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Artigo de Revisão

Effectiveness of crisis resolution and home treatment teams in mental health crisis: a systematic review protocol

A efetividade das equipas de hospitalização domiciliária psiquiátrica: um protocolo de revisão sistemática

La efectividad de los equipos de hospitalización domiciliaria de atención psiquiátrica: un protocolo de revisión sistemática

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Abstract

Background: People with mental health crises may need intensive care support that, in many countries, implies a psychiatric hospitalization that may negatively affect the individual. Furthermore, it involves the individuals' removal from their daily spaces, which implies an adaptive effort when returning to the community. In order to reduce

the treatment's impact of a mental health crisis, Crisis Resolution or Home Treatment (CRHT) Teams have been providing an alternative to inpatient treatment.

Aim: To analyze and highlight CRHT teams' effectiveness in reducing days of treatment, relapse, and rehospitalization of adults (18-65 years) compared to treatment as usual defined as inpatient treatment.

Methods: We will develop a systematic review of the current literature by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2019 Statement. Two authors will independently conduct study inclusion, data extraction, quality, and bias risk assessments. We will include experimental study designs like randomized clinical trials, non-randomized, quasi-experimental, before and after studies, prospective and retrospective cohort studies, and case-control studies involving working-age adults (18-65 years) irrespective of culture, ethnicity, or mental health diagnosis.

Results: We will include primary outcomes like days of treatment, relapse (as defined by each study), and rehospitalization. Secondary outcomes will be service user satisfaction, dropout rate, and the proportion of patients with adverse events (suicide, self-harm, or aggression/violence).

Conclusions: This study will allow evidence to determine the need to create and encourage the implementation of CRHT teams to provide an effective alternative response to psychiatric hospitalization.

Keywords: Crisis Intervention; Hospitals, Psychiatric; Home Care Services; Systematic Review

Resumo

Contexto: A pessoa em crise de saúde mental pode precisar de tratamento intensivo que, em muitos países, implica um internamento psiquiátrico que pode afetar negativamente o indivíduo. Além disso, envolve o seu afastamento dos espaços quotidianos, o que implica um esforço adaptativo ao retornar à comunidade. A fim de reduzir o impacto do tratamento de uma crise de saúde mental, as Equipes de Hospitalização Domiciliária Psiquiátrica (EHDP) constituem-se como alternativa ao internamento hospitalar.

Objetivo: Analisar e evidenciar a eficácia das EHDP na redução de dias de tratamento, recaídas e reinternamento de adultos (18-65 anos) em comparação com o tratamento usual definido como internamento hospitalar.

Métodos: Desenvolveremos uma revisão sistemática da literatura de acordo com o Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2019 Statement. Dois autores conduzirão independentemente a inclusão de estudos, a extração de dados, a avaliação da qualidade e do risco de viés. Incluiremos estudos

experimentais como ensaios clínicos randomizados, não randomizados, quase-experimentais, estudos pré e pós-teste, estudos de coorte prospetivos e retrospetivos e estudos de caso-controle envolvendo adultos em idade ativa (18-65 anos), independentemente da cultura, etnia ou diagnóstico de saúde mental.

Resultados: Incluiremos outcomes primários como dias de tratamento, recaída (conforme definido por cada estudo) e reinternamento. Os outcomes secundários incluem a satisfação do cliente com o serviço, taxa de abandono e proporção de pacientes com eventos adversos (suicídio, automutilação ou agressão/violência).

Conclusões: Este estudo trará evidências para determinar a necessidade de criar e incentivar a implementação de EHDP como uma resposta alternativa eficaz ao internamento psiquiátrico.

Palavras-Chave: Intervenção na Crise; Hospitais Psiquiátricos; Serviços de Assistência Domiciliar; Revisão Sistemática

Resumen

Contexto: Las personas con crisis de salud mental pueden necesitar apoyo en cuidados intensivos que, en muchos países, implica una hospitalización psiquiátrica que puede afectar negativamente al individuo. Además, implica la salida de los individuos de sus espacios cotidianos, lo que implica un esfuerzo adaptativo al regresar a la comunidad. Para reducir el impacto del tratamiento de una crisis de salud mental, los equipos de resolución de crisis o de tratamiento en el hogar (ERCTH) han estado brindando una alternativa al tratamiento hospitalario.

