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Does joint decision making reduce the need for compulsion in psychiatry?

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The paper by de Jong et al in this issue raises fundamental questions about the practice of psychiatry ¹. In essence the review finds that advance statements can reduce the occurrence of compulsory admission by about a quarter, while community treatment orders, medication compliance enhancement, and integrated treatment measures were ineffective in reducing compulsion. Why is this 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 compulsion 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. Various forms of words have 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 role professional role is now subject to a profound challenge from the United Nations Convention on the Rights of Persons with Disability (CRPD) ². 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. As 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 authorised or de facto powers of compulsion, in both hospital and in community settings, are compatible with the CRPD or not³. These are complex issues that need to respect the fundamental human rights of all persons, including those with disabilities, and which 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. The responsible implementation of the CRPD is therefore a pressing international challenge to the mental health sector.

Against this background, the paper by de Jong adds very important evidence to support these debates on how to reduce compulsion in mental health care. The authors tested 4 candidate interventions to reduce compulsory hospital admission: community treatment orders (sometimes named involuntary outpatient commitment, 3 studies), medication compliance enhancement techniques (2 studies), and augmentation of standard care (which they called 'integrated treatment', 4 studies), alongside assessing the impact of advance statements (including advance

directives and joint crisis plans, 4 studies). The first three options were ineffective. Advanced statements showed a 23% risk reduction in compulsory admissions.

The term 'advance statements' covers a number of joint decision making interventions which vary with respect to their basis in legislation and the manner in which health professionals are involved in their creation⁴. In the US, supporting people to create a psychiatric advance directive is viewed as a component of recovery-oriented treatment planning. Psychiatric advance directives aim to promote consumer choice, prioritize the goal of autonomy, and to improve the working alliance with mental health professionals. But they have not been shown to have an effect on rates of involuntary hospitalisation. The most likely reason for this is that they are enacted only when the holder is deemed to have lost capacity to make treatment decisions, and are therefore only used at a late stage of a relapse of illness.

Routine treatment or care plans lie at the other, more paternalistic, end of the crisis planning spectrum, as they may be produced without service user involvement, although by consensus this 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. Joint crisis planning (JCP) lies toward the centre of this spectrum, as an application of the shared decision making model. To achieve this, JCPs require an external facilitator 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 joint crisis plan. Developed after consultation with consumer, this process aims to empower service users or consumers whilst facilitating early detection and treatment of relapse. Held by the service user, a joint crisis plan contains his/her treatment preferences for any future psychiatric emergency using first person language.

The results of a pilot randomized controlled trial of joint crisis plans for people with psychotic or bipolar illness showed reduced use of involuntary hospitalization associated with their use⁵ and reported positive views of the plans by service users and mental health professionals. The larger Crimson multi-site trial of joint crisis plans delivered in routine practice found a positive effect on service user-rated therapeutic relationships, but reduced compulsory admission rates only for non-white patients⁶. There was clear evidence that the full JCP process had not been fully implemented by many members of staff, because of attitudinal barriers by clinicians to sharing clinical decision making powers with patients⁷.

Joint decision making therefore faces challenges both in principle (such whether compulsory admission powers should be retained by psychiatrists) and in practice (for example whether staff will genuinely implement jointly agreed treatment plans with patients as a part of an advanced statement). Indeed the implementation of evidence-based practice is the bugbear of clinical service improvement. For example of the 'integrated treatment' interventions included in the review, one version was crisis resolution teams. While some trials suggest they have the potential to reduce hospital admissions, rates of compulsory inpatient admissions in the UK have risen between 1998-2008 despite the national provision of these specialist community mental health teams, again reflecting their partial and variable implementation

The review by de Jong et al therefore 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 would be the antithesis of what consumer groups may describe as the paternalistic model of medical care, but if fully implemented may well be evidence-based, and promote liberty.

Conflict of interest statement

The authors declare no conflicts of interest

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