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2017

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van Oenen, F. J. (2017). *Feedback Informed Treatment in emergency psychiatry, a poor FIT?*.

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*CHAPTER 8 INVOLVING
RELATIVES IN EMERGENCY
PSYCHIATRY*

**Involving relatives in emergency psychiatry;
an observational patient-control study in a crisis resolution
and home treatment team**

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Journal of Family Therapy, 2017, DOI:10.1111/1467-6427.12189, in press

Abstract

Background

The involvement of relatives is seen as important element of treatment in crisis resolution and home treatment teams.

Aim

To investigate the effects of involving relatives in treatment during a crisis situation.

Method

The outcomes for patients from a relatives-involved group (RIG) and relatives-not-involved group (RNIG) were compared. Relatives were provided with general information about the service and assessments, psycho-education and, in some cases, additional family interventions.

Results

Relatives were involved in the treatment of 168 of 263 patients (64 %). There were no significant differences between the RIG and RNIG in terms of mean scores for BSI (RIG at T12: 1.23, *SD* = 0.83; RNIG at T12: 1.19, *SD* = 0.85) or client satisfaction (total satisfaction score varied between 2.82 (*SD* = 0.74) and 3.13 (*SD* = 0.68) in RNIG and between 2.70 (*SD* = 0.76) and 2.86 (*SD* = 0.74) in RIG).

Conclusion

The involvement of relatives was achieved in the majority of cases. No link with outcomes was found. Since involvement of relatives was not randomised and the number and duration of contacts with relatives were limited, this finding should be interpreted cautiously.

Practitioner points

- Using a structured motivational model, it is possible to involve relatives in the treatment of psychiatric crisis patients in the majority of cases.
- There is no reason to be reticent about involving relatives in treatment, even if patients seem to be reluctant at first sight.
- Living alone was in this study identified as a negative predictor of family involvement

Introduction

Background and goals

Research has shown that collaboration with patients' relatives enhances treatment outcomes in psychiatric disorders (Lyman et al., 2014; McFarlane et al., 2003; Miklowitz et al., 2003; Liddle et al., 2009) resulting in fewer inpatient admissions, shorter inpatient stays and better quality of life reports by patients (Eassom et al., 2014). However, family involvement may not always improve results (Miklowitz, 2004) and involving relatives in an effective way takes time: Cuijpers (1999) found that interventions of less than ten sessions have no effect on the family burden, and Pitschel-Walz et al. (2001) found that family psychoeducational interventions are most effective when they last at least three months. Finally, data are lacking about relatives' emotional involvement as a predictor of who best responds to family-based interventions (Fredman et al., 2015). Notwithstanding these difficulties, international guidelines have been outlining in detail the importance of early family involvement for over fifteen years (APA, 2000; Multidisciplinaire richtlijn schizofrenie, 2012). However, despite the vast evidence base for family interventions, family involvement is often not implemented in routine mental health care (Eassom et al., 2014; Maybery et al., 2014; Kim and Salyers, 2008). Burbach and Stanbridge (2006) describe initiatives to make mental health services more family-/carer-friendly. They found that the successful implementation of family interventions can lead to a significant increase in confidence in skills for working with families, a modest increase in the average number of family meetings (Stanbridge et al., 2009) and – in in-patient wards for older people – a significant improvement in the number of carers registered and the number of carer assessments (Stanbridge et al., 2013). However, these projects did not measure the effect of the involvement of relatives on the well-being of patients or on the well-being of relatives.

Studies looking specifically at crisis resolution and home treatment teams (CRHT teams) (Murphy et al., 2012; Wheeler et al., 2015) have not specified the effect of the involvement of relatives either. Only one study (Cramer et al., 2009) reported specifically on this issue in an inpatient emergency setting. These authors found no improvement in outcome after implementing a systemic treatment model. To our knowledge, there have been no studies of the effect of collaboration with relatives on the symptoms and well-being of patients in CRHT teams. This observational study investigated, in a naturalistic emergency psychiatry setting in a population of patients with different diagnoses, to what extent the therapists of the CRHT team managed to involve relatives in treatment and whether the involvement of relatives affected treatment outcome. Outcome was measured as reduction of symptoms, improvement of well-being, number of sessions and patient satisfaction with treatment.

