Atkinson, J.M. and Garner, H.C. and Harper Gilmour, W. (2004) Models of advance directives in mental health care: stakeholder views. *Social Psychiatry and Psychiatric Epidemiology* 39(8):pp. 673-680.

Jacqueline M. Atkinson · Helen C. Garner · W. Harper Gilmour

Models of advance directives in mental health care:

Stakeholder views

Accepted: 9 February 2004

Abstract *Objective* The aim of this study was to examine perceptions of the place of advance directives in mental health care. *Methods* Postal survey of stakeholders was carried out to assess their views on different models of advance directives in mental health care. A total of 473 responded. *Results* In all, 28% of psychiatrists thought advance directives were needed compared to 89 % of voluntary organisations and above two-thirds of the other stakeholder groups. There were clear tensions between patient 'autonomy' and 'right to treatment' which underpin many of the concerns raised. Autonomy provided by advance directive can be contrasted with a co-operative partnership approach to advance planning. The legal status of advance directives is important for some people in relation to treatment refusal. There was general concern about the practical issues surrounding their implementation. *Conclusion* There is a wide range of views in all stakeholder groups about the possible form advance directives should take. Although there is a widespread desire to increase patient involvement in treatment decisions, which advance directives could possibly help to realise, they may also have unwanted consequences for mental health services and individuals.

Introduction

The reviews of mental health legislation in Scotland [1, 2] and England and Wales [3, 4] have raised the profile of advance directives in mental health care which have, until now, received little interest in the UK. Although some user groups have had an interest in advance directives for some time [5, 6], there has been little public debate either within professions or between professions and users and carers. Some organisations have developed their own template for an advance directive [7]. One version of this type where patients completed a 'Preferences for Care' booklet has been subject to a randomised controlled trial [8]. Results did not show any observable impact on the outcome of care at 12 months when compared to the control arm of the study. Other forms of advance planning, such as crisis cards, have been explored [9]. Evidence given to the Scottish Parliament Health and Community Care Committee about advance directives gave public expression to both user and professional views [10, 11]. Advance statements are included in the new Mental Health (Care and Treatment) (Scotland) Act [12]. The situation in relation to the legislation for England and Wales is less certain since the apparent fall of the Mental Health Bill [13, 14]. Interest has been greater in the United States [15, 16] which may have increased following the implementation of the Patient Self-Determination Act 1990 [17, 18]. Conceptual issues in using advance directives in practice have been discussed elsewhere [19]. This research looks at survey results of the views of different stakeholder groups to models of advance directives.

Subjects and methods

The study involved a postal questionnaire exploring views about five different models of advance directives. The models of advance directives had been developed through an earlier stage of the research (20).

J. M. Atkinson B.A., PhD, C.Psychol (✉) · H. C. Garner B.A. (Econ), M.P.H. · W. H. Gilmour, M.Sc, C.Stat
Public Health and Health Policy
Division of Community Based Sciences
University of Glasgow
1 Lilybank Gardens
Glasgow, G12 8RZ, Scotland
Tel.: +44-141/330-5009
Fax: +44-141/330-5018
E-Mail: j.m.atkinson@clinmed.gla.ac.uk

Stakeholders

Stakeholder groups were selected as having a potential interest in advance directives.

Users

A purposive sample was chosen of 100 mental health voluntary organisations in Scotland and England representing users and carers who were likely to have members who might receive inpatient treatment or be liable to detention.

Psychiatrists

This group comprised all general adult consultant psychiatrists (316) in Scotland (previous research database updated) and a random sample of 151 consultants in general adult psychiatry in England supplied by the Royal College of Psychiatrists.

Nurses

The Royal College of Nursing Network for Psychiatric Nursing Research was the only organisation identified able to selectively reach nurses with an interest in mental health. The organisation mailed the questionnaire to their membership in England and Scotland (200).

Social workers

A database developed for previous research of Mental Health Officers in Scotland (MHOs) engaged in mental health casework (as opposed to only doing emergency work) was used (315).

Directors of National Health Service (NHS) Trusts

Details of NHS Trusts were sought in the Institute of Healthcare Management Yearbook 2000/2001 [21], through the Internet, from DoH and frequently checked by telephone with NHS Executive Regional Offices and Health Boards (245).

