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ORIGINAL ARTICLE

Users' and Health Professionals' Values in Relation to a Psychiatric Intervention: The Case of Psychiatric Advance Directives

P. Nicaise · V. E. Soto · V. Dubois · V. Lorant

Abstract Although clinical and organisational benefits have been expected from Psychiatric Advance Directives (PADs), their take-up rates remain low and their evaluation disappointing. The endorsement of PADs by stakeholders is decisive for their use and understanding stakeholders' preferences for implementation is crucial. A Multinomial Discrete Choice analysis was carried out of options for designing, completing, and honouring PADs, with a view to enhancing user autonomy, therapeutic alliance, care coordination, and feasibility. Although autonomy underlies the whole process, the criteria determining options varied with the stage of the intervention. These criteria should be taken into account in future PAD intervention and evaluation processes.

Keywords Psychiatric Advance Directives · Crisis plans · Therapeutic alliance · Delivery of health care · Integrated

Introduction

The use of Psychiatric Advance Directives (PADs) is an intervention for severe and chronic users, aimed at planning in advance action to be taken during a crisis relapse. It is centred on a document in which the user notifies his/her preferences for treatment and may appoint a surrogate decision-maker for the period of incompetence (Atkinson et al. 2004; Atkinson 2007; Campbell and Kisely 2009). PADs should contribute to numerous clinical and organisational aims in psychiatric care, including empowerment of the user and recovery (Elbogen et al. 2007; Srebnik et al. 2003; Szmukler 2007), improving compliance with treatment (Swanson et al. 2000; Thomas and Cahill 2004), continuity of care (Swartz et al. 2006), and therapeutic alliance (Kim et al. 2008; Thornicroft et al. 2011; Van Dorn et al. 2008); they should also eventually contribute to reducing the number of voluntary and involuntary hospitalisations (Henderson et al. 2004). However, with the exception of the last study cited, randomised clinical evaluations have had disappointing results, showing little or no significant differences between intervention and control groups for primary outcomes (Borschmann et al. 2013; Campbell and Kisely 2009; Papageorgiou et al. 2002; Thornicroft et al. 2011). Their actual implementation and use during crisis episodes is still an issue (Henderson et al. 2010; Srebnik and Brodoff 2003). This could explain why rates of uptake of PADs have remained low regardless of their type and why results obtained during clinical trials have been disappointing (Thornicroft et al. 2011). At the same time, most studies noted that the endorsement of PADs by users and health professionals was decisive for their actual use (Atkinson et al. 2004; Elbogen et al. 2006, 2007; Thornicroft et al. 2011); hence, understanding the theoretical expectations and values of stakeholders is crucial.

A realist systematic literature review noted that the effectiveness of PADs depended on the theoretical expectations underlying the intervention (Nicaise et al. 2013). Nicaise and colleagues identified three distinct theoretical frameworks that underlay the rationale for which a PAD intervention would be effective. In the first of these, the

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PAD intervention was set up with a view to enhancing user autonomy. The use of a PAD is supposed to foster the involvement of the user in his/her own treatment (Elbogen et al. 2007; Szmukler 2007), support his/her empowerment in treatment decision-making (Atkinson et al. 2004; Kim et al. 2007), and eventually contribute to his or her recovery (Backlar et al. 2001; Scheyett et al. 2007). This approach particularly influenced the development of facilitated PADs (f-PADs) in the United States (Swanson et al. 2006a). In the second theoretical framework, a PAD intervention was expected to improve the quality of the therapeutic alliance between clinicians, users, and carers as a tool for exchanging information, facilitating mutual understanding, and support compliance with treatment (Atkinson et al. 2003b; Henderson et al. 2004, 2008; Papageorgiou et al. 2002). This second framework underlay the development of Joint Crisis Plans (JCP) in the United Kingdom (Henderson et al. 2004, 2009; Thornicroft et al. 2011). In the third theoretical framework, PADs were supposed to encourage the coordination of care between different clinicians and providers (Backlar et al. 2001; Swanson et al. 2000; Swartz et al. 2006). This latter theoretical framework in relation to PAD effectiveness has not been assessed so far, and clinicians raised concerns about the capacity of care systems to actually honour PAD statements when a crisis occurs (Van Dorn et al. 2006).