Method

Setting

The study setting was a crisis resolution and home treatment team (the 'CIBT Team') between September 2009 and May 2012. The CIBTT provides immediate assessments and - if needed - treatment in crisis situations in an area of Amsterdam, the Netherlands (with 200,000 inhabitants). The services are delivered on an outpatient basis. Patients are referred by GPs and mental health practitioners in the area. The treatment team includes nurses in community mental health, medical staff and family therapists. In most cases, psychiatrists examine the patients themselves. The CIBTT offers a flexible treatment programme based upon the principle of shared decision-making. The intensity and duration of the treatment can vary, with the maximum duration being 24 weeks. Treatment is based on a systemic model (Oenen et al., 2012) and a medical model.

A motivational model consisting of four steps was used to encourage relatives to get involved:

- 1) The referring professional was asked to encourage patients to bring a relative to the first session.
- 2) If no relative was present at the first session, patients were asked to invite a relative to the next session.
- 3) If patients were reluctant, they were actively encouraged to contact a relative.
- 4) When there were serious concerns about the safety of a patient, the therapist got in touch with relatives and invited them to a session, even when patients were reluctant.

All relatives were told that their presence was crucial if the therapist was to offer the best possible treatment.

Treatment approach

The organisation of the team resembles that of Assertive Community Treatment teams: intensive outreach care, partial sharing of caseloads, working in co-therapy and immediate availability. Since the target group consists of patients suffering from a variety of symptoms, the therapeutic approach also covers a broad range of interventions. The content of the method applied includes elements from family therapy, picking up on strengths and individual responsibilities in the system, and elements from the solution-driven approach. The attitude places a strong emphasis on motivational techniques.

Clients undergo standard psychiatric examination, psycho-education, supportive and structuring interventions and systemic interventions. Pharmacotherapy, a monitoring plan, change-oriented interventions or admission to a clinic are treatment options on offer.

Family involvement in mental health services can take different forms, depending on the level of need and availability of services. Generally, it can be conceived on a spectrum from more basic functions to specialised interventions, the minimal level including the provision of general information on the mental health service and assessments. On a more complex level, services can offer families psychoeducation of some sort or, family interventions and therapies (Mottagipur & Bickerton, 2005).

In all cases, the treatment in this study included the provision of general information and a form of family psycho-education. In some cases, there were family interventions focusing on the interactions and/or expressed emotions in the system.

Treatment is delivered in the community as much as possible. The basic philosophy of the CIBTT involves supplying 'system-oriented tailored care': the optimal combination and intensity of interventions is established for each client system. These can vary during the course of the treatment. Treatment continuity is a goal; treatment is delivered as much as possible by the same two therapists. The therapists come from different disciplines: doctors (residents), psychiatrists, psychologists and psychiatric nurses. The core team consists of experienced therapists. The team is supplemented by a group of residents that changes every six months. The primary focus of the treatment is to help clients regain a sense of mastery over their lives again.

Study design, randomisation and inclusion criteria

All patients referred to the CIBTT in the study period who continued treatment at the CIBTT after two assessment sessions were included.

Informed consent and data security

This study is based on data from a randomised controlled trial focusing on the effect of feedback (Oenen et al., 2013; Oenen et al., 2016). The study procedure and informed consent procedure were endorsed by the Medical Ethics Committee for Mental Health Care Institutions.

Measures

Independent variables

The data collected at baseline (the first emergency consultation) were: age, gender, domestic situation and ethnicity. A psychiatrist determined the main DSM IV diagnostic category during intake. A record was also made of the service that referred the patient to the CIBTT team.

Clinical Global Impression scale

The Clinical Global Impression (CGI) (Guy, 1976) consists of two questions to be completed by the therapist and provides a short global assessment.

The Brief Symptom Inventory (BSI)

The BSI (22 Boulet and Boss, 1991) is the concise version of the Symptom Checklist 90 (53 statements) for measuring symptoms of psychopathology in adults. Patients rate their level of distress during the past week for each of 18 symptoms using a 5-point Likert-type scale. The total score may vary from 0 to 4 points. A higher score reflects greater distress. The reliability (alpha coefficient) of the Dutch version of the scale as a whole is .96 (De Beurs and Zitman, 2006).