Objetivo: Analizar y destacar la efectividad de los ERCTH en la reducción de días de tratamiento, recaída y rehospitalización de adultos (18-65 años) en comparación con el tratamiento habitual definido como tratamiento hospitalario.

Metodología: Desarrollaremos una revisión sistemática de la literatura actual mediante la Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2019 Statement. Dos autores realizarán de forma independiente la inclusión de los estudios, la extracción de datos, las evaluaciones de la calidad y riesgo de sesgo. Incluiremos diseños de estudios experimentales como ensayos clínicos aleatorizados, no aleatorizados, cuasiexperimentales, estudios de antes y después, estudios de cohortes prospectivos y retrospectivos, y estudios de casos y controles con adultos en edad laboral (18-65 años) independientemente de la cultura, origen étnico o diagnóstico de salud mental.

Resultados: Incluiremos resultados primarios como días de tratamiento, recaída (según la definición de cada estudio) y rehospitalización. Los resultados secundarios será la satisfacción del cliente del servicio, la tasa de abandono y la proporción de pacientes con eventos adversos (suicidio, autolesiones o agresión/violencia).

Conclusiones: Este estudio aportará evidencias para determinar la necesidad de crear y fomentar la implementación de ERCTH para ofrecer una respuesta alternativa efectiva a la hospitalización psiquiátrica.

Palabras Clave: Intervención en la Crisis; Hospitales Psiquiátricos; Servicios de Atención de Salud a Domicilio; Revisión Sistemática

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Introduction

Psychiatric hospitalization is one of the primary therapeutic modalities used to help people with an outbreak of severe mental illness (Loch, 2014). It is noteworthy that psychiatric hospitalization is comprehensively considered beneficial has patients express feeling better than before (Tomás et al., 2021). However, this results in the sense of disruption that hospitalization brings to the hospitalized person's life (Niimura et al., 2016), as it implies a physical distancing from the person's familiar and usual spaces for a particular time. Literature has described returning home and resuming daily life after inpatient psychiatric discharge as difficult and complex (Tomás et al., 2021; Mutschler et al., 2019). The person has to deal with the symbolic weight of psychiatric hospitalization that projects their inability to remain in the community, weakening their sense of autonomy and perceived self-efficacy, but also deal with stigma and discrimination, still present in our society, resulting from the disclosure of psychiatric hospitalization and consequent diagnosed mental illness (Tomás et al., 2021; Mutschler et al., 2019). Furthermore, several studies point out the possibility that the event of psychiatric hospitalization may be traumatic for the person, impairing their adherence to the therapeutic plan and, in particular, to the use of psychiatric services when they are in the prodromal phase of a new exacerbation episode of their disease (Wu, Cheng, Leung, Chow & Lee, 2020). Moreover, there are adverse outcomes of psychiatric hospitalization that we must consider, such as rehospitalization, suicide, risk of violence, the stigma of their mental illness, and a declining sense of mastery and control over their lives, mainly when there is a history of several admissions or long-stay admissions (Loch, 2014; Birken & Harper, 2017).

The Crisis Resolution and Home Treatment (CRHT) teams emerge as a way to provide intensive health care to individuals experiencing an acute mental health crisis who receive their treatment at home instead of an inpatient psychiatric unit (Lloyd-Evans et al., 2019; Alba Palé et al., 2019). This prerogative enlightens the guiding principle for the provision of mental health care that is intended to be mainly community-based and carried out in the least restrictive possible context (León-Caballero et al., 2020;

Department of Health, 2001; European Union Agency for Fundamental Rights, 2012). On that account, CRHT teams arose as an alternative to psychiatric admission in the mid-1990s with an implementation in several countries such as the United Kingdom, United States, Australia, Norway, Belgium, Germany, Spain, Canada, and the Republic of Ireland (Morant et al., 2017; Wheeler et al., 2015; Alba Palé et al., 2019). These countries have published studies on the implementation of CRHT teams reporting a reduction in hospital admissions and treatment costs, as well as higher levels of satisfaction on the part of people who have had access to this type of service compared to those who had usual care (psychiatric hospitalization) (Morant et al., 2017; Wheeler et al., 2015).

These teams seek out the possibility of offering another therapeutic modality to people in an acute crisis of mental illness, which in many countries, namely Portugal, consists exclusively of psychiatric hospitalization.