Moreover, the review also noted that much had been investigated about the definition and content of the PAD document and how to draw one up, but very little was known about the honouring of PAD statements when a crisis occurs (Srebnik and Brodoff 2003; Srebnik and Russo 2008, 2007).

Consequently, in this study, we carried out an analysis of stakeholders' preferences in relation to implementing a complete PAD intervention. Taking the above-mentioned results into account, we decided to consider three stages in the intervention: (1) the PAD intervention design, (2) the process of drawing up a PAD (completion), and (3) PAD access and honouring when a crisis occurs. A Multinomial Discrete Choice (MDC) analysis was performed on these preferences in order to elicit the values underlying stakeholders' choices. The different theoretical frameworks were considered as criteria for assessing the performance of several options on PAD effectiveness.

Method

The study followed the conclusions of the literature review mentioned above (Nicaise et al. 2013) and was in two phases, which were carried out in Belgium between 2010 and 2011.

First Phase: Selection of Options and Criteria for the Three Stages of the Intervention

During the literature review, numerous options for the implementation of the three stages of a PAD intervention (PAD intervention design, PAD completion process, and PAD access and honouring) had been identified. During the first phase, six focus groups were organised, with a total of 51 participants: four groups with a total of 40 patients and two groups with a total of 11 health professionals. These groups were organised in order to explore the strengths and weaknesses of the options identified. As a result of this first phase, twenty options were retained for inclusion in the second phase. The options selected corresponded to different possible uses of PADs, as well as to potential differences in stakeholders' priorities in Belgium (see Table 1).

At the intervention design stage, the literature review reported that the range of stakeholders involved in the drawing up of PADs was one key variable among types of PADs (Henderson et al. 2008; Nicaise et al. 2013). When developed with a view to enhancing user autonomy, PADs were meant to be produced by the user alone or within a facilitation process, but without the involvement of clinicians (Amering et al. 2005; Atkinson et al. 2004; Khazaal et al. 2008; Sherman 1998; Swanson et al. 2006b; Van Citters et al. 2007). Conversely, when developed with a view to supporting the therapeutic alliance and the coordination of care, PADs such as JCP were meant to involve a broad range of stakeholders, including clinicians, care coordinators, and friends or relatives of the user (Henderson et al. 2004; Ruchlewska et al. 2012; Thornicroft et al. 2010). The first four options reflect these approaches to PADs as they might be introduced in Belgium: the request for a PAD by users or advocacy associations is related to the enhancement of users' autonomy, while the suggestion of a PAD by a health professional is related to the improvement of the therapeutic alliance and the suggestion of a PAD by a non-health professional is related to care coordination. The three remaining options are about the time, place, and persons involved in initiating a PAD. These three options also correspond to three different uses of PADs: recording users' wishes (user autonomy), anticipating future hospitalisations (coordination of care), and preventing crisis relapses by maintaining contacts with community care providers (therapeutic alliance).

At the drawing-up stage, the literature reported that the information contained in PADs is useful for different purposes, such as preventing a crisis episode (e.g. with de-escalating methods), managing care during a crisis episode (e.g. with care coordinator designation and treatment preferences), and managing the social life of the user during a crisis episode (through non-medical statements such as paying rent or feeding a pet) (Atkinson et al. 2004;

Table 1 Options for the implementation of PADs at the three stages of the intervention and mean scores for stakeholders' preferences per value criterion