Directors of social work

A commercially available database of Directors of Social Work in England (150) and Scotland (34) was purchased for 32 local authorities.

Models

The five models as used in the questionnaire are given in the appendix. The models specifically about ECT were added because this topic had dominated some earlier discussions and was so important to some people that there was concern that if it was not mentioned separately, it could preclude consideration of all other issues.

Questionnaire

The questionnaire incorporating the five models of advance directives asked respondents for comments about what was positive and negative about each. There were also a few closed general questions about the involvement of patients in decision-making. Several versions of the questionnaire were piloted with a small number of specialist registrars and social workers. The final questionnaire went to all stakeholder groups with a covering letter explaining that dementia and end of life situations were excluded from consideration in this research and giving a generic description of an advance directive as *'a document that allows someone when well to make a statement about the specific sorts of mental health care they do or do not want in the event of that person becoming incapable of making their own treatment decisions by reason of mental illness.'*

Procedure

A total of 1.520 questionnaires were sent out between April and July 2001. A reminder letter was sent 5 weeks after the initial mailing. A reply-paid envelope was provided.

Analysis

Data were entered into Microsoft Access. The qualitative free comments were analysed for themes, first in terms of the positive and negative categories for each model and stakeholder group and then globally.

Results

Response rates

There was a total of 550 (36 %) questionnaires returned, of which 473 (31 %) contained responses. Details of response by group are given in Table 1.

Involvement of patients in decision-making

Responses to the question 'Do you think we need advance directives?' are given in Table 2.

It is clear that psychiatrists were significantly less convinced of the need for advance directives than other groups (28 % versus 75 % $p < 0.001$) Just over a quarter of psychiatrists agreed with the statement although 34 % did not know. There were no significant differences between other groups excluding psychiatrists. This pattern was repeated in response to two general statements. Psychiatrists were significantly less likely to agree or strongly agree (56 %) with the statement 'generally psychiatric services need to change in order to give patients more control over their care and management' than other groups (91 %) ($p < 0.001$). Less than half the psychiatrists (48 %) disagreed or disagreed strongly with the statement 'generally psychiatric services currently

Table 1 Response rates for questionnaire (in rank order)

Group	Total mailing	Completed questionnaires
Directors Social Work Scotland	34	17–20* (50 %)
Trusts Scotland	18	8 (44 %)
Psychiatrists Scotland	316	130 (41 %)
Voluntary organisations	100	39 (39 %)
Trusts England	236	68–71* (29 %)
Psychiatric Nurses	200	56 (28 %)
Mental Health Officers	315	86 (27 %)
Psychiatrists England	151	38 (25 %)
Directors Social Services England	150	31 (21 %)
Total	**1,520**	**473 (31 %)**

* Multiple responses from three Scottish Social Work Departments and three English Trusts have not been included in the response rates, but have been included as individuals elsewhere in the quantitative and qualitative analysis

Table 2 'Do you think that we need advance directives?' (in rank order)

Group		Yes	No	Don't know
Voluntary organisations	(37)	33 (89 %)	2 (5 %)	2 (5 %)
Directors Social Work/Services	(50)	41 (82 %)	0 (0 %)	9 (18 %)
Psychiatric Nurses	(56)	44 (79 %)	5 (9 %)	7 (13 %)
Trusts	(77)	55 (71 %)	10 (13 %)	12 (16 %)
Mental Health Officers	(82)	54 (66 %)	10 (12 %)	18 (22 %)
Psychiatrists	(152)	43 (28 %)	58 (38 %)	51 (34 %)

help patients take as much responsibility for their treatment as is appropriate' compared to 72 % of other groups ($p < 0.001$). Psychiatrists' responses are also significantly lower than the next lowest group (MHOs) (48 % versus 62 % $p = 0.02$)

Overall, psychiatrists were significantly less likely to want to work with models which allowed people to opt out of treatment ($p < 0.001$) and this difference in comparison with voluntary organisations is extreme ($p < 0.001$). The difference in views about an opt-in model (IV) were not significant ($p = 0.22$) and in no groups were a majority willing to work with this model.

