

Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* **MH** *clinical question-answering service*

Question

“In adults of a working age with symptoms of psychosis how effective are family interventions when compared to any other treatment in achieving improved patient outcomes.”

Clarification of question using PICO structure

Patients: In adults of a working age with symptoms of psychosis
Intervention: Family interventions
Comparator: Any other treatment
Outcome: Any patient outcomes

Clinical and research implications

The authors of a systematic review (SR) stated that clinicians may feel that a family intervention is worth the time and effort, assuming that a high-quality family service is available. The SR demonstrated a lack of high quality research in this area, and they emphasized that more, large, well-designed trials are needed to clarify several of the short-term and long-term outcomes. A randomised controlled trial (RCT) that met the inclusion criteria above did not explicitly state any clinical or research implications.

What does the evidence say?

Number of included studies/reviews (number of participants)

We identified one SR (Pharoah et al. 2010) and one RCT (Girón et al. 2010) that met the inclusion criteria outlined above. The SR included 53 RCTs or quasi-RCTs, and the RCT randomised 50 participants.

Main findings

The majority of trials included in the SR compared family based interventions with usual care in people with schizophrenia or schizophrenia-like conditions. Participants who received family based interventions demonstrated significantly reduced hospital admissions at one year (n = 481, eight RCTs, RR 0.78 CI 0.6 to 1.0), and up to 18 months (n = 228, three RCTs, RR 0.46 CI 0.3 to 0.7), although no differences between groups were observed at 6 months, or at two years. The participants in the intervention group also had decreased frequency of relapse at 12 months (n = 2981, 32 RCTs, RR 0.55 CI 0.5 to 0.6), 18 and 24 months, but not at six months. Family interventions may also encourage compliance with medication (n = 695, 10 RCTs, RR 0.60 CI 0.5 to 0.7). No significant differences between groups were observed for some outcomes including suicide, employment, a person's ability to perform work tasks, or independent living.

The RCT compared family intervention plus individual counselling plus standard treatment with individual counselling and standard treatment in participants with *severe* schizophrenia. Significant differences in favour of family intervention were observed for clinical relapses (p=0.02), hospitalizations and major incidents (p=0.002), positive (p=0.001) and negative symptoms (p=0.003), social role performance (p=0.005), social relations (p=0.002) and employment (p=0.009) when compared with standard treatment.

Authors conclusions

The authors of the SR concluded that family interventions may reduce the number of relapse events and hospitalisations. They also stated that the treatment effects of the trials included in the SR may be overestimated due to their poor methodological quality. The authors of the RCT concluded that family intervention is effective in severe schizophrenia independently of compliance and prognostic factors.

Reliability of conclusions/Strength of evidence

The SR was well conducted, although it is debatable whether or not some of the studies should have been pooled due to clinical heterogeneity amongst the studies. The authors stated, however, that the quality of reporting in most studies was poor. Overall, the authors' conclusion was suitably cautious given the methodological limitations of the studies included in the SR. Aspects of the RCT

were well conducted, although the methods of randomisation and allocation concealment were not reported, so that overall, this trial had an unclear risk of bias.

What do guidelines say?

NICE guidance on schizophrenia reported the following clinical evidence:

“In 32 RCTs including 2,429 participants, there was robust and consistent evidence for the efficacy of family intervention. When compared with standard care or any other control, there was a reduction in the risk of relapse with numbers needed to treat (NNTs) of 4 (95% CIs 3.23 to 5.88) at the end of treatment and 6 (95% CIs 3.85 to 9.09) up to 12 months following treatment. In addition, family intervention also reduced hospital admission during treatment and the severity of symptoms both during and up to 24 months following the intervention. Family intervention may also be effective in improving additional critical outcomes, such as social functioning and the patient’s knowledge of the disorder. However, it should be noted that evidence for the latter is more limited and comes from individual studies reporting multiple outcomes across a range of scale based measures.”

The following recommendations for family treatment were made in the NICE guideline:

Treatment of acute episode

Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.

Family intervention should:

- include the person with schizophrenia if practical
- be carried out for between 3 months and 1 year
- include at least ten planned sessions
- take account of the whole family’s preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.