Outcome Questionnaire 45 (OQ45)

The OQ45 (Lambert and Burlingame, 1996) consists of 45 statements in three subscales that assess symptom distress (SD), social-role functioning (SR) and interpersonal relationships (IR). The total score may vary from 0 to 180 points. A higher score means a more severe situation. Internal consistency for the Total score of the Dutch OQ-45 ranges from 0.92 to 0.96 (Jong et al., 2007).

Satisfaction questionnaire

This is a short version of the Dutch Mental-Health-Thermometer (Trimbos Instituut, 2000), a questionnaire used to measure patient satisfaction in regular mental health care. The first author devised this short version because it was assumed that patients in emergency psychiatry would not have the patience to complete a lengthy questionnaire. Satisfaction about the four main items of the original questionnaire, ‘information’, ‘shared decision-making’, ‘therapist’ and ‘result’ were scored on a five-point Likert scale. The total score may vary from 0 to 4 points. As the questionnaire was developed specifically for this study, reliability and validity were not established.

Outcome measurement

The number of therapy sessions and the duration of treatment were taken from the patient registration systems of Arkin Mental Health Care in Amsterdam. The link to the database of this system was established with an encrypted code. The CGI, BSI and OQ45 and Satisfaction questionnaires were completed at baseline and every other six weeks during a maximum period of 24 weeks. There was follow-up measurement three months after closing.

Data analysis

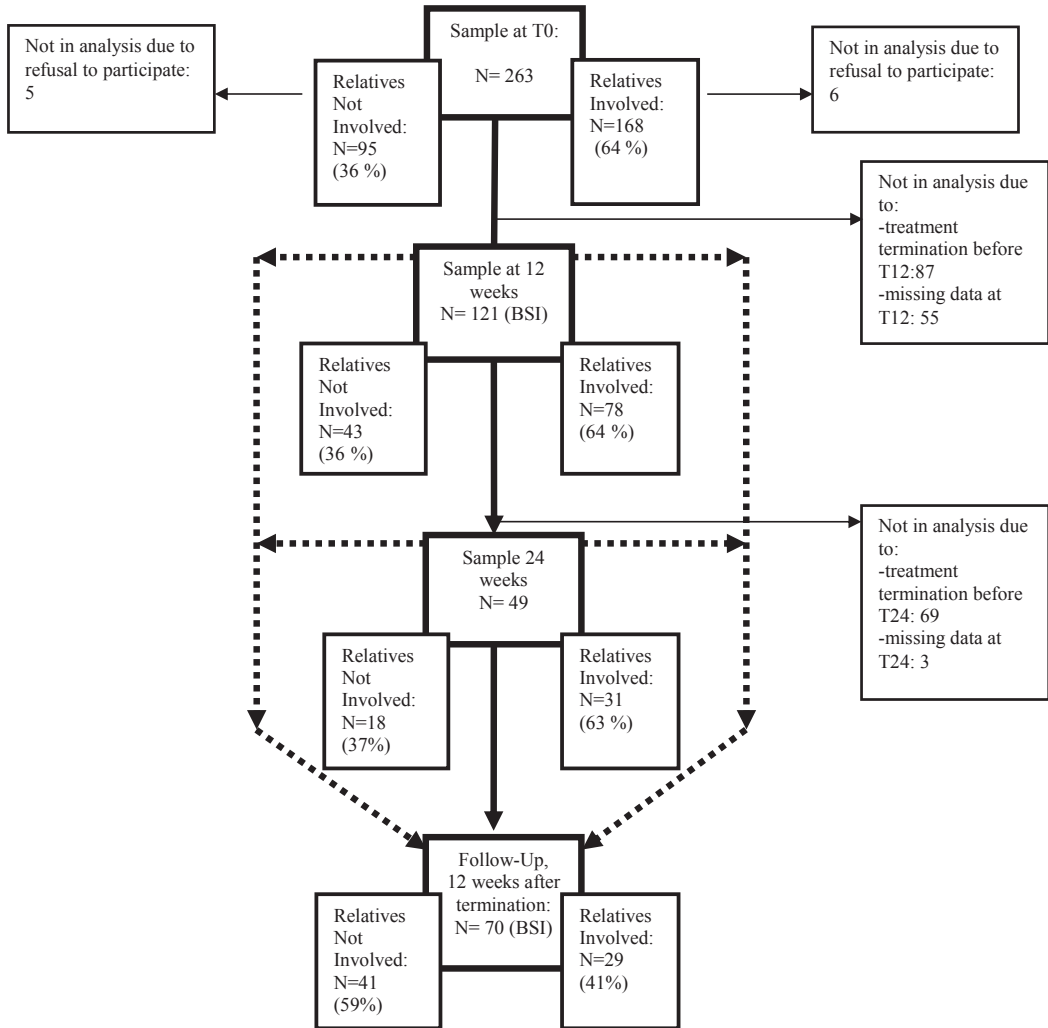
The outcomes of RNIG and RIG were compared using the repeated-measures General Linear Model (GLM) with conditions and the number of sessions as the covariates. Subsequent measurements were compared separately with the baseline measurement. Analyses on BSI, OQ45 and satisfaction scores were performed on an imputed dataset. All variables included in this study were used as predictors to create 50 imputed datasets. Satisfaction scores in RIG and RNIG were compared using the Mann-Whitney U-test. Analyses of baseline characteristics, number of sessions and duration of treatment were performed on the observed data set only. All statistical analyses were executed in SPSS 22.0. A significance level of $p < .05$ was used.

