Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial

Graham Thornicroft, Simone Farrelly, George Szumukler, Max Birchwood, Waquas Waheed, Clare Flach, Barbara Barrett, Sarah Byford, Claire Henderson, Kim Sutherby, Helen Lester, Diana Rose, Graham Dunn, Morven Leese, Max Marshall

Summary

Background The CRIMSON (CRisis plan IMpact: Subjective and Objective coercion and eNgagement) study is an individual level, randomised controlled trial that compared the effectiveness of Joint Crisis Plans (JCPs) with treatment as usual for people with severe mental illness. The JCP is a negotiated statement by a patient of treatment preferences for any future psychiatric emergency, when he or she might be unable to express clear views. We assessed whether the additional use of JCPs improved patient outcomes compared with treatment as usual.

Methods Patients were eligible if they had at least one psychiatric admission in the previous 2 years and were on the Enhanced Care Programme Approach register. The study was done with 64 generic and specialist community mental health teams in four English mental health care provider organisations (trusts). Hypotheses tested were that, compared with the control group, the intervention group would experience: fewer compulsory admissions (primary outcome); fewer psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved therapeutic relationships; and improved engagement. We stratified participants by centre. The research team but not participants nor clinical staff were masked to allocation. This study is registered with ClinicalTrials.gov, number ISRCTN11501328.

Findings 569 participants were randomly assigned (285 to the intervention group and 284 to the control group). No significant treatment effect was seen for the primary outcome (56 [20%] sectioned in the control group and 49 [18%] in the JCP group; odds ratio 0·90 [95% CI 0·58–1·39, p=0·63]) or any secondary outcomes, with the exception of an improved secondary outcome of therapeutic relationships (17·3 [7·6] vs 16·0 [7·1]; adjusted difference −1·28 [95% CI −2·56 to −0·01, p=0·049]). Qualitative data supported this finding.

Interpretation Our findings are inconsistent with two earlier JCP studies, and show that the JCP is not significantly more effective than treatment as usual. There is evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients’ preferences. The study therefore raises important questions about implementing new interventions in routine clinical practice.

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Introduction

Two guiding principles of mental health policy are that patients should exercise self-determination with respect to their treatment,1,2 and that they should receive the least restrictive form of care. In England, the Care Programme Approach (CPA)3 provides a framework for integrated mental health care. It is directed at the most vulnerable mental health service users and requires: the systematic assessment of health and social needs; the formation of a care plan; the appointment of a key worker or care coordinator to monitor and coordinate care; and regular review and amendments to care plans where necessary. As part of the CPA process patients now routinely participate in care planning, yet the number of patients admitted on a compulsory basis to psychiatric hospitals in England and Wales per head of population increased by over 50% in the decade to 1995, and then rose by 13%, from 26 632 to 30 092, during the decade to 2010–11.4 Rates of involuntary hospitalisation are difficult to compare internationally, but in countries with reliable data, per person rates are also increasing.5 Most patients find involuntary treatment a negative experience, and have described it as unjustified even a year later.6,7 A Joint Crisis Plan (JCP) aims to empower patients while facilitating early detection and treatment of relapse.8,9 The JCP format was developed after widespread consultation with patient groups.10 It is formulated by the patient in collaboration with staff. Held by the patient, it contains his or her treatment preferences for any future psychiatric emergency, when he or she may be too unwell to express clear views. The assumption is that such active involvement by the patient in the process of crisis planning will increase the likelihood of averting major relapse and the need for compulsory detention.

Two studies have suggested that JCPs might reduce compulsory treatment and improve therapeutic relationships. A pilot study of JCPs done in south London11 showed that at 6–12 month follow-up, most participants with JCPs reported feeling more involved in their care, were positive about their situation, and felt more in
control of their mental health. An exploratory randomised study of JCPs found that use of the Mental Health Act (MHA) was significantly reduced for the intervention group, the first clinical intervention to do so in mental health services. A health economic analysis of this trial found that the intervention had a high probability of being cost effective.13

In this paper we report the clinical outcomes of a definitive trial of JCPs. An economic evaluation of the trial is in submission. The primary hypothesis tested was that compared with the control group, the intervention group would have fewer compulsory admissions. Secondary hypotheses tested whether, compared with the control, the intervention group would have fewer psychiatric admissions, shorter psychiatric stays, lower perceived coercion, improved therapeutic relationships, and improved engagement. We stratified participants by centre. The research team (but not participants nor clinical staff) were masked to allocation. A prespecified subgroup analysis investigated the use of the MHA for black patients since a high rate of MHA use has been noted in the black population in England.14