In addition to providing home treatment (generally at least daily), CRHT teams provide rapid assessment and the possibility to facilitate early discharge from the hospital by transferring inpatients to intensive home treatment (Wheeler et al., 2015). The recommendations on the functioning and structure of these teams include: (1) a gatekeeping role, with patients admitted to acute beds only if the CRHT team has assessed and agreed that this is necessary; (2) a rapid response with a 24-hour cover, including access to a psychiatrist or a medical prescriber; (3) a minimum of one visit per day; (4) a multidisciplinary response, with high-quality training health workers; (5) a limited number of different visiting professionals per service user; (6) ability to provide medical, psychological and social interventions (Wheeler et al., 2015).

However, there is variability in the organizational characteristics within these teams, and it is not possible to effectively define the characteristics that allow for a consistent definition of the effectiveness of the results obtained (Wheeler et al., 2015).

Hence, it is crucial to analyze and highlight CRHT teams' effectiveness in reducing days of treatment, relapse, and rehospitalization of adults (18-65 years) compared to treatment as usual defined as inpatient treatment.

This study provides an opportunity to define the efficacy and safety of CRHT teams compared to inpatient treatment and put forward the development of this kind of service to manage mental health crises.

Methods

To accomplish these aims, we will develop a systematic review of the current literature by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2019 Statement.

To ensure that this systematic review has no duplication until now, on March 12th, 2022, we conducted a preliminary search of JBI EBP Resources on Ovid, PROSPERO, Cochrane Database of Systematic Reviews, MEDLINE Complete, and Database of Abstracts of

Reviews of Effects (For more details see https://data.mendeley.com/datasets/kj9x4hzbz8/1). No current or active systematic reviews were found. However, we need to document review papers that partially address the same issue but do not present the same focus we propose.

Wheeler et al.'s review (2015) "excluded studies comparing CRT services to treatment as usual where the latter involved only inpatient care or outpatient appointments with a psychiatrist" (p. 3) and therefore does not integrate publications from countries where the mental health system is particularly hospital-based. Furthermore, the search for papers is until November 2013 (the included studies date between 1993 and 2011), and it does not include studies from Latin countries like Spain or Italy. Regarding Toot, Devine, & Orrell's (2011) paper, the participants of this review are older people with mental health problems. Finally, Towicz, Yang, Moylan, Tindall, & Berk's publication (2021) presents a narrative review about home care treatment's design, implementation, and outcomes, stating that there is limited evidence regarding clinical measures and consumer satisfaction, and effects on caregivers and staff. Regrettably, we could not retrieve the full text even though we requested a copy directly from the authors.

Criteria for considering studies for this review

Types of studies: We will include experimental study designs, including randomized clinical trials, quasi-experimental studies, before and after studies, prospective and retrospective cohort studies, and case-control studies. The language will be limited to Portuguese, Spanish, and English. We establish no time limit to literature search to find evidence from the beginning of this subject's research.

Types of participants: Studies that evaluate people with mental health crises requiring intensive mental health care, i.e., hospital admission to a mental health unit or an intensive home treatment provided by CRHT teams. Participants must be working-age adults (18-65 years), irrespective of culture, ethnicity, or mental health diagnosis.

Types of intervention: Studies with crisis resolution or home treatment teams will be compared with treatment as usual, defined as inpatient treatment.

Types of outcome measures: Primary outcomes will be days of treatment, relapse (as defined by each study), and psychiatric readmissions. Secondary outcomes will be service user satisfaction, dropout rate, and the proportion of patients with adverse events (suicide, self-harm, or aggression/violence).

Search methods for identification of studies

The main source of studies consists in a computer-aided search of electronic databases: MEDLINE; CINAHL; Cochrane Central Register of Controlled Trials; SCOPUS; ScienceDirect; MedicLatina; SciELO. Examples of keywords used in the search strategy

include: Mental health, Crisis Intervention, Crisis resolution, Home care or Home treatment. For reference's management, we choose Mendeley® Reference Management Software.

Data collection and analysis

All studies identified by the electronic searches will be independently assessed by two authors, and relevant studies will be selected based on the inclusion criteria described above. We will only include studies published in the abstract form if the complete article is available or if the authors provide further information. Any disagreement among authors will be resolved through discussion and consensus. If consensus is not possible, a final decision is up to the first author. Studies selection will be displayed in a flow diagram accordingly to the PRISMA statement (Page et al., 2021).

