Appendix H. Previous Systematic Reviews

Table H1. Previous systematic reviews

| Reference | Search Strategy/ Evidence Base | Key Inclusion/ Exclusion Criteria | Participant Characteristics | Outcomes Reported | Method of Assessing Quality | Method of Synthesizing Evidence | Results and/or Authors’ Conclusions |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Griffiths et al., 201222 | AMED, AMI, APAIS Health, CINAHL, CINCH-Health, Cochrane Library, DRUG, emedicine clinical knowledge database, Embase, International Pharmaceutical Abstracts, Medline, Proquest 5000 International, Psycinfo, Scopus and Web of Science for qualitative and quantitative studies discussing the use of psychotropic medication in prisoners. Eight Australian State and territorial government correctional services Web sites and one specialized journal, Journal of Correctional Health Care, were searched as well. | Study population was adult prisoners on a psychotropic medication of interest with full text available in English published between January 1999 and October 2009. Article had to be available in full text format. | 32 articles were included. | Review reported in a qualitative manner. Authors’ opinions on the following five themes were presented: polypharmacy, high dosing, duration of treatment, documentation and monitoring, and environment. | Checklist by Liberati was used for qualitative and quantitative studies and risk of bias was assessed with the Cochrane risk of bias assessment. | Qualitative | Five themes emerged from the included articles: polypharmacy (use of more than one antipsychotic is strongly discouraged but was widespread); high doses (dosages above the maximum recommended daily dose is discouraged as very high doses are no more efficacious and lead to more side effects); duration of treatment (insufficient time is given to initial monotherapy with one antipsychotic before a second supplementary drug was prescribed and therapy with hypnotics and benzodiazepines was too long); documentation and monitoring (generally found to be inadequate); environment (lack of consistency between prescribers and across sites). |

| Table H1. Previous systematic reviews (continued) | | | | | | | |
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| Reference | Search Strategy/ Evidence Base | Key Inclusion/ Exclusion Criteria | Participant Characteristics | Outcomes Reported | Method of Assessing Quality | Method of Synthesizing Evidence | Results and/or Authors’ Conclusions |
| Heilbrun et al., 201286a | NR | Experimental and quasi-experimental studies of community-based interventions (ACT, ICM, and correctional reentry programs) versus treatment as usual for offenders with SMI were the preferred design. Observational studies were also included in this review. | NR | Criminal justice outcomes (any booking, felony booking, any conviction, felony conviction) and quality of life indicators (alcohol problems, global functioning, homelessness, employment) | NR | Qualitative | Generally, individuals in ACT-based and ICM-based programs had better criminal justice outcomes and quality of life than individuals receiving TAU. One study of correctional reentry found that nearly 50% of participants were engaged in community services 3 months after program participation. |
| Martin et al.,  201121 | Searched PsycINFO and Web of Science for articles published no later than 2008.  Evidence base consisted of 25 studies published between 1989 and 2008. | Inclusion criteria: 1) article published in peer review journal or have gone through some other peer review process; 2) included comparison group; 3) tested the hypothesis that intervention improves mental health or reduces re-involvement in CJS; 4) had a sample size of at least 5; 5) reported necessary statistics to compute an effect size; and 6) had a sample of adults with mental disorders who were involved in the CJS.  Exclusion criteria: 1) substance use, intellectual/cognitive, and/or antisocial personality disorders as sole mental health diagnosis; 2) study considered a sex offender program; 3) comparison group made up of treatment refusal or dropouts; and 4) study included only subjective mental health measures. | NR | CJS outcomes included: number of arrests, violent arrests, jail days, and breach of conditions.  Mental health outcomes included: functioning, symptoms, service utilization, and medication use.  Moderator outcomes included: study design characteristics (e.g., sample size, quality rating, randomized), intervention characteristics (e.g., treatment location, duration, and whether voluntary), and mental health outcomes (if mental health outcomes were measured). | Quality was assessed by modifying a coding tool developed for sex offender treatment outcome research (Beech et al., 2007). The scale assesses 20 items falling within 7 categories: administrative control of the independent variable, experimenter expectancies, sample size, attrition, equivalence of groups, outcome variables, and correct comparison conducted. | Quantitative The authors used meta-analysis to derive an overall effect of interventions provided to adults with SMI in the CJS on CJS outcomes and mental health outcomes. | The results indicated that combined effect sizes from 25 studies support the effectiveness of interventions for reductions in any CJS involvement. However, interventions had no significant impact on an aggregate mental health outcome, but demonstrated significant improvement on some distinct mental health outcomes, such as functioning.  