Svar från SBU:s upplysningstjänst nr UT202120 • **Diarienummer:** SBU 2021/152 • **Datum:** 6 september 2021

Självvald inläggning vid allvarlig psykisk sjukdom

Personer med allvarlig psykisk sjukdom och hög vårdkonsumtion kan själva välja att läggas in. Metoden innebär att en patient får möjlighet att identifiera sitt eget behov av sjukhusvård, och kan skriva in sig för en kortare vistelse på psykiatrisk vårdavdelning, utan att först bedömas av vårdpersonal. Metoden är ny och har implementerats i flera olika regioner i Skandinavien.

Fråga

> Vilka vetenskapliga studier finns om självvald inläggning på psykiatrisk vårdavdelning?
>
> *Frågeställare: Socialstyrelsen*

Sammanfattning

Självvald inläggning är en relativt ny vårdform som riktar sig till personer med allvarlig psykisk sjukdom och stort vårdbehov. Vården bygger på att ett kontrakt upprättas mellan vårdgivaren och patienten som innebär att patienten bedömer sitt eget behov av sjukhusvård och får möjlighet till kortare vistelse inom slutenvården utan att först bedömas av läkare.

Forskningen inom området är begränsad och de studier som finns är framför allt utförda i de skandinaviska länderna.

Upplysningstjänsten har efter litteratursökning, relevansgranskning och bedömning av risk för bias inkluderat en systematisk översikt från år 2015 i svaret. Översikten har brister i rapporteringen av litteratursökning samt i granskning och rapportering av de ingående studierna, men redovisas i svaret eftersom den bedöms ha identifierat den relevanta litteratur som fanns publicerad vid tidpunkten för sökningen. Författarna till översikten drog slutsatsen att för patienter med allvarlig psykisk sjukdom och hög vårdkonsumtion, kan självvald inläggning öka patienternas autonomi och minska den totala tiden patienten är inlagd. Översikten visar även att interventionen är uppskattat av patienterna. Författarna påpekar dock att de ingående studierna har lågt evidensvärde.

Upplysningstjänsten har även identifierat 27 primärstudier. Dessa har undersökt självvald inläggning i olika populationer av patienter med allvarliga psykiatriska

diagnoser och hög vårdkonsumtion. Primärstudier granskas inte med avseende på risk för bias av Upplysningstjänsten så de ingående primärstudierna kan ha högre risk för bias än de SBU inkluderar i andra rapporter. Studierna finns beskrivna i tabellform i Bilaga 2.

Faktaruta 1. Om SBU:s upplysningstjänst

- På SBU:s upplysningstjänst identifierar och redovisar vi systematiska översikter* som svar på en avgränsad fråga.
- Vi bedömer risken för bias (snedvridning eller systematiska fel) i systematiska översikter och presenterar författarnas slutsatser från översikter med låg eller måttlig risk för bias.
- I Upplysningstjänstens svar väger vi inte samman resultat eller bedömer grad av vetenskaplig tillförlitlighet.
- Upplysningstjänsten identifierar primärstudier då det är relevant men gör ingen bedömning av risk för bias hos dessa och av den anledningen presenteras inga resultat.
- Vid behov bedömer vi kvalitet och överförbarhet av resultat i hälsoekonomiska studier.

*Sammanställning av resultat från sådana studier som med systematiska och explicita metoder har identifierats, valts ut och bedömts kritiskt och som avser en specifikt formulerad fråga.

Bakgrund

Självvald inläggning (SI)[1] vid svåra psykiatriska tillstånd är en relativt ny vårdform där en patient själv kan bedöma sitt behov av sjukhusvård med möjlighet att skriva in sig själv till kortare vistelser i heldygnsvården. Förutsättningarna för inläggningen regleras i ett kontrakt som skapas vid ett vårdplaneringsmöte och innebär att kontraktsinnehavaren vid behov kan skriva in sig för en kortare vistelse (ofta runt tre dygn) på en psykiatrisk avdelning utan att det först krävs bedömning av vårdpersonal. Under vistelsen ingår oftast samtal med sköterskor och möjlighet att delta i aktiviteter på avdelningen, men förändringar i medicinering eller kontakt med psykiater ingår som regel inte.

Interventionen riktar sig till personer med ett stort vårdbehov på grund av allvarlig psykisk sjukdom, och har använts för patienter med psykossjukdom, ätstörningar, emotionell instabilitet och självskadebeteende. Att erbjuda personer med de här sjukdomstillstånden möjligheten att själva styra över inskrivningen syftar till att öka deras självbestämmande och förmåga att uppmärksamma signaler på försämring. Självvald inläggning beskrivs som en möjlighet för patienterna att få andrum och ger de personer som har ett kontrakt för inläggning en modell för krishantering. I förlängningen syftar vårdformen till att kunna föregå allvarliga försämringar och därigenom minska behov av tvångsvård och långvariga inskrivningar.

Svaret från SBU:s Upplysningstjänst utgår från ett regeringsuppdrag att bistå Socialstyrelsen med kunskapsunderlag till uppdraget ”Utvärdera det vetenskapliga stödet och den beprövade erfarenheten avseende metoden självvald inläggning” (Socialstyrelsens regleringsbrev för budgetåret 2021, S2019/04465, S2020/09593), samt ändring av regleringsbrev för budgetåret 2021 avseende Statens beredning för medicinsk och social utvärdering, ”Sammanställa det vetenskapliga underlaget avseende metoden självvald inläggning”, S2021/03115).

Avgränsningar

Upplysningstjänsten har gjort sökningar (se Bilaga 1) i databaserna CINAHL, Embase, MedLine, Psychology and Behavioral Sciences Collection, PsycInfo, Scopus och SocINDEX.

Upplysningstjänsten har tillsammans med frågeställaren formulerat frågan enligt följande PICO[2]:

[1] Andra benämningar är brukarstyrd inskrivning/brukerstyrt inleggelse (BI), Brief Admission/Patient-initiated brief admission (BA/PIBA), Patient-controlled admission (PCA), Self-referral to inpatient treatment (SRIT), Bed op recept (Säng på recept, BoR)

[2] PICO är en förkortning för patient/population/problem, intervention/index test, comparison/control (jämförelseintervention) och outcome (utfallsmått).

• Population: Personer med allvarlig psykisk sjukdom och/eller personal inom psykiatrisk vård
• Intervention: Självvald inläggning, en vårdform där patienten får ett kontrakt som ger tillgång till kortare inläggningar för vård på psykiatrisk avdelning utan att vårdbehovet först bedömts av vårdpersonal
• Control: Sedvanlig vård
• Outcome: Antal vårddygn, antal inläggningar, funktion i vardagen, livskvalitet (för patienter). Upplevelser och erfarenheter (för patienter och personal).

Både sammanställd forskning i form av systematiska översikter och primärstudier eftersöktes. För att vi skulle inkludera en artikel i svaret krävde vi att den var publicerad på engelska eller ett av de skandinaviska språken, samt publicerad i en vetenskaplig tidskrift och genomgått en peer-review.

Bedömning av risk för bias

I en systematisk översikt finns det risk för bias, det vill säga att resultatet blir snedvridet på grund av brister i avgränsning, litteratursökning och hantering av resultatet. Det är därför viktigt att granska metoden i en systematisk översikt. Två utredare bedömde risken för bias i översikterna med stöd av SBU:s granskningsmall för att översiktligt bedöma risken för snedvridning/systematiska fel hos systematiska översikter (Bilaga 5). Granskningsmallen har sex steg och bygger på frågorna i AMSTAR granskningsmall [1]. Om översikten inte uppfyllde kraven i ett steg bedömdes den inte vidare i efterföljande steg. En systematisk översikt har bedömts ha måttlig till låg risk för bias om den uppfyller alla kraven till och med steg 4 i SBU:s mall (Bilaga 5 och Faktaruta 2).

Faktaruta 2. Bedömning av risk för bias
Risken för bias avser den vetenskapliga kvaliteten hos en systematisk översikt och dess förmåga att besvara en viss fråga på ett tillförlitligt och transparent sätt. En översikt som bedömts ha låg till medelhög risk för bias uppfyller följande:

- En tydligt definierad frågeställning
- En välgjord litteratursökning som matchar frågeställningen och är dokumenterad så att den kan återskapas.
- Studiernas relevans har granskats av minst två personer oberoende av varandra
- De inkluderade studiernas resultat och karakteristika finns redovisade
- De inkluderade studiernas kvalitet har granskats och dokumenterats
- En sammanvägd beskrivning av resultatet finns gjord, antingen i form av metaanalys, metasyntes eller enbart beskrivning på det sätt som var lämpligast utifrån de inkluderade studierna.

Primärstudier bedöms inte för risk för bias av SBU:s upplysningstjänst eftersom det ställer krav på sakkunskap inom forskningsområdet. Det är därför möjligt att flera av de relevanta primärstudier som inkluderats i svaret kan ha högre risk för bias än de studier som SBU inkluderar i andra rapporter.

Resultat från sökningen

Upplysningstjänstens litteratursökning genererade totalt 1 516 artikelsammanfattningar (abstrakt) efter dubblettkontroll. Ytterligare 30 identifierades genom referenssökning. Ett flödesschema för urvalsprocessen visas i Bilaga 3. Två utredare på SBU läste alla artikelsammanfattningar och bedömde att 74 kunde vara relevanta. Dessa artiklar lästes i fulltext av två utredare och de artiklar som inte var relevanta för frågan exkluderades. Exkluderade artiklar finns listade i Bilaga 4.

En identifierad översikt var relevant för frågan. Två utredare på Upplysningstjänsten granskade översikten och bedömde att den hade hög risk för bias, det fanns brister i redovisningen av litteratursökningen och bedömning av risk för bias i ingående studier var bristfällig.

I svaret ingår även en lista med beskrivning av 27 primärstudier som är relevanta för frågan men som inte bedömts med avseende på risk för bias.