Promoting recovery

Offer family intervention to families of people with schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation

Family intervention may be particularly useful for families of people with schizophrenia who have:

- recently relapsed or are at risk of relapse
- persisting symptoms.

Research recommendations

For people with schizophrenia from black and minority ethnic groups living in the UK, does ethnically adapted family intervention for schizophrenia (adapted in consultation with black and minority ethnic groups to better suit different cultural and ethnic needs) enable more people in black and minority ethnic groups to engage with this therapy, and show concomitant reductions in patient relapse rates and carer distress?

Research is needed to identify the competencies required to deliver effective family intervention to people with schizophrenia and their carers.

A SIGN guideline on psychosocial interventions in the management of schizophrenia reported the following summary recommendations:

PSYCHOSOCIAL INTERVENTIONS IN THE MANAGEMENT OF SCHIZOPHRENIA

C The treatment of individuals with schizophrenia requires a co-ordinated multidisciplinary approach.

C A Care Plan should be drawn up which specifies all aspects of the care to be provided.

C Care should be taken to avoid overly stressful interventions which may result in worsening of psychotic symptoms.

ACUTE PHASE

B Families and carers should be involved from the outset (with the patients consent).

B Once a diagnosis has been established, information should be provided to families and carers on the illness, its aetiology, course, treatment and the services available, including information regarding local and national support groups.

A Information should be provided by an experienced health professional who is familiar with the concerns and circumstances of the carers/relatives.

✓ Information may not be assimilated in one session and repetition may be required.

STABILISATION PHASE

Families and carers will continue to receive education and support in this phase, which may be integrated into a Family Intervention Programme.

A An Education Programme for patients should be undertaken in this phase, giving information on the illness and on the benefits and side effects of medication, which should allow optimal prescribing and hence improved compliance.

✓ Information should be skilfully delivered in a way that meets individual needs.

A Family Intervention Programmes should be implemented in appropriate cases following assessment.

A The Family Intervention Programme should include:

- an education programme

- analysis of family relationships and functioning

- family sessions to address the problems identified in the analysis

- relatives' support group.

✓ Family Intervention Programmes should be integrated with other aspects of care.

C Family relationships should be assessed to identify the need for family sessions to address relationship difficulties.

✓ A relationship of trust and an explanation of the aims of the programme are essential.

✓ The aims of family sessions should include:

construction of an alliance with the family
improvement of adverse family atmosphere
enhancement of the capacity of the relatives to anticipate and solve problems
reduction of feelings and expressions of anger and guilt by the family
maintenance of reasonable expectations for patient performance
attainment of desirable change in relatives behaviour and belief system.

C The Intervention Programme should continue for at least nine months with family sessions at least monthly.

A Intervention Programmes should be carried out by a trained health professional.

STABLE PHASE

Family Intervention Programmes will continue into this phase.

A Cognitive Behaviour Therapy should be considered for symptoms of psychosis which are distressing and resistant to conventional treatment.

Date question received: 27/02/2012

Date searches conducted: 07/03/2012

Date answer completed: 12/03/2012

References

Systematic Reviews

1. Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews* 2010, Issue 12. Art. No.: CD000088. DOI: 10.1002/14651858.CD000088.pub3. (Accessible from <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000088.pub3/pdf>)

RCT

2. Giron M, Fernandez-Yanez A, Mana-Alvarenga S, Molina-Habas A, Nolasco A and Gomez-Beneyto M. Efficacy and effectiveness of individual family intervention on social and clinical functioning and family burden in severe schizophrenia: a 2-year randomized controlled study. *Psychological Medicine* (2010), 40, 73–84. (<http://openurl.proquest.com/in?service=pq&issn=0033-2917&volume=40&issue=1&spage=73> requires Athens log-in)

Guidelines

3. NICE Clinical Guideline 82 Schizophrenia Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (Updated Edition) 2010
<http://www.nice.org.uk/nicemedia/live/11786/43607/43607.pdf>

4. SIGN National Clinical Guideline 030 (Scotland). Psychosocial Interventions in the Management of Schizophrenia 1998 <http://www.sign.ac.uk/pdf/sign30.pdf>

