ER assessment to be eligible for admission.<br>**Adequate concealment of allocation?**<br>• Yes<br>All assessors were blind to allocation, as was the patient at baseline assessment.<br>**Comparable groups at baseline?**<br>• Unclear. Although it is said there were no significant differences, characteristics not given. Authors do say that there were differences in the population entered into the study and the possible 244 consecutive admissions who might have taken part – e.g. 30 individuals not approached at request of CMH who had more problematic conditions.<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?** | Attrition rates for other clinical data were higher than expected, despite various counter measures. Complete data was collected for 138 (76%) of participants evaluated at 2-week follow-up, 96 (53%) located at 6-months and 71 (39%) at 1-year follow-up. Attrition rates were similar across groups—about 10% higher for controls at 2 weeks and 6 months, but higher for the experimental group at 1 year follow-up' (p31).<br>• Comparison drop-outs<br>'Regional hospitalization data was available for 100% of participants. Attrition rates for other clinical data were | • Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of detection bias effect**<br>• Unclear<br>**Do conclusions match findings?**<br>• Yes | initial hospital stays' (p32).<br>Comparison of an intervention with routine care (which may itself be very variable) is not ideal, but failing to offer care would be unethical.<br>Main impact on costs concerns people diverted from admission (which is not absolutely relevant to our RQ). | **clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>There were differences in the population entered into the study and the possible 244 consecutive admissions who might have taken part – e.g. 30 individuals not approached at request of CMH who had more problematic conditions. |

<table>
<tr><td colspan="5">Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34</td></tr>
<tr><th>Study design/theoretical approach</th><th>Data collection</th><th>Analysis & reporting</th><th>Limitations</th><th>Quality assessment</th></tr>
<tr><td>• Unclear/unknown risk. The authors do comment that refusers, and in particular the 30 that CMH advised not to recruit, might have higher levels of pathology so the eventual sample may not represent the general population admitted.<br>**Direction of bias effect**<br>• Unclear<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept ‘blind’ to how the intervention/s were allocated?**<br>• Unclear<br>Unclear if they would have known what was usual care, esp. as some had no prior admissions.<br>**Were individuals who administered the care and support kept ‘blind’ to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias**</td><td>higher than expected, despite various counter measures. Complete data was collected for 138 (76%) of participants evaluated at 2-week follow-up, 96 (53%) located at 6 months and 71 (39%) at 1-year follow-up. Attrition rates were similar across groups—about 10% higher for controls at 2 weeks and 6 months, but higher for the experimental group at 1 year follow-up’ (p31).<br>**Groups comparable on intervention completion?**<br>• No<br>**Missing outcome data**<br>• Intervention missing outcome data, see above</td><td></td><td></td><td></td></tr>
</table>

Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **effect**<br>• Unclear | • Compar. missing outcome data, see above<br>Groups comparable on available data?<br>• Unclear<br>Attrition bias appraisal<br>• Unclear/unknown risk of bias<br>Likely direction of attrition bias effect<br>• Unclear | | | |

Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: Randomised clinical trial. The British Journal of Psychiatry 202: 212–9

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Mixed | **Follow-up. Were all groups followed up for an equal length of time?**<br>• Yes. Participants were followed to the first event, a readmission to hospital, or to the date | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to** | The patients in the control group received very different interventions – community psychiatric centres, private specialists in psychiatry or a local psychiatrist. Data is not available on | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes |

Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: Randomised clinical trial. The British Journal of Psychiatry 202: 212–9

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Study aim**<br>• To investigate whether treatment in a specialised mood disorder clinic (pharmacological treatment + group psychoeducation) early in the course of illness among patients discharged from their first, second or third admission to hospital for bipolar disorder reduces hospital readmissions and rates of relapse compared with standard psychiatric outpatient treatment.<br>**Country**<br>• Denmark<br>Seven out of the 9 psychiatric wards in the Capital Region of Denmark.<br>**Appropriate randomisation?**<br>• Yes. Computer generated allocation/ block randomisation sequence stratified for psychiatric centre and previous number of admissions.<br>**Adequate concealment of allocation?**<br>• Yes<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal** | of death or emigration or to the end of the study on 31 December 2011, whichever came first. The follow up period ranged from 0 to 6 years with an average length of 2.5 years.<br>**Dropout numbers**<br>• Intervention dropouts: 4<br>One died and 3 emigrated.<br>• Comparison drop-outs: 0<br>**Groups comparable on intervention** completion?<br>• Unclear<br>No more information given on the 4 people who dropped out of the intervention group.<br>**Missing outcome data**<br>• Intervention missing outcome data | **determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes<br>Primary outcome (readmissions) was based on public register data using masking for the intervention. All other outcomes were assessed without masking to the intervention.<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>Detection bias appraisal<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Partly. Only readmission rates and cost outcomes are presented in tables. Other outcomes are presented in narrative form so it is not possible to check for alignment | the frequency of outpatient visits for this group. | **Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: Randomised clinical trial. The British Journal of Psychiatry 202: 212–9 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Low risk of bias<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>Patients in the standard care group were treated at the local community mental health centre (n=49, 56.5%), by a private psychiatrist (n=21, 24.7%), by a local psychiatrist associated with the discharging ward (n=33, 15.3%) or by the GP (n=3, 3.5%).<br>**Allocation – participants. Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Allocation – practitioners. Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias | No missing data on primary outcome (redamissions). 57 (79.2%) of the 72 patients completed and returned the mailed questionnaire 1 or 2 years after discharge from the index hospital admission.<br>• Comparison missing outcome data<br>No missing data on primary outcome (redamissions); 46 (53.5%) of the 86 patients in standard care completed and returned the mailed questionnaire 1 or 2 years after discharge from the index hospital admission.<br>**Groups comparable on available data?**<br>• Yes<br>Intention to treat | of reporting. | | |

Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: Randomised clinical trial. The British Journal of Psychiatry 202: 212–9

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
|  | analysis used.<br>**Attrition bias appraisal**<br>• Unclear/unknown risk of bias<br>No more information given on the dropouts. |  |  |  |

Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate an individualised psychoeducational programme together with crisis cards and 24 month preventive monitoring for adults who have been admitted as compulsory patients during the past 24 months. This paper reports on main outcome of reducing admissions – including compulsory ones – and time | **Follow-up. Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts:<br>at 12 months, 67% (80 of 118) patients remained in study.<br>• Comparison dropouts | **Did the study have an appropriate length to follow-up?**<br>• No. But this is an interim report on 'halfway' findings<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?** | This was an open trial, with no blinding. Recruitment did not proceed as planned, with fewer consenting than expected, and the planned sample size of 400 was not possible. Gains made at 12 months may also under- or overestimate longer term gains (study | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?** |

| Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| spent in hospital at 12 months (interim findings). Importantly, the programme starts at the interface of in- and outpatient care (discharge).<br>**Country**<br>• Switzerland<br>**Appropriate randomisation?**<br>• Unclear<br>Method not given. Recruitment from 4 psychiatric hospitals.<br>**Adequate concealment of allocation?**<br>• No<br>Nature of the intervention did not permit blinding – this is an open trial.<br>**Comparable groups at baseline?**<br>• Unclear. The major difference identified is that CG/TAU group had a higher rate of schizophrenia patients than did the intervention group, which had a higher number of patients with neurotic and stress-related disorders.<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>Not clear that there were not systematic differences in those consenting to take part, and those not, | at 12 months: 85.7 of TAU CG (102 of 118) remained in study.<br>**Groups comparable on intervention completion?**<br>• No. Higher drop-out rate at 12 months in intervention group.<br>Missing outcome data<br>• Intervention<br>Data on main outcomes was from inpatient records: available for all 67% remaining in study.<br>• Comparison<br>Data on main outcomes was from inpatient records: available for all 86% remaining in study.<br>**Groups comparable on available data?**<br>• Unclear<br>**Attrition bias appraisal**<br>• Unclear/unknown risk | • Yes<br>Hospital records.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• No<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of detection** bias effect<br>• Unclear<br>**Do conclusions match findings?**<br>• Partly. Though not shown to be harmful, the intervention's efficacy may be overstated. | planned to run for 24 months). Analysis was of those remaining in treatment at 12 months. Results for those dropping out of treatment may be far less positive than for those remaining in treatment. | • Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| as 756 inpatients were approached to take part (and 238 agreed).<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias** effect<br>• Unclear | of bias<br>**Likely direction of attrition bias effec**t<br>• Unclear<br>It is possible, for example, that the higher drop-out rate in IG represented unwillingness to proceed with treatment (and this is a feasibility study). | | | |

| Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–19 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate whether use of advance directives by patients with mental illness reduces rates of compulsory readmission to hospital.<br>**Country**<br>• UK<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>Block randomisation, sealed envelopes.<br>**Adequate concealment of allocation?**<br>• Yes<br>**Comparable groups at baseline?**<br>• Yes<br>Only difference was that intervention group has spent less time in hospital during the index admission than the | **Were both groups followed up for an equal amount of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts 20 lost to follow up<br>• Comparison dropouts 22 lost to follow up<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Groups comparable on available data?**<br>• Yes. Where there were missing data a sensitivity analysis was conducted using the last observation carried forward.<br>**Attrition bias appraisal**<br>• Low risk of bias | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>Hospital records for readmission data and validated scales for secondary outcomes.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Partly | The authors describe 'advance directive' as a 'preference statement' which was not 'intended to address compulsory admission directly' and was not legally binding. This does not fit with other definitions such as that given by the British Medical Association's Code of Practice, Advance Statements About Medical Treatment: advance directives (refusal) – 'Competent, informed adults have an established legal right to refuse medical procedures in advance.' The use of 'directive' emphasises the legally binding refusal of specific medical treatment or procedure, which is as valid as a decision made at the time treatment options | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Unclear<br>**Are the outcomes relevant?**<br>• Unclear<br>See above.<br>**External validity**<br>• - |

| Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–19 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| control group. grouped median (min, max), intervention=94 (13,545), control =123 (13, 1546)<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes.<br>All patients receive standard community psychiatric care (coordinated care programme provided by multi-disciplinary community psychiatric team).<br>**Allocation – participants. Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Allocation – practitioners. Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias | | | are being considered. Arguably the intervention was not substantially different from what should be expected within good standard mental healthcare to have a marked effect. | |

Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>Prospective, randomised, multicentre study.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Mixed. The whole range of outcome measures are not reported in this paper. Families emotion status, satisfaction with treatment and other subjective measure are only available in German. The main outcomes reported here relate to RQ6, reducing readmissions. Primary outcomes are hospital readmission, number of readmission, days in hospital and medication compliance (which is out of scope).<br>**Study aim**<br>• Psychoeducation Information Project (PIP) study was set up to examine the | **Follow-up – were all groups followed up for an equal length of time?**<br>• Yes<br>Data was collected at the same time across both groups.<br>**Dropout numbers**<br>• Intervention drop-outs: 23% drop out rate<br>• Comparison drop-outs: 20% drop out rate<br>**Groups comparable on intervention completion?**<br>• Yes<br>Dropout patients did not differ from study completers in regard to sociodemographic or illness related variables. | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>Seven-year outcomes for TUM subsection reported in linked paper: Bäuml et al. (2007) Psychoeducation in schizophrenia: 7-year follow-up concerning rehospitalisation and days in hospital in the Munich Psychosis Information Project Study. The Journal Of Clinical Psychiatry 68(6): 8561.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear<br>No information given on method used to capture outcome data.<br>**Were investigators kept** | As the intervention was aimed at both people being discharged from psychiatric hospital and their carers it isn't possible to isolate the effect of the intervention to either group (carer or patient) which received it.<br>Other subjective measures (emotion status, satisfaction with treatment etc.) are available in a German language paper. The author has been contacted but as far as we can ascertain these results are not available in English. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Unclear<br>Only looks at carers of people with schizophrenia.<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| long-term outcomes and benefits of psychoeducation; the study describes the effects of psychoeducational groups (intervention) in comparison with routine care (control group) on compliance and rehospitalisation rates.<br>**Country**<br>• 3 German psychiatric hospitals<br>**Appropriate randomisation?**<br>• Yes<br>Eight to 12 patients from each study centre were block randomised to either group.<br>**Adequate concealment of allocation?**<br>• Yes<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Was selection bias present?**<br>• Low risk of bias<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Yes<br>**Were the participants receiving care** | **Missing outcome data**<br>• Compar. missing outcome data: Missing data on medication compliance reported for 3 members of control group. (However we're not reporting on this.)<br>Groups comparable on available data?<br>• Yes<br>**Attrition bias appraisal**<br>• Unclear/unknown risk of bias | **'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match findings?**<br>• Yes | | |

Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **and support kept 'blind' to how the intervention/s were allocated**?<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• Yes<br>**Performance bias appraisal**<br>• Low risk of bias | | | | |

Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To examine the feasibility and effectiveness of using peer support (recovery mentors) to reduce recurrent psychiatric hospitalisations.<br>**Country**<br>• Not UK<br>**Is the study clear in what it seeks to do?** | **Were both groups followed up for an equal amount of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts 8<br>• Comparison dropouts 7<br>**Groups comparable on intervention** | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes | Issues around intervention delivery. Around one-third (34%) of the members of the intervention group did not have any contact with their peer mentor during the study period. The authors do not relay any more information other than 'reliable information about | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to** |

| Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Clear<br>**Relevance to our RQ(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>Sealed envelopes and computer generated schemes.<br>**Adequate concealment of allocation?**<br>• Yes<br>Staff involved with the procedure were not directly linked to the study.<br>**Comparable groups at baseline?**<br>• Yes. Apart from a difference of statistical significance in 1 category: Marital status Intervention: n=8 (21%) were married. Control: n=1 (3%) were married (p<.02).<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>13 of the 38 patients (34%) who were assigned a peer mentor had no | **completion?**<br>• Yes<br>**Missing outcome data**<br>• Hospitalisation data available for all 74 patients<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal**<br>• Low risk of bias | **Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• N/A<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Low risk of bias<br>**Do conclusions match findings?**<br>• Yes | contacts was obtained from 55% of the patients in the peer mentor group. Over 9 months, frequency of contact ranged from one to 39 visits (mean±SD contacts=13.43±11.46)' (p543). | **RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| contact with their mentor during the study period. Total hours of contact with the peer mentor ranged from 2 to 61 hours (mean 24.15 ±17.41).<br>**Allocation – participants. Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Allocation – practitioners. Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias | | | | |

Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services 52: 330–6

| Study design/theoretical approach | Data collection | Analysis & reporting | Limitations | Quality assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim** | **Were all groups followed up for an equal length of time?** | **Did the study have an appropriate length to follow-up?** | Limited generalisability of other outpatient commitment programmes because | **Internal validity**<br>• +<br>**Is the setting similar to** |

| Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services 52: 330–6 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • To evaluate the effectiveness of a 3-year outpatient commitment pilot program established in 1994 at Bellevue Hospital in NYC.<br>**Country**<br>• US, New York<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>**Adequate concealment of allocation?**<br>• Unclear<br>**Comparable groups at baseline?**<br>• Yes<br>Only significant difference was that subjects in the control group were more likely to have been homeless at the time of their index hospitalisation (33% vs 10%).<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Did the comparison groups receive** | • Yes<br>**Dropout numbers**<br>• Intervention dropouts<br>For both groups: at 1 month 7% (n=10) At 5 months 7% (n=10) At 11 months 14% (n=17)<br>• Comparison dropouts<br>For both groups: At 1 month 7% (n=10) At 5 months 7% (n=10) At 11 months 14% (n=17)<br>**Groups comparable on intervention completion?**<br>• Unclear<br>Missing outcome data<br>• Intervention missing outcome data<br>Too impaired to participate in interview 1 month: 9% (n=12) 5 months: 7% (n=10) 11 months: 11% (n=13) Moved out of the NY area 1 month: 2% (n=3) 5 months: 9% | • Yes<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept ‘blind’ to participants’ exposure to the intervention?**<br>• Unclear<br>**Were investigators kept ‘blind’ to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match findings**?<br>• Partly<br>Not all effect sizes given. | people with a history of violence were not included in the population of study. | **the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

<table>
<tr><td colspan="5">Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services 52: 330–6</td></tr>
<tr><th>Study design/theoretical approach</th><th>Data collection</th><th>Analysis & reporting</th><th>Limitations</th><th>Quality assessment</th></tr>
<tr><td><b>the same care and support apart from the intervention/s studied?</b><br>• Yes<br><b>Were the participants receiving care and support kept ‘blind’ to how the intervention/s were allocated?</b><br>• No<br><b>Were individuals who administered the care and support kept ‘blind’ to the intervention allocation?</b><br>• No<br><b>Performance bias appraisal</b><br>• Unclear/unknown risk of bias</td><td>(n=12) 11 months: 10% (n=12)<br><b>Groups comparable on available data?</b><br>• Yes<br>Logistic regression analysis carried out.<br><b>Attrition bias appraisal</b><br>• Unclear/unknown risk of bias</td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="5">Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75</td></tr>
<tr><th>Study design/theoretical approach</th><th>Data collection</th><th>Analysis & reporting</th><th>Limitations</th><th>Quality assessment</th></tr>
<tr><td><b>Methodology</b><br>• RCT<br><b>Is the study clear in what it seeks to do?</b><br>• Mixed<br>It departs from the original RQ and 2</td><td><b>Were all groups followed up for an equal length of time?</b><br>• Yes<br><b>Dropout numbers</b><br>• Intervention</td><td><b>Did the study have an appropriate length to follow-up?</b><br>• Yes<br><b>Did the study use a precise definition of outcome?</b></td><td>Link of analysis to findings and effect sizes presented is not clear. Original study design did not take account of differences in length of OPCOs (though it could</td><td><b>Internal validity</b><br>• +<br><b>Is the setting similar to the UK?</b><br>• Unclear<br><b>Is there a clear focus on</b></td></tr>
</table>

| Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| randomised groups.<br>**Study aim**<br>• Evaluate effectiveness of involuntary outpatient commitment orders (OPCOs) in reducing hospital admissions among adults with severe mental illness<br>**Country**<br>• US, North Carolina region<br>**Relevance to our review question(s)?**<br>• Yes<br>**Appropriate randomisation?**<br>• Unclear<br>No detail on how this was carried out.<br>**Adequate concealment of allocation?**<br>• No<br>Neither subjects, providers or judges were blind to allocation. It is not clear whether – given the strict protocols, such as no use of OPCOs in the control group – allocation could have been affected.<br>**Comparable groups at baseline?** | dropouts: 20.9% (n=27) in intervention group<br>Attrition was if person refused further interaction or could not be found.<br>• Comparison drop-outs: 15.6% (n=21) in control group<br>**Groups comparable on intervention completion?**<br>• No<br>The analysis of data was carried out with 2 important modifications: the length of OPCO was split in the intervention group to less or more than 180 days; and the analysis split those with non-affective disorders from those with affective disorders. Neither of these – and in | • Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• No<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear. Investigators are not stated to be blind or otherwise - but no other participants were blind and the hospital records could have stated other detail, including assignation.<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>Likely direction of detection bias effect<br>• Unclear<br>**Do conclusions match findings?**<br>• Partly<br>The narrative findings are not | have done). It is unclear whether randomisation could have been skewed by lack of blinding: e.g., people in the intervention group may have had more contacts with and attention from community case managers. | **population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• - |

| Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Yes<br>**Selection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Was selection bias present?**<br>• Unclear/unknown risk<br>**Direction of bias effect**<br>• Unclear<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>Both groups had case management, but it is not clear they had the same amount or intensity of OP support.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of performance bias effect** | particular the first condition – were part of the randomisation (although they might have been as the protocol for the use of OPCOs was quite tightly followed, e.g. none of the controls had an OPCO).<br>**Groups comparable on available data?**<br>• Unclear<br>**Attrition bias appraisal**<br>• Unclear/unknown risk of bias<br>**Likely direction of attrition bias effect**<br>• Unclear | illustrated well by the effect sizes in the table: e.g. it is difficult to match the effect sizes to this statement: 'As shown in table 2, relative to control subjects, sustained outpatient commitment reduced mean admissions by roughly 57% and hospital use by 20 days. The proportion of subjects with any hospital admissions, although showing this trend, failed to reach statistical significance in these bivariate analyses' (p1971). | | |

| Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Unclear | | | | |

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To determine whether the drawing up of a JCP with people with severe mental illness and at least 1 admission would experience (compared with TAU group) 'fewer compulsory admissions (primary outcome); fewer psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved therapeutic relationships; and improved engagement' (from abstract).<br>**Country**<br>• UK<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?** | **Were all groups followed up for an equal length of time?**<br>• Yes<br>**Dropout numbers**<br>• Intervention dropouts Data for the primary outcome (admission to hospital under a compulsory section of the MHA) were missing (i.e. refused access) for 22 of the 569 participants (4%). Those with missing data for the primary outcome were similar to those with such data, except that the former had significantly worse self- | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>18 months seemed reasonable as participants had all been admitted within past 24 months.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Yes<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• Yes<br>Except for those collecting qualitative data – this was all | 'Limitations of the study include the fact that at least some of the community mental health teams were not adequately prepared to deliver the JCP intervention as separate from the CPA and had little sense of ownership in it' (p1640). Authors also state that their fidelity measures regarding the implementation were insufficiently sensitive. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• ++ |

<table>
<tr><td colspan="5">Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41</td></tr>
<tr><th>Study design/theoretical approach</th><th>Data collection</th><th>Analysis & reporting</th><th>Limitations</th><th>Quality assessment</th></tr>
<tr><td>• Yes<br>**Appropriate randomisation?**<br>• Yes<br>After baseline assessment, participants stratified by site and randomly allocated to intervention or control group using permuted blocks of randomly varying block size, with equal allocation to the 2 groups. The allocation sequence was generated by the independent clinical trials unit at the study coordinating centre.<br>**Adequate concealment of allocation?**<br>• Unclear<br>Participants and clinical staff were not masked to allocation – this would not be practical. Research team were.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias<br>Randomisation was carried out independently of the clinicians, recruits were from 4 sites, there were few exclusion criteria.<br>**Was selection bias present?**</td><td>rated therapeutic relationship (WAIC) scores (18·6 vs 15·8, p=0·043) and were more likely to be in the intervention group (n=18, 6%) than in the control group (n=4, 1%)' (p1637). A total of 18 from the intervention group could not be followed up for primary outcome, and 46 were not available (refused, deceased, etc.) at follow-up<br>• Comparison dropouts Primary outcome data was not available for 4 of the control group, and 19 people were not available for follow up measures.<br>**Groups comparable on intervention completion?**<br>• No. 64 within the</td><td>from clinicians and patients in intervention group.<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear since they would have accessed records (on admissions) with patient consent<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>Likely direction of detection bias effect.<br>• Unclear. However, admissions data (primary and secondary outcome) is an objective measure not open to bias<br>**Do conclusions match findings?**<br>• Partly … 'we conclude that Joint Crisis Plans seem to positively affect the therapeutic relationship from the service users' perspective, but might only affect outcomes such as use of the Mental Health Act when clinical staff are positively engaged in their development</td><td></td><td></td></tr>
</table>

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| • Low risk of bias<br>See above. However, we do not know if the people approached and consenting to take part were representative of this population<br>**Direction of bias effect**<br>• Unclear<br>**Did the comparison groups receive the same care and support apart from the intervention/s studied?**<br>• Unclear<br>This would be difficult to assess across 4 different sites involving 64 CMHTs.<br>**Were the participants receiving care and support kept 'blind' to how the intervention/s were allocated?**<br>• No<br>**Were individuals who administered the care and support kept 'blind' to the intervention allocation?**<br>• No<br>**Performance bias appraisal**<br>• It was not possible to blind participants and practitioners, as JCPs depend on their active participation and cooperation. | intervention group did not receive it (for various reasons) although all the controls received TAU<br>**Missing outcome data**<br>• 'Those with missing data for the primary outcome were similar to those with such data, except that the former had significantly worse self-rated therapeutic relationship (WAIC) scores (18·6 vs 15·8, p=0·043) and were more likely to be in the intervention group (n=18, 6%) than in the control group (n=4, 1%). The degree of missing data varied across secondary outcome measures: 20% of participants were missing | and implementation' (p1640). Reasons for doubting full engagement are given in the discussion: The JCP challenges the ethos of the CPA because it calls for the clinician to share or cede significant power to the patient. Where the JCP meeting worked well, patients reported feeling respected, and clinicians talked about how the patient 'came alive' as an individual, indicating a more personalised approach to care. | | |

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| **Likely direction of performance bias effect**<br>• Unclear | perceived coercion score, 24% were missing engagement with care scores, and 22% were missing WAIC and WAIT scores at follow-up. Participants missing secondary outcomes at follow-up were more likely to come from the intervention group for all outcomes: 56% perceived coercion, 60% service engagement, 64% WAIC, and 63% of those missing WAIT. Diagnosis was also associated with missing data in all of the secondary outcomes. Site was associated with missing data for perceived coercion, service engagement, and WAIC. | | | |

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | | |
|---|---|---|---|---|
| **Study design/theoretical approach** | **Data collection** | **Analysis & reporting** | **Limitations** | **Quality assessment** |
| | Missing service engagement data was also associated with a higher Global Assessment of Functioning score, missing WAIC associated with number of previous admissions, and missing WAIT associated with marital status and Global Assessment of Functioning score' (p1637).<br>'Data for demographic, therapeutic relationship, and patient engagement were obtained from the case managers or other named clinicians (care coordinators); however, 35 (6%) of 569 of the care coordinators did not complete these at | | | |

<table>
<tr><td colspan="5">Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41</td></tr>
<tr><th>Study design/theoretical approach</th><th>Data collection</th><th>Analysis & reporting</th><th>Limitations</th><th>Quality assessment</th></tr>
<tr><td></td><td>baseline’ (p1637). Not clear which data from which groups this corresponds to.<br><b>Groups comparable on available data?</b><br>• Unclear<br><b>Attrition bias appraisal</b><br>• Unclear/unknown risk of bias<br><b>Likely direction of attrition bias effect</b><br>• Unclear</td><td></td><td></td><td></td></tr>
</table>

## Findings tables

### Tables reporting impact studies

### Review Question 6: What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate the impact of acceptance and commitment therapy, delivered in 4 sessions pre-discharge, on rehospitalisation of patients with psychotic symptoms.<br>**Linked study**<br>• This study did have a further paper published in 2012 which attempted to find a positive result for the sample at 12 months, bearing in mind previous admissions history, but with the small sample size, the number of projections and assumptions made and the fact that treatment finished before, at or within a few days of an index | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number<br>40 (less 5 excluded, see 2012 paper). However, p1132 suggests rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>• Comparison numbers<br>40 (less 5 excluded, see 2012 paper). However, p1132 suggests rehospitalisation data was only available for 33 ACT and 30 TAU patients.<br>• Sample size<br>80 – 87 agreed to take part, but 7 were discharged before they could be randomised, and in the course of the study (this info is from 2012 paper), results for only 70 were available (2 in prison, 2 died, 5 relocated).<br>**Sample characteristics**<br>• Sex<br>ACT plus TAU (IG): 27/40 (68%) male<br>TAU (CG): 24/40 (60%) male<br>• Level of need/diagnosis<br>All inpatients, all had psychotic disorder | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Service outcomes<br>**Findings – effect sizes**<br>• Of the 35 participants in the study in each condition, 7 of the ACT participants (20%) and 14 of the TAU participants (40%) were rehospitalised during the 4 months following release. ACT participants were hospitalised at a significantly lower rate than were TAU participants (at 0.05 significance): Wilcoxon's statistic (1, n=70) = 4.26 p <.05; ACT participants remained out of the hospital an average of 22 days longer than control participants during the 4 month follow-up period. This was felt to be associated with the treatment, as baseline measures on those who had been hospitalised at the Nevada State Hospital showed an average of 78.5 days in the ACT group and 75.3 in the TAU group, a nonsignificant difference, F(1, 61)=0.07, ns (i.e both groups were vulnerable to re-admissions). The difference between the 2 conditions in the number of days to hospitalization during follow-up was statistically significant, F(1, 60) =4.74, p=.03.<br>There were no significant differences measured in the distress felt by individuals at baseline or follow-up (both groups showing similar measures and | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>Except that a wide range of psychological treatments appear to be available.<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| admission before 2002, this seems somewhat spurious. And incomprehensible to anyone without a stats degree. The additional 7 months' data is presented in survival curves which are very difficult to tabulate, AND no significant differences emerged. The study reference is: Long-Term Effects of Brief Acceptance and Commitment Therapy for Psychosis (2012), Bach, Hayes and Gallop. It has been excluded on evidence type.<br>**Source of funding**<br>• Government<br>NIH, National Institute on Drug Abuse.<br>**Country**<br>• US<br>Single Nevada hospital. | and experienced auditory hallucinations or delusions at the time of their admission. exclusions included having substance-misuse psychosis or dementia or delirium – average frequency more than once a day. 90% of those volunteering to take part had previous admissions (range 1–58).<br>**Intervention**<br>• Acceptance and commitment therapy (ACT). 4 sessions were delivered once the inpatient was sufficiently well, spaced (drawing on 2012 description) approximately every 3 days, with the last one either 72 hours pre- or post-discharge. Sessions covered: 1. How patient currently experiences and copes with symptoms; trigger events; introducing idea that the way of handling them is more important than the symptoms; describes and tests ways of distancing them; role of medication; goals. 2. More on personal experience, letting go of the struggle and accepting the symptoms. 3. Review of the strategy for acceptance, focus on goals, focus on coping and carrying on regardless. 4. | reductions across time), nor in medication compliance (which might have accounted for other effects).<br>'The frequency of reported symptoms was not significantly different between the ACT and TAU participants, whether at baseline, F(1, 69)=2.12, ns, or at follow-up, F(2, 29) = 0.36, ns. ACT participants were twice as likely as TAU participants to report symptoms at all, however, with 21 ACT participants (60%) and 11 TAU participants (31%) reporting symptoms at follow-up, a significant difference, $X^2$(1, n=70) = 5.76, p = .016. With a small sample (some discrepancies on numbers) and a high level of significance, ACT participants appeared to have fewer reshospitalisations in the 4 months after discharge, and remained out of hospital longer than the TAU group.<br>There were no significant differences measured in the distress felt by individuals at baseline or follow-up (both groups showing similar measures and reductions across time), nor in medication compliance (which might have accounted for other effects).<br>ACT respondents were more likely to report symptoms (which may for some patients have been an admission likely to lead to re-admission). Authors suggest that the ACT sessions made them | |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | Review of acceptance, distancing, successful attainment of goals, continuing strategy, etc. Note that all those asked to consent to treatment already deemed eligible, and receiving, psychoeducational groups (which may mean they are not typical patients) and individual psychotherapy is also available and used by some of sample. After discharge, psychosocial rehab classes, psychotherapy and assertive community treatment were available (and 60% of the sample had 1 or more of these).<br>**Follow-up OR time of interview**<br>• 4 months. Data on rehospitalisation collected from the only state hospital (for nearly 200 miles). 35 patients in each arm. | more aware of delusions and more accepting of them. 'ACT patients also seemed to show less likelihood of believing in their symptoms as reflecting reality. .016 … One possible explanation is that higher levels of symptom reporting in the ACT condition was an indirect measure of acceptance, at least for those participants who still had active symptoms. If participants were more accepting of symptoms that occurred, they presumably would be more likely to acknowledge them rather than deny them' (p1133).<br>Participants were asked about 'believability' – the extent to which they believed that the content of delusions or hallucinations represented reality. 'Believability decreased from a mean value of 78.7 at baseline to 40.7 at follow-up among ACT participants and from a mean value of 75.4 to 63.6 among TAU participants (see Figure 4). An analysis of covariance of follow-up believability ratings was conducted with the baseline ratings as a covariate. The difference in believability ratings between the two groups was statistically significant, F(1, 29)=4.36, p<.05' (p1134).<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>With a small sample (some discrepancies on | |

| Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | numbers) and a high level of significance, ACT participants appeared to have fewer rehospitalisations in the 4 months after discharge, and remained out of hospital longer than the TAU group.<br>There were no significant differences measured in the distress felt by individuals at baseline or follow-up (both groups showing similar measures and reductions across time), nor in medication compliance (which might have accounted for other effects).<br>ACT respondents were more likely to report symptoms (which may for some patients have been an admission likely to lead to readmission). Authors suggest that the ACT sessions made them more aware of delusions and more accepting of them. ACT patients also seemed to show less likelihood of believing in their symptoms as reflecting reality. | |

| Barrett B, Waheed W, Farrelly S, et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes PloS One 8(11): e74210 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology** | **Participants** | **Outcomes 2 (quant)** | No rating given for |

| Barrett B, Waheed W, Farrelly S, et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes PloS One 8(11): e74210 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| • RCT.<br>Thornicroft et al. (2013) will be appraised for the RCT. Marija to complete the economic evaluation of this paper.<br>• ECONOMIC study<br>**Study aim**<br>• To explore the relative costs and cost-effectiveness of drawing up a joint crisis plan (with the service user) in conjunction with TAU (as opposed to TAU alone), mainly through reducing future admissions under the Mental Health Act in a population with recurring psychotic episodes. NB: title is a bit misleading, as 'compulsory treatment' could cover CTOs, but they are not considered in this study. | • Adults with MH conditions<br>Adults over 16, psychiatric patients with at least 1 admission in past 2 years, and on Enhanced CPA (complex needs)<br>• People NOT subject to the MHA (voluntary admission)<br>Initial sample was of patients with at least 1 admission in past 2 years, but not CURRENTLY subject to MHA (to reduce possible sense of coercion).<br>**Sample size**<br>• Intervention number: 285 (64 did not receive intervention, but seems to be an ITT analysis)<br>• Comparison numbers: 284<br>• Sample size: Total 569 randomised<br>**Sample characteristic**s<br>• Sex<br>Two groups 50:50 male:female<br>• Ethnicity<br>62% White; 22% Black; 10% Asian<br>• Level of need/diagnosis<br>All had major mental illness (74% schizophrenia disorder spectrum; 26% affective disorder) with at least 1 prior admission, and were on Enhanced CPA (complex needs). | • Admissions under MHA<br>Primary outcome (18 months post JCP). (CTOs not mentioned as possible outcome.)<br>• Service outcomes<br>At baseline, service use in previous 3 months collected using AD-SUS, and at 18 months (end of study) same measure used for the prior 18 months. Hospital and case records used to verify data (especially on admissions under MHA, primary outcome)<br>**Costs**<br>• Economic evaluation – full or partial<br>• RQ 4 – Admission<br>• RQ 6 – Reducing readmission<br>**Findings – effect sizes**<br>• No significant effect on compulsory admissions, nor on societal cost per individual. However, for service costs, 80% likelihood JCP is cost-effective (white and Asian groups) and 90% for black groups.<br>**Findings – narrative**<br>**• RQ4 Admissions**<br>It is suggested here that JCP improved therapeutic relationship (possibly especially with black service users)<br>**• RQ6 Reducing readmissions**<br>No significant effect on compulsory admissions, nor on societal cost per individual. However, for service | transparency (see narrative summaries and economic checklist of Barrett 2013 for more information). |

| Barrett B, Waheed W, Farrelly S, et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes PloS One 8(11): e74210 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Linked studies**<br>• Thornicroft et al. (2013) Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. Lancet 381: 1634–41; Thornicroft et al. (2010) CRIMSON (CRisis plan IMpact: Subjective and Objective coercion and eNgagement) protocol: a randomised controlled trial of joint crisis plans to reduce compulsory treatment of people with psychosis. Trials 11: 102. PROTOCOL ONLY. Henderson et al. (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMJ 329: 136. BUT NOTE THIS EARLY DATE WHICH | **Intervention**<br>• Joint Crisis Plan (with TAU including care by CMHT). A JCP facilitator met with patient and their care coordinator twice – once to explain JCP and suggest what might be in it, and at least a week later to write the plan. Person contacted 6 months later to ascertain if any changes needed.<br>**Follow-up OR time of interview**<br>• 18 month follow up | costs, 80% likelihood JCP is cost-effective (white and Asian groups) and 90% for black groups. | |

