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Special Feature Article

Discussion on the Introduction of Practical Advocates in a Psychiatric Hospital

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Abstract

A model project for promoting decision-making and expression of intention of persons with mental disorders related to hospitalization was conducted and Advocate guidelines were proposed, under the initiative of the Japan Psychiatric Hospitals Association using the 2015 Health, Labor and Welfare Science Research Grant for comprehensive welfare promotion for persons with disabilities. Nowadays, the expression "advocate" is used instead of "advocator" because of valuing the protection of patients' rights. Currently, in non-psychiatric general hospitals, medical staff usually assist inpatients in decision-making. In order to introduce effective advocacy in psychiatric hospitals, well-balanced procedures are necessary, including prioritizing patients' will, after the medical staff fully understand the medical condition, respecting intentions of the patients' family members, and considering the maximum benefits for patients.

In Goryokai Medical Corporation, an ethics conference is held based on four principles of medical ethics (autonomy, non-maleficence, beneficence, and justice), proposed by T. M. Beauchamp and J. F. Childress in their textbook titled "Principles of Biomedical Ethics," so that medical professions can adequately discuss ethical issues. Medical staff sometimes face a dilemma between support for patients' decision-making and actual treatment, as allowing non-voluntary inpatients to express their thoughts is considered to be disadvantageous, which is caused by a poor understanding of mental illness. In this article, efforts by the Goryokai Medical Corporation that led to support for patients'

decision-making and advocacy are introduced and the necessity of well-balanced procedures is discussed.

Keywords: decision-making, advocator, advocate, ethics conference, psychiatric hospital

Introduction

As part of the 2015 Health, Labour and Welfare Science Research Grant for the Promotion of Comprehensive Welfare for Persons with Disabilities, a model project, entitled: "Model Project on the Decision-Making and Expression of Will of Persons with Mental Disorders Related to Hospitalization", was implemented by the Japan Psychiatric Hospitals Association (JPHA), and advocate guidelines were developed.³⁾

The author was closely involved in this project as the person in charge. While the advocate guidelines are considered practically applicable in current psychiatric hospitals, there are also opinions that the "advocator" as defined within them is insufficient for protecting patients' rights. In recent years, the term "advocate" has come to be used in order to distinguish it from the "advocator" defined by JPHA. At present, support for decision-making by persons with mental disorders is often provided not by external supporters, but by internal medical staff within hospitals. Generally speaking, in non-

psychiatric hospitals, inpatient decision-making support is typically handled by healthcare professionals. For the practical implementation of advocate activities within psychiatric hospitals, it is essential for healthcare providers to fully understand the patient's condition, give highest priority to the patient's will, consider the wishes of family members, and comprehensively evaluate what is in the patient's best interest. Thus, a balanced and thoughtful approach is required.

I. Practical Advocate Activities

Regarding decision-making support for inpatients at Goryokai Mental Hospital (hereinafter referred to as "our hospital"), peer supporters from outside do not take on the role of advocates, but they do occasionally visit wards and hold tea gatherings with patients. Generally, decision-making support for inpatients is provided by medical staff. Because patients may sometimes hesitate to speak frankly with medical staff, there is some validity to the opinion that external advocates should

take on this role. However, since external supporters are not connected to the insurance system or medical reimbursement, they offer no practical benefit to hospitals, and in reality, it is difficult for them to be involved in hospital settings. At our hospital, we hold "Ethics Conferences" to consider how medical professionals should resolve the ethical issues they face based on the four principles of biomedical ethics: respect for autonomy, non-maleficence, beneficence, and justice, proposed by Beauchamp, T.L. et al. in *Principles of Biomedical Ethics*.¹⁾ In particular, there are cases where involuntarily hospitalized patients do not fully understand their illness and request actions that are detrimental to themselves, leading to dilemmas between supporting patient decision-making and providing treatment. Amid such conflicts, the following are examples of initiatives at our hospital that contribute to decision-making support.

1. Hypothetical Case

The patient was a man in his 40s who had been diagnosed with schizophrenia in his 20s. He had no understanding of his illness and repeatedly relapsed due to non-adherence to medication. Although he exhibited marked hallucinations and delusions, he interpreted them as spiritual

experiences and strongly maintained the belief that he was not ill. This perception became solidified and was difficult to correct. His behavior, controlled by internal abnormal experiences, became deviant, leading to involuntary hospitalization with the consent of his father under medical protection. The patient stated: "I am not ill, so I don't need to take medication", and strongly refused to take it. Respecting his will, no pharmacological treatment was initially administered, and his condition was observed. However, he began exhibiting ritualistic behavior in front of mirrors, inappropriate smiling, and made phone calls to his family saying: "Kill [name]". He also shouted loudly: "For the sake of exorcism", showing signs of restlessness. As a result, isolation was initiated, and a one-week course of intramuscular haloperidol was administered out of necessity. As the medication proved effective, isolation was discontinued, and the patient expressed a strong desire to attend a concert. The family strongly urged the hospital to guide him toward gaining awareness of his condition and taking his medication appropriately. They also expressed a strong desire to see his conversations with spiritual experiences and auditory hallucinations come to an end. Allowing him to go out with the family's consent was also considered, but his parents

expressed distrust and anger toward the hospital, saying: "Why are you leaving the decision to the family when his condition is clearly severe?" Taking the family's concerns into account and given the persistence of delusional symptoms, the patient's request to go out was denied. He reacted with strong frustration over being unable to leave the hospital.

