Decision-making and mental capacity

Appendix C1: Evidence tables and methodology checklists

Economic evaluations

Review Question 1

Planning in advance, including for people who experience fluctuating capacity

1.1 What interventions, tools, aids and approaches are effective and cost-effective in supporting advance planning for decision-making for people who may lack mental capacity in the future?

1.2 What are the views and experiences of people who may lack mental capacity, their families and carers, practitioners and others interested in their welfare, on the acceptability of interventions, tools, aids and approaches to support planning in advance for decision-making?

Study details, country, study type, service description	Study population, design & data sources	Outcomes, Resource use, Costs	Results Cost-effectiveness	Summary
Study details Dixon et al	POPULATION	Individual health or	Price year Varies	Applicability
(2015)	Excluded: psychiatric patients, children	wellbeing outcomes not		Sufficiently
	(<18 years old)	measured, focus is on	Findings	applicable (+)
Study design Systematic		cost-savings and health	Authors conclude that	
review of economic	• 3 studies = nationally representative	service use	impact on economic	Quality
studies.	data from US Health and		implications is limited	Good quality with
	Retirement study of older people	RESULTS	and equivocal but there is	some limitations (++)
Country 12 US, 1 Canada,	(p.872).	Cost-savings ranged from	no evidence suggesting	0
1 Singapore, 2 UK	• 1 study = random sample of	USD 64,827 for the	that ACP is more costly	Summary
	Medicare beneficiaries (p.878)	terminal hospital stay to	(p.882).	This systematic
Date Included studies	• 1 study = patients admitted to an	USD 56,700 for total		review covered economic studies on
published between 1990-	inpatient oncology unit in a US	healthcare costs over the	5 better-designed non-UK	
2014	hospital (p.878)	past 6 months for people	studies found a significant	ACP. The findings
External & internal	• 1 study = high-cost and low-income	with dementia and USD	relationship between ACP and healthcare savings.	of the review suggest that ACP might
validity of the systematic	Medicare beneficiaries (p.878)	1,041 in hospital costs over the last week of life	Ũ	reduce the costs for
review (+/++)	• 7 studies focus on hospital-based	for those with cancer		hospital care.
ieview (1/11)	samples (p.878)	for those with cancer	nursing homesPeople with high	nospital care.
Follow-up period	• The remaining 5 studies are not	However, because of	 People with high support needs and 	
Varies: last year or last	described in summary although	differences in	low income	Individual studies
week of life or unrelated	population description is provided	methodologies, results are	 Individuals living 	only captured costs
to death (1 year post-	for each study in the tables.	not comparable between	• Individuals living with dementia in	and did not capture
intervention) (1 study)	DATA SOURCES	studies.	community	the effectiveness of
(p.881)	Sources of effectiveness data	studies.	 Individuals living in 	ACP in terms of
(1	In total, 18 studies included.		high health-care	potential health and
Study type	 5 RCTs 	Resource use	spending region	wellbeing benefits to
Systematic review of	 3 non-randomised controlled 	11/18 studies with	spending region	persons at end of life
economic evaluations;	designs	positive results found the	Sensitivity analyses	and their families
however, no cost-	 10 natural experiments using 	source of cost-savings to	Considers whether there	and carers.
effectiveness studies	statistical methods to control for	vary, but mainly due to	are differences in findings	
identified. Most were	confounding	reductions in hospital	depending on 'general	
cost-savings studies.	comounding	-	ACP' study or	

Intervention Advanced care planning (ACP) doe people reaching end-of-life

	Sample size ranges from n=50 to	admissions and/or ICU	'intervention evaluation',	Generally, studies
Intervention	n=3,000+	use.	study design, sample size,	had a limited cost
ACP as a part of a wider			and setting.	perspective, with a
intervention or in the	Sources of resource use data Varied, 10		8	focus on hospital
absence of a wider	focused on hospital-based service		In all but 1 of the	care. The impact on
intervention as long as	use/costs, 8 include hospital and		comparisons, results show	community health
ACP was substantial	community healthcare costs (p.880).		mixed findings, with	and social care as
component; excluded			approximately 50% of	well as on unpaid
were studies of	Sources of unit cost data		studies finding positive	care remained
interventions that were	Varied (p.779)		impact and remaining	unknown.
solely about medical	 6 studies = Medicare charges 		finding no difference. The	
orders or about advance	• 1 study = Medicare charges and co-		exceptions are 2 studies of	The review was of
decisions in regards to	payments		nursing homes where	overall good quality
power of attorney	• 1 study = Medicare and Medicaid		both studies find positive	with some
	charges		results.	limitations, which
8 studies were non-	• 3 studies = direct charges to patients			means that findings
intervention studies.	or insurers			need to be
• They were "exploring	• 7 studies = accounting costs			interpreted with
the impact of ACP in	reflecting different accounting			some level of
general" – all but 1	systems			caution.
rely on secondary				
sources of data				
(p.878)				
Comparison				
Care as usual				

Methodolo	Methodological quality checklist for systematic review				
Study ider	Study identification: Dixon et al (2015)				
Guideline	topic: Decision-making and mental capacity				
Economic	Economic priority area: 1 Q: 1				
1. Study re	1. Study relevance to review question				
1.1 Does th	1.1 Does the study's research question match the review question?				
Yes "To review and summarise economic evidence on advance care planning"					
1.2 Has the study dealt appropriately with any ethical concerns?					

N/A	Not needed as this was a systematic review and there was no primary data collection involved.
1.3 Were s	service users involved in the study?
N/A	This was a systematic review.
2. Study r	elevance to scope
2.1 Is ther	e a clear focus on the guideline topic?
Yes	Advance care planning
2.2 Is the	study population the same as at least one of the groups covered by the guideline?
Yes	People at risk of losing mental capacity towards the end of life
2.3 Is the	study setting the same as at least one of the settings covered by the guideline?
Yes	The review includes two UK studies and covers a range of settings such as hospital, care home, home, hospice
2.4 Does t	he study relate to at least one of the activities covered by the guideline?
Yes	Advance care planning
2.5 (For ef	fectiveness questions) Are the study outcomes relevant to the guideline?
Partly	Does not include individual health and wellbeing outcomes, does not include impact on carers/family.
2.6 (For vi	ews questions) Are the views and experiences reported relevant to the guideline?
N/A	
2.7 Does t	he study have a UK perspective?
Sufficient;	2 UK studies identified; most are from USA (12); other studies from Canada (1), Singapore (1)
3. Overall	assessment of external validity (-, +, ++)
(+)	Downgraded quality due to limited number of UK studies (2), cost perspective only; however, the review is applicable to the overarching Guideline review question.
Internal v	
	vriate and clearly focused question?
Partly	The aim of the study was to review and summarise economic evidence on advance care planning; there is no specific research question
	clarifying the purpose
	on of relevant individual studies?
Partly	Authors state that there were difficulties in developing an adequate search strategy due to the diversity of the literature; two studies were thus identified outside of the main search and authors state that it was possible that some relevant studies were missed
3. Rigorou	as literature search?
Yes	A wide range of relevant database were searched including one economic one (EconLit)
	juality assessed and reported?
Partly	Study quality assessed using tools for effectiveness studies but no quality assessment tools relevant for economic studies were used

5. Adequ	5. Adequate description of methodology?			
Yes	Search strategy and review process is explained in sufficient detail and presented in graphical form.			
6. Do con	6. Do conclusions match findings?			
Partly	Conclusions summarize the main findings and limitations; however some conclusions about sub groups were drawn by generalising			
-	inappropriately from single studies that had substantial limitations and were heterogenous			
7. Overal	7. Overall assessment of internal validity (- , +, ++)			
(++)	This was an overall good quality study with some minor limitations.			