Barrett B, Waheed W, Farrelly S, et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes PloS One 8(11): e74210

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| SUGGESTS MAY BE A PILOT.<br>**Source of funding**<br>• Government<br>NIHR supplemented MRC funding.<br>• Funding council<br>MRC.<br>**Country**<br>• UK<br>Trusts participating: London, Manchester, Lancashire, Birmingham. | | | |

Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet 381: 1627–33

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| **Methodology**<br>• OCTET is a non-blinded, parallel arm randomised controlled trial<br>**Study aim**<br>• To test the hypothesis | **Participants**<br>• Adults aged 18–65 with MH conditions<br>• People subject to the MHA (involuntary admission)<br>**Sample size**<br>• Intervention number: 167<br>• Comparison numbers: 169 | **Outcomes 2 (quant)**<br>• Clinical outcome<br>Brief Psychiatric Rating Scale<br>• Service outcomes<br>**Findings – effect sizes**<br>• CTO (n=166) Section 17 (n=167) | **Internal validity**<br>• ++<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear** |

| Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet 381: 1627–33 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| that patients with a diagnosis of psychosis who are discharged from hospital on community treatment orders (CTOs) will have a lower rate of readmission than those discharged on Section 17 leave.<br>**Linked studies**<br>Burns T, Molodynski A (2014) Community treatment orders: background and implications of the OCTET trial; Rugkasa et al. (2014) CTOs: clinical and social outcomes and a subgroup analysis from the OCTET RCT. This adjunct to Burns et al. (2013) OCTET study looks at symptoms, social outcomes and perceived coercion of CTOs. It does not deal with our specified | • Sample size<br>CTO n=167<br>Section 17 n=169<br>Total n= 336<br>**Sample characteristics**<br>• Age<br>CTO (n=167) mean (SD) 39.8 years (11.2)<br>Section 17 (n=169) mean (SD) 39.5 (11.7)<br>• Ethnicity<br>White<br>CTO (n=167) 102 (61%)<br>Section 17 (n=169) 104 (62%)<br>Black<br>CTO (n=167) 38 (23%)<br>Section 17 (n=169) 40 (24%)<br>Asian<br>CTO (n=167) 15 (9%)<br>Section 17 (n=169) 14 (8%)<br>Mixed and other<br>CTO (n=167) 12 (7%)<br>Section 17 (n=169) 11 (7%)<br>• Level of need/diagnosis<br>Schizophrenia CTO (n=167) 141 (84%)<br>Section 17 (n=169) 145 (86%) | N (%) or median (IQR) or mean (SD) EFFECT<br>Psychiatric hospital readmission<br>59 (36%) 60 (36%) 1.0(0.75 to 1.33)<br>* see whole table for more results<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>Primary, secondary, or clinical outcomes did not differ between groups. At 12 months, neither the number of patients readmitted<br>(59 (36%) CTO vs 60 (36%) Section 17; RR 1.00 (95% CI 0.75 - 1.33), nor the time to readmission from randomisation, nor the number of days in hospital differed. | **focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• ++ |

| Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet 381: 1627–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| outcomes.<br>**Source of funding**<br>• Government National Institute of Health Research.<br>**Country**<br>• UK | Brief Psychiatric Rating Scale (BPRS)<br>CTO (n=167)<br>Median (IQR) 38 (30-48)<br>Section 17 (n=169) 38<br>Median (IQR) (32-49)<br>Global Assessment of Functioning (GAF)<br>CTO (n=167) Mean (SD) 38.3 (9.4)<br>Section 17 (n=169)Mean (SD) 39.3 (10.2)<br>• Previous admissions<br>Number of past psychiatric admissions<br>CTO (n=167) Median (IQR) 6 (3-8)<br>Section 17 (n=169) Median (IQR) 5 (3-9)<br>Number of past involuntary admissions<br>CTO (n=167)4 (2-7)<br>Section 17 (n=169) 3 (2–8)<br>**Intervention**<br>• Community treatment order (CTO)<br>Imposed when the responsible clinician (normally consultant psychiatrist) and an approved mental health worker consider a patient who is being discharged after a period of involuntary hospital treatment to be at risk of relapse and/or readmission. The CTO can stipulate, as a condition, that the patient must take medication outside of the hospital but the CTO does | | |

| Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet 381: 1627–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | not authorise the clinicians to administer medication by force. Instead the clinician can recall the patient for up to 72 hrs to review treatment without formally readmitting them. A range of conditions can be imposed – including place of residence and attendance at assessments.<br>Section 17<br>Used for brief periods to assess suitability of a patient's recovery after and during a period of involuntary hospitalisation. The treatment order remains active and the patient can be immediately readmitted without additional legal processes. 'A legal opinion on the trial concluded that, although there are undoubtedly differences between the CTO and leave regimes, and area of genuine equipoise exists; is unclear whether either regime is more restrictive that the other and it is possible for a patient simultaneously to meet the criteria for both' (p1629).<br>**Follow-up OR time of interview**<br>• 12-month follow up in each group | | |

| Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To demonstrate the potential of a brief intensive transitional acute intervention for reducing admissions and the costs of admissions, delivered to people already admitted, or presenting to the ER and having been assessed and agreed as needing admission.<br>**Source of funding**<br>• Voluntary/charity<br>What looks like a charity, for Medicaid demonstration (as clients are rural poor and Medicaid are funders of care)<br>**Country**<br>• US<br>Rural area with high | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 90<br>• Comparison numbers: 92<br>• Sample size: 182<br>**Sample characteristics**<br>• Level of need/diagnosis<br>Eligible population were those admitted to acute MH ward, or those referred into acute inpatient service via the ER (emergency room). From the wider sample (from which patients refused to take part, or CMH clinicians advised against asking), about one-third had psychosis, and most others had severe depression or adjustment disorders in the wake of personal crises. Characteristics of the eventual sample (IG and CG) are not given in paper.<br>Intervention<br>• Clinical team delivering an acute, intensive short-term transitional support programme, targeting people who might be at high risk of readmission, or | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Quality of life<br>• Service outcomes<br>• Social care outcome<br>**Costs**<br>• Patterns of service use (no detail given)<br>**Findings – effect sizes**<br>• ‘Averting hospitalization with ER intervention for 12 participants produced the largest single contribution to outcome (p<.001). Of the total difference in hospital use, about 34% was produced by averting initial hospitalisation altogether for 12 of 17 participants treated initially in the ER. Among participants not averted (i.e. admitted for hospitalisation), average length of stay was 6.18 days for the experimental group (SD=6.18) versus 7.22 days for controls (SD=5.84)’ (p31). ‘Collectively, total days in the hospital averaged 7.57 for the experimental group (SD = 9.42) and 10.39 for controls (SD=10.44), thus 27% lower with transitional acute care’ (p31). ‘The team intervened later during the study for participants who reappeared at the ER, averting hospitalization in 7 of 10 cases. Overall, the average number of relapses (rehospitalisations) was nearly double for | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear if the rural, poor area, the ER service and the participants are similar to those seen in England<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• +<br>There were |

Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| levels of poverty | unknown to services (e.g. if came through ER). Was intended to be ‘a brief, hospital-based bridge to other resources’ (p29). Support ended with transfer to CMH (at first follow-up appointment), though active treatment could be resumed. Elements varied, but typically were: assessment and treatment plan for stabilisation and transitional support; brief individual behavioural therapy, with family if possible, oriented to problem-solving and reassurance; an 8-session CB relapse prevention group was introduced after a few months; home care and home assessments; follow-up care in home, possibly psychological treatments and assistance with practical problems such as transport. Investigators flag the likely importance of home support, use of health aides for in-home support and basic care, ability to respond quickly, 24/7, and functional linkage with hospital and community services.<br>**Follow-up OR time of interview**<br>• 2 weeks, 6 months and 1 year follow-ups. | controls versus experimental participants (50 versus 26). Twenty-three control participants had at least 1 readmission (25%), compared to 12 in the experimental group (13%). When they were readmitted, experimental participants spent an average of 2.46 days in the hospital (SD=9 01) versus 3 .17 days for controls (SD=6.62)’ (p32). There were no significant differences between groups in relation to MH and functioning measures.<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>Although all participants, including those recruited in ER, were scheduled for admission, 12 in the experimental group (IG) and none in the control group were not admitted and instead received transitional support. (10 of these had never before been admitted.) Total number of readmissions after the ‘index’ admission were 26 in IG and 50 in control group (CG). These applied to 12 people in IG and 23 in CG. Unclear whether admissions are measured at 1-year follow-up (Table 1) – this is likely. When readmitted, the intervention resumed, and the IG spent fewer days in hospital (though this was not significant using univariate analyses). Costs were therefore lower for IG, but there is no detail of how this was calculated. On the structured ratings, there were no significant differences in clinical | differences in the population entered into the study and the possible 244 consecutive admissions who might have taken part – e.g. 30 individuals not approached at request of CMH who had more problematic conditions. |

<table>
<tr><td colspan="4">Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34</td></tr>
<tr><td><b>Research aims</b></td><td><b>Population</b></td><td><b>Findings</b></td><td><b>Overall quality assessment</b></td></tr>
<tr><td></td><td></td><td>outcomes at 2 weeks (which is what is reported). Overall, the service achieved substantial reductions in hospital use and relapses.</td><td></td></tr>
</table>

<table>
<tr><td colspan="4">Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial. The British Journal of Psychiatry 202: 212–9</td></tr>
<tr><td><b>Research aims</b></td><td><b>Population</b></td><td><b>Findings</b></td><td><b>Overall quality assessment</b></td></tr>
<tr><td><b>Methodology</b><br>• RCT<br>• Study aim<br>To investigate whether treatment in a specialised mood disorder clinic (pharmacological treatment + group psychoeducation) early in the course of illness among patients discharged from their first, second or third</td><td><b>Participants</b><br>• Adults with MH conditions<br>Patients aged 18 - 70 with a primary diagnosis of a single manic episode or bipolar disorder discharged for their first, second or third hospital admission from an in-patient psychiatric ward. Comorbidity with alcohol or substance misuse and other psychiatric disorders were allowed. Exclusion criteria: moderate/ severe dementia, poor understanding of Danish, those under commitment (compulsory treatment), those not willing to give informed consent.</td><td><b>Outcomes (quantitative)</b><br>• Satisfaction<br>• Service outcomes<br>Costs<br>• RQ 6 – Reducing readmission<br><b>Findings – effect sizes</b>
<table>
<tr><td rowspan="2">Treatment</td><td rowspan="2">N</td><td rowspan="2">Events*</td><td rowspan="2">Yrs of post-randomisation survival time, mean (95% CI)</td><td colspan="2">Log rank test</td></tr>
<tr><td>$\chi^2$ (d.f)</td><td>P</td></tr>
<tr><td>Mood Disorder</td><td>72</td><td>26</td><td>4.1 (3.5-4.7)</td><td>4.49</td><td>0.034</td></tr>
</table></td><td><b>Internal validity</b><br>• +<br><b>Is the setting similar to the UK?</b><br>• Unclear<br><b>Is there a clear focus on population of interest?</b><br>• Yes<br><b>Is the intervention clearly relevant</b></td></tr>
</table>

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<tr>
<td>admission to hospital for bipolar disorder reduces hospital readmissions and rates of relapse compared with standard psychiatric outpatient treatment.<br><b>Country</b><br>• Denmark<br>Seven out of the 9 psychiatric wards in the Capital Region of Denmark.<br>Source of funding<br>• Pharmaceutical Lundbeck Foundation and by the Research Foundation of the Hovedstadens Sygehusfællesskab (The Capital Hospital Corporation).</td>
<td><b>Sample size</b><br>• Mood disorder clinic (intervention) n=72<br>• Standard treatment (control) n=86<br>Total=158<br>Sample characteristics<br>• Sex<br>Female<br>Intervention n=44 (61.1%)<br>Control n=42 (48.8%)<br>• Age at randomisation, years: median (quartiles)<br>Intervention: 37.6 (27.3-48.2)<br>Control: 35.2 (27.9-46.3)<br>• Employed<br>Intervention n=50 (69.4%)<br>Control n=43 (50.0%)<br>Unemployed<br>Intervention n=22 (30.6%)<br>Control n=43 (50.0%)<br>• Previous admissions<br>Patients with previous admission before index admission:<br>Intervention n=31 (43.1%)</td>
<td><table>
<tr><td>Clinic</td><td></td><td>(36.1%)</td><td></td><td>(1)</td><td></td></tr>
<tr><td>Standard Care</td><td>86</td><td>47 (54.7%)</td><td>3.2 (2.7-3.8)</td><td colspan="2"></td></tr>
</table>
*Readmissions<br><b>Findings – narrative</b><br><b>• RQ6 Reducing readmissions</b><br>A total of 26 (36.1%) patients treated in the mood disorder clinic vs 47 (54.7%) patients treated with standard care were readmitted (log rank test; p=0.034).<br>‘The duration of first readmission following randomisation was shorter for those in the mood disorder clinic group compared with the standard care group, however, the difference was not statistically significant (p=0.3, mood disorder clinic vs standard care, median (quartiles): 12.0 (3.0–46.5) days vs 22.0 (4.8–54.8) days).<br>Similarly, the mood disorder clinic group experienced a decreased number of total readmissions following randomisation, but the difference was not statistically significant (p=0.11; mood disorder clinic vs standard care, mean: 0.97 (s.d.= 1.74) v. 1.58 (s.d.= 2.57).<br>The cumulated duration of all admissions following randomisation was significantly shorter for those in the mood disorder clinic group (p=0.01; mood disorder clinic vs standard care, median (quartiles): 33.0 (10.5–133.5) days vs 49.0 (21.0–127.5) days)’ (p215).</td>
<td><b>to RQ(s)?</b><br>• Yes<br><b>Are the outcomes relevant?</b><br>• Yes<br><b>External validity</b><br>• +</td>
</tr>
</table>

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<tr><td colspan="4">Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial. The British Journal of Psychiatry 202: 212–9</td></tr>
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<tr><td></td><td>Control n=46 (53.5%)<br>Patients without previous admission before index admission:<br>Intervention n=41 (56.9%)<br>Control n=40 (46.5%)<br>Intervention<br>• The 2-year intervention is a combination of evidence-based pharmacological treatment and group psychoeducation. A medical doctor evaluates all patients in the clinic as early as possible following discharge from an in-patient admission and no later than 2 weeks after discharge. The physician followed the patients with regular appointments depending on their clinical status and needs.<br>Patients took part in 3 different sequential group sessions:<br>Group 1: Settling in group for patients just discharged. The focus was on current clinical status and beliefs and experiences in relation to the recent admission. Patients stayed in this group until they were clinically stable and had remitted from depressive and</td><td>Major Depression Inventory (MDI) 25 patients (35.1%) in the intervention group relapsed into a depressive episode compared with 37 patients (43.5%) in the standard treatment group, however this difference was not statistically significant (p=0.4).<br>Mood Disorder Questionnaire (MDQ)<br>Similarly, there was no statistically significant difference in relapse rates for a hypomanic or manic episode according to the MDQ. Intervention n=45, 62.9%, control n=49, 57.1% (p=0.6). Satisfaction with treatment showed a statistically highly significant difference between patients in the mood disorder clinic v the standard care group. (VSSS-A total score: 132.2 (s.d = 16.9) v 114.9 (s.d=31.6), unadjusted p=0.001, adjusted p=0.01).</td><td></td></tr>
</table>

| Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial. The British Journal of Psychiatry 202: 212–9 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | manic symptoms, at least in part (i.e typically 6 months).<br>Intermediary stage and group 3: once stable, the patients were transferred to the second and intermediary group, consisting of group psychoeducation. These were weekly 1.5 hr sessions held for 12 consecutive weeks, followed by 3 booster sessions. In both groups the focus was on knowledge and acceptance of having bipolar disorder, identifying depressive and manic symptoms from normal reactions, personal identity, risk situations, stress management, the need for sustained pharmacological maintenance treatment, and adverse effects of treatment and identification of individual early warning signs of upcoming depressive/manic episodes. CBT approaches were included, focussing on cognitive distortions in identity and behaviour and inter-individual conflicts.<br>Discharge group: over 3 to 6 months | | |

| Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial. The British Journal of Psychiatry 202: 212–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | patients were helped to prepare for re-referral either to a GP, a private psychiatrist or the community psychiatric centre. The aim was to help participants identify individual early warning signs and to communicate these to the relevant clinicians for an adequate behavioural response or pharmacological re-evaluation.<br>Staff:patient ratio<br>Six to 8 patients and 2 therapists (psychiatrists and psychologist or nurse) participated in each group.<br>**Follow-up or time of interview**<br>• 'All patients were followed to the first event, a readmission to hospital, or to the date of death or emigration or to end of the study on 31 December 2011, whichever came first ... The follow-up period from the discharge date following randomisation was between 0 and 6 years with an average follow-up of 2.5 years' (p215). | | |

| Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate an individualised psychoeducational programme together with crisis cards and 24 month preventive monitoring for adults who have been admitted as compulsory patients during the past 24 months. This paper reports on main outcome of reducing admissions - including compulsory ones – and time spent in hospital at 12 months (interim findings). Importantly, the programme starts at the interface of in- and outpatient care (discharge).<br>**Source of funding**<br>• Voluntary/charity | **Participants**<br>• Adults (no specified age) with MH conditions<br>• People subject to the MHA (involuntary admission)<br>Swiss version of involuntary admission – at least 1 in past 24 months.<br>**Sample size**<br>• Intervention number: 119<br>• Comparison numbers: 119<br>• Sample size: 238<br>**Sample characteristics**<br>• Sex: 60% of IG female, 52% of CG female<br>• Sample age<br>41.5 IG, 43.4 CG.<br>• Level of need/diagnosis<br>IG: 34% schizophrenia/BPD 20% substance misuse 30% depressive or neurotic disorder.<br>• Length of illness<br>15.6 years SD12.5 CG: 43% schizophrenia/BPD 19% substance misuse 23% depressive or neurotic disorder 16.7 years SD 12.5.<br>• Previous admissions<br>IG: no. of admissions: 8.5 SD12.1 | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Admissions under MHA<br>• Service outcomes<br>**Findings – effect sizes**<br>• 67% and 86% of the initial samples remained at 12 months in the IG and CG respectively. Number of voluntary readmissions per patient did not differ significantly between groups (IG 1.4, SD 2.5; CG 0.9, SD 1.4), and the length of voluntary admissions was also not significantly different. Number of compulsory readmissions per patient for IG group was 0.3 per patient (SD 0.8); vs 0.7 (SD 1.2) per patient in CG, p=0.04. The length of compulsory readmissions was shorter for the IG: 9.1 SD 21.8 days, vs 14.8 SD 31.2 days for CG, p=0.08.<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>67.2 % of the intervention group and 85.7 % of the TAU group remained for a period of 12 months in the intervention programme and completed 12 month assessments (most of dropouts could not be contacted). 52.5 % of the intervention group (56.9 % TAU) had been readmitted to a psychiatric hospital for some time, and in all there were 143 readmissions among the 80 left in the IG; 115 of these were voluntary admissions. Compulsory | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>External validity<br>• + |

| Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Country**<br>• Switzerland | No. of compulsory admissions: 3.8 SD5.2.<br>CG: no. of admissions: 9.3 SD14.4.<br>No. of compulsory admissions: 4.8 SD8.5.<br>• Follow-up or time of interview<br>Follow-up at 12 months for assessment, primarily of hospital admissions and compulsory hospital admissions.<br>**Intervention**<br>• Intervention programme is based on individualised psycho-education focusing on behaviour prior to and during crisis, looking at individual needs, abilities, etc. Sessions delivered by same worker (implied but not stated they are not those that provided care on wards). Sessions ranged from 1–11, totalling 3–4 hours. It is implied these start at inpatient stage. Prior to discharge a checklist of personal risk factors for relapse, and info on who to contact, medications. This became a CRISIS CARD, and study participants used these in a variety of ways. After discharge, each person in IG was contacted every fourth week by telephone, for 24 months. Worker | inpatient readmissions were registered in 22.5 % of the intervention group, compared with 35.3 % in TAU group. With a mean number of 0.3 compulsory readmissions per patient during the 12-month period, this is around half the number of compulsory readmissions that was found in TAU patients (mean 0.7). The proportion of time (days accumulated over all compulsory stays/days from baseline to 12 months) is 0.02 in the intervention group and 0.04 in the TAU group, suggesting that 2% and 4% respectively of the 12 months has been spent in hospital in connection with compulsory inpatient episodes. The trend established at the 12 month interim assessment is that treatment is having a positive effect on the number and length of compulsory admissions in the intervention group. | |

Lay B, Blank C, Lengler S, et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| | reviewed MH status, crisis card and signs of escalating risk of relapse, offering support as needed. The approach attempts to support self-management as a supplement to TAU. TAU involves referring a psychiatric patient to outpatient care (CMHT type) or another healthcare professional for further treatment, and there is no further outreach if the person doesn't use it. In this study, CG were contacted at 3-month intervals to validate continuation in the study. | | |

Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–9

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To evaluate whether | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size** | **Outcomes quantitative**<br>• Admissions under MHA<br>• Satisfaction<br>• Service outcomes | **Internal validity**<br>• +<br>**Is the setting similar to the UK?** |

| Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| use of advance directives by patients with mental illness reduces rates of compulsory readmission to hospital.<br>**Linked study**<br>• Linked to Papageorgiou et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. See views papers for evidence tables<br>**Source of funding**<br>• NHS Trust<br>National Health Service (NHS) Executive, London Research and Development Programme.<br>**Country** | • Intervention group n=79 Control n=77<br>Total n=156<br>**Sample characteristics**<br>• Sex Male<br>Intervention n=42 (53%) Control n=51 (66%)<br>• Ethnicity<br>White<br>Intervention n=43 (54%) Control n=48 (62%) black<br>Intervention n=22 (28%) Control n=24 (31%) other<br>Intervention n=14 (18%) Control n=5 (6%)<br>• Sample age<br>Mean yrs (SD)<br>Intervention 35.5 (11.3) Control 36.3 (12.6)<br>• Diagnosis<br>Psychosis<br>Intervention n=50 (63%)<br>Control n=49 (64%)<br>Depression/ bipolar disorder<br>Intervention n=22 (28%) Control n=22 (29%) Other Intervention n=7 (9%) Control n=6 (8%)<br>• Employment status<br>Unemployed<br>Intervention n=31 (39%) | **Findings – effect sizes**<br>• 15 participants (19%) in the experimental group and 16 (21%) in the control group were readmitted to hospital under section within 1 year of discharge ($x^2$=0.08, d.f. = 1, p=0.8). Number of subsequent sections under Mental Health Act:<br>Intervention (n=79) Control (n=77)<br>0 64 (81%) 61 (79%)<br>1 9 (11%) 11 (14%)<br>2 4 (5%) 5 (6%)<br>>2 2 (2%) 0<br>Days on subsequent sections (%)<br>Intervention (n=79) Control (n=77)<br>0 64 (81) 61 (79)<br>1-100 10 (13) 14 (18)<br>101-365 5 (6) 2 (2)<br>Days as an in-patient on a subsequent voluntary admission (%)<br>Intervention (n=79) Control (n=77)<br>0 52 (66) 49 (64)<br>1-100 20 (25) 22 (29)<br>101-200 6 (7) 5 (6) | • Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Unclear<br>Advance directives are relevant to our RQ – however the description here does not seem to align with current practice. The Mental Capacity Act 2005 gives people over the age of 18 a legal right to refuse medical procedures in advance. For example, you may wish to say that you do not want electroconvulsive |

| Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–9 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| • UK<br>Two inner-London acute psychiatric services. | Control n=29 (38%)<br>Sickness benefit<br>Intervention n=34 (43%)<br>Control n=39 (51%)<br>Employed (full and part time)<br>Intervention n=4 (5%)<br>Control n=5 (6%)<br>Household composition<br>Lives alone Intervention n=11 (14%)<br>Control n=7 (9%)<br>Lives with partner<br>Intervention n=16 (20%)<br>Control n=12 (16%)<br>Lives with parent<br>Intervention n=20 (25%)<br>Control n=41 (53%)<br>Other<br>Intervention n=20 (25%)<br>Control n=17 (22%)<br>Intervention<br>• Advance directive provided in the form of a booklet ‘Preferences for care’. It contained – name of GP, community psychiatric nurse, keyworker, consulting psychiatrist and social worker – 7 statements on future preferences for | 201-365 1 (1) 1(1)<br>Number of patients readmitted voluntarily<br>13 (16) 12 (16)<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>There was no significant difference between the groups in the numbers of subsequent compulsory readmissions, numbers of patients readmitted voluntarily, or days spent in hospital. Neither was there any difference in self-efficacy at follow-up (advance directives grouped median 42.66; control arm grouped median 42.25).<br>Analysis of covariance (controlling for baseline values) of Basis–32 and Hospital Service Satisfaction scores for those interviewed at baseline and at follow-up also showed no significant difference between the groups. Just 8 (13.5%) of the 59 patients in the intervention group who were interviewed at follow up found the advance directive useful. They reported that it helped them to evaluate their illness; reminded them of things they could do to make things better; helped to inform other people that they had been ill and when they might be relapsing. Psychiatrists, whilst supportive, voiced concern that the advance | therapy (ECT) if you become unwell.<br>However, the authors state that the booklets indicated that professionals were not legally bound to comply with the preferences for care. As such this study does not seem to be a fair representation of current advance directive use.<br>**Are the outcomes relevant?**<br>• Unclear<br>See above.<br>**External validity**<br>• - |

<table>
<tr><td colspan="4">Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–9</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Overall quality assessment</th></tr>
<tr><td></td><td>treatment the advance directive was not intended to address compulsory treatment directly but it aimed to give patients an opportunity to consider their future treatment on a wider basis and in doing so increase their trust and compliance – potentially reducing the need for compulsory treatment. A rider at the end of the booklet indicated that professionals were not legally bound to comply with preferences for care (note implications of this in light of 2005 legislation).</td><td>directives were ‘yet another administrative burden’ (p516).</td><td></td></tr>
</table>

<table>
<tr><td colspan="4">Pitschel-Walz G, Bäuml J, Bender W et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Overall quality assessment</th></tr>
<tr><td><b>Methodology</b><br>• RCT<br>Prospective, randomised, multicentre study.<br><b>Study aim</b></td><td><b>Participants</b><br>• Adults with MH conditions aged 18–65<br>• Carers/family members of people with MH conditions<br><b>Sample size</b><br>• Intervention n=125, control n=111</td><td><b>Outcomes 2 (quantitative)</b><br>• Quality of life<br>German version of the Lancashire Quality of Life Profile<br>• Service outcomes<br>• Compliance assessed by the treating psychiatrist</td><td><b>Internal validity</b><br>• +<br><b>Is the setting similar to the UK?</b><br>• Unclear<br><b>Is there a clear</b></td></tr>
</table>

Pitschel-Walz G, Bäuml J, Bender W et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| • Psychoeducation Information Project (PIP) study was set up to examine the long-term outcomes and benefits of psychoeducation; the study describes the effects of psychoeducational groups (intervention) in comparison with routine care (control group) on compliance and rehospitalisation rates over a 24 month follow-up period.<br><br>• Details of any linked studies: Bäuml Joseph et al. (2007) Psychoeducation in schizophrenia: 7-year follow-up concerning rehospitalization and days in hospital in the Munich Psychosis | Total=236 (from 3 different psychiatric hospitals LMU: Ludwig-Maximilians-University; BKH Haar: Community Hospital of Munich; TUM: Technical University of Munich). ** After a period of 2 years it was only possible to further treat the patients of TUM .<br>The data of the 7-year follow up are based exclusively on this subsample.<br>Total=101; Intervention n=51 Control n=50<br>Total received allocated treatment=82<br>Completers at 7 year follow up<br>Intervention=24, Control=24, Total n=48<br>**Sample characteristics**<br>• Sex<br>Intervention 51% female, control 57% female **TUM Sample Completers at 7 years follow-up; intervention n=14 (58%); female control n=16 (67%) female<br>• Sample age<br>Mean, Y, intervention 33, control 34<br>**TUM Sample Completers at 7 years follow-up<br>Mean, Y Intervention 33 Control 36<br>• Previous admissions<br>Previous hospitalisations, mean intervention 3, control 4 | (using 4-point compliance scale). This is based on medication adherence.<br>**Findings – effect sizes**<br>Survival analysis considering the time up to first rehospitalisation showed a significant difference in favour of the intervention group within the first year. (p=.009) and within 2 years (p=.015).<br>The rehospitalisation rate at the 12 month follow-up for intervention group was 21% (n=17) compared to 38% (n=31) in the control group (p=0.25).<br>At 24 months follow up, 41% (n=32) of the intervention group and 58% (n=43) of the control group had to be rehospitalised (P=0.36).<br>In the intent-to-treat analyses with all dropouts assessed as rehospitalisations (worst-case scenario), the differences were not statistically significant (n= 194; 1 year follow-up; 37% vs 45%, p=.301; 2 year follow up: 54% vs 66%, P=.107).<br><br>Number of rehospitalisations after 12 months:<br>Intervention group mean (SD) 0.3 (0.7)<br>Control group mean (SD) 0.6 (0.8) P=.086<br>after 24 months:<br>Intervention group mean (SD) 0.6 (1.1) | **focus on population of interest?**<br>• Unclear<br>Only looks at people with schizophrenia and their carers.<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Pitschel-Walz G, Bäuml J, Bender W et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| Information Project Study. The Journal Of Clinical Psychiatry 68(6): 854–61.<br>Seven-year outcomes from this study (**TUM sub-sample) are presented here to avoid double counting of evidence.<br>**Country**<br>• 3 German psychiatric hospitals | First admission<br>Intervention 28%, control 18%<br>**TUM Sample (completers at 7-year follow up)<br>Previous hospitalisations, mean intervention 4.4, control 3.2, duration of index hospitalisation, mean, D Intervention=97, SD=54.0, control=96, SD=73.9<br>**Intervention**<br>• Patients and their relatives were encouraged to attend 8 sessions of psycoeducational programmes over a period of 4 to 5 months – sessions were separate for patients and carers but consisted of similar material to help them 'speak the same language'. Sessions 1 to 4 took place weekly, mostly during the patients' inpatient stay (after reduction of acute symptoms), and sessions 5 to 8 took place monthly, predominantly during the outpatient period. Information was given to patients about symptoms, etiology, acute treatment, relapse prevention, and psychological treatment of schizophrenia; adequate coping strategies were discussed; and individual crisis plans were | Control group mean (SD) 1.1 (1.4) p=.31<br>Number of days in hospital after 12 months:<br>Intervention group mean (SD) 17(46.6)<br>Control group mean (SD) 30 (54.4) p=.105<br>after 24 months<br>Intervention group mean (SD) 39 (90.4)<br>Control group mean (SD) 78 (127.2) p=.034<br>Rehospitalisation rates at 12 and 24 months, differentiated according to the number of previous psychotic episodes.<br>At 12 months %<br>Psychotic episodes<br>1 Intervention group 15<br>Control group 13 p=1.00<br>2–5 Intervention group 18<br>Control group 47 p=.006<br>6 or more Intervention Group 38<br>Control Group 36 p=1.00<br>Rehospitalisation rates at 24 months, %<br>1 Intervention group 37<br>Control group 39 P=1.00 | |