Psychiatrists based in Scotland (24 %) were less likely to think that advance directives were needed than psychiatrists based in England (44 %) ($p = 0.003$). There were no other significant differences within the professional groups where comparison was possible between Scotland and England.

Themes

There was a wide range of views of the different models both for each model and within each stakeholder group although the variety of the negative comments was greater than the variety of the positive comments. There were no outstanding differences between the comments made by the different professional groups or between the two countries. People identified positive elements in the various models of advance directive even if they said that they would not choose to work with the model. People said positive and negative things about the same model.

Since many themes occurred in response to all models, these have been grouped together. No themes emerged for Model V regarding ECT which did not emerge under the general opt-in and opt-out models and, therefore, Model V was not included separately in the analysis.

Positive themes

Autonomy, empowerment and reassurance. This was the positive theme most strongly present for all models. Respondents were positive about giving people choice in their treatment, making them feel involved in the treatment process and letting them take responsibility for their illness. Model I was commended as it could be written without any constraints from professionals and was seen as increasing the legal authority of the patient. The legally binding advance directives (III and IV) were seen as giving legal clarity to patient's autonomy, even to the point of refusing life-saving treatment.

Responsibility. Promoting responsibility in patients for the management of their illness was noted by a few respondents as a positive aspect of advance directives, especially the two legally binding models (III and IV). Thus, some expressed the view directly or by assumption that if people were able to take more responsibility for their treatment and care through advance directives this would, in turn, make them act in a more responsible way. It was suggested that there would be a greater responsibility put on professionals to give more information to patients.

Planning and crises prevention. Responses for all models suggested that the process of making an advance directive of itself could help to reduce emergency admissions by encouraging early treatment. It was expected that trust would be built up through discussions about possible future treatment which would help to develop people's insight into their illness and their knowledge of treatments. This would enable them to approach services sooner for treatment and possibly avoid crisis interventions. In the case of Model III, it was suggested that having more control over what would happen might possibly also encourage early approaches for help. There was some expectation that in the co-operative models the process of planning would help staff get to know patients better which would help them intervene rapidly.

Model II, being made co-operatively, was expected to be better informed with consequently less concern over issues such as judging competency, locating, updating, reviewing and interpreting the document. Also, being made co-operatively would give all involved an opportunity to consider unconventional treatments. The opt-in Model IV was seen as positive in promoting early intervention and could reassure staff that they were doing the right thing and protect them from litigation.

Destigmatising. Models I and III were seen as destigmatising as they gave the same rights to refuse treatment to psychiatric patients as to those patients who wished to refuse general medical treatment. Model IV was also seen as potentially destigmatising if, by using this model, patients could receive treatment voluntarily rather than being detained.

Good practice. Except for Model III, there were comments that suggested everything positive in these models either could be or was being achieved through current good practice. This theme was particularly strong in relation to Model IV where many expressed bewilderment about what the model could add beyond good practice with appropriate use of the existing mental health legislation. Several comments noted that Model IV is happening *de facto*.

Negative themes

There was a group of themes that were noted as negative for all four models. They can perhaps be characterised as practical issues that probably all respondents would agree would need to be dealt with regardless of their position on the desirability of advance directives. As practical issues, they were commonly asked as questions: How does one ensure that advance directives:

- are based on accurate and full information?
- take into account new developments in knowledge and treatments that occur in the time between making and implementing the advance directive?
- represent the current views of the advanced directive maker?
- represent the views of the advance directive maker without undue pressure or coercion from anyone?
- can be located at the critical time?
- were made when the individual concerned was competent/capable?
- are activated only when the individual concerned is no longer competent/capable?
- are made with a widely accepted way of judging competency/capacity?
- refer unambiguously to future circumstances which by definition cannot be accurately predicted?
- can be changed by the individual concerned in ways that do not compromise the purpose of the advance directive (e. g. can they be changed when the person is not capable/competent?)