Options for the implementation of PADs	Mean (std) for user autonomy ($n = 102$)	Mean (std) for therapeutic alliance ($n = 102$)	Mean (std) for coordination of care ($n = 102$)	Mean (std) for feasibility ($n = 102$)	Number of times chosen as best option per stage among stakeholders ($n = 102$)
Stage A: PAD intervention design					
A1 The PAD is requested by the user	8.31 (2.06)	7.86 (2.00)	7.81 (2.02)	7.02 (2.34)	38
A2 The PAD is suggested to the user by a health professional	7.19 (1.78)	7.80 (1.80)	7.84 (1.65)	7.71 (1.82)	30
A3 The PAD is suggested to the user by a non-health professional (mediator, lawyer, sickness fund…)	5.37 (2.17)	4.77 (2.48)	5.40 (2.41)	5.10 (2.46)	3
A4 The PAD is suggested to the user by a user's advocacy association	6.33 (2.29)	5.76 (2.26)	5.93 (2.48)	5.85 (2.46)	1
A5 The PAD is drawn up by the user whenever he/she wishes it	7.90 (2.31)	7.36 (2.35)	6.91 (2.48)	6.94 (2.40)	11
A6 The PAD is drawn up at the hospital with the help of a health professional	6.53 (2.12)	7.16 (1.98)	7.18 (2.12)	7.46 (1.91)	10
A7 The PAD is drawn up in a community health service with the help of a health professional	7.36 (1.73)	7.68 (1.65)	7.93 (1.64)	7.64 (2.00)	9
Stage B: PAD completion process					
B1 The PAD should include a brief chronological account of medical events	6.41 (2.59)	6.83 (2.60)	7.63 (2.00)	6.92 (2.29)	7
B2 The PAD allows the user to designate a reference person, professional coordinating the honouring of the PAD statements in times of a crisis	7.36 (2.23)	7.86 (1.79)	8.28 (1.52)	7.56 (1.99)	26
B3 The PAD allows the user to designate a trusted nominee, professional or non-professional, who could support the user in times of crisis	8.02 (2.02)	8.02 (1.66)	8.37 (1.55)	7.62 (1.93)	27
B4 The PAD allows the user to explain his/her treatment preferences (medication. treatment locations. and health professionals)	8.33 (1.81)	8.28 (1.60)	8.04 (1.76)	7.51 (1.92)	18
B5 The PAD allows the user to refuse specific medication, treatment locations, or health professionals	7.92 (2.26)	7.47 (2.18)	7.44 (2.16)	6.73 (2.40)	4
B6 The PAD should include de-escalating or crisis prevention methods	8.08 (1.74)	8.25 (1.63)	8.31 (1.68)	7.55 (1.77)	20
B7 The PAD should include non-medical statements	7.27 (2.43)	7.30 (2.08)	7.30 (2.40)	7.01 (2.20)	0
Stage C: PAD access and honouring					
C1 The PAD document should be registered with health professionals, in addition to those who signed it	7.27 (2.47)	7.59 (2.17)	7.88 (1.95)	7.56 (1.95)	33
C2 The PAD document should be registered in a central database with secure access, in addition to those who signed it	6.20 (2.99)	6.04 (2.72)	7.08 (2.52)	6.36 (2.64)	19
C3 The honouring of PAD statements requires a coordination role (case-manager, reference person…)	7.52 (2.14)	7.71 (1.80)	8.28 (1.64)	7.36 (1.88)	29
C4 The honouring of PAD statements requires an evaluation of the patient's competence at the time of the completion of the document	5.99 (3.08)	6.01 (3.00)	6.26 (2.75)	5.81 (2.67)	1
C5 The honouring of PAD statements requires specific training for health professionals	7.46 (2.32)	7.84 (2.04)	7.75 (2.03)	7.24 (2.08)	19
C6 The honouring of PAD statements requires a financial incentive	3.97 (3.15)	4.04 (3.00)	4.47 (3.02)	4.90 (2.91)	1

Elbogen et al. 2006; Henderson et al. 2004; Swanson et al. 2006a). The options included in the second stage reflect these different possibilities. Some options, however, although extensively discussed in the literature, e.g. in relation to electroconvulsive therapy (Elbogen et al. 2007; Nicaise et al. 2013; Swanson et al. 2006b) or the legal status of the document (Atkinson et al. 2004; Henderson et al. 2008), and overriding statements (Swanson et al. 2007), were not included in the survey as they did not apply to the current situation in the Belgian care system or did not provoke differences of opinion among stakeholders.

Finally, the literature review reported that very little was known about the honouring stage (Nicaise et al. 2013; Srebnik and Russo 2008, 2007). The options included in the study for the third stage of the intervention were suggested during the focus groups.