<table>
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<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Overall quality assessment</th></tr>
<tr><td></td><td>drawn up. Relatives’ sessions covered similar information to the patients’ groups but also allowed relatives to discuss how they can better help the patient with schizophrenia and how they can obtain support and emotional relief for themselves.** For TUM sample only after the 2nd year, patients were encouraged to continue their medication but it was no longer possible to involve their relatives. After the 4th year outpatient treatment in the study centre had to be discontinued completely, and all patients were referred to general psychiatrists.<br>**Follow-up OR time of interview**<br>• Data recorded on study entry, on discharge, and at 6, 12, 18, and 24 months after discharge.<br>**For TUM subsample Rehospitalisation and number of days spent in hospital were reconstructed from the information given by the patients and their relatives and by interviewing the patients and studying the documents of the hospitals involved.</td><td>2–5 Intervention group 34<br>Control group 65 P=.008<br>6 or more Intervention group 63<br>Control group 58 P=1.00<br>***TUM sub-sample<br>Seven years after index discharge, 54% (n=13) of the intervention and 88% (n=21) of the control patients were rehospitalised (p<.05) P=0.024<br>The mean number of rehospitalisations per patient (SD) was 1.5 (1.6) in the intervention and 2.9 (2.6) in the control group (p<.05) p=0.029.<br>Days spent in hospital per patient<br>Intervention n=75<br>Control n=225 p=.021<br>BPRS (Brief Psychiatric Rating Score) total score<br>Intervention = 32.7 (12.0)<br>Control = 32.9 (10.4) p=.929 (no significant difference)<br>GAF (Global Assessment Functioning) score<br>Intervention=61.7 (19.3)<br>Control=62.8 (14.4) p=.826 (no significant difference).</td><td></td></tr>
</table>

| Pitschel-Walz G, Bäuml J, Bender W et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | Quality of life score<br>Intervention = 4.9 (1.9)<br>Control = 5.3(1.2) p=.625 (no significant difference). | |

| Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• RCT<br>**Study aim**<br>• To examine the feasibility and effectiveness of using peer support (recovery mentors) to reduce recurrent psychiatric hospitalisations.<br>**Source of funding**<br>• Eli Lilly and Company (Dr Sledge, principal investigator), the Connecticut Department of Mental Health and | **Participants**<br>• Adults with MH conditions<br>Eligibility inclusion criteria:<br>>18<br>- experienced 2 or more psychiatric hospitalisations in the 18 months before index hospital admission.<br>- have a diagnosis of schizophrenia, schizoaffective disorder, psychotic disorder not otherwise specified, or major depressive order<br>- willing to accept random assignment to a peer recovery mentor with usual care or to usual care alone.<br>Exclusion criteria: | **Findings – effect sizes**<br>Hospital admissions and hospital days following enrolment<br>In recovery mentor programme vs comparison group hospitalisations<br>Condition Mentor Treatment as usual<br>Subjects 38 36<br>Mean .89 +/- 1.35 1.53 +/- 1.54<br>Statistic F=3.07 df=1,71 p=.042 (1 tailed partial eta squared= .04<br>Hospital days<br>Condition Mentor Treatment as usual<br>Subjects 38 36 | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes** |

| Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| Addiction Services, and the George D. and Esther S. Gross Professor of Psychiatry endowment.<br>**Country**<br>• US, Yale, New Haven | - inability to give consent<br>- inability to speak English<br>- imminent incarceration<br>- primary diagnosis of substance abuse or dependence (patients with co-occurring diagnosis of included conditions were allowed).<br>**Sample size**<br>• Intervention n=46, control n=43 Total n=89<br>**Sample characteristics**<br>• Sex<br>Male Intervention: n=17 (45%)<br>Control: n=38.7 (58%)<br>• Sample age<br>Mean +/- SD<br>Intervention: 42.4 +/-11.5<br>Control: 38.7+/-8.4<br>• Level of need/diagnosis<br>Mood disorder<br>Intervention: n=12 (32%)<br>Control: n=11 (31%)<br>Psychotic disorder<br>Intervention: n=26 (68%) | Mean 10.08 +/- 17.31 19.08 +/- 21.63<br>Statistic F=3.63, df=1,71 p=.03 (1 tailed) partial eta squared =.05<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>Participants allocated to the recovery mentor group had significantly fewer admissions than those in usual care (.89±1.35 and 1.53±1.54 admissions; F=3.07, df=1 and 71, 1 tailed p=.042; partial η2=.04) and significantly fewer hospital days (10.08±17.31 and 19.08±21.63 days; F=3.63, df=1 and 71, 1 tailed p<.03; η2=.05).<br>A sub-analysis of the intervention group data showed that there was no significant association between the number of mentor contacts and hospitalisation outcomes.<br>It was also investigated whether there was a differential effect based on diagnostic group. Those with a psychotic diagnosis were compared against those with a non-psychotic diagnosis in an effort to determine if there was a difference in hospitalisation experience through an interaction between diagnosis and the treatment condition.<br>There is a trend for an effect of diagnosis on hospital days with non-psychosis patients having | **relevant?**<br>• Yes<br>**External validity**<br>• + |

| Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | Control: n=25 (69%)<br>• Previous admissions<br>Mean number of hospitalisations in prior 18 months: Intervention: 3.76 +/-1.08, control: 3.94 +/-1.31<br>**Intervention**<br>• Recovery mentors were recruited via formal job postings and once recruited, 8 mentors received training and ongoing weekly supervision sessions from PRCH (Program for Recovery and Community Health). The mentors were instructed not to aim for any specific goal other than to support their participant partners in a partnership-relationship. They were trained to use their own first hand experiences as a basis from which to provide support. The frequency of contact was determined by the mentee in collaboration with his/her mentor.<br>**Follow-up OR time of interview**<br>• Nine months | fewer hospital days and episodes when compared to patients with a psychotic condition. However this does not reach trend levels of probability. | |

<table>
<tr><td colspan="4">Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services. 52: 330–6</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Overall quality assessment</th></tr>
<tr>
<td><b>Methodology</b><br>• RCT<br><b>Study aim</b><br>• To evaluate the effectiveness of a 3-year outpatient commitment pilot programme established in 1994 at Bellevue Hospital in NYC<br><b>Linked study</b><br>• Detail (name, date) of SR in which cited<br>This was cited in Kisely et al. (2007) and was therefore ordered and should be included in RR question<br><b>Source of funding</b><br>• Not reported<br>Country<br>• US, New York</td>
<td><b>Participants</b><br>• Adults (no specified age) with MH conditions<br>People with 2 previous involuntary hospitalisations in the 18 months before the index admission, with a history of noncompliance to treatment who agreed to participate in outpatient commitment as a condition of discharge from Bellevue Hospital. Exclusion criteria: no pick-up order procedures for noncompliant subjects in the court-ordered group were implemented – such procedures allow the New York City police to transport noncompliant subjects and bring them to the hospital. Persons with a history of violence were excluded from the programme.<br><b>Sample size</b><br>• Outpatient commitment n=78<br>Control group (enhanced-service package) n=64<br>Total n=142<br><b>Sample characteristics</b><br>• Not reported<br>‘The two study groups were quite</td>
<td><b>Outcomes 2 (quant)</b><br>• Clinical outcome<br>• Quality of life<br>• Service outcomes<br>• Arrests<br><b>Findings – effect sizes</b><br>• Psychiatric hospitalisations in the outpatient commitment and control groups during follow-up (follow-up was 11 months for most subjects).
<table>
<tr><th>Hospitalisation(s)</th><th colspan="2">Outpatient commitment (n=70)</th><th colspan="2">Control group (n=60)</th><th colspan="2">Total (n=130)</th></tr>
<tr><td></td><td>N</td><td>%</td><td>N</td><td>%</td><td>N</td><td>%</td></tr>
<tr><td>At least 1</td><td>36</td><td>51</td><td>25</td><td>42</td><td>61</td><td>47</td></tr>
<tr><td>Multiple</td><td>19</td><td>21</td><td>8</td><td>13</td><td>27</td><td>21</td></tr>
</table>
*see table in original paper for complete findings<br><br><b>Findings – narrative</b><br><b>• RQ6 Reducing readmissions</b><br>On all major outcome measures, no statistically significant differences were found between the 2 groups; 18% of the court-ordered group and 16% of the control group were arrested at least once. The percentage rehospitalised during follow-up was</td>
<td><b>Internal validity</b><br>• +<br><b>Is the setting similar to the UK?</b><br>• Unclear<br><b>Is there a clear focus on population of interest?</b><br>• Yes<br><b>Is the intervention clearly relevant to RQ(s)?</b><br>• Yes<br><b>Are the outcomes relevant?</b><br>• Yes<br><b>External validity</b><br>• +</td>
</tr>
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| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| | comparable. They did not differ significantly in gender, race, age, and median length of stay. Fifty-four patients (69 percent) in the experimental group were men, compared with 40 (62 percent) in the control group. The numbers by race were 25 (32 percent) and 27 (42 percent) Caucasian, respectively; 30 (39 percent) and 23 (36 percent) African American; and 16 (21 percent) and nine (14 percent) Latino. The mean ±SD ages were 41± 11 years for the experimental group and 41±12 years for the control group. The median lengths of stay for the index hospitalization were 53 days and 51 days, respectively' (p.331).<br>Intervention<br>• One group received court-ordered treatment, which included the enhanced services and the other group received enhanced services only (no court involvement). Enhanced services included: an inpatient assessment, a comprehensive person-centred post-discharge treatment plan, arrangements for ongoing case management, and | about the same for both groups – 51 and 42%, respectively. The groups did not differ significantly in the total number of days hospitalised during the follow-up period. Participants' perceptions of their quality of life and level of coercion were about the same. | |

Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services. 52: 330–6

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
|  | continued oversight of the patient by the outpatient commitment coordinating team. For the group that received court-ordered treatment, the outpatient treatment plan was formalised by a court proceeding and an explicit judicial order.<br>**Follow-up or time of interview**<br>• Follow up at 1, 5 and 11 months |  |  |

Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• Evaluate effectiveness of involuntary outpatient commitment orders (OPCOs) in reducing hospital admissions among adults with severe mental illness<br>**Linked studies**<br>• Details of any linked study (or studies) | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 129<br>• Comparison numbers: 135<br>• Sample size: 264<br>Sample characteristics<br>• Sex<br>Male<br>Controls 49.6%; Intervention 50.4%<br>• Ethnicity | **Outcomes 2 (quant)**<br>• Clinical outcome<br>• Service outcomes<br>**Findings – effect sizes**<br>• Results were divided as follows: control (n=135); OPCO <180 days (n=82) and OPCO <180 days (n=47). Groups shown here as 1, 2, 3 as above.<br>Total psychiatric admissions in 12 months:<br>(1) 1.4 mean, SD 1.55; (2) 0.91, SD 1.23; (3) 0.45, SD 0.80. Summary X2 6.27, df2, p=0.04.<br>Total hospital days:<br>(1) 27.92, SD 51.05; (2) 37.66, SD 61.37; (3) 7.51, | **Internal validity**<br>• +<br>Would need a statistician to assess the findings.<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Yes |

| Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| This study is using the SAME data as Swartz et al. (2001) – we should not double count. This paper is used as it has full details for methods, baseline data, and effect sizes (none of which are reported in 2001 paper, which is really a discursive summary)<br>• Detail (name, date) of SR in which cited<br>Kisely et al. (2007). Randomised and non-randomized evidence for the effect of compulsory community and involuntary outpatient treatment on health service use: systematic review and meta-analysis<br>**Source of funding**<br>• Government<br>NIMH grant.<br>Country | African-American<br>Controls 64.4%; intervention 62.8%<br>• Sample age<br>Controls mean 39.8; Intervention mean 39.6<br>• Level of need/diagnosis<br>Schizophrenic and psychotic disorders: 83% in control group; 95% in intervention group.<br>Bipolar: 31.1% and 20.9%<br>Major depression: 7.4% and 5.4%<br>Intervention<br>• Involuntary outpatient commitment after discharge (OPC order). This is permitted (through courts at clinician's request) in all US states, but may not function well, with weak enforcement. Criteria include SMI, clinical history indicating need for treatment to reduce risk of 'dangerousness'; but capacity to survive in the community. Initial period of up to 90 days is allowed. Forced medication is not allowed: if the patient fails to adhere to treatment, police can be asked to escort person to community provider for 'persuasion'. If this fails, or the person repeatedly does not adhere, involuntary | SD 15.90. Summary X2 8.51, df2, p=0.01.<br>Results solely for those with non-affective psychotic disorders:<br>Results were divided as follows: controls (n=83); OPCO <180 days (n=60) and OPCO <180 days (n=35).<br>Total psychiatric admissions in 12 months:<br>(1) 1.23 mean, SD 1.73; (2) 0.95, SD 1.28; (3) 0.34, SD 0.80. Summary X2 11.81, df2, p=0.003.<br>Total hospital days:<br>(1) 32.84, SD 55.72; (2) 40.08, SD 61.67; (3) 4.57, SD 12.96. Summary X2 14.29, df2, p=0.001.<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>'As shown in table 2, relative to control subjects, sustained outpatient commitment reduced mean admissions by roughly 57% and hospital use by 20 days. The proportion of subjects with any hospital admissions, although showing this trend, failed to reach statistical significance in these bivariate analyses' (p1971).<br>However, the summary table 2 does not show the advantage to have been as great as implied here. The authors also state that 'When we refined the above analyses on two clinical subgroups stratified by diagnoses, we found the effect of sustained | **Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• - |

| Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| • US, North Carolina region | inpatient commitment is the sanction. Orders can be repeated after the 90-day period expires, or at any other time. Typically, they were initiated at 30 or 60 days, but rose to over 180 days in some of the sample (separate analysis). Note that ALL participants received case management, and intensity of treatment in community was determined by need as usual. NONE of the controls were able (under study protocol) to be put on an OPCO, but any of the sample could be rehospitalised.<br>**Follow-up OR time of interview**<br>• Interviews were conducted with subject, carer and case manager at 4,8 and 12 months - but the content of these is not described. Data on use of community-based treatment services, outpatient commitment proceedings and psychiatric admissions were collected at 12 months (i.e patient use of services was followed up for 12 months) and reported here. Study also measured global functioning and insight and treatment attitudes (using structured measures), but these were used only to compare the 2 groups at | outpatient commitment on hospital outcomes occurred primarily among study subjects with non-affective psychotic diagnoses (schizophrenia, schizoaffective, or other psychotic disorder), where mean admissions were significantly reduced approximately 72% and mean hospital stays by 28 days. Psychotic subjects in the sustained outpatient commitment group were also admitted less than half as often as those in the control group' (p1971).<br>No such effect was seen in the sub-sample with affective disorders (i.e in mean admissions or hospital bed days). The authors conclude that there may be an effect attributable to longer periods of outpatient commitment, AND that the intensity of outpatient treatment may also have an effect in reducing readmissions: but it is a major limitation of the study that neither of these were under experimental control. Further modelling was carried out within the psychotic group in relation to the number of outpatient visits they had attended. This claims to conclude that the beneficial fall in hospital admissions for psychotically disordered subjects occurred because they received higher levels of services. Having more OP appointments was associated with lower cumulative hospital appointments across the 12 months, particularly for those with more than 180 days' OPCO (as the | |

Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
|  | baseline (i.e there was no aim to compare treatment effects over the year). | controls and <180 days converged at around 6 months). (This is illustrated by a graph which is difficult to replicate here.) |  |

Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• RCT<br>**Study aim**<br>• To determine whether the drawing up of a JCP with people with severe mental illness and at least 1 admission would experience (compared with TAU group) 'fewer compulsory admissions (primary outcome); fewer psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• Intervention number: 285<br>• Comparison numbers: 284<br>• Sample size: 569<br>Sample characteristics<br>• Sex: 51% male<br>• Ethnicity: 62% white, 10% Asian or British Asian, 22% black or black British<br>• Sample age: mean 39.8 years, eligible if over 16<br>• Level of need/diagnosis<br>SMI, at least 1 psychiatric admission in past 2 years, on enhanced Care | **Outcomes 1 (qualitative)**<br>• what works well<br>Interviews undertaken with sample of participants from intervention group<br>**Outcomes 2 (quant)**<br>• Admissions under MHA<br>This is primary outcome (formal admissions). Also, fewer psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved therapeutic relationships; and improved engagement.<br>• Service outcomes<br>Fewer formal and (all type) psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved therapeutic relationships; and improved engagement. In addition to records of admissions, | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes** |

Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| therapeutic relationships; and improved engagement' (from abstract).<br>Linked study<br>• Details of any linked study (or studies)<br>Barrett et al. (2013) RCT of JCPS ... Economic outcomes. Henderson et al. (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMJ 329: 136. BUT NOTE THIS EARLY DATE WHICH SUGGESTS MAY BE A PILOT.<br>**Source of funding**<br>• Government<br>NIHR.<br>• Funding council<br>MRC.<br>**Country**<br>• UK | Programme Approach.<br>• Previous admissions<br>One or more within past 2 years<br>Intervention<br>• Joint Crisis Plan: 'The JCP is a negotiated statement by a patient of treatment preferences for any future psychiatric emergency, when he or she might be unable to express clear views.'<br>Follow-up or time of interview<br>• 18 months | scales used at follow up were: For the therapeutic relationship (self and clinician rated Working Alliance Inventory [WAIC and WAIT] adapted for use in community settings), perceived coercion (MacArthur Perceived Coercion Scale, self-rated), and engagement (Service Engagement Scale, clinician-rated).<br>**Costs**<br>• Economic evaluation – full or partial<br>Reported in Barrett et al. (2013).<br>• RQ 6 – Reducing readmission<br>**Findings – effect sizes**<br>• No significant treatment effect was seen for the primary outcome, compulsory or formal admission (56 [20%] sectioned in the control group and 49 [18%] in the JCP group; odds ratio 090 [95% CI 0.58-1.39, p=0.63]). Mean duration of 20·6 (SD 73·4) days in the control group and 22·3 (72·0) days in the JCP group. For any admission (compulsory or voluntary), the mean durations were 26·4 (76·2) days in the control group and 29·5 (75·7) days in the JCP group. There were a total of 158 admissions: 81 (29%) in the control group and 77 (29%) in the JCP group. No significant effect seen within other secondary measurable outcomes, with the exception of an improved secondary outcome of therapeutic relationships (173 [76] vs 160 [71]; | **relevant?**<br>• Yes<br>**External validity**<br>• ++<br>Not sure that the guidance here is good – the study is very relevant, but the intervention was not implemented well, which is why it only has a + for internal validity. However, the poor implementation IS likely to be similar across other UK settings. |

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | adjusted difference -1.28 [95% CI -2.56 to -0.01, p=0.049]).<br>**Findings – narrative**<br>**• RQ6 Reducing readmissions**<br>The intervention (JCP) had no significant impact on formal admissions, any psychiatric admissions, LOS, perceived coercion or improved engagement. There was a small improvement in therapeutic relationships, which is consistent with the qualitative data. Qualitative data (p1638–9) suggested improvement in patients’ views of the therapeutic relationships and suggested that JCPs could make patients feel respected and more understood by clinicians, feeling ‘listened to’. Some clinicians seemed to gain a wider understanding of how patients felt when unwell. However, some patients did not recall the JCP being discussed as it did not stand out from the general CPA process and meetings, and it seemed that there had been poor engagement in the majority of cases by clinicians with the process, who did not think the JCP planning was a worthwhile intervention which added anything to CPA, nor that it needed to be patient-led. (This is not consistent with the authors’ reporting of high fidelity with the intervention, see p1637, but the nurse facilitators may have found it difficult to ‘steer’ psychiatrists, who are of higher rank). In addition, | |

| Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381: 1634–41 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | ‘many patients complained that the agreements in the JCPs were not honoured in practice and only 5 of the 28 care coordinators reported referring to or using the JCP during the follow-up period (p1639). | |

## Critical appraisal tables

### Table reporting views studies

## Review Question 6: What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

| Canvin K, Rugkåsa J, Sinclair J, Burns T (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–82 | | | | |
|---|---|---|---|---|
| **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• In depth qualitative interviews<br>**Is the study clear in what it seeks to do?** | **Was the sampling carried out in an appropriate way?**<br>• Inappropriate<br>Purposive sampling. Patients were invited from the OCTET | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable | Representativeness of sample is questionable, as psychiatrists and patients were recruited through OCTET trial which has | **As far as can be ascertained from the paper, how well was the study** |

| Canvin K, Rugkåsa J, Sinclair J, Burns T (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–82 | | | | |
|---|---|---|---|---|
| **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| • Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>Participants were from a range of settings in the UK: Northwest, South West, South East, East, East and West Midlands and London.<br>**Study approved by ethics committee?**<br>• Yes. Staffordshire NHS Research Ethics Committee<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | RCT sample, as were psychiatrists from the pool of those used for OCTET. Family carers were recruited via carer organisations and health trusts. (NB Tom Burns, author of the OCTET trial RCT is a co-author of this paper).<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Data collection was just by 1 method, but findings discussed among team and in relation to other studies.<br>**Is the role of the researcher clearly described?**<br>• Clearly described | **Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | been criticised for not including patients with higher risk profiles, or more serious conditions (clinicians have to deem patients suitable to be randomised to s17 leave or CTO).<br>Not all professionals involved in administering CTOs were interviewed – notably AMHPS were absent from the study.<br>The overwhelming majority of carers interviewed were parents (n=22/24) and the views and experiences of this group may differ from those of family carers who were e.g. spouses or siblings. | **conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 |
|---|

| Study design | Study methods | Data collection | Analysis & reporting | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Survey<br>Objectives of the study clearly stated?<br>• Yes<br>Relevance to our review question(s)?<br>• Yes | **Research design clearly specified and appropriate?**<br>• Partly<br>**Clear description of context?**<br>• Yes<br>References made to original work if existing tool used?<br>• N/A<br>**Reliability and validity of new tool reported?**<br>• N/A<br>**Survey population and sample frame clearly described?**<br>• Yes<br>**Representativeness of sample is described?**<br>• Partly<br>A list of patients subject to CTO was provided by Mental Health Act offices in the Merseyside area in November 2010 following local NHS trust approval. Population may not be representative but be biased towards those in | **Describes what was measured, how it was measured and the outcomes?**<br>• Yes<br>The authors designed a structured interview based upon information in patient leaflets provided by a local mental health trust. The interview included 14 questions based upon 4 main themes: involvement in planning of CTO, quality of provided information, awareness of CTO process and legal rights and outcomes and satisfaction. The questions referred to ‘CTO’ (community treatment order) as this was the term the authors believed would be recognised by patients in the survey population.<br>**Measurements valid?**<br>• Yes<br>**Measurements reliable?**<br>• Yes<br>**Measurements reproducible?** | **Basic data adequately described?**<br>• Yes<br>**Results presented clearly, objectively and in enough detail for readers to make personal judgements?**<br>• Yes<br>**Results internally consistent?**<br>• Yes<br>**Data suitable for analysis?**<br>• Yes<br>Clear description of data collection methods and analysis?<br>• Yes<br>Methods appropriate for the data?<br>• Yes<br>A Likert scale was used for each interview question where 1=strongly disagree, 2=disagree, 3=neither agree or disagree, 4=agree and 5=strongly agree. Also each structured question was followed by an open-ended question to explore patient experience, beliefs and expectations related to the SCT process. Two authors conducted a face-to-face interview and survey in the patient’s home – 1 to conduct the interview and the other to transcribe verbal responses. The length of each interview was 45–90 minutes. | **Internal validity**<br>• -<br>This study has significant limitations.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the review question?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | favour of SCT.<br>**Subject of study represents full spectrum of population of interest?**<br>• Partly<br>Primary diagnosis of participants and numbers as follows: schizophrenia (12) schizoaffective disorder (3) delusional disorder (1) mental disturbance due to drugs or alcohol (1). However low female and ethnic minority representation.<br>**Study large enough to achieve its objectives, sample size estimates performed?**<br>• No<br>**All subjects accounted for?**<br>• Yes<br>**All appropriate outcomes considered?**<br>• Yes<br>Key outcome – hospital | • Yes | **Statistics correctly performed and interpreted?**<br>• Yes<br>Response rate calculation provided?<br>• No<br>**Methods for handling missing data described?**<br>• No<br>**Difference between non-respondents and respondents described?**<br>• No<br>**Results discussed in relation to existing knowledge on subject and study objectives?**<br>• Yes<br>**Limitations of the study stated?**<br>• Yes<br>The authors state that a limitation of this study is that it is based upon a small sample size. The survey was conducted within 25 months of SCT being introduced in England and Wales and most patients had not been recalled to hospital. Those who were held considerably more negative views about SCT. The survey was | |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| | readmission.<br>**Ethical approval obtained?**<br>• N/A<br>This was a service evaluation and as such the NHS Trust waived the requirement for formal ethics approval. But an information sheet was developed clarifying the study aims and objectives and the voluntary nature of participation, as dictated by good practice.<br>**Measures for contacting non-responders?**<br>• No | | retrospective and relied upon the ability of patients to recall events from up to 25 months ago. The bulk of questioning was about events that happened prior to discharge when a patient's cognitive function may have been poor due to acute or residual mental illness. There is likely to be significant recall bias in the study.<br>R**esults can be generalised?**<br>• Partly<br>**Appropriate attempts made to establish 'reliability' and 'validity' of analysis?**<br>• No | |

| Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| **Methodology** | **Research design clearly specified and** | **Describes what was measured, how it was** | **Basic data adequately described?**<br>• Partly | **Internal validity**<br>• - |

| Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88 | | | | |
|---|---|---|---|---|
| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
| • Survey<br>**Objectives of the study clearly stated?**<br>• Partly<br>**Relevance to our review** question(s)?<br>• Yes | **appropriate?**<br>• Partly<br>**Clear description of context?**<br>• Partly<br>**References made to original work if existing tool used?**<br>• N/A<br>**Reliability and validity of new tool reported?**<br>• N/A<br>**Survey population and sample frame clearly described?**<br>• Partly<br>**Representativeness of sample is described?**<br>• No<br>**Subject of study represents full spectrum of population of interest?**<br>• Unclear<br>**Study large enough to achieve its objectives, sample size estimates performed?** | **measured and the outcomes?**<br>• Partly<br>'Presents details of the patients' preferences for care, their views on the usefulness of the booklet and the comments of their key-workers'. However, the references back to the original RCT were quite haphazard which made it problematic trying to disentangle information from this views study<br>**Measurements valid?**<br>• Yes<br>**Measurements reliable?**<br>• Yes<br>**Measurements reproducible?**<br>• Yes | Responses presented in tabular format. No in-depth examination of key themes.<br>**Results presented clearly, objectively and in enough detail for readers to make personal judgements?**<br>• Partly<br>More exploration of key themes would have been useful.<br>**Results internally consistent?**<br>• Unclear<br>**Data suitable for analysis?**<br>• Yes<br>**Clear description of data collection methods and analysis?**<br>• Partly<br>The detail of the research methods was not clearly described in the paper. Analysis was more explicit in that data obtained from the patients' directives and the keyworkers' questionnaires were content analysed independently by 2 researchers and entered into a word processing package to establish descriptive categories (Krippendorf 1980). The number of responses under each category were then counted | Methods section not entirely clear.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the review question?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>Primary outcome was rate of compulsory readmission over 12 months.<br>**Overall assessment of external validity**<br>• + |

Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88

| **Study design** | **Study methods** | **Data collection** | **Analysis & reporting** | **Overall assessment** |
|---|---|---|---|---|
|  | • Yes<br>Patients in the intervention group completed a questionnaire about their experience of the advance directive and how to improve it. At 12 months follow-up consultant psychiatrists and keyworkers were asked by questionnaire about their awareness of, and use of the ‘existence of the preference for care booklet’, and how it could be improved.<br>**All subjects accounted for?**<br>• No<br>80 patients were randomly allocated to the intervention group but 79 advance directives were analysed. One unaccounted.<br>All appropriate outcomes considered?<br>• Yes<br>**Ethical approval** |  | independently and inter-rater reliability was calculated by using Cohen’s kappa coefficient (k=0.88).<br>**Methods appropriate for the data?**<br>• Partly<br>Structured interview format does not allow for fuller exploration of key themes.<br>**Statistics correctly performed and interpreted?**<br>• N/A<br>Mainly based on views data.<br>**Response rate calculation provided?**<br>• No<br>**Methods for handling missing data described?**<br>• No<br>**Difference between non-respondents and respondents described?**<br>• No<br>**Results discussed in relation to existing knowledge on subject and study objectives?**<br>• Yes<br>**Limitations of the study stated?** |  |

Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88

| Study design | Study methods | Data collection | Analysis & reporting | Overall assessment |
|---|---|---|---|---|
|  | **obtained?**<br>• No<br>**Measures for contacting non-responders?**<br>• No |  | • No<br>**Results can be generalised?**<br>• Partly<br>**Appropriate attempts made to establish ‘reliability’ and ‘validity’ of analysis?**<br>• Unclear |  |

Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92

| Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Linked study**<br>• Same study, different paper<br>Stroud et al. (2013) An exploration of service user and practitioner experiences of community treatment orders | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>There was an amendment to the original recruitment strategy of service users which involved 2 samples; 1 prospective sample from the study period and 1 retrospective sample from the year prior to the study period. Due to challenges in recruiting desirable numbers of service | **Are the data ‘rich’?**<br>• Rich<br>Responses compared from all groups involved: service users, nearest relative, clinicians, AMHPS, accommodation providers.<br>**Is the analysis reliable?**<br>• Somewhat reliable<br>Data from interviews was analysed using thematic analysis and NVivo – unclear | Researchers experienced considerable challenges in recruiting the desired number of services users, and as a result, amended the original recruitment strategy. Response rates for services users were ultimately still very low, approximately around 12%. Response rates for nearest relatives was only slightly | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat |

| Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92 | | | | |
|---|---|---|---|---|
| **Qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| (presents full findings of qualitative interviews and discussion of the misunderstandings of the power of CTOs).<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>Qualitative research is appropriate to identify significant issues and good practice in relation to CTO. A research group of 4 paid service users was involved in designing interview schedules, conducting some of the interviews, reviewing findings and data analysis and in other aspects of the research process.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes | users the final sample was drawn from CTO records from November 2008, when CTOs first became available, to December 2012.<br>**Response rates**<br>Response rate for service users was roughly around 12%<br>Response rate for nearest relative = 15%<br>Response rate for service providers = 50%<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>Interviews took 30–60 minutes and were digitally recorded.<br>**Were the methods reliable?**<br>• Somewhat reliable<br>**Is the role of the researcher clearly described?**<br>• Unclear | how many researchers were involved, or how disagreements were resolved.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | higher at 15%. | relevant |

Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92

| Qualitative methods | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| Ethics and governance approval was received from the University of Brighton's Faculty of Health and Social Science Research Ethics and Governance Committee (sponsors of the research); NHS Research Authority NRES Committee South East Coast – Surrey; the SPFT; Brighton and Hove County Council; West Sussex County Council and East Sussex County Council.<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | | | | |

## Findings tables

## Table reporting views studies

## Review Question 6: What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

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|---|
| Canvin K, Rugkåsa J, Sinclair J, Burns T (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–82 |

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| **Methodology**<br>• Qualitative study In-depth qualitative interviews.<br>**Study aim**<br>• To examine participants' experiences of the mechanisms via which the CTO was designed to work. In particular the conditions that form part of the order, the power of recall, legal clout and impressions of CTO effectiveness. Overall the paper aims to contribute to the fuller picture of how the law is implemented and how CTOs operate in practice.<br>**Country**<br>• UK<br>**Source of funding**<br>• NIHR | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Carers/family members of people with MH conditions<br>• Professionals<br>**Sample size**<br>• Psychiatrists n=25<br>Patients n=26<br>Carers n=24 including 3 couples (cared for n=21)<br>Sample characteristics<br>• Sex<br>Male<br>Psychiatrists (n=25): 19 patients (n=26): 18<br>Carers (n=24) : 7<br>• Ethnicity<br>Psychiatrists Patients Carers<br>White 18 14 21<br>Black 1 7 0<br>Others 7 5 3<br>• Level of need/diagnosis<br>Primary diagnosis (/of cared for)<br>Patient Carer<br>Schizophrenia 18 (21)<br>Bipolar 7 (3)<br>Other psychosis 1 (0)<br>Depot 14 (11) | FINDINGS – NARRATIVE<br>• RQ1 SERVICE USER VIEWS<br>For patients CTOs were synonymous with their conditions. Most patients described 'having to' do something as part of their CTO. On the whole, this involved 'having to' take medication, which was not always appreciated.<br>'They just want me to take the medication but I think the mental health services rely too much on medication and not enough on other means of solving people's problems' (p1876/7).<br>Despite this, some expressed confusion about whether their CTO included conditions at all and others referred to them without being prompted. None of the patients interviewed distinguished between mandatory and discretionary conditions.<br>Patients' responses to conditions were very varied – some rejected them outright and others greeted them with matter-of-fact acceptance.<br>Some patients questioned the need for compulsion: 'I'm not a criminal; I don't know why I have to report everything I do' (p1877).<br>Medication ties, travel restrictions and conditions around accommodation were view as patients as restricting their freedom; some expressed feeling 'trapped' or 'imprisoned'.<br>One or 2 however, welcomed the security offered by the CTO:<br>'On the surface [the CTO] does seem freer ... It was better than being on a section because you would end up in hospital being away from everybody' (p1877).<br>RECALL<br>Patients were very aware of what the perceived to be the 'threat' of recall 'hanging over them'. Only 2 patients used the term 'recall' unprompted and some could not remember if they had ever been | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Canvin K, Rugkåsa J, Sinclair J, Burns T (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–82 | | | |
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| | History<br>of violence not known (12)<br>• Previous admissions<br>• Not reported<br>Relationship to cared for:<br>Carers<br>Parent 22<br>Spouse 1<br>Sibling 1<br>Intervention<br>• Community treatment order<br>Time of interview<br>• CTO status at interview<br>Patient Carer<br>Ongoing CTO 13 (14)<br>Revoked 4 (2)<br>Ended for unknown reason 8 (0) | recalled.<br>In contrast to the psychiatrists, patients generally believed that recall had a relatively low threshold and could be used for non-compliance with conditions, one-off refusal of medication, or simply ‘on a whim’.<br>A few patients who had experience of recall said the power could be used if they showed signs of illness:<br>‘All I know is that if I don’t take my Depot and they think – and my CPN or my doctor thinks I’m not very well then they can put me back into hospital without me having a say in it really’ (p1878).<br>Patients expressed that there was little difference between recall and being involuntarily detained: both led to unwanted hospitalisation. However, some preferred the recall procedure because it meant being recalled by letter, rather than ‘everybody coming round’, being transported to hospital in a car rather than ambulance, and being admitted more quickly.<br>LEGAL CLOUT<br>Most seemed to understand that adherence to the conditions of the CTO was a ‘legal requirement’. They saw the CTO as tantamount to being forced to take medication – and this feeling of being forced also led them to take the medication. ‘If it was free choice I would say, “No, I don’t want it”’ (p1879).<br>IMPRESSIONS OF CTOs EFFECTIVENESS<br>Some patients described feeling well and enjoying greater stability since being on a CTO. However, not many thought that they had spent less time in hospital or had fewer readmissions.<br>‘I’m the sort of person who is in and out of hospital like a Yo–Yo with | |