Results

Composition of study sample and treatment termination during follow-up

Between 2009 and 2012, a total of 861 patients were referred to the CIBTT, and 335 patients who were unable to fill out a questionnaire at intake or who terminated treatment before the first measurement at six weeks were excluded (figure 1).

Figure 1: Participant flow



A group of 263 patients were offered only a diagnostic evaluation that resulted in either immediate admission to a psychiatric hospital or referral to the patient's own general practitioner/ therapist (when no indication for acute psychiatric help was found). The final study sample included 263 patients whose crisis intervention was followed by brief therapy (defined as more than two sessions including the crisis evaluation sessions). Testing for selective drop-out between the total group and the final study sample showed no differences for any of the baseline characteristics.

Since 87 patients (33%) terminated treatment before T12, 40 (15 %) did not complete the questionnaires at T12 and 15 patients (6 %) refused to participate, a total of 121 patients were participating at 12 weeks. At 24 weeks, 49 patients were participating. A follow-up measurement three months after treatment terminated was completed by 70 patients.

Baseline characteristics, number of sessions and duration of treatment

It proved to be impossible to involve the relatives of 95 (36 %) of the 263 patients; 168 patients (64 %) did have relatives involved in their treatment. Bivariate analyses with Pearson chi-square tests of independence for counts and ANOVA for means were conducted to examine differences between the RIG group and RNIG group, involving baseline functioning scores (BSI, OQ45, CGI), age, gender, cultural background, living situation, diagnosis and referring service or person.

This analysis showed three significant differences in characteristics between RNIG and RIG: in the RIG, more patients were younger than 22 years ($X^2(4)$, $N=263$, 13.64 , $p = .009$) and older than 50 years, and fewer patients were living alone ($X^2(5)$, $N=263$, 16.37 , $p = 0.006$) than in RNIG. Patients in RIG were also referred by their GP ($X^2(6)$, $N=263$, 14.30 , $p = .026$) more often than those in RNIG. On average, patients suffered from severe distress (the mean BSI score was 1.83 at T0).

The mean duration of treatment in the total group was 105 days ($SD = 51.56$; range 10-231 days). The mean number of treatment sessions offered to all patients was 7.6 ($SD = 4.84$); 174 patients (66.2 %) completed their treatment within eight sessions. A relative attended 44.1 % of the sessions in the RIG (mean percentage per treatment), with a mean of 3.2 ($SD = 2.7$) sessions with relatives per treatment. The mean satisfaction score in the total group varied at different time points between 2.76 ($SD = 0.79$) and 2.91 ($SD = 0.71$) on a scale from 0 to 4. Finally, significant improvement was found for BSI and the OQ45 scales (analysis on imputed data) in the full sample at six weeks.

