# Psykososial behandling av ikke-affektive psykoser

Notat

Litteratursøk med sortering

April 2010

**Bakgrunn:** Arbeidsgruppen for Nasjonale retningslinjer for diagnostisering og behandling av ikke-affektive psykoser (herunder schizofreni) ønsket at det skulle innhentes kunnskap om nettverkstilnærming, bolig, kontinuitet i behandling av schizofreni og medikamentelle og psykososiale tiltak mot rusinduserte psykoser • **Metode:** Vi søkte etter nyere systematiske oversikter om effekten av psykososiale tiltak i behandling av personer med ikke-affektive psykoser (herunder schizofreni). Vi brukte søketermer for å fange opp boligtiltak (supported housing), nettverkstiltak, og kontinuitet i behandling. Vi søkte i databasene OVID MEDLINE, OVID PsycInfo, Cochrane Library, herunder HTA-rapporter og DARE-rapporter. I MEDLINE og EMBASE ble søket avgrenset med søkefilter for systematiske oversikter • **Resultat:** Totalt satt vi igjen med 37 referanser som vi vurderte som sannsynlig relevante treff. Vi fant flere systematiske oversikter på nettverkstilnærminger, og her har vi inkludert familieintervensjoner, Assertive community, jevnaldergrupper, psykososiale tiltak, Expressed Emotions, Morita Terapi, sosialt nettverk og samarbeid i et nettverk av

*(fortsetter på baksiden)*

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*(fortsettelsen fra forsiden)* omsorgspersoner. Under boligoppfølging (Supported Housing) har vi tatt med oppsummeringer knyttet til tiltak som Community Mental Health Teams (CMHT), Assertive Community Treatment (ACT) og Community Support System (CSS).

| | |
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Kunnskapssenteret vil takke bibliotekarene Marita Heinz i Helsedirektoratet for å ha bidratt med sin ekspertise i dette prosjektet. Kunnskapssenteret tar det fulle ansvaret for synspunktene som er uttrykt i rapporten.

Nasjonalt kunnskapssenter for helsetjenesten
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# Oppsummering

Hva er effekten av psykososiale tiltak som nettverk, bolig, og kontinuitet i behandlingen for personer med ikke-affektive psykoser (herunder schizofreni)? Hva er effekten av medikamentelle og psykososiale tiltak for personer med rusinduserte psykoser?

Nasjonalt kunnskapssenter for helsetjenesten har publisert et notat der grunnlaget er et systematisk og omfattende søk i databasene Cochrane Library, MEDLINE og EMBASE. Søket resulterte totalt i 1371 treff. To personer leste gjennom tittel og sammendrag uavhengig av hverandre. Vi inkluderte 37 referanser i henhold til fastsatte inklusjonskriterier og sorterte disse referansene ut fra to ulike innfallsvinkler, pasientpopulasjon og tiltak. Sammendraget (originale abstract) av hver enkelt oversikt er presentert. Vi har ikke vurdert den metodologiske kvaliteten, sammenfattet eller gradert kunnskapen av oversiktene. Vi minner derfor om at vi har tilgjengelige sjekklister for å vurdere kvaliteten: http://kunnskapssenteret.no/Verktøy/2031.cms.

Denne kartleggingen av forskningspublikasjoner viser hva som finnes av oppsummert forskning om psykososiale tiltak i behandlingen av personer med ikke-affektive psykoser (herunder schizofreni). Vi har sett spesielt på bruk av nettverk, boligtiltak, og kontinuitet i behandlingen. For rusinduserte psykoser søkte vi etter forskning om effekt av medikamentelle tiltak og psykososiale tiltak.

Oversiktene vi henviser til er ikke nødvendigvis systematiske eller av høy kvalitet. Konsekvensen er at vi anbefaler å kritisk vurdere kunnskapen vi henviser til før den eventuelt tas i praktisk bruk

# Key messages

What is the effect of psychosocial interventions such as network, supported housing, and continuity of care for persons with non-affective psychoses (including schizophrenia)? What is the effect of medication and psychosocial treatment for persons with drug-induced psychosis?

The Norwegian Knowledge Centre for the Health Services was commissioned by the Norwegian Directorate of Health to perform a systematic search for studies on psychosocial and medical interventions for persons with non-affective psychoses. We performed systematic searches in the Cochrane Library, OVID MEDLINE, PsycInfo, and EMBASE. The search identified 1371 articles. Two persons read and assessed title and abstracts independently. We included 37 studies that were considered relevant after using predefined inclusion criteria, and sorted these references according to type of population and intervention. Abstracts of included reviews are presented in the appendix. We did not assess the methodological quality of the studies, nor did we summarize or grade the knowledge from included studies. We highly recommend using checklist to assess the quality of the studies.

Our mapping of research publications showed the existing summarized research on psychosocial interventions such as network, supported housing, and continuity of care for persons with non-affective psychoses (including schizophrenia). We searched both for medication and psychosocial treatment for drug-induced psychoses.

The reviews we refer to are not necessarily systematic or of high quality. These potential weaknesses show the need for thorough assessment. We strongly recommend a critical appraisal, before utilization of this knowledge into practice.

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# Forord

Nasjonalt kunnskapssenter for helsetjenesten fikk i oppdrag fra Helsedirektoratet ved seniorrådgiver Åste Herheim å foreta et søk og sorter av internasjonal forskning for fire kliniske spørsmål om effekten av nettverk, bolig, rusinduserte psykoser og kontinuitet i behandlingen av personer med ikke-affektive psykoser (herunder schizofreni). I dette notatet viser vi oversiktsartikler som vi har identifisert via litteratursøkene våre.

Bakgrunnen for bestillingen var at Arbeidsgruppen for Nasjonale retningslinjer for diagnostisering og behandling av ikke-affektive psykoser (herunder schizofreni) ønsket å få et dokumentasjonsgrunnlag. I dette arbeidet har vi ikke lest artiklene i fulltekst eller vurdert den metodiske kvaliteten av dem. I vedlegget til Kunnskapssenterets håndbok "Slik oppsummerer vi forskning" finnes det sjekklister som kan brukes til å vurdere kvaliteten av studier med ulike design. Sjekklistene kan være gode hjelpemidler i det videre arbeidet med å ta stilling til forskningens kvalitet, herunder gyldighet og troverdighet. Håndboken med sjekklister er tilgjengelig på nettsiden til Kunnskapssenteret http://www.kunnskapssenteret.no/Verkt%C3%B8y/2139.cms.

Dette dokumentet gir en oversikt over forskningslitteraturen om effekten av tiltak som nettverk, bolig, andre psykososiale tiltak og kontinuitet i behandlingen av personer med ikke-affektive psykoser (herunder schizofreni) og rusinduserte psykoser. Vi håper at det vil gjøre det enklere å fatte velinformerte beslutninger i det videre arbeidet med å lage retningslinjer, bestille ny norsk forskning, eller utføre kunnskapsoppsummeringer om effekter av tiltak for denne pasientpopulasjonen.

Kunnskapssenterets arbeidsform er å først og fremst å lete etter gode og oppdaterte systematiske oversikter som besvarer spørsmål om effekt(er) av tiltak. Årsaksspørsmål om psykiske lidelser er utenfor vårt mandat å besvare. I tillegg til å systematisk søke frem kunnskap om effekt av tiltak på denne utvalgte populasjonen og intervensjonen, kan vi kritisk vurdere og re-analysere, sammenstille og gradere forskningsfunn for å si noe om det totale kunnskapsbildet.

| Gro Jamtvedt | Geir Smedslund | Asbjørn Steiro |
|---|---|---|
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# Innledning

## BEGRUNNELSE FOR BESTILLING

Arbeidsgruppen for Nasjonale retningslinjer for diagnostisering og behandling av ikke-affektive psykoser (herunder schizofreni) ønsket at det skulle innhentes kunnskap om nettverkstilnærming, bolig, kontinuitet i behandling av schizofreni og medikamentelle og psykososiale tiltak mot rusinduserte psykoser.

Den vitenskapelige basis for skillet mellom schizofreni og alvorlige affektive lidelser er ufullstendig. Dersom det er affektive symptomer som mani og depresjon i symptombildet, må hovedsymptomene ved schizofreni ha vært tilstede først. Schizoaffektiv lidelse (F25) danner en overgang mellom schizofreni og affektive lidelser, hovedsymptomene både for schizofreni og affektive lidelser må være til stede samtidig (1).

Personer med ikke-affektive psykoser trenger både medikamentell behandling og psykososiale tiltak. Som ledd i et komplett behandlingsopplegg kan forskjellige psykososiale tiltak forbedre forløpet av schizofreni når det er integrert med medikamentell behandling. Disse tilbudene retter seg mot forebygging av tilbakefall, bedre mestring av hverdagens utfordringer, sosial og arbeidsmessig fungering og økt evne til å fungere selvstendig (1).

Familien kan tilbys strukturert skolering om schizofreni alene eller sammen med andre pårørende. Ved innleggelse er det av stor betydning å bidra til at kontakten med pasientens sosiale nettverk opprettholdes. En god og trygg behandlingsallianse regnes som grunnleggende forutsetning for god behandling av schizofreni. Kontinuitet i kontakt mellom pasient og behandler er derfor viktig.

## SCOPINGSØK VED BESTILLING

Vi gjennomførte et scoping søk, og oversiktene vi fant på rusinduserte psykoser skilte seg ut. Vi ble derfor enige om å søke tematisk på problemstilling 1, 2 og 4 sammen (se under presisering av problemstilling). Vi gjennomførte egne søk på første gangs rusinduserte psykoser (se pkt 3 under).

## PROBLEMSTILLINGER

- Hva er effekten av nettverkstilnærming for mennesker med gjentatte episoder ikke-affektive psykoselidelser?
- Hva er effekten av boligoppfølging for mennesker med gjentatte episoder ikke-affektive psykoselidelser?
- Hva er effekten av psykososiale tiltak for individer diagnostisert med F 19.x5 (ICD 19); 291.3,291.5 og 292.1 (DSM IV) rusinduserte psykoser for første gang?
- Hva er effekten av kontinuitet i behandlingen for mennesker med gjentatte episoder ikke-affektive psykoselidelser?

Den fullstendige listen over problemstillinger (PICO) ligger helt bakerst i dette notatet.

# Metode

## LITTERATURSØK

Vi søkte etter nyere systematiske oversikter om effekten av psykososiale tiltak i behandling av personer med ikke-affektive psykoser (herunder schizofreni). Vi brukte søketermer for å fange opp boligtiltak (supported housing), nettverkstiltak, og kontinuitet i behandling. Vi søkte i databasene OVID MEDLINE, OVID PsycInfo, Cochrane Library, herunder HTA-rapporter og DARE-rapporter. I MEDLINE og EMBASE ble søket avgrenset med søkefilter for systematiske oversikter. Detaljert søkestrategi er gjengitt i vedlegget bakerst.

## INKLUSJONSKRITERIER

Etter en gjennomgang av titler og sammendrag, laget vi en liste over mulig relevante referanser. Kriteriene for å anses som mulig relevant var en eksplisitt bruk (enten i tittel, nøkkelord eller sammendrag) av følgende: Systematisk oversikt med søkestrategi, valide kriterier for kvalitetsbedømmelse, og oppsummering av effekter/metaanalyser. I tillegg måtte oversiktsartikkelen være publisert etter år 2000.

Vi inkluderte tiltak som så ut til å omhandle boligoppfølging, nettverkstiltak og/eller samhandling i form av kontinuitet i behandlingsoppfølgingen. For å bli inkludert måtte det stå nevnt psykose, rusindusert psykose, førstegangs-psykose eller vedvarende psykose. For rusinduserte psykoser inkluderte vi referanser til mulige systematiske oversikter om både medikamentelle og psykososiale behandlingstiltak.

## UTVELGELSE OG SORTERING

I første omgang sorterte vi ut alle duplikater og irrelevante treff. Etter at referansene var identifisert som mulig relevante publikasjoner sorterte vi dem i følgende to hovedkategorier: 1) Type tiltak som nettverk, bolig, og kontinuitet i behandlingen 2) Type psykisk lidelse/diagnoser som schizofreni, atferdsforstyrrelse, bipolar lidelse, psykoser, rusinduserte psykoser eller klassifisert som alvorlige mentale lidelser.

# Resultat

Bibliotekar Marita Heintz i Helsedirektoratet utførte litteratursøket etter systematiske oversikter på nettverk, bolig, rusinduserte psykoser og kontinuitet i behandlingen den 25. januar 2010. Søket ga 420 treff i MEDLINE, 192 treff i Embase, 434 i PsycInfo og 221 treff i Cochrane-databasene. Etter duplikatsjekk var det 903 referanser hvorav 866 ble ekskludert som åpenbart irrelevant. Bibliotekar Ingrid Harboe i Kunnskapssenteret utførte søket på tiltak for rusinduserte psykoser den 1. februar 2010. Søket ga 468 treff og av disse ble 10 vurdert som mulig relevante. Totalt satt vi igjen med 37 referanser som vi vurderte som sannsynlig relevante treff.

Vi fant flere systematiske oversikter på nettverkstilnærminger, og her har vi inkludert familieintervensjoner, Assertive community, jevnaldergrupper, psykososiale tiltak, Expressed Emotions, Morita Terapi, sosialt nettverk og samarbeid i et nettverk av omsorgspersoner. Under boligoppfølging (Supported Housing) har vi tatt med oppsummeringer knyttet til tiltak som Community Mental Health Teams (CMHT), Assertive Community Treatment (ACT) og Community Support System (CSS).

I tabellene nedenfor er referanser til mulige oversiktsartikler listet opp. Hvis man skal være helt sikker på at de treffer våre inklusjonskriterier må referansematerialet innhentes og leses i fulltekst. Vi innhentet ikke studiene i fulltekst. Oversiktene kan ha varierende kvalitet.  Vi har ikke kritisk vurdert artiklene i fulltekst eller den metodiske kvaliteten. Vi har ikke vurdert ekstern validitet eller hvorvidt det lar seg gjøre å overføre denne kunnskapen til norsk praksis.

Ut fra tittel og sammendrag sorterte vi referansene både i forhold til type tiltak og diagnosegrupper.

## TABELL 1: REFERANSER SORTERT ETTER TILTAK

| Tiltak | Antall referanser<br>37 |
|---|---|
| **Nettverkstilnærming (2-11)** | 10 |
| **Bolig (12-17)** | 6 |

| | |
|---|---|
| **Medikamentelle og/eller psykososiale tiltak for rusinduserte psykoser (18-27)** | 10 |
| **Kontinuitet i behandlingen (28-38)** | 11 |

### TABELL 2: REFERANSER SORTERT ETTER DIAGNOSE

| Diagnose | Antall referanser 37 |
|---|---|
| **Alvorlige mentale lidelser (5;12;13;16;28;29;31-34;37)** | 11 |
| **Schizofreni, atferdsforstyrrelser, bipolar forstyrrelse (2-4;6-11;14;17;30;35;38)** | 14 |
| **Psykoser (15;36)** | 2 |
| **Rusinduserte psykoser, eller andre diagnoser (18-27)** | 10 |

# Diskusjon

Vi søkte etter systematiske oversikter og kan derfor ikke si noe om dette er et forskningsfelt hvor det fremdeles publiseres nye randomiserte kontrollerte studier.

I vurdering av studiene for inklusjon var det ikke overraskende overlapp for kontinuitet i behandlingen både med nettverkstilnærming og boligoppfølging. Inndelingen vår må derfor ikke oppfattes som gjensidige utelukkende, men heller som en grov kategorisering av innholdet i tiltakene.

Teoretisk og begrepsmessig er det omfattende referanser til kontinuitet i behandlingen, men det er få empiriske studier (34). Det var store utfordringer forbundet med å søke på kontinuitet i behandling (continuity of care) og bruk av spesifikke søketermer i databasene som kan fange opp relevante oversikter på dette tema. Med så brede termer kan en få et stort antall treff i databasene.