Country, study type,	Study population, design & data	Outcomes, Resource use	Results	Summary
service description	sources		Cost-effectiveness	
Study details Klingler et al (2016)	POPULATION All patient groups but excluded were: children; psychiatric patients	Studies that assessed healthcare costs or cost-effectiveness as primary or secondary outcome	Price year Not reported Findings	Applicability Sufficiently applicable (+)
Study design Systematic		measure; excluded were studies	Authors conclude that	11 ()
review of economic	Settings	that investigated other endpoints	limited data indicate net	Quality
studies Country 6 US, 1 Canada	 3 studies = hospital setting 1 study = nursing home setting 3 studies = home care settings 	like hospitalization rates or days spent in the intensive care unit (ICU)	cost savings may be realised with ACP	Overall good quality with some limitations
Date Included studies	Medical conditions		Findings are discussed in the context of previously	(+)
published between 1994- 2010	 1 study = advanced cancer 1 study = chronic obstructive 	RESULTS Except for one study (cluster RCT) all studies found reduced	published findings from studies that investigated advance directives (ADs) -	Summary The systematic
External & internal validity of the systematic review (+/+)	 pulmonary disease (COPD) and congestive heart failure (CHF) 1 study = COPD, CHF, cancer 1 study = life threatening 	Cost reductions were significant ($p < 0.05$) in n=3 studies; n=2	defined as presence of signed legal documents - and which do not find cost reductions; authors	review of economic studies found that ACP
Follow-up period Time frames varied widely from 1 week before death to 18 months after implementing the	 disease 1 study = heart failure, severe diabetes 2 studies = no restrictions in regards to diseases, most 	studies did not report significance and n=1 found non-significant effect Cost-savings ranged from USD	conclude that this might suggest that ACP is more likely to lead to cost savings if it is implemented comprehensively	decreased life prolonging treatments, increase the use of hospice and
intervention Study type	common ones were malignant neoplasm, respiratory diseases, cardiopulmonary diseases	1,041 to USD 64,827 per patient; relative cost reductions ranged from 5% to 68%	The authors also explain that for the study that did not find cost reductions, the	palliative care and reduce hospitalisations.

conomic evaluations; however, no cost- effectiveness studies were iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studies iffectiveness studiesInterfective in meeting iffective in meeting iffective implementing ACP makes if difficult implementing ACP makes if difficult occursarials between studiesInterfective in meeting iffective in meeting iffective implementing ACP makes if difficult occursarials between studiesInterfective in meeting iffective in meeting iffective implementing ACP makes if difficult occursarials and in the source studies investigated different costs to the public sector with a involving the patient ord legal proxy about involving the patient of rure medical careSample size ranges from n=43 to note that information on the source of ACP, the studies investigated different costs to the public sector with a if ord on the source of order of the public sector with a of order of the public sector with a of order of the public sector with a if order on the source of order of the public sector with a of order of the public sector wit	Systematic review of	DATA SOURCES	Only n=3 studies reported the	intervention was also	It is concluded
effectiveness studies were identified, most were identified, most were recors.• 4 RCTs (including 2 cluster RCTs)1,968challenges of effectively implementing ACPdefining ACP makes it difficult to conclusions.Intervention Included: Any intervention process facilitated by a professional caregiver involving the patient or future medical care- 2 Cohort studies (1 retrospective, 1 prospective)Because of differences in methodologies, results were not comparable between studiesSensitivity analyses very sick patients, who used for studies investigated different costs to the public sector with a of clust information on the sources resource use were not reported; information une provided on the types or for true medical careSources of resource use data note that information on the sources resource use were not reported; information une provided on the types overheadsNote that information on the sources resource use were not reported; information une provided on the types overheadsOther effects nedstudies investigated different costs to the public sector with a difficient to cost savings 2 studies = improved patient satisfaction, 1 study no effect on patient or family satisfaction, 1 study = no effect on physician's awareness of patients' preferences;Istudy = costs of impatient and outpatient, any significant care, (costs for discuss or quality of death) to source ave of bospital insting preferences;Istudy = nore ADS completed, 1 study = no effect on incidence or 1 study = costs of hospital insting preferences;Istudy = nore ADS completed, 1 study = nore for Nore discuss or quality of death)Istudy = nore for study = nore for Nore study s one reports po-00019; 1T	economic evaluations;	Sources of effectiveness data	costs of implementing ACP; costs	ineffective in meeting its	that the
identified; most were cost-savings studies.RCTs)makes it difficult cost-savings studies.implementing ACPmakes it difficult to come to final come to final comparable between studiesimplementing ACPmakes it difficult to come to final come to final comparable between studiesIntervention intervention containing a communication process facilitated by aSample size ranges from n=43 to n=3,000+Resource useSensitivity analyses scarried out; however; it is reported that that the two highest cost reductions study concluded that information on the source information were provided on the types of costs collected:Resource useSensitivity analyses scarried out; however; it is reported that that the two highest cost reductions were achieved for studies were achieved for studiesIn regards to different types of ACP, the studies investigated different costs to the public sector with a focus on hospital costsIn regards to that information on the sources reported that that the two hospice cost collected:Note refrects ne=6 studies measured afferts in addition to cost savings 2 studies = improved patient studies interventions hospice, diagnostic services, overheadsOther effects naddition to cost savings 2 studies = narpoved patient studies did not use the trem ACP but talked about end-of-life (EDL) discussions, Advance Directives (AD), EOL counselling1 study = cost so for hospitalization, hospice care, life-sustaining procedures1 study = costs of hospital inpatient attwal = no effect on inpsychological distress or quality of death1 study = costs of hospital istudy = no effect on inpsychological distress or quality of deathInterventio	however, no cost-	In total, 7 studies included.	were CAD 113, USD 452 and USD	primary goals suggesting	challenge of
cost-savings studies.• 1 Before-after study • 2 Cohort studies (1 retrospective, 1 prospective)Because of differences in methodologies, results were not comparable between studiesI to come to final condusions.Intervention intervention containing a facilitated by a professional caregiver ind/or legal proxy about the patient's preferences for future medical careSample size ranges from n=43 to n=3,000+Resource use Studies investigated different costs to the public sector with a focus on hospital costsSensitivity analyses to the public sector with a to focus on hospital costsIn regards to carried out; however, is reported that that the two by that had populations of very sick patients, who used considerable amount outpatient, nursing home, inpatient sustification to described in sufficient detail in hospice, diagnostic services, overheadsIstudy = costs for hospitalization, hospice care, life-sustaining proceduresIstudy = costs of inpatient and outpatient, ransing home, inpatient and outpatient care (costs for medication no induded)Istudy = costs of inpatient and outpatient care (costs for medication no induded)Istudy = noeffect on patient or family satisfaction; taving = noeffect on patient or family satisfaction; taving = noeffect on patient or family satisfaction; taving = noeffect on physician's awareness of patients' preferences; hospice care, life-sustaining proceduresIstudy = costs of nospital inpatient atiety = noeffect on inpsychological distress or quality of death)Intervertion inpsychological distress or quality of death)Intervertion that findings need to be timitations, which means distress or gosts of hospital inpatient advy = no effect on IN	effectiveness studies were	• 4 RCTs (including 2 cluster	1,968	challenges of effectively	defining ACP
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intervention to improve study = reduced use of					
		inputerit care			
	EOL care	Sources of unit cost data	Study Teduced use of		