The authors concluded that the “results suggested some relationship between intervention effects on mental health and criminal justice reinvolvement, although future research is needed in this area, especially given the absence of mental health outcome data.” |
| Mitchell and Braham, 201191 | Psycinfo and Medline through present date were searched for psychological treatment needs of deaf mentally disordered offenders residing in high secure settings. | Due to a lack of direct evidence on this topic the authors expanded the inclusion criteria to include low-, medium-secure and prison settings. Any type of article was included (e.g., narrative reviews). | Mentally disordered offenders with all types of hearing loss were included except when combined with blindness. Child studies and nonpsycho-therapeutics (e.g., psychopharma­cological) were also excluded. | A literature synthesis was presented, no predefined outcomes. | NR | Qualitative | When delivering treatment to the deaf mentally disordered offender expectation have to be adjusted, group interventions with deaf peers works best, and extra time and visual aids are required. There is a lack of evidence on effective treatments for deaf sex offenders. |
| Morgan et al., 201120 | Searched PsycInfo, Medline, and SocialSciAbs.  Evidence base consisted of 26 articles published between 1973 and 2004.  Settings represented in articles include 64% sanction-oriented facilities and 28% treatment-oriented facilities. | Inclusion criteria: 1) study published in English; 2) study evaluated an intervention provided in CJS; 3) participants suffered from a major DSM Axis 1 disorder; 4) the study included some form of control procedure or used a repeated measures design, and 5) study included sufficient data or summary statistics that allowed calculation of an effect size.  No exclusion criteria reported. | The total sample across studies included 1,649 offenders, with 1,369 participants in treatment groups and 280 participants in control groups. Forty-two percent of the studies included participants with schizophrenia, 15.4% with a mood disorder, and 19.2% with multiple Axis 1 disorders. | Mental health symptoms, coping, institutional adjustment, behavioral functioning, criminal recidivism, psychiatric recidivism, treatment-related factors, and financial benefit. | Used a portion of the Maryland Scale of Scientific Rigor to evaluate studies on the presence and composition of a comparison group relative to the treatment group. | Calculated individual study effect sizes and conducted meta-analysis on each treatment outcome. | Interventions for offenders with mental disorders reduced mental health symptoms, improved ability to cope with problems, and improved behavioral markers including institutional adjustment and behavioral functioning. Results of meta-analysis were statistically inconclusive about the effects of intervention on recidivism. |
| Huband et al., 201023 | Central, Medline, Embase, Cinahl, and Psycinfo, metaRegister of Controlled Trials and ClinicalTrials.gov through April 2009. Cochrane Schizophrenia Group register of trials on aggression, National Research Record and hand searches. | Prospective, placebo controlled trials of antiepileptic drugs taken regularly by individuals with recurrent aggression to reduce the frequency or intensity of aggressive outbursts. | Studies included a wide array of subjects in a variety of settings, including but not limited to: children and adolescent with conduct disorder or pervasive developmental disorder, outpatient adult males with impulsive aggression, impulsively aggressive adults with cluster B personality disorder, women with borderline personality disorder, male prisoners with personality disorders | Aggression, impulsivity, hostility, anger, anger-hostility, noncompliance, and adverse events. | Two authors independently completed the Cochrane Collaborations’ tool for assessing risk of bias. | Quantitative when possible | One study included in this systematic review found diphenylhydantoin 300 mg/day to be superior to diphenylhydantoin 24 mg/day for treating aggression and associated impulsivity in male prisoners at an institution for dangerous and emotionally unstable recidivists. |