Effektmålene vi fant på rusinduserte psykoser så primært på selve psykosen med hensyn til behandlingsrespons, endring, psykotiske symptomer, komorbid, kognisjon. Det er muligens ikke i samsvar med bestillingen. Behandlingstiltakene så ut til å være rettet mot selve psykosetilfellet og ikke på eventuell bakenforliggende rus eller avhengighetsproblematikk.

Oversiktene vi henviser til er ikke nødvendigvis systematiske eller av høy kvalitet. Vi anbefaler å kritisk vurdere kunnskapen vi referer til før den eventuelt tas i bruk.

Det er usikkert om vi har funnet frem til alle relevante systematiske oversikter i og med at søket er begrenset til et fåtall databaser. Søk i ytterligere databaser vil kunne gi flere relevante treff.

# Referanser


1. Schizofreni kliniske retningslinjer for utredning og behandling. Oslo: Statens Helsetilsyn; 2000. (Utredningsserien 9)

2. Barbato A, D'Avanzo B. Family interventions in schizophrenia and related disorders: a critical review of clinical trials (DARE structured abstract). Acta Psychiatrica Scandinavica 2000;102: 81-97.

3. Bustillo JR, Lauriello J, Horan WP, Keith SJ. The psychosocial treatment of schizophrenia: An update. The American Journal of Psychiatry 2001;.158(2):Feb-175.

4. Diamond G, Siqueland L. Current status of family intervention science. Child and Adolescent Psychiatric Clinics of North America 2001;10(3):641-61.

5. Drake RE, O'Neal EL, Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. Journal of Substance Abuse Treatment 2008; 34(1):123-38.

6. Glynn SM, Cohen AN, Niv N. New challenges in family interventions for schizophrenia. Expert Review of Neurotherapeutics 2007;neurotherapeutics.(1):33-43.

7. Held T. Family therapy of schizophrenia. Fortschritte der Neurologie Psychiatrie 2000;68(SUPPL. 1):S46-S49.

8. He Y, Li C. Morita therapy for schizophrenia. Cochrane Database of Systematic Reviews 2007;(1):CD006346.

9. Jung XT, Newton R. Cochrane reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psychosis, and bipolar disorder: A systematic literature review. International Journal of Mental Health Nursing 2009;.18(4):Aug-249.

10. Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database of Systematic Reviews: Reviews. In: Cochrane Database of Systematic Reviews 2006 Issue 4. Chichester (UK): John Wiley & Sons, Ltd; 2006.

11. Pitschel-Walz G, Leucht S, Baumnl J, Kissling W, Engel RR. The effect of family interventions on relapse and rehospitalization in schizophrenia - A meta-analysis. Schizophrenia Bulletin 2001;27(1):73-92.

12. Burns T, Knapp M, Catty J, Healey A, Henderson J, Watt H, et al. Home treatment for mental health problems: a systematic review. Health Technology Assessment (Winchester, England) 2001;5(15):1-139.

13. Chilvers R, Macdonald GM, Hayes AA. Supported housing for people with severe mental disorders. Cochrane Database of Systematic Reviews 2002;(4):CD000453.

14. Macpherson R, Edwards TR, Chilvers R, David C, Elliott HJ. Twenty-four hour care for schizophrenia. Cochrane Database of Systematic Reviews: Reviews. In: Cochrane Database of Systematic Reviews 2009 Issue 2. Chichester (UK): John Wiley & Sons, Ltd; 2009.

15. Gale J, Sanchez Espana B. Evidence for the effectiveness of therapeutic community treatment of the psychoses. Philosophy, history and clinical practice; 2008.

16. Leff HS, Chow CM, Pepin R, Conley J, Allen IE, Seaman CA. Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. Psychiatric Services 2009;60(4):473-82.

17. Newman SJ. Housing attributes and serious mental illness: implications for research and practice. Psychiatr Serv 2001;52(10):1309-17.

18. Berk M, Rathbone J, Mandriota-Carpenter SL. Clotiapine for acute psychotic illnesses. Cochrane Database of Systematic Reviews 2004;(4):CD002304.

19. Curran C, Byrappa N, McBride A. Stimulant psychosis: systematic review. Br J Psychiatry 2004;185:196-204.

20. Frieling H, Hillemacher T, Ziegenbein M, Neundorfer B, Bleich S. Treating dopamimetic psychosis in Parkinson's disease: structured review and meta-analysis. Eur Neuropsychopharmacol 2007;17(3):165-71.

21. Hermle L, Kovar KA, Ebert D, Ruchsow M. Amphetamine-induced psychological disorders and medical complications. [German]. Nervenheilkunde: Zeitschrift fur interdisziplinaere Fortbildung 2008;27(8):759-66.

22. Hjorthoj C, Fohlmann A, Nordentoft M. Treatment of cannabis use disorders in people with schizophrenia spectrum disorders - A systematic review. Addictive Behaviors 2009;34(6-7):520-5.

23. Huf G, Alexander J, Allen MH, Raveendran NS. Haloperidol plus promethazine for psychosis-induced aggression. Cochrane Database of Systematic Reviews 2009;(3):CD005146.

24. Mathias S, Lubman DI, Hides L. Substance-induced psychosis: a diagnostic conundrum. J Clin Psychiatry 2008;69(3):358-67.

25. Schuckit MA. Comorbidity between substance use disorders and psychiatric conditions. Addiction 2006;101(SUPPL. 1):76-88.

26. Shoptaw SJ, Kao U, Ling W. Treatment for amphetamine psychosis. Cochrane Database of Systematic Reviews 2009;(1):CD003026.

27. Srisurapanont M, Kittiratanapaiboon P, Jarusuraisin N. Treatment for amphetamine psychosis. Cochrane Database of Systematic Reviews 2001;(4):CD003026.

28. Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: Systematic review and meta-regression. British Medical Journal 2007;335(7615):336-40.

29. Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database of Systematic Reviews 2009;(1):CD005963.

30. Hewitt J, Coffey M. Therapeutic working relationships with people with schizophrenia: literature review. Journal of Advanced Nursing 2005;52(5):561-70.

31. Malone D, Newron-Howes G, Simmonds S, Marriot S, Tyrer P. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. Cochrane Database of Systematic Reviews 2007;(3):CD000270.

32. Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 2000;(2):CD001089.

33. Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. Cochrane Database of Systematic Reviews 2000;(2):CD000050.

34. Mitton CR, Adair CE, McDougall GM, Marcoux G. Continuity of care and health care costs among persons with severe mental illness (Brief record). Psychiatric Services 2005;56:1070-6.

35. NHS Centre for Reviews and Dissemination. Psychosocial interventions for schizophrenia (DARE structured abstract). York: Centre for Reviews and Dissemination (CRD) 2000;8.

36. Penn DL, Waldheter EJ, Perkins DO, Mueser KT, Lieberman JA. Psychosocial treatment for first-episode psychosis: a research update. American Journal of Psychiatry 2005;162(12):2220-32.

37. Taylor TL, Killaspy H, Wright C, Turton P, White S, Kallert TW, et al. A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. BMC Psychiatry 2009;9:55.

38. Udechuku A, Olver J, Hallam K, Blyth F, Leslie M, Nasso M, et al. Assertive community treatment of the mentally ill: service model and effectiveness (DARE structured abstract). Australasian Psychiatry 2005;13:129-34.

# Vedlegg

## SØKESTRATEGI

Oppdrag: Nasjonale retningslinjer for diagnostisering og behandling av ikke-affektive psykoser (herunder schizofreni)

**Søk**: Marita Heintz
**Database:** Ovid MEDLINE(R) 1950 to January Week 2 2010
**Dato**: 5.01.2010
**Antall treff**: 420

| # | Searches | Results |
|---|---|---|
| 1 | exp "schizophrenia and disorders with psychotic features"/ | 96751 |
| 2 | hallucinations/ | 7532 |
| 3 | alcohol withdrawal delirium/ | 1472 |
| 4 | korsakoff syndrome/ | 192 |
| 5 | alcohol amnestic disorder/ | 1093 |
| 6 | wernicke encephalopathy/ | 1163 |
| 7 | delusions/ | 5627 |
| 8 | (paranoia or paranoias or paranoid or paranoidism or paraphrenia or psychoses or psychosis or psychotic or schizophrenia? or schizophrenic or hallucinosis or (delirium adj1 tremens) or megalomania or (persecution adj1 complex) or hallucination? or acouasm or acousma or (fata adj morgana) or delusion? or erotomania or grandiosity or (beriberi adj1 cerebral)).tw. | 95613 |
| 9 | ((schizoaffective or schizo affective or schizophreniform or delusional or (shared adj (paranoid or psychotic)) or (alcohol adj amnestic)) adj1 disorder?).tw. | 3246 |
| 10 | ((capgras or korsakoff or ((alcoholic or (alcohol adj induced) or alcoholinduced) adj korsakoff) or othello or charles bonnet or deficit or negative or positive or (alcohol adj amnestic)) adj1 syndrome?).tw. | 2590 |
| 11 | (((alcoholinduced or (alcohol adj induced)) adj (dysmnesic or amnestic or (persisting adj amnestic)) adj1 (disorder? or syndrome?)) or ((amnestic or dysmnesic or (persisting adj amnestic)) adj (disorder? or syndrome?) adj (alcohol or alcoholinduced or (alcohol adj in- | 5 |

| | | |
|---|---|---|
| | duced)))).tw. | |
| 12 | ((wernicke$ or (gayet adj wernicke) or gayetwernicke) adj1 (encephalopathy or encephalopathies or (superior adj hemorrhagic adj1 polioencephalitis) or syndorme? or disease)).tw. | 812 |
| 13 | (dementia adj1 (praecox or precox or intensive care)).tw. | 213 |
| 14 | (folie adj a adj (deux or trois or famille)).tw. | 196 |
| 15 | (acute adj1 (psychotic adj episode)).tw. | 109 |
| 16 | (post-schizoprenic adj1 depression).tw. | 0 |
| 17 | ((morbid or pathologic or pathological) adj jealousy).tw. | 71 |
| 18 | (persecutory adj (idea or ideation)).tw. | 36 |
| 19 | (((intensive adj care) or (alcohol adj withdrawal)) adj1 delirium).tw. | 69 |
| 20 | ((deficit or negative or positive) adj symptom?).tw. | 5602 |
| 21 | (delusional adj1 (pregnancy or pseudo-pregnancy or pseudopregnancy or jealousy)).tw. | 35 |
| 22 | (autonomic adj hyperactivity adj1 (alcohol adj withdrawal adj associated)).tw. | 0 |
| 23 | or/1-22 | 132634 |
| 24 | communication/ | 49410 |
| 25 | crisis intervention/ | 4703 |
| 26 | family therapy/ | 6723 |
| 27 | group processes/ | 9760 |
| 28 | social support/ | 36796 |
| 29 | language/ | 19783 |
| 30 | emergency services, psychiatric/ | 1824 |
| 31 | community networks/ | 3521 |
| 32 | (Seikkula or communication or language? or dialogue? or dialogical or conversation or network? or network-based or (crisis adj1 intervention?) or vector therapy).tw. | 270334 |
| 33 | (((emergency or emergencies) adj1 (psychiatric adj2 service?)) or service?).tw. | 232709 |
| 34 | (family adj1 (therapy or therapies or intervention or psychiatry or psychotherapy or treatment or counseling)).tw. | 3360 |
| 35 | (group adj1 (processes or process or meetings og meeting or discussion)).tw. | 2550 |
| 36 | ((social or psychosocial) adj1 (support or therapy or interaction)).tw. | 19017 |
| 37 | or/24-36 | 580115 |
| 38 | group homes/ | 687 |
| 39 | public housing/ | 764 |
| 40 | housing/ | 10887 |
| 41 | halfway houses/ | 982 |
| 42 | residential facilities/ | 3927 |

| | | |
|---|---|---|
| 43 | assisted living facilities/ | 529 |
| 44 | independent living/ | 23 |
| 45 | community mental health services/ | 14797 |
| 46 | Home Care Services/ | 23787 |
| 47 | (housing or (halfway adj1 house?) or (residential adj1 facilit$) or ((independent or assisted) adj1 living) or homecare).tw. | 16207 |
| 48 | ((community adj1 ((treatment adj2 assertive) or treatmentassertive or (mental adj health adj service?))) or (service? adj (community adj1 (mental adj health))) or (health adj service? adj community adj mental)).tw. | 863 |
| 49 | ((home or domiciliary or domestic health or home health or residential or (home adj psychiatric)) adj1 care).tw. | 13103 |
| 50 | ((transitional or group or service? or treatment?) adj1 home?).tw. | 2194 |
| 51 | or/38-50 | 73778 |
| 52 | continuity of patient care/ | 10634 |
| 53 | Continu$.tw. | 503926 |
| 54 | 52 or 53 | 511249 |
| 55 | 23 and (37 or 51 or 54) | 16090 |
| 56 | limit 55 to (yr="1970 -Current" and "reviews (specificity)") | 420 |

**Database:** EMBASE 1980 to 2010 Week 03
**Dato**: 25.01.2010
**Antall treff**: 192

| # | Searches | Results |
|---|---|---|
| 1 | Psychosis/ | 28940 |
| 2 | acute psychosis/ | 670 |
| 3 | affective psychosis/ | 265 |
| 4 | exp alcohol psychosis/ | 1060 |
| 5 | brief psychotic disorder/ | 66 |
| 6 | delusion/ | 6040 |
| 7 | Capgras syndrome/ | 314 |
| 8 | delusional disorder/ | 610 |
| 9 | delusional misidentification/ | 64 |
| 10 | delusional pregnancy/ | 9 |
| 11 | erotomania/ | 105 |
| 12 | grandiose delusion/ | 215 |

| | | |
|---|---|---|
| 13 | jealous delusion/ | 69 |
| 14 | paranoia/ | 4183 |
| 15 | persecutory delusion/ | 314 |
| 16 | shared psychotic disorder/ | 56 |
| 17 | somatic delusion/ | 96 |
| 18 | depressive psychosis/ | 412 |
| 19 | endogenous psychosis/ | 96 |
| 20 | exp hallucination/ | 13669 |
| 21 | intensive care psychosis/ | 60 |
| 22 | manic depressive psychosis/ | 7412 |
| 23 | manic psychosis/ | 76 |
| 24 | exp paranoid psychosis/ | 6062 |
| 25 | puerperal psychosis/ | 593 |
| 26 | exp schizophrenia/ | 67982 |
| 27 | delirium tremens/ | 740 |
| 28 | (paranoia or paranoias or paranoid or paranoidism or paraphrenia or psychoses or psychosis or psychotic or schizophrenia? or schizophrenic or hallucinosis or (delirium adj1 tremens) or megalomania or (persecution adj1 complex) or hallucination? or acouasm or acousma or (fata adj morgana) or delusion? or erotomania or grandiosity or (beriberi adj1 cerebral)).tw. | 81279 |
| 29 | ((schizoaffective or schizo affective or schizophreniform or delusional or (shared adj (paranoid or psychotic)) or (alcohol adj amnestic)) adj1 disorder?).tw. | 3477 |
| 30 | ((capgras or korsakoff or ((alcoholic or (alcohol adj induced) or alcoholinduced) adj korsakoff) or othello or charles bonnet or deficit or negative or positive or (alcohol adj amnestic)) adj1 syndrome?).tw. | 2478 |
| 31 | (((alcoholinduced or (alcohol adj induced)) adj (dysmnesic or amnestic or (persisting adj amnestic)) adj1 (disorder? or syndrome?)) or ((amnestic or dysmnesic or (persisting adj amnestic)) adj (disorder? or syndrome?) adj (alcohol or alcoholinduced or (alcohol adj induced)))).tw. | 5 |
| 32 | ((wernicke$ or (gayet adj wernicke) or gayetwernicke) adj1 (encephalopathy or encephalopathies or (superior adj hemorrhagic adj1 polioencephalitis) or syndorme? or disease)).tw. | 683 |
| 33 | (dementia adj1 (praecox or precox or intensive care)).tw. | 152 |
| 34 | (folie adj a adj (deux or trois or famille)).tw. | 123 |
| 35 | (acute adj1 (psychotic adj episode)).tw. | 120 |
| 36 | (post-schizoprenic adj1 depression).tw. | 0 |
| 37 | ((morbid or pathologic or pathological) adj jealousy).tw. | 73 |