Involvement of relatives and improvements in well-being and symptoms

Comparison of the mean total BSI and OQ45 scores for RNIG and RIG on the basis of imputed data analysis showed no significant difference at any measurement point ($p \geq .05$ for all measurements)(table 1).

Table 1

Outcome according to involvement of relatives: total scores for BSI and OQ45
(means of observed cases, analyses on imputed data)

Time (wks)	Relatives Not Involved (RNIG)		Relatives Involved (RIG)		Total		RNIG versus RIG	RIG 1 versus RIG 3 ¹
BSI								
	<i>N</i>	Mean(<i>SD</i>)	<i>N</i>	Mean(<i>SD</i>)	<i>N</i>	Mean(<i>SD</i>)	Δ^3 (se), F (df) ⁵ , <i>p</i>	Δ (se), F (df), <i>p</i>
0	95	1.80(0.88)	168	1.84(0.87)	263	1.83(0.87)	$\Delta = .02$ (.11), F(1,259) = .023, $p > .05$	$\Delta = .10$ (.18), F(1,105) = .288, $p > .05$
6	57	1.40(0.87)	120	1.42(0.88)	177	1.41(0.87)	$\Delta = -.04$ (.10), F(1,259) = .387, $p > .05$	$\Delta = -.12$ (.15), F(1,105) = .977, $p > .05$
12	43	1.19(0.85)	78	1.23(0.83)	121	1.21(0.84)	$\Delta = -.03$ (.13), F(1,259) = .509, $p > .05$	$\Delta = -.04$ (.20), F(1,105) = .323, $p > .05$
18	20	1.33(0.95)	48	1.27(0.76)	68	1.29(0.81)	$\Delta = -.04$ (.12), F(1,259) = .657, $p > .05$	$\Delta = -.05$ (.19), F(1,105) = .483, $p > .05$
24	18	1.19(0.89)	31	1.27(0.6)	49	1.00(0.72)	$\Delta = -.04$ (.13), F(1,259) = .606, $p > .05$	$\Delta = .01$ (.20), F(1,105) = .366, $p > .05$
FU ²	29	1.16(0.75)	41	.82(.77)	70	.96(.77)	$\Delta = -.04$ (.13), F(1,259) = .614, $p > .05$	$\Delta = -.09$ (.21), F(1,105) = .898, $p > .05$
OQ45								
	<i>N</i>	Mean(<i>SD</i>)	<i>N</i>	Mean(<i>SD</i>)	<i>N</i>	Mean(<i>SD</i>)	Δ (se), F (df), <i>p</i>	Δ (se), F (df), <i>p</i>
0	78	91.4(28.68)	141	92.4(28.68)	219	92.04(28.62)	$\Delta = .67$ (3.47), F(1,259) = .046, $p > .05$	$\Delta = 1.38$ (5.31), F(1,105) = .074, $p > .05$
6	45	81.29(29.57)	86	85.33(29.37)	131	83.94(29.93)	$\Delta = 1.01$ (3.14), F(1,259) = .342, $p > .05$	$\Delta = -3.27$ (4.76), F(1,105) = .976, $p > .05$
12	29	77.87(32.97)	66	79.51(25.43)	95	79.01(27.78)	$\Delta = .04$ (3.98), F(1,259) = .608, $p > .05$	$\Delta = -3.61$, F(1,105) = .9861, $p > .05$
18	11	85.28(32.3)	34	76.05(31.11)	45	78.31(31.29)	$\Delta = -1.49$ (3.83), F(1,259) = .727, $p > .05$	$\Delta = -3.64$ (5.83), F(1,105) = .778, $p > .05$
24	12	67.82(33.6)	22	69.7(27.31)	34	69.04(29.19)	$\Delta = -.59$ (3.91), F(1,259) = .487, $p > .05$	$\Delta = -.65$ (6.25), F(1,105) = .350, $p > .05$
FU ²	23	68.35(29.05)	35	57.73(30.19)	58	61.94(29.95)	$\Delta = -1.58$ (4.21), F(1,259) = .856, $p > .05$	$\Delta = -5.03$ (6.42), F(1,105) = 1.468, $p > .05$