	•	Insurance claims, hospital	ventilations, resuscitation, ICU	
Comparison Any		charges	admission	
intervention				
			2 studies – no effect on death	
			(survival) rates;	
			1 study = no effect on pain	
			1 study = no effect on hospice	
			admission or length of stay; 1	
			study = more outpatient hospice	
			care and longer stays in	
			outpatient hospice (but no effect	
			on inpatient hospice No services	
			utilized)	

Methodo	ological quality checklist for systematic review			
	entification: Klingler et al (2016)			
Guidelir	ne topic: Decision-making and mental capacity			
Economi	ic priority area: 1 Q: 1			
	relevance to review question			
1.1 Does	the study's research question match the review question?			
Yes	It is stated that the aim of the study was to systematically review the evidence on the cost implications of comprehensive ACP programmes and to analyse findings in the context of ethical considerations			
1.2 Has t	he study dealt appropriately with any ethical concerns?			
Yes	The study discussed ethical tensions and implications of findings about cost savings			
1.3 Were	service users involved in the study?			
N/A	This was a systematic review			
2. Study	relevance to scope			
2.1 Is the	ere a clear focus on the guideline topic?			
Partly	Some of the interventions included in this systematic review referred to service improvement programmes towards end of life with ACP being one component only			

2.2 Is the	study population the same as at least one of the groups covered by the guideline?
Yes	People at risk of losing mental capacity towards the end of life
2.3 Is the	study setting the same as at least one of the settings covered by the guideline?
Partly	Settings include hospital, nursing home, home and hospice, which are all covered by the guideline; however, all but one study took place in the US and none of the studies was from the UK
2.4 Does	the study relate to at least one of the activities covered by the guideline?
Yes	Advance care planning although focus of some studies was on broader service improvement in end of life care thus covering a broader scope than covered in the guideline
2.5 (For e	ffectiveness questions) Are the study outcomes relevant to the guideline?
Yes	Includes cost and service outcomes as well as effects on individuals and families in form of health and wellbeing outcomes
2.6 (For v	riews questions) Are the views and experiences reported relevant to the guideline?
N/A	
2.7 Does	the study have a UK perspective?
No	None of the included studies was from the UK
3. Overa	ll assessment of external validity (-,+,++)
(+)	Downgraded quality due to lack of UK studies. However, the review is sufficiently applicable to the overarching Guideline review question.
Internal	validity
1. Appro	priate and clearly focused question?
Partly	Overall there were thus some inconsistencies in the research question(s); for example it is stated in the introduction section that the authors sought to investigate the cost implications of ACP defined as professionally facilitated communication process as well as consider ethical implications; in the method section it is stated that the study sought to investigate ACP defined as facilitated communication process as well as its systematic implementation but that the latter was not possible
2. Inclus	ion of relevant individual studies? (Yes, somewhat relevant, no, unclear, N/A)
Partly	As stated by the authors it was not feasible to answer the research question they had set out because there were no studies that looked at ACP as what the authors call a facilitated communication process and systematic implementation; they thus broadened the inclusion criteria retrospectively; however it is not clear which studies that then allowed to include that beforehand were excluded; generally it was not clear what they authors were investigating and how this differed from the previously published review by Dixon et al (2015)
3. Rigoro	ous literature search? (yes, partly, no, unclear)
Partly	It is not clear why 2010 was chosen as cut off year (considering the study was published in 2016); a number of relevant studies were published thereafter and thus including a later cut-off year would have been very beneficial; the authors also state that they might have missed relevant studies
4. Study	quality assessed and reported?
Partly	It is referred to the study design but no further detail on how the quality of studies was assessed

5. Adequa	5. Adequate description of methodology?				
Partly	Systematic review stated that it followed the Preferred Reporting Items for Systematic reviews and Meta-Analysis Statement. However,				
-	there were also some limitations in the method description; for example, the search terms used were not presented and it was not clear				
	how information on costs were extracted; some information was missing, for example about the price year of studies				
6. Do con	clusions match findings?				
Yes	Conclusions were generally appropriately matching findings although				
7. Overall	7. Overall assessment of internal validity (- , +, ++)				
(+)	Overall the study was of good quality with some limitations				

Study ID	Intervention details	Study population	Costs: description and values	Results: Cost-	Comments
Country		Study design	Outcomes: description and values	effectiveness	
Study type		Data sources			
Abel et al	Intervention:	Population:	1. Outcomes	Those who used	Applicability:
(2013)	Advance care planning	All patients who were	<u>1a. Description</u>	ACP spent less	Sufficiently
	(ACP) defined as	known to the hospice who	Primary outcomes measures: Place of	time in hospital	applicable (+)
England, UK	discussions taking place	died between 01 January	death (including whether person	in their last year.	
-	about place of death;	2009 and 30 June 2011	died in their preferred place of	ACP was	<u>Quality</u> : (+)
Cost-	'Planning Ahead'		death for those who had expressed	associated with	
effectiveness	document includes	<u>Study design:</u>	a preference/ were part of ACP	a reduction in	Perspective:
and saving	general treatment	Retrospective cohort study	group)	the number of	Hospital costs
	preferences as well as	over 2.5-year period		days in hospital	only
	advance decisions		<u>1b. Values</u>	in the last year	
		<u>Setting:</u>	ACP group	of life with less	Discounting:
	<u>Control:</u> No ACP	Hospice in the South West of	• N=14 (75%) achieved their	hospital costs.	No
		England	choice of place of death;		
			• For those who chose home,		Price year:
	Both groups:	Statistical analysis:	n=34 (11.3%) died in hospital;		2009-11, £
	Both groups received	T-tests (two-sided) to	• For those who chose a care		
	specialist palliative care	compare means; logistic	home n=2 (1.7%) died in		Summary: This
	provided in hospice,	regression	hospital;		England based
	which includes inpatient		• For those who chose a hospice		cohort study
	and outpatient services,	Source of effectiveness data:	n=14 (11.2%) died in hospital;		examined some of
	visits from specialist	From electronic patient	• For those who chose to die in		the costs and
	palliative care	records; Secondary User	hospital n=6 (86%) did so.		outcomes of ACP