| 38 | (persecutory adj (idea or ideation)).tw. | 35 |
|---|---|---|
| 39 | (((intensive adj care) or (alcohol adj withdrawal)) adj1 delirium).tw. | 55 |
| 40 | ((deficit or negative or positive) adj symptom?).tw. | 6169 |
| 41 | (delusional adj1 (pregnancy or pseudo-pregnancy or pseudopregnancy or jealousy)).tw. | 41 |
| 42 | (autonomic adj hyperactivity adj1 (alcohol adj withdrawal adj associated)).tw. | 0 |
| 43 | or/1-42 | 121293 |
| 44 | family therapy/ | 4950 |
| 45 | interpersonal communication/ | 29229 |
| 46 | conversation/ | 1743 |
| 47 | verbal communication/ | 4716 |
| 48 | language/ | 17444 |
| 49 | "speech and language"/ | 150 |
| 50 | crisis intervention/ | 1840 |
| 51 | group process/ | 96 |
| 52 | psychosocial care/ | 6615 |
| 53 | social support/ | 18343 |
| 54 | social network/ | 1022 |
| 55 | (Seikkula or communication or language? or dialogue? or dialogical or conversation or net-work? or network-based or (crisis adj1 intervention?) or vector therapy).tw. | 221335 |
| 56 | (((emergency or emergencies) adj1 (psychiatric adj2 service?)) or service?).tw. | 146768 |
| 57 | (family adj1 (therapy or therapies or intervention or psychiatry or psychotherapy or treatment or counseling)).tw. | 2849 |
| 58 | (group adj1 (processes or process or meetings og meeting or discussion)).tw. | 1809 |
| 59 | ((social or psychosocial) adj1 (support or therapy or interaction)).tw. | 15540 |
| 60 | or/44-59 | 410514 |
| 61 | halfway house/ | 238 |
| 62 | home/ | 4478 |
| 63 | home environment/ | 624 |
| 64 | home mental health care/ | 75 |
| 65 | residential home/ | 1814 |
| 66 | housing/ | 5343 |
| 67 | assisted living facility/ | 264 |
| 68 | community living/ | 779 |
| 69 | mental health services/ | 14874 |
| 70 | community mental health/ | 1880 |
| 71 | home care/ | 14675 |

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|---|---|---|
| 72 | (housing or (halfway adj1 house?) or (residential adj1 facilit$) or ((independent or assisted) adj1 living) or homecare).tw. | 10679 |
| 73 | ((community adj1 ((treatment adj2 assertive) or treatmentassertive or (mental adj health adj service?))) or (service? adj (community adj1 (mental adj health))) or (health adj service? adj community adj mental)).tw. | 762 |
| 74 | ((home or domiciliary or domestic health or home health or residential or (home adj psychiatric)) adj1 care).tw. | 5787 |
| 75 | ((transitional or group or service? or treatment?) adj1 home?).tw. | 1706 |
| 76 | or/61-75 | 53415 |
| 77 | patient care/ | 90114 |
| 78 | Continu$.tw. | 427585 |
| 79 | 77 or 78 | 511487 |
| 80 | 43 and (60 or 76 or 79) | 18431 |
| 81 | limit 80 to ("reviews (2 or more terms high specificity)" and yr="1970 -Current") | 192 |

**Database:** PsycINFO 1806 to January Week 3 2010
**Dato**: 25.01.2010
**Antall treff**: 434

| # | Searches | Results |
|---|---|---|
| 1 | exp Psychosis/ | 73590 |
| 2 | Delusions/ | 3465 |
| 3 | Auditory Hallucinations/ | 976 |
| 4 | Drug Induced Hallucinations/ | 86 |
| 5 | Hallucinations/ | 2100 |
| 6 | Hypnagogic Hallucinations/ | 58 |
| 7 | Visual Hallucinations/ | 603 |
| 8 | Erotomania/ | 65 |
| 9 | Grandiosity/ | 71 |
| 10 | Paranoia/ | 601 |
| 11 | Paranoid Personality Disorder/ | 234 |
| 12 | "Positive and Negative Symptoms"/ | 1767 |
| 13 | (paranoia or paranoias or paranoid or paranoidism or paraphrenia or psychoses or psychosis or psychotic or schizophrenia? or schizophrenic or hallucinosis or (delirium adj1 tremens) or megalomania or (persecution adj1 complex) or hallucination? or acouasm or acousma or (fata adj morgana) or delusion? or erotomania or grandiosity or (beriberi adj1 cerebral)).tw. | 120204 |

| | | |
|---|---|---|
| 14 | ((schizoaffective or schizo affective or schizophreniform or delusional or (shared adj (paranoid or psychotic)) or (alcohol adj amnestic)) adj1 disorder?).tw. | 4640 |
| 15 | ((capgras or korsakoff or ((alcoholic or (alcohol adj induced) or alcoholinduced) adj korsakoff) or othello or charles bonnet or deficit or negative or positive or (alcohol adj amnestic)) adj1 syndrome?).tw. | 2498 |
| 16 | (((alcoholinduced or (alcohol adj induced)) adj (dysmnesic or amnestic or (persisting adj amnestic)) adj1 (disorder? or syndrome?)) or ((amnestic or dysmnesic or (persisting adj amnestic)) adj (disorder? or syndrome?) adj (alcohol or alcoholinduced or (alcohol adj induced)))).tw. | 4 |
| 17 | ((wernicke$ or (gayet adj wernicke) or gayetwernicke) adj1 (encephalopathy or encephalopathies or (superior adj hemorrhagic adj1 polioencephalitis) or syndorme? or disease)).tw. | 121 |
| 18 | (dementia adj1 (praecox or precox or intensive care)).tw. | 1258 |
| 19 | (folie adj a adj (deux or trois or famille)).tw. | 260 |
| 20 | (acute adj1 (psychotic adj episode)).tw. | 138 |
| 21 | (post-schizoprenic adj1 depression).tw. | 0 |
| 22 | ((morbid or pathologic or pathological) adj jealousy).tw. | 116 |
| 23 | (persecutory adj (idea or ideation)).tw. | 50 |
| 24 | (((intensive adj care) or (alcohol adj withdrawal)) adj1 delirium).tw. | 36 |
| 25 | ((deficit or negative or positive) adj symptom?).tw. | 6270 |
| 26 | (delusional adj1 (pregnancy or pseudo-pregnancy or pseudopregnancy or jealousy)).tw. | 52 |
| 27 | (autonomic adj hyperactivity adj1 (alcohol adj withdrawal adj associated)).tw. | 0 |
| 28 | or/1-27 | 125771 |
| 29 | Interpersonal Communication/ | 11526 |
| 30 | communication/ | 11388 |
| 31 | Verbal Communication/ | 11902 |
| 32 | Conversation/ | 5862 |
| 33 | Oral Communication/ | 10372 |
| 34 | Group Discussion/ | 2934 |
| 35 | language/ | 22658 |
| 36 | Family Therapy/ | 16178 |
| 37 | Family Intervention/ | 1193 |
| 38 | Crisis Intervention/ | 2587 |
| 39 | Crisis Intervention Services/ | 1130 |
| 40 | Emergency Services/ | 3641 |
| 41 | Social Support/ | 21098 |
| 42 | Social Interaction/ | 13988 |

| | | |
|---|---|---|
| 43 | Social Networks/ | 3811 |
| 44 | (Seikkula or communication or language? or dialogue? or dialogical or conversation or network? or network-based or (crisis adj1 intervention?) or vector therapy).tw. | 238546 |
| 45 | (((emergency or emergencies) adj1 (psychiatric adj2 service?)) or service?).tw. | 136491 |
| 46 | (family adj1 (therapy or therapies or intervention or psychiatry or psychotherapy or treatment or counseling)).tw. | 16304 |
| 47 | (group adj1 (processes or process or meetings og meeting or discussion)).tw. | 7391 |
| 48 | ((social or psychosocial) adj1 (support or therapy or interaction)).tw. | 37559 |
| 49 | or/29-48 | 444754 |
| 50 | Home Care/ | 3148 |
| 51 | Home Environment/ | 6598 |
| 52 | Outpatient Treatment/ | 4423 |
| 53 | Living Alone/ | 148 |
| 54 | Living Arrangements/ | 1614 |
| 55 | Assisted Living/ | 333 |
| 56 | Housing/ | 2519 |
| 57 | community mental health services/ | 5667 |
| 58 | Group Homes/ | 898 |
| 59 | Homebound/ | 107 |
| 60 | Independent Living Programs/ | 304 |
| 61 | Halfway Houses/ | 263 |
| 62 | Residential Care Institutions/ | 7032 |
| 63 | (housing or (halfway adj1 house?) or (residential adj1 facilit$) or ((independent or assisted) adj1 living) or homecare).tw. | 12119 |
| 64 | ((community adj1 ((treatment adj2 assertive) or treatmentassertive or (mental adj health adj service?))) or (service? adj (community adj1 (mental adj health))) or (health adj service? adj community adj mental)).tw. | 1667 |
| 65 | ((home or domiciliary or domestic health or home health or residential or (home adj psychiatric)) adj1 care).tw. | 5324 |
| 66 | ((transitional or group or service? or treatment?) adj1 home?).tw. | 2012 |
| 67 | or/50-66 | 42507 |
| 68 | Continuum of Care/ | 544 |
| 69 | Continu$.tw. | 128349 |
| 70 | 68 or 69 | 128397 |
| 71 | 28 and (49 or 67 or 70) | 20738 |
| 72 | limit 71 to ("reviews (high specificity)" and yr="1970 -Current") | 434 |

**Database:** The Cochrane Library. Other Reviews, Methods Studies, Technology Assessments og Economic Evaluations
**Dato**: 25.01.2010
**Antall treff**: 221 (Cochrane Reviews: 116, Other Reviews: 15, Methods Studies: 4, Technology Assessments: 3, Economic Evaluations: 83)

| ID | Search | Hits |
|---|---|---|
| #1 | MeSH descriptor **Schizophrenia and Disorders with Psychotic Features** explode all trees | 4839 |
| #2 | MeSH descriptor **Hallucinations**, this term only | 187 |
| #3 | MeSH descriptor **Alcohol Withdrawal Delirium**, this term only | 56 |
| #4 | MeSH descriptor **Korsakoff Syndrome**, this term only | 7 |
| #5 | MeSH descriptor **Alcohol Amnestic Disorder**, this term only | 22 |
| #6 | MeSH descriptor **Wernicke Encephalopathy**, this term only | 3 |
| #7 | MeSH descriptor **Delusions**, this term only | 100 |
| #8 | (paranoia or paranoias or paranoid or paranoidism or paraphrenia or psychoses or psychosis or psychotic or schizophrenia? or schizophrenic or hallucinosis or (delirium NEAR/1 tremens) or megalomania or (persecution NEAR/1 complex) or hallucination? or acouasm or acousma or (fata NEXT morgana) or delusion? or erotomania or grandiosity or (beriberi NEAR/1 cerebral)):ti,ab | 5825 |
| #9 | ((schizoaffective or schizo affective or schizophreniform or delusional or (shared NEXT (paranoid or psychotic)) or (alcohol NEXT amnestic)) NEAR/1 disorder?):ti,ab | 52 |
| #10 | ((capgras or korsakoff or ((alcoholic or (alcohol NEXT induced) or alcoholinduced) NEXT korsakoff) or othello or charles bonnet or deficit or negative or positive or (alcohol NEXT amnestic)) NEAR/1 syndrome?):ti,ab | 7 |
| #11 | (((alcoholinduced or (alcohol NEXT induced)) NEXT (dysmnesic or amnestic or (persisting NEXT amnestic)) NEAR/1 (disorder? or syndrome?)) or ((amnestic or dysmnesic or (persisting NEXT amnestic)) NEXT (disorder? or syndrome?) NEXT (alcohol or alcoholinduced or (alcohol NEXT induced)))):ti,ab | 0 |
| #12 | ((wernicke* or (gayet NEXT wernicke) or gayetwernicke) NEAR/1 (encephalopathy or encephalopathies or (superior NEXT hemorrhagic NEAR/1 polioencephalitis) or syndorme? or disease)):ti,ab | 1 |
| #13 | (dementia NEAR/1 (praecox or precox or intensive care)):ti,ab | 1 |
| #14 | (folie NEXT a NEXT (deux or trois or famille)):ti,ab | 0 |
| #15 | (acute NEAR/1 (psychotic NEXT episode)):ti,ab | 14 |

| #16 | (post-schizoprenic NEAR/1 depression):ti,ab | 0 |
|---|---|---|
| #17 | ((morbid or pathologic or pathological) NEXT jealousy):ti,ab | 0 |
| #18 | (persecutory NEXT (idea or ideation)):ti,ab | 2 |
| #19 | (((intensive NEXT care) or (alcohol NEXT withdrawal)) NEAR/1 delirium):ti,ab | 1 |
| #20 | ((deficit or negative or positive) NEXT symptom?):ti,ab | 1097 |
| #21 | (delusional NEAR/1 (pregnancy or pseudo-pregnancy or pseudopregnancy or jealousy)):ti,ab | 0 |
| #22 | (autonomic NEXT hyperactivity NEAR/1 (alcohol NEXT withdrawal NEXT associated)):ti,ab | 0 |
| #23 | (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22) | 8955 |
| #24 | MeSH descriptor **Communication**, this term only | 900 |
| #25 | MeSH descriptor **Crisis Intervention**, this term only | 116 |
| #26 | MeSH descriptor **Family Therapy**, this term only | 502 |
| #27 | MeSH descriptor **Group Processes**, this term only | 276 |
| #28 | MeSH descriptor **Social Support**, this term only | 1627 |
| #29 | MeSH descriptor **Language**, this term only | 305 |
| #30 | MeSH descriptor **Emergency Services, Psychiatric**, this term only | 47 |
| #31 | MeSH descriptor **Community Networks**, this term only | 66 |
| #32 | (Seikkula or communication or language? or dialogue? or dialogical or conversation or network? or network-based or (crisis NEAR/1 intervention?) or vector therapy):ti,ab | 4117 |
| #33 | (((emergency or emergencies) NEAR/1 (psychiatric NEAR/2 service?)) or service?):ti,ab | 5676 |
| #34 | (family NEAR/1 (therapy or therapies or intervention or psychiatry or psychotherapy or treatment or counseling)):ti,ab | 647 |
| #35 | (group NEAR/1 (processes or process or meetings og meeting or discussion)):ti,ab | 554 |
| #36 | ((social or psychosocial) NEAR/1 (support or therapy or interaction)):ti,ab | 1452 |
| #37 | (#24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36) | 13950 |
| #38 | MeSH descriptor **Group Homes**, this term only | 40 |
| #39 | MeSH descriptor **Public Housing**, this term only | 33 |
| #40 | MeSH descriptor **Housing**, this term only | 172 |

| | | |
|---|---|---|
| #41 | MeSH descriptor **Halfway Houses**, this term only | 19 |
| #42 | MeSH descriptor **Residential Facilities**, this term only | 100 |
| #43 | MeSH descriptor **Assisted Living Facilities**, this term only | 23 |
| #44 | MeSH descriptor **Community Mental Health Services**, this term only | 604 |
| #45 | MeSH descriptor **Home Care Services**, this term only | 1336 |
| #46 | (housing or (halfway NEAR/1 house?) or (residential NEAR/1 facilit*) or ((independent or assisted) NEAR/1 living) or homecare):ti,ab | 1573 |
| #47 | ((community NEAR/1 ((treatment NEAR/2 assertive) or treatmentassertive or (mental NEXT health NEXT service?))) or (service? NEXT (community NEAR/1 (mental NEXT health))) or (health NEXT service? NEXT community NEXT mental)):ti,ab | 159 |
| #48 | ((home or domiciliary or domestic health or home health or residential or (home NEXT psychiatric)) NEAR/1 care):ti,ab | 1090 |
| #49 | ((transitional or group or service? or treatment?) NEAR/1 home?):ti,ab | 18 |
| #50 | (#38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49) | 4463 |
| #51 | MeSH descriptor **Continuity of Patient Care**, this term only | 400 |
| #52 | (Continu*):ti,ab | 36126 |
| #53 | (#51 OR #52) | 36392 |
| #54 | (**#23** AND ( **#37** OR **#50** OR **#53** )) | 1177 |