Methods

Study design and participants

We did an individual level, single-blind, intention-to-treat randomised trial, which compared the JCP intervention, combined with treatment as usual, with a control group who received only treatment as usual. We recruited participants in three sites across England (Birmingham and Solihull Mental Health Foundation Trust; Lancashire Care NHS Foundation Trust and Manchester Mental Health and Social Care Trust; and South London and Maudsley NHS Foundation Trust) between August, 2008, and March, 2010, and followed them up 18 months after randomisation. Eligibility criteria were: a relapsing psychotic illness; aged over 16; at least one psychiatric admission in the previous 2 years; and registered on Enhanced CPA (ie, the integrated mental health care system for those mental health service users with the most complex needs). We excluded those who were detained under the MHA or were current inpatients, to reduce perceived pressure to participate. To enhance the generalisability of the sample, we made no further exclusions. Translations of materials and interpreters were used when needed. The trial received ethical approval by the King’s College Hospital Research Ethics Committee (07_H0808_174) and is registered with Current Controlled Trials ISRCTN11501328.

We recruited from generic and specialist community mental health teams in four English Mental Health Trusts. In each Trust a list of eligible participants was generated and research assistants approached the relevant clinical team to arrange a meeting. Patients were given a leaflet about the study and were asked to give written consent for participation and access to their medical records.

Sample size

The sample size of 270 in each group was chosen so that, after allowing for 15% loss to follow up and using a significance level of 0·05, a reduction by half in primary outcome of the overall proportion admitted under the MHA could be detected with 90% power (from 30% to 15%). This sample size would also allow detection of a proportionate reduction for a prespecified subgroup of interest, black patients, with 80% power (from 40% to 20%), assuming that the overall sample would yield an achieved subsample of 91 per group based on the proportions of black patients at the three sites. Effect sizes for continuous secondary outcomes of around 0·3, with 90% power would also be detected.

Randomisation and masking

After baseline assessment, we stratified participants by site and randomly allocated them to intervention or control group using permuted blocks of randomly varying block size, with equal allocation to the two groups. The allocation sequence was generated by the independent clinical trials unit at the study coordinating centre. The JCP facilitators at each site were notified by an automatic email from the clinical trials unit of participants at their Trust who were allocated to the intervention or control. Investigators, research assistants (who did the follow-up), and trial statisticians were masked to allocation. Qualitative data were collected by separate qualitative researchers (SF, HL, DR) who were not involved in baseline and follow-up assessments, and occurred after a participant’s follow-up to ensure research assistants were unmasked. Qualitative researchers were not masked because they specifically interviewed intervention group participants only.

Procedures

To establish whether the JCP was better than standard care, we chose treatment as usual under the CPA as our control condition. The trial therefore compared JCP with CPA versus CPA alone.

The JCP intervention is described in detail elsewhere. In brief, five senior mental health nurses were employed as JCP facilitators to deliver the intervention. In addition to treatment as usual, each participant in the intervention group was invited to two meetings (preparatory and planning), organised by the JCP facilitator. At the preparatory meeting, the facilitator introduced the participant and their care coordinator to the principles of Joint Crisis Planning and the so-called JCP menu, a list of types of content that participants might want to include in their JCP. The planning meeting was to be attended by the participant, their psychiatrist, the JCP facilitator, and the care coordinator. Participants could also invite a friend or relative. At this meeting the JCP was finalised. The presence of the JCP facilitator was thought to empower the participant to express and discuss their own treatment wishes with clinicians,
which would in turn facilitate earlier help-seeking and self-help strategies, reducing the need for compulsory admission. The free expression of participants’ wishes and subsequent discussion with clinicians moderated by the JCP facilitator was thought to be a key difference between the JCP process and the routine care planning undertaken as part of the CPA. After the planning meeting the JCP was approved by the participant, and a paper copy was disseminated to the participant, psychiatrist, care coordinator, and anyone else nominated by the participant, and was uploaded to the participant’s electronic patient record. 9 months later the JCP facilitator again contacted participants to ask if they wanted to update the plan. To ensure fidelity, we provided week-long training and assessment for the JCP facilitators before starting, and weekly supervision with one of the developers of the JCP (KS). Fidelity ratings of a randomly selected sample of recordings from each facilitator, and from the beginning, middle, and end of the intervention period, were rated by KS using a standardised form. 16 items measured the extent to which facilitators developed rapport with the participant, remained neutral in the negotiations, structured the meetings, addressed disagreement (when applicable), encouraged discussion between participants and their clinicians, facilitated patient choice, and accurately presented the participants’ treatment wishes as agreed at the planning meeting. Items were scored on a Likert scale ranging from 0 to 2, with higher ratings indicating higher fidelity. A final fidelity score was generated by summing the items and dividing by the number of applicable items to generate a percentage. Deviations from the model were addressed during supervision. We also rated the quality of each JCP using a standardised format. Higher quality JCPs were defined as those that were written in the first person, with unambiguous and non-technical language, and without grammatical or spelling errors.