A standardized data extraction form will be designed and used to extract information on relevant features and results of the included studies. Two authors will independently extract data from the included studies. Data to extract will include: (1) Country, year, and aims of the study; (2) Patient characteristics (e.g., patient demographics; compulsory or voluntary admissions; psychiatric diagnosis); (3) CRHT teams characteristics (e.g., 24-hour service, gatekeeping role reported and implemented, included staff, early discharge service, community services articulation reports and implemented); (4) Methods and Study design features (e.g., methods used for random allocation, allocation concealment, and blinding; inclusion and exclusion criteria); (5) Primary outcomes; (6) Secondary outcomes.

Assessment of risk of bias in included studies is assured independently by two authors using the Cochrane risk of bias tool (Higgins et al., 2011). We will evaluate the methodology in respect of: (1) Random sequence generation; (2) Allocation concealment; (3) Blinding of participants and treatment providers; (4) Blinding of outcome assessment; (5) Incomplete outcome data; (6) Selective outcome reporting; (7) Other risks of bias; (8) The overall risk of bias.

The strategy for disagreements consists of discussion and the pursuit of consensus. Study authors will be contacted for additional information if any items appear unclear.

The methodological quality assessment of cohort and case-control studies leans on the Newcastle-Ottawa Scale (Wells, 2021). We will use the GRADE approach (Grading of Recommendations, Assessment, Development and Evaluations) to rate the overall quality of evidence for the primary outcomes and selected secondary outcomes of interest. Randomized trials start as high-quality evidence but could downgrade due to: (1) limitations in design and implementation (risk of bias); (2) indirectness of evidence; (3) inconsistency (unexplained heterogeneity); (4) imprecision (sparse data); and (5) reporting bias (publication bias). Each outcome's overall quality of evidence is determined after considering each element. The evaluation consists of four categories: (1) high-quality (i.e., further research is very unlikely to change our confidence in the

estimate of effect); (2) moderate quality (i.e., further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate); (3) low quality (i.e., further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate); (4) or very low quality (i.e., we are very uncertain about the estimate) (Schünemann, 2020).

Finally, this study does not involve individual patient data, and we do not require ethics approval.

Results

Through data synthesis, we will organize results according to: (1) primary outcomes, such as, days of treatment, relapse (as defined by each study), and rehospitalization; and (2) secondary outcomes, comprising service user satisfaction, dropout rate, and the proportion of patients with adverse events (suicide, self-harm, or aggression/violence). The principal summary measure will be the correlation coefficient due to correlational findings, that will only take place if data are homogeneous, otherwise the synthesis will only be narrative. However, a descriptive summary of means, standard deviations, correlation coefficients, p-values, and effect sizes will also be synthesized, where available in studies. A summary of each study will be written in a Word document in a tabular form accompanied by a narrative synthesis.

We expect to publish this review in 2024 in a peer-review journal.

Conclusions

This paper consists of a systematic review protocol produced according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2019 Statement. The aims of analyzing and highlighting the effectiveness of CRHT teams intervention compared to treatment as usual represents an opportunity to define the efficacy and safety of CRHT teams compared to inpatient treatment and put forward the development of this kind of service for the management of mental health crises.

Regarding the development of the theme and its secondary investigation, we intend to align its results with the impetus for implementing a psychiatric home hospitalization unit in countries like Portugal, where we practice our profession as specialist nurses in mental health and psychiatry nursing. Home hospitalization is already a reality in our country, but building a path for this to be a reality for other areas of care, such as mental health, may mean the need to build more evidence. The decisions taken to carry out this research project provide robustness to the proposals that may emerge from this work, contributing to a change in mentality and reducing professionals' resistance, accustomed

to traditional treatment. Therefore, research emerges pragmatically as part of the driving force behind health services management that can influence decision-making and consequent investments.

We wish to strengthen the arguments necessary for the change process, associating it with feelings of greater security and optimism. New models of care, like CRHT, advocate transferring health professionals' settings to a more naturalist environment, as is the case of home hospitalization. We believe that nurses should constitute themselves as key elements in the search for new possibilities for care responses, contribute to their decentralization and actively contribute to the construction and dissemination of services in the places where they are needed, that is, within communities and in closeness to people.

With this tone, we seek to become agents of change dedicated to the innovation and optimization of health services through the proposal to implement psychiatric home hospitalization units.

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