## Søkestrategi: 2. Rusinduserte psykoser (effekt av alle typer behandlingstiltak)

Databaser: Ovid Medline, EMBASE, PsycINFO, Cochrane Library
Dato: 01.02.2010
Studiefilter: Ovids spesifikke filter for systematiske oversikter med tillegg (linje 32)
Søk: Ingrid Harboe, forskningsbibliotekar
Referanser: 468 (548 inkludert dubletter)

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1950 to Present

| # | Searches | Results |
|---|---|---|
| 1 | Alcohol Drinking/ | 39511 |
| 2 | amphetamine/ | 10210 |
| 3 | dextroamphetamine/ | 6081 |
| 4 | methamphetamine/ | 5272 |

| | | |
|---|---|---|
| 5 | Cocaine/ | 18381 |
| 6 | Crack Cocaine/ | 976 |
| 7 | Cannabis/ | 5891 |
| 8 | exp Hallucinogens/ | 18764 |
| 9 | Lysergic Acid Diethylamide/ | 4228 |
| 10 | Mescaline/ | 895 |
| 11 | exp Phenethylamines/ | 77530 |
| 12 | exp Benzodiazepines/ | 52360 |
| 13 | (alchohol? or amphetamin* or metamphetamin* or cannabis or marihuana or hallucinogen* or LSD or lyseric acid* or indolealkylamin* or mescalin* or phenylisopropylamin* or phenethylamin* or benzodiazepin*).tw. | 52365 |
| 14 | (intoxicant? or addict* or abuse or misuse or depend* or "drug usage" or "intoxicating substance?" or stimulant? or "substance use").tw. | 1337251 |
| 15 | or/1-14 | 1509682 |
| 16 | Substance-related disorders/ | 64769 |
| 17 | Psychotic Disorders/ | 26058 |
| 18 | psychoses, alcoholic/ | 2175 |
| 19 | psychoses, substance-induced/ | 3981 |
| 20 | (psychosis or psychoses or psychotic or hallucin*).tw. | 42739 |
| 21 | or/16-20 | 121047 |
| 22 | exp Therapeutics/ | 2615511 |
| 23 | exp Psychiatry/ | 76235 |
| 24 | exp Psychology/ | 51382 |
| 25 | exp Antipsychotic Agents/ | 106773 |
| 26 | (therap* or treatment* or rehabilitation or (antipsychotic adj (agent? or treatment? or therap* or medic* or drug?))).tw. | 3075585 |
| 27 | ((psycho* or medic*) adj3 (care or cure or action? or treatment? or therap*)).tw. | 133798 |
| 28 | or/22-27 | 4905680 |
| 29 | 15 and 21 and 28 | 23828 |
| 30 | limit 29 to yr="1970 -Current" | 23272 |
| 31 | limit 30 to "reviews (specificity)" | 248 |
| 32 | systematic* review*.tw. | 22229 |
| 33 | 30 and 32 | 76 |
| 34 | 31 or 33 | 256 |

## STUDIER MED ABSTRACT SORTERT ETTER TILTAK

### 1 Nettverkstilnærminger

2. Barbato A, D'Avanzo B. Family interventions in schizophrenia and related disorders: a critical review of clinical trials (DARE structured abstract). Acta Psychiatrica Scandinavica 2000;102:81-97.

3. Bustillo JR, Lauriello J, Horan WP, Keith SJ. The psychosocial treatment of schizophrenia: An update. The American Journal of Psychiatry 2001;.158(2):Feb-175.
Abstract: Sought to update the randomized controlled trial literature of psychosocial treatments for schizophrenia. Computerized literature searches were conducted to identify randomized controlled trials of various psychosocial interventions, with emphasis on studies published since a previous review of psychosocial treatments for schizophrenia in 1996. Results show that family therapy and assertive community treatment have clear effects on the prevention of psychotic relapse and rehospitalization. However, these treatments have no consistent effects on other outcome measures (e.g., pervasive positive and negative symptoms, overall social functioning, and ability to obtain competitive employment). Social skills training improves social skills but has no clear effects on relapse prevention, psychopathology, or employment status. Supportive employment programs that use the place-and-train vocational model have important effects on obtaining competitive employment. Some studies have shown improvements in delusions and hallucinations following cognitive behavior therapy. Preliminary research indicates that personal therapy may improve social functioning. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

4. Diamond G, Siqueland L. Current status of family intervention science. Child and Adolescent Psychiatric Clinics of North America 2001;10(3):641-61.
Abstract: Looking at the field as a whole through meta-analysis, Shadish et al concluded (based on 162 studies) that marital and family therapies were significantly more effective than no treatment and at least as effective as other forms of psychotherapy. Although these reviews and others are positive, individual studies raise many questions. For instance, based on research findings, family treatments increasingly have become standard care for patients with schizophrenia. It remains unclear what degree and type of family involvement is needed for which patients at which stage of their disorder. In the area of anxiety and depression, there are too few studies to make any strong conclusion. Although investigators such as Barrett, Cobham, and Diamond have produced some positive results, the Lewinsohn and Clark studies fail to demonstrate the added benefit of family involvement. Although Brent's study showed CBT to reduce depression faster, family therapy and supportive therapy did just as well in the long run, and family conflict was a strong risk factor for relapse. In the area of anorexia, Russell and Robins produced strong results

from family interventions, whereas Geist found no difference between different types of family interventions. Family treatments for obesity have been inconsistent. In a meta-analysis of 41 studies, parental involvement did not contribute significantly to outcomes. In the Epstein study, however, which included 5- and 10-year follow-up, the results of family intervention were impressive. Although many of these studies can be cited for various methodologic flaws, the most consistent problem is that sample sizes are too small to detect difference between two or more active treatments. The most consistent findings (and most well-done, large studies) that support the efficacy of family-based interventions are done with externalizing problems. Work groups led by Patterson, Eisenstadt, Webster-Stratton, Alexander, and Henggeler all have produced impressive reductions of oppositional and antisocial behavior. Clinical programs that treat these populations without using a family-based intervention as at least a component of a treatment package are seriously ignoring the findings of contemporary intervention science. Programs of research by Henggeler, Szapocznik, and Liddle demonstrate similarly impressive results for substance abusing adolescents. Although preliminary results from the Dennis et al study suggest that various treatment approaches may benefit this population. Family interventions have had less success in reducing ADHD symptoms, yet these psychosocial treatments have been essential in reducing much of the family and school behavior problems associated with this disorder. Many investigators would agree that a combined medication and family treatment approach may be the treatment of choice for children with ADHD. In fact, many studies across various disorders suggest that patients respond best to comprehensive treatment packages, of which a family treatment is at least one component. Although the data are promising, many challenges lie ahead. Although collectively many family intervention studies exist, many disorders lack enough rigorous and large-scale investigations to make any strong conclusions. Kazdin argues that sample sizes of 150 are essential to detect significant differences between active treatments, and few of the reviewed studies include these kinds of patient numbers. Furthermore, not enough committed and sophisticated family treatment researchers have carried out some of the major studies. For example, the Brent study on depression and the Barkley study of ADHD, although testing family approaches, lacked well-developed and published treatment manuals, a demonstration of the necessary expertise to supervise these treatments, and data about training and adherence to these models. Although the absence of expertise limits investigator allegiance biases, treatment development and modification are essential for tailoring family treatments to target family processes specific to each disorder. Investigators such as Patterson and Liddle have invested great effort in rigorously dismantling the treatment process, identifying and refining essential ingredients, and repackaging more potent treatment protocols. This process has paid off well. Programmatic treatment development is needed for many disorders to address myriad questions. What are the essential disorder-specific family processes that should be targeted by interventions? Hostility, criticism, communication, attachment and autonomy, attributional sets, and behavior management are important processes of family life, but each may have more relative importance for specific

disorders. With a greater understanding of these processes, treatments could be tailored to target these mechanisms more efficiently and effectively. Once these treatment components are assembled and proven effective, studies should address questions regarding which dose, duration, and type of family treatment (e.g., individual family therapy, psychoeducational groups, family support, home-based services, or combined treatment packages) might be necessary and essential to impact these processes. The interaction between treatment outcome and patient age, developmental stage of the disorder (e.g., prevention, early intervention, acute care, maintenance care, after care), and the effect of parental psychopathology are also crucial questions that must be investigated. Finally, studies of treatment costs, cost-effectiveness, and cost-benefits are essential for understanding the value and viability of these treatment models, particularly in a managed care environment. Another decade of programmatic investigations along these lines would yield a more accurate picture of the value of family-based treatments

5. Drake RE, O'Neal EL, Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. Journal of Substance Abuse Treatment 2008;34(1):123-38. Abstract: This report reviews studies of psychosocial interventions for people with co-occurring substance use disorder and severe mental illness. We identified 45 controlled studies (22 experimental and 23 quasi-experimental) of psychosocial dual diagnosis interventions through several search strategies. Three types of interventions (group counseling, contingency management, and residential dual diagnosis treatment) show consistent positive effects on substance use disorder, whereas other interventions have significant impacts on other areas of adjustment (e.g., case management enhances community tenure and legal interventions increase treatment participation). Current studies are limited by heterogeneity of interventions, participants, methods, outcomes, and measures. Treatment of co-occurring severe mental illness and substance use disorder now has a large but heterogeneous evidence base that nevertheless supports several types of interventions. Future research will need to address methodological standardization, longitudinal perspectives, interventions for subgroups and stages, sequenced interventions, and the changing realities of treatment systems. copyright 2008

6. Glynn SM, Cohen AN, Niv N. New challenges in family interventions for schizophrenia. Expert Review of Neurotherapeutics 2007;neurotherapeutics.(1):33-43. Abstract: This review first outlines the rationale and research base supporting the development of family interventions for schizophrenia. The over-riding principles guiding effective family interventions for schizophrenia are then presented, along with the key components (engagement, assessment, education, communication skills training and problem-solving) shared by most family programs in schizophrenia. Meta-analyses demonstrating the efficacy of family interventions in reducing relapse and rehospitalization in schizophrenia are then discussed, along with issues regarding minimal duration of effective treatment, differential benefits of single and

multiple family modalities and mixed evidence for the maintenance of treatment effects after termination. The benefits of participation in family-organized, nonprofessional support and education programs are then described. Finally, three issues meriting further study are outlined. [References: 97]

7. Held T, Falloon IR. Family therapy of schizophrenia. Fortschritte der Neurologie Psychiatrie 2000;68 Supplement 1:46-9.
Abstract: Family therapy of schizophrenia has long been conceived and practised under etiological premises. Familial disturbances as pathological regression/fixation (psychoanalytical) and individuation-impairing family dynamics (systemic) were addressed directly in the hope of "curing" the disorder. The efforts to prove the viability of the concepts and/or the efficacy of the therapeutic approach were largely unsuccessful. Newer strategies of family therapy of schizophrenia are both more precise in their theoretical assumptions and more performing in the pursuit of their therapeutic goals. We analyse the basis of modern family therapy in the "Expressed-Emotions (EE)"--research and propose a newer, more adequate understanding of the EE phenomenon. From our own studies and from a general review of relevant studies we derive an understanding of the rationale of family work and family therapy of schizophrenia. We discuss the results of a meta-analysis on the active ingredients and the conditions of efficacy of family interventions

8. He Y, Li C. Morita therapy for schizophrenia. Cochrane Database of Systematic Reviews 2007;(1):CD006346.
Abstract: BACKGROUND: Morita therapy was founded in 1919 by Shoma Morita (1874-1938). The therapy involves a behavioural structured programme to encourage an outward perspective on life and hence an increased social functioning. OBJECTIVES: To evaluate the effects of Morita therapy for schizophrenia and schizophrenia-like psychoses. SEARCH STRATEGY: We searched the Cochrane Schizophrenia Groups Trials Register, the Chongqing VIP Database, the Wanfang Database (August 2006), all relevant references and contacted the first author of each included study. SELECTION CRITERIA: We included all randomised clinical trials comparing Morita therapy with any other treatment. DATA COLLECTION AND ANALYSIS: We reliably selected studies and extracted data. For homogenous dichotomous data we calculated random effects, relative risk (RR), 95% confidence intervals (CI) and, where appropriate, numbers needed to treat (NNT) on an intention-to-treat basis. For continuous data, we calculated weighted mean differences (WMD). MAIN RESULTS: We found 11 small, studies of medium-poor quality (total n=1041). The standard care versus Morita therapy comparison (total n=679 people) had very low attrition (<2%, 9 RCTs, RR 1.02 CI 0.3 to 3.1). Mental state did tend to improve with Morita therapy (n=76, 1 RCT, RR no >25-30% decline in BPRS RR 0.36 CI 0.1 to 0.9, NNT 5 CI 4 to 25). For negative symptoms data were inconsistent, with data from three trials favouring Morita therapy (n=243, RR -10.87 CI -20.5 to -1.2), but heterogeneity was considerable (I(2) =92%). Morita therapy plus standard treatment did significantly improve the ability of daily living compared with stan-

dard treatment alone (n=104, 1 RCT, WMD -4.1 CI -7.7 to -0.6). Compared with a rehabilitation programme Morita therapy did not promote attrition (n=302, 2 RCTs, RR 1.00 CI 0.5 to 2.1). In two very similar studies Morita therapy showed better effect on mental state with lower BPRS score (n=278, 2 RCTs, WMD -6.95 CI 9.3 to 4.6, I(2) =0%) insight (n=278, 2 RCTs, WMD -1.11 CI -1.3 to -0.9, I(2) = 0%) and social functioning (n=278, WMD average IPROS score -18.14 CI -21.3 to -15.0, I(2) =0%). AUTHORS' CONCLUSIONS: Currently trial based data on Morita therapy is inconclusive. Morita therapy for schizophrenia remains an experimental intervention, new trials are justified and specific outlines for design of future studies are outlined in additional tables. [References: 52]

9. Jung XT, Newton R. Cochrane reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psychosis, and bipolar disorder: A systematic literature review. International Journal of Mental Health Nursing 2009;.18(4):Aug-249.
Abstract: Mental health-care professionals are striving to keep up to date with health interventions that are effective and beneficial to patients. The Cochrane Reviews make available a systematic and up-to-date review of a comprehensive range of health interventions. We identified a total of 28 interventions from a systematic search and review of the Cochrane Reviews for either schizophrenia, psychosis, schizoaffective, or bipolar disorder. These interventions have been graded into tables of: strong support that merits application, moderate support that warrants consideration of application, not supported, and data that is deemed inconclusive. The tables provide a comprehensive summary and classification of evidence-based practices. This information is presented in a way to enable nurses and other health-care professionals to analyze their own practices to improve mental health services and outcomes for patients. Of the 28 interventions identified in this review, four had strong support and five had moderate support meriting application. Limitations of this review are discussed. (PsycINFO Database Record (c) 2009 APA, all rights reserved) (journal abstract)

10. Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database of Systematic Reviews: Reviews. In: Cochrane Database of Systematic Reviews 2006 Issue 4. Chichester (UK): John Wiley & Sons, Ltd; 2006.
Abstract: BACKGROUND: People with schizophrenia from families that express high levels of criticism, hostility, or over involvement, have more frequent relapses than people with similar problems from families that tend to be less expressive of emotions. Forms of psychosocial intervention, designed to reduce these levels of expressed emotions within families are now widely used. OBJECTIVES: To estimate the effects of family psychosocial interventions in community settings for people with schizophrenia or schizophrenia-like conditions compared to standard care. SEARCH STRATEGY: We updated previous searches by searching The Cochrane Schizophrenia Group's Register (November 2002 and June 2005), searched references of all new included studies for further trial citations, and contacted authors of

trials. SELECTION CRITERIA: We selected randomised or quasi-randomised studies focusing primarily on families of people with schizophrenia or schizoaffective disorder that compared community-orientated family-based psychosocial intervention with standard care. DATA COLLECTION AND ANALYSIS: We independently extracted data and calculated fixed effects relative risk (RR), the 95% confidence intervals (CI) for binary data, and, where appropriate, the number needed to treat (NNT) on an intention-to-treat basis. For continuous data, we calculated weighted mean differences (WMD). MAIN RESULTS: This 2005-6 update adds data of 15 additional trials (1765 participants, 43% of the total 4124). Family intervention may decrease the frequency of relapse (n=857, 16 RCTs, RR 0.71 CI 0.6 to 0.8, NNT 8 CI 6 to 11), although some small but negative studies may not have been identified by the search. Family intervention may also reduce hospital admission (8 RCTs, n=481, RR 0.78 CI 0.6 to 1.0, NNT 8 CI 6 to 13) - and this finding is a change to the previous equivocal data reported in 2002. Family intervention may also encourage compliance with medication (n=369, 7 RCTs, RR 0.74 CI 0.6 to 0.9, NNT 7 CI 4 to 19) but does not obviously affect the tendency of individuals/families to drop out of care (n=481, 6 RCTs, RR 0.86 CI 0.5 to 1.4). It may improve general social impairment and the levels of expressed emotion within the family. We did not find data to suggest that family intervention either prevents or promotes suicide. AUTHORS' CONCLUSIONS: Clinicians, researchers, policy makers and recipients of care cannot be confident of the effects of family intervention from the findings of this review. Further data from already completed trials could greatly inform practice and more trials are justified as long as their participants, interventions and outcomes are applicable to routine care. FAMILY INTERVENTION FOR SCHIZOPHRENIA: People with schizophrenia are more likely to experience a relapse within family groups when there are high levels of expressed emotion (hostility, criticism or over involvement) within the family, compared to families who tend to be less expressive of their emotions. There are several psychosocial interventions available involving education, support and management to reduce expressed emotion within families. In this review we compare the effects of family psychosocial interventions in community settings for the care of people with schizophrenia or schizophrenia-like illnesses.Studies were conducted in Europe, Asia and North America with packages of family intervention varying between studies; although there were no clear differences in study design. Results indicated that family intervention may reduce the risk of relapse and improve compliance with medication. However data were often inadequately reported and therefore unusable. As this package of care is widely employed there should be a further study to properly clarify several of the short-term and long-term outcomes

11. Pitschel-Walz G, Leucht S, Baumnl J, Kissling W, Engel RR. The effect of family interventions on relapse and rehospitalization in schizophrenia - A meta-analysis. Schizophrenia Bulletin 2001;27 (1):73-92.
Abstract: Twenty-five intervention studies were meta-analytically examined regarding the effect of including relatives in schizophrenia treatment. The studies investi-

gated family intervention programs to educate relatives and help them cope better with the patient's illness. The patient's relapse rate, measured by either a significant worsening of symptoms or rehospitalization in the first years after hospitalization, served as the main study criterion. The main result of the meta-analysis was that the relapse rate can be reduced by 20 percent if relatives of schizophrenia patients are included in the treatment. If family interventions continued for longer than 3 months, the effect was particularly marked. Furthermore, different types of comprehensive family interventions have similar results. The bifocal approach, which offers psychosocial support to relatives and schizophrenia patients in addition to medical treatment, was clearly superior to the medication-only standard treatment. The effects of family interventions and comprehensive patient interventions were comparable, but the combination did not yield significantly better results than did a treatment approach, which focused on either the patient or the family. This meta-analysis indicates that psychoeducational interventions are essential to schizophrenia treatment

## 2 Boligoppfølging

12. Burns T, Knapp M, Catty J, Healey A, Henderson J, Watt H, et al. Home treatment for mental health problems: a systematic review. Health Technology Assessment (Winchester, England) 2001;5(15):1-139.
Abstract: OBJECTIVE: This review investigates the effectiveness of 'home treatment' for mental health problems in terms of hospitalisation and cost-effectiveness. For the purposes of this review, 'home treatment' is defined as a service that enables the patient to be treated outside hospital as far as possible and remain in their usual place of residence. METHODS - SYSTEMATIC LITERATURE SEARCH: 'Home treatment' excluded studies focused on day, residential and foster care. The review was based on Cochrane methodology, but non-randomised studies were included if they compared two services; these were only analysed if they provided evidence of the groups' baseline clinical comparability. METHODS - REVIEW OF ECONOMIC EVALUATIONS: Economic evaluations among the studies found were reviewed against established criteria. METHODS - IDENTIFICATION OF SERVICE COMPONENTS: A three-round Delphi exercise ascertained the degree of consensus among expert psychiatrists concerning the important components of community-based services that enable them to treat patients outside hospital. The identified components were used to construct the follow-up questionnaire. METHODS - FOLLOW-UP OF AUTHORS: As a supplement to the information available in the papers, authors of all the studies were followed up for data on service components, sustainability of programmes and service utilisation. METHODS - DATA ANALYSIS: The outcome measure was mean days in hospital per patient per month over the follow-up period. (1) Comparative analysis - compared experimental to control services. It analysed all studies with available data, divided into 'inpatient-control' and 'community-control' studies, and tested for associations between service components and difference in hospital days. (2) Experimental services analysis - analysed

only experimental service data and tested for associations between service components and hospital days. RESULTS - SYSTEMATIC LITERATURE SEARCH: A total of 91 studies were found, conducted over a 30-year period. The majority (87) focused on people with psychotic disorders. RESULTS - REVIEW OF ECONOMIC EVALUATIONS: Only 22 studies included economic evaluations. They provided little conclusive evidence about cost-effectiveness because of problems with the heterogeneity of services, sample size, outcome measures and quality of analysis. RESULTS - DELPHI EXERCISE: In all, 16 items were rated as 'essential', falling into six categories: home environment; skill-mix; psychiatrist involvement; service management; caseload size; and health/social care integration. There was consensus that caseloads under 25 and flexible working hours over 7 days were important, but little support for caseloads under 15 or for 24-hour services, and consensus that home visiting was essential, but not on teams being 'explicitly dedicated' to home treatment. RESULTS - RESPONSE TO FOLLOW-UP: A total of 60% of authors responded, supplying data on service components and hospital days in most cases. Other service utilisation data were far less readily available. RESULTS - SERVICE CHARACTERISATION AND CLASSIFICATION: The services were homogeneous in terms of 'home treatment function' but fairly heterogeneous in terms of other components. There was some evidence for a group of services that were multidisciplinary, had psychiatrists as integrated team members, had smaller caseloads, visited patients at home regularly and took responsibility for both health and social care. This was not a cohesive group, however. RESULTS - SUSTAINABILITY OF SERVICES: The sustainability of home treatment services was modest: less than half the services whose authors responded were still identifiable. Services were more likely to be operational if the study had found them to reduce hospitalisation significantly. RESULTS - META-ANALYSIS: Meta-analysis with heterogeneous studies is problematic. The evidence base for the effectiveness of services identifiable as 'home treatment' was not strong. Within the 'inpatient-control' study group, the mean reduction in hospitalisation was 5 days per patient per month (for 1-year studies only). No statistical significance could be measured for this result. For 'community-control' studies, the reduction in hospitalisation was negligible. Moreover, the heterogeneity of control services, the wide range of outcome measures and the limited availability of data might have confounded the analysis. Regularly visiting at home and dual responsibility for health and social care were associated with reduced hospitalisation. Evidence for other components was inconclusive. Few conclusions could be drawn from the analysis of service utilisation data. RESULTS - LOCATION: Studies were predominately from the USA and UK, more of them being from the USA. North American studies found a reduction in hospitalisation of 1 day per patient per month more than European studies. North American and European services differed on some service components, but this was unlikely to account for this finding, particularly as no difference was found in their experimental service results. CONCLUSIONS - STATE OF RESEARCH: There is a clear need for further studies, particularly in the UK. The benefit of home treatment over admission in terms of days in hospital was clear, but over other community-based alternatives was inconclusive. CONCLU-

SIONS - NON-RANDOMISED STUDIES: Difficulties in systematically searching for non-randomised studies may have contributed to the smaller number of such studies found (35, compared with 56 randomised controlled trials). This imbalance was compounded by a relatively poor response rate from non-randomised controlled trial authors. Including them in the analysis had little effect. CONCLUSIONS - LIMITATIONS OF THIS REVIEW: A broad area was reviewed in order to avoid the problem of analysing by service label. While reviews of narrower areas may risk implying a homogeneity of the services that is unwarranted, the current strategy has the drawback that the studies cover a range of heterogeneous services. The poor definition of control services, however, is ubiquitous in this field, however reviewed areas are defined. Inclusion of mean data for which no standard deviations were available was problematic in that it prevented measuring the significance of the main findings. The lack of availability of this data, however, is an important finding, demonstrating the difficulty in seeking certainty in this area. Only days in hospital and cost-effectiveness were analysed here. The range and lack of uniformity of measures used in this field made meta-analysis of other outcomes impossible. It should be noted, however, that the findings pertain to these aspects alone. The Delphi exercise reported here was limited in being conducted only with psychiatrists, rather than a multidisciplinary panel. Its findings were used as a framework for the follow-up and analysis. Their possible bias should be borne in mind when considering them as findings in themselves. CONCLUSIONS - IMPLICATIONS FOR CLINICIANS: The evidence base for home treatment compared with other community-based services is not strong, although it does show that home treatment reduces days spent in hospital compared with inpatient treatment. There is evidence that visiting patients at home regularly and taking responsibility for both health and social care each reduce days in hospital. CONCLUSIONS - IMPLICATIONS FOR CONSUMERS: Services that visit patients at home regularly and those that take responsibility for both health and social care are likely to reduce time spent in hospital. Psychiatrists surveyed in this review also considered support for carers to be essential. The evidence from this review, however, was that few services currently have protocols for meeting carers' needs. CONCLUSIONS - RECOMMENDATIONS FOR RESEARCH AND COMMISSIONERS: A centrally coordinated research strategy, with attention to study design, is recommended. Studies should include economic evaluations that report health and social service utilisation. Service components should be collected and reported for both experimental and control services. Studies should be designed with adequate power and longer durations of follow-up and use comparable outcome measures to facilitate meta-analysis. Research protocols should be adhered to throughout the studies. It may be advisable that independent researchers conduct studies in future. It is no longer recommended that home treatment be tested against inpatient care, or that small, localised studies replicate existing, more highly powered studies. [References: 106]

13. Chilvers R, Macdonald GM, Hayes AA. Supported housing for people with severe mental disorders. Cochrane Database of Systematic Reviews 2002;(4):CD000453.

Abstract: BACKGROUND: There has been a significant reduction in the number of people with severe mental illness who spend extended periods in long-stay hospitals. Psychiatric and social services, both statutory and voluntary, aim to assist these people to stay in their local community. District health authorities, local authorities, housing associations and voluntary organisations are jointly expected to provide support for people with severe mental disorder/s. This 'support' may well involve some sort of special housing. OBJECTIVES: To determine the effects of supported housing schemes compared with outreach support schemes or 'standard care' for people with severe mental disorder/s living in the community. SEARCH STRATEGY: Cochrane Schizophrenia Group's Register of trials (February 2001) and the Cochrane Library (Issue 1, 2001) were searched using relevant phrases. These databases are compiled by methodical searches of BIOSIS, CINAHL, Dissertation abstracts, EMBASE, LILACS, MEDLINE, PSYNDEX, PsycINFO, RUSSMED, Sociofile, supplemented with hand searching of relevant journals and numerous conference proceedings. Reference list screening of relevant papers was performed. SELECTION CRITERIA: Relevant randomised, or quasi-randomised, trials dealing with people with 'severe mental disorder/s' allocated to supported housing, outreach support schemes or standard care focusing on outcomes of service utilisation, mental state, satisfaction with care, social functioning, quality of life, and economic data, were sought. DATA COLLECTION AND ANALYSIS: Studies were reliably selected, quality rated and data extracted. For dichotomous data, relative risks (RR) would have been estimated, with the 95% confidence intervals (CI). Where possible, the number needed to treat statistic (NNT) was to have been calculated. Analysis would have been by intention-to-treat. Normal continuous data were to have been summated using the weighted mean difference (WMD). Scale data were to have been presented for only those tools that had attained pre-specified levels of quality. Tests of heterogeneity and for publication bias were to have been undertaken. MAIN RESULTS: No studies met the inclusion criteria although 139 citations were acquired from the searches. REVIEWER'S CONCLUSIONS: Dedicated schemes whereby people with severe mental illness are located within one site or building with assistance from professional workers have potential for great benefit as they provide a 'safe haven' for people in need of stability and support. This, however, may be at the risk of increasing dependence on professionals and prolonging exclusion from the community. Whether or not the benefits outweigh the risks can only be a matter of opinion in the absence of reliable evidence. There is an urgent need to investigate the effects of supported housing on people with severe mental illness within a randomised trial. [References: 14]

14. Macpherson R, Edwards TR, Chilvers R, David C, Elliott HJ. Twenty-four hour care for schizophrenia. Cochrane Database of Systematic Reviews: Reviews. In: Cochrane Database of Systematic Reviews 2009 Issue 2. Chichester (UK): John Wiley & Sons, Ltd; 2009.
Abstract: BACKGROUND: Despite modern treatment approaches and a focus on community care, there remains a group of people who cannot easily be discharged

from psychiatric hospital directly into the community. Twenty-four hour residential rehabilitation (a 'ward-in-a-house') is one model of care that has evolved in association with psychiatric hospital closure programmes. OBJECTIVES: To determine the effects of 24 hour residential rehabilitation compared with standard treatment within a hospital setting. SEARCH STRATEGY: We searched the Cochrane Schizophrenia Group Trials Register (May 2002 and February 2004). SELECTION CRITERIA: We included all randomised or quasi-randomised trials that compared 24 hour residential rehabilitation with standard care for people with severe mental illness. DATA COLLECTION AND ANALYSIS: Studies were reliably selected, quality assessed and data extracted. Data were excluded where more than 50% of participants in any group were lost to follow-up. For binary outcomes we calculated the relative risk and its 95% confidence interval. MAIN RESULTS: We identified and included one study with 22 participants with important methodological shortcomings and limitations of reporting. The two-year controlled study evaluated "new long stay patients" in a hostel ward in the UK. One outcome 'unable to manage in the placement' provided usable data (n=22, RR 7.0 CI 0.4 to 121.4). The trial reported that hostel ward residents developed superior domestic skills, used more facilities in the community and were more likely to engage in constructive activities than those in hospital - although usable numerical data were not reported. These potential advantages were not purchased at a price. The limited economic data was not good but the cost of providing 24 hour care did not seem clearly different from the standard care provided by the hospital - and it may have been less. AUTHORS' CONCLUSIONS: From the single, small and ill-reported, included study, the hostel ward type of facility appeared cheaper and positively effective. Currently, the value of this way of supporting people - which could be considerable - is unclear. Trials are needed. Any 24 hour care 'ward-in-a-house' is likely to be oversubscribed. We argue that the only equitable way of providing care in this way is to draw lots as to who is allocated a place from the eligible group of people with serious mental illness. With follow-up of all eligible for the placements - those who were lucky enough to be allocated a place as well as people in more standard type of care - real-world evaluation could take place. In the UK further randomised control trials are probably impossible, as many of these types of facilities have closed. The broader lesson of this review is to ensure early and rigorous evaluation of fashionable innovations before they are superseded by new approaches. TWENTY-FOUR HOUR CARE FOR SCHIZOPHRENIA: Schizophrenia is a long-term, chronic, illness with a worldwide lifetime prevalence of about one per cent. It has a high disability rate and the cost to individuals, their carers and health services is substantial. Although the majority of people with schizophrenia learn to cope in the community, there are some people who need help and reminders if they are to manage self-care and other aspects of day-to-day living. In many countries these people end up as long stay patients on hospital wards. This review aims to look at the economic costs and quality of life of people in 24 hour non-hospital care compared to those still in hospital. Only one trial of 22 people and lasting two years was identified, and it took place in the UK. Most of the participants but not all had schizophrenia. Half were assigned to live in a house staffed by a psy-

chologist, and enough nurses and nursing assistants to provide 24 hour care. The staff were expected to help prepare and share meals with the residents and the residents had a programme of domestic work and some self-care tasks. The psychologist worked with each individual to improve social interaction and behaviour. The control group had normal hospital care with access to occupational therapy, industrial therapy and recreational facilities. They were also allowed home on leave and were counted as part of the group if they were discharged, transferred to hostels or in prison. The majority of the data were difficult to interpret because the numbers needed to make statistical comparisons were not given. Three people from the house had to be readmitted to the hospital and several of the others had short stays there. Those people who were resident in the house were reported to be significantly more likely to use social facilities and spent more time in socially constructive activities (self-care, eating with the group). All other measures reported were not significantly different between the groups. The costs for each group were similar, however if cost was calculated for those in the house who did not use the hospital at all, it was slightly less expensive. This was a small study which was not designed well. A larger, well-designed trial would answer the question of whether 24 hour care would benefit this group of people.(Plain language summary prepared for this review by Janey Antoniou of RETHINK, UK www.rethink.org)