Systematiska översikter

SBU:s upplysningstjänst identifierade en relevant systematisk översikt av Strand och medarbetare publicerad år 2015 [2]. Översikten har brister i rapportering av litteratursökningsstrategin och bedömning och rapportering av de ingående studiernas risk för bias, vilket gör att den inte uppfyller kraven för måttlig risk för bias. Upplysningstjänsten har dock gjort bedömningen att översiktsförfattarna med sin sökning har identifierat den relevanta litteratur som fanns publicerad vid tidpunkten för sökningen, och inkluderar översikten då den översiktligt beskriver den då tillgängliga forskningen. Majoriteten av relevanta primärstudier har dock publicerats efter författarnas sökdatum (se Bilaga 2, Inkluderade primärstudier). Översiktsförfattarnas bedömning av risk för bias hos primärstudierna baseras främst på studietyp där alla ingående studier bedömts ha lågt evidensvärde vilket de också lyfter fram i sina slutsatser.

I översikten inkluderades sex artiklar som byggde på fyra studier med både kvantitativa och kvalitativa data (två av studierna är även inkluderade under rubriken Primärstudier och presenteras i Bilaga 2; övriga artiklar är rapporter eller publicerade i tidskrifter utan peer-review och presenteras inte). Patienter inkluderade i studierna var diagnostiserade med olika typer av allvarliga psykiska sjukdomstillstånd, som schizofreni och affektiva störningar, flera med samtidigt allvarligt missbruk. Modellen för självvald inläggning utgick från ett kontrakt som

sattes upp med patienten i samarbete med kontaktpersoner i öppenvården och personal från avdelningen som ansvarade för självvald inläggning. Kontraktshållaren kunde skriva in sig själv utan bedömning av personal och stanna på avdelningen i maximalt fem dagar. Patienterna togs emot alla dagar i veckan under dag- och kvällstid, men inte nattetid. I tre av fyra inkluderade studier användes en karantänperiod på två till tre veckor innan en ny inläggning kunde påbörjas. Platserna som reserverats för självvald inläggning var placerade på psykiatrisk vårdavdelning. Alla studier var utförda i Norge. Författarna konstaterade dock att självvald inläggning inte enbart prövats i Norge, utan även varit brett implementerat i Nederländerna, men utan att några uppföljande studier har publicerats.

Kvantitativa resultat

I studierna mättes och jämfördes kvantitativa utfall för studiedeltagare med tillgång till självvald inläggning jämfört med en kontrollperiod då deltagarna inte haft tillgång till självinläggning. Författarna redovisade en generell ökning av antalet inläggningar under perioden med självvald inläggning, men en minskning av den totala inläggningstiden, både frivillig och som resultat av tvångsåtgärder. Det är viktigt att notera att resultaten bygger på studier utan kontrollgrupp, vilket är en studietyp som inte lämpar sig för att bedöma effekt.

Kvalitativa resultat

Det kvalitativa materialet visade att patienterna upplevde att självvald inläggning ökade deras förmågor kopplade till områden som självkänsla, självkontroll och autonomi vilket också sågs som ett viktigt mål med interventionen. Artikelförfattarna menar även att insikt om sin sjukdom och att söka hjälp i tid är förmågor som kan påverkas positivt av självvald inläggning. En försvårande faktor för tidigt hjälpsökande i den konventionella inskrivningsmodellen har varit att tydliga och allvarliga sjukdomstecken och symtom har krävts för att patienterna ska skrivas in. Det har försvårat för patienterna att få tillgång till tidig vård, och mötet mellan patient och vårdpersonal före inskrivning har beskrivits av författarna som en maktkamp där patienten behöver uppvisa svåra symtom för att prioriteras för vårdplats i slutenvården. Genom att ta bort kravet på vårdpersonalens bedömning undveks maktkampen och självvald inläggning upplevdes stödja patienterna att identifiera tidiga symtom och att söka vård innan akutvård krävdes.

Författarna såg också att patienterna beskrev att den självvalda inläggningen fyllde en funktion som en möjlighet att komma bort från destruktiva situationer och miljöer. Vården erbjöd ett socialt sammanhang med meningsfulla aktiviteter med andra i liknande situation, vilket inte kunde tillgodoses genom öppenvården.

I studierna saknades däremot tydliga resultat på om möjligheten till självvald inläggning minskade förekomsten av sjukdomssymtom. Författarna konstaterade dock att det kan vara relevant att göra en distinktion mellan att tillfriskna från psykisk sjukdom och att fungera väl med psykisk sjukdom. Att fungera väl med

psykisk sjukdom inkluderar att patienterna förbättrar sin funktion i vardagen, och självvald inläggning stöder aspekter som autonomi och positiv självuppfattning som är beståndsdelar i att fungera väl med psykisk sjukdom.

I de inkluderade studierna ingick en karantänperiod mellan inläggningarna för att förhindra överanvändning av kontraktet. Författarna konstaterade att överanvändning inte verkar vara ett problem och att karantänsregler kan vara överflödiga.

Tabell 1. Inkluderade systematiska översikter /Table 1. Included systematic reviews

Included studies	Population/Intervention	Outcome and Results
Strand et al (2015) [2] Patient-controlled hospital admission in psychiatry: A systematic review		
6 publications (articles and reports) from 4 studies. 3 publications reporting quantitative data 5 publications reporting qualitative data **Setting:** Norway, all studies	**Population:** Patients with severe mental illness and previously high inpatient care consumption. **Intervention:** Patient-controlled admission to inpatient care. **Control comparison**: data from control period of similar length before intervention started.	**Number of admissions (total) control period vs intervention period** 2 studies: 1) During control period 46, during intervention period 70, change +52% 2) During control period 69, during intervention period 178, change +158% **Days/weeks in inpatient care, control period vs intervention period** 3 studies: 1) During control period 1560 days, during intervention period 684 days, change –56% 2) During control period 1099 days, during intervention period 854 days, change –22% 3) During control period 265 weeks, during intervention period 178 weeks, change –33% **Days/weeks in involuntary inpatient care** 2 studies:

Included studies	Population/Intervention	Outcome and Results
		1) During control period 122 days, during intervention period 47 days, change –61% 2) During control period 181 weeks, during intervention period 88 weeks, change –51% **Days/weeks in psychiatric emergency care** 2 studies: 1) During control period 198 days, during intervention period 52 days, change –74% 2) During control period 76 days, during intervention period 20 days, change –74%
Authors' conclusion: "This review shows that patient-controlled admission can be a successful concept in promoting patient autonomy and reducing the total time spent hospitalized when aimed at heavy consumers of psychiatric care." "However, available studies are small and quality of evidence is generally low."		

Primärstudier

SBU:s upplysningstjänst identifierade 27 primärstudier [3-29]. Dessa har undersökt självvald inläggning i olika populationer av patienter med allvarliga psykiska diagnoser och hög vårdkonsumtion. Primärstudierna finns beskrivna i Bilaga 2 uppdelat på kvantitativa studier med och utan kontrollgrupp, hälsoekonomiska studier samt kvalitativa studier med och utan kontrollgrupp som undersökt upplevelser och erfarenheter hos både patienter och vårdpersonal. En översiktlig beskrivning av vilken studiedata som undersökts och analyserats finns i Tabell 2. Två av primärstudierna [12, 21] är även inkluderade i översikten av Strand och medarbetare som redovisats ovan.

Tabell 2. Översiktlig beskrivning av inkluderade primärstudier

Clinical trials and published studies	Quantitative data	Controlled[a]	Qualitative data
Akershus University Hospital Patient controlled admission (PCA) study, Norway			
Nyttingnes et al, 2020, [18]	x		
Nyttingnes et al, 2021, [19]	x		

Clinical trials and published studies	Quantitative data	Controlled[a]	Qualitative data
Brief Admission Skåne randomized controlled trial (BASRCT), Sweden			
Helleman et al, 2018, [11]			x
Lindkvist et al, 2019, [13]			x
Westling et al, 2019, [29]	x	x	
Lindkvist et al, 2021, [14]			x
Brief admission (BA) intervention Stockholm, Sweden			
Eckerström et al, 2019, [4]			x
Eckerström et al, 2020, [5]			x
Self-admission (SA) study. Stockholm Centre for Eating Disorders (SCÄ), Sweden			
Strand et al, 2017a, [26]			x
Strand et al, 2017b, [27]			x
Strand et al, 2020, [24]	x	x	
Strand et al, 2021, [25]	x		
Patient controlled admission study (PCA), Denmark			
Ellegaard et al, 2017a, [6]	x		
Ellegaard et al, 2017b, [7]	x		
Ellegaard et al, 2018, [8]			x
Thomsen et al, 2018, [28]	x	x	
Ellegaard et al, 2020, [9]			x
Self-referral to inpatient treatment (SRIT) study, Norway			
Rise et al, 2014*, [21]		x	x
Moljord et al, 2016, [15]	x	x	
Olsø et al, 2016, [20]			x
Moljord et al, 2017, [16]	x	x	
Sigrunarson et al, 2017, [22]	x	x	
Single publication studies			
Cotgrove et al, 1995, [3]	x	x	
Helleman et al, 2014, [10]			x
Heskestad et al, 2008*, [12]	x		
Mortimer-Jones et al, 2019, [17] (details in Mortimer-Jones 2016 [30])			x
Skott et al, 2021, [23]	x		

*Included in Strand et al, 2015, [2]
[a]Clinical study with a separate control group

Projektgrupp

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Bilaga 1 Sökdokumentation

Multi-database searching: CINAHL, Psychology and Behavioral Sciences Collection, PsycINFO, SocINDEX via EBSCO 24 June 2021

Title: Brief Admission

Search terms		Items found
Intervention:		
1.	TI (((brief OR "patient controlled" OR "patient guided") N3 admission*)) OR AB (((brief OR "patient controlled" OR "patient guided") N3 admission*)) OR SU (((brief OR "patient controlled" OR "patient guided") N3 admission*))	231
2.	TI (admission* N1 contract*) OR AB (admission* N1 contract*) OR SU (admission* N1 contract*)	22
3.	TI "self admission*" OR AB "self admission*" OR SU "self admission*"	33
4.	TI (("self referral*" OR selfreferral*) AND ("mental health" OR psychiatr* OR admission*)) OR AB (("self referral*" OR selfreferral*) AND ("mental health" OR psychiatr* OR admission*)) OR SU (("self referral*" OR selfreferral*) AND ("mental health" OR psychiatr* OR admission*))	373
5.	TI (((crisis N3 admission*) AND ("mental health" OR psychiatr* OR inpatient))) OR AB (((crisis N3 admission*) AND ("mental health" OR psychiatr* OR inpatient))) OR SU (((crisis N3 admission*) AND ("mental health" OR psychiatr* OR inpatient)))	155
6.	TI (((brief N1 hospitalization) AND ("mental health" OR psychiatr* OR admission*))) OR AB (((brief N1 hospitalization) AND ("mental health" OR psychiatr* OR admission*))) OR SU (((brief N1 hospitalization) AND ("mental health" OR psychiatr* OR admission*)))	177
Combined sets:		
7.	1 OR 2 OR 3 OR 4 OR 5 OR 6	
Final result		
8.		**957**

AB = Abstract; **AU** = Author; **DE** = Term from the thesaurus; **MH**= Exact Subject Heading from CINAHL Subject Headings; **MM** = Major Concept; **TI** = Title; **TX** = All Text. Performs a keyword search of all the database's searchable fields; **ZC** = Methodology Index; ***** = Truncation; **" "** = Citation Marks; searches for an exact phrase; **N** = Near Operator (N) finds the words if they are a maximum of x words apart from one another, regardless of the order in which they appear.; **W** = Within Operator (W) finds the words if they are within x words of one another, in the order in which you entered them.