Repeated Measures General Linear Model (GLM): condition and number of sessions as co-variables

¹ RI 1: in 1 session relatives involved; RI 3: relatives involved in more than 3 sessions

² FU: Follow-up, twelve weeks after terminating treatment

³ Δ : Pooled difference between means for groups

⁴ se: Pooled standard error of the difference between means of groups

⁵ df: degrees of freedom between groups

To see whether there was a correlation between the number of sessions with relatives and the outcome of treatment, we conducted a post-hoc analysis in which we distinguished between two RIG subgroups: a group of relatives involved in which there was only one session with relatives (RIG1) (N=57) and a group of relatives involved when there were three or more sessions with relatives (RIG3) (N=52). The outcomes for both subgroups were compared (GLM-analysis, subgroup as co-variable) and no differences were found here either (table 1). To show the significance of the differences in treatment gains for clinical practice, the final outcomes were broken down on the basis of the percentages of patients who did and did not benefit from treatment (on the basis of the BSI and OQ45 scores) at T12 and T24 (figure 2 and 3).

This involved calculating the effect sizes of the difference between baseline and follow-up measurements for each patient by dividing the differences found for the total scores by the standard deviation of the pre-treatment scores. A cut-off was established at an effect size of 0.3 on the basis of Cohen’s d (Cohen, 1988). Clients with an increase $> 0.3 SD$ on BSI or OQ45 total scores were classified as ‘improved’, clients with a change $\leq 0.3 SD$ and > -0.3 as ‘not changed’ and clients with an effect size $\leq -0.3 SD$ as ‘deteriorated’ (figure 2 and 3).

Figure 2: Percentage of clients with improvement, no change or deterioration on BSI scores (observed data)

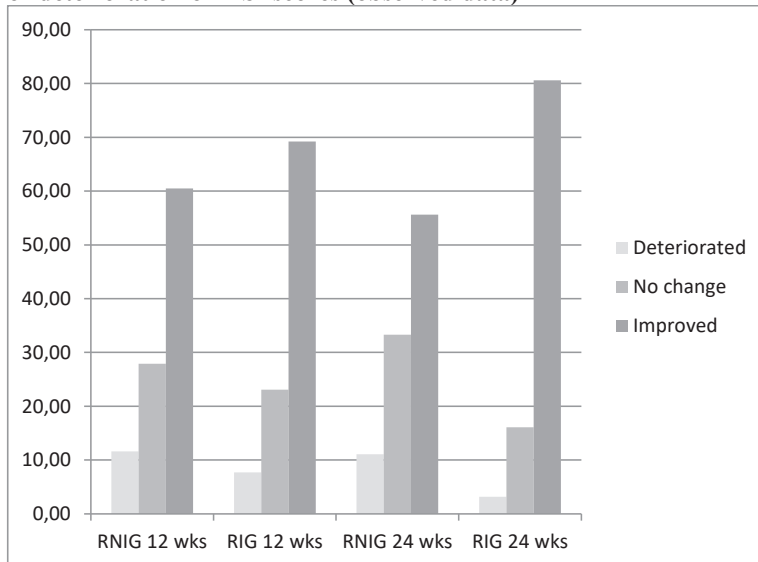
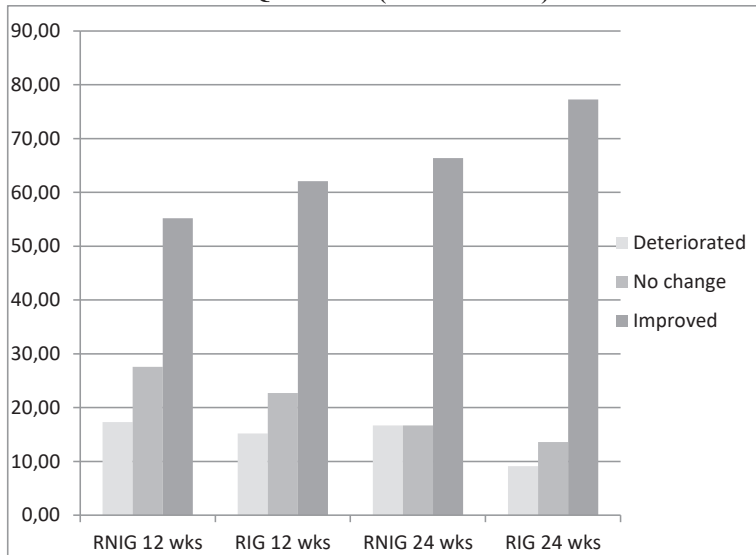