15. Gale J, Sanchez Espana B. Evidence for the effectiveness of therapeutic community treatment of the psychoses. Philosophy, history and clinical practice; 2008. Abstract: (from the chapter) Lees et al. (2004) brought together a wide range of papers discussing all aspects of therapeutic community research. They consider which methods are most appropriate in the unique environment of therapeutic communities, as well as ethical questions. The volume includes several research studies undertaken in the UK. Other studies showing the effectiveness of therapeutic community treatment have also been published in the UK (Dolan et al. 1997; Griffiths 1997). Lees et al. (1999) undertook a systematic review of therapeutic community effectiveness in various settings in 1998, including a meta-analysis, of 29 studies. The therapeutic community modality of treatment represents a useful framework within which other treatment interventions can be applied. It fuses therapeutic approaches and practice from both psychodynamic and CBT traditions with rehabilitation, practical skills learning and retraining for work. There is a growing body of evidence in the UK and elsewhere to suggest that group CBT can be effective with people with psychosis. Contemporary studies are shifting their focus from the treatment of individual positive symptoms--especially delusions and hallucinations--to therapy with people who present with complex and diverse difficulties. This is particularly relevant for therapeutic communities, as the group itself is an important component of the treatment. The group provides a forum for peer relating, safely experimenting with new behaviours and solidarity for bolstering self-regard through the challenging of negative social stereotypes. There is now convincing evidence from controlled trials for the effectiveness of group CBT at reducing symptoms and associated distress in people with medication resistant psychosis, acute episode and early psycho-

sis. Following their systematic international literature review, Lees et al. (1999) concluded that: "[T]herapeutic communities have not produced the amount or quality of research literature that we might have expected, given the length of time they have been in existence and the quality of staff we know exists and has existed in therapeutic communities. This may be partly due to a lack of emphasis placed on research in the early days of therapeutic community development, and more recently to a lack of resources, in terms of finance, staff and adequate research methodologies, designs and instruments" (Lees et al. 1999: 3). Although this study was commissioned to look at therapeutic communities for people with a personality disorder, undoubtedly the same could be said in the case of therapeutic communities for those with psychosis. The tide does, however, at last seem to have changed. First, with the work of Loren Mosher, followed by that of Luc Ciompi and later that of Raman Kapur and his colleagues at Threshold, Northern Ireland, therapeutic communities that treat psychoses are assembling a body of evidence to demonstrate their effectiveness. This chapter has endeavoured to show how a small organisation, Community Housing and Therapy (CHT), is managing to incorporate research into its programmes by outsourcing the research function through partnerships and by bringing in research consultants. While still embryonic, this engagement with research has enabled CHT to participate as a stakeholder in the review of the UK National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia and thus to play a small part in the formation of mental health policy at the national level. The next stage is likely to involve finding ways to include some forms of randomised control trials within therapeutic communities. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

16. Leff HS, Chow CM, Pepin R, Conley J, Allen IE, Seaman CA. Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. Psychiatric Services 2009;60(4):473-82.
Abstract: Objective: Numerous studies have evaluated the impacts of community housing models on outcomes of persons with severe mental illness. The authors conducted a meta-analysis of 44 unique housing alternatives described in 30 studies, which they categorized as residential care and treatment, residential continuum, permanent supported housing, and nonmodel housing. Outcomes examined included housing stability, symptoms, hospitalization, and satisfaction. Methods: Outcome scores were converted to effect size measures appropriate to the data. Effect sizes were combined to estimate random effects for housing models, which were then compared. Results: All models achieved significantly greater housing stability than nonmodel housing. This effect was greatest for permanent supported housing (effect size=.63, p<.05). No differences between housing models were significant. For reduction of psychiatric symptoms, only residential care and treatment differed from nonmodel housing (effect size=.65, p<.05). For hospitalization reduction, both residential care and treatment and permanent supported housing differed from nonmodel housing (p<.05). Permanent supported housing achieved the highest effect size (.73) for satisfaction and differed from nonmodel housing and residential

care and treatment ($p<.001$ and $p<.05$, respectively). Conclusions: The meta-analysis provides quantitative evidence that compared with nonmodel housing, housing models contribute to stable housing and other favorable outcomes. The findings also support the theory that different housing models achieve different outcomes for different subgroups. Data were not sufficient to fully answer questions designed to enable program planners and providers to better meet consumers' needs. It is important to answer these questions with research that uses common measures and adheres to scientific conventions

17. Newman SJ. Housing attributes and serious mental illness: implications for research and practice. Psychiatric Services 2001;52(10):1309-17.
Abstract: OBJECTIVES: This paper critically reviews studies of the relationship between housing attributes and serious mental illness, highlights important gaps in the research, generates hypotheses to be tested, and suggests a research agenda. METHODS: Studies published between 1975 and March 2000 were identified through computerized searches, previous literature reviews, and consultation with mental health and housing researchers. Criteria for inclusion included the presentation of quantitative evidence, a systematic sample of known generalizability, and systematic analytic techniques. RESULTS AND CONCLUSIONS: The 32 studies that met these criteria relied on one or more of three conceptualizations of the role of housing: housing attributes or assessments as an outcome or dependent variable; housing attributes as inputs or independent variables in a model in which the outcome pertains to a nonhousing factor, such as a mental health outcome; or housing as both an input and an outcome. Three studies found no long-term effect of improved housing adequacy on housing satisfaction above and beyond case management. Three studies found better outcomes for settings that have fewer occupants. Another study suggested that persons who live in small-scale, good-quality, noninstitutional environments are less likely to engage in disruptive behavior when a larger proportion of other tenants also have serious mental illness. The strongest finding from the literature on housing as an input and an outcome was that living in independent housing was associated with greater satisfaction with housing and neighborhood. Most of the studies had methodological weaknesses, and few addressed key hypotheses. There is a critical need for a coherent agenda built around key hypotheses and for a uniform set of measures of housing an input and an outcome

## 3 Psykososiale tiltak for rusinduserte psykoser

18. Berk M, Rathbone J, Mandriota-Carpenter SL. Clotiapine for acute psychotic illnesses. Cochrane Database of Systematic Reviews 2004;(4):CD002304.
Abstract: BACKGROUND: Acute psychotic illnesses, especially when associated with agitated or violent behaviour, require urgent pharmacological tranquillisation or sedation. Clotiapine, a dibenzothiazepine neuroleptic, is being used for this purpose in

several countries. OBJECTIVES: To estimate the effects of clotiapine when compared to other 'standard' or 'non-standard' treatments for acute psychotic illnesses in controlling disturbed behaviour and reducing psychotic symptoms. SEARCH STRATEGY: We updated previous searches by searching the Cochrane Schizophrenia Group Register (April 2004) SELECTION CRITERIA: The review included randomised clinical trials comparing clotiapine with any other treatment for people with acute psychotic illnesses. DATA COLLECTION AND ANALYSIS: Relevant studies were selected for inclusion, their quality was assessed and data extracted. Data were excluded where more than 50% of participants in any group were lost to follow up. For binary outcomes we calculated a standard estimation of the risk ratio (RR) and its 95% confidence interval (CI). For continuous outcomes, endpoint data were preferred to change data. Non-skewed data from valid scales were summated using a weighted mean difference (WMD). MAIN RESULTS: We identified five relevant trials. None compared clotiapine with placebo, but control drugs were either antipsychotics (chlorpromazine, perphenazine, trifluoperazine and zuclopenthixol acetate) or benzodiazepines (lorazepam).Versus the antipsychotics, the results for 'no important global improvement' did not suggest clotiapine to be superior, or inferior, to chlorpromazine, perphenazine, or trifluoperazine (n = 83, 3 RCTs, RR 0.82 CI 0.22 to 3.05, I-squared 58%). Use of clotiapine when compared with chlorpromazine did change the proportion of people ready for hospital discharge by the end of the study (n = 49, 1 RCT, RR 1.04 95%CI 0.96 to 2.12). Overall, attrition rates were low. No significant difference was found for those allocated to clotiapine compared with people randomised to other antipsychotics (n = 121, RR 2.26 95%CI 0.40 to 13). Weak data suggests that clotiapine may result in less need for antiparkinsonian treatment compared with zuclopenthixol acetate (n = 38, RR 0.43 95%CI 0.02 to 0.98). Compared with lorazepam, clotiapine, when used to control aggressive/violent outbursts for people already treated with haloperidol, did not significantly improve mental state (WMD -3.36 95%CI -8.09 to 1.37). We could not pool much data due to skew or inadequate presentation of results. Economic outcomes and satisfaction with care were not addressed. AUTHORS' CONCLUSIONS: We found no evidence to support the use of clotiapine in preference to other 'standard' or 'non-standard' treatments for management of people with acute psychotic illness. All trials in this review have important methodological problems. We do not wish to discourage clinicians from using clotiapine in the psychiatric emergency, but well-designed, conducted and reported trials are needed to properly determine the efficacy of this drug. CLOTIAPINE FOR ACUTE PSYCHOTIC ILLNESSES: Clotiapine is an antipsychotic drug and is currently used in the management of acute psychotic symptoms in Argentina, Belgium, Israel, Italy, Luxemburg, South Africa, Spain, Switzerland and Taiwan. This review highlights limited evidence for the effects of clotiapine compared with other drugs also used in this emergency situation

19. Curran C, Byrappa N, McBride A. Stimulant psychosis: systematic review. Br J Psychiatry 2004;185:196-204.

Abstract: BACKGROUND: Psychosis associated with stimulant use is an increasing problem, but there is little research evidence about the nature of the problem and its management. AIMS: To critically review the literature on stimulant psychosis and sensitisation. METHOD: Systematic review of studies that have investigated stimulant use and psychosis in humans. The main outcome measures were increases in psychosis with stimulant use, and differences between stimulant users and non-users. RESULTS: Fifty-four studies met the inclusion criteria. Experimental studies show that a single dose of a stimulant drug can produce a brief increase in psychosis ratings (a "response") in 50-70% of participants with schizophrenia and pre-existing acute psychotic symptoms, unaffected by the presence of antipsychotic medication. Those with schizophrenia who do not have acute psychotic symptoms respond, but less frequently (30%). There has been little research into the longer-term effects of use. CONCLUSIONS: Compliance with antipsychotic medication by someone with schizophrenia will not prevent a relapse or worsening of psychotic symptoms if stimulants are used. Low-dose antipsychotic treatment may be beneficial in stimulant users, to prevent sensitisation. [References: 63]

20. Frieling H, Hillemacher T, Ziegenbein M, Neundorfer B, Bleich S. Treating dopamimetic psychosis in Parkinson's disease: structured review and meta-analysis. Eur Neuropsychopharmacol 2007;17(3):165-71.
Abstract: Psychosis due to dopamimetic treatment is a difficult problem in patients with Parkinson's disease (PD). The aim of this structured review with meta-analysis was to evaluate which neuroleptic drugs can efficiently be used to treat drug-induced psychosis (DIP) in Parkinson's disease. Electronic databases were screened for the key words Parkinson's disease and psychosis. Only 7 trials with a satisfactory allocation concealment and data reporting were included into the study. Two trials compared low-dose clozapine versus placebo with a significantly better outcome for clozapine regarding efficacy and motor functioning. In one trial clozapine was compared against quetiapine showing equivalent efficacy and tolerability. However, in two placebo controlled trials quetiapine failed to show efficacy. In two further placebo controlled trials olanzapine did not improve psychotic symptoms and significantly caused more extrapyramidal side effects. Based on randomized trial-derived evidence which is currently available, only clozapine can be fully recommended for the treatment of DIP in PD. Olanzapine should not be used in this indication. [References: 55]

21. Hermle L, Kovar KA, Ebert D, Ruchsow M. Amphetamine-induced psychological disorders and medical complications. [German]. Nervenheilkunde: Zeitschrift fur interdisziplinaere Fortbildung27; 2008; (8):759-66.
Abstract: Objective: The purpose of this article is to provide an overview of the current research on amphetamine induced psychiatric disorders. Amphetamine/methamphetamine are increasingly used by adolescents and young adults. Methods: Relevant literature and related articles were identified by means of a computerized MEDLINE search including the years 2000 to 2007. As keywords "(meth)-

amphetamines-induced psychological disorders", amphetamine-methamphetamine-induced psychosis" were used. Finally, 55 journal articles out of 109 were included in the review. Results: The typical adverse effects of repetitive abuse are comprised of euphoria, sleep deprivation, increased motor drive, schizophrenia like psychosis, stereotypies and a characteristic withdrawal syndrome, including increased appetite and hypersomnia. Long term abuse of amphetamines results in adaptive mechanisms like sensitization or desensitization in conditioning and learning processes resulting in severe dependences of amphetamine type. The different methamphetamine/amphetamine-induced psychic, somatic and social consequences and adverse effects including new therapeutic approaches ore discussed in clinical context. (PsycINFO Database Record (c) 2009 APA, all rights reserved) (journal abstract)

22. Hjorthoj C, Fohlmann A, Nordentoft M. Treatment of cannabis use disorders in people with schizophrenia spectrum disorders - a systematic review. Addict Behav 2009;34(6-7):520-5.
Abstract: BACKGROUND: Cannabis use disorders (CUD) are prevalent among people with schizophrenia spectrum disorders (SSD), with a range of detrimental effects, e.g. reduced compliance to medication and psychosocial interventions, and increased level of psychotic-dimension symptoms. The aim of this study was to review literature on treatments of CUD in SSD-patients. METHODS: PubMed, PsycINFO, EMBASE, and The Cochrane Central Register of Controlled Trials were searched. RESULTS: 41 articles were selected, 11 treating cannabis as a separate outcome. Contingency management was only effective while active. Pharmacological interventions appeared effective, but lacked randomized controlled trials (RCTs). Psychosocial interventions, e.g. motivational interviewing and cognitive behavior therapy (CBT), were ineffective in most studies with cannabis as a separate outcome, but effective in studies that grouped cannabis together with other substance use disorders. CONCLUSIONS: Insufficient evidence exists on treating this form of dual-diagnosis patients. Studies grouping several types of substances as a single outcome may overlook differential effects. Future RCTs should investigate combinations of psychosocial, pharmacological, and contingency management