Data were extracted at baseline and at 18 months after randomisation. Our primary outcome was admission under the MHA. Data for admissions were extracted from clinical records, while other outcomes were assessed from interviews with participants. Our hypothesis was that the primary outcome (number of compulsory admissions) would be significantly lower in the intervention group at follow up. Our secondary outcomes were chosen because they covered a range of critical issues identified through our initial literature review, exploration of stakeholder perspectives, and preparatory research. In addition to voluntary admissions and length of stay, they included the therapeutic relationship (self and clinician-rated Working Alliance Inventory [WAIC and WAIT] adapted for use in community settings\(^2\)), perceived coercion (MacArthur Perceived Coercion Scale,\(^8\) self-rated), and engagement (Service Engagement Scale,\(^7\) clinician-rated). Higher scores were worse on all scales. Masked research assistants also rated the Global Assessment of Functioning (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition),\(^18\) and collected service use and demographic information. A subgroup analysis specifically investigated the use of the MHA for black patients. The main hypotheses of our study are listed in panel 1.

**Statistical methods**

All analyses used SPSS version 16 or Stata version 11. Bias due to missing follow-up data was assessed by comparing baseline characteristics of those with and without complete data. Analysis was done under intention-to-treat principles. The proportions admitted to hospital at follow up were compared between randomisation groups using \(\chi^2\) tests and logistic regression. Days in hospital and under a section of the MHA were analysed using \(t\) tests and linear regression with robust standard errors to account for skewed data. Number of admissions (voluntary and under the MHA) were analysed using \(t\) test and rank sum non-parametric test, and Poisson regression. These analyses were controlled for site, and for variables associated with missing outcomes. Continuous outcomes were analysed with linear regression. These were controlled for baseline (pre-intervention) measures, site, and variables associated with missing outcomes. As a sensitivity analysis, the regressions were repeated including random effects for mental health teams. The analyses were repeated within the black subgroup, prespecified as those specifying their ethnicity as black/black British (Caribbean), black/black British (African), black/black British (other), mixed (white and black Caribbean), or mixed (white and black African).

**Qualitative evaluation**

Focus groups and semi-structured interviews with intervention group participants were done at each site. Separate patient and care coordinator focus groups were held, followed by combined groups. Individual interviews were also done with psychiatrists, care coordinators, and other stakeholders. The analyses were repeated including random effects for mental health teams.

**Panel 1: Hypotheses**

The primary hypothesis was that, compared with controls, the proportion of participants sectioned under the Mental Health Act would be significantly lower for the intervention group.

Secondary hypotheses were that, compared to controls, for the intervention group:
- The proportion of participants admitted to a psychiatric unit would be significantly lower.
- The length of stay on a psychiatric unit would be significantly shorter.
- Self-rated perceived coercion would be lower.
- Self-rated and clinician-rated therapeutic relationships would be improved.
- Clinician-rated patient engagement would be improved.
Articles

and patients. Different qualitative methods were used for pragmatic reasons (eg, almost all psychiatrists preferred one-to-one rather than group interviews) and specifically to use the strength of focus groups in terms of drawing out views on sensitive issues where group dynamics can add particular value. All interviews and focus groups were done after the follow-up assessment. Inductive thematic analysis, including constant comparison methods, were used to analyse data that specifically related to explaining the trial outcomes. Disconfirming evidence was sought throughout. NVIVO version 9 was used to help manage the data.