Second Phase: Design of the Survey

During the second phase, a survey was carried out with 102 stakeholders involved in psychiatric care for severe and chronic illnesses (schizophrenia, major depression, and bipolar disorders), divided into four groups: (1) patients and representatives of users' associations; (2) health professionals, mainly psychiatrists, psychologists, and social workers in mental health; (3) carers, and representatives of family associations; and (4) policymakers and experts in the organisation of psychiatric care (Buse 2005; Martin et al. 2003; Atkinson et al. 2004; Srebnik and La Fond 1999). Stakeholders were selected according to their experience of psychiatric care and involuntary commitment. The list was drawn up in three steps (Varvasovszky and Brugha 2000): an initial set of names was identified by using national and official directories, including publications available on the web; this list was validated and complemented by a panel of experts; finally, snowball sampling was used to increase the sample size and diversity by asking interviewees to nominate influential or knowledgeable people involved in advance directives, patient participation, or involuntary commitment in psychiatry. Particularly, additional patients were recruited through snowball sampling from the representatives of users' and family associations contacted initially. One hundred and thirty-eight stakeholders were eventually identified and contacted, of whom 102 agreed to participate (see Table 1): 25 stated that they did not have time, 5 did not feel they had sufficient expertise, 2 were unreachable, and 4 respondents did not completely fill in the questionnaire and were rejected (Table 2).

Survey Format and Measures

The survey was carried out during questionnaire-assisted face-to-face interviews. Data were collected between March and July 2010. Trained interviewers conducted it. On the one hand, it included the twenty options that were selected after the first phase of the study. On the other hand, the three theoretical frameworks identified by the systematic literature review (Nicaise et al. 2013), i.e. user autonomy, therapeutic alliance, and coordination of care, were considered as value criteria for choosing options. A fourth value criterion was added: feasibility. For the purpose of the survey, user autonomy was defined as the user's power and control over his/her choices for treatment, medication, and the management of his/her health issues. Therapeutic alliance was defined as the quality of the relationships between the user and the health professionals involved in his/her care. Coordination of care was defined as the organisation of care continuity within or between crisis episodes. Finally, feasibility was defined as the availability of the human, logistic, and funding resources required for the implementation of the intervention.

Each interviewee was presented with the set of twenty PAD options and was asked to score each option on a scale ranging from 0 (performs very poorly) to 10 (performs very well), for each of the four criteria. In addition, interviewees were asked to choose one most favoured option within each stage of the intervention (design, completion process, access and honouring). Information on socio-demographic status and experience with psychiatry was also collected.

Statistical Analysis

Multinomial Discrete Choice (MDC) analysis was applied. MDC analysis aims to describe and explain choices between different options, taking several criteria into account, and makes it possible to measure the influence of criteria on the overall choices made. This approach is widely used in econometrics and has been used for manpower planning priorities (Lorant et al. 2011), obesity prevention programmes (Millstone and Lobstein 2007), and health technologies (Wilson et al. 2007). It makes it possible to understand the extent to which the influence of each criterion increases the likelihood of choosing an option. One important standard for MDC is to present the respondent with the relevant alternatives together, so that he/she can choose an order of preference. In our study, respondents were asked to score the performance of options, to rank these options, and to pick their preferred option at each stage. A second important standard is that alternatives criteria, on the basis of which respondents usually make their choices, should be presented to them. Finally, a third important standard is to limit the number of alternatives presented to the respondent. Seven alternatives are often considered to be the maximum for ranking.

The decision-making process of stakeholders, i.e. their identification of the best option at each stage, was modelled

Table 2 Characteristics of stakeholders interviewed in the survey

Groups	*N* (total = 102)
Policymakers	23
Health professionals	32
Family and carers	20
Patients	27
Language	
Dutch	49
French	53

with the help of multinomial logit, which makes it possible to model both the effects of respondent characteristics (e.g. stakeholders group) and the effects of criteria on the choices made. In addition, conditional logit makes it possible to capture correlations between the observations of the same respondent. We built three models: the first model included the influence of the four criteria on the overall intervention; the second model was stratified by stage; the third model, finally, investigated interactions between criteria and individual characteristics that were more likely to predict preferences (stakeholder group and experience with psychiatry and involuntary commitment, either as a professional or as a patient). Statistical analysis was carried out with SAS 9.2.

Results

Descriptive Results (see Table 1)

At the first stage of the intervention, PAD design, two options stand out as the best: "the PAD is requested by the user" and "the PAD is suggested to the user by a health professional". These two options reflect, however, two different approaches to PADs (user autonomy and therapeutic alliance), as explained above. Conversely, there was very little support for "the PAD is suggested to the user by a non-health professional" or "by a users' advocacy association". These options involve introducing a third party into the direct therapeutic relationship between the clinician and the user. However, no significant difference was found between the scores of all these options for the four criteria selected.