23. Huf G, Alexander J, Allen MH, Raveendran NS. Haloperidol plus promethazine for psychosis-induced aggression. Cochrane Database of Systematic Reviews 2009;(3):CD005146.
Abstract: BACKGROUND: Health services often manage agitated or violent people, and for emergency psychiatric services such behaviour is particularly prevalent (10%). The drugs used in this situation should ensure that the person swiftly and safely regains composure. OBJECTIVES: To examine whether haloperidol plus promethazine is an effective treatment for psychosis induced agitation/aggression. SEARCH STRATEGY: We searched the Cochrane Schizophrenia Group's Register (January 2008). SELECTION CRITERIA: We included all randomised clinical trials involving aggressive people with psychosis for which haloperidol plus promethazine was being used. DATA COLLECTION AND ANALYSIS: We reliably selected, quality

assessed and extracted data from all relevant studies. For binary outcomes we calculated standard estimations of risk ratio (RR) and their 95% confidence intervals (CI). Where possible we estimated weighted number needed to treat or harm (NNT/H). MAIN RESULTS: We identified four relevant high quality studies. One compared the haloperidol plus promethazine mix with midazolam (n=301), one with lorazepam (n=200), one with haloperidol alone (n=316) and one with olanzapine IM (n=300). In Brazil, haloperidol plus promethazine was an effective means of tranquillisation with over two thirds of people being tranquil or sedated by 30 minutes, but midazolam was more swift (n=301, RR 2.9 CI 1.75 to 4.80, NNH 5 CI 3 to 12). In India, compared with lorazepam, more people were tranquil or sedated by 30 minutes if allocated to the combination treatment (n=200, RR 0.26 CI 0.10 to 0.68, NNT 8 CI 6 to 17). Over the next few hours of treatment reported differences are negligible. One person given midazolam had respiratory depression (0.7%, reversed by flumazenil); one given lorazepam (1%) had respiratory difficulty. About 1% of people given any haloperidol treatment experienced a seizure. By 20 minutes intramuscular haloperidol plus promethazine was more tranquillising than intramuscular haloperidol (1 RCT, n=316, RR 0.65 CI 0.49 to 0.87, NNT 7 CI 5 to 17). Haloperidol given without promethazine in this situation causes frequent serious adverse effects (NNH 15 CI 14 to 40). Olanzapine is as rapidly tranquillising as the haloperidol/promethazine combination (1 RCT, n=300, RR tranquil or asleep at 15 mins 0.74 CI 0.38 to 1.41), but did not have an enduring effect and more people needed additional drugs within four hours (1 RCT, n=300, RR 0.48 CI 0.33 to 0.69, NNT 5 CI 4 to 8) and to be re-assessed by the doctor (1 RCT, n=300, RR 0.47 CI 0.30 to 0.73, NNT 6 CI 5 to 12). AUTHORS' CONCLUSIONS: All treatments evaluated within the included studies are effective. Benzodiazepines, however, have the potential to cause respiratory depression, probably midazolam more so than lorazepam, and use of this group of drugs outside of services fully confident of observing for and managing the consequences of respiratory distress is difficult to justify. Haloperidol used on its own is at such risk of generating preventable adverse effects that unless it is the only choice, this evidence directs that this sole treatment should be avoided. Olanzapine IM is valuable when compared with haloperidol plus promethazine but its duration of action is short and re-injection is frequently needed. Haloperidol plus promethazine used in two diverse situations in Brazil and India has much evidence to support its swift and safe clinically valuable effects. [References: 48]

24. Mathias S, Lubman DI, Hides L. Substance-induced psychosis: a diagnostic conundrum. J Clin Psychiatry 2008;69(3):358-67.
Abstract: OBJECTIVE: To critically examine the DSM-IV-TR criteria for substance-induced psychotic disorder (SIPD). DATA SOURCES: Leading electronic databases (such as MEDLINE, PubMed) were searched for the years 1992 through 2007, using combinations of the following key search terms: substance abuse/dependence, alcohol, marijuana, cannabis, methamphetamine, crack, cocaine, amphetamine, ecstasy, ketamine, phencyclidine, LSD, mental health, drug-induced psychosis, substance-induced psychosis, psychosis, and schizophrenia. References identified from bibliog-

raphies of pertinent articles and books in the field were also collected and reviewed. DATA EXTRACTION: Only research studies or case reports/series that presented data on populations diagnosed with SIPD by using clinical or structured diagnostic interviews and that were published in English were used to assess the validity of the current SIPD criteria. DATA SYNTHESIS: We identified 49 articles that presented clinical data on SIPD. Almost half of these publications were case reports, with 18 articles specifically focusing on delineating the clinical characteristics or outcomes of individuals diagnosed with SIPD. While several large studies have recently been conducted to assess the stability of SIPD, there is a dearth of research that rigorously examines the validity of DSM-IV diagnostic criteria across substances. CONCLUSIONS: There remains a striking paucity of information on the outcome, treatment, and best practice for substance-associated psychotic episodes. Further work is clearly required before the advent of DSM-V. We propose an alternative, broader classification that better reflects the current evidence base, inferring association rather than causation. [References: 71]

25. Schuckit MA. Comorbidity between substance use disorders and psychiatric conditions. Addiction 2006;101 Suppl 1:76-88.
Abstract: AIM: To review information relevant to the question of whether substance-induced mental disorders exist and their implications. DESIGN AND METHOD: This paper utilized a systematic review of manuscripts published in the English language since approximately 1970 dealing with comorbid psychiatric and substance use disorders. FINDINGS: The results of any specific study depended on the definitions of comorbidity, the methods of operationalizing diagnostic criteria, the interview and protocol invoked several additional methodological issues. The results generally support the conclusion that substance use mental disorders exist, especially regarding stimulant or cannabinoid-induced psychoses, substance-induced mood disorders, as well as substance-induced anxiety conditions. CONCLUSIONS: The material reviewed indicates that induced disorders are prevalent enough to contribute significantly to rates of comorbidity between substance use disorders and psychiatric conditions, and that their recognition has important treatment implications. The current literature review underscores the heterogeneous nature of comorbidity. [References: 138]

26. Shoptaw SJ, Kao U, Ling W. Treatment for amphetamine psychosis. Cochrane Database of Systematic Reviews 2009;(1):CD003026.
Abstract: BACKGROUND: Chronic amphetamine users may have experience of paranoia and hallucination. It has long been believed that dopamine antagonists, such as chlorpromazine, haloperidol, and thioridazine, are effective for the treatment of amphetamine psychosis. OBJECTIVES: To evaluate risks, benefits, costs of treatments for amphetamine psychosis. SEARCH STRATEGY: MEDLINE (1966-2007), EMBASE (1980-2007), CINAHL (1982-2007), PsychINFO (1806-2007), CENTRAL (Cochrane Library 2008 issue 1), references of obtained articles. SELECTION CRITERIA: All randomised controlled and clinical trials (RCTs, CCTs) evalu-

ating treatments (alone or combined) for people with amphetamine psychosis DATA COLLECTION AND ANALYSIS: Two authors evaluated and extracted the data independently. Dichotomous data were extracted on an intention-to-treat basis in which the dropouts were assigned as participants with the worst outcomes. The Relative Risk (RR) with the 95% confidence interval (95% CI) was used to assess the dichotomous data. The Weighted Mean Difference (WMD) with 95% CI was used to assess the continuous data. MAIN RESULTS: The comprehensive searches found one randomised controlled trial of treatment for amphetamine psychosis meeting the criteria for considering studies. The study involved 58 participants and compared the efficacy and tolerability of two antipsychotic drugs, olanzapine (a newer antipsychotic) and haloperidol (a commonly used antipsychotic medication used as a control condition), in treating amphetamine-induced psychosis. The results show that both olanzapine and haloperidol at clinically relevant doses were efficacious in resolving psychotic symptoms, with the olanzapine condition showing significantly greater safety and tolerability than the haloperidol control as measured by frequency and severity of extrapyramidal symptoms. AUTHORS' CONCLUSIONS: Only one RCT of treatment for amphetamine psychosis has been published. Outcomes from this trial indicate that antipsychotic medications effectively reduce symptoms of amphetamine psychosis, the newer generation and more expensive antipsychotic medication, olanzapine, demonstrates significantly better tolerability than the more affordable and commonly used medication, haloperidol.There are other two studies that did not meet the inclusion criteria for this review. The results of these two studies show that agitation and some psychotic symptoms may be abated within an hour after antipsychotic injection.Whether this limited evidence can be applied for amphetamine psychotic patients is not yet known.The medications that should be further investigate are conventional antipsychotics, newer antipsychotics and benzodiazepines. However, naturalistic studies of amphetamine psychotic symptoms and the prevalence of relapse to psychosis in the presence of amphetamine, are also crucial for advising the development of study designs appropriate for further treatment studies of amphetamine psychosis. [References: 39]

27. Srisurapanont M, Kittiratanapaiboon P, Jarusuraisin N. Treatment for amphetamine psychosis. Cochrane Database of Systematic Reviews 2001;(4):CD003026.
Abstract: BACKGROUND: During the phase of chronic, high-dose consumption of amphetamines, many amphetamine users may have the experience of paranoia and hallucination. It has long been believed that dopamine antagonists, such as chlorpromazine, haloperidol, and thioridazine, are effective for the treatment of amphetamine psychosis. OBJECTIVES: To search and determine risks, benefits, and costs of a variety treatments for amphetamine psychosis. SEARCH STRATEGY: Electronic searches of MEDLINE (1966-2000), EMBASE (1980-2000), CINAHL (1982- January 2001) and Cochrane Controlled Trials Register (Cochrane Library 2000 issue 4) were undertaken. References to the articles obtained by any means were searched. SELECTION CRITERIA: All relevant randomised controlled trials

(RCTs) and clinical trials (CCTs) were included. Participants were people with amphetamine psychosis, diagnosed by any set of criteria. Any kinds of biological and psychological treatments both alone and combined were examined. A variety of outcomes, for example, number of treatment responders, score changes, were considered. DATA COLLECTION AND ANALYSIS: Two reviewers evaluated and extracted the data independently. The dichotomous data were extracted on an intention-to-treat basis in which the dropouts were assigned as participants with the worst outcomes. The Relative Risk (RR) with the 95% confidence interval (95% CI) was used to assess the dichotomous data. The Weighted Mean Difference (WMD) with 95% CI was used to assess the continuous data. MAIN RESULTS: The comprehensive searches found no controlled trials of treatment for amphetamine psychosis meeting the criteria for considering studies. REVIEWER'S CONCLUSIONS: The evidence about the treatment for amphetamine psychosis is very limited. To our knowledge, no controlled trials of treatment for amphetamine psychosis have been carried out. The results of two studies in amphetamine users show that agitation and some psychotic symptoms may be abated within an hour after antipsychotic injection. Whether this limited evidence can be applied for amphetamine psychotic patients is not yet known. The risks and benefits of giving an antipsychotic injection should be further investigated in amphetamine psychotic patients. Medications that have been used for the treatment of acute exacerbation of schizophrenia should be studied in amphetamine psychotic patients. The medications that may be of interest are conventional antipsychotics, newer antipsychotics and benzodiazepines. However, naturalistic studies of amphetamine psychotic symptoms and course are also crucial for the development of study designs appropriate for further treatment studies of amphetamine psychosis. [References: 20]

## 4 Kontinuitet i behandlingen

28. Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: Systematic review and meta-regression. British Medical Journal 2007;335(7615):336-40.

Abstract: Objectives: To explain why clinical trials of intensive case management for people with severe mental illness show such inconsistent effects on the use of hospital care. Design: Systematic review with meta-regression techniques applied to data from randomised controlled trials. Data Sources: Cochrane central register of controlled trials, CINAHL, Embase, Medline, and PsychINFO databases from inception to January 2007. Additional anonymised data on patients were obtained for multicentre trials. Review methods: Included trials examined intensive case management compared with standard care or low intensity case management for people with severe mental illness living in the community. We used a fidelity scale to rate adherence to the model of assertive community treatment. Multicentre trials were disaggregated into individual centres with fidelity data specific for each centre. A multi-

variate meta-regression used mean days per month in hospital as the dependent variable. Results: We identified 1335 abstracts with a total of 5961 participants. Of these, 49 were eligible and 29 provided appropriate data. Trials with high hospital use at baseline (before the trial) or in the control group were more likely to find that intensive case management reduced the use of hospital care (coefficient -0.23, 95% confidence interval -0.36 to -0.09, for hospital use at baseline; -0.44, -0.57 to -0.31, for hospital use in control groups). Case management teams organised according to the model of assertive community treatment were more likely to reduce the use of hospital care (coefficient-0.31, -0.59 to -0.03), but this finding was less robust in sensitivity analyses and was not found for staffing levels recommended for assertive community treatment. Conclusions: Intensive case management works best when participants tend to use a lot of hospital care and less well when they do not. When hospital use is high, intensive case management can reduce it, but it is less successful when hospital use is already low. The benefits of intensive case management might be marginal in settings that have already achieved low rates of bed use, and team organisation is more important than the details of staffing. It might not be necessary to apply the full model of assertive community treatment to achieve reductions in inpatient care

29. Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database of Systematic Reviews 2009;(1):CD005963. Abstract: BACKGROUND: An advance directive is a document specifying a person's preferences for treatment, should he or she lose capacity to make such decisions in the future. They have been used in end-of-life settings to direct care but should be well suited to the mental health setting. OBJECTIVES: To examine the effects of advance treatment directives for people with severe mental illness. SEARCH STRATEGY: We searched the Cochrane Schizophrenia Group's Register (February 2008), the Cochrane Library (Issue 1 2008), BIOSIS (1985 to February 2008), CINAHL (1982 to February 2008), EMBASE (1980 to February 2008), MEDLINE (1966 to February 2008), PsycINFO (1872 to February 2008), as well as SCISEARCH and Google - Internet search engine (February 2008). We inspected relevant references and contacted first authors of included studies. SELECTION CRITERIA: We included all randomised controlled trials (RCTs), involving adults with severe mental illness, comparing any form of advance directive with standard care for health service and clinical outcomes. DATA COLLECTION AND ANALYSIS: We extracted data independently. For homogenous dichotomous data we calculated fixed-effect relative risk (RR) and 95% confidence intervals (CI) on an intention-to-treat basis. For continuous data, we calculated weighted mean differences (WMD) and their 95% confidence interval again using a fixed-effect model. MAIN RESULTS: We were able to include two trials involving 321 people with severe mental illnesses. There was no significant difference in hospital admission (n=160, 1 RCT, RR 0.69 0.5 to 1.0), or number of psychiatric outpatient attendances between participants given advanced treatment directives or usual care. Similarly, no significant differences were found for compliance with treatment, self harm or number of arrests. Partici-

pants given advanced treatment directives needed less use of social workers time (n=160, 1 RCT, WMD -106.00 CI -156.2 to -55.8) than the usual care group, and violent acts were also lower in the advanced directives group (n=160, 1 RCT, RR 0.27 CI 0.1 to 0.9, NNT 8 CI 6 to 92). The number of people leaving the study early were not different between groups (n=321, 2 RCTs, RR 0.92 CI 0.6 to 1.6). AUTHORS' CONCLUSIONS: There are too few data available to make definitive recommendations. More intensive forms of advance directive appear to show promise, but currently practice must be guided by evidence other than that derived from randomised trials. More trials are indicated to determine whether higher intensity interventions, such as joint crisis planning, have an effect on outcomes of clinical relevance. [References: 86]

30. Hewitt J, Coffey M. Therapeutic working relationships with people with schizophrenia: literature review. Journal of Advanced Nursing 2005;52(5):561-70.
Abstract: AIM: The aim of this paper is to review the evidence for the necessity and sufficiency of therapeutic relationships when working with people with enduring mental health problems, such as schizophrenia. BACKGROUND:The value of therapeutic relationships in mental health nursing has been the subject of some debate within the profession. This debate has centred on the spectrum of beliefs about therapeutic relationships, ranging from the position that the relationship is both necessary and sufficient to enable change, to more technical approaches, to therapeutic intervention which de-emphasises the influence of the relationship. METHODS: Searches for published material in English between 1986 and 2003 were carried out using the following databases: Cumulative Index of Nursing and Allied Health Literature; MEDLINE; Applied Social Sciences Index and Abstracts; Sociological abstracts; and social service abstracts. The search terms were: therapeutic alliance; therapeutic relationship; working alliance; and nurse-patient relationships. Papers chosen for inclusion in the review were those with a research focus on the elements and potential benefits/costs of therapeutic relationships in nursing. RESULTS: People who experience a relationship as being therapeutic appear to have better outcomes. A consistent finding of a number of meta-analyses is that therapeutic relationships characterized by facilitative and positive interpersonal relationships with the helper have in-built benefits, and that this is an important element of advanced techniques. In order for cognitive behavioural therapy to be successful, people need to feel understood and involved in the therapeutic relationship. CONCLUSION: Therapeutic relationships are necessary but not sufficient to enable change when working with people with schizophrenia. [References: 70]