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| | | CTOs or without them' (p1879).<br>A few patients acknowledged that the CTO had improved their treatment adherence and said that they preferred the way things were under the CTO. One patient identified the use of depot medication as helping with treatment adherence.<br>Close monitoring of medication (for e.g., checking that pills were swallowed) was seen by some as unnecessarily intrusive and disempowering. They felt it got in the way of them living a 'normal life' including social life and the ability to work.<br>• RQ2 CARERS' VIEWS<br>Carers perspectives of CTOs<br>(The Mental Health Act Code of Practice states that patients and their families should be consulted about the CTO, its conditions and the need to recall.)<br>Carers described conditions as a helpful mechanism because the CTO carried legal authority that carers did not or could not apply themselves – at least not without risk of jeopardising their relationship with the person they cared for.<br>As with the patients, medication adherence and keeping in contact with services were the most frequently mentioned conditions.<br>Many, but not all, had been informed and/or seen formal documentation of what conditions applied.<br>Even so some carers struggled to distinguish the conditions of the CTO from other restrictions/conditions imposed on the person they cared for, for example, parole conditions or curfew imposed by supported housing. Carers reported that the mental health team also appeared uncertain | |

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| | | about how CTO conditions could be used.<br>For example, some said that they had been told the depot medication was a necessary CTO condition. One carer reported being told that abstinence from alcohol could not constitute a CTO condition.<br>Some carers expressed disappointment about the limited scope of the conditions and mentioned that they would have liked the conditions to have included social engagement.<br>‘C: If the team were active and found something for this intelligent man to do … then I would see a way of recovery in terms of being included in things and going out and getting fresh air.<br>I: Would he do it do you think if [the team] came knocking on the door?<br>C: If he had to.<br>I: OK, so it would have to be made conditional?<br>C: Absolutely. If it meant that rather than hospital he would [do it]’ (p1877).<br>RECALL<br>Family carers described the power of recall and the ‘threat’ or ‘fear’ of readmission as instrumental in increasing medication adherence.<br>Knowing that their relative could be returned to hospital without full relapsing allayed some carers’ concerns about patient well-being and, in some cases, their own safety.<br>One carer explained that the power of recall meant she was ‘not the nervous wreck [she] was’ (p1878).<br>Those who had experience of recall said that helpfully, it had happened without delay: | |

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| | | 'He wouldn't take his medication when he relapsed and that was the reason they could take him back into hospital. So we would have perhaps a fortnight of it instead of 4 months … It makes such a difference. It saves us all so much distress' (p1878).<br>A couple of carers described situations where they had intervened with decisions about recall – 1 of which was considered premature and the other was when the carer found out there weren't any beds available locally. However, not all family members reported having that level of influence.<br>Many carers believed that recall would occur automatically if a condition (especially medication related) was breached. Others were able to explain that other signs of deterioration would also be necessary. Many expressed confusion around the exact criteria for recall.<br>LEGAL CLOUT<br>Like patients, family carers also largely described the rationale of the CTO as obliging patients to take medication.<br>They described their relative's respect for the law and/or the power of recall as the key mechanism for achieving adherence. Legal clout was viewed as more effective than pressure from friends or family.<br>IMPRESSIONS OF CTOs EFFECTIVENESS<br>Most carers reported unprecedented adherence during and beyond the CTO period; several said that their relative had not been back to hospital (either voluntarily or by recall) under the CTO.<br>Carers spoke of improvements in social functioning, such as 2 patients gaining part-time employment, and 2 forming romantic relationships. Some carers attributed these outcomes to the CTO working as it should, | |

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| | | while others were mindful that other factors may have been involved.<br>Lack of support beyond medication was a serious concern shared by all carers.<br>‘He’s simply being held by a drug really. A drug he needs, but that isn’t all that he needs … I’d like to see compliance strengthened by really good CMHT. Some people say well he has more freedom on a CTO because he takes the medication. But I don’t see that. I see that he doesn’t have more freedom because it doesn’t address the other issues’ (p1880).<br>The focus on medication means that CTOs did not address lack of motivation or desire to engage socially (and focussed instead on dealing with symptoms such as hearing voices, hallucinations). Failing to address social issues was seen as insufficient for recovery or ‘having a life’.<br>Many family carers saw that their involvement and communication with mental health teams contributed to the effectiveness of the CTO.<br>Some described being in continuous communication with clinicians. Others said they were ignored or excluded from decision making, while others welcomed the opportunity to step back. As the CTO moved the onus on to services rather than individual carers, the CTO relieved pressure for some carers.<br>• RQ3 PRACTITIONERS’ VIEWS<br>CTO CONDITIONS<br>Many described inserting only ‘minimal’ conditions, the ‘usual’ ones being medication adherence and contact with the mental health team.<br>Achievability and enforceability were the main drivers guiding the design | |

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| | | of conditions. None of the psychiatrists interviewed described including conditions related to work or social activities as they were seen as ‘unworkable and pointless’.<br>RECALL<br>Psychiatrists perceived the power of recall to be the mechanism that gave CTO traction. They believed that adherence was driven by patient’s belief that non-adherence would lead directly to hospitalisation via recall. There were varying interpretations of the law and the Code of Practice relating to the use of recall. Most – but not all – understood the Code of Practice as requiring evidence of deterioration in the patient’s mental health for recall. For some, this set the threshold for recall disappointingly high and limited the utility of CTOs in practice.<br>Others admitted that they purposefully withheld information from the patient:<br>‘The patient is not always entirely clear what happens and I don’t always clarify exactly what happens either’ (p1877).<br>Others expressed concern over the ethics of reminding non-compliant patients about the potential for recall, asking ‘Is it blackmailing when you say “recall or injection”?’ (p1877).<br>Overall the view of recall was positive, but many described the procedure as too complex and time-consuming.<br>Following limitations were mentioned:<br>- 72h assessment period deemed inadequate<br>- insufficient availability of beds limits use of recall<br>- lack of clarity about out-of-hours or out-of-area procedures had caused | |

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| | | logistical difficulties in several cases.<br>LEGAL CLOUT<br>The main purpose of the CTO for psychiatrists was legally obliging patients to engage with services and adhere to medication regimes.<br>‘I think a bit of the law actually helps because they worry, “Oo, better keep going with it. This is the law. The doctor says it’s the law so I’ll stick with it”’ (p1879).<br>IMPRESSIONS OF CTO’s EFFECTIVENESS<br>Most psychiatrists reported examples of where they thought the CTO had been effective for achieving adherence to medication and readmissions, and those where it had not.<br>One assertive outreach psychiatrist commented that in his experience if he had 15 to 20 patients on CTOs:<br>‘One-third or so have a major beneficial response. There’s another third who it makes some difference but it’s not the entire answer – and it’s never going to be- and the other third it doesn’t make a shadow of difference’ (p1879).<br>Some said that the numbers were too small to judge, and it would only be possible to draw a conclusion based on 100s of cases. Psychiatrists were also reluctant to attribute changes in outcomes directly to the CTO.<br>None of the psychiatrists said that CTO patients received more or less preferential treatment than those not on CTOs. Even so, some referred to benefits which the CTO brought with it, such as a period of stability and structure.<br>• RQ6 REDUCING READMISSIONS | |

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| | | All 3 groups perceived the main purpose of the CTO to be enforcement of medication, and that the legal clout was instrumental in achieving medication adherence.<br>Even so, all 3 groups also acknowledged that the CTO was only effective for certain patients and a range of shortcomings were identified.<br>- The focus on medication – to the exclusion of additional support of service provision - was considered a major flaw by carers, and one that impeded their relative’s recovery.<br>- In contrast, psychiatrists emphasised that CTOs were not treated preferentially, perhaps because they wanted to emphasise that there were no perverse incentives (such as additional support), for placing a patient on a CTO.<br>The way that the CTOs’ mechanisms worked in practice could be influenced by people’s understanding of those mechanisms. Participants’ understanding of how those mechanisms worked varied drastically.<br>All groups expressed uncertainty over the enforceability of discretionary conditions, and the exact criteria for recall.<br>A wide range of experiences was identified in each group, implying that there is no such thing as a definitive patient, psychiatrist or carer experience of CTOs. | |

| Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64 |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
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| **Methodology**<br>• Survey (use 7 CA)<br>**Study aim**<br>• This paper explores the views of patients subject to supervised community treatment (SCT) within 2 mental health teams in Merseyside<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>**Sample size**<br>• 17 patients<br>**Sample characteristics**<br>• Sex<br>Of the 17 patients who took part in the survey 14 (82%) were male and 3 (18%) female<br>• Disability<br>In total, 12 (70.6%) subjects had a primary diagnosis of schizophrenia, 3 (17.6%) with schizoaffective disorder, 1 (5.9%) with delusional disorder and 1 (5.9%) with a mental and behavioural disorder secondary to alcohol.<br>• Ethnicity<br>White British<br>• Sample age ranged from early 20s to mid-60s<br>**Intervention**<br>• Supervised community treatment<br>The mean duration of SCT was 15.6 months (range 2 months to 25 months). | FINDINGS – NARRATIVE<br>• RQ1 SERVICE USER VIEWS<br>Generally, there was mixed satisfaction with SCT. Some patients were positive (41%, n=7), others were indifferent (12%, n=2) and a proportion saw this as damaging to their life (47%, n= 8). Two patients who had been recalled to hospital conveyed strong dissatisfaction with SCT. A common theme identified was an overall restriction of a patient's liberty and anxiety that he or she would be detained if they did not adhere to the conditions of SCT. One patient said 'The CTO restricts my liberty. The police can come to my flat whenever they want. They own my life. I've got no liberty'.<br>Patients with positive responses included 'I believe that if I did relapse the doctor would be able to give me medication. I feel like a better person, more normal again' (p162).<br>• RQ5 DISCHARGE<br>See RQ5 above<br>• RQ6 REDUCING READMISSIONS<br>Most patients (59%, n=10) believed SCT prevented readmission to hospital, for example, through having to conform to medication regimes because they believed they would be recalled to hospital if otherwise.<br>'It made me speak to the doctor more. I have more contact with the CPNs. I'm on an injection – I can't not take it. It made me take my injection more' (p162). | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on the population of interest?**<br>• Yes<br>**Is there a clear focus on the review questions?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

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| | | However, some patients believed other changes would prevent readmission rather than SCT – such as depot medication and lifestyle choices.<br>There was a common misunderstanding that the patient must strictly adhere to the conditions of their SCT to stay in the community, and there was a lack of knowledge about the harm criteria and the responsible clinician's ability to recall a patient to hospital even if they abided by the conditions. There was a common misunderstanding that the patient must firmly abide by the conditions of their SCT to remain in the community, and there was a lack of awareness that recall was dependent on the 'harm criteria' (as set out in 'Section 17E (1) (a) (b) – namely the consideration of risk to the patient's own health or safety, or the safety of others'). The author posits that 'the effectiveness of SCT may be thought to be based on a perception that is fallacious'.<br>A significant proportion of patients lacked the motivation or ability to understand the verbal and written information affecting their legal rights at the time it was given, usually immediately prior to hospital discharge. | |

| Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88 |
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| Research aims | Population | Findings | Overall quality assessment |
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| **Methodology**<br>• Survey<br>**Study aim**<br>• 'To examine the content of advance directives used in psychiatric care and both patients' and professionals' views concerning their content, implementation and usefulness'<br>**Linked study**<br>• Details of any linked study (or studies)<br>There is also a 2002 Papageorgiou paper, which is the RCT.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Professionals/practitioners<br>**Sample size**<br>• 161 inpatients, who were due for discharge from a hospital commitment order, were recruited between October 1997 and October 1998 from 2 psychiatric units in North London in the RCT. This views study was focused on only the intervention group of 80 individuals<br>**Sample characteristics**<br>• Sample age<br>18–65.<br>Intervention<br>• Advance directives – the content of the directives was analysed along with patient and staff views regarding their use.<br>**Follow-up OR time of interview**<br>• 12 months from first interview with patients | **Outcomes 1 (qualitative)**<br>• What works well<br>• Experiences described<br>**Outcomes 2 (quant)**<br>• Service outcomes<br>**Costs**<br>• No<br>FINDINGS – NARRATIVE<br>• RQ1 SERVICE USER VIEWS<br>In terms of content of the preference for care booklet, patients' fundamental preferences concerned reduced coercion or enhanced human rights, the increased availability of alternative therapies, counselling, psychotherapy, better hospital facilities (e.g. 'my own room') and staff contact with their families. Patients did not use the directives as a chance to refuse all treatment as is a misconception. Patients said if they became ill again they would like various options including: more talking therapies (29%), more service input (29%), support to take medication (25%), and family and/or social support (24%). The majority of the patients asked for 1 or more family members to be contacted.<br>The patients' views<br>Three-quarters of patients at follow-up remembered having drawn up an advance directive. But over half did not remember what had become of it. This suggests a lack of understanding of the importance of the directive or a lack of affirmation of the directive by staff. | **Internal validity**<br>• -<br>Methods section not entirely clear.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on the population of interest?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>Primary outcome was rate of compulsory readmission over 12 months.<br>**Overall assessment of external validity**<br>• + |

| Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | A small percentage found advance directives useful mainly as a therapeutic tool to help them evaluate their condition, or as a way of seeking care and engaging themselves in activities that might improve their condition and quality of life. While over 40% reported that they would want to use the directives again or would recommend them to others, the authors suggest that a similar number did not find the current advance directives useful because the professionals involved in their care did not refer to, or acknowledge them in subsequent care.<br>• RQ3 PRACTITIONERS' VIEWS<br>The majority of psychiatrists could not recollect the existence of the patient's directive (71%) or find it useful in the management of that patient's care (61%). Only psychiatric consultants who returned questionnaires said the directives were worthwhile as it gave them more insight into their patients' values and subjective experiences and saw its potential for patients' empowerment. Briefing of health professionals about the directives, sending a copy for each patient to them and placing a further copy at the front of the medical notes, did not promote the awareness or use of the directives. Those staff who did not find it useful, said that it was not integrated into the patient's care plan or they were not involved in the procedure of drawing up the booklet. The authors suggest embedding the advance directive into the CPA might improve compliance, | |

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| | | as may the integration of advance directives into relapse prevention programmes.<br>• RQ6 REDUCING READMISSIONS<br>See RQ1 and RQ3 | |

Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92

| Research aims | Population | Findings | Overall quality assessment |
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| **Methodology**<br>• Qualitative study<br>**Study aim**<br>• To explore the experiences of services users, care coordinators, responsible clinicians (RCs), approved mental health professionals (AMHPs) service providers and nearest relatives with the aim of identifying significant issues and good practice in relation to CTOs. | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Carers/family members of people with MH conditions<br>• Professionals/practitioners<br>**Sample size**<br>• 21 service users 35 practitioners (16 care coordinators; 10 responsible clinicians and 9 AMHPs). Seven nearest relatives 9 service providers (housing)<br>**Sample characteristics**<br>• Ethnicity<br>Service users from an ethnic | • RQ2 CARERS' VIEWS<br>Nearest relatives (NRs) and housing providers, who often felt unsupported by services and saw themselves placed in the 'front line' of care provision, valued the reassurance of the safety net provided by the CTO. They felt reassured by the regular support provided to the service user and the compulsion to take medication. In particular they appreciated having clear contacts to call and that an emergency appointment could be triggered. They also valued that the CTO enabled their relative to be admitted to hospital more quickly, without having to go through a new assessment under the Act. Many nearest relatives reported feeling that the CTO had made a positive impact on their own relationship to services and that communication between their relative's care team and themselves had | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Linked study**<br>• Same study, different paper<br>Stroud et al. (2013) An exploration of service user and practitioner experiences of community treatment orders (presents full findings of qualitative interviews and discussion of the misunderstandings of the power of CTOs).<br>**Country**<br>• UK<br>**Source of funding**<br>• NIHR School of Social Care research. | minority (i.e classified as other than 'white British' (19%) were well represented in comparison with the overall population (18%).<br>• Sample age<br>Service users included those from the youngest (18–25) to the oldest age group (over 70) with a mean age of 36.<br>• Level of need/diagnosis<br>Diagnoses included schizophrenia, schizoaffective disorder and bipolar affective disorder. 12 (57%) of the service users interviewees were on a CTO at the time of interview, while for the remaining 9 (43%) it had been discharged.<br>Intervention<br>• Community treatment order (CTO) is the legislative power by which patients with mental health difficulties who are treated involuntarily in hospital can be discharged into the community but still remain subject to compulsory treatment. | improved. While nearest relatives regarded CTOs positively, many had an incomplete or patchy understanding of the CTO and its powers.<br>An overwhelming amount of NRs voiced a preference for verbal information over written information; the information they had retained about the CTO was that which had been relayed by a clinician or care coordinator involved in their relative's care. Written information was viewed as hard to understand and full of jargon. Some NRs described the social care element as inadequate and poor in relation to the resounding emphasis CTOs placed medical treatment.<br>• RQ3 PRACTITIONERS' VIEWS<br>Some practitioners said that for the 'wrong' kind of services user, the CTO is ineffective and potentially harmful for therapeutic relationships.<br>**Responsible clinicians**<br>Responsible clinicians were often ambivalent about the usefulness of the CTO framework and it legal powers. More frequently than other professional groups, they referred to the CTO as having 'no real teeth' in relation to administering medication in the community and recall to hospital. Many RCs found the CTO process administratively burdensome.<br>They viewed CTOs as beneficial for 2 reasons:<br>1) Encouraging compliance with medical treatment. | |

| Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | 2) Early and speedy recall. (However, in some respects these are also benefits associated with s17 leave).<br>Many RCs recognised that CTOs were in part a result of pressures from the bed management policy, and were issued as a way to discharge inpatients and reduce inpatient stays. Opinions about the CTO varied greatly amongst the clinicians. The opinion of those who were positive about them was commonly tempered by the cumbersome paperwork. Some clinicians deemed that the CTO would be potentially effective for service users on depot medication (when the medication is given by injection and slowly released into the body over a number of weeks). Service users can be monitored and there is no doubt as to whether they are taking their medication.<br>AMHPs<br>Many AMHPs felt there was a lack of any clear guidelines in relation to CTOs and that they had to learn through experience. AMHPS voiced concern about the increasing use of CTOs in the place of s17 leave. Many AMHPs were strongly critical of CTOs and concerned about the lack of understanding and input on the part of the service users. Some AMHPs argued that the reason that CTOs are not properly explained is because ‘it would put a spanner in the works’ if service users objected to it. In particular, AMHPs were critical of the implied threat that a breach of | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | conditions always meant instant recall to hospital – rather than it being explained that they would only be recalled if there was a significant deterioration in their mental health.<br>AMHPs thought that information given to patients about advocacy and independent mental health advocacy (IMHA) service was insufficient, and sometimes non-existent. It was felt that such information should be built into the system in a more solid way.<br>Care coordinators (CCs)<br>CCs often felt the ethically complex terrain around choice and compulsion was often something that more directly affected their relationship with the service user, in comparison to other professional groups. The potential effect of CTOs on therapeutic relationships makes for a complex picture, with CCs giving both negative and positive comments.<br>Service providers (SPs)<br>Similarly to NRs, SPs were largely positive about CTOs. Having a direct telephone number to a named coordinator, e.g., was highly valued. However, SPs did still identify constraints within the system, and there was still a varying degree to which SPs were informed or involved in the CTO process – i.e being made aware of the conditions, being invited to review meetings. Although this was variable across the board – other SPs described a good relationship | |

| Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92 | | | |
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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | with the CC and consultant and were kept well informed.<br><br>RQ6 REDUCING READMISSIONS<br>Four common themes emerged:<br>- A CTO provides a legal recognition of the need for care.<br>- A CTO provides a structure and containment for the ‘right’ user.<br>- Care is defined as predominantly medical.<br>- There are misunderstandings surrounding the power and conditions of the CTO.<br>STRUCTURE AND SUPPORT AS REASSURANCE<br>Across all groups the CTO was seen as providing a valuable ‘safety net’. Specific advantages being:<br>1) The speed with which recall could be issued.<br>2) That a new mental health assessment was not needed upon admission.<br>3) That the service user could come into hospital for 72 hours and then be discharged back into the community on the same CTO.<br><br>The legal recognition of the need for care and support was associated with stability and containment. One clinician (RC) described the CTO as:<br>‘A bit like an agreement that provides boundaries. And boundaries ... are very containing to somebody who suffers from psychosis ... so, you refuse to come to your appointment, we take you to hospital, make sure that you | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | get your injection: not a big deal ... I think that in itself has a calming effect' (Stroud et al. 2015, p89).<br>Some practitioners considered that this sense of structure was only useful to certain users, but not all. One AMHP said that CTOs were most appropriate for 'people who would benefit from a sense of structure, they know that things will kick into place quickly if they get unwell' (Stroud et al. 2015, p89/90).<br>Although, under s117 of the MHA, support should be provided according to need, service users equated being on a CTO with receiving higher levels of support and were keen to stay on it as a result. The conditions attached to the CTO may surpass definitions of need, ensuring that practitioners provide greater opportunities for engagement:<br>'It makes it incumbent on the team … to provide, by law, certain basic treatments for the patients...you also have to be available to provide them more, you are duty bound to do so. So it works for the patients as well in that sense. When they are no longer on the CTO, then it is purely on the need basis' (Stroud et al. 2015, p90).<br>Capacity for quick recall was also seen as a benefit of the CTO. One housing service provider explained to a patient: 'I'd more or less said it to him, 'Look this is really about your care in a sense and this is about, you know, if you come back to us, if you have a CTO, you can go back to hospital immediately. Whereas, you know, generally in admission you could be waiting days on end, they might | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | not have a bed available' (Stroud et al. 2015, p90).<br>RESPECT FOR THE AUTHORITY OF THE LEGAL FRAMEWORK<br>Practitioners expressed how for a CTO to 'work', service users needed to agree with the CTO process and respect its legal authority. Whilst some service users experience the CTO as punitive and restrictive, others experience it as reassuring or helpful as it shifts an element of responsibility away from themselves as individuals and onto services. Some service users explained that the CTO gave them extra motivation, primarily related to a desire to avoid rehospitalisation.<br>One interviewee spoke of how the CTO influenced her to adhere to treatment and engage with services, even when she was feeling unwell and unmotivated:<br>'There were times when I ... was feeling more paranoid and the voices were worse, then I didn't want to come in, but having that … CTO in place sort of gave me the motivation of 'if I don't go and get it [medication] I will end up in hospital' (Stroud et al. 2015, p90).<br>However, where respect for the authority of the CTO was absent, practitioners felt the CTO as unlikely to achieve any positive impact. One care coordinator opined:<br>'where people don't buy into it and don't accept the authority...then you can recall them, you can try to enforce | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | it but ... it's not therapeutic, it's not building their relationship of trust' (Stroud et al. 2015, p90).<br>Whether or not a CTO is successful or not depends on a range of factors including:<br>1) Motivation to get well and/or progress to independence.<br>2) Find structure and/or legal recognition of need for care reassuring.<br>3) Respect for legal power and/ or regard recall to hospital as a deterrent.<br>4) (Grudging) acceptance that conditions of the CTO are in their best interest (although this often comes retrospectively).<br>ETHICAL ISSUES<br>The issue of service users needing to accept the authority of the CTO raised ethical concerns, with a sense of unease among practitioners (particularly AMHPs) that legal powers were weaker than presented. While service users often believed, mistakenly, that to break a condition would automatically result in recall. Practitioners were not incentivised to ensure that users were fully informed, for fear that is would lessen the respect for the power of the CTO.<br>ACCEPTANCE AND UNDERSTANDING OF CONDITIONS<br>Service users did not tend to perceive conditions positively, however those who benefited from being on a CTO | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | expressed an understanding and ‘grudging‘ acceptance that they were in their best interests. Service users spoke about difficult relationships with medication, but retrospectively agreed that compliance had been beneficial, enabling them to continue living in the community.<br>One service user said:<br>‘You need to ... agree on the terms of the doctors and in turn you get your freedom instead of going in and out of hospital all the time, which takes time, a bit of while to get used to the medication and understand that and realise that medication helps. It takes a long time, a very long time, to understand that but I believe that everyone who wants to get on with their lives will see a CTO as a beneficial thing’ (Stroud et al. 2015, p91).<br>Many practitioners felt that before a CTO is made, the service users need to have some insight into their condition.<br>One AMHP explained:<br>‘In terms of the service users that most benefit, those who have had lots of admissions to hospital and are likely to be admitted again but have a certain level of understanding of their mental health issues, are able to reflect on the circumstance that brought them to hospital, maybe when they’re well, less when they’re unwell but there’s a beginning of understanding and sort of collaboration with | |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | services' (Stroud et al. 2015, p91).<br>CONDITIONS<br>CTOs were most effective when conditions were kept to a minimum and included on the essential stipulations about complying with medication, allowing access to care staff or residing in a specific place if appropriate, and engaging with services. More specific conditions around substance abuse or restricting people they were allowed to see were found to be difficult to enforce and meaningless when a breach cannot automatically result in a recall to hospital.<br>CONCLUSION<br>Experiences and legal interpretations affecting practice are diverse. CTOs can be considered most useful when service users are accepting of their authority, but potentially counterproductive for those antagonised by it. CTOs often facilitated increased support, owing to the associated legal obligations on the part of the practitioners and the increased motivation of services users to comply with medication. However, this increased support for those on CTOs may affect those who are not on CTOs who have similar mental health conditions – especially in the context of serious resource constraints. There is also ethical concern surrounding service users' misunderstanding the powers of CTOs and professionals' views that these misperceptions support the efficacy of CTOs. Still, CTOs | |

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| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | may be used beneficially for a restricted group of ‘revolving door’ patients with certain needs and perceptions for whom other options have been unsuccessful. CTOs were found to be more successful when they were carefully planned interventions, rather than where they were made almost as a matter of course. | |

## Critical appraisal tables

## Table reporting impact studies

## Review Question 8: What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

Fontanella CA, Pottick KJ, Warner LA, et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents. Social Work in Mental Health 8: 117–33

| Study design | Theoretical approach | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|

Fontanella CA, Pottick KJ, Warner LA, et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents. Social Work in Mental Health 8: 117–33

| Study design | Theoretical approach | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Secondary data study<br>**Addresses a clearly focused issue?**<br>• Yes<br>**Good case made for chosen approach?**<br>• Yes. This is the first study to systematically examine the effects of multiple clinical stabilisation strategies on early readmission.<br>**Direct comparison provided for additional frame of reference?**<br>• No | **Were those involved in data collection also providing a service to the user group?**<br>• Yes<br>**Appropriate methods used to select users and clearly described?**<br>• Yes.<br>Users were selected from Medicaid register consecutively admitted to 3 private psychiatric hospitals in Maryland over a 1-year period. The sampling strategy involved firstly, each hospital providing a computerised list of all adolescents (n=1595) admitted between 1 July 997 and 30 June 1998. 545 adolescents met the following inclusion criteria: (1) covered by Medicaid at admission; (2) aged 11 to 17.99; and (3) resident in Maryland. 23 cases were excluded on the following criteria: (a) discharged against medical advice (n=17), (b) eloped from the hospital (n=5), | **Results**<br>• Response rate and sample representativeness<br>Selection based on pre-defined inclusion and exclusion criteria.<br>**Reliable data collection instrument/method?**<br>• Yes.<br>Trained coders collected data using a standardised data abstraction form that was tested beforehand at the 3 hospitals. Coders were trained thoroughly with an extensive coding manual and data collection began as soon as inter-rater reliability was firmly established. Data collection instrument used was an adapted version of the Restrictiveness of Living Environment Scale (ROLES) (Hawking et al. 1992) to assess the extent of change in living situations between admission and discharge (p121).<br>**Results complete and analysis easy to interpret?** | Study was also about effects of medication management. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

Fontanella CA, Pottick KJ, Warner LA, et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents. Social Work in Mental Health 8: 117–33

| Study design | Theoretical approach | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
|  | or (c) case records missing (n=1) leaving a sample of 522. Five further cases were excluded where psychotropic medications were not prescribed for pregnant adolescents, leaving a final sample of 517 adolescents. | • Yes<br>**Limitations in methodology identified and discussed?**<br>• No<br>**Conclusions based on honest and objective interpretation?**<br>• Yes<br>**Results can be applied to other service users?**<br>• Partly |  |  |

Kyriakopoulos M, Ougrin D, Fraser C, et al. (2015) Emergency mental health admissions for children: A naturalistic study. Clinical Child Psychology and Psychiatry 20: 8–19

| Study design (qualitative) | Study design (quantitative) | Mixed methods component | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Mixed methods. Service evaluation. Retrospective, naturalistic study.<br>**Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question?** | **Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed-methods question)?**<br>• Yes. Sample of all cases of children discharged from Acorn Lodge Unit over a 3-year period from October 2009 and October 2012 were retrospectively included in this study. First UK sample of children routinely admitted as | **Is the mixed-methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed-methods** | The GC may wish to consider the improvement of the emergency admissions (EA) group's Children's Global Assessment Scale (CGAS) in light of the fact that EA group started at a considerably lower mean Children's | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?** |

| Kyriakopoulos M, Ougrin D, Fraser C, et al. (2015) Emergency mental health admissions for children: A naturalistic study. Clinical Child Psychology and Psychiatry 20: 8–19 | | | | |
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| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Limitations** | **Overall assessment** |
| • Yes<br>Acorn 9-item Satisfaction Questionnaire for parents incorporating 2-item section for children. Responses based on Likert scale.<br>**Is the process for analysing qualitative data relevant to address the research question?**<br>• Yes<br>**Is appropriate consideration given to how findings relate to the context, such as the setting, in which the data were collected?**<br>• Yes<br>Both the parent score (7 items) and the total score (9 items) of the questionnaire were comparable to the CGAS change (r=0.316, p=0.006 and r=0.268, p=0.042 respectively) identified through the retrospective data analysis phase of enquiry. | emergencies in a national children's inpatient unit.<br>**Is the sample representative of the population under study?**<br>• Yes<br>**Are measurements appropriate (clear origin, or validity known, or standard instrument)?**<br>• Yes<br>Hypotheses tested planned admissions with emergency admissions where children in latter group would: a) show no significant differences in terms of global functioning and mental health needs at admission; b) demonstrate no significant difference in the meaningfulness of the admission as measured by functioning on discharge; c) be no more likely to be linked to significant violent/risk incidents on the unit; d) children and families of children admitted routinely as emergencies would experience comparable satisfaction levels as those admitted in a more planned way.<br>**Is there an acceptable response rate** | **question?**<br>• Yes<br>**Is the integration of qualitative and quantitative data (or results) relevant to address the research question?**<br>• Yes<br>**Is appropriate consideration given to the limitations associated with this integration, such as the divergence of qualitative and quantitative data (or results)?**<br>• No | Global Assessment Scale (CGAS) score on admission than the planned admission group:  EA=23; PA =30 in the first place. This lower score potentially could have allowed greater room for improvement in this group. The authors do highlight this discrepancy as an issue within the study.<br>There are also limitations in terms of the reporting of the children's satisfaction questionnaire. | • Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

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|---|---|---|---|---|
| **Study design (qualitative)** | **Study design (quantitative)** | **Mixed methods component** | **Limitations** | **Overall assessment** |
| **Is appropriate consideration given to how findings relate to researchers' influence; for example, though their interactions with participants?**<br>• No | **(60% or above)?**<br>• Retrospective data analysis of secondary data | | | |