Embase via Elsevier 24 June 2021

Title: Brief Admission

Search terms		Items found
Intervention:		
1.	((brief NEAR/2 hospitalization):ti,ab,kw) AND ('mental health':ti,ab,kw OR psychiatr*:ti,ab,kw OR admission*:ti,ab,kw)	275
2.	(admission* NEAR/2 contract*):ti,ab,kw	54
3.	'self admission*':ti,ab,kw	35
4.	('self referral*':ti,ab,kw OR selfreferral*:ti,ab,kw) AND ('mental health':ti,ab,kw OR psychiatr*:ti,ab,kw OR admission*:ti,ab,kw)	361
5.	((crisis NEAR/4 admission*):ti,ab,kw) AND ('mental health':ti,ab,kw OR psychiatr*:ti,ab,kw OR inpatient:ti,ab,kw)	118
6.	((brief NEAR/2 hospitalization):ti,ab,kw) AND ('mental health':ti,ab,kw OR psychiatr*:ti,ab,kw OR admission*:ti,ab,kw)	91
Combined sets		
7.	1 OR 2 OR 3 OR 4 OR 5 OR 6	904
Final result		
8.		**904**

/de = Term from the EMTREE controlled vocabulary; **/exp** = Includes terms found below this term in the EMTREE hierarchy **/mj** = Major Topic; **:ab** = Abstract; **:au** = Author; **:ti** = Article Title; **:ti,ab** = Title or abstract; ***** = Truncation; **' '** = Citation Marks; searches for an exact phrase; **NEAR/n** = Requests terms that are within 'n' words of each other in either direction; **NEXT/n** = Requests terms that are within 'n' words of each other in the order specified

Medline via OvidSP 24 June 2021

Title: Brief Admission

Search terms		Items found
Intervention: XX / Index test: XX		
1.	((brief or patient controlled or patient guided) adj4 admission*).ab,kf,ti.	167
2.	(admission* adj2 contract*).ab,kf,ti.	33
3.	"self admission*".ab,kf,ti.	26
4.	(self referral* or selfreferral*).ab,kf,ti and (mental health or psychiatr* or admission*).ab,kf,ti.	241
5.	(crisis adj4 admission*).ab,kf,ti and (mental health or psychiatr* or inpatient).ab,kf,ti.	73
6.	(brief adj2 hospitalization).ab,kf,ti and (mental health or psychiatr* or admission*).ab,kf,ti.	66
Combined sets		
7.	1 or 2 or 3 or 4 or 5 or 6	580
Final result		
8.		**580**

.ab. = Abstract; .**ab,ti.** = Abstract or title; **.af.** = All fields; **Exp** = Term from the Medline controlled vocabulary, including terms found below this term in the MeSH hierarchy; **.sh.** = Term from the Medline controlled vocabulary; **.ti.** = Title; **/** = Term from the Medline controlled vocabulary, but does not include terms found below this term in the MeSH hierarchy; ***** = Focus (if found in front of a MeSH-term); *** or $** = Truncation (if found at the end of a free text term); **.mp** = Text, heading word, subject area node, title; **" "** = Citation Marks; searches for an exact phrase; *ADJn* = Positional operator that lets you retrieve records that contain your terms (in any order) within a specified number (n) of words of each other.

Scopus via Elsevier 24 June 2021

Title: Brief Admission

Search terms		Items found
Intervention:		
1.	TITLE-ABS-KEY ((brief OR "patient controlled" OR "patient guided") W/3 admission*)	204
2.	TITLE-ABS-KEY (admission* W/1 contract*)	56
3.	TITLE-ABS-KEY ("self admission*")	38
4.	TITLE-ABS-KEY (("self referral*" OR selfreferral*) AND ("mental health" OR psychiatr* OR admission*))	365
5.	TITLE-ABS-KEY ((crisis W/3 admission*) AND ("mental health" OR psychiatr* OR inpatient))	117
6.	TITLE-ABS-KEY ((brief W/1 hospitalization) AND ("mental health" OR psychiatr* OR admission*))	124
Combined sets		
7.	1 OR 2 OR 3 OR 4 OR 5 OR 6	873
Final result		
8.		**873**

TITLE-ABS-KEY = Title or abstract or keywords; **ALL =** All fields; **PRE/n =** "precedes by". The first term in the search must precede the second by a specified number of terms (n).; **W/n =** "Within". The terms in the search must be within a specified number of terms (n) in any order.; ***** = Truncation; **" "** = Citation Marks; searches for an exact phrase; **LIMIT-TO (SRCTYPE, "j"** = Limit to source type journal; **LIMIT-TO (DOCTYPE, "ar"** = Limit to document type article; **LIMIT-TO (DOCTYPE, "re"** = Limit to document type review

Bilaga 2 Inkluderade primärstudier

Kvantitativa studier med kontrollgrupp

Study	Intervention	Population	Outcome measures
Cotgrove et al 1995 [3] Secondary prevention of attempted suicide in adolescence. ***Study type:*** RCT	***Intervention:*** In the intervention group patients received a token, green card, on discharge from the hospital in addition to standard care. In case of feeling suicidal they were able to get immediate re-admission into pediatric ward in hospital without questions if a bed was available. ***Control:*** Control group received standard follow-up and treatment. ***Setting:*** London, UK. Hospitals with local child and adolescencent department/clinics. Seven invited to participate, data collected from five centres.	Adolescents aged 16 year or younger who had made a suicide attempt. Mean age 14,9 years. Intervention n=47 Control n=58	Repeated suicide attempts Use of the token Data were collected by reviewing hospital or clinic notes.
Moljord et al 2016 [15] Short time effect of a self-referral to inpatient treatment for patients with severe mental disorders: a randomized controlled trial. ***Study type:*** RCT **(SRIT, Norway)**	***Intervention:*** SRIT (self-referral to inpatient treatment), in addition to usual treatment. Contract for self-referral to inpatient treatment, limited to maximum 5 days and a quarantine time of 14 days between each stay. Participants had a consultation with specialist nurse in psychiatry and followed usual rules and structure of the unit. Normally no changes in medication. Participants could choose ordinary admission via normal procedure. ***Control:*** Treatment as usual (TAU) consisted of ordinary psychosocial and pharmacological treatment including contact with the general practitioner, emergency department, or duty doctor if they needed hospitalization. Admission to hospital followed ordinary procedures. All participants were motivated to establish an individual treatment plan and were	Adult patients with severe mental disorders. Patients were well known in the rehabilitation unit. Patients with severe substance abuse or self-destructive behavior were excluded, as well as inability to consent or participate in SRIT. n=53 Intervention n=26 (12 women/14 men) Control n=27 (10 women/ 17 men) ***Main diagnoses:*** 51 of 53 diagnosed with bipolar disorder or schizophrenia. Substance abuse in 25% of the participants.	***Primary outcome:*** Patient activation, measured using Patient Activation Measure (PAM) ***Secondary outcomes:*** Recovery, measured using Recovery Assessment Scale (RAS) Self-assessment questionnaires at baseline and after four months. Data analysed according to ITT (intention to treat)

	offered intervention after one year. ***Setting:*** Central Norway. Single site community mental health centre (CMHC).		
Moljord et al 2017 [16] Twelve months effect of self-referral to inpatient treatment on patient activation, recovery, symptoms and functioning: A randomized controlled study. ***Study type:*** RCT **(SRIT, Norway)**	***Intervention:*** SRIT (self-referral to inpatient treatment), in addition to usual treatment. Contract for self-referral to inpatient treatment, limited to maximum 5 days and a quarantine time of 14 days between each stay. Participants had a consultation with specialist nurse in psychiatry and followed usual rules and structure of the unit. Normally no changes in medication. Participants could choose ordinary admission via normal procedure. ***Control:*** Treatment as usual (TAU) consisted of ordinary psychosocial and pharmacological treatment including contact with the general practitioner, emergency department, or duty doctor if they needed hospitalization. Admission to hospital followed ordinary procedures. All participants were motivated to establish an individual treatment plan and offered SRIT intervention after one year. ***Setting:*** Central Norway. Single site community mental health centre (CMHC).	Adult patients with severe mental disorders. Patients with severe substance abuse or self-destructive behavior were excluded, as well as inability to consent or participate in SRIT. ***Main diagnoses:*** 51 of 53 diagnosed with bipolar disorder or schizophrenia. Substance abuse in 25% of the participants. n=53 Intervention n=26 (12 women/14 men) Control n=27 (10 women/ 17 men)	***Primary outcome:*** Patient activation, using Patient activation measure (PAM -13) ***Secondary outcomes***: Recovery using Recovery assessment scale (RAS) Behaviour and symptoms using Behaviour and Symptom Identification Scale (BASIS-32) Self-report questionnaires at baseline and at 12 months. Data analyzed according to ITT (intention to treat)