The staff were left struggling with how to respect the wishes of both sides: the patient, who denied having an illness and refused treatment, and the parents, who made strong demands to the medical staff regarding his condition and treatment. Such cases are discussed in clinical ethics conferences to evaluate the kind of approach that would be the most appropriate.

From a medically standard best judgment perspective, pharmacological therapy, recognized as the standard treatment for schizophrenia, is essential to improve and maintain remission. Rather than aiming for complete symptom elimination, the treatment goal was to alleviate symptoms and stabilize the condition to a manageable level. The patient insisted: "I have spiritual sensitivity, not an illness. I don't need medication or treatment. It's painful when evil spirits gather and can't be exorcised. Even with spiritual experiences, I can live normally. I can live alone". In contrast,

the family pleaded: "We want the illness cured. Not prescribing medication is the same as not treating him at all. You're leaving him to do whatever he wants. We want proper instruction and education. Don't leave the judgment to the parents; make medical decisions at the hospital". Thus, there was a significant gap between the patient and family regarding the goals and content of treatment, and their respective wishes were entirely incompatible.

At the ethics conference, the patient's best interest was considered in terms of social fairness and justice, meaning a perspective grounded in social norms. Supporting the patient's decision-making required a comprehensive approach that incorporated both the "medically standard best judgment" and "family's concerns". From the patient's perspective, the optimal outcome was to live independently and stably, be free from the threat of symptoms, and maintain daily functioning without disruption due to the illness. At the same time, achieving this best outcome required consideration for minimizing the burden on the family. When necessary, care for the family must also be considered, and their thoughts respected. To this end, the hospital provided opportunities to explain the patient's condition and treatment progress to the family, and help them understand the patient's perspective.

By listening carefully to both the patient and family, efforts were made to find common ground and continue treatment in a way that minimized the patient's pain and stress. Ultimately, the goal was to reach a situation acceptable to both the patient and family.

II. Discussion

The theme of this special feature article is: "Concrete Forms of the Advocate System in Psychiatric Hospitalization". The author has discussed advocate activities that are concrete and practically feasible to implement at the specialized psychiatric hospital where the author is employed. It is questionable whether the term "advocate" itself has been firmly established as a shared understanding among many mental health professionals. The scope of advocate activities tends to be interpreted broadly, ranging from responding to patient requests such as going out, overnight stays, or discharge, to decision-making support and rights advocacy. Therefore, in the 2015 Health, Labour and Welfare Science Research Grant project for the Promotion of Comprehensive Welfare for Persons with Disabilities, entitled: "Model Project on the Decision-Making and Expression of Will of Persons with Mental Disorders Related to

Hospitalization", implemented by JPHA, the author and colleagues created the Advocate Guidelines. The definition of an advocator is as follows: An advocator is a trusted individual whom people hospitalized in psychiatric hospitals can consult regarding difficulties in their daily hospital life. In situations where patients feel they are not receiving adequate explanations or are not being listened to, the advocator adopts the patient's perspective, understands their feelings and circumstances, and, when necessary, speaks on their behalf. By doing so, the advocator provides indirect support that enables the individual to live in accordance with their own feelings and engage proactively in psychiatric care. The advocator should be someone who understands the individual's words without prejudice and does not have conflicting interests.

Regarding this definition of an advocator, some have expressed concerns that it lacks a sufficient perspective on rights advocacy, leading to the growing use of the term "advocate". However, the author is concerned that, in the field of psychiatric care, confusion may arise over the usage of terms such as decision-making support, advocate, and rights advocacy, as their definitions remain ambiguous.

Psychiatric hospitals tend to avoid external involvement, and this tendency

has become even stronger due to the recent COVID-19 pandemic. For decision-making support and rights advocacy to be truly satisfactory for patients, families, and medical staff, external supporters will likely be needed. However, real-world challenges such as securing qualified personnel and the issue of personnel costs remain. To prevent these ideas from becoming nothing more than ideals on paper, practical and feasible methods that can be implemented immediately must be considered. At our hospital, we hold clinical ethics conferences based on the four principles of biomedical ethics: respect for autonomy, non-maleficence, beneficence, and justice, as proposed by Beauchamp et al. in *Principles of Biomedical Ethics*.¹⁾ At present, these conferences primarily reflect opportunities for staff to assess whether they are engaging in ethical practices. However, it is possible to examine within the hospital whether decision-making support is being provided and whether rights advocacy is being practiced in accordance with the four principles of biomedical ethics. If it is judged that the internal staff alone are insufficient, the possibility of inviting external members should also be considered. While this does not deny the necessity of external support in realizing "concrete forms of the advocate system in psychiatric hospitalization",

the first priority should be to examine how to effectively utilize existing personnel and implement a feasible model.²⁾

Conclusion

As a concrete form of the advocate system in psychiatric hospitalization, this paper introduced the clinical ethics conference held at Goryokai Medical Corporation, a specialized psychiatric hospital, and considered that this method could serve as a practical starting point for the introduction of an advocate system. Rather than advocating for ideals that are far from reality, it is desirable to design a system that can be realistically implemented within the current medical framework.

Editorial note

This special feature article is based on the symposium held at the 117th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Naoko Satake (Department of Psychiatry, Kohnodai Hospital, National Center for Global Health and Medicine) as the representative.

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