| Nagi and Davies, 201024 | To describe and present evidence for psychological interventions intended to address offending behavior in individuals with offending histories cared for in low secure forensic mental health services. | Articles (reviews, systematic reviews) on what works including gray literature (reports on the Home Office Web site, papers and posters at conferences); hand searches; and prominent author searches published in English since 1990 were included. Articles specific to women or learning disabled populations were excluded. | Varied offender groups | Reoffending | NR | Qualitative | CBT is most effective and is the dominant treatment category being offered internationally, based on consensus opinion. Risks, needs and responsivity principles are only now starting to influence the treatments being offered. More research is needed in the low secure forensic mental health service area. |
| Sacks et al.,  201025 | Single-investigator meta-analysis | Studies performed by one investigator which assessed the effectiveness of modified therapeutic community versus standard of care for clients with co-occurring substance use and mental disorders to determine the consistency of effect across studies. | Adults with co-occurring substance abuse and mental disorders in the following settings: homeless population, offenders, outpatients or with HIV/AIDS. | Substance abuse, mental health, crime, HIV-risk behavior, employment and housing | NR | Quantitative when possible | Modified therapeutic community was superior to standard of care in reducing substance abuse and crime and improving mental health, employment and housing across a variety of settings. |
| Khalifa et al., 200829 | Medline, Embase, Psycinfo, Association of Telehealth Service Providers (ATSP online) and Telemedicine Information Exchange (TIE) published between 1998 to 2006 were searched for the use of videoconferencing in forensic settings. This search was supplemented by hand searches. | 24 articles of any design were included. Videoconferencing was broken down into three categories: for clinical and forensic applications, including determining competence to stand trial; for use in court; and for legal and ethical issues. | Those involved in the CJS including youth, rural victims of domestic violence, prison inmates with and without an SMI | Cost, inmate preference, number of hospital referrals, telemedicine utilization in prison | NR | Qualitative | There is preliminary evidence that videoconferencing is effective in forensic settings. However, the available evidence is limited by lack of control group, small sample size, and limited outcome reporting. |
| Duncan et al., 200692 | Searched CINAHL, EMBASE, MEDLINE, and Psych Info for articles published between 1980 and 2002.  Evidence base consisted of 20 studies that met inclusion criteria (8 used a control or comparison group design). 10 studies conducted in British high security hospital, 6 in British medium security hospital, and 4 in Canada or the U.S. (security level not specified). | Inclusion criteria: 1) study evaluated the efficacy/effectiveness of structured single-form group interventions specifically for offenders with mental disorders; 2) study evaluated the efficacy/effectiveness of structured complex group interventions specifically for offenders with mental disorders; and 3) published in English.  No exclusion criteria reported. | 19 studies included only males and 1 included only females.  Patient diagnoses:  Not specified (6 studies),  Axis I (3 studies),  personality disorder (4 studies),  psychotic disorder (1 study),  borderline personality disorder (1 study),  sex offender (1 study),  mentally ill (1 study),  antisocial (1 study), and  schizophrenia (1 study). | Studies were categorized by the focus of the intervention: problem solving skills, anger/aggression management, deliberate self-harm, or other. Outcomes focused on improvements in those categories (e.g., improved problem solving skills, anger management, etc.). | NR | When possible, individual study effect sizes calculated. Meta-analysis was not possible due to heterogeneity of study populations, small sample size and lack of comparable data. | Individual effect size calculations indicate positive effects, with a medium to high effect observed for self-harm interventions.  The authors conclude that more rigorous and consistent research be applied, including an agreement on common outcome measures and development of networks to improve individual study sample sizes. |

a This review mainly covered diversion settings. Parts of the review that were at least partially relevant to this report are detailed above.  
ACT=Assertive community treatment; AIDS=acquired immune deficiency syndrome; AMED=Allied and Complementary Medicine Database; AMI=Australian Medical Index; APAIS Health=Australian Public Affairs Information Service; CBT=cognitive behavior therapy; CINCH-Health: Health Issues in Criminal Justice (within CINCH, the Australian Criminology Database); CINAHL=Cumulative Index to Nursing and Allied Health Literature; CJS=criminal justice system; DRUG=DRUG Database; DSM=Diagnostic and Statistical Manual; ICM=intensive case management; HIV=human immunodeficiency virus; NR=not reported: SMI=serious mental illness; TAU=treatment as usual