Crisis cards†

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The interaction between health service staff and the people they care for is constantly evolving. 'Patients' no longer consider themselves as passive recipients of care administered by all knowing and all powerful doctors. They have become consumers, clients or service users, aspiring to be equal partners in determining their care.

Mental health service users have become more organised and influential. A large number of user organisations have emerged in the UK, both nationally and locally. The larger national groups are Survivors Speak Out, the UK Advocacy Network and MindLink. Each of these contains hundreds of local groups. One aspect of their work is advocacy. It is from this strand of self-advocacy that the crisis card first emerged in the late 1980s when the International Self Advocacy Alliance launched its model card, since endorsed by the House of Commons Health Select Committee (House of Commons Health Committee, 1993).

There are essentially two types of crisis cards; the original crisis card was a global statement of a user's wishes, regardless of a professional's advice or preferences. The second category, often originating from staff, is the joint crisis card, which includes very practical information on issues like keyworkers, housing and medication. It is similar to an emergency care plan. Professionals have argued that the process of drawing up a joint crisis card means that it is more likely that a user's wishes will be respected.

However, this ignores the radical intent of the original crisis card. From the perspective of the user, a joint crisis card means that power ultimately still rests with those that run the service. For example, the original crisis card may contain statements which a professional might find untenable, and unable to accept in the event of a crisis. It supports a user's right to make choices, and with that to make mistakes affecting their own lives.

An important point for users is the enforceability of cards. They have no particular status in English law over and above any other expression of intent. However, treatment can always be challenged afterwards, and the outcome would then depend on the interpretation of mental incapacity or competence, recently reviewed by the Law Commission (1995), and the court's view as to whether the user's expressed wishes were relevant and binding in the specific set of circumstances which actually arose. In addition, the Mental Health Act allows a user's wishes to be overturned in the specific circumstances it sets out.

The paper by Sutherby & Szmukler (1998) gives a good overview of the present situation. The popularity of crisis cards is likely to grow, and they might become a logical complement to care plans and assist in treatment adherence. Psychiatrists will have to accept that they are also an indicator of the growing independence of the user movement. It is good news for professionals that users are taking personal responsibility for their care, even though in the short term tensions are likely to emerge as a consequence of mutually unrealistic expectations.

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