## Findings tables

## Table reporting impact studies

## Review Question 8: What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

| Fontanella CA, Pottick KJ, Warner LA, et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents. Social Work in Mental Health 8: 117–33 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Secondary data study<br>**Study aim**<br>• This study aimed to understand the medication and discharge planning strategies employed by psychiatrists and social workers in inpatient hospitals for adolescents, and to describe their impact on preventing early readmission. Medication is not reviewed here as it is out of scope<br>**Source of funding**<br>• Not reported<br>**Country**<br>• US | **Participants**<br>• Adolescents with MH conditions<br>**Sample characteristics**<br>• Sex<br>53.4% female (n=276)<br>46.6% male (n=241)<br>• Sample age<br>Mean age at admission 14.3 years (1.70 SD).<br>**Sample size**<br>• 517 adolescents<br>**Intervention**<br>• 'Three variables were used to measure discharge planning practices and aftercare: placement at discharge, change in living situation, and referral to a partial hospitalization program' (p.121) | **Effect sizes**<br>A significantly greater proportion of youths were placed in residential treatment centres at discharge (11.6% vs 4.6%; c2=29.17, df=1, p<.0001) and respite/transitional care (10.6% versus 1.9%%; c2=35.20, df=1, p<.0001) than at admission.<br>**Children and young people**<br>The number of youths placed in out-of-home settings at admission and discharge rose from 39.1% to 49.7%.<br>At discharge, a significantly greater proportion of youths were placed in residential treatment centres.<br>26.9% of youths changed living arrangement from admission to discharge. The majority (78.4%) of the placements were in more restrictive settings, 18.7% in equally restrictive settings, and 2.9% had moved to less restrictive settings.<br>**Reducing readmission**<br>Discharge planning had a strong impact on readmission. Change in living arrangement at discharge reduced the risk of readmission by 82%. Type of aftercare arrangement was also significantly linked with readmission; the rate of readmission was 3.45 times more for youths placed in group homes at discharge compared to those placed with their families and 2.84 times greater for those receiving aftercare in a partial hospitalisation programme. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Kyriakopoulos M, Ougrin D, Fraser C, et al. (2015) Emergency mental health admissions for children: A naturalistic study. Clinical Child Psychology and Psychiatry 20: 8–19 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Mixed methods<br>Service evaluation. Retrospective, naturalistic study.<br>**Study aim**<br>• Emergency mental health admissions (EA) for children under 13 years are not routinely offered in the UK, which may be related to misconceived ideas about their safety, suitability and acceptability. The study aim was ‘To evaluate routinely offered Emergency Admission (EA) of children in a national unit over a three-year period’ (p8).<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>Acorn Lodge Children’s Unit. | **Participants (tick all that apply)**<br>• Children and young people with MH conditions<br>Children below the age of 13.<br>• Carers/family members of people with MH conditions<br>Sample characteristics<br>• Disability<br>From the sample of 82 children, 7 children (8.5%) had global learning disability (including moderate and severe learning disability with or without additional specific learning difficulties) and 8 children (10%) had specific learning difficulties in addition to their ICD-10 Axis I diagnosis.<br>**Sample size** | FINDINGS – EFFECT SIZES<br>• Data were analysed with chi-square and t-tests for categorical and continuous variables respectively (emergency admission) EA and Planned Admission (PA) were compared on demographic and clinical characteristics, outcome measures, length of stay (LOS), significant risk-related incidents and children and parent satisfaction. Children’s Global Assessment Scale (CGAS) change was the main outcome measure – these scores provide specific information about the outcome of child psychiatric patients.<br>1. OUTCOME MEASURES<br>• EA differed from PA in the main outcome measure (mean CGAS change in EA: 36, mean CGAS change in PA: 25; t=2.595, df=80, p=0.011).<br>• Mean CGAS also differed between EA and PA on admission (EA: 23, PA: 30; t=-2.296, df=80, p=0.024) but not discharge<br>• Mean LOS did not differ significantly between EA and PA<br>• The EA group did not differ in significant risk-related incidents from the PA group<br>• The percentage of children being out of education on admission was greater in the PA group compared to EA (Pearson’s χ2=8.645, df=1, p=0.006). At discharge, there was no difference<br>2. SATISFACTION QUESTIONNAIRE (parents and children)<br>91% of parents returned the completed Acorn Satisfaction Questionnaire. 70% of children completed the relevant children’s section.<br>The 9-item questionnaire used a Likert scale ranging from 1–5, | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention clearly within RQs and scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• + |

| Kyriakopoulos M, Ougrin D, Fraser C, et al. (2015) Emergency mental health admissions for children: A naturalistic study. Clinical Child Psychology and Psychiatry 20: 8–19 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | • 47 emergency admissions 35 planned admissions. Total=82 children below the age of 13 (who were discharged between October 2009 and October 2012)<br>**Intervention**<br>• Acorn Lodge is the first children's unit in the UK to routinely offer emergency admissions, including out of hours. This service is offered in an attempt to provide a more flexible response and responsive service for children who require inpatient treatment. Emergency admissions (EAs) were defined by the unit's decision to admit the child on the basis of the information included in the referral | where 1 was 'very unhappy' and 5 'very happy'. The mean questionnaire score for parents in (EA) was 31.1 and in (PA) was 28.3 (t=2.119, df=73, p=0.037), which translates to an average score of 4.42 in EA and 4.06 in PA (both between 'happy' and 'very happy' on the scale).<br>Comparing both the EA and PA groups on different items, a statistically significant difference favouring EA was noted in the following items:<br>Item 1 – reflecting the speed of the unit's response (EA: 4.75, PA: 4.06; t=3.276, df=73, p=0.002)<br>Item 6 – giving parents information about prognosis (EA: 4.43, PA: 3.90; t=2.036, df=73, p=0.045)<br>Item 7 – reflecting continuity of care (EA: 4.61, PA: 4.16; t=2.190, df=73, p=0.032).<br>Generally, satisfaction levels did not differ between children with EA and with PA (EA: 7.64, PA: 6.68; t=1.588, df=56, p=0.118).<br>Both the parent score (7 items) and the total score (9 items) of the questionnaire correlated with Children's Global Assessment Scale (CGAS) change (r=0.316, p=0.006 and r=0.268, p=0.042 respectively).<br>FINDINGS – NARRATIVE<br>• CARERS' VIEWS<br>Satisfaction data suggest that parents were not averse to emergency admission. Parents were at ease with the rapid response from the unit. Prior thorough discussion with the clinician making the referral, phone contact with the unit, access to information from the unit's comprehensive website, and the | |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | letter without a pre-admission assessment. Planned admissions (PAs) were defined by the presence of a pre-admission assessment. | choice to stay in the unit's family flat for the first days of their child's admission may have reassured families that the inpatient option was suitable for their child.<br>• CHILDREN AND YOUNG PEOPLE<br>EA children (n=47) did not differ from PA children (n=35) in age, length of admission, medication treatment, significant risk related incidents, functioning at discharge, access to education at discharge and satisfaction levels. EA children had lower functioning and were less likely to have been out of education on admission. Evidence shows that EA for children are not linked with increased numbers of inappropriate admissions, are safe and more accepted by families compared to PA, and also demonstrating the value of outcome measurement in service development. | |

## Critical appraisal tables

## Tables reporting views studies

## Review Question 8: What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Survey<br>Seven multiple choice questions and 3 open-ended questions which requested ideas on how to improve the discharge letters.<br>**Objectives of the study clearly stated?**<br>• Yes<br>**Relevance to our RQ(s)?**<br>• Mixed<br>**Research design clearly specified and appropriate?**<br>• Yes<br>**Clear description of context?**<br>• Yes<br>**References made to original work if existing tool used?**<br>• N/A<br>**Reliability and validity of new tool reported?**<br>• No<br>**Survey population and sample frame clearly described?**<br>• Yes. Youth inpatient unit – 8-bed tertiary mental health non-secure facility for youth aged 16–18 who | **Describes what was measured, how it was measured and the outcomes?**<br>• Yes<br>**Measurements valid?**<br>• Partly<br>**Measurements reliable?**<br>• Partly<br>**Measurements reproducible?**<br>• Yes | **Basic data adequately described?**<br>• Yes<br>**Results presented clearly, objectively and in enough detail for readers to make personal judgements?**<br>• Yes<br>**Results internally consistent?**<br>• Yes<br>**Data suitable for analysis?**<br>• Yes<br>**Clear description of data collection methods and analysis?**<br>• Yes<br>**Methods appropriate for the data?**<br>• Yes<br>**Statistics correctly performed and interpreted?**<br>• Yes<br>**Response rate calculation provided?**<br>• Yes | Sample size small (n=38) and all taken from 1 8-bed inpatient unit in a New Zealand hospital (and their respective family/professionals). | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• No<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the review question?**<br>• Mixed<br>**Are the outcomes relevant?**<br>• Unclear<br>**Overall assessment of external validity**<br>• - |

| Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| have a severe psychiatric disorder.<br>**Representativeness of sample is described?**<br>• No<br>**Subject of study represents full spectrum of population of interest?**<br>• Unclear<br>Young people, their families and mental health professionals based in outpatient services.<br>**Study large enough to achieve its objectives, sample size estimates performed?**<br>• No<br>**All subjects accounted for?**<br>• Yes<br>**All appropriate outcomes considered?**<br>• Partly<br>**Ethical approval obtained?**<br>• Partly<br>All data collection conducted in accordance to the National Ethics Advisory Committee (2006) ethical guidelines for audits and related activities. | | 59% of 65 surveys were returned.<br>**Methods for handling missing data described?**<br>• Partly<br>Authors indicate where a question was left blank but no action taken.<br>**Difference between non-respondents and respondents described?**<br>• No<br>**Results discussed in relation to existing knowledge on subject and study objectives?**<br>• Yes<br>**Limitations of the study stated?**<br>• No<br>**Results can be generalised?**<br>• Partly<br>**Appropriate attempts made to establish ‘reliability’ and ‘validity’ of analysis?** | | |

Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Measures for contacting non-responders?**<br>• Yes<br>Follow-up included a phone call at 2 weeks and a second posting after 1 month. | | • Unclear | | |

Clemens EV, Welfare LE, Williams AM (2011) Elements of successful school re-entry after psychiatric hospitalization. Preventing School Failure 55: 202–13

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>Efforts were made to maximise representativeness of findings. The sample was heterogeneous in | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>Professionals were randomly selected, aside from inpatient clinicians. As there was a much smaller pool of suitable inpatient clinicians, purposive sampling was applied.<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>Interviews were conducted | **Are the data 'rich'?**<br>• Mixed<br>While job titles are sometimes given in relation to qualitative data, there could be more helpful comparisons made across the findings. Especially as the sample was chosen from across a variety of settings and roles.<br>**Is the analysis reliable?**<br>• Reliable.<br>Thorough process involving consensus and discussion | On topic but only provides lists of barriers and facilitators as identified by mental health professionals supporting children and young people through hospital to school transitions – no input from young people, or their parents. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Clemens EV, Welfare LE, Williams AM (2011) Elements of successful school re-entry after psychiatric hospitalization. Preventing School Failure 55: 202–13 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| professional identity and work setting (4 different psychiatric hospitals and 4 different schools across 3 different states), whilst ensuring all participants had recent experience with adolescents who were undergoing hospital to school transition.<br>**Study approved by ethics committee?**<br>• Not stated<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | by 3 members of the team who had developed an 8 question interview protocol.<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Not much info given.<br>**Is the role of the researcher clearly described?**<br>• Clearly described<br>Primary research team consisted of 2 faculty members and 1 doctoral student. All have experience working with adolescents and their families in the relevant school, residential and hospital settings. | throughout. An outside auditor also checked data analysis and gave objective feedback. Coding comparison query used for anything with less than 95% agreement.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | | |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology** | **Were those involved in data** | **Response rate and sample** | Study has major | **Internal validity** |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | | |
|---|---|---|---|---|
| **Study design** | **Theoretical approach** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| • Secondary data study<br>**Addresses a clearly focused issue?**<br>• Yes<br>**Good case made for chosen approach?**<br>• Partly<br>The consultant records used for retrospective qualitative analysis were only summaries.<br>**Direct comparison provided for additional frame of reference?**<br>• No | **collection also providing a service to the user group?**<br>• Yes<br>Two consumer consultants also analysed the data. Introduces potential bias in the analysis and interpretation of data. Two independent auditors minimised this risk of bias.<br>**Appropriate methods used to select users and clearly described?**<br>• Partly<br>Study states: 'records of 26 consultancy sessions provided over a 2-year period were available for analysis'. Although it is not clear whether this represents all available records. | **representativeness**<br>• The sample only represents the experiences of the families who chose to access the consumer consultants (which was a minority of all families of children admitted to the unit during the study period). As such the sample does not represent the experience of all families visiting the unit, but is limited to those who used the service.<br>**Reliable data collection instrument/method?**<br>• Partly<br>Consensual qualitative research (CQR) which adopts a team approach to analysis. For this study a group of 4 researchers collaborated to identify key domains in the material, and then determined themes within each domain. The process involved discussion and debate until agreement was reached.<br>**Results complete and** | limitations.<br>The consultant records were only summaries (context may have been lost). Two researchers who analysed data were consumer consultants who were part of the same service being analysed. | • -<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**Overall assessment of external validity**<br>• + |

Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62

| Study design | Theoretical approach | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| | | **analysis easy to interpret?**<br>• Yes<br>**Limitations in methodology identified and discussed?**<br>• Yes<br>Limitations discussed – sample only represents those who chose to use service. Records examined were only summaries (important information may have been lost). Possible that there was selective recording or omission of themes. Data analysed by 2 members of the consumer consultant team.<br>**Conclusions based on honest and objective interpretation?**<br>• No<br>**Results can be applied to other service users?**<br>• Partly | | |

Hepper F, Weaver T, Rose G (2005) Children's understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study based on semi-structured, in-depth interviews<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>Qualitative research design was deemed appropriate as studying a difficult-to-engage study population and it seemed the best way to understand the subtleties of the treatment process.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>All of the participants were taken from the same unit. Owing to the relatively low admission rate for the unit the sample was created through selecting consecutive admissions.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Health of the Nation Outcome Scores for Children and Adolescents (HoNOSCA) were retrieved from clinical notes. Interviewer was also a junior doctor on unit, which may have introduced risk of response bias. However, it is likely that the children's familiarity and the interviewers' opportunities to join children during | **Are the data 'rich'?**<br>• Rich<br>Is the analysis reliable?<br>• Reliable.<br>Inter-rater reliability of coding was checked by a colleague with experience of qualitative research methods. This exercise indicated broad areas of consensus in relation to emergent themes. New themes identified by the independent coding were discussed and amalgamated into the coding framework.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Somewhat adequate | Sample small and only taken from 1 unit. Also, this particular unit espouses a behavioural model which encourages children to become active collaborators in their own treatment. Treatment aims are explained to children at a pre-admission planning session. Both these measures will influence findings.<br>The study only maps onto the review question in part, as children's views on admission are addressed as part of a wider question about children's perception of their involvement in their treatment. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

Hepper F, Weaver T, Rose G (2005) Children’s understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73

| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
|  | games or break times would have enhanced their trust when responding to questions.<br>**Is the role of the researcher clearly described?**<br>• Clearly described |  |  |  |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults’ retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews that included open questions and prompts.<br>Is the study clear in what it seeks to do?<br>• Clear<br>How defensible/rigorous is the research design/methodology?<br>• Somewhat defensible<br>Semi-structured interview schedule | **Was the sampling carried out in an appropriate way?**<br>• Inadequately reported<br>Authors give very little information on sampling process or the context of units from which the sample was taken. Participants were recruited either from ‘past inpatient records from general adolescent units’ (6 of total | **Are the data ‘rich’?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>Primary researcher shared random pages of the interview transcripts with fellow qualitative researchers and compared analyses. An audit trail (from original coding to clustering of themes) was conducted. | The approach to sampling was questionable in terms of risk for introducing bias to the study. Authors give no context about the units from which the sample was recruited and ‘face to face contact with clinicians in adult inpatient eating disorder units’ is given | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| which had open ended questions and prompts was used flexibly in order to allow participants to determine direction of the interview. Data was coded and analysed thematically in accordance with the principles of interpretative phenomenological analysis (IPA).<br>**Is the context clearly described?**<br>• Unclear<br>All participants were white, British females.<br>**Study approved by ethics committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | sample) or via face-to-face contact with clinicians in adult inpatient eating disorder units (1 from sample). Fifty participants were invited to take part in the study and 7 opted in.<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>Interviews were between 60 to 90 minutes and conducted at either the participants' home or at a local clinic.<br>**Were the methods reliable?**<br>• Somewhat reliable<br>**Is the role of the researcher clearly described?**<br>• Unclear | Member checking was conducted to verify participants' understanding of themes.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | as an extra way of recruiting participants. The retrospective nature of the interviews could potentially result in misremembered details, although the length of time is arguably necessary in order to allow for reflection on the suitability of services. | |

Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|

| Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>Interviews alongside observations.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>Institutional review board.<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>Data from 2 different units were used. Views of relationships were considered from parents', staff members' and researcher's point of view.<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Reliable<br>Two methods of data collection, observation and interview.<br>**Is the role of the researcher clearly described?**<br>• Clearly described<br>Researcher had extensive work experience in child psychiatry units and also spent numerous visits to units involved in study to | **Are the data 'rich'?**<br>• Mixed<br>**Is the analysis reliable?**<br>• Somewhat reliable<br>Only 1 researcher, but member checks and electronic audit trail of data were carried out.<br>**Are the findings convincing?**<br>• Somewhat convincing<br>**Are the conclusions adequate?**<br>• Adequate | Continued contact with units for participant observation aspect may have introduced bias due to over-familiarity with participants. US study which is fairly dated. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| | gain an understanding of the culture, build trust, and make persistent observations. | | | |

Turrell SL, Davis R, Graham H, et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>Open ended questionnaire.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>This is only a pilot study and the sample was homogeneous. The authors based the study on family systems approach and in keeping with this view – which advocates the connectedness and interrelation of the family and healthcare team – perspectives of multiple informants were ascertained, specifically | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate. The study only included adolescents admitted for the first time to 1 eating disorder unit. Arguably the data would have been richer if repeat admissions were included in the study, in addition to sampling from across more than 1 unit.<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>The questionnaire | **Are the data 'rich'?**<br>• Mixed<br>**Is the analysis reliable?**<br>• Reliable<br>Three independent researchers undertook content analysis of the data. Inter-rater reliability is presented for each item and there are no items for which at least 2 of judges did not agree.<br>**Are the findings convincing?**<br>• Somewhat convincing<br>**Are the conclusions adequate?**<br>• Somewhat adequate | Pilot study. Small homogenous sample from 1 unit in Canada. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Turrell SL, Davis R, Graham H, et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| patients with AN, their parents, and nursing staff.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Not stated<br>Researchers always approached parents for consent first. If the parents agreed, then the adolescent was approached to participate in study. | contained just 1 open-ended question: 'As a teenager who has been hospitalized with anorexia nervosa, what conditions should exist for you to feel ready for discharge, to continue your recovery at home?' This is useful way to start preliminary research (as a pilot study) and it allowed for diverse responses, however it severely limits the generalisability of the findings. Data collection also took place over a long time period (between September 1997 and May 1999).<br>**Were the methods reliable?**<br>• Somewhat reliable<br>Responses were written down within the space for 5 answers on each questionnaire<br>**Is the role of the** | | | |

| Turrell SL, Davis R, Graham H, et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | **researcher clearly described?**<br>• Unclear<br>Only info given is that 1 researcher worked part time, hence slow data collection! | | | |

## Findings tables

## Tables reporting views studies

## Review Question 8: What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

<table>
<tr><td colspan="4">Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Quality assessment</th></tr>
<tr>
<td><b>Methodology</b><br>• Survey<br>Seven multiple-choice questions and 3 open-ended questions which requested ideas on how to improve the discharge letters.<br>Study aim<br>• To gain insight and assess the usefulness of narrative discharge letters* written to adolescent psychiatric inpatients as rated by the patients, family members and professionals who received them.<br>*As an alternative to a copy of the professional discharge letter.<br><b>Source of funding</b><br>• Not reported<br><b>Country</b></td>
<td><b>Participants</b><br>• Adolescents with MH conditions<br>• Carers/family members of people with MH conditions<br>• Professionals<br><b>Sample size</b><br>• 16 young people, 11 family members and 11 professionals completed the survey<br><b>Intervention</b><br>• Narrative discharge letter<br>On admission each patient is allocated a case manager and a primary nurse. Depending on the staff member’s relationship with the patient and availability, either the case manager or the primary nurse initiated the discharge letter</td>
<td>EFFECT SIZES<br>• 32 (84%) respondents said they had read the letter after discharge. Most respondents liked the format of the letter or thought it was OK (n=28, 73%). Although family members preferred the format over youth and health professionals (Kruskal–Wallis test, c2=10.03, p=.007). Similarly, family members and health professionals found the language and style of the letter more useful than the young people did (Kruskal–Wallis test, c2=7.653, p=.022).<br>The following responses (%) were given to the question: overall, was the narrative letter useful for you?
<table>
<tr><th></th><th>Youth<br>n=16 (%)</th><th>Family<br>n=11 (%)</th><th>Professionals<br>n=11 (%)</th><th>All<br>n=38 (%)</th></tr>
<tr><td>Yes</td><td>7 (43.5)</td><td>9 (82)</td><td>8 (73)</td><td>24 (63)</td></tr>
<tr><td>No</td><td>3 (19)</td><td>1 (9)</td><td>2 (18)</td><td>6 (16)</td></tr>
<tr><td>Don’t know</td><td>6 (37.5)</td><td>1 (9)</td><td>1 (9)</td><td>8 (21)</td></tr>
</table>
• NARRATIVE<br>‘Family members expressed the most benefit, appreciating the information provided, the format, the language and style of the letter, the lack of medical jargon, and the ability for reflection. Meanwhile, professionals appreciated the letters’ ability to facilitate working collaboratively with both youth and the inpatient unit’ (p187).<br><br>• What works well</td>
<td><b>Internal validity</b><br>• +<br><b>Is the setting similar to the UK?</b><br>• No<br><b>Is there a clear focus on mental health transitions?</b><br>• Yes<br><b>Is the intervention clearly relevant to the review question?</b><br>• Mixed<br><b>Are the outcomes relevant?</b><br>• Unclear<br><b>Overall assessment of external validity</b><br>• -</td>
</tr>
</table>

| Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| • New Zealand | writing process. All letters were written with input from the core team and completed in collaboration with the patient. Writing of the letter began up to a week before discharge, with a draft form being discussed with the youth a few days before discharge. Letters contained an overview of the admission, progress, difficulties, successes, including recommendations for healthy coping strategies that had been displayed on the unit. The primary aim for the content of the letter was to be supportive and reflective, as well as objective.<br>**Follow-up or time of interview** | Many respondents appreciated that the narrative letters were written using language which was easy to understand:<br>‘Easy to understand – no medical jargon that’s hard to understand. Not threatening in style – user friendly. Demystifies mental illness which is scary enough on its own’ (family member) (p185).<br>‘Mental illness can be scary enough on its own – so informal style is very reassuring’ (family member) (p187).<br>Respondents said that the narrative letters conceptualised the youth’s experience, progress, and aided future plans. By mapping their journey young people and their family gained insight and empowerment:<br>‘It helped me see what I was like when I first went to hospital, and how much I changed’ (youth) (p185).<br>‘Liked the way it told the story, helped me when out to know what to do next’ (youth) (p185).<br>‘The letter also focuses on the progress the client has made, so positives are really important in changing a client’s negative cognitions. The process is including clients and not excluding, in their own journey to ‘recovery’ (health professional) (p185). | |

| Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | • Letters were sent between February and October 2006 and surveys were sent in January 2007 | Narrative letters helped parents to feel prepared for the future:<br>‘It made me more aware of the problems and anxiety that____ was feeling before admission and so made me aware of what to look out for in the future’ (family member) (p186).<br>‘That it was clearly formatted about ___’s experience, so ____ and family can reread and have a reference to the situation’ (family member) (p186).<br>Outpatient professionals appreciated the narrative letter’s ability to support working in partnership with the young person and across services:<br>‘Summarised issues in a way client could understand, the personal plan was very clear, her responsibilities and actions to take was clear and precise; since everyone had a copy everyone could support ___ with the same approach; guidelines for intervention following discharge enabled continuity of care’ (health professional) (p186).<br>‘Think it will be an excellent tool particularly in the community team to reflect with (youth), to refocus and remember what happened to prepare for what ifs. Much better therapeutic tool than clinical notes’ (health professional) (p186). | |

| Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | • What can be improved<br>Young people remarked that the letters could be improved by being made 'less boring' (p187). Suggestions included using colour and not using abbreviations, for example using 'deliberate self-harm' as opposed to DSH.<br>Some responses showed that the young people did not feel represented in their letter:<br>'Don't think the information was a real or true indication of my personal account/circumstances. The discharge letter was more an overview of the staff's views and opinions. It to a point left out my own observations and view points' (youth) (p187).<br>Some family members felt that they could have benefitted from more information with a systemic focus:<br>'Personally, I would like a copy for parents with maybe more detail than the narrative from a professional standpoint also' (family member) (p187).<br>'... Could I suggest a discharge letter with a more family focus might be more helpful & have a less blaming feel & may encourage a broader consideration by all (age appropriate) family members' (health professional) (p187). | |

| Clemens EV, Welfare LE, Williams AM (2011) Elements of Successful School Re-entry after Psychiatric Hospitalization. Preventing School Failure 55: 202–13 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study Semi-structured interviews.<br>**Study aim**<br>• To explore mental health professionals' views on the barriers and facilitators to adolescents' successful school reintegration after psychiatric hospitalisation.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• US | **Participants**<br>• 14 mental health professionals who provide support to adolescents who are transitioning from a short-term psychiatric hospitalisation back to their previous school setting<br>**Sample characteristics**<br>• Sex: 13 females 1 male<br>• Ethnicity:<br>African American n=3<br>Caucasian n=10<br>No ethnicity given n=1<br>• Level of qualification<br>Licensure counsellor n=4; school counsellor n=5; psychologist n=1; social worker n=2; unlicensed n=2<br>**Professionals' setting**<br>• Mental health professionals working | NARRATIVE<br>• Review Question 3: PRACTITIONERS' VIEWS SCHOOL-BASED FACTORS<br>**Coordination among school personnel**<br>Professionals explained that coordinating with teachers about lessening workloads, arranging extensions on deadlines, and supplying relevant notes can all benefit students returning to school.<br>**Support and understanding in schools**<br>An identified, adult support person in the school can be of benefit.<br>'Just knowing that there's an adult that's supporting them. Most of the times I think it helps kids with their confidence. I really think it's just a sense of relief that they don't have to go it alone' (p207).<br>**Re-entry interventions and follow-through**<br>Having an initial planning meeting with teachers, parents, and the student that includes time to follow-up and evaluate is helpful.<br>When they come back you always set a follow-up date saying,<br>'Okay, we're going to meet again in two weeks,' or whatever it is, so that that follow–up date actually happens. For evaluation, we do a couple a different things. The kid does a self-assessment, like a daily self-assessment … We have a standard form, but we usually individualize it to that student' (p207). | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Clemens EV, Welfare LE, Williams AM (2011) Elements of Successful School Re-entry after Psychiatric Hospitalization. Preventing School Failure 55: 202–13 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | in: inpatient setting n= 4;<br>outpatient setting n=4;<br>school n=6<br>Total n=14<br>Intervention<br>• School re-entry after psychiatric inpatient stay | **Step-down programmes and re-entry options**<br>Step-down programmes offer alternatives to immediate integration into school. They may not be necessary for all students who are returning but they can help with having more flexible re-entry plans.<br>A part-time return can prove useful at the initial stage after discharge.<br>'Some schools do half day when they get out, and they seem to be more successful that day, you know, by doing an abbreviated day before they're put in all the way' (p208).<br>**Student factors**<br>Student investment in recovery<br>Lack of investment was seen as a barrier – with adolescents they haven't usually lost a great deal so are blasé about substance abuse etc.<br>**Student experience of symptoms**<br>Side-effects of medication can be really difficult to manage. Concentration issues are common with students with depression.<br>FAMILIAL FACTORS<br>**Parental investment in recovery**<br>When parental investment is low reintegration becomes more | |

| Clemens EV, Welfare LE, Williams AM (2011) Elements of Successful School Re-entry after Psychiatric Hospitalization. Preventing School Failure 55: 202–13 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | difficult.<br>‘Consistent parent involvement I think is the key, and that’s the piece that sometimes kind of gums up the works – when it doesn’t happen’ (p208).<br>**Parents’ response to hospitalisation and re-entry**<br>Direct and honest parental responses to students and the school about the hospitalisation are assets during reintegration process.<br>**Parents’ understanding of resources**<br>An outpatient counsellor, Gene, described the importance<br>of parents’ understanding of resources:<br>‘I think they really need to be aware of what the schools can or cannot do … A lot of parents … don’t know what … their rights are … I think it’s important that they know what the rights of their children are’ (p209).<br>This is especially important as parents tend to be the main advocates for getting children back in to school.<br>MENTAL HEALTH CARE SYSTEM<br>**Continuity of care and attention to school re-entry**<br>Planning for potential challenges and ensuring the student has support are facilitators of successful re-entry. | |

| Clemens EV, Welfare LE, Williams AM (2011) Elements of Successful School Re-entry after Psychiatric Hospitalization. Preventing School Failure 55: 202–13 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | **Systemic factors**<br>Communication was a category that came up across all cases.<br>Participants spoke at length about the importance of communication.<br>An inpatient counsellor explained the overall importance of communication:<br>‘If the parents will allow us to talk to the school, I think that’s been helpful … we’ve had some really good school counsellors that actually will come and meet with myself or the other counsellor on the unit to try to figure out what’s the best plan for us to be able to help this kid … I think when the parents are on board with that, and the kid is on board, for us to be able to talk to the school, I think that’s what’s most helpful because we can … provide them some insight into maybe what they haven’t talked about at school but obviously they’ve admitted here that it’s an issue for them’ (p209).<br>The re-entry coordinator serves as the communication hub for all stakeholders. They have the responsibility to ensure that all information disseminated is guided by the parent/guardian and student and reflects legal and ethical requirements for transmitting confidential information. Their role should be seen as a facilitator of a multidisciplinary team rather than the person solely responsible for facilitating the reintegration process. | |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Secondary data study<br>**Study aim**<br>• To investigate how parents have used a consumer consultant support service provided in the inpatient unit of a Queensland child and youth mental health service<br>**Source of funding**<br>• Not reported<br>**Country**<br>• Australia<br>**Outcomes**<br>• What can be improved<br>• Experiences described | **Participants**<br>• Carers/family members of people with MH conditions<br>**Sample characteristics**<br>• Not reported<br>**Sample size**<br>• 26 consultancies (over a 2-year period) to 50 parents/carers of children who were inpatients of a child and youth acute mental inpatient unit<br>**Intervention**<br>• Consumer consultancy service<br>One hour peer support service which took place near the child and youth mental health unit every other Tuesday. Friendly, informal support was offered by consultants who shared their own experiences | NARRATIVE<br>• EMOTIONAL RESPONSE TO THE CHILD'S ADMISSION<br>Unsurprisingly, parents expressed distress when talking about their experience of their child being admitted to a mental health unit.<br>In order of frequency in which the themes appeared in the notes, the most common emotions were:<br>Guilt and blame (appeared in 36% of the records)<br>Anxiety and worry (appeared in 29% of the records)<br>Stigma and shame (appeared in 18% of the records)<br>Loss and grief (appeared in 15% of the records)<br>Anger and frustration (appeared in 12% of the records)<br><br>**Guilt and blame**<br>Feelings of guilt were associated with either concern that they had failed the child in some way, or were responsible for their illness. Blame was not so much a result of personal responsibility, but reports of concern that others – staff, neighbours and family members – held them accountable for the child's illness.<br>Illustrative examples<br>'A mother of an eating disorder patient thought staff would think they are weak parents and must just let her do what she likes' (p257). | **Internal validity**<br>• -<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to the RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**Overall assessment of external validity**<br>• + |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | as parents and carers of children with severe mental health problems. | ‘A dad said his daughter’s eating disorder was the hardest thing he has ever coped with. He said he wondered why this had happened and if it the result of his divorce a while back’ (p257).<br>**Stigma and shame**<br>‘The parents of a girl with anorexia nervosa spoke about how other relatives and friends just say: “It’s simple; just make her eat!”’ (p257).<br>Her daughter had panicked out when she saw the sign ‘mental health’ on the door into the unit and had been pleading with her mum to get her out: ‘She didn’t belong here with all these psychos’ (p257).<br>**Loss and grief**<br>The themes of grief and loss were less prominent, but still featured in a few records. Some parents described feeling like they had lost the child that they had raised because they had changed in an irrevocable way.<br>‘As they were leaving the ward to go home, they could hear their son crying and begging them not to leave him. Both parents were very upset at leaving him in this condition, and his mother was crying as well’ (p257). | |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | COPING WITH CHALLENGES<br>Family challenges (appeared in 35% of records)<br>Analysis of records suggests that admission is a very disruptive event for many families. Challenges included:<br>- concerns about disruption on other children in the family<br>- isolation brought about by lack of wider family support<br>- difficulties managing extra demands on top of normal parental role.<br>‘Both parents are finding the admission to be a very stressful time for their family. They have three other children. The younger girls had been in trouble at school with acting-out behaviours. The children had been arguing more, and both parents were feeling very stretched’ (p258).<br>Practical difficulties (appeared in 29% of records) included:<br>- economic cost associated with admission<br>- transport, parking, accommodation<br>- difficulties finding somewhere to stay during the admission (especially for parents located out of the town)<br>- having to take time off work.<br>NEED FOR INFORMATION | |

| Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | This was the least prominent domain, present in only 36% of the records.<br>The most frequently occurring theme was need for information about child's mental illness (present in 24% of records).<br>Parents described being unclear as to the causes and effects of symptoms, e.g., being unsure if sleep deprivation led to the illness, or if it was the illness that had exacerbated sleeping problems. Certain terms also caused confusion:<br>'One mother heard the term "medically compromised", but did not understand what this meant' (p258).<br>Need for information about treatment options and<br>need for information about support and research both featured in 6% of records.<br>Appreciation of the consumer consultancy service was detected in 53% of the themes. Parents appreciated the opportunity to discuss their concerns with non-clinical people who had been through similar experiences.<br>'V thanked us for being so open, and said that by speaking to someone who had lived with this, was given some hope' (p256).<br>NB The peer support service was only taken up by a minority of the overall cohort of eligible parents, and the records can only | |

Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | speak on behalf of those who took it up. | |

Hepper F, Weaver T, Rose G (2005) Children's understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Qualitative study based on semi-structured, in-depth interviews<br>**Study aim**<br>• - To describe how children saw the nature of 'the problem' that led to their admission<br>- To explore children's explanation of the treatment process (what was or was not beneficial)<br>- To investigate children's perceptions of how (and to what extent) their views were taken into account by staff in clinical decision-making | **Participants**<br>• Children and young people with MH conditions.<br>Children aged over 8 years old (up to 13 years old) who were consecutively admitted to the unit during 1 year recruitment period.<br>**Sample characteristics**<br>• Sex<br>11 boys, 7 girls<br>• Sample age<br>Between 8 and 13 years old.<br>**Sample size** | **Clinical outcomes**<br>• Health of the Nation Outcome Scores for Children and Adolescents (HoNOSCA) as rated by clinicians at admission and discharge<br>The mean change in HoNOSCA between admission and discharge was -10.4.<br>NARRATIVE<br>• RQ4 ADMISSIONS<br>All 18 participants viewed admission in terms of getting help for emotional or behavioural problems.<br>The nature of the problems varied but common themes involved the sense that their problems were beyond their control and that their unacceptable behaviour ran the risk of them being excluded from home, school and rejection by peers.<br>11 children described their difficulty as having 'temper problems'. Some blamed the provocations of others as the cause of their | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Hepper F, Weaver T, Rose G (2005) Children’s understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| - To obtain children’s views about the potential social and personal costs of inpatient admission<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>Specialist provision in West London. | • 18 participants<br>Only 8 were attending school regularly (5 had impaired attendance in relation to their illness, 3 were permanently excluded and 2 temporarily so).<br>**Intervention**<br>• Admission to specialist unit and children’s perceived involvement in clinical decision-making<br>**Follow-up OR time of interview**<br>• Follow-up or time of interview:<br>Phase I – shortly after admission.<br>Phase II – shortly before discharge. | temper, while others attributed it to an underlying medical condition. Others (L, R, J, B) saw it as a personal failing.<br>Generally, the children felt that they could not control their tempers and it led them to do things they did not want to. For example:<br>‘They just make me fight. They call my mum a tramp and that makes me really angry with the person who said it. I just want to whack him but I can’t because he’s my friend’ (child H).<br>‘She was trying to say “be a good boy” but I just can’t’ (child R) (p563).<br>The second most common reason for admission was an emotional problem such as ‘worries’ (A, C, O, P) or depression (K,M).<br>PERSONAL AND SOCIAL COSTS OF INPATIENT TREATMENT<br>None of the children felt that admission was punitive, and only 1 child described feeling homesick.<br>While the sense of containment offered by inpatient treatment was cited as a key benefit, the constant surveillance was also a problem for some participants. The loss of independence interfered with coping strategies used at home.<br>Child M was aggravated by the constant supervision:<br>‘You can’t do anything without everybody knowing. You’ve got nothing to yourself. It’s really annoying – I mean, every move you | |

| Hepper F, Weaver T, Rose G (2005) Children’s understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | do is watched’ (child M) (p568).<br>She went on to explain that she was so ‘annoyed’ that she increased her self-harming behaviour as a result.<br>SOCIAL STIGMA OF INPATIENT ADMISSION<br>Children strove to protect their social identity with a number of inventive strategies that legitimised their illness but promoted the social admission and reinvented psychiatric treatment as ‘cool’.<br>Strategies included:<br>- limiting who was told about the admission, only telling trusted close friends<br>- controlling others’ impression of the unit, either by normalising the unit by describing it as a school or glamorising it by describing it as a ‘big brother’ type institution with ‘cool’ equipment.<br>CHILDREN’S PERCEPTIONS OF HOW (AND TO WHAT EXTENT) THEIR VIEWS WERE LISTENED TO IN CLINICAL DESCISION-MAKING<br>At Phase I 6 children reported feeling that admission plans had been rushed through without them having time to respond or think about the proposed plan.<br>Accounts of pre-admission visits suggested they had not informed the children of the nature of the therapeutic work undertaken on the unit or how they might play an active role.<br>At Phase II children explained that they would have liked more | |