Results

Systematic Reviews

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Pharoah, Mari, Rathbone, Wong (2010)	December 2008	<p>Studies All relevant randomised or quasi-randomised controlled trials were included.</p> <p>Participants Studies were eligible where most (more than 75%) families include one member with a diagnosis of schizophrenia and/or schizoaffective disorder. Participants in all the included trials (except Szmukler 2003 and Leavey 2004) were diagnosed as having schizophrenia or schizoaffective disorder. Most studies used structured clinical assessments to determine the diagnosis (DSM 20 studies, CCMD 15 studies, ICD-10 seven studies, RDC two studies, New Haven Index one study, and PSE six studies). Szmukler 2003 included more than 80% with a diagnosis of schizophrenia-like illnesses, whilst the remainder suffered from bipolar affective disorder, or psychotic</p>	53 studies (overall sample size not stated)	<p>Any family based interventions (more than five sessions) versus standard care There was a statistically significant difference in favour of family based interventions for the following outcomes: reduced hospital admission at one year (n = 481, eight RCTs, RR 0.78 CI 0.6 to 1.0); hospital admissions up to 18 months (n = 228, three RCTs, RR 0.46 CI 0.3 to 0.7); number of days spent in hospital at 3 months (n = 48, one study, MD -6.67 CI -11.6 to -1.8); reduced relapse events at 12 months (n = 2981, 32 RCTs, RR 0.55 CI 0.5 to 0.6), 18 months (n = 181, 3 RCTs, RR 0.64 CI 0.5 to 0.9) and at 24 months (n = 1019, 13 RCTs, RR 0.64 CI 0.6 to 0.8), although data are heterogeneous ($I^2 = 67\%$); 'improvement' (n = 112, 2 RCTs, RR 0.40 CI 0.2 to 0.7); global assessment of functioning (n = 32, MD -10.28 CI -20.3 to -0.2); self-reported psychiatric symptom scores (one study, n = 80, MD -22.01 CI -30.9 to -13.0); BPRS data favoured family intervention at one year (n = 170, 3 RCTs, MD -8.32 CI -10.9 to -5.7), although data were heterogeneous ($I^2 = 79\%$); PANSS endpoint total scores at one year (n = 174, 2 RCTs, MD -7.90 CI -11.9 to -3.8); compliance with medication (n = 695, 10 RCTs, RR 0.60 CI 0.5 to 0.7); Social Disability Screening Schedule at 3 years (n = 150, MD -1.94 CI -2.90 to -1.0)</p>	Low