Sigrunarson et al **2017** [22] A randomized controlled trial comparing self-referral to inpatient treatment and treatment as usual in patients with severe mental disorders. ***Study type:*** RCT **(SRIT, Norway)**	***Intervention:*** SRIT (self-referral to inpatient treatment), in addition to usual treatment. Contract for self-referral to inpatient treatment, limited to maximum 5 days and a quarantine time of 14 days between each stay. Patients participated in the daily routines of the unit but did not receive any specific treatment during that stay. ***Control:*** Treatment as usual (TAU) consisted of ordinary psychosocial and pharmacological treatment including contact with the general practitioner, emergency department, or duty doctor if they needed hospitalization. Admission to hospital followed ordinary procedures. All participants were motivated to establish an individual treatment plan and offered intervention after one year. ***Setting:*** Central Norway. Single site community mental health centre (CMHC).	***Main diagnoses:*** All participants, except two, were diagnosed with bipolar disorders or schizophrenia. Substance abuse in 25% of patients. Extensive users of primary and psychiatric health care services over at least two years recruited following an admission to the rehabilitation section at CMCH. n=53 Intervention n=26 (12 women and 14 men). Control n=27 (10 women and 17 men)	***Primary outcome:*** Inpatient days in any psychiatric department at the university hospital or CMHC from baseline to 12 months after inclusion. ***Secondary outcomes:*** Any inpatient days and admissions at the CMHC, both included and excluded SRIT, hospital acute and rehabilitation ward, and use of coercion. Data was collected from the patient administrative systems of the hospital. Data were analyzed according to ITT.

Strand et al 2020 [24] Self-admission to inpatient treatment in anorexia nervosa: Impact on healthcare utilization, eating disorder morbidity, and quality of life. ***Study type:*** Cohort with two registry control groups. **(ED Stockholm study)**	***Intervention:*** Self-admission to inpatient eating disorder clinic. Patients can admit at will for a maximum of 7 days by contacting ward directly. No quarantine between admissions. Waiting list was used if self-admission beds were occupied. Patients could keep up normal daily activities (work/school). Participants had to maintain continuous treatment contact with outpatient or day treatment units. Regular admission was available for participants if necessary. Contract valid for one year, possibility of renewal. ***Control:*** Registry control groups from National eating disorder register Stepwise. Group was divided into low and moderate treatment utilization. ***Setting:*** Stockholm, Sweden. Specialist eating disorder clinic. Residential care. 2 of 11 beds designated as self-admission beds, 18 contracts.	***Diagnosis:*** Anorexia nervosa Intervention group: Anorexia nervosa patients in a self-admission program. Patients needed to have continuous treatment contact at the adult outpatient or day-treatment units and have had at least one treatment episode in the adult inpatient ward during the past 3 years. n=29, mean age 29.7 years. All 34 participants in program invited to participate in study. 93% women. 55.2% also diagnosed with affective disorder 41.4% also diagnosed with anxiety disorder ***Control group:*** Patients included in the National eating disorder register. Low utilization comparison group, n=113, mean age 27.8 years. Matched controls based on age, duration of illness and BMI. 98% women. 30.1% affective disorder 31% anxiety disorder Moderate-utilization comparison group, n=27, mean age 30.2 years. Matched individuals who had received inpatient treatment in the 12 month-period before baseline. 96% women. 44.4% affective disorder 51.9% anxiety disorder	***Health care utilization:*** Number of days in treatment Frequency of inpatient treatment Days in involuntary inpatient treatment Number of outpatient visits. Data from National Patient register and patient records. **Intervention group only (due to insufficient data in control), between baseline and 12-month follow-up:** Morbidity, by measuring: Changes in BMI Eating Disorders Examination Questionaire (EDE-Q) 6.0 scores Clinical Impairment Assessment Questionnaire (CIA) 3.0 scores Functioning: Global Assessment of Functioning (GAF) Health related quality of life (HRQoL): EQ-5D-3L Short Form 36 (SF-36)

Thomsen et al 2018 [28] Patient-controlled hospital admission for patients with severe mental disorders: a nationwide prospective multicentre study. ***Study type:*** Prospective cohort study, matched registry control group. **(PCA Denmark study)**	***Intervention:*** Patient-controlled admission (PCA) PCA contract gave the patient the right to initiate a brief admission to hospital, lasting a maximum of 5–7 days. 3 of 5 regions used a 14-day quarantine period between admissions. Patients brought their own medicine and had access to activities in unit. Although not explicitly part of PCA, mental health professionals also supported patients on the phone when patient call in to inquire on bed availability Participants could also be admitted through regular admission. ***Control:*** Treatment as usual (TAU). ***Setting:*** Denmark, all five regional authorities. 8 mental health hospitals. 11 units, total of 21 PCA beds (1–3 PCA beds per unit). Minimum 15 patient contracts per bed.	Adult psychiatric patients with severe mental disorder(s), frequent users of healthcare services, long duration of illness and a history of coerced measures. 4 out of 5 regions required patient contact or treatment in outpatient team for inclusion. Intervention group: n=422 Female: 55.7% Self-harm behaviour:11.4% ***Main diagnoses:*** 62.8% Schizophrenia spectrum disorder 28.4% Affective disorder 2.8% Anxiety disorder 3.6% Personality disorder Control group (TAU): n=2110 Female: 55.7% Exact match to intervention group on diagnoses and gender. Patients who received TAU had ordinary psychosocial and psychopharmacological treatment through contact with private psychiatrists, and relevant out-patient and hospital admission following an assessment in the emergency department with doctors acting as gatekeepers.	***Primary outcome:*** The use of any coercive measure (compulsory admission/involuntary detention, restraint or forced treatment). ***Secondary outcomes:*** Number of admissions Inpatient days Medication use Self-harm behaviour Client satisfaction (CSQ-8) Assessment of functioning (GAF)
Westling et al 2019 [29] Effect of Brief Admission to Hospital by Self-referral for Individuals Who Self-harm and Are at Risk of Suicide: A	***Intervention:*** Participants in the Brief admission (BA) group negotiated a contract with details on time limits and responsibility for safety and help-seeking. Contract holders could decide when to be admitted with a maximum duration and frequency (ie, 3 nights in a row, 3 times per month). Nurses' aide or nurse had an admission conversation.	Adult patients age 18 to 60 years. ***Diagnosis:*** Self-harm and/or recurrent suicidality, at least 3 diagnostic criteria for borderline personality disorder. Hospitalization at least 3 times in the last 6 months. Regular	***Primary outcome:*** Days admitted to hospital; voluntary admission, BA by self-referral, and compulsory admissions. ***Secondary outcomes:*** Frequency of compulsory measures. Disability Assessment Schedule II (WHODAS II) scores

Randomized Clinical Trial. ***Study type:*** RCT **(BA Skåne study)**	Contract holders had access to up to two daily conversations with staff (15–20 minutes), and participation in activities at the ward. No medication were offered by staff, no consultation with physician or psychiatrist, no changes in treatment. Staff were explicitly instructed to approach patients seeking BA with warmth. ***Control:*** Control group received treatment as usual. ***Setting:*** Sweden, Skåne region. Three psychiatric hospital wards in three different cities. BA beds located in emergency ward.	contact with an out-patient psychiatric clinic was required. Intervention n=62 (56 women and 6 men) Control n=63 (50 women and 13 men)	The 5 Self-harm Behavior Groupings Measure scores for nonsuicidal self-injuries (NSSIs). Data from medical records 6 months retrospectively at study inclusion (T1), at 6-month follow-up (T2), and at 12-month follow-up (T3).

Kvantitativa studier utan kontrollgrupp

Study	Intervention	Population	Outcome measures
Ellegaard et al 2017a [6] Use of patient-controlled psychiatric hospital admissions: Patients' perspective. ***Study type:*** Survey **(PCA Denmark study)**	***Intervention:*** Patient-controlled admission (PCA) PCA contract give the patient the right to initiate a brief admission to hospital, lasting a maximum of 5–7 days. 3 of 5 regions used a 14-day quarantine period between stays. Patients bring their own medicine and have access to activities in unit. 4 of 5 regions required contact or treatment in outpatient team. Participants could also be admitted through regular admission. Although not explicitly part of PCA, mental health professionals also support patients on the phone when patient call in to inquire on bed availability ***Setting:*** Denmark, all five regional authorities. 8 mental health hospitals. 11 units, total of 21 PCA beds (1–3 PCA beds per unit). Minimum 15 patient contracts per bed.	Adult patients diagnosed with a severe and persistent mental illness, and a history of frequent and/or long duration of admissions to psychiatric inpatient units. 1 of 5 units included only patients with severe psychosis. Survey (n=462) Questionnaire distributed at each admission. 862 admissions registered by regional authorities. 600 questionnaires collected. 462 questionnaires included in analysis (exclusion based on missing id or returned blank). 190 individual patients completed questionnaires. Based on registrated PCAs, response rate 53.6%.	Patients' perspectives: Motives for signing contract Motives for and purpose of admission Reasons for discharge Satisfaction with PCA
Ellegaard et al 2107b [7] Use of patient-controlled psychiatric hospital admissions: mental	***Intervention:*** Patient-controlled admission (PCA) PCA contract give the patient the right to initiate a brief admission to hospital, lasting a maximum of 5-7 days. 3 of	Mental health professionals (MHP), (n=252) from all psychiatric units with PCA-beds in the multi-centre Danish PCA programme. Nurses (n=55.96%) Healthcare assistant (n=36.54%) Healthcare helper (n=2.69%	Mental health professionals' perspectives: Evaluation of PCA programme Satisfaction with PCA programme

health professionals' perspective **Study type:** Survey **(PCA Denmark study)**	5 regions used a 14-day quarantine period between stays. Patients bring their own medicine and have access to activities in unit. 4 of 5 regions required contact or treatment in outpatient team. Participants could also be admitted through regular admission. Although not explicitly part of PCA, mental health professionals also support patients on the phone when patient call in to inquire on bed availability ***Setting:*** Denmark, all five regional authorities. 8 mental health hospitals. 11 units, total of 21 PCA beds (1–3 PCA beds per unit). Minimum 15 patient contracts per bed.	Physiotherapist/Occupational therapist (n=0.58%) Student (n=4.23%) Survey response rate 63.3%	Agreement with patients' perspecitves
Heskestad et al 2008 [12] Brukerstyrte kriseinnleggelser ved alvorlig psykisk lidelse. ***Study type:*** Pre-post study **(Jaeren study)**	***Intervention:*** User-controlled admissions. Contract entails self-admission for maximum 5 days with 14 days quarantine. Availability on telephone. No medical treatment, no activities outside ward and no leave. No alcohol or substance use allowed. Patients in need of psychiatric or medical treatment were referred to ordinary admission. ***Setting:*** Norway, Jaeren. District psychiatry centre. Two out of 11 beds in ward made into self-referral beds.	Adult patients that had held a contract for user-controlled admissions for at least 12 months (n=18). ***Diagnosis:*** Psychotic disorder. Schizophrenia (n=16), schizoaffective disorder (n=1), unspecified persistent delusional disorder (n=1). Additional substance use disorder (n=10). All patients with a history of frequent hospital admissions and long-time severe disorder.	Number of admissions Number of involuntary admissions Inpatient weeks Involuntary inpatient weeks

