Joint Decision Making and Reduced Need for Compulsory Psychiatric Admission

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The article by de Jong et al in this issue of JAMA Psychiatry raises fundamental questions about the practice of psychiatry. In essence, the review finds that advance statements can reduce the occurrence of compulsory admissions by approximately one-quarter, while community treatment orders, medication compliance enhancement, and integrated treatment measures were ineffective in reducing compulsory admissions. Why is this issue important? Writing in On Liberty, John Stuart Mill differentiated between liberty as the freedom to act and liberty as the absence of coercion. Yet, it is clear that in most countries of the world (whether codified and regulated by law or not) measures to treat people with mental illness on a basis of compulsory admissions are used and are sometimes commonly used. Within the psychiatric profession, there has been an uneasy elision between the duty to care for patients and the responsibility to act for society, on whose behalf physicians often use compulsory admissions (eg, to protect the public from risk by people who are mentally unwell). Various wording has been used to try to reconcile these separate and often contradictory roles, such as the provision of the “least restrictive alternative” form of treatment by the physician.

This dual professional role is now subject to a profound challenge from the United Nations Convention on the Rights of Persons With Disabilities (CRPD). Among many other provisions, the CRPD makes clear that direct decision making by patients and forms of supported decision making are permissible under the convention, but that substituted decision making (which is the essence of compulsory treatment decisions by psychiatrists) is not allowed. Because the CRPD has now been signed by 159 countries worldwide and ratified (made legally binding) by 151, a vital question arises over whether the traditional practices of psychiatrists’ exercising legally authorized or de facto powers of compulsory admissions, in both hospital and community settings, are compatible with the CRPD or not. These considerations are complex issues that need to respect the fundamental human rights of all persons, including those with disabilities. They also need to take into account the day-to-day clinical dilemmas faced by staff who treat and care for people who at times may lack mental capacity in specific domains and who, for example, may actively threaten to harm themselves or others. Therefore, the responsible implementation of the CRPD is a pressing international challenge to the mental health sector.

Against this background, the article by de Jong et al adds important evidence to support these debates on how to reduce compulsory admissions in mental health care. The authors tested the following 4 candidate interventions to reduce compulsory hospital admissions: community treatment orders (sometimes called involuntary outpatient commitment) (3 studies), compliance enhancement techniques (2 studies), and augmentation of standard care (which they termed integrated treatment) (4 studies), alongside assessing the effect of advance statements (including advance directives and joint crisis plans (JCPs)) (4 studies). For the first 3 options, there was no evidence that they were effective. Admittedly, the sample size for each category was small, and arguably they each contained somewhat heterogeneous interventions. For example, integrated treatment included several different types of augmented standard care, namely, crisis resolution teams, integrated treatment in first-episode schizophrenia, and psychoeducation. For the community treatment orders and compliance enhancement interventions, these studies (both individually and when analyzed by group) also demonstrated no evidence of benefit, as shown in the forest plot in the article by de Jong et al.

Yet, advance statements showed a 23% risk reduction in compulsory admissions. The term advance statements covers a range of decision-making interventions, which vary with respect to their basis in legislation and the manner in which health professionals are involved in their creation. Advance directives lie at one extreme of this range because their content is determined solely by the patient or consumer. In the United States, supporting people to create a psychiatric advance directive is viewed as a component of recovery-oriented treatment planning, and indeed these directives may have the power of law. Psychiatric advance directives aim to promote consumer choice, prioritize the goal of autonomy, and improve the working alliance with mental health professionals. However, they have not been shown to have an effect on rates of involuntary hospitalization. The most likely reason for this observation is that they are enacted only when the holder is deemed to have lost capacity to make treatment decisions, are only used at a late stage of a relapse of illness, and may not be able to prevent such admissions.

Routine treatment or care plans lie at the other, more paternalistic, end of the crisis planning spectrum because they may be produced without any patient or consumer involvement, although by consensus it is not seen as good practice. This form of treatment planning has generally acted as the control in trials of other types of advance statements. In addition to advanced statement and care plans, the third type of such advance statements includes JCPs, which lie toward the cen-
ter of this spectrum as a particular application of shared decision making. To achieve this directive, JCPs require an external facilitator, namely, an independent third party, to complete the crisis plan. The facilitator, a mental health professional independent of the treatment team, aims to engage the service user and treating mental health professionals in writing the JCP. Developed after consultation with consumers, this process aims to empower service users or consumers, while facilitating early detection and treatment of relapse. Held by the service user, a JCP contains his or her treatment preferences for any future psychiatric emergency using first-person language.

The results of a pilot randomized clinical trial of JCPs for people with psychotic or bipolar illness showed reduced involuntary hospitalization associated with their use, and the authors reported positive views of the plans by service users and mental health professionals compared with treatment by the usual types of local community mental health teams that used largely staff-written care plans. The larger CRIMSON (Crisis Plan Impact: Subjective and Objective Coercion and Engagement) multisite trial of JCPs delivered in routine practice found a positive effect on service user–rated therapeutic engagement, despite barriers by healthcare professionals to share clinical decision making indepen- dent of the treatment team, aimsto engage the service user and treating mental health professionals in writing the JCP. Developed after consultation with consumers, this process aims to empower service users or consumers, while facilitating early detection and treatment of relapse. Held by the service user, a JCP contains his or her treatment preferences for any future psychiatric emergency using first-person language.

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Therefore, joint decision making faces challenges both in principle (eg, whether compulsory admission powers should be retained by psychiatrists) and in practice (eg, whether staff will genuinely implement jointly agreed treatment plans with patients as a part of an advance statement). Increasingly, such implementation barriers are being recognized as a critical brake on health care improvement. For example, clinical guidelines are now produced to a high technical standard in many countries worldwide, based on exhaustive reviews of the relevant evidence, yet there are few studies of how far they are implemented in routine clinical practice. Such studies more often identify barriers than facilitators to successful implementation. Therefore, the field now sometimes termed dissemination and implementation science is one of growing significance to translate the findings of clinical trials into routine patient benefit.

The review by de Jong et al raises the intriguing possibility that hospital admissions using compulsory powers can be substantially reduced by actively including patients (on an equal footing with staff) as partners in planning future treatment and care options. Such an approach, based upon patient choice, would be the antithesis to the paternalistic model of medical care. When fully implemented and evidence based, it will promote liberty.

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