Options at the second stage, PAD completion, received the highest scores. However, scores were generally lower on the feasibility criterion. The two preferred options involved the designation of a third party, either a reference person to coordinate the action to be taken or a trusted nominee to support the user during the crisis. The inclusion of explanations of treatment preferences received the highest scores on user autonomy and therapeutic alliance, while the inclusion of crisis prevention methods was highly scored on coordination of care. The least supported options were the inclusion of non-medical statements and the right to refuse treatment. Conceptually, these two options underlie the user autonomy framework. However, they did not scored significantly less than the other options on any criteria, except feasibility.

Scores were generally lower for options at the third stage, PAD access and honouring. The most supported options were the registration of the document with health professionals and the requirement for a coordination role to implement the statements. Assessment of the user's competence when the PAD document is being drawn up and financial incentives were the least supported options. Again, the lowest scores were found on the feasibility criterion.

Modelling the Effect of the Value Criteria on the Choice of Options

The four criteria had significant and positive effects on choices. In Model 1 (See data in the upper part of Table 3), the criteria of user autonomy and of coordination of care had more influence on choices than the criteria of therapeutic alliance and feasibility (OR $\geq$ 1.38 vs. OR $\leq$ 1.27). User autonomy was an important criterion across the three stages, which is consistent with the primary aim of PADs. However, the other three criteria had different effects according to the stage (Model 2, see data in the lower part of Table 3). Coordination of care and user autonomy turned out to be of equal importance for choosing options at the PAD completion and PAD access and honouring stages. Feasibility, which had a low effect on choices in the first two stages, turned out to be more important at the last stage. Conversely, therapeutic alliance appeared to have less influence on choices at the third stage as compared to the first two stages. Figure 1 illustrates the changing importance of the four criteria across the three stages.

Finally, we tested the effect of these four criteria on choices according to stakeholder group (patient vs. non-patient), and according to experience with psychiatry and involuntary commitment, either as a professional or as a patient (Model 3). Although patients tended to attribute less importance to feasibility (OR = 1.06 vs. OR = 1.25; $p = 0.16$) and to autonomy (OR = 1.36 vs OR = 1.50, $p = 0.50$) than non-patients, these differences were not statistically significant.

Discussion

Main Findings

Although options for employing PADs were chosen according to a complex blend of value criteria, the MDC

analysis showed how choices varied according to the stage of the intervention. Stakeholder analysis is a method for understanding actors' intentions, interest, and influence over a process (Varvasovszky and Brugha 2000), and finally facilitating consensual decision-making. Our results should help to draw up a consensual whole-intervention scenario. At the design stage, options for PADs should perform well both in terms of the criterion of user autonomy and that of the therapeutic alliance. This result is positive for certain types of PADs, such as facilitated PADs (f-PADs) (Swanson et al. 2006a), in which the user is helped to state his/her preferences, or JCP (Henderson et al. 2004; Thornicroft et al. 2011), in which users and health professionals are involved in a negotiated completion process. Of the options selected in this study, the results favoured a PAD requested by the user or suggested by a health professional and oriented towards preventing crisis relapses by being drawn up in a community setting.

At the completion stage as well as at the access and honouring stage, coordination of care gained in importance for driving choices with user autonomy. Feasibility also appears to be an important criterion at the access and honouring stage. Interestingly, the two preferred options at the completion stage concerned the designation of a third party to help drawing up the PAD, and a coordinator (such as a case-manager) is the second most frequent option at the access/honouring stage. This result could be related to the function of surrogate decision-maker, which is the function most used in PADs in the USA (Elbogen et al. 2006; Nicaise et al. 2013; Swanson et al. 2006b). Finally, coordination of care appears to be decisive for the implementation of PADs. The results of our survey indicate that honouring PAD statements remains the major issue: a coordination role is required as well as training programmes for health professionals. This suggests that there is a need for a reference coordinator who would be able to access the PAD in times of crisis and to organise action intended to honour the statement as far as possible.