Role of the funding source
The sponsor of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the manuscript. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results
569 participants from 64 generic and specialist mental health teams provided informed consent and were randomised (figure). Table 1 shows the baseline characteristics of the participants. Stratified randomisation ensured roughly equally sized samples from each site in each group and there were no substantial differences in any baseline characteristics. The median length of follow up was 557 days (18·5 months, range 3 months [death due to unrelated physical causes] to 36 months [difficulties locating participant]) Masking was maintained in 93% of cases.

The degree of missing data varied across secondary outcome measures: 20% of participants were missing perceived coercion score, 24% were missing engagement with care scores, and 22% were missing WAIC and WAIT scores at follow up. Participants missing secondary outcomes at follow-up were more likely to come from the intervention group for all outcomes: 56% perceived coercion, 60% service engagement, 64% WAIC, and 63% of those missing WAIT. Diagnosis was also associated with missing data in all of the secondary outcomes. Site was associated with missing data for perceived coercion, service engagement, and WAIC. Missing service engagement data was also associated with a higher Global Assessment of Functioning score, missing WAIC associated with number of previous admissions, and missing WAIT associated with marital status and Global Assessment of Functioning score.

Data for demographic, therapeutic relationship, and patient engagement were obtained from the case managers or other named clinicians (care coordinators); however, 35 (6%) of 569 of the care coordinators did not complete these at baseline. Care coordinators were 65% women, 71% were white, 62% were nurses, and they had an average age of 42 years.

Admissions data at follow-up are shown in table 2. For the primary outcome (compulsory admission), 56 (20%) in the control group and 49 (18%) in the JCP group were admitted compulsorily, with a mean duration of 20·6 (SD 73·4) days in the control group and 22·3 (72·0) days in the JCP group. For any admission (compulsory or voluntary), the mean durations were 26·4 (76·2) days in the control group and 29·5 (75·7) days

Figure: Trial profile
*18 and 14 missing primary outcome data.
in the JCP group. There were a total of 158 admissions under either compulsory or voluntary status: 81 (29%) in the control group and 77 (29%) in the JCP group. Medians for these admission data are shown in table 2. In bivariate analyses, no significant differences were noted between the randomisation groups in terms of proportion of admissions, number, or duration of admissions over the follow-up period.

Regression analyses adjusting treatment effect estimates for site (which was a design factor) and the WAIC, (which was associated with having missing data) showed no significant treatment effect for the primary outcome or for any of the other admissions outcomes. When random effects for the 64 mental health teams were included, very similar results were obtained.

The three continuous secondary outcomes are summarised in table 3. There was some evidence for an improvement in self-rated therapeutic relationship (WAIC) in the intervention group (17·3 [7·6] vs 16·0 [7·1], unadjusted difference −1·29 [95% CI −2·67 to 0·09, p=0·066]), when controlling for factors associated with the trial design and loss to follow-up (baseline value, site, number of previous admissions, diagnosis, and baseline WAIC [−1·28 95% CI −2·56 to −0·01, p=0·049]). There were no significant differences between groups in the other secondary outcomes. Regression analyses with adjustment made negligible difference to these findings (appendix).

147 black/black British participants were recruited and randomly assigned, 75 to the control group and 72 to the JCP group. We obtained admissions data at follow up for 138 (94%) of the participants. A further nine did not complete the follow up interview, giving 129 (88%) with follow up information. No baseline characteristics were found to be significantly associated with missing admissions data in this subgroup, although as a sensitivity analysis and for consistency with the full sample analysis we adjusted for baseline WAIC.

No significant difference was seen within the black subgroup for any admission outcomes between those randomised to the JCP group compared with controls. 13 (20%) participants assigned to the JCP group had a compulsory admission in the follow up period compared with 23 (32%) in the control group (adjusted odds ratio 0·56, 0·25–1·25, p=0·16). Admission outcomes are shown in table 4. There were a total of 45 admissions under compulsory or voluntary status: 18 (27%) in the JCP group and 27 (38%) in the control group (adjusted odds ratio=0·67, 0·32–1·39, p=0·28). There was no significant treatment effect of JCP over controls found in any of the secondary measures within the subgroup (appendix).

12 focus groups were done: five patient groups, five care coordinator groups, and two combined groups. Respondent validation occurred during combined focus groups with ten participants who had participated previously. Overall, 58 people attended a focus group: 35 patients, 22 care coordinators, and one psychiatrist (at a combined group). 37 individual interviews were also done with 16 psychiatrists, six care coordinators, and 15 patients. 52% of patients were women, mean age 39·2 years (SD 7·0), and 64% were white, 32% were black, and 4% were Asian. 58% of care coordinators were women, mean age 43·8 years (SD 8·0) and 75% were community psychiatric nurses. 20% of psychiatrists were women, with an average of 6·5 years (range 3–11 years) as a consultant. 85 people were included in the qualitative study.