community nurses at	Services database for	Non ACP group	in a hospice
home and a day care	matching patient information	• 112 (26.5%) died in hospital.	environment;
centre	to number of days in hospital		
home and a day care		 112 (26.5%) died in hospital. 2. Costs <u>2a. Description</u> Cost figures were actual costs adjusted for length of stay and complexity of care 2b. Values Significantly lower mean number of days in hospital in the last year of life in IG 18.1 vs. CG 26.5 (p<0.001); Non-significantly (p=0.3) lower mean number of emergency admissions in IG 1.61 (95% CI 1.4 to 1.8) vs. CG 1.75 (95% CI 1.6 to 1.9) Non-significantly (p=0.4) lower mean costs of emergency admissions in IG £5,260 (95% CI 4,586 to 5,934) vs. CG £5, 691 (95% CI 4,984 to 6,398) Cost differences were explored by looking at the group of people who died in hospital vs. those who did not die in hospital: Mean cost of hospital treatment during the last year of life for those who died in hospital was £11,299, those dying outside of hospital £7,730; MD 3,569; p<0.001 	
		 Mean number of emergency admissions for those who died 	

 in hospital was 2.2 and who died elsewhere was 1.7 (p<0.001). 3. Sub groups <i>Cancer</i> Preferred place of death in IG (cancer vs. non-cancer): home 53% vs. 67%, care home 20% vs. 27%, hospice 26% vs. 6%, hospital 1% vs. 0%; Number of people dying in hospital: IG 10% vs. 26%; p<0.001; Mean number of days in hospital: IG 20.2 days. Vs. 30.6 days (p<0.0001).
4. Sensitivity analysis N/A

Study identifica	tion: Abel et al (2013)				
Guideline topic: Decision-making and mental capacity					
Economic prior	ity area: 1	Q: 1			
Checklist: Sectio	<u>n 1</u>				
Yes/No/Partly/N	/A Detail				
1.1 Is the study	population appropriate for the review question?				
Partly	Partly People at the end of life who had been receiving specialist palliative care in one hospice; population thus referred to a specific population and				
was thus not representative of health and social care context for all people at the end of life					
1.2 Are the inte	rventions appropriate for the review question?				

Yes	The intervention was Advance Care Planning, which included discussions and choices about treatment preferences as well as advance decisions
	to refuse treatment regulated by the Mental Capacity Act; indicator of whether ACP had taken place was that a preferred place of death was
	recorded
	ent social care system in which the study was conducted sufficiently similar to the current UK social care context?
Yes	Study was of recent date and based on data from area south west England
	rspectives clearly stated and what are they?
Partly	The perspective was not clearly stated but it was clear that it referred to hospital costs only.
1.5 Are all dire	ect effects on individuals included
Partly	Preferred place of death as stated in ACP is used in the intervention group and actual place of death is used in both groups; no other health or
	wellbeing or satisfaction outcomes are included
1.6 Are all futi	ire costs and outcomes discounted appropriately?
N/A	The study looked at costs only at the last year in life so that discounting was not required.
1.7 How is the	value of effects expressed?
Yes	Values of effects were expressed in natural units (place of death, days in hospital, number of emergency admissions)
1.8 Are costs a	nd outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?
No	Limited cost perspective
General conclu	ision
This study was	sufficiently applicable (+).
2 1 Doos tha m	odel structure adequately reflect the nature of the topic under evaluation?
N/A	This study was a cost-effectiveness analysis as part of a cohort study
	horizon sufficiently long to reflect all important differences in costs and outcomes?
Yes	Costs and outcomes were measured over the period of a year which is likely to include important differences considering the type of
	interventions
2.3 Are all imp	oortant and relevant outcomes included?
No	No health or wellbeing outcomes and no information on preferences or engagement
2.4 Are the est	imates of baseline outcomes from the best available source?
No	There were no significant differences between groups in regards to age and gender but no further characteristics were controlled for
2.5 Are the est	imates of relative intervention effects from the best available source?
Unclear	From cohort study
2.6 Are all imp	oortant and relevant costs included?
Unclear	From cohort study
2.7 Are the est	imates of resource use from the best available source?
Yes	
2.8 Are the uni	it costs of resources from the best available source?
Partly	
J	

N/A	
2.10 Are all important parameters whose values are uncertain subjected to appropriate sensitivity analysis?	
N/A	
2.11 Is there any potential conflict of interest?	
No	
2.12 Overall assessment	
The study was of overall good quality but had some potentially serious limitations due to the nature of the study (which was a feasibility trial with a relatively sample size) (+).	/ small