The main aim of this study was to contribute to setting up a complete PAD intervention scenario that would be appropriate in the context of the Belgian mental-health care system. Thus, it is worth noting that the stakeholders interviewed had no actual experience of using PADs. However, the effect of value criteria on choosing specific options may be of interest beyond the limited set of options selected within the context of this study. For example, one important issue discussed in the literature about PADs is their possible legally binding status, the liability of clinicians to honour the statements, and the definition of conditions for overriding them (Atkinson et al. 2003a; 2004; Van Dorn et al., 2006), particularly for proscriptive PADs (Elbogen et al. 2006; Kim et al. 2008; Swanson et al. 2007). Although the legal status of the document was not discussed in our study, our results indicate that options for designing a PAD intervention should be driven by the enhancement of user autonomy, which might, in some contexts, mean making the PAD document legally enforceable. However, at the same time, options for PAD content should be chosen

Table 3 Effect of criteria on the choice of PAD options: conditional logit Model I (overall intervention), and Model II (odd ratios per stage of the intervention)

Criteria	Odd ratios	Log likelihood	R-square pseudo	*N*
Overall intervention				
User autonomy	1.46 (1.31–1.63)***	−582.80	0.19	2040
Therapeutic alliance	1.27 (1.13–1.44)***			
Coordination of care	1.38 (1.22–1.57)***			
Feasibility	1.19 (1.07–1.32)***			
Stage A: PAD design				
User autonomy	1.39 (1.16–1.65)***	−153.91	0.22	714
Therapeutic alliance	1.37 (1.12–1.68)***			
Coordination of care	1.25 (1.03–1.51)**			
Feasibility	1.12 (0.95–1.31)^{ns}			
Stage B: PAD completion				
User autonomy	1.54 (1.25–1.90)***	−157.86	0.20	714
Therapeutic alliance	1.29 (1.04–1.61)**			
Coordination of care	1.43 (1.12–1.82)***			
Feasibility	1.17 (0.99–1.39)*			
Stage C: PAD access and honouring				
User autonomy	1.48 (1.20–1.82)***	−115.02	0.37	612
Therapeutic alliance	1.15 (0.93–1.42)^{ns}			
Coordination of care	1.58 (1.23–2.02)***			
Feasibility	1.37 (1.10–1.70)***			

The results for Model III, i.e. including stakeholder group characteristics, are not presented, as this model did not show significant differences between groups

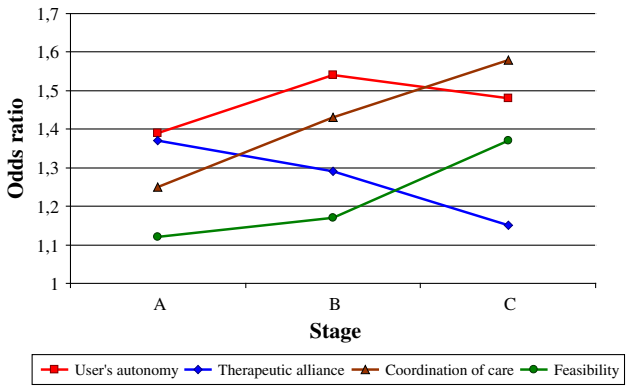

Fig. 1 Variation of odd ratios of criteria per stage of the intervention. Odd ratios estimated from conditional logit model including robust errors. Chow test = 89.78 $p < 0.0001$. This test was calculated based on model 2. It allows us to split the sample by stage

with a view to supporting therapeutic alliance, which might mean some agreement between the user, carers, and clinicians in interpreting the statements. This is consistent with previous studies, which showed that clinicians would be less keen to override treatment refusals when mental health professionals were involved in drawing up the PAD document (Srebnik et al. 2005).

The value criteria highlighted in our study are also quite consistent with other studies. In particular, Henderson et al. (2010) carried out a Delphi study with 55 experts (users and non-users) of several options and procedures for implementing PADs. Stakeholders in two different organisational and study contexts may differ in their views about some practical options. However, in Henderson's study, experts strongly agreed that users' choices should drive the way the overall intervention is implemented. Moreover, they underlined the importance of the therapeutic alliance when drawing up a PAD document. For example, they stressed the need for users to be assisted in drawing it up properly and stated that all persons involved in the care of a user should take part in the discussion of its content. Finally, it was more difficult to reach a consensus among experts when it came to accessing PADs; lack of communication and lack of coordination of care, however, were mentioned as major barriers to accessing and honouring PAD statements and training was requested in relation to this stage.