Our qualitative data provide support for the improvement in patients’ views of the therapeutic relationships and suggest that JCPs could make a positive difference to both patients and clinicians. For example, patients felt respected and more understood by clinicians, particularly in relation to their wishes regarding future treatment.
Some clinicians seemed to gain a wider understanding of patients’ views of care and presentation in a crisis. These benefits appeared to occur when the JCP meeting acted as a vehicle for clinicians to demonstrate respect for patients’ views of care and presentation in a crisis. These benefits might have improved considerably since our first study, although this also seems unlikely since an assessment of the fidelity scale a rating of whether the JCP meeting was done at the same time as the routine clinical review meeting. Second, crisis planning in the control group was clinician led rather than patient led. For the JCP meeting to be beneficial, it needed to be sufficiently demarcated from a CPA meeting both in terms of time and ethos (which was not achieved since 48% of JCP meetings took place in association with a routine CPA meeting). There was also considerable ambivalence about routine care planning generally, as many clinicians saw it as a bureaucratic exercise with limited clinical benefit. Second, most clinicians failed to recognise that implementing the JCP required a change in the usual clinician-patient relationship on their part, beginning with active discussion of treatment options and supporting patient choice both in the meeting and in implementation. Third, implementation in practice required commitment by all participants within a complex system; however, many patients complained that the agreements in the JCPs were not honoured in practice and only five of the 28 care coordinators reported that the agreements in the JCPs were not honoured in practice.

Discussion

We found no differences between the intervention and control groups for the primary outcome (namely compulsory admissions), either for the total sample or black subgroup. We found a modest improvement in therapeutic relationship in the intervention group, but no other differences on other secondary outcome measures. Qualitative analysis found that although some patients had a positive experience of JCP, many described how clinical services struggled to put it into practice.

Why should these findings be so markedly different from those of two previous JCP studies? First, the intervention might have been delivered with lower fidelity to the model, but this is unlikely because the mean fidelity score was high in this trial (although we did not include in the fidelity scale a rating of whether the JCP meeting was done at the same time as the routine clinical review meeting). Second, crisis planning in the control group might have improved considerably since our first study, although this also seems unlikely since an assessment of routine crisis plans for the trial participants indicated that they were of poor quality (eg, only 27% contained one or more items of information specific to the individual). Third, clinician engagement could have been poor both at instance through active listening. However, a more common scenario was poor engagement with the process of developing the JCP and implementation of the JCP in practice. Many patients, for example, could not remember the JCP planning meeting as anything distinct from a routine CPA meeting. There were three particular barriers to implementation. First, many clinicians believed they were already carrying out joint care planning and that the JCP added very little. However, clinician descriptions of joint planning in CPA meetings suggest that both the meeting and the plans generated were clinician led rather than patient led. For the JCP meeting to be beneficial, it needed to be sufficiently demarcated from a CPA meeting both in terms of time and ethos (which was not achieved since 48% of JCP meetings took place in association with a routine CPA meeting). There was also considerable ambivalence about routine care planning generally, as many clinicians saw it as a bureaucratic exercise with limited clinical benefit. Second, most clinicians failed to recognise that implementing the JCP required a change in the usual clinician-patient relationship on their part, beginning with active discussion of treatment options and supporting patient choice both in the meeting and in implementation. Third, implementation in practice required commitment by all participants within a complex system; however, many patients complained that the agreements in the JCPs were not honoured in practice and only five of the 28 care coordinators reported referring to or using the JCP during the follow-up period.