Nyttingnes et al 2020 [18] When patients decide the admission - a four-year pre-post study of changes in admissions and inpatient days following patient controlled admission contracts. ***Study type:*** Pre-post study **(Akershus study)**	***Intervention:*** PCA contracts were offered to patients who could initiate brief inpatient stays of up to five days at a community mental health centre. The ward reserved two beds for PCAs. A call for PCA could be made on any weekday between 09:00 and 20:00. If the dedicated PCA beds were occupied, the patient was asked to call back later or to initiate a standard referral procedure. ***Setting:*** Norway Four CMHCs with open-door inpatient wards, outpatient services and specialist teams. Two beds at each ward reserved for PCA.	Adults. Included patients were well known in the ward and with a recent history of admissions to inpatient mental health care. PCA had to be considered by a psychiatrist or psychologist to be a good solution for the patient. With some exceptions, patients with severe addiction problems were not offered PCA. n=57 Female: 52.6% ***Main diagnosis:*** 28.1% Schizophrenia spectrum disorder 17.5% Personality disorder 15.8% Bipolar disorder 14% Depressive disorder 14% Anxiety disorder Seven out of total 64 eligible patients were omitted from the final analysis.	***Primary outcome:*** Inpatient days. ***Secondary outcomes:*** Admissions Involuntary inpatient days Use of mental health inpatient services measured during two years before the introduction of the PCA contract compared to two years after.
Nyttingnes et al 2021 [19] Patient-controlled admission contracts: a longitudinal study of patient evaluations. ***Study type:*** Cohort. Outcome measures at multiple time points for each patient (after each admission). **(Akershus study)**	***Intervention:*** Following each request for a PCA, staff filled in a form with information on the PCA request and time of admission and discharge, and finalized the form at discharge, by conducting a structured interview with the patient. The interview form covered custom made items on precursors and motivations, social activities during the PCA stay, and evaluation of the stay. ***Setting:*** Norway Four CMHCs with open-door inpatient wards, outpatient services and specialist teams. Two beds at each ward reserved for PCA.	Adults. Included patients were well known in the ward and with a recent history of admissions to inpatient mental health care. PCA had to be considered by a psychiatrist or psychologist to be a good solution for the patient. ***Main diagnosis***: Psychotic or bipolar. With some exceptions, patients with severe addiction problems were not offered PCA. Patients analysed for PCA admissions (n=67) Patients analysed for two-year evaluation of PCA (n=61)	Patient reports from PCA initiation Motives for PCAs Satisfaction with PCA stays and the PCA arrangement

Skott et al 2021 [23] Patient-controlled admissions to inpatient care: A twelve-month naturalistic study of patients with schizophrenia spectrum diagnoses and the effects on admissions to and days in inpatient care. ***Study type:*** Pre-post study	***Intervention:*** Patient controlled admission. A PCA contract gave access to a maximum 5-day inpatient stay, with no quarantine period and not limit on number of admissions per month. A waiting list was implemented when the PCA bed was occupied. No formal instruction on content of PCA care. Focus on patient needs, and consultation with psychiatrist possible. At admission, a registered nurse completed a patient risk assessment, and in case of suicidal ideation or violent behaviour, a regular intake to inpatient care was made. Follow-up and possible renewal of contract after 12 months. ***Setting:*** Six inpatient wards, with paired outpatient clinics. In total 6 of 93 beds designated to PCA, one at each inpatient ward. Region Stockholm, Sweden	Adults with mean age 46.2 years. ***Main diagnosis:*** Schizophrenia spectrum diagnosis Patients eligible to receive contract for PCA if they had at least one period of inpatient care, a history of recurrent care or with a first episode of psychosis, had an up-to-date care plan that included management of potential substance abuse, being motivated and able to be involved in care, and had an ongoing contact with inpatient and outpatient wards. Included patients (n=56), patients with complete data for primary outcomes (n=42), patients with complete data for secondary outcomes (EQ-5D-3L/VAS n=24; CGI n=20)	***Primary outcomes:*** Number of admissions to inpatient care Number of involuntary admissions Number of days in inpatient care Number of days in involuntary care ***Secondary outcomes:*** *Self-report health measures* EQ-5D-3L VAS *Clinician-administered health measures* CGI-I CGI-S

Hälsoekonomiska studier

Study	Intervention	Population	Outcome measures
Strand et al 2021 [25] Self-admission in the treatment of eating disorders: an analysis of healthcare resource reallocation. ***Study type:*** Cohort with two registry control groups. **(ED Stockholm study)**	***Intervention:*** Self-admission to inpatient eating disorder clinic. 9 regular inpatient beds. 2 beds designated as self-admission beds. Mean number of simultaneous contracts: 13.2 ***Control:*** 11 regular inpatient beds. ***Setting:*** Stockholm, Sweden. Specialist eating disorder clinic. Residential care.	Adults, mean age 29.7 years ***Diagnosis:*** Anorexia nervosa Intervention group: Anorexia nervosa patients in a self-admission program. n=29 Control group: Patients included in the National eating disorder register. Low utilization comparison group, n=113. Moderate-utilization comparison group, n=27	Health care utilization (*Days spent in inpatient treatment*). No financial costs included in the analysis. No HRQoL, QALY or morbidity outcomes included.

Kvalitativa studier med kontrollgrupp

Study	Intervention	Population	Outcome measures
Rise et al (2014) [21] How do patients with severe mental diagnosis cope in everyday life-a qualitative study comparing patients' experiences of self-referral inpatient treatment with treatment as usual? ***Study type:*** Qualitative interviews **(SRIT Norway study**	***Intervention:*** SRIT (self-referral to inpatient treatment), in addition to usual treatment. Contract for self-referral to inpatient treatment, limited to maximum 5 days and a quarantine time of 14 days between each stay. SRIT-model aims to involve patients in treatment decisions, admission, and increase knowledge of disorder and early signs, with purpose of reducing hospital stay. ***Control:*** Treatment as usual (TAU) consisted of ordinary psychosocial and pharmacological treatment including contact with the general practitioner, emergency department, or duty doctor if they needed hospitalization. Admission to	***Diagnosis:*** Psychosis or bipolar disorder with or without abuse problems. n=25 Participants in RCT on self-referral to inpatient treatment (the SRIT study). All participants were in need of long-term treatment and were suggested for SRIT by treating psychiatrist or other health care professional. Intervention group (n=11), control (n=14)	User experience of BA and treatment as usual at 4 months after initiation of study.

	hospital followed ordinary procedures. All participants were motivated to establish an individual treatment plan and offered intervention after one year. ***Setting:*** Central Norway. Single site community mental health centre (CMHC).		

Kvalitativa studier utan kontrollgrupp

Study	**Intervention**	**Population**	**Outcome measures**
Eckerström et al 2019 [4] Brief admission (BA) for patients with emotional instability and self-harm: nurses' perspectives-person-centred care in clinical practice. ***Study type:*** Interview **(BA Stockholm study)**	***Intervention:*** Brief admission intervention developed from Dutch model (Helleman et al, 2014a, 2014b). BA is initiated by the patient, last for no more than three days for any single admission, and is available up to three times per month. Managed entirely by nurses. The aim of BA is to promote constructive coping strategies. Individual BA contract, designed by patient together with the patients' health care professional and a specialist psychiatric nurse from the BA inpatient ward. Part of care planning. Education of staff in BA emphasizes warmth and trust, and continuing patient involvement in planning and evaluating admissions. ***Setting:*** Stockholm, Sweden. One psychiatric clinic, two wards. One BA bed per ward.	Nurses (n=8) working with patients who selfharm, have emotional instability and/ or borderline personality disorder.	Nurses' perspective

Eckerström et al 2020 [5] Brief admission (BA) for patients with emotional instability and self-harm: A qualitative analysis of patients' experiences during crisis. ***Study type:*** Interview **(BA Stockholm study)**	***Intervention:*** Brief admission intervention developed from Dutch model (Helleman et al, 2014a, 2014b). BA is initiated by the patient, last for no more than three days for any single admission, and is available up to three times per month. Managed entirely by nurses. The aim of BA is to promote constructive coping strategies. Individual BA contract, designed by patient together with the patients' health care professional and a specialist psychiatric nurse from the BA inpatient ward. Part of care planning. Education of staff in BA emphasizes warmth and trust, and continuing patient involvement in planning and evaluating admissions. ***Setting:*** Stockholm, Sweden. One psychiatric clinic, two wards. One BA bed per ward.	***Diagnosis:*** Emotional instability and self-harm. Exclusion: Primary diagnosis of psychotic disorder, bipolar disorder or depression disorder. n=15 Patients recruited by purposeful sampling, starting with contacting the patients that had used BA the most. BA usage among study participants: Range: 1–4 Average: 3.64 Medial: 2.5 Total: 51	Patients' experiences with BA. Patients' view of key components of BA. Relevant improvements of BA from patients' perspective.
Ellegaard et al (2018) [8] Integrating a patient-controlled admission program into mental health hospital service: A multicenter Grounded Theory study. ***Study type:*** Grounded theory (**PCA Denmark study)**	***Intervention:*** Patient-controlled admission (PCA) PCA contract give the patient the right to initiate a brief admission to hospital, lasting a maximum of 5–7 days. 3 of 5 regions used a 14-day quarantine period between stays. Patients bring their own medicine and have access to activities in unit. 4 of 5 regions required contact or treatment in outpatient team. Participants could also be admitted through regular admission.	Mental health professionals (n=26) working with patients with a PCA contract, either in one of the 11 inpatient units or in an associated outpatient treatment team. Nurses (n=18), health care assistant (n=7), social worker (n=1). Inpatient unit (n=23), outpatient unit (n=3)	Mental health professionals' experiences in PCA implementation.