31. Malone D, Newron-Howes G, Simmonds S, Marriot S, Tyrer P. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. Cochrane Database of Systematic Reviews 2007;(3):CD000270.
Abstract: BACKGROUND: Closure of asylums and institutions for the mentally ill, coupled with government policies focusing on reducing the number of hospital beds for people with severe mental illness in favour of providing care in a variety of non-

hospital settings, underpins the rationale behind care in the community. A major thrust towards community care has been the development of community mental health teams (CMHT). OBJECTIVES: To evaluate the effects of community mental health team (CMHT) treatment for anyone with serious mental illness compared with standard non-team management. SEARCH STRATEGY: We searched The Cochrane Schizophrenia Group Trials Register (March 2006). We manually searched the Journal of Personality Disorders, and contacted colleagues at EN-MESH, ISSPD and in forensic psychiatry. SELECTION CRITERIA: We included all randomised controlled trials of CMHT management versus non-team standard care. DATA COLLECTION AND ANALYSIS: We extracted data independently. For dichotomous data we calculated relative risks (RR) and their 95% confidence intervals (CI) on an intention-to-treat basis, based on a fixed effects model. We calculated numbers needed to treat/harm (NNT/NNH) where appropriate. For continuous data, we calculated weighted mean differences (WMD) again based on a fixed effects model. MAIN RESULTS: CMHT management did not reveal any statistically significant difference in death by suicide and in suspicious circumstances (n=587, 3 RCTs, RR 0.49 CI 0.1 to 2.2) although overall, fewer deaths occurred in the CMHT group. We found no significant differences in the number of people leaving the studies early (n=253, 2 RCTs, RR 1.10 CI 0.7 to 1.8). Significantly fewer people in the CMHT group were not satisfied with services compared with those receiving standard care (n=87, RR 0.37 CI 0.2 to 0.8, NNT 4 CI 3 to 11). Also, hospital admission rates were significantly lower in the CMHT group (n=587, 3 RCTs, RR 0.81 CI 0.7 to 1.0, NNT 17 CI 10 to 104) compared with standard care. Admittance to accident and emergency services, contact with primary care, and contact with social services did not reveal any statistical difference between comparison groups. AUTHORS' CONCLUSIONS: Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. The evidence for CMHT based care is insubstantial considering the massive impact the drive toward community care has on patients, carers, clinicians and the community at large. [References: 119]

32. Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 2000;(2):CD001089. Abstract: BACKGROUND: Assertive Community Treatment (ACT) was developed in the early 1970s as a response to the closing down of psychiatric hospitals. ACT is a team-based approach aiming at keeping ill people in contact with services, reducing hospital admissions and improving outcome, especially social functioning and quality of life. OBJECTIVES: To determine the effectiveness of Assertive Community Treatment (ACT) as an alternative to i. standard community care, ii. traditional hospital-based rehabilitation, and iii. case management. For each of the three comparisons the main outcome indices were i. remaining in contact with the psychiatric services, ii. extent of psychiatric hospital admissions, iii. clinical and social outcome and iv. costs. SEARCH STRATEGY: Electronic searches of CINAHL (1982-1997), the

Cochrane Schizophrenia Group's Register of trials (1997), EMBASE (1980-1997), MEDLINE (1966-1997), PsycLIT (1974-1997) and SCISEARCH (1997) were undertaken. References of all identified studies were searched for further trial citations. SELECTION CRITERIA: The inclusion criteria were that studies should i. be randomised controlled trials, ii. have compared ACT to standard community care, hospital-based rehabilitation, or case management and iii. have been carried out on people with severe mental disorder the majority of whom were aged from 18 to 65. Studies of ACT were defined as those in which the investigators described the intervention as "Assertive Community Treatment" or one of its synonyms. Studies of ACT as an alternative to hospital admission, hospital diversion programmes, for those in crisis, were excluded. The reliability of the inclusion criteria were evaluated. DATA COLLECTION AND ANALYSIS: Three types of outcome data were available: i. categorical data, ii. numerical data based on counts of real life events (count data) and iii. numerical data collected by standardised instruments (scale data). Categorical data were extracted twice and then cross-checked. Peto Odds Ratios and the number needed to treat (NNT) were calculated. Numerical count data were extracted twice and cross-checked. Count data could not be combined across studies for technical reasons (the data were skewed) but all relevant observations based on count data were reported in the review. Numerical scale data were subject to a quality assessment. The validity of the quality assessment was itself assessed. Numerical scale data of suitable quality were combined using the standardised mean difference statistic where possible, otherwise the data were reported in the text or 'Other data tables' of the review. MAIN RESULTS: ACT versus standard community care Those receiving ACT were more likely to remain in contact with services than people receiving standard community care (OR 0.51, 99%CI 0.37-0.70). People allocated to ACT were less likely to be admitted to hospital than those receiving standard community care (OR 0.59, 99%CI 0.41-0.85) and spent less time in hospital. In terms of clinical and social outcome, significant and robust differences between ACT and standard community care were found on i. accommodation status, ii. employment and iii. patient satisfaction. There were no differences between ACT and control treatments on mental state or social functioning. ACT invariably reduced the cost of hospital care, but did not have a clear cut advantage over standard care when other costs were taken into account. ACT versus hospital-based rehabilitation services Those receiving ACT were no more likely to remain in contact with services than those receiving hospital-based rehabilitation, but confidence intervals for the odds ratio were wide. People getting ACT were significantly less likely to be admitted to hospital than those receiving hospital-based rehabilitation (OR 0.2, 99%CI 0.09-0.46) and spent less time in hospital. Those allocated to ACT were significantly more likely to be living independently (OR (for not living independently) 0.19, 99%CI 0.06-0. (A [References: 27]

33. Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. Cochrane Database of Systematic Reviews 2000;(2):CD000050.

Abstract: BACKGROUND: Since the 1960s, in many parts of the world, large psychiatric were closed down and people were treated in outpatient clinics, day centres or community mental health centres. Rising readmission rates suggested that this type of community care may be less effective than anticipated. In the 1970s case management arose as a means of co-ordinating the care of severely mentally ill people in the community. OBJECTIVES: To determine the effects of case management as an approach to caring for severely mentally ill people in the community. Case management was compared against standard care on four main indices: (i) numbers remaining in contact with the psychiatric services; (ii) extent of psychiatric hospital admissions; (iii) clinical and social outcome; and (iv) costs. SEARCH STRATEGY: Electronic searches of CINAHL (1997), the Cochrane Schizophrenia Group's Register of trials (1997), EMBASE (1980-1995), MEDLINE (1966-1995), PsycLIT (1974-1995) and SCISEARCH (1997) were undertaken. References of all identified studies were searched for further trial citations. SELECTION CRITERIA: The inclusion criteria were that studies should be randomised controlled trials that (i) had compared case management to standard community care; and (ii) had involved people with severe mental disorder mainly between the ages of 18-65. Studies of case management were defined as those in which the investigators described the intervention as 'case' or 'care' management rather than 'Assertive Community Treatment' or 'ACT'. DATA COLLECTION AND ANALYSIS: A study was carried out to test the reliability of the inclusion criteria. Categorical data were extracted twice and then cross-checked, any disagreements being resolved by discussion. Odds ratios and the number needed to treat were estimated. Continuous data collected by a measuring instrument was only included if the instrument (i) had been described in a peer-reviewed journal; (ii) was a self-report or had been completed by an independent rater; and (iii) provided a summary score for a broad area of functioning. Normally distributed continuous data were included if means and standard deviations were available. Non-normal data were included if analysed either after transformation or using non-parametric methods. Tests for heterogeneity were conducted. MAIN RESULTS: Case management increased the numbers remaining in contact with services (for case management odds ratio = 0.70; 99%CI 0.50-0. 98; n=1210). Case management approximately doubled the numbers admitted to psychiatric hospital (OR 1.84; 99% CI 1.33-2.57; n=1300). Except for a positive finding on compliance, from one study, case management showed no significant advantages over standard care on any psychiatric or social variable. Cost data did not favour case management but insufficient information was available to permit definitive conclusions. REVIEWER'S CONCLUSIONS: Case management ensures that more people remain in contact with psychiatric services (one extra person remains in contact for every 15 people who receive case management), but it also increases hospital admission rates. Present evidence suggests that case management also increases duration of hospital admissions, but this is not certain. Whilst there is some evidence that case management improves compliance, it does not produce clinically significant improvement in mental state, social functioning, or quality of life. There is no evidence that case management improves outcome on any other clinical or social variables. Present

evidence suggests that case management increases health care costs, perhaps substantially, although this is not certain. In summary, therefore, case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services. It is hard to see how policy makers who subscribe to an evidence-based approach can justify retaining case management as 'the cornerstone' of community mental hea [References: 17]

34. Mitton CR, Adair CE, McDougall GM, Marcoux G. Continuity of care and health care costs among persons with severe mental illness (Brief record). Psychiatric Services 2005;56:1070-6.

35. NHS Centre for Reviews and Dissemination. Psychosocial interventions for schizophrenia (DARE structured abstract). York: Centre for Reviews and Dissemination (CRD) 2000;8.

36. Penn DL, Waldheter EJ, Perkins DO, Mueser KT, Lieberman JA. Psychosocial treatment for first-episode psychosis: a research update. American Journal of Psychiatry 2005;162(12):2220-32.
Abstract: OBJECTIVE: This article reviews research on psychosocial treatment for first-episode psychosis. METHOD: PsycINFO and MEDLINE were systematically searched for studies that evaluated psychosocial interventions for first-episode psychosis. RESULTS: Comprehensive (i.e., multielement) treatment approaches show promise in reducing symptoms and hospital readmissions, as well as improving functional outcomes, although few rigorously controlled trials have been conducted. Individual cognitive behavior therapy has shown modest efficacy in reducing symptoms, assisting individuals in adjusting to their illness, and improving subjective quality of life, but it has shown minimal efficacy in reducing relapse. Some controlled research supports the benefits of family interventions, while less controlled research has evaluated group interventions. CONCLUSIONS: Adjunctive psychosocial interventions early in psychosis may be beneficial across a variety of domains and can assist with symptomatic and functional recovery. More randomized, controlled trials are needed to evaluate the effectiveness of these interventions, particularly for multielement, group, and family treatments. [References: 100]

37. Taylor TL, Killaspy H, Wright C, Turton P, White S, Kallert TW, et al. A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. BMC Psychiatry 2009;9:55.
Abstract: Background: A proportion of people with mental health problems require longer term care in a psychiatric or social care institution. However, there are no internationally agreed quality standards for institutional care and no method to assess common care standards across countries. Methods: We aimed to identify the key components of institutional care for people with longer term mental health problems and the effectiveness of these components. Results: We undertook a systematic

review of the literature using comprehensive search terms in 11 electronic databases and identified 12,182 titles. We viewed 550 abstracts, reviewed 223 papers and included 110 of these. A "critical interpretative synthesis" of the evidence was used to identify domains of institutional care that are key to service users' recovery. Conclusion: We identified eight domains of institutional care that were key to service users' recovery: living conditions; interventions for schizophrenia; physical health; restraint and seclusion; staff training and support; therapeutic relationship; autonomy and service user involvement; and clinical governance. Evidence was strongest for specific interventions for the treatment of schizophrenia (family psychoeducation, cognitive behavioural therapy (CBT) and vocational rehabilitation). Institutions should, ideally, be community based, operate a flexible regime, maintain a low density of residents and maximise residents' privacy. For service users with a diagnosis of schizophrenia, specific interventions (CBT, family interventions involving psychoeducation, and supported employment) should be provided through integrated programmes. Restraint and seclusion should be avoided wherever possible and staff should have adequate training in de-escalation techniques. Regular staff supervision should be provided and this should support service user involvement in decision making and positive therapeutic relationships between staff and service users. There should be clear lines of clinical governance that ensure adherence to evidence-based guidelines and attention should be paid to service users' physical health through regular screening. copyright 2009 Taylor et al; licensee BioMed Central Ltd

38. Udechuku A, Olver J, Hallam K, Blyth F, Leslie M, Nasso M, et al. Assertive community treatment of the mentally ill: service model and effectiveness (DARE structured abstract). Australasian Psychiatry 2005;13:129-34.

## BESTILLING – PICO

### 1 Nettverkstilnærminger

P: Mennesker med første episode ikke-affektive psykoselidelser (og evt med gjentatte episoder), F20-29 (ICD 10) og 295, 297, 298 (DSM IV) i alle aldre
I: Nettverksarbeid (a.m Seikkula) (open dialogue approach)
C: Treatment as usual (TAU)
O: Større andel av pasientene oppnår remisjon innen ett år etter index behandlingskontakt, lavere tilbakefallsprosent (relapse), bedre livskvalitet, færre innleggelser/innleggelsesdøgn, mindre bruk av tvang/tvangsinnleggelser, mindre bruk av medikamenter, høyere grad av tilfredshet med behandlingen, høyere grad av deltakelse i arbeidslivet

## 2 Boligoppfølging

P: Mennesker med gjentatte episoder ikke-affektive psykoselidelser, F20-29 (ICD 10) og 295, 297, 298 (DSM IV) i alle aldre.
I: Supported housing
C: Treatment as usual (TAU)
O: Mindre symptombelastning, bedre livskvalitet, færre innleggelser/innleggelsesdøgn per år, mindre bruk av tvang/tvangsinnleggelser, høyere grad av tilfredshet med behandlingen, høyere grad av deltakelse i arbeidslivet

## 3 Psykososiale tiltak for rusinduserte psykoser

P: Alle individer diagnostisert med F 19.x5 (ICD 19); 291.3,291.5 og 292.1 (DSM IV) rusinduserte psykoser for første gang.

I: alle former for medikamentelle og psykososiale tiltak

C: Her har vi ingen standard behandling å sammenlikne med, og ønsker egentlig de enkelte systematiserte behandlingstiltak som finnes (om noen?) sammenliknet innbyrdes.
O: Hvilken andel av pasientene oppnår remisjon innen ett år etter index behandlingskontakt, tilbakefallsprosent (relapse), livskvalitet, innleggelser/innleggelsesdøgn, bruk av tvang/tvangsinnleggelser, bruk av medikamenter, grad av tilfredshet med behandlingen, høyere grad av deltakelse i arbeidslivet?

## 4 Kontinuitet i behandlingen

P:
a. Mennesker med første episode ikke-affektive psykoselidelser, F20-29 (ICD 10); 295, 297, 298, (DSM IV) i alle aldre
b. Mennesker med gjentatte episoder av ikke-affektive psykoselidelser F20-29 (ICD 10); 295, 297, 298, (DSM IV) i alle aldre
c. Generelle pasientpopulasjoner på tvers av diagnosegrenser, mennesker med alvorlig psykiske lidelser som går i lengrevarende behandling i psykisk helsevern
I: Continuity of care (behandler-pasientrelasjonen[1])
C: Treatment as usual (TAU)
O: Større andel av pasientene oppnår remisjon innen ett år etter index behandlingskontakt, lavere tilbakefallsprosent (relapse), bedre livskvalitet, færre innleggelser/innleggelsesdøgn, mindre bruk av tvang/tvangsinnleggelser, mindre bruk av medikamenter, høyere grad av tilfredshet med behandlingen, høyere grad av deltakelse i arbeidslivet

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[1] Ønsker inklusjon slik at all forskning på kontinuitet i profesjonelle hjelperelasjoner overfor mennesker med psykoselidelser