Hepper F, Weaver T, Rose G (2005) Children's understanding of a psychiatric in-patient admission. Clinical Child Psychology & Psychiatry 10: 557–73

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | 'say' in decisions about medication and goal setting. One child explained that he would have liked the chance to be able to explain why he didn't want to take his medicine (which was because of the stigma associated with taking a 'chill pill'). | |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews that included open questions and prompts.<br>**Study aim** | **Participants**<br>• Seven adolescents with MH conditions<br>**Sample characteristics**<br>• Sex<br>All female<br>• Ethnicity | NARRATIVE<br>• Control and collaboration<br>Several participants reported that on admission an initial taking away of their control over eating was helpful and relieving:<br>'I felt I had to. And that kind of helped me because it was like, "It's not my decision, I'm not eating cos I want to be well, I'm not eating cos I deserve to eat, I'm eating cos they're telling me to, | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline** |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| • To find out the views of young adults on the treatment they had received for anorexia nervosa while admitted to a general adolescent psychiatric unit. It also aimed to elicit participants' views regarding their admission and discharge.<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>Not explicitly stated, but participants are all British and researchers are from UK institutions and they describe UK context of general adolescent psychiatric units. | White British<br>• Sample age 16–23 years<br>**Intervention**<br>• Admission and discharge from general adolescent psychiatric unit (for treatment for anorexia nervosa)<br>**Follow-up or time of interview**<br>• Participants had been discharged 2–5 years prior to the study | and that kind of lessened the guilt. Which is what I felt I needed"' (Sophie) (p382).<br>Failure to take a holistic approach that included the needs of other family members, and prioritising emotional or psychological needs were all seen to be unhelpful.<br>'Creating individualised, empowering and collaborative approaches to care, which encourage connections with the outside world and positive relationships with fellow inpatients, may serve to minimise some of the otherwise negative effects of hospitalisation. The findings also suggest that it is important to provide adequate preparation prior to discharge, rather than abrupt discharge following achievement of target weight' (p386).<br>With hindsight, many participants agreed on the importance of receiving a relatively high level of support from services following discharge, even though they may not have wanted continued contact at the time.<br>Having rules in place over portion sizes and diet plans was often seen as helpful during the admission, but unhelpful when trying to eat more normally following discharge.<br>**Removal from normality vs connecting with the outside world**<br>The majority of participants experienced a pervasive sense of being removed from the outside world upon admission. This brought with it a sense that their development was temporarily suspended. | • Highly relevant |

| Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | This caused problems in terms of their emotional wellbeing and sense of self, and posed a challenge to subsequent readjustment to the 'real world' following discharge.<br>Many participants felt that they were actively discouraged from engaging in real-world activities – even those not linked to exercise or their eating disorder. This added to the feeling that life moved on for their peers whilst theirs remained stagnant:<br>'… but I was very aware that they were getting on with their lives, erm, they were doing their A levels, they were gonna be going off to university at the end of the year, and that was really hard for me cos I had fears of everybody going … and I'd never catch up … it meant that I sort of stayed stuck because I didn't have much incentive to sort of move-on. I thought, well ''this is it now''' (Sarah, 1 admission lasting 6 months) (p379).<br>Creating an 'informal environment' and promoting normal life was regarded as important.<br>Several people felt that a 'normal' activity outside of the unit would have helped their transition following discharge and also served as an incentive to get well. Similarly, after discharge the key to successful readjustment for many involved having incentives such as a college course, new friends or a job which provided a motivation to stay well and distracted focus away from eating difficulties. | |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | CONTRASTS IN STRUCTURE AND SUPPORT<br>Participants frequently commented that the contrast between high levels of structure and support in the unit and the lack of structure and support in the outside world, proved problematic. This often led to high levels of dependency and painful emotions on discharge.<br>Abrupt transitions were experienced as scary while those planned in a gradual and collaborative manner were experienced more positively.<br>'everything, was slowly introduced, so we decided that in x amount of weeks I was going to leave and … it was sort of … slowly done, instead of saying, this weekend you're going home, next weekend you're going to school, week after you're gonna leave, it was done slowly' (Katie, 2 admissions, total length 15 months) (p380).<br>Several people reported that it would have been helpful to have received ongoing psychological/emotional support from the practitioner they saw whilst in hospital. However others preferred support provided by local services; discharge marking a 'fresh start'.<br>It was important that the level of support reflected the individual's stage of recovery.<br>'For example, Katie viewed the support she received initially as too superficial and infrequent, commenting that this may have contributed to her relapse. When nearing complete recovery, | |

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | having someone at a distance, although sometimes viewed as irritating, was regarded as necessary and helpful' (p380).<br>**Preparing for discharge – handing back control**<br>Participants often felt they had little control over their lives while in inpatient care and thus appropriate preparation for discharge was essential.<br>'Several participants talked about helpful unit practices that enabled them to gradually build up their level of control, such as being given more freedom, having more control over decisions, and preparing one's own meals. In the absence of such careful preparation, participants often described finding the sudden availability of freedom following discharge unmanageable' (p383). | |

Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Qualitative study Interviews alongside observations.<br>**Study aim** | **Participants**<br>• Carers/family members of people with MH conditions 12 parents | NARRATIVE<br>• CARERS' VIEWS<br>**Parents' perspective on admission**<br>Brief admission period sets the tone for the whole hospitalisation period. After the first 48 hours the parents started to understand | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• + |

| Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| • To describe the crucial nature of the admission process and the relationships that develop between parents and nurses in child psychiatric units<br>**Source of funding**<br>• Voluntary/charity<br>The American Nurses Foundation (ANF) and the Robert O. Gilbert Foundation.<br>Country<br>• US | (n=9 biological, n=1 foster parent, n=2 legal guardians)<br>• Professionals<br>13 nursing staff of child psychiatric unit.<br>Sample characteristics<br>• Sex<br>10 female 1 male (1 unknown)<br>• Sample age<br>Parents' mean age: 42 years range 26–62<br>**Sample size**<br>• 12 parents, 13 nursing staff and a total of 21 relationships<br>Intervention<br>• Admission to child psychiatric unit<br>**Follow-up or time of interview**<br>• Author attempted prolonged engagement with sample, but there was | the unit's structure.<br>All parents found the process of admitting their child distressing, and described feeling a sense of failure, fear or frustration. In particular 1 parent described having to leave the ward while their child was crying as 'a major trauma' (p731).<br>Some parents with prior experience of psychiatric care had expectations of being judged or blamed and this made them feel on edge.<br>One mother said: 'I think it is important for the staff to understand what parents are going through. You know they're going through the guilt and feel like everything they have done and are doing is being put under a microscope. That's the initial feeling' (p736).<br>However, a non-judgmental, reassuring attitude from the admitting nurse can help mitigate these fears. A mother who was concerned about being blamed was pleasantly surprised by the staff's response:<br>'Just the reassurance that I wasn't a bad parent because this had happened to my child. That was a major help because your self-esteem goes down and it went down over a number of years for me. I started questioning everything I had done as a parent' (p737).<br>• PRACTITIONERS' VIEWS<br>**Nursing staff's perspectives on admission**<br>The nursing staff described the admission period as time to start building relationships with the parents and to gather information from them. | **Relevance to the MH transitions guideline**<br>• Somewhat relevant |

Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | no official follow-up after interviews | As 1 nurse commented:<br>‘Admission is very important because it is the initial contact that you have with a parent and that’s the primary exchange of information time. We find a natural fact, they form a bond, usually if things are going well with the person who did that admission’ (p733).<br>Nurses also described admission as the time to offer orientation to the programme and explaining expectations of the parents. Many nurses routinely encouraged parents to call the unit with any questions and to maintain a close involvement with their child’s progress:<br>‘We tell them when groups are, parents’ group. We tell them the general game plan of how things run around here. They are told visiting hours. We have pretty open visiting, and that they can visit any time except certain times of groups, and that’s always encouraged. I think the expectation’s right from the beginning that you can visit, we’d like you to visit and be here and to work through this with us … If you [the parent] ever want information on how your child is doing, you can call the nurses any time’ (p733).<br>Admission was a critical time for information-sharing. However, expectations and perceptions of either parents or staff could affect the development of the relationships during this phase.<br>One nurse described a difficult situation where she wasn’t able to determine if the biological mother or grandmother was the primary caregiver to a child. As the family were withholding | |

| Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | information from her it made it difficult for the nurse to make informed decisions about their (grand)son's care.<br>• ADMISSIONS<br>Admission was identified as a critical time in relationship-building between parents and nursing staff (especially in light of decreasing lengths of stay).<br>Nurses described situations where they had heard reports about parents from other nurses, and – especially when they were negative as a result of a difficult admission – this influenced all staff and their interactions with the parent. | |

| Turrell SL, Davis R, Graham H et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study Open-ended questionnaire.<br>**Study aim**<br>• To explore the perspectives of adolescent patients with anorexia nervosa, their parents and nursing staff | **Participants**<br>• Adolescents with MH conditions<br>• Carers/family members of people with MH conditions<br>• Professionals<br>**Sample characteristics**<br>• Sex | NARRATIVE<br>• The following 4 themes were identified by all 3 groups as being important to discharge readiness:<br>**Medical stability**<br>Adolescents, parents and nurses each described aspects of medical stability as being necessary for discharge readiness.<br>**Education** | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Turrell SL, Davis R, Graham H et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| about the conditions necessary for those involved to be ready for discharge<br>**Source of funding**<br>• Not reported<br>**Country**<br>• Canada | Patients: all 14 were female<br>Parents: 12 female, 2 male<br>• Ethnicity<br>Patients (n=14) 13 white, 1 Asian<br>Parents (n=14) 14 white registered nurses (n=14) 13 white, 1 African Canadian<br>• Sample age<br>Patients' mean age = 14.6<br>**Sample size**<br>• 14 adolescents with anorexia nervosa (AN) (first time admission for AN to the inpatient eating disorders unit),<br>14 parents and<br>14 registered nurses (RNs)<br>**Intervention**<br>• Discharge readiness from eating disorders unit | The adolescent participants described wanting 'to know how to manage our meals if we are more active at home' (p120).<br>Both parents and the nurses thought it was important for adolescents to have a clear understanding of meal plans – how much to eat and when; and the outpatient process, goals and expectations.<br>**Psychological changes**<br>Used as an overarching term that included cognitive, emotional and behavioural changes.<br>Adolescents commented that they would have to be able to 'eat without supervision' (p121).<br>The majority of parents' responses also identified psychological changes for their child to make, e.g., 'having decreased anxiety about food and eating' and a 'better understanding of body image, less distortion' (p121).<br>Parents also responded by saying they wanted compliance from their adolescent with regards to following food plans.<br>While nurses suggested that psychological changes would be necessary for both parents and adolescents, parents did not identify this need for themselves.<br>Nurses suggested that the 'family needs to know how to help kids with eating problems, to supervise meals, and to understand their child will not be cured right away' (p121).<br>**Community resource planning** | |

| Turrell SL, Davis R, Graham H et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | **Follow-up or time of interview**<br>• Questionnaires were completed following the first pass home from the inpatient unit as it ‘afforded the family an opportunity to identify needs through in vivo experience of caring for their child’ (p118)<br>Adolescents were asked to complete their questionnaires on their return to the hospital. | Responses under this theme identified a need for follow-up care, beyond meal and exercise plans. Adolescent responses included: ‘to be given as much warning as possible, so we can be ready,’ and wanting ‘individual counselling near our home’ (p121).<br>Parents sought coordination of follow-up with local family doctor; continuing counselling; and a hotline for urgent problems.<br>Both nurses and parents identified a need for a plan for school re-integration. Nurses also identified the need for ‘for planned community involvement, such as social activities, after school groups, and peer support network’ (p121).<br>**Themes unique to adolescents: support**<br>Although this is alluded to other themes, support was identified as a specific element of discharge readiness only by adolescents. In particular they wanted to make sure they had ‘a trustworthy person for all meals and snacks, someone who can help you get through this’ (p121).<br>**Themes unique to registered nurses: parents as a member of treatment team**<br>Nurses described wanting parents to agree about the severity of the illness and to be a part of the treatment team; to ‘take on real parental responsibilities, using their relationship with their child’s nurse to problem-solve’ (p121). | |

## Critical appraisal tables

## Table reporting impact studies

## Review Question 9: What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

| Cassidy E, Hill S, O'Callaghan E (2001) Efficacy of a psycho-educational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & Reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Case-control study<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question?**<br>• Yes<br>Relevant to readmissions; not clear when (in relation to admissions or discharges) it was delivered.<br>**Question appropriate and focused?**<br>• Well covered<br>**Comparable populations?**<br>• Well covered | **Same exclusion criteria?**<br>• Not reported<br>**Participation rate for each group?**<br>• Cases<br>Unclear. Remark in discussion suggests that not all carers referred did undertake the intervention (or attended all sessions). Not reported.<br>• Controls<br>28 matched from hospital records, so no dropout.<br>**Comparison of participants?**<br>• Well covered<br>**Cases clearly defined?**<br>• Well covered<br>**Distinguishing of cases from controls?**<br>• Well covered<br>**Measures to prevent knowledge of primary exposure?**<br>• Not reported<br>**Exposure status** | **Statistical analysis**<br>• Confidence intervals (CIs) provided<br>**Do conclusions match findings?**<br>• Yes | Unfortunate that there were only 28 matched controls, so the outcomes for readmission use a very small sample, and the results may not be generalisable. The data is old. | **Overall assessment of internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention in scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>However, with small sample, cannot be generalised with certainty. |

Cassidy E, Hill S, O'Callaghan E (2001) Efficacy of a psycho-educational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50

| Study design | Data collection | Analysis & Reporting | Limitations | Overall assessment |
|---|---|---|---|---|
|  | • Not reported<br>Assumption is relatives of control had no intervention.<br>Confounding factors<br>• Adequately addressed |  |  |  |

Macdonald P, Rhind C, Hibbs R, et al. (2014) Carers' assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>Two arm multi-centre group RCT. Prospective comparison study using qualitative data.<br>**Country**<br>• UK<br>15 inpatient or day-patient hospital centres.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>'... To explore the patients' (with anorexia nervosa) perceptions of their relationship and involvement | **Follow-up**<br>• Yes<br>Self-report and interview assessments at admission, discharge, 6-, 12- and 24-month post-discharge follow up for both groups.<br>**Dropout numbers**<br>• Intervention dropouts<br>19 out of 89 caregivers in the ECHO group 37 out of 89 patients in the ECHO group.<br>• Comparison dropouts<br>18 out of 89 caregivers in | **Did the study have an appropriate length to follow-up**?<br>• Yes<br>**Did the study use a precise definition of outcome?**<br>• Unclear<br>Questionnaires/feedback forms providing qualitative data.<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear<br>**Were investigators kept 'blind' to participants'** | Treatment as usual (TAU) is not described, and – owing to the 15 different treatment sites – is likely to be heterogeneous. Moreover, the skills training book is available for the general public to buy and a few members of the TAU group seem to have implied within their responses that they have also accessed ECHO or | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Carers of people with anorexia nervosa only. Some members of sample receiving day hospital treatment.<br>**Is the intervention** |

| Macdonald P, Rhind C, Hibbs R, et al. (2014) Carers' assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| with their caregiver/patient following inpatient care, and to examine whether the quality of this differs as a result of their parents having obtained the intervention' (p437).<br>**Relevance to our RQ(s)?**<br>• Mixed<br>Condition specific, but looks at caregiver/patient relationships post discharge. The study population are those are receiving intensive inpatient as well as day-patient treatment (day-treatment patients are out of scope).<br>**Appropriate randomisation?**<br>• Yes. Web based system used to randomise participants.<br>**Adequate concealment of allocation?**<br>• Yes<br>Database programmer who prepared the web-based system was independent from the trial team.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias | TAU 40 out of 89 patients in ECHO.<br>**Groups comparable on intervention completion?**<br>• Yes<br>**Missing outcome data**<br>• Intervention missing outcome data<br>141 out of 178 caregivers returned their feedback questionnaires (ECHO n=70; TAU n=71).<br>Although this study only analysed data from primary caregivers (ECHO n=55; TAU n=60) representing 64% of those that responded.<br>101 out of 178 (57%) patients returned their questionnaires (ECHO n=52; TAU n=49).<br>**Groups comparable on available data?**<br>• Yes<br>Attrition bias appraisal | **exposure to the intervention?**<br>• Yes<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Yes<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match findings?**<br>• Partly<br>It's not possible to draw definite conclusions from the comparison of the frequency of themes mentioned between the comparison and intervention groups. The conclusion says that the evidence suggests the usefulness of providing skills training to caregivers, rather than saying the effectiveness of the intervention is proved. | similar material, thus affecting the reliability of the TAU group as a reliable comparator.<br>The sample of patients was taken from those admitted for both intensive inpatient and day-patient treatment (day-patient treatment is out of scope). | **clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• + |

<table>
<tr><td colspan="5">Macdonald P, Rhind C, Hibbs R, et al. (2014) Carers’ assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8</td></tr>
<tr><td><b>Study design</b></td><td><b>Data collection</b></td><td><b>Analysis & reporting</b></td><td><b>Limitations</b></td><td><b>Overall assessment</b></td></tr>
<tr><td><b>Was selection bias present?</b><br>• Low risk of bias<br><b>Did the groups receive equal treatment aside from the intervention?</b><br>• Unclear.<br>Those not receiving the intervention had treatment as usual, although no more information on this is given. As the sample was recruited across 15 study sites it is unlikely that TAU constituted the same in all sites.<br><b>Were the participants receiving care kept ‘blind’ to how the intervention was allocated?</b><br>• N/A<br>This would not be possible.<br><b>Allocation – practitioners</b><br>• N/A<br><b>Performance bias appraisal</b><br>• Unclear/unknown risk of bias</td><td>• Low risk of bias</td><td></td><td></td><td></td></tr>
</table>

| Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 |
|---|

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• RCT<br>Prospective, randomised, multicentre study.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**Relevance to our review question(s)?**<br>• Mixed<br>The whole range of outcome measures is not reported in this paper. Families emotion status, satisfaction with treatment and other subjective measure are only available in German. The main outcomes reported here relate to RQ6, reducing readmissions. Primary outcomes are hospital readmission, number of readmission, days in hospital and medication compliance (which is out of scope).<br>**Appropriate randomisation?**<br>• Yes<br>Eight to 12 patients from each study centre were block randomised to either group.<br>**Adequate concealment of allocation?** | **Follow-up**<br>• Yes<br>Data was collected at the same time across both groups.<br>**Dropout numbers**<br>• Intervention dropouts<br>23% drop out rate.<br>• Comparison dropouts<br>20% drop out rat<br>**Groups comparable on intervention completion?**<br>• Yes<br>Dropout patients did not differ from study completers in regard to sociodemographic or illness related variables.<br>**Missing outcome data**<br>• Comparison group missing outcome data<br>Missing data on medication compliance reported for 3 members of control group. (however we're not reporting on this).<br>**Groups comparable on available data?**<br>• Yes<br>**Attrition bias appraisal** | **Did the study have an appropriate length to follow-up?**<br>• Yes<br>24 months. Majority of trials would only cover 6 months post discharge.<br>**Did the study use a precise definition of outcome?**<br>• Yes<br>**Was the method used to determine the outcome valid and reliable?**<br>• Unclear<br>No information given on method used to capture outcome data.<br>**Were investigators kept 'blind' to participants' exposure to the intervention?**<br>• N/A<br>This wouldn't be possible.<br>**Were investigators kept 'blind' to other important confounding factors?**<br>• Unclear<br>**Detection bias appraisal**<br>• Unclear/unknown risk of bias<br>**Do conclusions match** | Some outcome criteria – such as satisfaction with treatment, families' expressed emotion – were not reported in this study and we are unable to obtain these findings in English.<br>Patients in the intervention group also received psycho-education sessions, so it's not possible to attribute all positive effects to the caregiver intervention alone.<br>The intervention group had a greater amount of patients who were experiencing their first admission (intervention n=28; control n=18) with the control group experiencing more pervious admissions than the control group (previous admissions, mean: intervention | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Unclear.<br>Only looks at carers of people with schizophrenia.<br>**Is the intervention clearly relevant to RQ(s)?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

| Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| • Yes<br>Randomisation lists were generated by computerised random sampling.<br>**Comparable groups at baseline?**<br>• Yes<br>**Selection bias appraisal**<br>• Low risk of bias<br>**Was selection bias present?**<br>• Low risk of bias<br>**Did the groups receive equal treatment aside from the intervention?**<br>• Yes<br>**Were the participants receiving care kept 'blind' to how the intervention was allocated?**<br>• N/A<br>They would have to know in order to receive the psycho-education sessions.<br>**Were individuals who administered the care kept 'blind' to the intervention allocation?**<br>• Yes<br>**Performance bias appraisal**<br>• Low risk of bias | • Unclear/unknown risk of bias | **findings?**<br>• Yes | n=3, control n=4). | |

## Findings tables

## Table reporting impact studies

## Review Question 9: What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

| Cassidy E, Hill S, O'Callaghan E (2001) Efficacy of a psycho-educational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Case-control study<br>**Study aim**<br>• To establish if a brief psycho-educational intervention for relatives is effective in increasing their knowledge about schizophrenia and reducing hospitalisation<br>**Source of funding**<br>• Not reported<br>**Country**<br>• Irish Republic | **Participants**<br>• Carers/family members of people with MH conditions<br>101 relatives (mostly parents) of 55 patients with psychotic illness<br>**Sample characteristics**<br>• Sample age, sex, illness duration<br>Copied from sample section note, edit: 28 matched patient cases (because only relatives of 28 of the 55 relative sets that completed the intervention) could be followed up over the 2-year follow-up period.<br>Matched on age (mean 27), illness onset (age 24), gender (21 male, 7 female), illness duration (16 <2 years, 3 2–5 years, 9>5 years).<br>**Sample size**<br>• Comparison numbers<br>28 matched patient cases.<br>Note that control group was from computerised records, | **Outcomes**<br>• Service outcomes<br>• Other: 28 cases followed up to 2-year outcomes (i.e. number of hospitalisations; and length of time (median survival time with readmission of as the terminal event). Also increase in knowledge before/after educational programme<br>FINDINGS – EFFECT SIZES<br>**Carer knowledge**<br>'The carers made significant (P < 0.0001) gains in their knowledge about schizophrenia with a mean total knowledge gain of 22.4%, SD 13.6; 95%CI: 18.6, 26.1. Carers made significant gains in knowledge about schizophrenia in all areas tested (table 1). The greatest gains in knowledge were about treatment: 27.8%, SD 19.1; 95% CI: 22.6, 33; P < 0.0001' (p447). Areas tested included aetiology, demography, course, symptoms, treatment, coping.<br>**Rehospitalisation**<br>'After the intervention, controls (17/28) were significantly more likely to be readmitted than cases (8/28) at 2-year follow-up (OR = 3.86, 95% CI: 1.3, 11.8; P = 0.03). The median survival time (with readmission as the terminal event) was longer (figure 1) for cases (730 days) than controls (593 days) at 2 years after the intervention (Wilcoxon-Gehan statistic 4.813; P < 0.05).<br>Analysing the data by year showed that while cases spent significantly (P< 0.01) fewer days in hospital (6 days, SE 2) than | **Overall assessment of internal validity**<br>• +<br>Unfortunate that there were only 28 matched controls, so the outcomes for readmission use a very small sample.<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population of interest?**<br>• Yes<br>**Is the intervention in scope?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**Overall assessment of external validity**<br>• +<br>However, with small sample, cannot be |

| Cassidy E, Hill S, O'Callaghan E (2001) Efficacy of a psycho-educational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | matched as above and under the same consultant's care and admitted in the same period as the index case (not matched on medication).<br>• Intervention number<br>101 carers, 43 mothers, 33 fathers, 6 others of 55 patients with schizophrenia (ICD10)<br>• Sample size<br>28/28 for full follow-up; 55 completed a self-report measure on knowledge at baseline and end of 7-week intervention<br>Intervention<br>• Psycho-educational Carers Education Programme (delivered 1995-8). 7x2-hour weekly group sessions with therapists. See effect sizes for the range of topics covered. Multiple choice questionnaire administered before first session, and at | controls (31 days, SE 10) in the first 12 months following the intervention, the effect was not statistically significant at 24 months (cases 16 days, SE 6; controls 39 days, SE 9)' (p448). | generalised with certainty. |

| Cassidy E, Hill S, O’Callaghan E (2001) Efficacy of a psycho-educational intervention in improving relatives’ knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | end of final session.<br>**Follow-up or time of interview**<br>• 28 cases followed up to 2-year outcomes (i.e. number of hospitalisations; and length of time) (median survival time with readmission of as the terminal event). Matched cases selected for comparison from hospital records. | | |

| Macdonald P, Rhind C, Hibbs R et al. (2014) Carers’ assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>Two-arm multi-centre group RCT<br>Prospective comparison study using qualitative data. | **Participants**<br>• Adults (no specified age) with MH conditions<br>• Carers/family members of people with MH conditions<br>**Sample characteristics**<br>• Sex | Patient themes (52 ECHO/ 49 TAU)<br>PERCEIVED CHANGES IN CAREGIVER STYLE (positive changes)<br>Greater understanding, awareness and coping abilities.<br>Number of patients who report experiences belonging to this theme: | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on population** |

Macdonald P, Rhind C, Hibbs R et al. (2014) Carers' assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Study aim**<br>• To explore the patients' perceptions of their relationship and involvement with their caregiver/parent in the year post-discharge, and to examine whether the quality of this differs as a result of their caregiver having obtained the intervention.<br>**Linked study**<br>• Goddard E et al. (2013) Carers' assessment, skills and information sharing: theoretical framework and trial protocol for a randomised controlled trial evaluating the efficacy of a complex intervention for carers of inpatients with anorexia nervosa. European Eating Disorders Review 21, 60–71. (Protocol contained additional | ECHO Female 93.9%<br>TAU Female 98.1%<br>• Ethnicity<br>ECHO white British/Irish/Other: 97.9%<br>TAU white British/Irish/Other: 94.2%<br>• Sample age<br>Mean age (SD) 26.88 (10.03)<br>• No. of previous admissions:<br>ECHO (n= 52)<br>0 admission n=21 (50.0%)<br>1 admission n=13 (33.3%)<br>2 admissions n=3 (7.1%)<br>3 admissions n=0<br>4 admissions n=1 (2.4%)<br>5 admissions n=3 (7.2%)<br>Missing n=7 (14.3%)<br>TAU (n=49)<br>0 admission n=18 (37.5%)<br>1 admission n=11 (22.9%)<br>2 admissions n=8 (16.7%)<br>3 admissions n=5 (10.4%)<br>4 admissions n=2 (4.2%)<br>more than 5 admissions n=4 (8.4%) | ECHO n=32: TAU n=21<br>Number of times references are made to particular sub-theme:<br>ECHO n=76: TAU n=32<br>'I have noticed especially my dad has become more understanding and patient with me. He seems more knowledgeable of how to deal with me when I had tough times (ECHO)' (p433).<br>REDUCED CRITICISM, OVERPROTECTION AND ANXIETY<br>Responses indicate a decrease in hostility, criticism and over-protective behaviours, as well as a greater sense of calmness in the family.<br>Number of patients who report experiences belonging to this theme:<br>ECHO n=16: TAU n=6<br>Number of times references are made to particular sub-theme:<br>ECHO n=31: TAU n=8<br>IMPROVED COMMUNICATION AND RELATIONSHIPS<br>A higher number of patients in the intervention group reported improved communications and relationships<br>Number of patients who report experiences belonging to this theme:<br>ECHO n=24: TAU n=12<br>Number of times references are made to particular sub-theme:<br>ECHO n=44: TAU n=26<br>'Communication is more direct, honest, clearer and more supportive ... We also know when a certain communication | **of interest?**<br>• Unclear<br>Anorexia nervosa patients only, some receiving intensive day-patient treatment (as well as inpatient care).<br>**Is the intervention clearly relevant to RQs?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• + |

| Macdonald P, Rhind C, Hibbs R et al. (2014) Carers' assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| information on intervention)<br>**Source of funding**<br>• Government<br>National Institute for Health Research (NIHR)<br>**Country**<br>• 15 inpatient or day-patient hospital centres across the UK<br>**Outcomes 1 (qualitative)**<br>• Experiences described<br>This is the qualitative arm of the study | Missing n=4 (7.7%)<br>**Sample size**<br>• From 178 caregiver/patient dyads, the study analysed feedback from:<br>Patients<br>TOTAL n=101<br>ECHO n=52<br>TAU n=49<br>Primary caregivers<br>TOTAL n=115<br>ECHO n=55<br>TAU n=60<br>**Intervention**<br>• (ECHO) Experienced Carers Helping Others guided self-help skills training intervention developed to address unmet needs, alleviate distress and provide skills training to carers of people with severe or chronic anorexia nervosa. Carers are encouraged to reflect on their responses to the illness and to build awareness of how they can | method isn't working/ appropriate and so we will try other methods which we wouldn't have done before (ECHO)' (p433).<br>Notably patients in the ECHO group also reported feeling 'overprotection and anxiety' as an unhelpful strategy with more frequency than the TAU group (ECHO n=30; TAU n=20). However, the frequency of utterances of this theme within the TAU group is slightly greater (ECHO n=39; TAU n=42).<br>Caregiver themes (55 ECHO/ 60 TAU)<br>SERVICE PROVISION AND CAREGIVER SUPPORT<br>Negatives perceptions of care, services post-discharge support.<br>Number of caregivers who report experiences belonging to this theme:<br>ECHO n=27: TAU n=46<br>Number of times references are made to particular sub-theme:<br>ECHO n=54: TAU n=97<br>Negative experiences included: problematic inpatient care and or transition; post-discharge support deemed unacceptable, inadequate or absent; frustration at level of care from the medical profession; or conflict with the specialist team.<br>PERCEIVED IMPROVEMENTS IN SITUATION<br>Reports of acceptable functioning in sufferer<br>Number of caregivers who report experiences belonging to 'acceptable functioning in sufferer' theme:<br>ECHO n=33: TAU n=22<br>Number of times references are made to particular sub-theme: | |

<table>
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<tr><td><b>Research aims</b></td><td><b>Population</b></td><td><b>Findings</b></td><td><b>Quality assessment</b></td></tr>
<tr><td></td><td>adapt their behaviour to have a positive effect on the eating disorder. Carers are taught to be role models to the person they are caring for. They are encouraged to engage in self-care adaptive coping and emotional intelligence.<br><b>Follow-up or time of interview</b><br>• Self-report assessment by post at admission to treatment hospital, discharge from hospital and 6 and 12 months post-discharge</td><td>ECHO n=54: TAU n=38<br>‘A has suffered with anorexia for 18 years. This year, despite a significant separation in the family, she has volunteered, started an apprenticeship as a gardener and started a horticulture course. For the first time since the start of her illness, she will have the kind of future most of us regard as a norm (ECHO)’ (p436).<br>IMPROVED COMMUNICATION AND RELATIONSHIPS<br>Just under half of the sample reports a noticeable improvement in communication and relationships within the family – especially between patient and caregiver this was mentioned with a higher frequency in the ECHO group.<br>Number of caregivers who report experiences belonging to the ‘improved communication’ theme:<br>ECHO n=31: TAU n=23<br>Number of times references are made to particular sub-theme:<br>ECHO n=58: TAU n=26<br>‘I let her make the decisions rather than me telling her what to do and we are much better at communicating with each other without it becoming an argument (ECHO)’ (p436).<br>PERCEIVED CAREGIVER CHANGES<br>Nearly a third of the participants mention that they had noticed reduced high emotion in terms of their approach to the illness. They perceived a greater sense of calm, less anxiety and a less controlling/ directive relationship with their loved one.<br>Number of caregivers who report experiences belonging to the ‘reduced anxiety’ theme:</td><td></td></tr>
</table>