		<p>depression. Leavey 2004 included people described as having a psychotic illness. Overall, the age of participants ranged from 16 to 80 years. Of those studies which reported the sex of the participants, most included both men and women, although Glynn 1992, Liu 2007, Zhang 1994, and Zhang 2006a included only male patients. Patients had varied histories. Most studies involved families whose relatives had had multiple admissions, although three trials did involve substantial proportions of people with first episodes of illness (Goldstein 1978; Linszen 1996; Zhang 1994).</p> <p>Intervention Any psychosocial intervention with relatives of those with schizophrenia that required more than five sessions.</p> <p>Comparison Standard care, but this was not restricted to an in-patient context/environment.</p> <p>Outcomes Primary outcomes 1. Suicide and all causes of</p>		<p>(Family outcomes were also reported, but have not been data extracted)</p> <p>There were no statistical differences between groups for the following outcomes: hospital admissions at six months, hospital admissions at 2 years; 'relapse events' at six months; relapse at three years; BPRS negative scores; PANSS positive and negative scores; average change in general mental state scores for insight; average endpoint score of the mental state rating scale; compliance with community care at one year, and at two years; suicide; employment; a person's ability to perform work tasks; independent living; imprisonment; Social Disability Screening Schedule at 2 years;</p> <p>NOSIE endpoint scores favoured the control group (one study, n = 142, MD 59.10 CI 54.6 to 63.6)</p> <p>Behavioural family-based versus supportive family-based interventions (more than five sessions))</p> <p>There were no statistical differences between groups for the following outcomes: hospital admission; the numbers of people being rated as unstable at 6 months</p> <p>Group family-based interventions versus individual family-based interventions (more than five sessions)</p> <p>More people allocated to individual family intervention were able to live independently</p>	
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		mortality 2. Service utilisation 2.1 Hospital admission 3. Clinical global response 3.1 Relapse Secondary outcomes 1. Service utilisation 2. Clinical global response 3. Mental state and behaviour 4. Social functioning 5. Family outcome 6. Economic outcomes		compared with those who had been randomised to the group-based family intervention (one study, n = 23, RR 2.18 CI 1.1 to 4.4). There were no statistical differences between groups for the following outcomes: relapse; leaving a study early; compliance with medication	
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RCTs/DTAs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Giron (2010)	Participants The patients fulfilled the following selection criteria: (i) schizophrenia or schizophreniform disorder according to DSM-IV criteria (APA, 1994); (ii) to select patients with severe and persistent disorder but with sufficient stability to allow for establishing a reliable baseline, the following operative criteria were applied: persisting positive psychotic symptoms for more than 1 year or a clinical relapse in the previous years, with at least 2 months of clinical stability, defined as no variations in two Psychiatric Assessment Scale (PAS) ratings taken at an interval of 1 month. Patients with such severe persistent symptoms that it was not possible to	N = 50	Family intervention was associated with fewer clinical relapses (3/25 (12%) vs. 10/25 (40%), p=0.02, hospitalizations and major incidents 0/25 (0%) vs. 8/25 (32%, p=0.002, and an improvement in positive (mean change 2.00 vs. -0.44, p=0.001) and negative symptoms (mean change 0.64 vs. 0.19, p=0.003), social role performance (mean change 0.64 vs. -0.15, p=0.005), social relations (mean change -57.26 vs. 9.09, p=0.002), employment (mean change -0.88 vs. -0.04, p=0.009) and family burden. The reduction in hospitalizations in the family intervention group was significantly greater than that observed in the group of patients who refused to participate but this was not the case for the control group. The effects of family intervention were independent of compliance and prognostic factors.	Unclear

	<p>identify a clinical relapse on the PAS were excluded;</p> <p>(iii) aged 17–55 years;</p> <p>(iv) having lived at home for more than 1 month with a key relative (identified as the relative with the greatest number of hours of face-to-face contact with the patient) with a critical attitude, measured by means of the Semantic Differential (at least one item with a positive score under the dimension of negative evaluation or passivity), or a deficit in empathic capacity (index of empathic capacity ≤ 0.5) measured using the Empathy Questionnaire (Giron & Gomez-Beneyto, 1995, 2004); (v) absence of mental retardation, serious cognitive disorder, abuse or dependence on toxic substances according to the DSMIV criteria in the patient and their relative, including serious mental illness in the latter ; and (vi) family group or key relative had not received psychoeducational family intervention lasting for more than 3 months.</p> <p>Intervention Family intervention + individual counselling + standard treatment.</p> <p>Comparator Individual counselling + standard treatment.</p> <p>Outcome The primary outcome was clinical</p>			
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	<p>relapse. The positive symptoms were evaluated by using the Spanish version of the PAS (Krawiecka et al. 1977; Perez-Fuster 74 M. Giro'n et al. et al. 1989). To establish clinical relapse, the method of Vaughn et al. (1984) was followed. Persisting positive symptoms were defined according to criteria described previously (Giro'n & Go'mez-Beneyto, 1995, 2004). Negative symptoms were measured using section 1 of the Spanish version of the World Health Organization Psychiatric Disability Assessment Schedule (WHO-DAS; WHO, 1988; Man' a' et al. 1998), and the performance of social roles using section 2 of the same document. An overall score for each of the sections corresponds to the mean of the items evaluated. Social relations were measured by means of the first eight items of the Quality of Life Scale (QOLS; Heinrichs et al. 1984). The ratings ranged from 0 (absent) to 6 (adequate), and the sum of the scores was used. The quantity of work was measures by means of the Quantity of Useful Work item of the Strauss & Carpenter Prognostic Scale (Strauss & Carpenter, 1974). The first measurement corresponds to the year before the intervention and the second to the last 12 months of the trial.</p> <p>Duration 2 years</p>			
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Risk of Bias:

SRs

Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Pharoah, Mari, Rathbone, Wong (2010)					

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Giron (2010)						

 Low Risk
  High Risk
  Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
<i>SRs and Guidelines</i>			
NICE	(schizophrenia OR psychosis) AND family – filtered by guidelines, NICE & SIGN	87	
DARE	1 (psychosis) 196 2 (psychotic) 311 3 (schizophrenia) 695 4 (schizo*) 715 5 MeSH DESCRIPTOR Psychotic Disorders EXPLODE ALL TREES 108 6 MeSH DESCRIPTOR Schizophrenia EXPLODE ALL TREES 354 7 MeSH DESCRIPTOR Schizophrenia and Disorders with Psychotic Features EXPLODE ALL TREES 422 8 MeSH DESCRIPTOR Schizophrenia, Paranoid EXPLODE ALL TREES 1 9 (family) 1862 10 MeSH DESCRIPTOR Family EXPLODE ALL TREES 274 11 MeSH DESCRIPTOR Family Characteristics EXPLODE ALL TREES 29 12 MeSH DESCRIPTOR Family Therapy EXPLODE ALL TREES 54 13 MeSH DESCRIPTOR Family Conflict EXPLODE ALL TREES 4 14 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 898 15 #9 OR #10 OR #11 OR #12 OR #13 2016 16 #14 AND #15 109	109	1 (As a recent, high quality systematic review was found, no further were included from the search results)
<i>Primary studies</i>			
CENTRAL	#1 MeSH descriptor Psychotic Disorders explode all trees 1327 edit delete #2 MeSH descriptor Family, this term only 822 edit delete #3 (psychotic):ti,ab,kw or (psychosis):ti,ab,kw 3631 edit delete #4 (#1 OR #3) 3631 edit delete #5 (family):ti,ab,kw 11450 edit delete #6 (#2 OR #5) 11450 edit delete #7 (#4 AND #6), from 2006 to 2012 54 edit delete	54	1

PsycINFO	<ol style="list-style-type: none"> 1. PsycINFO; PSYCHOSIS/; 16922 results. 2. PsycINFO; CHRONIC PSYCHOSIS/; 196 results. 3. PsycINFO; (psychosis OR psychotic).ti,ab; 44438 results. 4. PsycINFO; 1 OR 2 OR 3; 46791 results. 5. PsycINFO; (famil* adj3 work*).ti,ab; 11878 results. 6. PsycINFO; (famil* adj3 intervention*).ti,ab; 5585 results. 7. PsycINFO; FAMILY INTERVENTION/; 1491 results. 8. PsycINFO; 5 OR 6 OR 7; 17633 results. 9. PsycINFO; 4 AND 8; 328 results. 10. PsycINFO; 9 [Limit to: Publication Year 2006-2012]; 147 results. 11. PsycINFO; CLINICAL TRIALS/; 5843 results. 12. PsycINFO; random*.ti,ab; 106512 results. 13. PsycINFO; groups*.ti,ab; 319180 results. 14. PsycINFO; (doubl* adj3 blind*).ti,ab; 16030 results. 15. PsycINFO; (singl* adj3 blind*).ti,ab; 1306 results. 16. PsycINFO; EXPERIMENTAL DESIGN/; 8147 results. 17. PsycINFO; controlled.ti,ab; 66662 results. 18. PsycINFO; (clinical adj3 study).ti,ab; 6652 results. 19. PsycINFO; trial.ti,ab; 56080 results. 20. PsycINFO; "treatment outcome clinical trial".md; 21218 results. 21. PsycINFO; 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20; 489222 results. 22. PsycINFO; 10 AND 21 [Limit to: Publication Year 2006-2012]; 37 results. 23. PsycINFO; (random* OR RCT).ti,ab; 106757 results. 24. PsycINFO; 10 AND 23 [Limit to: Publication Year 2006-2012]; 14 results. 	14	
EMBASE	<ol style="list-style-type: none"> 26. EMBASE; PSYCHOSIS/; 52603 results. 27. EMBASE; CHRONIC PSYCHOSIS/; 1 results. 28. EMBASE; (psychosis OR psychotic).ti,ab; 45314 results. 29. EMBASE; 26 OR 27 OR 28; 71150 results. 30. EMBASE; (famil* adj3 work*).ti,ab; 6168 results. 31. EMBASE; (famil* adj3 intervention*).ti,ab; 4090 results. 32. EMBASE; FAMILY INTERVENTION/; 9633 results. 	52	