	Although not explicitly part of PCA, mental health professionals also support patients on the phone when patient call in to inquire on bed availability ***Setting:*** Denmark, all five regional authorities. 8 mental health hospitals. 11 units, total of 21 PCA beds (1–3 PCA beds per unit). Minimum 15 patient contracts per bed.		
Ellegaard et al (2020) [9] Feeling safe with patient-controlled admissions: A grounded theory study of the mental health patients' experiences. ***Study type:*** Grounded theory **(PCA Denmark study)**	***Intervention:*** Patient-controlled admission (PCA) PCA contract give the patient the right to initiate a brief admission to hospital, lasting a maximum of 5–7 days. 3 of 5 regions used a 14-day quarantine period between stays. Patients bring their own medicine and have access to activities in unit. 4 of 5 regions required contact or treatment in outpatient team. Participants could also be admitted through regular admission. Although not explicitly part of PCA, mental health professionals also support patients on the phone when patient call in to inquire on bed availability ***Setting:*** Denmark, all five regional authorities. 8 mental health hospitals. 11 units, total of 21 PCA beds (1–3 PCA beds per unit). Minimum 15 patient contracts per bed.	Patients (n=26) with a PCA contract. ***Primary diagnosis:*** Schizophrenia (n=12) Bipolar affective disorder (n=6) Emotionally unstable personality disorder (n=4) Other (n=4) Mean PSP score: 40 (21–70) Mean PCA use: 9 (2–40) Patients with contracts were invited to participate. Not all patients recruited at initiation of study. Later participants recruited to diversify in length of time of having contract and number of admissions.	Patients' experiences of PCA: -Significance of PCA programme -Patient management of self-management
Helleman et al (2014) [10]	***Intervention:*** In BA, patients were admitted for 1–3 nights. BA admitted when a bed	n=17 (out of 27 asked to participate) ***Diagnosis:***	Four meaning units in the transcripts were identified and analysed:

Experiences of patients with borderline personality disorder with the brief admission intervention: a phenomenological study. ***Study type:*** Interview.	was available. Contact with a nurse during that time. Upon arrival the specific goals of the patient's brief admission and other practical matters are discussed with the nurse. Patients do not follow structured therapy groups during the brief admission. ***Setting:*** Large mental health facility in a semi-urbanized eastern part in the Netherlands. Four psychiatric clinics.	Patients with a diagnosis of BPD diagnosed according to DSM-IV. Patients with experience from BA and who have a treatment plan. Patients able to tolerate an interview. Mean frequency of BA (3-year period prior) was 12 (range: 2–68) Patients with severe substance abuse problems were excluded.	1. Organization of the brief admission 2. Quality of the contact with a nurse 3. Time out from daily life 4. Experienced value of the intervention.
Helleman et al (2018) [11] Individuals' experiences with brief admission during the implementation of the brief admission Skåne RCT, a qualitative study. ***Study type:*** Interview **(BA Skåne study)**	***Intervention:*** Brief Admission (BA). Participants in the Brief admission (BA) group negotiated a contract with details on time limits and responsibility for safety and help-seeking is set up. Contract also includes an individualized treatment plan, signs for when to use BA and plans for practical arrangements during BA. Maximum 3 nights per admission and three admissions per month. Contract holders have access to up to two daily conversations with staff (15–20 minutes), and participation in activities at the ward. No medication offered by staff, no consultation with physician or psychiatrist, no changes in treatment. Contracts are non-negotiable, but renegotiated every 6 months. Staff explicitly instructed to approach patients seeking BA with warmth. ***Setting:*** Sweden, Skåne region. Three psychiatric hospital wards in three different cities.	***Diagnosis:*** Self-harm and/or repeated suicide attempts and at least three of the criteria for borderline personality disorder. All participants had been admitted to psychiatric hospital for at least 7 days or presented to the psychiatric emergency department at least 3 times during the last six months. n=8 women Participants randomized to the Brief admission (BA) intervention group in the BASRCT study.	A semi-structured interview from which the material was coded. Themes were actively sought to investigate: The strengths and limitations of BA implementation Most and least favourite parts of BA The reasons for requesting or not requesting BA.

	BA beds located in emergency ward.		
Lindkvist et al (2021) [14] A Brief Breathing Space: Experiences of Brief Admission by Self-Referral for Self-Harming and Suicidal Individuals with a History of Extensive Psychiatric Inpatient Care. ***Study type:*** Interview **(BA Skåne study)**	***Intervention:*** Brief Admission (BA). Participants in the Brief admission (BA) group negotiated a contract with details on time limits and responsibility for safety and help-seeking is set up. Contract also includes an individualized treatment plan, signs for when to use BA and plans for practical arrangements during BA. Maximum 3 nights per admission and three admissions per month. Contract holders have access to up to two daily conversations with staff (15–20 minutes), and participation in activities at the ward. No medication offered by staff, no consultation with physician or phychiatrist, no changes in treatment. Contracts are non-negotiable, but renegotiated every 6 months. Staff explicitly instructed to approach patients seeking BA with warmth. ***Setting:*** Sweden, Skåne region. Three psychiatric hospital wards in three different cities. BA beds located in emergency ward.	Selfharming individuals with >180 days of psychiatric admission over 12 months. 11 patients eligible for inclusion, of which 8 volunteered. 7 participants were interviewed. At interview, participants had held contracts for 1–3 years. ***Diagnoses:*** Self-harm and/or suicidal ideation. Each participants had 3–6 diagnoses, including PTSD (n=5), depressive disorder (n=5), ADHD (n=3), addictive disorders (n=3), others, including BPD, autism and bulimia (n=11). All participants had at some point used self-referral to BA.	Patients' experiences of BA and its main features. Reflections on improvements and adaptations.
Lindkvist et al (2019) [13] Predictable, collaborative and safe: Healthcare provider experiences of introducing brief admissions by self-referral for self-harming and suicidal persons with a history of	***Intervention:*** Brief Admission (BA). Participants in the Brief admission (BA) group negotiated a contract with details on time limits and responsibility for safety and help-seeking is set up. Contract also includes an individualized treatment plan, signs for	Healthcare providers (n=12) of BA among self-harming individuals with >180 days of psychiatric admission in the previous year. Nurses' aid (n=7), nurse (n=2), Psychologist (n=2), psychiatrist (n=1) 116 prospective participants invited to participate.	Healthcare providers' experiences

extensive psychiatric inpatient care. ***Study type:*** Interview **(BA Skåne study)**	when to use BA and plans for practical arrangements during BA. Maximum 3 nights per admission and three admissions per month. Contract holders have access to up to two daily conversations with staff (15–20 minutes), and participation in activities at the ward. No medication offered by staff, no consultation with physician or psychiatrist, no changes in treatment. Contracts are non-negotiable, but renegotiated every 6 months. Staff explicitly instructed to approach patients seeking BA with warmth. ***Setting:*** Sweden, Skåne region. Three psychiatric hospital wards in three different cities. BA beds located in emergency ward.		
Mortimer-Jones et al (2019) [17] Staff and client perspectives of the Open Borders programme for people with borderline personality disorder. [Expanded details on intervention and population from: Mortimer-Jones et al, (2016), [32]] ***Study type:*** Interview	***Intervention:*** Open Borders Programme Only open to BPD patients 3–7 day stays at residential facility 24 hours phone coaching Modified DBT, introduction to later formal DBT enrollment Self-referral Treatment plan set up at acceptance into programme, by client, case manager and key worker from the residential facility, detailing admissions and DBT. Clients responsible for own day-to-day tasks at facility, including medication, cooking,	All staff and clients at Open Borders Programme employed/enrolled at time of study (n=18) included. One staff declined participation. Interviews (n=17) ***Diagnosis:*** Borderline personality disorder. Clients (n=8), all with BPD diagnosis and a history of frequent hospital admissions and/or emergency department presentations, or triage with emotional instability, self-harm or suicidal ideation. Patients with illicit drug or alcohol dependence (but not use), and those with organic brain disorder or mental impairment excluded from programme.	Staff and client experiences.