Figure 3: Percentage of clients with improvement, no change or deterioration on OQ45 scores (observed data)



Bivariate analysis with Pearson's chi-square test of independence

¹ Improved: increase > 0.30 SD on GSI or OQ45

² No change: improvement < 0.30 SD on GSI or OQ45

³ Deterioration: dropping > 0.30 SD on GSI or OQ45

Finally, effect sizes for changes in BSI and OQ45 scores at T12 and T24 were calculated for each of the two conditions and for the whole study sample, and the effect sizes for RIG and RNIG were compared using ANOVA, with conditions and the number of sessions as covariates (table 2). An imputed dataset was analysed.

Significant differences in treatment gains were not found between RIG and RNIG for either the BSI or OQ45 scores.

The same was true when patients were classified using the reliable change index (.35) for the BSI (table 2).

Table 2							
Comparison of effect sizes for BSI sum score (GSI) and OQ 45 sum score at different time points							
Time	RNIG		RIG		Total Group		Comparison RNIG/RIG (analysis on imputed data)
	N	ES (SD)	N	ES (SD)	N	ES (SD)	Δ (se), F(df), p
Effect Size BSI							
12 wks	43	.57 (.839)	78	.74 (.937)	121	.69 (.903)	$\Delta = -.04$ (.15), F(1,259)= .509, $p > .05$
24 wks	18	.64 (.851)	31	1.01 (.957)	49	.87 (.929)	$\Delta = -.04$ (.15), F(1,259)= .606, $p > .05$
Effect Size OQ 45							
12 wks	29	.41 (.882)	66	.46 (.845), 66	95	.45 (.852)	$\Delta = .00$ (.15), F(1,259)= .608, $p > .05$
24 wks	12	.57 (.75)	22	.91 (1.05)	34	.79 (.953)	$\Delta = -.02$ (.15), F(1,259)= .487, $p > .05$

ANOVA with conditions and number of sessions as covariates
 Δ : pooled difference between ES of groups

Involvement of relatives and the duration and number of treatment sessions

A Mann-Whitney U-test was used to test the difference in mean duration (in days) and in the total number of treatment sessions between the RNIG and RIG. No significant differences were found in mean duration for RNIG (104 days, $SD = 52.10$) and RIG (107 days, $SD = 51.01$) ($U=8253$, $p = .645$).

A significant difference was found between the mean number of sessions in RIG (8.5, $sd 5.14$) and RNIG (6.0, $SD = 3.79$) ($U=10386$, $p \leq .001$), as well as a significant positive correlation between the number of sessions with relatives and the total number of sessions (Pearson's correlation .450, 95% [0.341 - 0.559], $p \leq .001$). This could indicate that the frequency of the involvement of relatives affects the number of sessions, or simply that treatment during multiple sessions is more likely to involve a relative at least once.

A sub-analysis did not show any correlation between the percentage of sessions with a relative and the mean number of sessions in the treatment as a whole (Pearson's correlation -.0460, 95%CI [-0.168 - 0.076], $p = .458$), suggesting that involvement of relatives does not affect the number of sessions.

Involvement of relatives and patient satisfaction with the treatment

The total satisfaction score varied at different time points between 2.82 ($SD = 0.74$) and 3.13 ($SD = 0.68$) in RNIG and between 2.70 ($SD = 0.76$) and 2.86 ($SD = 0.74$) in RIG. No differences were found in a comparison (using a Mann-Whitney U-test on an imputed dataset) of the scores for RIG and RNIG at T12 or at any other time point. A comparison of RIG 1 and RIG 3 did not show any differences either.