It was hypothesised that the disappointing results obtained during RCTs as well as the low rates of uptake of PADs in routine practice were related to the multiple theoretical frameworks as to how the PAD should work and to different stakeholders' expectations (Nicaise et al. 2013). Our results would indicate that these expectations could vary according to the stage of the intervention and consequently should be taken into account when choosing options for a whole PAD intervention. In consequence, the value criteria, i.e. user autonomy, therapeutic alliance, coordination of care, and feasibility, should also be measured within future RCTs on PADs. Nevertheless, a critical issue remains, which is the capacity of clinicians and of the health care system to use PADs and actually honour statements in times of crisis. The scores of the options suggested within our study for this stage were lower, particularly on the feasibility criterion. The results show that the most important value criterion for choosing options at this stage is coordination of care. This suggests that coordination of care is important for increasing the use of PADs and should be more thoroughly investigated.

Limitations

One major limitation of this survey was the lack of experience and knowledge of PADs. Indeed, the study was carried out with a view to introducing PADs into the Belgian mental health care system, where PADs are not currently in use. Some common issues concerning PADs, such as overriding statements, the legally binding status of the document, and PAD revocation were not addressed as they did not apply in this preparatory context. As a consequence, the results presented relied more on stakeholders' generic opinions than on their actual experience and practice of PADs. Nonetheless, respondents were selected according to their experience in psychiatric care, particularly in relation to compulsory admission and treatment. It has been shown elsewhere (Lorant et al. 2007) that the use of compulsory admissions has increased in Belgium due to the lack of care alternatives: PADs were regarded as a tool to facilitate such alternatives. In addition lack of experience may have led to a cognitive bias while assessing the different criteria. Although these criteria were carefully defined and explained to respondents during face-to-face interviews, we cannot guarantee that these criteria were clearly understood as totally independent. Indeed, we have noticed that mean scores per criterion in Table 1 are very close to one another.

A second limitation is related to the small sample size and its statistical power. Particularly in relation to the users and carers in the sample, we acknowledge that our survey might not be representative of average users and carers. However, respondents were carefully selected according to stakeholder survey methods. Indeed, the validity of a MDC survey depends on the participants' understanding of the choices they have to make, as well as on their understanding of the criteria suggested. Internal consistency was assessed by checking whether participants had chosen the options for PAD implementation with the highest overall scoring (by adding up the scores for all four criteria). Overall we found a Spearman correlation of −0.76

($p < 0.01$) between the score for PAD options and its ranking (the lower the better), suggesting that choices were related to the overall perception of option performance. We also assessed the external validity by comparing the expected values for answers across the stakeholder groups. We expected that policymakers would be keener on the criterion of feasibility, health professionals on therapeutic alliance, families and carers on coordination of care, and patients on their autonomy. It turned out that no difference was found between patients and non-patients on autonomy, contrary to expectations. Two factors may explain this unexpected result. First, the non-patient group was somewhat heterogeneous, as it included health professionals, carers, and policy-makers. Second, within-stakeholder group variance was shown to be as important as between-stakeholder group variance (Kapiriri and Norheim 2004; Oudhoff et al. 2007). This could be due to socio-demographic characteristics (Ryynanen et al. 1999), or to stakeholders supporting a more pluralistic blend of values in priority setting (Cookson and Dolan 1999). However, it is possible that a larger sample would have shown significant differences between stakeholder groups.

Conclusions

Our findings could help to facilitate the implementation of complete PAD interventions and make them more attractive. Indeed, the results indicate the consensual value criteria that should drive the choice of option for implementation at each stage of the process. Although user autonomy remains the primary value of the intervention, PADs are more likely to correspond to the needs of users and to be endorsed by health professionals, families, and policy-makers if the therapeutic alliance is taken into account at the stage of PAD design, whereas the importance of coordination of care and feasibility in driving choices grows at the completion stage and at the honouring stage. Further studies could be designed to evaluate actual scenarios of intervention where the value criteria are applied and others where they are not, and to assess any impact on outcomes. Similarly, value criteria should be assessed during further RCTs, particularly in relation to the actual use of PADs during crisis events.

This value process might also be illuminating for psychiatric health services managers. Indeed, although shared decision-making in treatment and user accountability for and involvement in treatment are widely acknowledged as elements of good practice in all fields of health care, these elements are difficult to include in mental health care. By separating the moment of negotiation, the moment of decision, and the moment of implementation of a psychiatric intervention, the case of PADs reveals a model of interaction between stakeholders that could be validated for other interventions in psychiatry: negotiation should rely on therapeutic alliance principles and implementation should take into account feasibility and the improvement of coordination of care.

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