	grocery shopping, laundry. The programme is nurse-led, with no psychiatrists at site, and offers an alternative to hospital environment. Staff team is small and consistently employed, focusing on continuity of care, relationship-building and staff accessibility. ***Setting:*** Australia, Western Australia. Residential facility, 10 beds. Nurse-led, no medical staff at site.	Staff (n=9), comprising registered nurses, enrolled nurses, and nursing assistants.	
Olsø et al (2016) [20] More than just a bed: mental health service users' experiences of self-referral admission. ***Study type:*** Interview **(SRIT Norway study)**	***Intervention:*** SRIT (self-referral to inpatient treatment), in addition to usual treatment. Contract for self-referral to inpatient treatment, limited to maximum 5 days and a quarantine time of 14 days between each stay. SRIT-model aims to involve patients in treatment decisions, admission, and increase knowledge of disorder and early signs, with purpose of reducing hospital stay. ***Setting:*** Central Norway. Single site community mental health centre (CMHC).	Participants in RCT on self-referral admission (See Moljord et al, 2016 [15]) who had at least 1 year of experience with a self-referral contract and gave sufficient information in the interviews. (n=28) ***Diagnoses:*** Participants had one or more diagnoses, including psychosis (n=19), mood disorders (n=8) and substance use disorder (n=10). Six participants did not self-refer for hospitalization during study period. 22 participants self-referred between 1 time (n=7) and 8 or more times (n=3). All participants in original RCT (Moljord et al, 2016 [15]) asked to participate (n=53)	Service-users' experiences
Strand et al (2017a) [26] Self-admission to inpatient treatment for patients with anorexia nervosa: The patient's perspective. ***Study type:*** Interview **(ED Stockholm study)**	***Intervention:*** Self-admission to inpatient eating disorder clinic. Patients can admit at will for a maximum of 7 days by contacting ward directly. No quarantine period. Waiting list if beds are self-admission beds are occupied. Patients can keep normal daily activities (work/school).	***Diagnosis:*** Anorexia nervosa n=16 Adult program participants (all 18 participants we asked to participate). All with at least one treatment episode in the adult inpatient ward during the past 3 years, and familiar with inpatient treatment framework and routines.	Patients' experiences of self-admission program at 6 months

	Contract valid for one year, possibility of renewal. Participants must maintain continuous treatment contact at outpatient or day treatment units. Regular admission available for participants if necessary. ***Setting:*** Stockholm, Sweden. Specialist eating disorder clinic. Residential care. 2 of 11 beds designated as self-admission beds, 18 contracts.	Patients with suicidal ideation, self-injurious behavior and/or untreated substance use are excluded. 13 participants offered contract upon discharge of regular inpatient treatment, 3 through participation in outpatient or day treatment. During first 6 months in program, 14 participants had self-admitted, two had not. Admission frequency ranged from one admission (5 participants) to 14 admissions (2 participants).	
Strand et al (2017b) [27] Self-admission to inpatient treatment in psychiatry: lessons on implementation. ***Study type:*** Interview **(ED Stockholm study)**	***Intervention:*** Self-admission to inpatient eating disorder clinic. Patients can admit at will for a maximum of 7 days by contacting ward directly. No quarantine period. Waiting list if beds are self-admission beds are occupied. Patients can keep normal daily activities (work/school). Contract valid for one year, possibility of renewal. Participants must maintain continuous treatment contact at outpatient or day treatment units. Regular admission available for participants if necessary. ***Setting:*** Stockholm, Sweden. Specialist eating disorder clinic. Residential care. 2 of 11 beds designated asself-admission beds, 18 contracts.	***Diagnosis:*** Anorexia nervosa n=16 Adult program participants (all 18 participants we asked to participate). All with at least one treatment episode in the adult inpatient ward during the past 3 years, and familiar with inpatient treatment framework and routines. Patients with suicidal ideation, self-injurious behavior and/or untreated substance use are excluded. 13 participants offered contract upon discharge of regular inpatient treatment, 3 through participation in outpatient or day treatment. During first 6 months in program, 14 participants had self-admitted, two had not. Admission frequency ranged from one admission (5 participants) to 14 admissions (2 participants).	Patients' experiences of practical considerations at 6 months

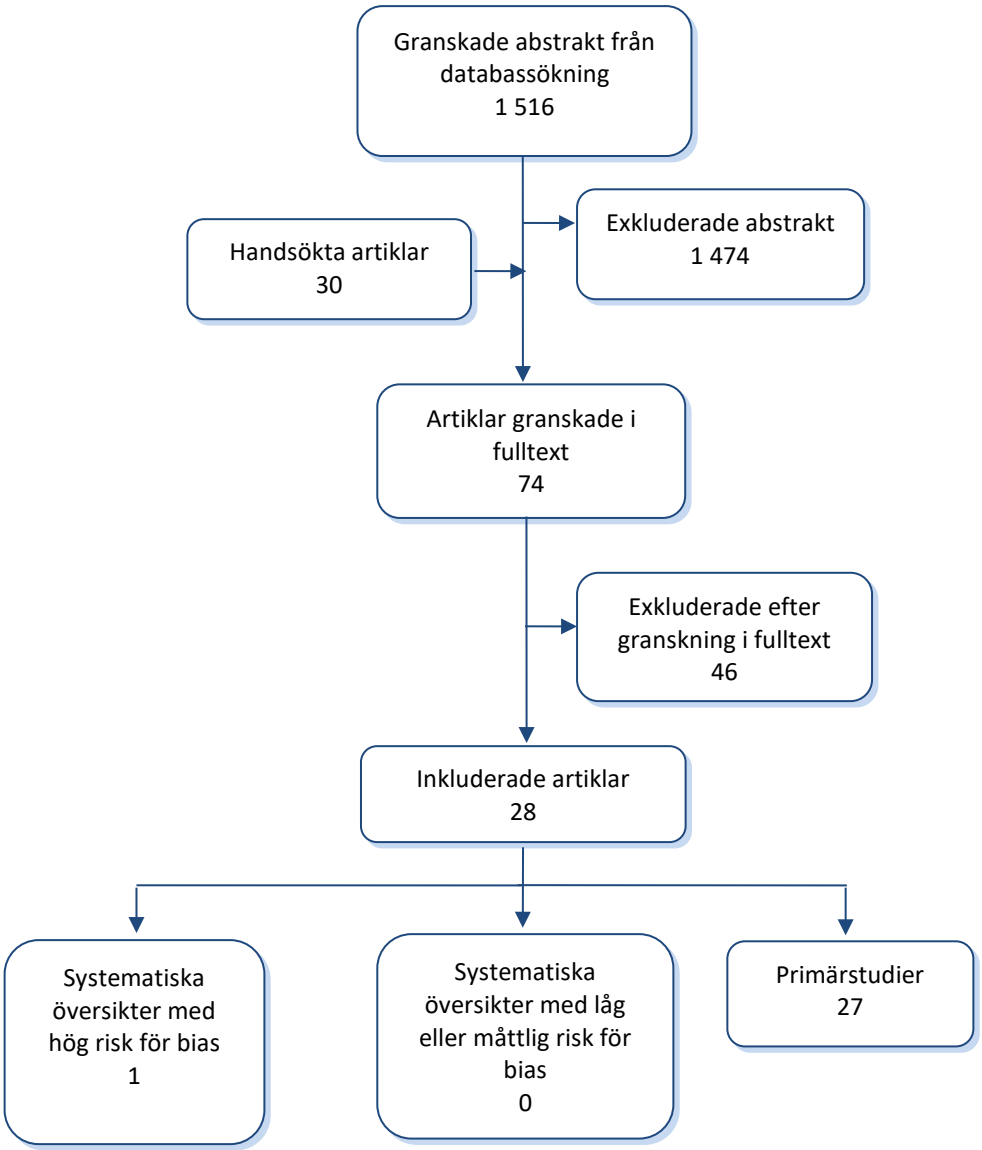
Artiklar uppdelade efter studie

Akershus study	**BA Skåne study**	**BA Stockholm study**	**ED Stockholm study**	**PCA Denmark study**	**SRIT Norway study**	**Single studies**
Nyttingnes et al 2020 (Cohort, no control)	Helleman et al 2018 (Interview)	Eckerström et al 2019 (Interview)	Strand et al 2017a (Interview)	Ellegaard et al 2017 (Survey)	Moljord et al 2016 (RCT)	Cotgrove et al 1995 (RCT)
Nyttingnes et al 2021 (Cohort, no control)	Lindkvist et al 2019 (Interview)	Eckerström et al 2020 (Interview)	Strand et al 2017b (Interview)	Ellegaard et al 2018 (Grounded theory)	Moljord et al 2017 (RCT)	Helleman et al 2014 (Interview)
	Lindkvist et al 2021 (Interview)		Strand et al 2020 (Cohort with control)	Ellegaard et al 2020 (Grounded theory)	Olsø et al 2016 (Interview)	Heskestad et al* 2008 (Cohort, no control)
	Westling et al 2019 (RCT)		Strand et al 2021 (Health care allocation study)	Thomsen et al 2018 (Cohort with control)	Rise et al* 2014 (Interview)	Mortimer-Jones et al 2019 (Interview)
					Sigrunarson et al 2017 (RCT)	Skott et al 2021 (Cohort, no control)

*Included in the Strand et al (2015) systematic review

BA = Brief Admission; **PCA** = Patient-controlled admission; **RCT** = Randomized controlled trial; **SRIT** = Self-referral to inpatient treatment

