A joint crisis plan negotiated with mental health staff significantly reduces compulsory admission and treatment in people with severe mental illness


Does a joint crisis plan reduce the use of inpatient services, and compulsory admission and treatment in people with severe mental illness?

METHODS

- **Design:** Randomised controlled trial.
- **Allocation:** Concealed.
- **Blinding:** Single blind (outcome assessor blinded).
- **Follow up period:** 15 months.
- **Setting:** Seven community mental health teams, South London and Kent, UK; recruitment 2000 to 2001.
- **Patients:** 160 people with psychotic illness, or bipolar affective disorder without psychotic symptoms. Exclusions: not admitted to hospital in the preceding two years; current inpatient, or unable to give informed consent.
- **Intervention:** Joint crisis plan: contained information on contact details, history of mental and physical illnesses, previous antidepressants and psychotherapies, signs predicting relapse, and instructions for care if a future relapse occurs. The plans were developed by negotiation and agreement between mental health staff and the person with severe mental illness. A carer, friend, or advocate was encouraged to help finalise the plan. Control: received information leaflets on mental illness and treatment, and local mental health services.
- **Outcomes:** Admission to hospital; time spent in hospital; compulsory admission and treatment in mental health services.
- **Patient follow up:** 100%.

MAIN RESULTS

At 15 months, people with a joint crisis plan were significantly less likely to experience compulsory admission and treatment (13% v 27%, RR 0.48, 95% CI 0.24 to 0.95) and there was a trend towards fewer overall admissions compared with control (30% v 44%, RR 0.69, 95% CI 0.45 to 1.04). The mean length of hospital stay after compulsory admission was significantly less for people with a joint crisis plan than controls (see http://www.ebmentalhealth.com/supplemental for table). There was no significant difference in the time spent in hospital for each group after non-compulsory hospital admission. The reasons for compulsory admission were similar for both groups, but people with a joint treatment plan were more likely to be released from hospital early after compulsory admission than controls.

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CONCLUSIONS

A joint crisis plan made with the help of mental health staff and a carer, friend, or advocate significantly reduces compulsory hospital admission and treatment in people with severe mental illness.

Commentary

Involuntary admissions in England have increased by 57% over 10 years. Compulsory community treatment has had most attention as an alternative. This article examines another: joint crisis plans developed by patients and their mental health team, including an advance agreement for treatment in an emergency when patients are too unwell to give consent.

Henderson et al showed that this intervention significantly reduced compulsory admissions in patients with severe mental illness. The reduction in overall admission only just fell short of statistical significance (p = 0.07). However, the study was small and power was further reduced by the lower than anticipated admission rate, a key outcome. There are caveats. Barely one third participated. Although there were no significant differences in age, sex, and length of contact between participants and non-participants, there were no data on ethnicity of non-participants. This is important given the high rates of involuntary admission in people of African-Caribbean descent, and their overrepresentation in secure units and special hospitals. The nature of the intervention meant that it was only single-blind, and allocation concealment in the randomisation was unclear.

Against this, the sample came from a range of settings (inner city, suburban, small town) and participants showed broad ethnic representation. These findings are different to those from another similar sized study in the London area where advance directives did not reduce involuntary admission. One explanation might be that the study of Henderson et al had a lower participation rate leading to selection bias: patients with a better prognosis may have differentially participated. Another is the intensity of their intervention: the plan was developed at a 30–50 minute meeting with the researcher, treating team, patient, and invited relative. In the other study, patients were only given booklets with seven statements for completion. This study needs replication but offers better proof than the evidence for compulsory community treatment.

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