Study ID Country Study type	Intervention details	Study population Study design Data sources	Costs: description and values Outcomes: description and values	Results: Cost- effectiveness	Comments
Flood et al	Intervention:	Population: Eligible patients	1. Outcomes	Cost	Applicability
(2006)	Joint crisis plan (JP);	had a clinical diagnosis of	<u>1a. Description</u>	effectiveness	: Sufficiently
	introductory meeting	psychotic illness or non-	Primary outcomes measures: Admission to	acceptability	applicable
England, UK	with facilitator, who	psychotic bipolar disorder,	hospital; length of time spent in hospital	curves	(+)
	explains procedure to	were not currently receiving	Secondary outcome measure: objective	suggested there	
Cost-	person and care	inpatient care, and had	coercion (i.e. compulsory treatment	was a greater	<u>Quality</u> : (++)
effectiveness	coordinator; contents of	experienced an admission in	under MHA 1983); service use over 15	than 78%	
	the plan are discussed	the previous two years.	months	probability that	Perspective:
	and completed by			JCP was more	NHS, social
	facilitator at second	Study design:	<u>1b. Values</u>	cost effective	services,
	meeting attended by	Single blind RCT; N=160; IG:	• Significant reduction in use of MHA	than	criminal
	person, care	n=80; CG: n=80	(=compulsory admission) in IG: 13%	standardised	justice, out-
	coordinator, and		vs. 27% (RR 0.48, 95% CI 0.24 to	service	of-pocket
	psychiatrist	Setting:	0.95, P = 0.03).	information in	expenditure
		Recruited from seven	 Non-significant reduction in 	reducing the	
	Control: Information	community mental health	hospital admissions in IG: 30% v	proportion of	Discounting:
	leaflets about Mental	teams across London and	44% (RR 0.69, 95% CI 0.45 to 1.04, P	patients	No
	Health Act, complaints	one in Kent	= 0.07)	admitted to	
	procedures, access to			hospital	Price year:
	case records, treatment	Statistical analysis:			2000/1,£
	options	Intention-to-treat; standard t-	2. Costs	JCP produced a	
		test for costs; bootstrapping	2a. Description	non-significant	Summary:
		for costs (findings not	Public sector perspective included NHS,	decrease in	This England
		reported as results similar to	Personal Social Services (PSS), criminal	admissions and	based RCT
		t-test ones); non-parametric	justice; societal perspective also	total costs.	examined the
		bootstrapping for differences	included out-of-pocket expenditure	Though the cost	cost-
		in costs and effects;		estimates had	effectiveness
		Cost effectiveness	JCO was costed on the basis of the time	wide confidence	of JCP versus
		acceptability curves were	spent by the facilitator and clinical	intervals, the	standardised
		used to explore uncertainty	teams in producing the crisis plans, plus	associated	service
			relevant administrative, managerial,	uncertainty	information.

Intervention Joint crisis plan (JCP) for people with mental illness

in estimates of costs and	and comital overheads. The cost of CC	augaata thans is	Eindinge
	and capital overheads. The cost of CG intervention was calculated on the basis	suggests there is	Findings
effects,		a relatively high	suggest that
	of the actual purchase cost of the	probability of	there was a
	information leaflets with the cost of the	the plans being	difference in
Source of effectiveness data:	facilitator's time in distributing them.	more cost	compulsory
From trial;		effective than	admissions
		standardised	but no
Source of resource use data:		service	significant
Client Service Receipt	<u>2b. Values</u>	information for	reduction in
Inventory (CSRI);	15 months	people with	overall costs.
supplemented by data on	Non-significantly lower mean total	psychotic	Since the
hospital admission, bed	cost per patient in IG: £7,264 vs.	disorders.	study was of
days, use of MHA from	£8,359 (MD £1,095; 95% CI-2814 to		high quality,
computerised hospital	5004; P = 0.57)		findings can
clinical activity systems and	Nor significant differences in cost		be used to
MHS office records	by providing sector.		inform
			recommenda
Source of unit cost data:			tions
NHS reference costs, and	3. Sub groups		
information provided by the	None		
South London and Maudsley			
NHS Trust finance	4. Sensitivity analysis		
department, PSSRU Unit cost	An additional reduction of 14 days in		
book of health and social	hospital per patient in IG would be		
care	required for mean total cost per patient		
Care	between the two groups to become		
Sensitivity analysis:	significant (mean difference £3381, 95%		
Threshold analysis;	0		
5	confidence interval 27 to 6735 , P = 0.05).		
reduction in hospital days;	No import on the significance of the		
	No impact on the significance of the		
Unit costs for bed days were	difference in mean total cost per patient		
varied $(+/-50\%)$; costs of the	even when the cost of bed days was		
JCP intervention	halved (£799, – 1308 to 2906, P = 0.46) or		
	doubled (mean difference £1688, – 5900		
	to 9274, P = 0.66).		
	Increasing the cost of JCP to bias the		
	results against the intervention, even		

		with a fourfold increase in facilitator time, did not alter the results	

Study identificatio	n: Flood et al 2006
	ecision-making and mental capacity
Economic priority	area: 1 Q: 1
Checklist: Section	<u>1</u>
Yes/No/Partly/N/A	Detail
1.3 Is the study po	opulation appropriate for the review question?
Yes	People with severe mental health problems (psychosis) at risk of compulsory admission to mental health hospital under MHA
1.4 Are the interv	entions appropriate for the review question?
Yes	The intervention was Joint Crisis Planning, which includes shared decision making and planning for future treatment in case of relapse
1.3 Is the current s	social care system in which the study was conducted sufficiently similar to the current UK social care context?
Partly	Study took place in England but as carried out before 2000/1; however, authors find in their recent study that there had not been changes to standard care in this area so that findings are still likely to apply (Thornicroft et al 2013)
1.4 Are the perspe	ctives clearly stated and what are they?
Yes	The perspectives were a public sector and a societal one.
1.5 Are all direct e	ffects on individuals included
No	Paper only refers to service outcomes including admission to hospital, length of time spent in hospital (primary outcome measures), and objective coercion (compulsory treatment under the MHA). Impact on individual's health and wellbeing is not reported.
1.6 Are all future of	costs and outcomes discounted appropriately?
Partly	Discounting would have been required but could not be applied to months 12 to 15. However, it is unlikely that this will have any substantial impact of findings due to relatively short period this refers to (3 months) and substantive sensitivity analysis carried out by the author.
1.7 How is the valu	ie of effects expressed?
Partly	The value was expressed in natural units of the primary outcome, which was a service use outcome (compulsory admission). No standardized measure of health-related quality of life was used.
1.8 Are costs and o	outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?
Partly	A wide range of costs is covered including health and social care, criminal justice, and out-of-pocket expenditure. The study did not include the costs of productivity losses and criminal activity.
General conclusion	
This study was suff	iciently applicable (+).
	<i>nitations (the level of methodological quality)</i> Id be used once it has been decided that the study is sufficiently applicable to the context of the social care guidance[a].

2.1 Does the model structure adequately reflect the nature of the topic under evaluation?

N/A	This study was a cost-effectiveness analysis carried out alongside a single-blind randomised controlled trial.
2.2 Is the time h	orizon sufficiently long to reflect all important differences in costs and outcomes?
Yes	Costs and outcomes were measured over the period of 15 month which seems appropriate considering the nature of the intervention.
2.3 Are all impo	ortant and relevant outcomes included?
No	See 1.5
2.4 Are the estim	mates of baseline outcomes from the best available source?
Unclear	Baseline characteristics and outcomes are not reported.
2.5 Are the estim	mates of relative intervention effects from the best available source?
Yes	Estimates were taken from a trial and appropriate statistical analysis was carried out.
2.6 Are all impo	ortant and relevant costs included?
Partly	A wide range of public sector costs was included and appropriate statistical analysis was carried out. However, it was not clear whether all of
	the important societal costs were included. In particular criminal activity was not included.
2.7 Are the estim	mates of resource use from the best available source?
Yes	Standard tool such as the CSRI are used and different data sources are used to complement the CSRI allowing for cross-checking and higher
	levels of accuracy
2.8 Are the unit	costs of resources from the best available source?
Yes	Generally unit costs appeared to have been taken from the appropriate sources including national and local sources; references to sources are
	provided
2.9 Is an approp	priate incremental analysis presented or can it be calculated from the data?
Yes	ICERs are derived based on changes in primary outcome and total costs; findings are presented in cost-effectiveness acceptability curves
2.10 Are all imp	oortant parameters whose values are uncertain subjected to appropriate sensitivity analysis?
Yes	Threshold analysis was applied in addition to bootstrapping and cost effectiveness acceptability curves
2.11 Is there an	y potential conflict of interest?
No	The primary funding source was the Medical Research Council; authors declare that they had no conflict of interest.
2.12 Overall ass	sessment
The study was o	f overall high quality with minor limitations (++).
2	