Bilaga 3 Flödesschema för urval av studier



Bilaga 4 Exkluderade artiklar

Exkluderade studier	Kommentar
Översikter	
Borschmann R, Henderson C, Hogg J, Phillips R, Moran P. Crisis interventions for people with borderline personality disorder. Cochrane Database Syst Rev. 2012(6):CD009353. Available from: https://doi.org/10.1002/14651858.CD009353.pub2.	Fel intervention
Helleman M, Goossens PJ, Kaasenbrood A, van Achterberg T. Evidence base and components of Brief Admission as an intervention for patients with borderline personality disorder: a review of the literature. Perspect Psychiatr Care. 2014;50(1):65-75. Available from: https://doi.org/10.1111/ppc.12023.	Systematisk översikt med fokus på kort behandling av patienter med borderline-personlighetsstörning. Inget krav på patientinitiering av interventionerna.
McCartan C, Davidson G. Personality Disorder Services Rapid Review. Belfast: Queen's University Belfast; 2020.	Inte systematisk översikt, inget fokus på patientinitiering.
Relevanta publikationer med fel publikations- eller studietyp	
Eikenes SS, Mjøen IO. Mitt liv, mitt valg: En kvalitativ studie om pasienters erfaringer med brukerstyrte sengeplasser: The University of Bergen; 2020.	Fel publikationstyp, masteruppsats
Emmen M. HET BED OP RECEPT, EEN ERVARING RIJKER: GGz Breburg; 2018.	Fel publikationstyp, uppsats
Hanneborg E, Ruud T. Sluttrapport.'Brukerstyrte innleggelser i åpen DPS døgn'. Et samarbeidsprosjekt mellom Grorud DPS, bydelene Grorud og Stovner samt Nittedalkommune. Lørenskog: Akershus universitetssykehus; 2011.	Fel publikationstyp, rapport. Inkluderade i Strand & von Hausswolff-Juhlin 2015
Helleman M, Goossens PJJ, Kaasenbrood A, van Achterberg T. Brief admissions during prolonged treatment in a case involving borderline personality disorder and posttraumatic stress disorder: Use and functions. J Am Psychiatr Nurses Assoc. 2016;22(3):215-24. Available from: https://doi.org/10.1177/1078390316636196.	Fel studietyp, fallstudie
Helleman M, Goossens PJJ, van Achterberg T, Kaasenbrood A. Components of Brief Admission as a Crisis Intervention for Patients With a Borderline Personality Disorder: Results of a Delphi Study. J Am Psychiatr Nurses Assoc. 2018;24(4):314-26. Available from: https://doi.org/10.1177/1078390317728330.	Fel studietyp, Delphi-studie (konsensuspanel)
Liljedahl SI, Helleman M, Daukantaite D, Westrin A, Westling S. A standardized crisis management model for self-harming and suicidal individuals with three or more diagnostic criteria of borderline personality disorder: The Brief Admission Skane randomized controlled trial protocol (BASRCT).	Fel publikationstyp, Protokoll för BASRCT-studien
Little J, Stephens D. A patient-based voucher system of brief hospitalisation. Aust N Z J Psychiatry. 1999;33(3):429-32. Available from: https://doi.org/10.1046/j.1440-1614.1999.00558.x.	Fel studietyp, fallstudie
Mortimer-Jones S, Morrison P, Munib A, Paolucci F, Neale S, Bostwick A, et al. Recovery and Borderline Personality Disorder: A Description of the Innovative	Fel studietyp, programbeskrivning

Open Borders Program. Issues Ment Health Nurs. 2016;37(9):624-30. Available from: https://doi.org/10.1080/01612840.2016.1191565.	
Salte IA. Gir lavere terskel mindre tvang? In: Herberts C, Wahlbeck K, editors. Vård utan tvång–en utopi? Alternativ till tvång i vård och omsorg. Konferensrapport från den nordiska konferensen i Vasa 20-22 juni 2011. 2011.	Fel publikationstyp, konferenspresentation
Samuelsen SS, Moljord IEO, Eriksen L. Re-establishing and preserving hope of recovery through user participation in patients with a severe mental disorder: the self-referral-to-inpatient-treatment project. Nurs Open. 2016;3(4):222-6.	Fel publikationstyp, beskrivning av SRIT-studien, inga nya data
Sollied L, Måsø Helland B. Rapport fra kvalitetsutviklingsprosjektet "Brukerstyrte innleggelser - makten skifter eier. Veien til mestring av eget liv?" Tromsø: Universitetssykehuset Nord-Norge HF; 2010.	Fel publikationstyp, rapport. Inkluderad i Strand & von Hausswolff-Juhlin 2015.
Strand M, Gustafsson SA, Bulik CM, Von Hausswolff-Juhlin Y. Patient-controlled hospital admission: A novel concept in the treatment of severe eating disorders. Int J Eat Disord. 2015;48(7):842-4. Available from: https://doi.org/10.1002/eat.22445.	Fel publikationstyp
Strand M, Sjostrand M. Self-admission in psychiatry: The ethics. Bioethics. 2019;33(1):132-7. Available from: https://doi.org/10.1111/bioe.12501.	Fel studietyp, etikstudie
Strand M, von Hausswolff-Juhlin Y. Is it time for a more nuanced view on self-admission to in-patient treatment in psychiatry? Acta Psychiatr Scand. 2018;138(1):83-4. Available from: https://doi.org/10.1111/acps.12903.	Fel publikationstyp, letter
Strand M. Self-admission as a treatment tool in severe anorexia nervosa [Dissertation]. Stockholm: Karolinska Institutet 2021.	Fel publikationstyp, avhandling. Alla fyra artiklar som ingår i avhandlingen är publicerade separat och inkluderade.
Støvind H, Hanneborg E, T R. Bedre tid med brukerstyrte innleggelser? Sykepleien. 2012;100(14). Available from: https://doi.org/https://doi.org/10.4220/sykepleiens.2012.0151.	Fel publikationstyp, inte peer-reviewedgranskad. Inkluderad i Strand & von Hausswolff-Juhlin 2015.
Torgaard Thomsen C, Eriksen Benros M, Maltesen T, Halling Hastrup L, Kragh Andersen P, Giacco D, et al. Patient controlled hospital admissions. European Psychiatry. 2018;48:S12	Fel publikationstyp, konferenspresentation
Tytlandsvik M, Heskestad S. Erfaringer med brukarstyrt innlegging ved psykosepost - ein kvalitativ evalueringsstudie. Vård i Norden. 2009;29(1):49-51.	Oklar publikationstyp. Inkluderad i Strand & von Hausswolff-Juhlin 2015.
Wilson AG. The Enhance Study: Effectiveness of a Clinical Pathway for the Acute Inpatient Care of Patients with Emotionally Unstable Personality Disorder. Perth: University of Western Australia; 2017.	Fel publikationstyp, avhandling.
Publikationer som inte motsvarar frågeställningen	
Ash D, Galletly C. Crisis beds: the interface between the hospital and the community. Int J Soc Psychiatry. 1997;43(3):193-8. Available from: https://doi.org/10.1177/002076409704300305.	Fel intervention
Breslow RE, Klinger BI, Erickson BJ. Crisis hospitalization in a psychiatric emergency service. New Dir Ment Health Serv. 1995(67):5-12. Available from: https://doi.org/10.1002/yd.23319650303.	Fel intervention

Bryson KK, Naqvi A, Callahan P, Fontenot D. Brief admission program. An alliance of inpatient care and outpatient case management. J Psychosoc Nurs Ment Health Serv. 1990;28(12):19-23.	Fel intervention
Clarke P, Hafner RJ, Holme G. The brief admission unit in emergency psychiatry. J Clin Psychol. 1997;53(8):817-23. Available from: https://doi.org/10.1002/(sici)1097-4679(199712)53:8<817::aid-jclp5>3.0.co;2-c.	Fel intervention
Cook DA, Skeldon I. The use of a contract admission procedure on an acute psychiatric admission ward. Br J Psychiatry. 1980;136:463-8. Available from: https://doi.org/10.1192/bjp.136.5.463.	Fel intervention
Crabtree Jr LH, Grossman WK. Administrative clarity and redefinition for an open adolescent unit. Psychiatry. 1974;37(4):350-9.	Fel intervention
Dawson DL, MacMillan HL. Relationship management of the borderline patient: from understanding to treatment: Routledge; 2013.	Fel intervention, fel publikationstyp
Gold SR, Coghlan AJ, editors. Locus of control and self-esteem among adolescent drug abusers: Effects of residential treatment. Drug Forum; 1976: Baywood Publishing Company.	Fel intervention, fel publikationstyp
Gysin-Maillart A, Schwab S, Soravia L, Megert M, Michel K. A Novel Brief Therapy for Patients Who Attempt Suicide: A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP). PLoS Med. 2016;13(3):e1001968. Available from: https://doi.org/10.1371/journal.pmed.1001968.	Fel intervention
Heskestad S, Tytlandsvik M. Patient-guided crisis admissions to an inpatient unit for psychotic conditions. Tidsskrift for den Norske Laegeforening. 2008;128(1):32-5.	Dubblett, annan översättning av den norska titeln.
Knapen S, de Leeuw M, Meinderts R, Fokkert M. Van onbehandelbaar naar behandelbaar? Tijdschrift voor Psychotherapie. 2016;42(2):86-103.	Fel intervention
Koekkoek B, van der Snoek R, Oosterwijk K, van Meijel B. Preventive psychiatric admission for patients with borderline personality disorder: a pilot study. Perspect Psychiatr Care. 2010;46(2):127-34. Available from: https://doi.org/10.1111/j.1744-6163.2010.00248.x.	Fel intervention. Kontrakt på inläggningar som planeras in i förväg, inte patientinitierade.
Michel K, Valach L, Gysin-Maillart A. A novel therapy for people who attempt suicide and why we need new models of suicide. Int J Environ Res Public Health. 2017;14(3):243.	Fel intervention
Morgan HG, Jones EM, Owen JH. Secondary prevention of non-fatal deliberate self-harm. The green card study. Br J Psychiatry. 1993;163(1):111-2. Available from: https://doi.org/10.1192/bjp.163.1.111.	Fel intervention. Green card ger tillgång till patientens läkare, men inte till inläggning.
Neffinger GG. The partial-hospital treatment of the young adult chronic patient. Int J Partial Hosp. 1987;4(2):117-25.	Fel intervention
Nehls N. Brief hospital treatment plans for persons with borderline personality disorder: perspectives of inpatient psychiatric nurses and community mental health center clinicians. Arch Psychiatr Nurs. 1994;8(5):303-11. Available from: https://doi.org/10.1016/0883-9417(94)90028-0.	Fel intervention
Nehls N. Brief hospital treatment plans: innovations in practice and research. Issues Ment Health Nurs. 1994;15(1):1-11. Available from: https://doi.org/10.3109/01612849409074929.	Fel intervention

Pettersen H, Lofthus A-M. Brukererfaringer med psykiske helsetjenester. Hva viser oppsummert forskning? Tidsskrift for psykisk helsearbeid. 2018;15(02-03):112-23.	Fel publikationstyp. Inkluderar brukarerfarenheter generellt samt inkluderad översikt av Strand och von Hausswolff.
Rise MB, Westerlund H, Bjorgen D, Steinsbekk A. Safely cared for or empowered in mental health care? Yes, please. Int J Soc Psychiatry. 2014;60(2):134-8. Available from: https://doi.org/10.1177/0020764012471278.	Fel intervention
Siefert CJ. A goal-oriented limited-duration approach for borderline personality disorder during brief inpatient hospitalizations. Psychotherapy (Chic). 2012;49(4):502-18. Available from: https://doi.org/10.1037/a0026128.	Fel intervention
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