Experiences were common to patients from different ethnic groups (see appendix for participant quotes).
crisis planning meetings and subsequently. This explanation is supported by our finding that in 48% of cases JCPs were not formulated at specific meetings, but were discussed at the same time as CPA reviews (this only took place where clinical staff did not make themselves available to discuss the JCP outside of the usual clinical review meeting). In a third of cases, the full clinical team was not present. Our qualitative work suggests that many patients could not remember the JCP planning meeting as distinct from a routine CPA meeting. Further, many patients complained that the content was not followed during a subsequent crisis. The clinicians’ readiness to engage in the approach could be a crucial component of success (panel 2). Our previous efficacy trial involved clinicians who expressed an interest in the intervention, whereas this effectiveness study involved an arguably more generalisable sample of clinicians, resulting in more variable clinician buy-in to the JCP process, and indeed participating teams and clinicians were assertively recruited and followed up within sites, with few outright refusals. In effect, therefore, the trial compared JCP plus CPA against CPA alone. Our results indicate that the effects of the two processes were in rather opposite directions. The CPA was seen by patients as a routine process that did not include their preferences in any meaningful way, whereas staff tended to see the CPA as an imposed operational requirement. Patients tended to see the JCP as a highly acceptable process that did respect their point of view, while many staff saw the JCP as an optional extra offering little extra benefit. In terms of the actual use of the JCPs, the results suggest a lack of buy-in by staff into the JCP process. In this context, the JCP fidelity measure did not sufficiently sensitively identify this lack of staff engagement.

The UK Department of Health’s Operating Framework for the NHS for 2012–13 states that it puts “patients at the centre of decision making”; our results suggest that the current CPA framework fails to facilitate this aspiration. The CPA is often seen as a bureaucratic structure that constrains both clinicians and patients within a power hierarchy. Some clinicians feel that rigid adherence to the CPA is a form of risk management against blame for any future adverse events. The JCP challenges the ethos of the CPA because it calls for the clinician to share or cede significant power to the patient. Where the JCP meeting worked well, patients reported feeling respected, and clinicians talked about how the patient “came alive” as an individual, indicating a more personalised approach to care.

Limitations of the study include the fact that at least some of the community mental health teams were not adequately prepared to deliver the JCP intervention as separate from the CPA, and had little sense of ownership of it. In the emerging field of implementation science, the factors needed to put a new intervention (one efficacious in early trials) into routine, effective clinical practice (ie, to optimise implementability) are becoming more clearly understood. For example, the few studies of implementing mental health clinical guidelines within mental health care have shown only modest results in terms of patient benefit. Furthermore, the JCP is a complex intervention and within this trial we did not include an extended formative stage where we could discuss the attitudes of clinicians to adoption in routine clinical use, and in retrospect this could have been a crucial limitation of the study. The JCP intervention was introduced to clinical teams without specific attention to the local staff or organisational context or readiness for this process, an important prerequisite for successful adoption of a new intervention. Our fidelity measure was also clearly not sufficiently sensitive and therefore requires further development. These considerations should be examined in subsequent replication studies. Furthermore, the economic evaluation (unpublished) highlights differential levels of cost-effectiveness by ethnic group, thus supporting further exploration of JCPs in particular for black ethnic groups.

Panel 2: Research in context

Systematic review

A recent Cochrane systematic review of advance treatment directives for people with severe mental illness identified two trials, our exploratory trial of Joint Crisis Plans and a trial of advance directives. The trial of advance directives was described by the reviewers as a less intensive intervention, in that no discussion with the mental health-care providers of the service users took place. Whereas the trial of Joint Crisis Plans showed reduced use of the Mental Health Act, the trial of advance directives did not, and meta-analysis showed no overall effect. Another trial, of facilitated advance directives, was excluded on the basis that its outcomes were not of interest.

Interpretation

Our trial showed no evidence of effectiveness for the Joint Crisis Plan in terms of use of the Mental Health Act, by contrast with the previous exploratory trial, but consistent with the overall findings of the Cochrane Review. However, we did find a positive effect for service user views of the therapeutic relationship, and this was also reported in the trial of facilitated psychiatric advance directives that was excluded from the Cochrane Review. In this context, and with our qualitative analyses, we conclude that Joint Crisis Plans seem to positively affect the therapeutic relationship from the service users’ perspective, but might only affect outcomes such as use of the Mental Health Act when clinical staff are positively engaged in their development and implementation.

Contributors

The study was designed by MB, SB, GD, CH, HL, ML, MM, DR, GS, KS, GT, and WW. The study was administered by MB, SB, SF, MM, GS, KS, GT, and WW. The trial manager was SF. GD and ML designed the statistical analyses, and CF and ML did the statistical analyses. BB and SB designed and undertook the economic analyses. HL, DR, and SF designed and undertook the qualitative analyses. All authors contributed to the interpretation of the data, the writing of the paper, and approved the final manuscript. GT had full access to all the data in the study and had full responsibility for the decision to submit for publication.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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