	<p>33. EMBASE; 30 OR 31 OR 32; 18501 results.</p> <p>34. EMBASE; 29 AND 33; 638 results.</p> <p>35. EMBASE; 34 [Limit to: Publication Year 2006-2012]; 257 results.</p> <p>48. EMBASE; (random* OR RCT).ti,ab; 687939 results.</p> <p>49. EMBASE; 35 AND 48 [Limit to: Publication Year 2006-2012]; 45 results.</p> <p>50. EMBASE; random*.tw; 685835 results.</p> <p>51. EMBASE; factorial*.tw; 17939 results.</p> <p>52. EMBASE; placebo*.tw; 165691 results.</p> <p>53. EMBASE; (crossover* OR cross-over*).tw; 58302 results.</p> <p>54. EMBASE; (doubl* adj3 blind*).tw; 121887 results.</p> <p>55. EMBASE; (singl* adj3 blind*).tw; 13345 results.</p> <p>56. EMBASE; assign*.tw; 191900 results.</p> <p>57. EMBASE; allocat*.tw; 64571 results.</p> <p>58. EMBASE; volunteer*.tw; 149381 results.</p> <p>59. EMBASE; CROSSOVER PROCEDURE/; 31987 results.</p> <p>60. EMBASE; DOUBLE-BLIND PROCEDURE/; 103334 results.</p> <p>61. EMBASE; SINGLE-BLIND PROCEDURE/; 14881 results.</p> <p>62. EMBASE; RANDOMIZED CONTROLLED TRIAL/; 298222 results.</p> <p>63. EMBASE; 50 OR 51 OR 52 OR 53 OR 54 OR 55 OR 56 OR 57 OR 58 OR 59 OR 60 OR 61 OR 62; 1136340 results.</p> <p>64. EMBASE; 35 AND 63 [Limit to: Publication Year 2006-2012]; 52 results.</p>		
MEDLINE	<p>65. MEDLINE; PSYCHOSIS/; 28712 results.</p> <p>66. MEDLINE; CHRONIC PSYCHOSIS/; 0 results.</p> <p>67. MEDLINE; (psychosis OR psychotic).ti,ab; 34701 results.</p> <p>68. MEDLINE; 65 OR 66 OR 67; 50978 results.</p> <p>69. MEDLINE; (famil* adj3 work*).ti,ab; 5662 results.</p> <p>70. MEDLINE; (famil* adj3 intervention*).ti,ab; 3250 results.</p> <p>71. MEDLINE; "randomized controlled trial".pt; 320665 results.</p> <p>72. MEDLINE; "controlled clinical trial".pt; 83580 results.</p> <p>73. MEDLINE; randomi?ed.ab; 282565 results.</p>	29	

	<p>74. MEDLINE; placebo.ab; 133288 results.</p> <p>75. MEDLINE; "drug therapy".fs; 1504349 results.</p> <p>76. MEDLINE; randomly.ab; 174058 results.</p> <p>77. MEDLINE; trial.ab; 244256 results.</p> <p>78. MEDLINE; groups.ab; 1140590 results.</p> <p>79. MEDLINE; 71 OR 72 OR 73 OR 74 OR 75 OR 76 OR 77 OR 78; 2882834 results.</p> <p>80. MEDLINE; 69 OR 70; 8784 results.</p> <p>81. MEDLINE; 68 AND 79 AND 80; 73 results.</p> <p>82. MEDLINE; 81 [Limit to: Publication Year 2006-2012]; 29 results.</p>		
Summary	NA	NA	

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