Study ID Country Study type	Intervention details	Study population Study design Data sources	Costs: description and values Outcomes: description and values	Results: Cost- effectiveness	Comments
Barrett et al	Intervention:	Population: 16yrs+, at least	1. Outcomes	ICER were	Applicability:
(2013)	Joint crisis plan (JP);	one psychiatric hospital	<u>1a. Description</u>	calculated	Sufficiently
	introductory meeting	admission in previous 2	Primary outcomes measures (at 18		applicable (+)
England, UK	with facilitator, who	years and on the Enhanced	<i>months</i>): Admission to hospital	JCP had 80%	
0	explains procedure to	Care Programme Approach	under MHA;	probability of cost-	Quality: (++)
Cost-	person and care	register	Secondary outcome measure: Not	effectiveness from	/
effectiveness	coordinator; contents of	-	reported in this study but in	public sector	

the plan are di	iscussed	parent study (Thornicroft et al	perspective (and	Perspective:
and completed		2013)	around 44% from a	Public sector
facilitator at se			societal	
meeting attend		1b. Values		perspective (health and
Ű	$CG: \Pi = 270$	<u>18-months</u>	perspective)	social care,
person, care			D 1(,
coordinator, as	<u></u> _	No significant reduction	Results varied	criminal justice)
psychiatrist	Recruited from sites in	compulsory admission:	noticeably between	and societal
	Birmingham, Lancashire/	n=49 (18%) in IG vs. 56	ethnic groups: For	perspective
9 months later		(20%) in CG (OR 0.90, 95%	White group, mean	(criminal
user in contact	5	CI 0.59 to 1.38, p = 0.63)	costs were higher	activity,
facilitator to ch		 No significant treatment 	for the JCP and no	productivity
he/she wanted		effects for any other	difference in	losses)
update the JCI		admissions outcomes,	effects; for the	
	regression for primary	although there was	Black group, costs	Discounting:
<u>Control:</u> Stand		evidence for improved	were lower for the	No
	and patient-rated Working	1 1	JCP group and	
<u>Both groups</u> : c		in the intervention arm,	effects were better;	Price year:
standard care	from local missing data)	described in detail in the	for Asian group,	2009-10, £
community m	ental	main paper by Thornicroft	costs were higher	Pound Sterling
health teams v		et al (2013)	for the JCP group	
part of the Car	e baseline costs and complete	é.	and effects were	Summary: This
Programme A		S 2. Costs	worse.	England based
includes for pa	atients to for total costs with CI for M	ID <u>2a. Description</u>		multi-centre
receive writter	n copies of estimated using non-	Public sector perspective included		RCT examined
their care plan	including parametric bootstrapping	health and social care, criminal		the cost-
'crisis continge	ency plan' and ordinary least squares	justice; societal perspective		effectiveness of
	regression for adjusted	included productivity losses and		JCP and
	analysis	criminal activity		standard care
				versus
	Cost-effectiveness through	JCO was costed on the basis of the		standardised
	calculation of ICER and cos	time spent by the facilitator and		care (both
	effectiveness acceptability	clinical teams in producing the		groups included
	curves were used to explor			crisis
	uncertainty in estimates of	administrative, managerial, and		contingency
	costs and effects	capital overheads.		plan). Findings
		1		suggest that
				there was the
		2b. Values		intervention

		1
Source of effectiveness data:	18 months	was cost-
Case notes, local Patient	No significant reduction in total	effective from a
Administration System,	public sector costs (N=504): IG	public sector
MHA Office data; interviews	£17,233 (SD 21,013) vs. CG £19,217	perspective but
with patients and care co-	(SD 28,133); MD -£1,994; 95% CI -	this was
ordinators	5,733 to 2,248; p=0.414	attributed to the
		high cost-
Source of resource use data:	No significant reduction from the	effectiveness in
Adult Service Use Schedule	societal perspective (N=504): IG	Black ethnic
(AD-SUS) completed by	£22,501 (SD 28,103) vs. CG £22,851	groups whereas
patients at baseline (covering	(SD 34,532); MD -£350; 95% CI -	cost-
service use over past 3	4,727 to 5,404; p = 0.902	effectiveness for
months) and 18-month		other ethnic
(covering service use over		groups (White,
past 18 months);	3. Sub groups	Asian) could not
supplemented by data on		be established
mental hospital admission	White (N=314)	
and community mental	Primary outcome	
health services from hospital	(=compulsory	
records; JCP facilitator	admissions); IG (n=164)	
records for staff inputs into	16% vs. CG (n=178) 16%;	
providing the intervention	MD 0.952; 95% CI 0.532 to	
	1.706; p=0.166	
Source of unit cost data:	• <i>Mean public sector costs:</i> IG	
NHS reference costs, and	(n=147) £17,680 (SD	
information provided by	20,505) vs. CG (n=167)	
NHS Trusts, PSSRU Unit cost	£16,013 (SD 24,435); MD	
book of health and social	£1,667; 95% CI -3,221 to	
care; British National	6,360; p=0.386	
Formulary for costs of	Mean societal costs: IG	
medications	(n=147) £22,469 (SD	
	27,611) vs. CG (n=167)	
<u>Sensitivity analysis:</u>	£19,823 (SD 32,882); MD	
Number of one-way	£2,646; 95% CI -2,987 to	
sensitivity analysis; 1)	9,429	
productivity costed		
differently (from zero to		
maximum value under	Black/ Black British (N=60)	
1		L