Themes for which there are both positive and negative comments

Restricting clinical judgement. Comments in all models expressed concern about limiting professionals' ability to use their clinical judgement in the best interests of the patient and that this compromised their duty of care. This was sometimes expressed as making it difficult to give patients helpful treatments. Model III especially was seen as potentially allowing someone to die who could have been treated successfully. This was expressed as contrary to the right to treatment (which Model IV promotes) and encouraged the idea that it was only worth treating patients who wanted to be treated. Finally, there was concern that doctors might simply refuse to treat patients with opt-out (III) advance directives. Set against this, some saw limiting clinical freedom as increasing patient autonomy and, therefore, positive. Model III was described as stopping the abuse of power by psychiatrists and forcing them to re-examine their practice and listen to patients.

Speed of access to treatment. Some thought that an advance directive would make it easier and quicker to get treatment when required and also streamline such matters as childcare when the parent was ill. Others were concerned that locating and interpreting such a document, especially if it were legally binding would make the process of delivering care slower.

Childcare and finances. For Models I, II and IV, there was positive comment that such an advance directive could be useful in helping people keep control of their lives beyond treatment and hospital, especially childcare during times of crisis and uninhibited spending during episodes of mania. MHOs and others sounded a note of caution in relation to childcare, which they pointed out is regulated by the Children's Act (1989). Thus, an advance directive would not be able to make binding arrangements for childcare. Similarly, although debt incurred due to illness was seen as a significant problem, it was not clear what authority or legal protection an advance directive could give to staff to intervene in patients' financial affairs.

Relationships between service users and professionals. There were many comments that indicated a wish to create more respectful and equal relationships between service users and professionals. Some considered that this could only happen if the service user was given more legal authority in their relationship with professionals. Others thought that the process of making a co-operative advance directive would bring about the desired changes. There was concern that relationships could be damaged if expectations were created that, by making an advance directive, service users would have more control over their treatment than actually turned out to be the case.

There were most comments in Model II about the positive nature of the co-operative two-way process that would be necessary to make an advance directive with this model. Concern was expressed about adverse outcomes in Models I and III, where co-operation between service users and professionals was not necessary to the production of the advance directive. There are comments that emphasise the need for professionals to listen as well as comments that put the emphasis on patients becoming more active.

Involvement of relatives and others. Although some respondents saw the possibility of the more co-operative models of advance directive being a vehicle to negotiate issues of information-sharing with relatives, they were also seen as potentially causing conflict with families, especially if they were legally binding. Some professionals feared that a binding directive with which the family did not agree would be subject to an appeal through the courts or be the source of litigation against the practitioners.

Similarly, in relation to Model IV, the expectation for many respondents was that proxies would be family members. This was seen by some as potentially very constructive. There was concern that proxies could pursue their own interests at the expense of the patient. Additionally, some feared that the stress of being a proxy could damage relationships to the detriment of the patient, the proxy or both. The assumption was generally that proxies would act on a best-interest basis rather than use substituted judgement.

In relation to coercion, there was both a fear that families could coerce people into agreements that were not in their best interests, and also an aspiration that families could prevent inappropriate coercion from services.

Relationship to the law. The predominant feeling was that it would be negative to change the legal basis on which treatment is given or refused by introducing legally binding advance directives. There was some support for making Models III and IV legally binding and frustration was expressed that Models I and II could be overturned by professionals. The ability to refuse treatments which had not worked in the past or which the patient felt were worse than the illness and have this adhered to was valued. Some who supported the concept of increasing the legal authority of the patient expressed concern that it would still leave the patient in a position of uncertainty because of the various matters that could be appealed by mental health services and/or family.

Many people expressed concern, in relation to all models, that changes in the law in relation to advance directives would make heavy demands on clinical time. As well as potential formal procedures and doing their best to ensure that the treatment was appropriate and in accord with any advance directive, professionals would have to spend more time ensuring that they were protected from litigation if they either followed or overturned an advance directive.

Who are advance directives for? There was some concern expressed for all models that the extensive use of advance directives could create a two-tier service. It was perceived that those people who are most articulate or best supported would be able to use advance directives to enforce or encourage a more responsive service that would divert resources from the rest of the population. Concern was expressed that if Model II was meant to be applied universally, it might be forced on people for whom it was inappropriate and create unnecessary anxieties.