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | ECHO n=21: TAU n=14<br>Number of times references are made to particular sub-theme: ECHO n=34: TAU n=20<br>22 caregivers report a greater understanding and knowledge about the illness (TAU n=13; ECHO n=9)<br>CONTINUED DIFFICULTIES AND CHALLENGES<br>Over two-thirds of the sample report continued struggles and burden signifying high emotion, despair, doubts, uncertainty and problematic coping.<br>The number of caregivers who mentioned this theme is slightly higher in the TAU group:<br>ECHO n=34: TAU n=41<br>However, the number of actual references to struggles throughout the feedback forms occurred with much more frequency within the TAU group, possibly indicating a greater experiential meaning for the caregiver:<br>ECHO n=63: TAU n=115<br>'I have stopped looking forward to my retirement. I will be 60 next year and often feel that death for me would be a slow release from watching B slowly destroying herself. I have let her go, and she's in God's hands, that's how I rationalise it now, she will either recover or have a short life expectancy, which is say to say ... or a premature death' (TAU) (p436).<br>CONCERN FOR THE FUTURE<br>There was a noticeable difference between the groups reports of concern for the future: | |

| Macdonald P, Rhind C, Hibbs R et al. (2014) Carers’ assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | ECHO n=3: TAU n=13<br>There were 15 reports of readmission to hospital:<br>ECHO n=5: TAU n=10 | |

| Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• RCT<br>Prospective, randomised, multicentre study.<br>**Study aim**<br>• Psycho-education Information Project (PIP) study was set up to examine the long-term outcomes and benefits of psycho-education; the study describes the effects of psycho-educational groups (intervention) in comparison with routine care (control | **Participants**<br>• Adults (no specified age) with MH conditions 18–65<br>• Carers/family members of people with MH conditions<br>**Sample characteristics**<br>• Sex<br>Intervention 51% female<br>Control 57% female<br>• Sample age<br>Mean years<br>intervention 33<br>Control 34<br>• Previous admissions<br>Previous hospitalisations, mean<br>Intervention 3 | **Effect sizes**<br>Survival analysis considering the time up to first rehospitalisation showed a significant difference in favour of the intervention group within the first year (p=.009) and within 2 years (p=.015).<br>The rehospitalisation rate at the 12 month follow up for intervention group was 21% (n=17) compared to 38% (n=31) in the control group (p=0.25).<br>At 24 months follow up, 41% (n=32) of the intervention group and 58% (n=43) of the control group had to be rehospitalised (p=0.36).<br>In the intent-to-treat analyses with all dropouts assessed as re-hospitalisations (worst-case scenario), the differences were not statistically significant (n=194; 1 year follow up; 37% vs 45%, p=.301; 2 year follow up: 54% vs. 66%, P=.107)<br>Number of rehospitalisations after 12 months:<br>Intervention group mean (SD) 0.3 (0.7)<br>Control group mean (SD) 0.6 (0.8)<br>p=.086 | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Unclear<br>**Is there a clear focus on population of interest?**<br>• Unclear. Only looks at carers of people with schizophrenia.<br>**Is the intervention clearly relevant to RQs?**<br>• Yes |

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<tr><td colspan="4">Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52</td></tr>
<tr><th>Research aims</th><th>Population</th><th>Findings</th><th>Quality assessment</th></tr>
<tr>
<td>group) on compliance and rehospitalisation rates over a 24-month follow-up period.<br><b>Country</b><br>• 3 German psychiatric hospitals</td>
<td>Control 4<br><br>First admission<br>Intervention 28%<br>Control 18%<br><br>• Sample size<br>Intervention n=125 patients<br>Control n=111 patients<br>Total=236 patients<br>Intervention<br>• Patients and their relatives were encouraged to attend 8 sessions of psycho-educational programmes over a period of 4 to 5 months – sessions were separate for patients and carers. Sessions 1 to 4 took place weekly, mostly during the patients’ inpatient stay (after reduction of acute symptoms), and sessions 5 to 8 took place monthly, predominantly during the</td>
<td>after 24 months:<br>Intervention group mean (SD) 0.6 (1.1)<br>Control group mean (SD) 1.1 (1.4)<br>p=.31<br>Number of days in hospital after 12 months:<br>Intervention group mean (SD) 17(46.6)<br>Control group mean (SD) 30 (54.4)<br>p=.105<br>after 24 months:<br>Intervention group mean (SD) 39 (90.4)<br>Control group mean (SD) 78 (127.2)<br>p=.034<br>Rehospitalisation rates at 12 and 24 months, differentiated according to the number of previous psychotic episodes.
<table>
<tr><th></th><th colspan="3">Rehospitalisation rates at 12 months % (n=163)</th><th colspan="3">Rehospitalisation rates at 24 months % (n=153)</th></tr>
<tr><th>No. of previous psychotic episodes</th><th>Intervention group</th><th>Control group</th><th>p</th><th>Intervention group</th><th>Control group</th><th>p</th></tr>
<tr><td>1</td><td>15</td><td>13</td><td>1.00</td><td>37</td><td>39</td><td>1.00</td></tr>
<tr><td>2–5</td><td>18</td><td>47</td><td>.006</td><td>34</td><td>65</td><td>.008</td></tr>
<tr><td>6 or more</td><td>38</td><td>36</td><td>1.00</td><td>63</td><td>58</td><td>1.00</td></tr>
</table>
• Narrative findings</td>
<td><b>Are the outcomes relevant?</b><br>• Yes<br><b>External validity</b><br>• +</td>
</tr>
</table>

| Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | outpatient period. Information was given to patients about symptoms, etiology, acute treatment, relapse prevention, and psychological treatment of schizophrenia; adequate coping strategies were discussed; and individual crisis plans were drawn up. Relatives' sessions covered similar information to the patients' groups but also allowed relatives to discuss how they can better help the patient with schizophrenia and how they can obtain support and emotional relief for themselves.<br>**Follow-up or time of interview**<br>• Data recorded on study entry, on discharge, and at 6, 12, 18, and 24 months after discharge | At 1 and 2 years from index discharge, the patients in the control group had on average nearly twice as many rehospitalisations as the patients in the intervention group.<br>The number of days spent in hospital was almost twice as great in the control group when compared with the intervention group.<br>* The study states that subjective outcome measures, such as gain in knowledge changes in illness concept, families expressed emotion status, satisfaction with treatment are available elsewhere. However, these findings are reported in German language reports. The team have contacted the author directly to ask if information is available in English. | |

## Critical appraisal tables

## Table reporting views studies

## Review Question 9: What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

Clarke D, Winsor J (2010) Perceptions and needs of parents during a young adult’s first psychiatric hospitalization: ‘we’re all on this little island and we’re going to drown real soon’. Issues in Mental Health Nursing 31: 242–47

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>Sample is very small (10) and recruitment was through a support group and ‘snowball sampling’ from people known to those in support group (possible bias in agreement, as issues may have been discussed there)<br>**Is the context clearly described?**<br>• Not sure<br>Recruitment is a little unclear, i.e. influence of support group experience.<br>**Study approved by ethics committee?**<br>• Not stated<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | **Was the sampling carried out in an appropriate way?**<br>• Not sure<br>Recruitment seemed a bit haphazard and via support groups (which may not represent all parents -see for example that 7/10 had degrees).<br>**How well was the data collection carried out?**<br>• Appropriately<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Not described | **Are the data ‘rich’?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | The sample is very small, and was recruited from support groups. This is a limitation, as people who attend such groups may well have already discussed their experience (and modified it with others), and may not be representative of all carers (7 out of 10 had university degrees).<br>The interviews commenced in 2004 so not current. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>Despite small sample, this is convincing, but the major limitation may be the apparently high educational status of the parent participants (not necessarily generalisable), and their recruitment through support groups. Introduces risk of class bias.<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant<br>Relevance is also limited because this is a Canadian study, which started in 2004. Hopefully attitudes and behaviour of inpatient staff will have changed! |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study.<br>Semi-structured interview schedules using open-ended questions. Topics were divided into 3 broad sections: events leading up to the admission, the admission itself and reflections on the experience post-discharge. The focus group guide asked service providers about their experiences of local mainstream admissions and the impact of joint service agreements on services.<br>Is the study clear in what it seeks to do?<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>Service users: the nature of the inquiry sought detail about some very personal experiences, so individual interviews were chosen as the most appropriate method for this part of the study.<br>Service providers: focus groups with | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>Participants were recruited from 2 areas in the UK (1 a large county, the other an inner-city area). Service user participants were identified via providers in intellectual disability services.<br>**How well was the data collection carried out?**<br>• Appropriately.<br>After consent was obtained, service users were given the option to be interviewed on their own or accompanied by a relative or nurse who was familiar to them. Where service users wanted to be | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Reliable<br>Initially, data from interviews with several participants were checked for levels of agreement. High levels of agreement were found. Results were analysed on a case by case basis, as opposed to comparing results across different groups of participants, which means that each case is about 1 person's admission experience, often from the viewpoint of several people. Focus group data were analysed separately with the purpose of identifying common themes among service provider experiences and views. Both interviews and focus groups were recorded and transcribed | This paper is not specific to answering RQ9 question about what is effective in supporting carers of people in transition. The sample is based on a small group of carers (9), which may mean that findings are not easy to generalise more widely. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>However, with small sample, cannot be generalised with certainty.<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| providers were employed to enable in-depth discussion of their experiences and views.<br>**Is the context clearly described?**<br>• Clear. Participants (user, carers and providers) were recruited from 2 areas in the UK – 1 a large county including urban and rural areas; the other an inner-city area. Both used mainstream, and 1 occasionally specialist mental health services for people with intellectual disabilities. Seven service providers took part in focus groups; all of them were members of specialist community intellectual disability teams.<br>Study approved by ethics committee?<br>• Yes. The study was granted ethical approval by an NHS research ethics committee<br>How clear and coherent is the reporting of ethics?<br>• Not stated | interviewed on their own, they were asked for permission to interview their carers separately. If agreed, researchers contacted the carer by telephone and explained the nature of the study and information was sent to those who wanted to take part. All interviews were digitally recorded and based either in participants' own homes or at a day centre and lasted between 30 and 90 mins. Invitations were sent to all learning disability and mental health staff through the participating trusts' email lists. Semi-structured interview schedules were designed and topics were divided into 3 broad sections covering events leading up to the admission, the admission itself and reflections on the experience after discharge. | verbatim and analysed thematically in accordance with the principles and processes of interpretative phenomenological analysis (Smith 2003; Willig 2001). Results were discussed stage by stage by all the 3 researchers and grouped according to themes. These themes were repeatedly reworked to make sure that they reflected the wording and meanings drawn from the raw data.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | | |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | Open-ended questions were used in interviews and designed to allow for a general level of consistency in topics covered across all the interviews. The focus group guide asked service providers about their experiences of local mainstream admissions, factors that help and hinder their practice, and the impact of joint service agreements on service provision.<br>**Were the methods reliable?**<br>• Reliable<br>Service users were given various options to participate in interviews, either independently, or accompanied by carers or a trusted professional. Interview methods seemed appropriate and allowed | | | |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | them to express their views and experiences quite openly. Interviews were bolstered by the findings from focus group discussions with providers. Where users did not want to, they asked for carers to stand in as proxy in interviews.<br>**Is the role of the researcher clearly described?**<br>• Not described | | | |

| Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>Somewhat small sample, not clear why.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics** | **Was the sampling carried out in an appropriate way?**<br>• Not sure<br>'Sample of convenience' (p2). Inpatients were asked to identify appropriate family member and | **Are the data 'rich'?**<br>• Rich<br>But could have been more widely reported.<br>**Is the analysis reliable?**<br>• Not sure/not reported<br>**Are the findings convincing?** | Again, a very small US sample, with issue of insurance cover limited to US, but the mix of ethnic groups is an advantage. Age of the data, convenience sampling and small | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>• Comments<br>Age of the data, convenience sampling |

Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **committee?**<br>• Yes<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | consent to them being contacted. Unclear why on families of 13 were interviewed. Interviews done in 1999–2002 so unlikely to represent current practice.<br>**How well was the data collection carried out?**<br>• Somewhat appropriately. Sample was 'a sample of convenience' (p2). No information on who carried out the interviews.<br>**Were the methods reliable?**<br>• Not sure<br>Seems a straightforward approach but not much description of recruitment or context of interviews.<br>**Is the role of the researcher clearly described?**<br>• Not described | • Convincing<br>But may be out of date.<br>**Are the conclusions adequate?**<br>• Adequate | sample prevent this study having higher rating and relevance. | and small sample prevent this study having higher rating and relevance.<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Jankovic J, Yeeles K, Katsakou C, et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives – a qualitative study. PloS One 6(10): e25425 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>The study aimed to better understand the experiences of family caregivers so a qualitative design was deemed appropriate.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>UK Multicentre Research Ethics Approval.<br>**How clear and coherent is the reporting of ethics?**<br>• Clear | **Was the sampling carried out in an appropriate way?**<br>• Somewhat appropriate<br>Purposive sampling across 12 different hospitals to maximise the range of views and relationships between caregiver and patient (i.e parents, siblings, children, partners).<br>**How well was the data collection carried out?**<br>• Appropriately<br>Family caregivers helped to design the list of topics for interview. Participants were asked to describe events relating to the index admission of their relative (the one which resulted in them being involved in the study) to help them focus on this admission specifically, rather than talking about services or | **Are the data 'rich'?**<br>• Mixed<br>Qualitative data attributed to person in terms of their relationship with patient (i.e wife, brother etc.), and also whether it was the patients' first admission or not.<br>**Is the analysis reliable?**<br>• Reliable<br>Two researchers devised a coding frame and this was developed at team meetings which included a family caregiver (not an interviewee). Disagreements in coding were settled by discussion involving both coders and other members of the team.<br>**Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Adequate | Only 50% of all eligible patients who had been involuntarily admitted to the participating hospitals during the study period agreed to take part in the study, and of those that did participate the majority lived alone and did not have a caregiver. Caregivers of patients who did not give consent may have represented those with more strained relationships with their family, or at least, a different set of experiences. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

Jankovic J, Yeeles K, Katsakou C, et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives – a qualitative study. PloS One 6(10): e25425

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| | involuntary treatments more generally. Interviews were mostly conducted at interviewee's home.<br>**Were the methods reliable?**<br>• Somewhat reliable<br>No triangulation, but findings are discussed alongside other studies.<br>**Is the role of the researcher clearly described?**<br>• Clearly described | | | |

Wilkinson C, McAndrew S (2008) 'I'm not an outsider, I'm his mother!' A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401

| Study design | Data collection | Analysis & reporting | Limitations | Overall assessment |
|---|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>**Is the study clear in what it seeks to do?**<br>• Mixed | **Was the sampling carried out in an appropriate way?**<br>• Inappropriate<br>**How well was the data** | **Are the data 'rich'?**<br>• Rich<br>**Is the analysis reliable?**<br>• Somewhat reliable<br>Just 1 researcher. | Very small sample size (4 participants) from a specific area of the UK. However, findings are supported by other | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• - |

Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401

| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
|---|---|---|---|---|
| **How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>As the research did not involve direct contact with any NHS users and did not take place on NHS premises, the school ethics committee advised that the local research ethics committee’s approval would not be required. However, the School of Healthcare ethics committee did ensure that ethical issues, such as doing no harm, informed choice, and confidentiality had been addressed. (p394).<br>How clear and coherent is the reporting of ethics?<br>• Clear | **collection carried out?**<br>• Somewhat appropriately<br>Individual in depth interviews. Some pre-planned questions to ensure focus on phenomenon in question. Researcher kept a reflexive journal during interviewing process.<br>**Were the methods reliable?**<br>• Unreliable<br>**Is the role of the researcher clearly described?**<br>• Unclear<br>Not much information given about researcher (apart from that they kept a reflexive diary throughout the interview process). | **Are the findings convincing?**<br>• Convincing<br>**Are the conclusions adequate?**<br>• Somewhat adequate | studies and are ‘rich’. | • Comments<br>Carer only perspective (no interviews with relevant professionals or service users). Very small sample size (4 participants) from a specific area of the UK.<br>**Relevance to the MH transitions guideline**<br>• Highly relevant<br>UK study. All carers had to have a loved one who was admitted to a mental health institution within the previous 2-year period, and there is a focus on the admission process (as well as general principles on how information is shared with carers, carer involvement and using the carer as a resource). |

## Findings tables

### Table reporting views studies

### Review Question 9: What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

| Clarke D, Winsor J (2010) Perceptions and needs of parents during a young adult’s first psychiatric hospitalization: ‘we’re all on this little island and we’re going to drown real soon‘. Issues in Mental Health Nursing 31: 242–47 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>Semi-structured interview schedules using open-ended questions. Topics were divided into 3 broad sections: events leading up to the admission, the admission itself and reflections on the experience post-discharge. The focus group guide asked service providers about their experiences of local mainstream admissions and the impact of joint service agreements on services.<br>**Study aim**<br>• The study aimed to firstly examine how service users with intellectual disabilities, their carers and service providers perceive mainstream in-patient | **Participants**<br>• Learning disability<br>• Carers/family members of people with MH conditions<br>•Professionals<br>**Sample characteristics**<br>• Ethnicity<br>To maintain anonymity, the ethnicity of participants from black and minority ethnic groups was not revealed.<br>• Sample age<br>All service users were aged between 30 and 55 years.<br>• Level of need/diagnosis<br>With exception of 1 case that was not specified, rest of sample of 11 presented with schizophrenia (1 paranoid sch.) or mood disorder. | **Outcomes**<br>• Clinical outcome<br>• Satisfaction<br>• Service outcomes<br>FINDINGS – NARRATIVE<br>RQ9 carer support<br>Study concerns carers’ perspectives, largely on transitional points during first MH inpatient admission.  These included:<br>Relief at admission (due to inability to cope with or understand the young adult’s behaviour).<br>**Disbelief and shock (especially when leaving the person on a locked unit)**<br>Feeling alone and stigmatised: this was influenced by several factors – public perception of mental illness, lack of acknowledgement or support from the inpatient staff (relatives felt ignored, invisible); lack of understanding among friends; the need to hide the fact that their child had a mental illness from friends and family.  ‘He said, I do not want you to tell anyone I am here’ (p244).<br>**Grieving for lost prospects/future**<br>Feeling excluded at discharge (by inpatient staff). ‘Every interviewed parent told a discharge story that expressed the feeling of being excluded from the process ... even when they had been invited to the discharge meetings. Parents wanted to | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

Clarke D, Winsor J (2010) Perceptions and needs of parents during a young adult’s first psychiatric hospitalization: ‘we’re all on this little island and we’re going to drown real soon‘. Issues in Mental Health Nursing 31: 242–47

| **Research aims** | **Population** | **Findings** | **Quality assessment** |
|---|---|---|---|
| mental health services, and secondly, to what extent their accounts are in line with key policy objectives.<br>**Source of funding**<br>• NHS Trust. The study was commissioned by North Essex Mental Health Foundation Trust and North East Essex Primary Care Trust.<br>**Country**<br>• UK<br>**Outcomes**<br>• what works well<br>• experiences described | • Socioeconomic position<br>Living alone, with family or in supported accommodation prior to the admission.<br>**Sample size**<br>• Overall, 42% (n=11) of service users who fitted the inclusion criteria took part or chose for their carer to take part. Seven service providers took part in focus groups. | be heard when they expressed their concerns or asked questions about discharge and wanted to know what and what not to do next. Receiving an invitation to a discharge meeting on the day of discharge did not allow sufficient time for the family to adjust ...’ (p244).<br>There was no collaborative discussion or even notice given.<br>Carers wanted:<br>Inpatient staff to acknowledge the family, make a connection;<br>Offer sympathy and coping mechanisms, e.g. recommend a support group.<br>Provide comprehensive and timely involvement at/before discharge.<br>Instil hope.<br>They also said that staff ‘hid behind’ the patient’s lack of consent to share information – but even if true, this did not preclude support for the carer.<br>Authors conclude: ‘Because parents need to be active members of the caregiving ‘team’ as their child heads out on the road to recovery, early engagement between parents and mental health professionals is crucial. Furthermore, health care providers must recognize that ‘just another admission’ for them is a profound life-changing crisis for the patient and their family’ (p247). | |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study. Semi-structured interview schedules using open-ended questions. Topics were divided into 3 broad sections: events leading up to the admission, the admission itself and reflections on the experience post-discharge. The focus group guide asked service providers about their experiences of local mainstream admissions and the impact of joint service agreements on services.<br>**Study aim**<br>• The study aimed to firstly examine how service users with intellectual disabilities, their carers and service | **Participants**<br>• People with a learning disability<br>• Carers/family members of people with MH conditions<br>• Professionals<br>**Sample characteristics**<br>• Disability<br>• Ethnicity<br>To maintain anonymity, the ethnicity of participants from black and minority ethnic groups was not revealed.<br>• Sample age<br>All service users were aged between 30 and 55 years.<br>• Level of need/diagnosis<br>With exception of 1 case that was not specified, rest of | Narrative RQ9 carer support<br>**Respite**<br>A key theme for the carers was that the admission provided them with much needed respite.<br>Even when carers were unconvinced about the benefits of the admission, they were nonetheless grateful that the person was in hospital.<br>Carers who were put in touch with other services during the admission felt that this vastly improved their situation on discharge.<br>Carers found it difficult to know who to liaise with and often felt left out.<br>‘I really had to find out what was happening through X. No one would tell me anything there and again I found that hard to comprehend. It’s like when I left I was really none the wiser’ (C1) (p219).<br>**A barrier to access**<br>Carers described that the search for help was often fraught and strewn with difficulties. Mental health service staff were frequently perceived as reluctant to assess someone with an intellectual disability. Carers described the situation as ‘fighting a | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| providers perceive mainstream in-patient mental health services, and secondly, to what extent their accounts are in line with key policy objectives.<br>**Source of funding**<br>• North Essex Mental Health Foundation Trust and North East Essex Primary Care Trust.<br>**Country**<br>• UK<br>**Outcomes 1 (qualitative)**<br>• what works well<br>• experiences described | sample of 11 presented with schizophrenia (1 paranoid sch.) or mood disorder.<br>• Socioeconomic position<br>Living alone, with family or in supported accommodation prior to the admission.<br>Sample size<br>• n=11<br>Overall, 42% of service users who fitted the inclusion criteria took part or chose for their carer to take part. Seven service providers took part in focus groups. | constant battle'. Sometimes this became such an intense struggle that carers had to resort to phoning the police or threatening to abandon the person to secure an admission.<br>Marked delays in receiving help created anger and frustration with services and forced carers to 'hold' the crisis alone.<br>At times carers also felt devalued and judged by the people they were seeking help from.<br>One carer reported that a doctor responded:<br>"'Relatives love looking after people'. I said, 'Yeah, they might if there's about half a dozen of them but when there's just one you just can't do it'" (C11) (p220).<br>Qualitative data from the focus groups was not attributed to service user/carer/professional, however the following is relevant to supporting carers across transitions:<br>Participants emphasised repeatedly that success stories were 'down to individual relationships that may have developed over time. It's about who you know'.<br>'It's so much easier once you have that relationship to go back, even for another client. Also for staff in the in-patient service, | |

Donner B, Mutter R, Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | they get to know that we're not just going to leave the person there but are actually going back' (p222).<br>A striking issue was that ward staff did not accommodate or properly understand a person's intellectual disability. Some carers felt that service users were discharged without adequate assessment and that individual needs were not properly accounted for (p220). | |

Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| **Methodology**<br>• Qualitative study. Interviews<br>Study aim<br>• To understand the experience of families | **Participants**<br>• Carers/family members of people with MH conditions<br>Sample characteristics<br>• Sex | FINDINGS – NARRATIVE<br>• RQ2 CARERS' VIEWS<br>Not much reporting of family experience – much of paper is discussion and call for change.<br>Carers accessed treatment in different ways – if they tried to set up appointments with outpatient providers, they might find it hard | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>• Comments |

| Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| seeking treatment and support for young people with recent-onset psychosis (bearing in mind that it can take years to get help).<br>**Source of funding**<br>• Government<br>National Institute for Mental Health.<br>• Voluntary/charity<br>Award from research charity.<br>**Country**<br>• USA (NY state)<br>**Outcomes (qualitative)**<br>• what can be improved<br>• experiences described | 9 mothers, 3 fathers, 1 brother, 1 aunt (14 because in 1 case, M and F interviewed together)<br>• Ethnicity<br>Inpatient characteristics: 5 Caucasians; 4 Hispanic, 3 Afro-American, 1 East Asian<br>• Sample age<br>Family members interviewed about 13 inpatients, 16–24, mean age 20.7 years<br>• Level of need/diagnosis<br>All inpatients (whose families were interviewed) had first been admitted for treatment for psychosis within the past year.<br>Sample size<br>• 14 family members/carers of 13 inpatients admitted for | to get patient to attend (and get no definitive answer).<br><br>For most, involuntary admission happened, described by most as 'traumatic but necessary' (author) (p3). 'I just felt I couldn't handle it anymore, and I saw that instead of getting better, he was just getting worse. So I said that's it' (family member) (p3).<br><br>Two-thirds of Afro-Americans had police involvement in admission – 1 teenage girl locked herself in bathroom and family's 911 call was answered by SWAT team who handcuffed her.<br><br>After trauma of involuntary admission, stigma of psychotic illness was strongly felt by carers (described as 'shame'): 'this is a dirty word ... I'm going to be dealing with it for the rest of my life' (family member) (p4). The attitudes and statements of staff and social workers confirmed that the illness would have a very negative impact on the person and would be lifelong. One mother waited weeks before the psychiatrist 'the big cheese' (p4), even spoke with her, and that was at the point of discharge. No reassurance and very pessimistic attitudes to the situation was reported by carers.<br><br>Help and advice at and after discharge, including advice on how to manage a psychotic episode, was rarely forthcoming. 'Three months into the process, is it reasonable for them to have some | Age of the data, convenience sampling and small sample prevent this study having higher rating and relevance.<br>**Relevance to the MH transitions guideline**<br>• Somewhat relevant |

| Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | first episode psychosis<br>**Follow-up or time of interview**<br>• All family carers interviewed within 1 year of the first inpatient admission of the person cared for (though some were in for a subsequent episode). | kind of conversation, provide some kind of information and education? Some therapy, something?' (family carer) (p4). Family carers also thought 'patient confidentiality' was used as a shield to avoid having conversations with them.<br>People who did get some useful information about their loved one, or how to help them, were very grateful.<br>In the US context, families also struggled to match services to their insurance cover. This was a problem for ongoing community support and also in the event of relapse, and it was not confined to poorer families.<br>Much of this paper is the use of material for campaigning for political and service change.<br>• RQ9 CARER SUPPORT<br>Similar to carer views findings<br>Carers' commentary on their experience showed they needed:<br>Less traumatic ways of seeking treatment (i.e before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic.<br>Greater recognition from staff on inpatient ward that they were | |

| Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–6 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning.<br>Information, education and dialogue about how to manage and support the person after discharge.<br>Support to find providers for ongoing care that insurance would cover.<br>Less negativity and more positive encouragement to face the future of their child. | |

| Jankovic J, Yeeles K, Katsakou C et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study. PloS One 6(10): e25425 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>In depth interviews.<br>**Study aim**<br>• To explore how family caregivers of patients who were involuntary admitted to psychiatric hospital experience the admission (and | **Participants**<br>• Carers/family members of people with MH conditions<br>Family caregiver defined as: 1) a partner or relative who lives with the patient or visits/meets him/her at least 3 times a week and 2) who has an | Narrative RQ9 carer support<br>DELAYS IN GETTING HELP<br>Frustration with delays in getting help from services n=18<br>Many caregivers said that mental health services had acted with a delay in the lead up to the admission, and they didn't know who they could contact for help. Caregivers believed the delay contributed to the deterioration of their relatives' condition and made the involuntary admission inevitable.<br>Some thought services responded to adverse events rather than | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• Highly relevant |

| Jankovic J, Yeeles K, Katsakou C et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study. PloS One 6(10): e25425 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| subsequent hospital treatment of their relative).<br>**Source of funding**<br>• Government<br>Policy Research Programme of the Department of Health.<br>Country<br>• UK<br>12 NHS hospitals across England.<br>**Outcomes 1 (qualitative)**<br>• experiences described | active role in the care of the patient<br>**Sample characteristics**<br>• Sex<br>12 male 19 female<br>• Ethnicity<br>Patient's ethnicity: white n=21 (72%) Asian n= 4 (14%) black n=1 (3%) mixed n= 2 (7%) missing n=1 (3%)<br>• Level of need/diagnosis<br>On discharge patients were diagnosed with:<br>schizophrenia n=8<br>bipolar affective disorder n=6<br>other psychotic disorder n=7<br>recurrent depressive disorder n=2<br>schizoaffective disorder n=1<br>Manic episode n=1<br>Borderline personality disorder n=1 | trying to prevent them.<br>'The mental health system was good at reaction, but hopeless at pro-action, and unless there was some serious incident, like the self-harming, or the time when she wouldn't get out of bed, to which they could respond with sort of blue lights flashing and so on, they were absolutely useless' (caregiver to a wife, 1st admission) (p4).<br>Caregivers reported that they did not know who they could contact to ask for help when their relative was becoming ill, and that this caused a lot of stress. They were often directed from 1 service to another, without any clear guidance. This issue was more pronounced in caregivers of patients who had not experienced a previous admission and had no familiarity with the mental health service.<br>'I mean on day he had me in tears, I had to walk out of the house and I just walked into a police station and I spoke to somebody on the desk, and they gave me a little bit of advice and they told me who to contact and stuff, and the next day I rang. I actually spoke to somebody but even that was a long process ... I said like, I need help now not like tomorrow or next week. I think like they got back to me three months later, it was really, really, hard to get any kind of help to start with' (caregiver to a brother, 1st admission) (p4).<br>BEING GIVEN THE BURDEN OF CARE<br>Being given the burden of care by services (n=8)<br>Family caregivers felt that too much responsibility for their relative's care was placed on them. They also reported they had | |

| Jankovic J, Yeeles K, Katsakou C et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study. PloS One 6(10): e25425 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | No mental illness n=1<br>Data unavailable n=2<br>• Previous admissions 15 patients (whom caregivers were caring for) had been admitted previously. 12 patients had not had previous admission. Data was missing for 2 patients.<br>**Sample size**<br>• 31 family caregivers of 29 patients with a range of relationships to the patient: parent n=16; partner n=7; sibling n=4; children n=2; grandmother n=1; elderly relative n=1<br>Intervention<br>• Involuntary admission | not been fully consulted on decisions about their relative's treatment, but they were still implicitly expected to take responsibility for further care.<br>Not accepting responsibility usually meant that their relative was subjected to more restrictive options, e.g. longer stay within the hospital.<br>Family caregivers also reported believing their relative was more unwell that clinicians would judge them to be, and that they felt they needed more support than they got from both clinicians and services than they received.<br>Family caregivers commonly believed that their relative should have been admitted earlier or should have been discharged later; this concern was voiced most frequently by caregivers of patients who had previous admissions.<br>'I've been begging them to go and section him and they've gone in and assessed him and they've said that he's perfectly alright, and it's been absolute rubbish ... I'm put through hell for like 2 weeks, and eventually he is so ill he's sectioned and if they'd only listened to me, like a fortnight beforehand, they could have had him in hospital, done something for him rather than keep calling people out to check him and getting phone calls 'no sorry in our opinion he's not sectionable, and then 10 days later they section him' (caregiver to a son, not 1st admission) (p4).<br>ISSUES AROUND CONFIDENTIALITY<br>Difficulties with confidentiality (n=7)<br>Family caregivers raised problems relating to lack of information | |

| Jankovic J, Yeeles K, Katsakou C et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study. PloS One 6(10): e25425 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | and issues surrounding confidentiality.<br>They understood that confidentiality was a delicate issues, but they also pointed out that they had a need to know certain information if they were expected to provide care.<br>'Before they will talk to me about anything, they always say is it alright if I talk to your mother which is fine because it's patient confidentiality. But you know, when I'm the one that's at risk, I expect a bit of a say in it. That's fine if you've got him in a safe place and he's being looked after, but when he's out in the community with me, then I expect a bit of a say in what goes on'<br>(caregiver to a son, not 1st admission) (p4).<br>Also relating to the issue of confidentiality, family caregivers wanted to provide important information to the clinicians but were concerned that the patient would be told about it. | |

| Wilkinson C, McAndrew S (2008) 'I'm not an outsider, I'm his mother!' A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| **Methodology**<br>• Qualitative study<br>**Study aim**<br>• 'To understand, from | **Participants**<br>• Carers/family members of people with MH conditions | FINDINGS – NARRATIVE<br>All of this is relevant to RQ9, carer support, but fits more with carer views on admission as it is not a specific intervention. | **As far as can be ascertained from the paper, how well was the study conducted?** |

| Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| the perspective of informal carers, what experiences they had when their relative was admitted to an acute psychiatric inpatient setting’ (p394).<br>**Source of funding**<br>• Not reported<br>**Country**<br>• UK<br>**Outcomes (qualitative)**<br>• What works well<br>• What can be improved<br>• Experiences described | **Sample size**<br>• Four carers of people with mental illness who had been admitted to an acute psychiatric hospital within the previous 2 years. | **Powerlessness**<br>All of the participants interviewed described feeling a sense of powerlessness once the person that they care for was admitted into hospital.<br>‘It’s like as soon as he enters the ward they (professionals) take over; it’s like I give my son up to their care … he’s at their mercy.’<br>Mary expressed similar views:<br>‘I went from doing everything for him (husband) to doing nothing for him … it felt like somehow I wasn’t needed anymore because he had the nurses to look after him and I was just in the way’ (p395).<br>As these quotes suggest, participants experienced a divide between themselves and the healthcare professionals in the wards.<br>James stated:<br>‘I just felt that as soon as she was sectioned, I handed over her care … I felt inferior, I didn’t know what was going on, I didn’t know how to make things right. The doctors and nurses were the experts and I had to trust them. I didn’t have any choice because I just felt that things were beyond my control’ (p395).<br>Whilst participants acknowledged that they attended ward | • Carer only perspective (no interviews with relevant professionals or service users). Very small sample size (4 participants) from a specific area of the UK.<br>**Relevance to the MH transitions guideline**<br>• Highly relevant<br>UK study. All carers had to have a loved one who was admitted to a mental health institution within the previous 2-year period, and there is a focus on the admission process (as well as general principles on how information is shared with carers, carer involvement and using the carer as a resource). |

| Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | meetings for example, the overriding sense is that they were passive rather than active in their loved one’s care.<br>This was highlighted by Rebecca:<br>‘I felt that the decisions were made without us [carer and son], and then we’d be invited into the ward round as a matter of courtesy to let us know their [professionals] plans. It’s like when they said they were going to put him back on olanzapine. I knew it wouldn’t work for him because it hasn’t in the past, but I didn’t say anything because the decision had been made and nothing I said would change that’ (p396).<br>Participants who are looking after a loved one in hospital are particularly at risk of becoming ill and suffering emotionally themselves.<br>James said: ‘She [wife] was in hospital and I felt lost and helpless, and well … I just felt useless. I hated myself. I was a failure’ (p396).<br>**Feeling isolated**<br>The admission of a loved one into hospital was a time of confusion and distress for the carers and a time when they needed support to understand and deal with what was happening. However, their experience was one of being ignored by healthcare professionals, which fostered a sense of isolation. | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | Mary stated:<br>'I cried when I came home from the hospital that first night. I felt so alone … I had wanted to speak to someone about what was happening, but when I tried I was told by the nurse that she couldn't speak to me, I should visit my doctor' (p396).<br>A further example of this is demonstrated by Rebecca:<br>'As soon as he was admitted to the ward I became a nobody, an outsider, but I'm not an outsider, I'm his mother!' (p396).<br>Despite wanting to learn more about their loved one's illness participants felt ignored.<br>Jean stated: 'Nobody ever spoke to me about the illness and nobody ever explained anything to me. I didn't understand what was going on' (p396).<br>James stated that: 'It got to a point where I just gave up trying to speak with the nurses. They were always too busy to talk to me and I just couldn't see the point in pushing it. It wouldn't have done any good anyway' (p396).<br>The participants found it difficult to build a relationship with healthcare professionals, particularly nursing staff, and felt that they used confidentiality as a means of avoiding engagement with carers (p396). | |