Discussion

It proved possible to involve relatives in treatment in about two-thirds of our cases. This may be considered a high percentage given the fact that family intervention in the treatment of, for instance, psychotic patients (a population that has been intensively studied in terms of family involvement) is startlingly under-implemented –clinical services manage to get only extremely low numbers of families actually involved (Eassom et al., 2014) – and the fact that patients may have scarce contact with their relatives (Harvey et al., 2001). However, it can equally be considered quite a low percentage given the fact that therapists in the CIBTT were strong advocates for the involvement of relatives. Harvey et al. (2001) found that it is hard to establish predictors of family involvement other than demographic factors. In our study, living alone was identified as a negative predictor of family involvement and the fact that half the patients in this Amsterdam cohort lived alone may have reduced the total percentage. Remarkably, in the cases where patients were referred directly by their GPs, more families participated than in cases where patients were referred by mental health services. This may reflect increased isolation from relatives in more chronic psychiatric patients. The mean number of sessions in RIG was higher than in RNIG. This was a naturalistic study and so no causal inferences can be made; a randomised trial would be needed to explore the nature of the relation between relative involvement and the number of sessions.

On the basis of our variables, we were not able to detect any improvement in treatment outcome associated with the involvement of relatives. In the context of an open naturalistic study, this finding should be interpreted cautiously. It could be attributed to the possibility that, after patients were encouraged to involve relatives, the wisest decision for a minority of patients may have been to continue treatment on an individual basis. Accordingly, involving relatives may be beneficial in about two-thirds of cases, with an individual approach working best for one-third of the patients. Also, it can be assumed that patients who insisted on not

having relatives involved were challenged to overcome the crisis without the help of relatives and that they may therefore have done better than they would have done in the absence of this challenge.

Limitations

First of all the involvement of relatives was not randomised and it reflected the actual availability and motivation of relatives. This factor may have affected our results. Secondly, the involvement of relatives was scored in a quantitative way only: the number of sessions attended by relatives. The quality of the relationship with the relatives and of the interaction was not measured. Thirdly, the duration of treatment and the number of treatment sessions offered were limited. Since two-thirds of patients completed their treatment within eight sessions, there was little opportunity to achieve substantial results. Also, the number of sessions with relatives may not have been enough to make a difference. Fourthly, follow-up was measured after three months only, while effects of family interventions sometimes emerge after a longer period (Couturier et al., 2013).

Fourthly, in the analysis at 12 weeks of mean BSI scores for observed cases in both groups (1.19 versus 1.23, $SD = 0.84$), the observed power (output SPSS) is .15. With the actual number of 121 observed cases at twelve weeks, a difference of .99 versus 1.43 could be detected with a statistical power of 80 %. With the actual number of 263 cases in the imputed dataset, a difference of 1.06 versus 1.36 (or more) could be detected with sufficient power. These figures indicate that relatively small differences will not be revealed in this sample. Finally, since this study did not measure the burden on relatives or the satisfaction of relatives, no conclusions can be drawn about the implications for them. It may be that the involvement of relatives was useful for these relatives, even if the patients themselves did not report a better outcome. Future research should include the evaluation of the outcome for relatives.

Strengths

This study has ecological validity since it was performed in a naturalistic setting and because it is unique, to our knowledge, in measuring both the actual involvement of relatives and the outcome of treatment in emergency psychiatry, and in examining the correlation between the two during treatment and in a follow-up measurement.

Since the same therapists operated in both groups, possible differences in therapist characteristics will not have been responsible for differences in outcome. The flip side to this strength is that the difference in the treatment approach between the two groups may have

been too small because even though virtually no relatives were present at the treatment sessions in RNIG, the therapists may have used a systemic frame of reference.

Conclusions

Using a structured motivational model, it was possible to involve relatives in the treatment of psychiatric crisis patients in about two-thirds of cases. In this open study, the outcomes of the treatment – including patient satisfaction – were the same after treatment with and without the involvement of relatives.

This suggests there is no reason to be reticent about involving relatives in treatment, even if patients seem to be reluctant at first sight. A randomised study will be required to determine whether involving relatives in treatment during a crisis situation has added value.

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