human capital value approach); 2) reduced costs of face-to-face contact by JCP coordinator to account for learning effects over time	• $Primary outcome$ (=compulsory admissions); IG (n=66) 20% vs. CG (n=72) 32%; MD 0.553; 95% CI 0.249 to 1.226; p=0.256 • <i>Mean public sector costs:</i> IG (n=60) £17,628 (SD 25,163) vs. CG (n=69) £28,377 (SD 36,627); MD £10,749; 95% CI -20,387 to 536; p=0.079 • Mean societal costs: IG (n=60) £23,150 (SD 29,588) vs. CG (n=69) £32,780 (SD 41,170); MD £9,630; 95% CI -21,043 to 3,106; p=0.16 Asian/ Asian British (N=51) • <i>Primary outcome</i> (=compulsory admissions); IG (n=32) 27% vs. CG (n=24) 14%; MD 7.538; 95% CI 0.867 to 65.52; p=0.139 • <i>Mean public sector costs:</i> IG (n=29) £14,536 (SD 14,384) vs. CG (n=22) £12,018 (SD 16,761); MD £2,518; 95% CI -5,267 to 12,137; p=0.853 • <i>Mean societal costs:</i> IG (n=29) £22,779 (SD 29,672) vs. CG (n=22) £12,784 (SD 16,444); MD £9,995; 95% CI -2,115 to 24,831; p=0.135
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	 4. Sensitivity analysis Productivity losses zero (N=504): IG £22,485 (SD 28,112) vs. CG £22,757 (SD 34,563); MD -£272; 95% CI -4,846 to 5,684; p=0.878 Lower cost of JCP intervention (N=504): IG £22,430 (SD 28,819) vs. CG £22,851 (SD 34,532); MD - £421; 95% CI -1,998 to 5,534; p=0.922 	
	Missing data included via multiple imputation (N=569): IG £22,575 (SD 25,930) vs. CG £22,819 (SD 33,339), MD -£244; 95% CI - 4,744 to 4,599; p=0.976	

Study identification:	Barrett et al (2013)
Guideline topic: Dec	ision-making and mental capacity
Economic priority an	rea: 1 Q: 1
Checklist: Section 1	
Yes/No/Partly/N/A	Detail
1.5 Is the study pop	ulation appropriate for the review question?
Yes	People with severe mental health problems at risk of compulsory admission to mental health hospital under MHA
1.6 Are the interven	tions appropriate for the review question?
Yes	The intervention was Joint Crisis Planning, which includes shared decision making and planning for future treatment in case of relapse
1.3 Is the current soc	cial care system in which the study was conducted sufficiently similar to the current UK social care context?
Yes	Study was of recent date and took place in sites in three largest cities in England
1.4 Are the perspecti	ives clearly stated and what are they?
Yes	The perspectives were a public sector and a societal one.

1.5 Are all direc	t effects on individuals included
Unclear	Primary outcome was compulsory admission to hospital and only effects for this outcome are reported. All other effects on individuals are
	reported elsewhere (Thornicroft et al 2013)
1.6 Are all futur	e costs and outcomes discounted appropriately?
Partly	Discounting would have been required but could not be applied to months 12 to 18. However, it is unlikely that this will have any substantial
	impact of findings due to relatively short period this refers to (6 months) and substantive sensitivity analysis carried out by the author.
	alue of effects expressed?
Partly	The value was expressed in natural units of the primary outcome, which was a service use outcome (compulsory admission). No standardized
	measure of health-related quality of life was used.
	d outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?
Yes	A wide range of costs is covered including health and social care, criminal justice, accommodation, productivity losses and criminal activity. The study did not include the costs of unpaid care and out-of-pocket expenditure but it is unlikely that this would have had an impact on findings.
General conclus	
This study was su	ufficiently applicable (+).
	ould be used once it has been decided that the study is sufficiently applicable to the context of the social care guidance[a]. del structure adequately reflect the nature of the topic under evaluation?
N/A	This study was a cost-effectiveness analysis carried out alongside a multi-centre randomised controlled trial.
	orizon sufficiently long to reflect all important differences in costs and outcomes?
Yes	Costs and outcomes were measured over the period of 18 month which seems appropriate considering the nature of the intervention.
	rtant and relevant outcomes included?
Unclear	The majority of (secondary) outcomes are reported in another paper (Thornicroft et al 2013).
	nates of baseline outcomes from the best available source?
Yes	It is reported that there were no substantial differences by randomisation arm in any of these baseline characteristics (for more details the authors refer to paper by Thornicroft et al 2013)
2.5 Are the estin	nates of relative intervention effects from the best available source?
Yes	Estimates were taken from a multi-centre trial and appropriate statistical analysis was carried out.
2.6 Are all impo	rtant and relevant costs included?
Yes	A wide range of costs were included (see 1.8) and appropriate statistical analysis is carried out.
2.7 Are the estin	nates of resource use from the best available source?
Yes	Different data sources are used allowing for cross-checking and higher levels of accuracy
2.8 Are the unit	costs of resources from the best available source?
Partly	Generally unit costs were taken from the appropriate sources but no further detail on some of the unit costs (e.g. criminal justice and criminal activity) is provided.
2.9 Is an approp	riate incremental analysis presented or can it be calculated from the data?
Yes	ICERs are derived based on changes in primary outcome and total costs; findings are presented in cost-effectiveness acceptability curves

2.10 Are all i	mportant parameters whose values are uncertain subjected to appropriate sensitivity analysis?
Yes	A range of one way sensitivity analysis was applied in addition to bootstrapping and cost effectiveness acceptability curves
2.11 Is there	any potential conflict of interest?
No	The primary funding source was the Medical Research Council; authors state that funders had no role in study design, data collection or analysis, decision to publish or preparation of the manuscript.
2.12 Overall	assessment
The study wa	s of overall high quality with minor limitations (++).

Study ID	Intervention details	Study population	Costs: description and values	Results:	Comments
Country		Study design	Outcomes: description and values	Cost-	
Study type		Data sources		effectiveness	
Borschmann et	Intervention: Joint crisis	Population: 18yrs+, with	1. Outcomes	Cost	Applicability:
al (2013)	plan (JCP); introductory	diagnosis of borderline	<u>1a. Description</u>	effectiveness	Sufficiently
	meeting with facilitator,	personality disorder; self-	Primary outcomes measures: Occurrence	was explored	applicable (+)
England, UK	who explains procedure	harmed in past year; under	of self-harming behaviour at 6 months	descriptively	
	to person and care	the ongoing care of a	Secondary outcome measure: depression,	following a	Quality: (++)
Cost-	coordinator; contents of	community mental health	anxiety, engagement, satisfaction with	cost	
consequences	the plan are discussed	team; able to give informed	services, quality of life, wellbeing and	consequence	Perspective: Health
	and completed by	consent	cost-effectiveness	s approach	and social care
	facilitator at second				
	meeting attended by		<u>1b. Values</u>	In the online	Discounting:
	person, care	Study design:	There were no significant differences	supplement	No
	coordinator, and	Pilot, single blind RCT;	between the groups on any of the	the ICER is	
	psychiatrist	N=88; IG: n=46; CG: n=42	primary or secondary outcome	reported as	<u>Price year</u> :
			measures at follow-up.	follows:	2009/10, £
		Setting: Community mental		-£32,358	
	Control: Information	health teams in south east	QALYs are presented in online	suggesting	<u>Summary:</u> This
	leaflets about MHA,	London	supplement: IG 0.31 (SD 0.11) vs. CG	that JCP	England based
	complaints procedures,		0.30 (SD 0.15)	dominates	feasibility RCT
	access to case records,	Statistical analysis:		standard	examined the cost-
	treatment options	Intention-to-treat; differences		care by being	effectiveness of JCP
		in service use only compared	2. Costs	less costly	versus
		descriptively; total cost per	2a. Description	and more	standardised care
		participant over the 6-month	Public sector perspective included	effective	for people with
		follow-up was calculated and	NHS, Personal Social Services (PSS)		borderline
		compared statistically;		Overall, the	personality
		although costs were not		authors	disorder. Findings