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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | Participants understood that there may be some information which had to remain private between the patient and professional; however, it was felt there was still a great deal more which could and should be shared with them.<br>Mary stated: ‘If I rang the ward, I was told that his care can’t be discussed over the phone because of confidentiality … they said I could be anyone ringing up … but I didn’t want to know all the details, I didn’t want to know what he (husband) discussed in confidence, I just wanted to know that he was safe. I needed peace of mind because I just felt so away from everything’ (p396).<br>Often decisions made during the hospital admission impacted upon the whole family, and consequently, the participants felt that family should be involved at the decision-making level. Unfortunately, this was not the case.<br>Rebecca said: ‘I wasn’t involved, I was an afterthought … no one told us anything, no one rang to keep us up to date with the plan of care. I only found out that he [son] had been started on an injection when he rang to tell me that he’d had a needle in his bum … How can I look after him at home if I don’t know what I’m supposed to be doing?’ (p397). | |

Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401

| Research aims | Population | Findings | Quality assessment |
|---|---|---|---|
| | | **A need to be recognised and valued**<br>All of the participants said they needed to be recognised and valued by healthcare professionals so as to feel involved throughout their loved one’s admission.<br>Jean expressed: ‘As a family, we went through a really traumatic experience leading up to the crisis and afterwards and nobody ever acknowledged this.’<br>Rebecca stated: ‘No one seemed to appreciate the impact his hospitalization had on me. I just wanted someone to recognize the hell that I’d gone through, to feel that someone cared about me’ (p397).<br>The participants felt that their emotional problems and stress would negatively impact upon their loved one’s mental health, and they looked to healthcare professionals to offer them support and advice.<br>The participants also expressed the need to be recognised and valued as being a source of knowledge.<br>When participants expressed their point of view, they felt they were not valued as a resource.<br>Mary stated: ‘They (professionals) should appreciate me for who I am. I’m his wife. I’ve lived with him for 30 years. I know him better than anybody. I’m not questioning what they do, I’m not complaining, I’m just trying to help make it easier for everybody’ (p397). | |

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<tr><td colspan="4">Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401</td></tr>
<tr><td><b>Research aims</b></td><td><b>Population</b></td><td><b>Findings</b></td><td><b>Quality assessment</b></td></tr>
<tr><td></td><td></td><td>This brought him a sense of relief and appeared to give him a feeling of value and self-worth.<br><br>James explains: ‘The turning point for me was when “M” [community psychiatric nurse (CPN)] visited the ward. He spent ages with me and it gave me the chance to ask all the questions I’d wanted to ask since my wife first went into hospital … It was like a dam had been building inside me and M had knocked it down. It was such a relief. I had so many fears and they just came flooding out, but it felt good and I felt so much better afterwards’ (p397).<br><br><b>A desire for partnership</b><br>Despite feeling a sense of powerlessness and isolation, all of the participants expressed a desire to work in partnership with healthcare professionals.<br>It was felt that this would improve the carer experience of acute psychiatric hospitals and increase their sense of involvement in the care package.<br>Jean explained: ‘It’s about working together, the team knowing that I have valuable things to contribute and vice versa, because we all want the same at the end of the day’ (p397).<br>It was not currently felt that professionals did work in partnership with them.<br>Rebecca stated: I’d like to be valued as someone who can contribute to my son’s care. For that to happen, the attitude of</td><td></td></tr>
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| Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401 | | | |
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| **Research aims** | **Population** | **Findings** | **Quality assessment** |
| | | the nurses and doctors has to change from “they know best”. I have so much to contribute, but it’s as though by asking me what I think it’s challenging their knowledge and know how and it’s just silly. They’re professionals in mental health. I’m a professional about my son. It needs to be about working together. It shouldn’t be about us and them.’<br>James stated: ‘I’d like to see more people on the ward like the CPN, more staff with his attitude. He encouraged me to be involved. I think nursing staff on the wards should be more proactive in involving family, like not waiting for people to approach them, but being more positive when talking to carers’ (p398). | |

# Critical appraisal table

## Table reporting impact study

## Review Question 10: What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings?

| Ellis HA (2014) Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. Archives of Psychiatric Nursing 28: 10–6 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Before/after cross-sectional study.<br>**Objectives of study clearly stated?**<br>• Yes<br>**Relevance to our review question(s)?**<br>• Yes<br>**Clearly specified and appropriate research design?**<br>• Yes<br>**Subjects recruited in acceptable way?**<br>• Partly<br>Convenience sample made up of police officers from 3 municipalities in Miami. No volunteers, participants were assigned by police training departments.<br>**Sample representative of defined population?**<br>• Partly<br>26 (93%) of the 28 officers | **Measurements and outcomes clear?**<br>• Partly<br>Number of items on scale and 4-point Likert scale as measurement given. Little contextual information given.<br>**Measurements valid?**<br>• Yes<br>The Mental Illness Knowledge Questionnaire (MIKQ), a 30-item, 4-point Likert Scale questionnaire was developed by Compton et al. (2006) and was designed to measure knowledge and understanding of mental illness.<br>The MIKQ also contains 3 subscales measuring personal knowledge, inconsistent knowledge and external knowledge. The Mental Illness Perception Questionnaire (MIPQ), a 6-item, 4-point Likert Scale questionnaire, was developed by Compton et al. (2006) and was operationally designed to measure officers’ | **Tables/graphs adequately labelled and understandable?**<br>• Yes<br>**Appropriate choice and use of statistical methods?**<br>• Yes<br>**In-depth description of the analysis process?**<br>• No<br>**Are sufficient data presented to support the findings?**<br>• Yes<br>**Results discussed in relation to existing knowledge on the subject and study objectives?**<br>• Yes<br>**Results can be generalised?**<br>• Unclear<br>The sample size was too small and specific only to 3 municipalities in Florida. | The study gave details of the content of a standard crisis intervention team (CIT) training programme (see Table 1 in Findings) but it is not clear if this was exactly that which was administered.<br>More nuanced knowledge-measurement tool rather than Likert Scale format may have resulted in a more precise measure of officers’ knowledge. Likert relies on levels of endorsement rather than a definitive right or wrong response to each question, so this scale may not capture full extent of changes in outcomes.<br>Field observations of the officers post- | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• No<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>To the extent that police are expected to refer people in crisis to the appropriate mental health service.<br>**Is the intervention clearly relevant to RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Yes<br>**External validity**<br>• + |

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|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| consented to participate in the study, and 25 (89%) completed both the training post-test measures. The sample was only taken from 3 municipalities out of a potential 35. (Racial/ethnic representation would have been more diversified the greater the number of municipalities.) Notably 100% of the sample had experience of people with mental illness, and 80% had arrested someone with mental illness prior to the training indicating a high rate of previous experience in this area. | perceptions of mental illness within the construct of their self-efficacy. The Mental Illness Attitude Questionnaire (MIAQ), a 4-item, 4- point Likert Scale questionnaire was developed by Compton et al. (2006) and was operationally designed to measure officers' attitudes toward someone with mental illness within the construct of social distance.<br>**Setting for data collection justified?**<br>• Unclear<br>No context given on data collection setting.<br>**All important outcomes and results considered?**<br>• Partly<br>Changes in knowledge, perception and attitude are useful indicators, however, continuing post-CTI training follow-up field evaluations might reveal more about knowledge, attitudes, and | **Do conclusions match findings?**<br>• Yes | training intervention could have demonstrated the impact. | |

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<tr><td colspan="5">Ellis HA (2014) Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. Archives of Psychiatric Nursing 28: 10–6</td></tr>
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<tr><td></td><td>perception scores.</td><td></td><td></td><td></td></tr>
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## Findings table

## Table reporting impact study

## Review Question 10: What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings?

Ellis HA (2014) Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. Archives of Psychiatric Nursing 28: 10–6

| Research aims | Population | Findings | Overall quality assessment |
|---|---|---|---|
| **Methodology**<br>• Cross-sectional study<br>**Study aim**<br>• To determine what impact a crisis intervention team (CIT) training would have on police officers' knowledge, perceptions, and attitudes towards people with mental illness from pre-CIT training<br>**Source of funding**<br>• Not reported<br>**Country**<br>• Florida, US | **Participants**<br>•Professionals/practitioners<br>**Sample size**<br>• 28 police officers from 3 municipalities.<br>**Sample characteristics**<br>• Sex<br>F %<br>Female 5 20<br>Male 20 80<br>• Ethnicity<br>F %<br>Black/African American<br>2 8<br>Hispanic/Latino<br>18 72<br>White/Caucasian<br>4 16<br>Missing 1 4<br>• Highest level of education<br>F %<br>Completed grade 12 2 8<br>Some college 10 40<br>Completed college 12 48 | **Outcomes 2 (quant)**<br>• Perception Mental Illness Perception Questionnaire (MIPQ); Attitude Mental Illness Attitude Questionnaire (MIAQ); Knowledge Mental Illness Knowledge Questionnaire (MIKQ). The MIKQ also contains 3 sub-scales measuring personal knowledge, inconsistent knowledge, and external knowledge.<br>FINDINGS – EFFECT SIZES<br>• Results of knowledge, perception and attitude pre- and post-training intervention<br>Questionnaire type<br>M SD t p η2 d<br>Knowledge<br>Pre 30.46 14.98 2.841 .009 .2517 0.80<br>Post 37.02 16.20<br>Perception<br>Pre 15.33 3.81 3.900 .001 .3981 1.13<br>Post 18.79 3.15<br>Attitude<br>Pre 7.50 2.04 3.456 .002 .3418 1.00<br>Post 9.33 3.00<br>Mean knowledge component scores comparison between pre- and post-training.<br>Knowledge type M SD t p η2 d<br>Personal<br>Pre 15.61 7.48 2.459 .022 .201 0.696 | **Internal validity**<br>• +<br>**External validity**<br>• +<br>This is a US study but generalizable to UK context where police are involved in crisis Intervention. |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | Graduate training after college 1 4<br>Current rank F %<br>Police 18 72<br>Sergeant 5 20<br>Lieutenant 1 4<br>Commander 1 4<br>Years as police officer<br>F %<br>1 to 5 10 40<br>5 to 10 5 20<br>10 to 15 1 4<br>15 to 20 3 12<br>More than 20 6 24<br>**Intervention**<br>• Crisis intervention team (CIT) is a systematic response intervention requiring the use of specialised skills when responding to calls involving people with mental illness. These may include assessing for the likely presence of mental illness, using communication and de-escalation techniques and | Post 18.88 8.33<br>Inconsistent<br>Pre 4.44 4.87 1.948 .063 .137 0.551<br>Post 5.72 5.00<br>External M SD t p η2 d<br>Pre 8.32 3.91 1.533 .138 .089 0.434<br>Post 9.53 4.08<br>Biological<br>Pre 3.48 1.33 2.221 .036 .170 0.628<br>Post 4.20 1.56<br>FINDINGS – NARRATIVE<br>• RQ10 TRAINING<br>Knowledge scores about mental illness were scored as M=30.46, SD=14.98 prior to the training. Post-training participant knowledge scores improved, M=37.02, SD=16.2 thus achieving statistical significance (p=.009). Perception scores were scored as M=15.33, SD=3.81 prior to the training. Post-training perception scores improved, M=18.79, SD=3.15 thus achieving statistical significance (p=.001). Attitudes were scored at M=7.50, SD=9.33 prior to the training. Post-training scores improved at M=9.33, SD=3.00, making them statistically significantly (p=.002). Knowledge about mental illness, perception and attitude scores all showed statistically significant improvements after the training intervention. | |

| Ellis HA (2014) Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. Archives of Psychiatric Nursing 28: 10–6 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | communicating with mental health providers. The behavioural health crisis management techniques taught in CIT is a core requirement of psychiatric nurses.<br>*See Table 1 for more details of an example of a standard crisis intervention team (CIT) 40-hour course.<br>**Follow-up**<br>• Outcomes captured before and after intervention (but no more information given around times) | **Additional findings**<br>A cluster analysis using a sub-scale to divide knowledge scores into sub-sets of: personal knowledge, inconsistent knowledge, external knowledge, and biological knowledge indicated improvements in each area, however none of these sub-scores reached statistical significance. Results indicated that a larger sample size may have resulted in a significant effect. | |

*Table 1: Standard crisis intervention team (CIT) 40 – hour course

| **Summary of standard CIT 40 – hour class didactics model** | **Summary of standard CIT 40 – hour course content model** |
|---|---|
| • Mental health disease processes<br>• Signs & symptoms of mental illness<br>• De-escalation techniques<br>• Situational role play scenarios<br>• Film vignettes<br>• Live testimonials from cit officers & consumers/families<br>• Field trips to local jails<br>• Field trips to local psychiatric facilities | • Signs & symptoms of mental illness<br>• Schizophrenia and psychotic disorders<br>• Mood – depressive & bipolar disorders<br>• Cognitive disorders<br>• Substance abuse & co-occurring disorders<br>• Anxiety & other brain disorders – PTSD<br>• Disorders in children & adolescents<br>• Risks to self & others<br>• Psychotropic medications<br>• Involuntary treatment<br>• Community resources<br>• Communication techniques<br>• Needs of mental health consumers<br>• Community perspective<br>• Resiliency for the officers on how to prevent PTSD<br>• Cultural sensitivity & mental illness |

## Critical appraisal tables

## Table reporting views studies

## Review Question 10: What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings?

| Bowers L, Clark N, Callaghan P (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33: 961–8 | | | | |
|---|---|---|---|---|
| **Study design & qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews.<br>**Is the study clear in what it seeks to do?**<br>• Mixed<br>This is a research note, rather than a fully-fledged study.<br>**How defensible/rigorous is the research design/methodology?**<br>• Defensible<br>Looks to explore multi-disciplinary perspectives so qualitative study is fitting.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Not stated<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | **Was the sampling carried out in an appropriate way?**<br>• Inappropriate<br>Convenience sample. Researchers argue that it was preferable to work with volunteers who were willing to act as informants, as opposed to randomly selected participants who may be hurried and reluctant.<br>**How well was the data collection carried out**?<br>• Not sure/inadequately reported<br>**Were the methods reliable?**<br>• Somewhat reliable<br>**Is the role of the researcher clearly described?**<br>• Clearly described | **Are the data 'rich'?**<br>• Mixed<br>**Is the analysis reliable?**<br>• Not sure/not reported<br>**Are the findings convincing?**<br>• Somewhat convincing<br>**Are the conclusions adequate?**<br>• Somewhat adequate | Skills and training only constituted 1 element of the interview questions. The study is from 2003 and, as such, involves approved social workers (ASWs). ASWs were responsible for organising assessments for compulsory admission, but since 2007 the ASW role has become defunct and has been superseded by the approved mental health professional role (AMHP). The 2 roles are not comparable. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• -<br>**Relevance to the MH transitions guideline**<br>• A bit relevant |

| Forchuk C, Martin ML, Jensen et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94 | | | | |
|---|---|---|---|---|
| **Study design & qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Qualitative study<br>Qualitative data in the form of field notes, monthly summaries of significant events and changes, ward minutes of meetings, progress summary (every 6 months). Focus groups. The study was developed and implemented as action research. It used a 'delayed implementation control group design' – a program evaluation design which uses randomisation and both quantitative and qualitative data collection methods.<br>**Is the study clear in what it seeks to do?**<br>• Clear<br>**How defensible/rigorous is the research design/methodology?**<br>• Somewhat defensible<br>Detailed ethnographic approach was used to | **Was the sampling carried out in an appropriate way?**<br>• Appropriate<br>**How well was the data collection carried out?**<br>• Somewhat appropriately<br>Data was collected through various methods (focus groups, progress reports, summaries). Each hospital assigned a nurse to the research project and these research staff members took on a leadership role for data collection at each site. Research staff and researchers had a weekly teleconference and face to face meetings for a full day every 3 months.<br>**Were the methods reliable?**<br>• Reliable<br>**Is the role of the researcher clearly described?**<br>• Clearly described | **Are the data 'rich'?**<br>• Mixed<br>**Is the analysis reliable?**<br>• Reliable<br>**Are the findings convincing?**<br>• Somewhat convincing<br>**Are the conclusions adequate?**<br>• Somewhat adequate | The study evaluates contextual factors around development and implementation of a transitional care intervention in Canada which includes – as 1 element – educational factors, but it does not reveal the impact of this training on patient outcomes in the community. Findings are not clearly attributed to either staff or service users, even though the authors state services users were involved in the focus groups. | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• +<br>**Relevance to the MH transitions guideline**<br>• A bit relevant |

| Forchuk C, Martin ML, Jensen et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94 | | | | |
|---|---|---|---|---|
| **Study design & qualitative methods** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| examine strategies for introduction of best practice relating to implementing TRM in psychiatric settings. There are no measures of the impact of the training itself, but some views are given in relation to the educational modules and other aspects of staff development in relation to the TRM intervention.<br>**Is the context clearly described?**<br>• Clear<br>**Study approved by ethics committee?**<br>• Yes<br>University of Western Ontario and St Joseph's Healthcare Hamilton and other research ethics boards.<br>**How clear and coherent is the reporting of ethics?**<br>• Not stated | | | | |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| **Methodology**<br>• Before/after cross-sectional study<br>**Objectives of study clearly stated?**<br>• Yes<br>**Relevance to our review question(s)?**<br>• Yes<br>**Clearly specified and appropriate research design?**<br>• Yes<br>**Subjects recruited in acceptable way?**<br>• Yes<br>**Sample representative of defined population?**<br>• Partly<br>Potential participants had to pass 2 stages of a selection process (if 'defined population' means potential peer support workers, then yes). | **Measurements and outcomes clear?**<br>• Unclear<br>The co-occurring recruitment process for the peer support roles introduced a risk of bias when responding to questions about their own qualities and their ability to perform many of the skills required for effective peer support (as people will tend to report themselves as having higher readiness to provide support if they want the role).<br>**Measurements valid?**<br>• No<br>The Nottingham Peer Support Training Evaluation Tool (NPSTET) is not a validated tool.<br>**Setting for data collection justified?**<br>• Partly<br>Pre-intervention outcomes may have been skewed as people | **Tables/graphs adequately labelled and understandable?**<br>• N/A<br>**Appropriate choice and use of statistical methods?**<br>• Yes<br>**In-depth description of the analysis process?**<br>• Yes<br>Quantitative data were analysed using SPSS version 16. Due to the small sample, the nonparametric Wilcoxon signed-rank test was used to determine any directional change of scores and also the strength of that change. Qualitative data from the open-ended items on the NPSTET, along with relevant responses from the focus groups and interviews, were | Very small sample (8 PSWs ultimately provided support). Recruitment for peer support worker positions occurring concurrently to data collection introduced strong risk of bias. The high pre-test scores are likely to be influenced by the participants' desire to show their suitability for the role. | **Internal validity**<br>• +<br>**Is the setting similar to the UK?**<br>• Yes<br>**Is there a clear focus on mental health transitions?**<br>• Yes<br>**Is the intervention clearly relevant to RQ?**<br>• Yes<br>**Are the outcomes relevant?**<br>• Unclear<br>**External validity**<br>• + |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | | |
|---|---|---|---|---|
| **Study design** | **Data collection** | **Analysis & reporting** | **Limitations** | **Overall assessment** |
| | wanted to demonstrate their suitability to peer support work. Post-intervention data collection happened on final day of training with peers and trainers present – the mood may have been celebratory and affected the accuracy of their responses.<br>**All important outcomes and results considered?**<br>• Partly | organised and explored with NVivo 6 software.<br>**Are sufficient data presented to support the findings?**<br>• Partly<br>**Results discussed in relation to existing knowledge on the subject and study objectives?**<br>• Yes<br>**Results can be generalised?**<br>• Partly<br>**Do conclusions match findings?**<br>• Yes | | |

## Findings tables

## Table reporting views studies

## Review Question 10: What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings?

Bowers L, Clark N, Callaghan P (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33: 961–8

| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
|---|---|---|---|
| **Methodology**<br>• Qualitative study<br>Semi-structured interviews.<br>**Study aim**<br>• Multidisciplinary reflections on assessment for compulsory admission that discusses the views of approved social workers, GPs, ambulance crews, police, community psychiatric nurses and psychiatrists. One element covered skills and training.<br>**Source of funding**<br>• Joint Research Board of St Bartholomew's Hospital, London.<br>**Country**<br>• UK<br>One NHS trust in London. An area of social deprivation and ethnic diversity. Psychiatric services are provided by 4 sectorised, multidisciplinary community | **Participants**<br>Professionals/practitioners<br>Convenience sample, interviewees were volunteers.<br>Doctors n=8; approved social workers n=5*; community psychiatric; nurses n=5; ambulance personnel n=5; police n=8<br>Total n=31<br>* Note that this role (ASW) no longer exists. Since 2007 approved mental health professionals (AMHPs) have taken over this role and the responsibility of assessments for compulsory admission.<br>**Sample size**<br>• 31 professionals<br>**Sample characteristics**<br>• Not reported<br>Intervention<br>• Assessment and detention | • RQ10 TRAINING<br>SKILLS AND TRAINING<br>Skills used by the 8 doctors to secure a smooth admission can be broadly grouped into team skills (working together with the ASWs); assessment skills (e.g. risk); building relationships (with family and patient) and using persuasion.<br>Given that the ASW sets up the assessment for compulsory admission it is not surprising that 4 ASWs spoke of organisational skills first – asking people to attend, briefing them prior to the assessment and keeping them informed throughout. Four of the ASWs spoke of the need for 'clear and honest communication' (p965) with the patient. 'Explaining what you're doing and why' (p966).<br>Ambulance crews used reassurance, patience, explaining what is going to happen, building trust (through eye contact and negotiation).<br>WHERE THE SKILLS ARE LEARNT<br>Medical school training on assessment skills were seen as being very poor.<br>Communication skills workshops were largely dismissed: 'Teaching on communication courses was very helpful – in how not to do it!' (p966).<br>Three doctors spoke of the skills as being part of their personality, another explained that he applied the principles of treating others as he would like to be treated himself. Most | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• -<br>**Relevance to the MH transitions guideline**<br>• A bit relevant |

| Bowers L, Clark N, Callaghan P (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33: 961–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| mental health teams and their acute wards, spread over 2 hospitals. | for compulsory admission. | of the doctors explained that there was 'nothing like experience', 3 suggested that doctors should shadow more experienced staff so they could learn by watching and modelling.<br>ASWS learned by watching and observation. The majority felt that they learned by experience: 'On the job, no question' (p966). Observing how others managed assessment and sharing stories with other staff were seen as a successful way of learning techniques.<br>Three community psychiatric nurses (CPNs) felt that their training had not prepared them well for real situations, with 1 saying 'the CPN course didn't train me for this' (p.966) and another explaining that previously they would not have needed to know about this process (prior to the creation of multidisciplinary teams). However, these 3 CPNs also felt that training could never prepare you completely. Another suggested nurses observing compulsory admissions as ASW trainees do.<br>All 5 ambulance crew felt there was very little training on mental health issues in the basic training. Three remembered a session on the MHA. 'A nurse came and gave a brief chat – law stuff'(p966), another commented that learning was mostly experiential.<br>Police officers reported having almost no formal training in dealing with mentally ill people. Instead they use 'tact, persuasion, officer safety' to try and ensure as smooth a | |

| Bowers L, Clark N, Callaghan P (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33: 961–8 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | section and transportation as possible' (p967). One officer said he learnt a lot from talking to doctors and nurses, and knew to turn his radio off and take his hat off when dealing with someone with mental health problems.<br>DISCUSSION<br>Although the required skills were clearly identified by all groups, formal training for managing assessment was seen to be absent or rated as poor by nearly all respondents. Interprofessional training and observing others with more experience were suggested modes of learning about the process during training. (NB although 1 drawback is that a doctor commented that they avoided overcrowding during the process.) | |

| Forchuk C, Martin ML, Jensen, et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Qualitative study<br>Qualitative data in the form of field notes, monthly summaries of significant events and changes, ward | **Sample size**<br>• 6 psychiatric hospital sites. 14 A wards (wards that had adopted the intervention in previous studies from 1998, 2005); 12 B wards | **Outcomes 1 (qualitative)**<br>• What works well<br>Educational modules<br>All wards valued having specific education on TRM prior to implementation. However, the content evolved with each set | **As far as can be ascertained from the paper, how well was the study conducted?**<br>• + |

| Forchuk C, Martin ML, Jensen, et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| minutes of meetings, progress summary (every 6 months). Focus groups. The study was developed and implemented as action research. It used a 'delayed implementation control group design' - a programme evaluation design which uses randomisation and both quantitative and qualitative data collection methods.<br>**Study aim**<br>• To examine best practice facilitators and barriers to implementing the Transitional Relationship Model (TRM). TRM is an evidence-based intervention designed to assist individuals as they leave psychiatric hospital and attempt to integrate into the community.<br>- What strategies are recommended by staff on wards that have implemented TRM? | (implemented TRM in year 1, with the implementation strategies suggestion by the A wards); 10 C wards (implemented last, with the implementation strategies suggested by the B wards). Variety of wards participated: admission, addictions, dual diagnosis and forensics. 200 people took part in the focus groups (staff and patients)<br>**Intervention**<br>• Implementation of the Transitional Relationship Model (TRM) during psychiatric hospital stay the hospital clinical staff member who has a therapeutic relationship with the client remains involved following hospital discharge until the client establishes a therapeutic relationship with a community care provider. Peer support is also offered from a consumer of mental | of wards and the methods of delivery became focused on faster implementation with successive sets of wards.<br>Education modules developed based on feedback from A and B wards:<br>HOSPITAL STAFF TRAINING TOPICS<br>- Introduction to transitional relationship model and best practices<br>- Therapeutic relationships<br>- Bridging and peer support specialists<br>- Therapeutic boundaries<br>- Transitional discharge planning<br>- Telephone practice<br>- Bridging safely<br>- Bridging and crisis intervention<br>- Partners and resources<br>Best practices and telephone practices were suggested by A wards.<br>Crisis intervention was added for the C wards.<br>The manner in which the staff modules were offered varied throughout the study. For A wards they were offered on-ward. However, for the B wards other staff training modules were taking place at the same time, so some B wards put modules online to speed up the process; 3 of the B wards pulled staff | **Relevance to the MH transitions guideline**<br>• A bit relevant |

| Forchuk C, Martin ML, Jensen, et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| - What are the facilitators and barriers to implementing TRM?<br>**Source of funding**<br>• Funding councils<br>The Canadian Institutes of Health Research (CIHR).<br>**Country**<br>• Canada | health services who is currently living in the community and who has specialised training in peer support. The 3 basic assumptions of TRM are:<br>• People heal in relationships (including staff and peer relationships).<br>• Transitions in care are vulnerable periods for individuals with mental illness.<br>• A network of relationships provided during transitional periods assists in recovery (p585) | off the wards for a full day workshop.<br>As a result full day workshops and online modules were recommended to the C wards.<br>At 1 C ward hospital staff complained of 14 annual online modules which they deemed too much. This highlights how quickly modes of learning can become unfeasible or unwarranted depending on other circumstances.<br>Interactive workshops continued to be valued.<br>**On-ward champions**<br>A wards recommended having on-ward champions - designated people whom staff could go to with questions or concerns. Having a key person to help staff with negotiating for resources, staffing changes to cover a home visit, and offer assistance to help with the process was seen as a major focal point for implementation.<br>B and C wards went on to include champions as part of their implementation strategy and staff comments confirmed their importance.<br>**Consistent factors of focus groups**<br>- Importance of developing and maintaining multiple relationships<br>- Ensuring meaningful participation throughout the process<br>- Working with consumer groups about how to find sources | |

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|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | | for the peer support<br>- Workload and work environment issues<br>Focus groups differences between wards.<br>Strategies that each of the wards found useful varied depending on the specific ward environment.<br>• What can be improved<br>Drowning, swamped, overwhelmed staff described being on 'educational overload' with the number of mandatory educational programs and the introduction of new projects which were introduced in addition to the study. They felt overwhelmed by the amount of paperwork and described feeling 'burnt-out' (p590). | |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| **Methodology**<br>• Cross-sectional study<br>**Study aim**<br>• To report the findings of an evaluation of a peer support | **Participants**<br>• Peer Support Workers<br>**Sample size**<br>• 13 people successfully completed training. All had | **Outcomes**<br>• The Nottingham Peer Support Training Evaluation Tool (NPSTET) 27 Likert-style items requiring respondents to reflect on their own qualities and assess their ability to perform many of the skills required for effective peer support. There | **Internal validity**<br>• +<br>**External validity**<br>• + |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| workers training and support intervention. Peer support workers (PSWs) were recruited to provide support alongside conventional aftercare to service users discharged from acute psychiatric units in London.<br>**Linked study**<br>• Simpson et al. (2014) Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. This pilot RCT study was included in the Discharge review area, however as it scored (-/-) it was not presented to the GC.<br>**Source of funding**<br>• National Institute for Health Research (NIHR) under its Research for Patient Benefit | previous experience of inpatient mental health care and a variety of relevant experience from informally supporting friends and family, attending support groups, specific mentoring, befriending, and support work. Due to problems with criminal record checks and people becoming unwell 8 PSWs provided support to service users as part of the study.<br>**Sample characteristics**<br>• Sex<br>Of the 13 trainees who completed training:<br>men n=9 women n=4<br>• Ethnicity<br>5 White British<br>4 Black Caribbean<br>3 Black British<br>3 ‘other white‘<br>2 British Bangladeshi<br>• Sample age<br>Of the 13 trainees who | are also 6 open-ended questions.<br>FINDINGS – EFFECT SIZES<br>• NPSTET Scores "pre-training scores on the adapted NPSTET were high, with an average of 6 (of a possible 7) across all questions, indicating that even before the training, trainees tended to ‘agree’ with most statements. There was no change post-training; the average score remained 6 of 7, indicating that trainees still tended to ‘agree’ with most statements.<br>Eight peer support trainees’ overall scores increased (although none significantly), whereas 5 peer support trainees’ overall scores decreased (although none significantly). Five trainees obtained significantly different scores between the pre- and post-training questionnaires and another almost reached significance, but the overall difference between pre- and post-training scores was not significant across trainees, t(12) = -0.508, p=0.620)" (p6).<br>**Qualitative findings**<br>• What works well<br>The PSWs reported very positive experiences, with the combination of training and working boosting their self-esteem and confidence.<br>The quality of relationships with their service user peers varied but most experienced productive, rewarding peer support interactions. Numerous examples of supportive emotional and | |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| (RfPB) Programme<br>**Country**<br>• UK<br>East London. | completed training:<br>Ages ranged from 32 to 55 (mean age of 42 (SD = 6.71)).<br>Intervention<br>• Peer support training was delivered over 12 weekly 1 day sessions from April to July 2010. The aim of the training was to prepare and support individuals to support people being discharged from hospital with their recovery through providing practical and emotional support and promoting hope during the transitional period from psychiatric hospital to home. Peer support was provided alongside conventional aftercare services. Training was divided into 2 clear objectives:<br>- emphasis on participants drawing from their own unique experiences; | practical therapeutic relationships emerged alongside evidence of constructive developments on the part of their peers.<br>PSWs described an increased understanding of their own recovery processes and positive effects on their wellbeing. However, many expressed their frustration that the 6 week training period was too short.<br>Various aspects of the training were mentioned and recalled positively and many people spoke of it providing them with confidence. Role-plays in particular were seen as 1 of the most useful parts of training.<br>PSWs were positive about the support they received from the peer support coordinator, and the importance of a supportive, proactive PSC was recognised by all. Many PSWs reported feeling that the PSC created a safe environment:<br>'Supervision covered everything – that was really important'; 'She made you feel wanted, valuable' (p7).<br>**What can be improved**<br>Many of the PSWs did not believe they had been adequately prepared for the strong emotions they would experience generally, and particularly in relation to the ending of the peer support relationship after 6 weeks.<br>'I found ending the relationship terribly hard, more help on endings and how to deal with people' (p6). | |

| Simpson A, Quigley J, Henry SJ, Hall C (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40 | | | |
|---|---|---|---|
| **Research aims** | **Population** | **Findings** | **Overall quality assessment** |
| | personal development – developing key skills and preparation for peer support role including communication training, and active, attentive listening. Each session began and ended with a brief check in to establish how the participants were feeling (relating to the training or otherwise). This helped to develop a sense of containment and safety.<br>*See Table 2 for more information on training programme. | | |

Table 2: Peer supporter training programme outline

| Session | Topic |
|---|---|
| **1** | Exploring peer support |
| **2** | Tree of Life* |

| | |
|---|---|
| **3** | Recovery and personal recovery plans |
| **4** | Recovery and personal recovery plans (continued) |
| **5** | Confidentiality, information-sharing, exploring boundaries |
| **6** | Active listening skills |
| **7** | Social inclusion |
| **8** | Appreciating differences |
| **9** | Responding to distressing situations |
| **10** | Revisiting boundaries and difficult situations – participants' choice |
| **11** | Preparing to be a peer supporter |
| **12** | Endings and celebrations |
| * The Tree of Life method. The training sessions were experiential, drawing on participants' individual and shared experiences of mental distress, service use, and recovery. This included using the Tree of Life methodology, a narrative approach that enables people to speak about their lives in ways that make them stronger. It involves people drawing their own 'tree of life' in which they get to speak of their 'roots' (where they come from), their skills and knowledge, their hopes and dreams, as well as the special people in their lives. The participants then join their trees into a 'forest of life' and, in groups, discuss some of the 'storms' that affect their lives and ways they respond to these storms and protect themselves and each other (p4). | |