ГI				
	normally distributed,	JCP was costed on the basis of the time	conclude that	suggest that there
	analysis compared mean	spent by the facilitator and clinical	no	was no significant
	costs between the two	teams in producing the crisis plans,	conclusions	difference in
	randomised groups using	plus relevant administrative,	can be drawn	outcomes or costs.
	standard parametric tests;	managerial, and capital overheads.	due to the	In the main paper
	parametric tests confirmed	The cost of CG intervention was	small sample	cost effectiveness
	using bias-corrected, non-	calculated on the basis of the actual	size other	findings are
	parametric bootstrapping;	purchase cost of the information	than that the	presented
	baseline cost and	leaflets with the cost of the facilitator's	interventions	following a
	stratification variables	time in distributing them.	is feasible	descriptive cost
	(alcohol misuse and			consequences
	depression) were included as			approach. Results
	covariates; cost-effectiveness			of an explorative
	acceptability curves	<u>2b. Values</u>		cost-utility analysis
				are presented in the
		Mean cost of the intervention: £146 per		online supplement
	Source of effectiveness data:	participant		and suggest that
	From trial			the JCP dominates
		No significant differences in mean		standard care.
	Source of resource use data:	total health and social care costs: IG		
	Adult service Use Schedule	£5,631 vs. CG £5,308, P = 0.20).		
	(AD-US) completed by			
	participants at baseline and			
	6-month follow up; use on all	3. Sub groups		
	hospital and community	None		
	health and social care use;			
	data were supplemented by	4. Sensitivity analysis		
	electronic clinical records of	Sensitivity analyses exploring the		
	the local NHS trust; this data	impact of missing data and the cost of		
	replaced self-reported	JCPs (available from the author on		
	contacts with other trusts	request) did not alter these findings.		
	Source of unit cost data:			
	NHS reference costs, and			
	information provided by the			
	South London and Maudsley			
	NHS Trust finance			

department, PSSRU Unit cost book of health and social care for community health and social care; medications costed using the British National Formulary		
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Guideline topic: Decision-making and mental capacity Economic priority area: 1 Q:1 Checklist: Section 1 Yes/No/Partly/N/A Detail 1.7 Is the study population appropriate for the review question?
Checklist: Section 1 Yes/No/Partly/N/A Detail 1.7 Is the study population appropriate for the review question?
Yes/No/Partly/N/A Detail 1.7 Is the study population appropriate for the review question?
1.7 Is the study population appropriate for the review question?
Yes People with severe mental health problems (borderline personality disorder) at risk of compulsory admission to mental health hospital under MHA
1.8 Are the interventions appropriate for the review question?
Yes The intervention was Joint Crisis Planning, which includes shared decision making and planning for future treatment in case of relapse
1.3 Is the current social care system in which the study was conducted sufficiently similar to the current UK social care context?
Yes Study was of recent date and took place in England
1.4 Are the perspectives clearly stated and what are they?
Yes The perspectives were a public sector one.
1.5 Are all direct effects on individuals included
Yes A wide range of health and wellbeing outcomes were included as well as satisfaction and engagement with services
1.6 Are all future costs and outcomes discounted appropriately?
N/A Discounting was not required as costs and outcomes were measured over a period of less than one year.
1.7 How is the value of effects expressed?
Yes Values of effects were expressed in natural units as well as in utility for health-related quality of life (measured with the EQ-5D)
1.8 Are costs and outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?
Partly Public sector costs refer to health and social care and criminal justice; societal costs such as productivity losses, criminal activity, unpaid care and out-of-pocket expenditure were not included.
General conclusion

This study was sufficiently applicable (+).

Section 2: Study limitations (the level of methodological quality)

This checklist should be used once it has been decided that the study is sufficiently applicable to the context of the social care guidance[a].

2.1 Does the model structure adequately reflect the nature of the topic under evaluation?

N/A This study was a cost-effectiveness analysis carried out alongside a multi-centre randomised controlled trial.

2.2 Is the time horizon sufficiently long to reflect all important differences in costs and outcomes?

No Costs and outcomes were measured over the period of 6 months; it is not clear whether this period is sufficiently long to capture all important differences in costs and outcomes; for example a longer time period might have shown a different impact on compulsory admissions

2.3 Are all important and relevant outcomes included?

Yes A wide range if health and wellbeing outcomes are included in addition to service user satisfaction and engagement

2.4 Are the estimates of baseline outcomes from the best available source?

Yes It is reported that there were no substantial differences by randomisation arm in any of the baseline characteristics.

2.5 Are the estimates of relative intervention effects from the best available source?

Partly Estimates were taken from a relatively small (feasibility) trial, which meant that no final conclusions could be drawn about clinical efficacy **2.6** Are all important and relevant costs included?

Partly A wide range of costs was included (see 1.8) and appropriate statistical analysis was carried out. However, data were from a relatively small (feasibility) trial so that no final conclusions can be drawn about relative costs.

2.7 Are the estimates of resource use from the best available source?

Yes Different data sources were used allowing for cross-checking and higher levels of accuracy

2.8 Are the unit costs of resources from the best available source?

Partly Generally unit costs were taken from the appropriate sources but no further detail on some of the unit costs (e.g. criminal justice) was provided.

2.9 Is an appropriate incremental analysis presented or can it be calculated from the data?

Yes ICERs are derived based on changes in primary outcome and total costs; findings are presented in cost-effectiveness acceptability curves

2.10 Are all important parameters whose values are uncertain subjected to appropriate sensitivity analysis?

Yes A range of one way sensitivity analysis was applied in addition to bootstrapping and cost effectiveness acceptability curves

2.11 Is there any potential conflict of interest?

No The primary funding source was the Medical Research Council; authors stated that there was no conflict of interest.

2.12 Overall assessment

The study was of overall good quality but had some potentially serious limitations due to the nature of the study (which was a feasibility trial with a relatively small sample size) (+).

References

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