Models II, III and IV were seen as not being suitable for people who were experiencing mental illness for the first time. Although Model I theoretically allows people to express their wishes without having prior experience, the view was expressed that it is unlikely that many people would do this and, if they did, there would be doubts about how well informed their decisions were, given that they would be made without mental health service input.

Several responses to Model IV were of the opinion that this option may have some positive elements, but only for a small group of people who are insightful of their regularly repeating episodes of mental illness.

Resources. Resources were a common source of comment in Models II, III and IV. There was less concern in relation to Model I because these advance directives were expected to be made by the individual without service co-operation. There was, however, mention of the additional costs that might be incurred if patients who refused treatment through Models I or III had to be managed in hospital without medication. Concern was also expressed that use of Model I might contribute to creating a two-tier service.

For Model II, the concern was that the necessary work to plan for future events that may not take place would create additional paperwork and bureaucracy and detract from current clinical practice and that to a certain extent it might be a duplication of other systems and existing good practice, for example, the Care Programme Approach. In relation to Model III, there was also concern about 'paperwork', but the emphasis was on legal costs and the cost of formal competency hearings or tests. For Model IV, the additional concern in relation to resources was that early intervention might not be possible in current circumstances where it is at times difficult to find a bed for emergency admissions. There was some concern that it might encourage dependency.

Discussion

Methodology and response rate

The decision to use a questionnaire rather than interviews was taken to try to achieve a wide coverage of views rather than the more in-depth interviews which lead to the development of the models [20]. Despite the low response rate, there is a wide range of responders and the majority of responses were detailed, thoughtful and often expressed what were clearly strongly held opinions. A number of respondents commented that just reading the questionnaire had made them think of new issues.

The questionnaire itself was complex and not something that could be completed in a few minutes. This might have added to the poor response rate, but this should be balanced against greater specificity in the answers. The format of the questionnaire may have encouraged respondents to raise practical problems as negative issues without offering solutions to them. Where solutions are offered, they are often also couched in negative terms, such as adding to bureaucracy or detracting from other clinical responsibilities (e. g. in competency assessments and hearings).

The descriptions of the models were necessarily limited and, thus, may have been interpreted differently by different people. For example, some people do not appear to have understood Model III as being able to prevent treatment or detention when there was a threat to others.

Importance of advance directives

Generally, apart from the psychiatrists, the view is that patients are not involved enough in decision-making regarding their treatment. This should be interpreted with caution as the response rates are low. Psychiatrists were the group most opposed to the introduction of advance directives and it is unlikely that this is an artefact of low response rates. Those who would expect to take clinical responsibility for patients, including those who opt-out of treatment, are likely to have the most concerns about changes to that responsibility. Coupled with the lack of public or professional debate on the subject, it would indicate that discussions between stakeholders about the way patients are involved in decision-making may be needed to explore divergent perceptions and value systems.

Themes

Many of the positive themes could be seen as aspirational, as ways of developing better services or better interactions between patients and professionals and are, thus, necessarily more hypothetical than the negative comments, which were more easily related to problems of everyday practice.

Tensions between patient autonomy and right to treatment

Although not always couched in terms of 'patient autonomy' and 'right to treatment', these terms were used and it is the tension between them that lies behind many of the concerns raised. There was a real sense of people 'wanting to do the right thing': they wanted to support patient choice, but at the same time wanted to minimise risk and adverse consequences. This led to apparently contradictory statements and a sense that the consequences of many responses had not been thought through.

In a number of responses, 'doing what is best for the patient' was equated with treating patients or not denying them treatment, even, apparently, if this was against the patient's will. This was equated with the patient's right to treatment. Three positions emerged. Firstly, patient autonomy should be respected in all circumstances even if it led to death. Secondly, that autonomy should be protected in every respect except if it meant risk to the patient. The third position was that any harm from lack of treatment was unacceptable. These positions seem to be irreconcilable and add to the need for debate. The questionnaire was ambiguous in respect of harm to others being sufficient grounds for enforcing treatment and detention.

Autonomy and co-operation

Autonomy was also contrasted with co-operative forms of future planning, with anxieties, on the one hand, that involving professionals would lead to a reduction in honouring patients' wishes and, on the other hand, a belief that co-operatively made advance directives would be more likely to be appropriate and, therefore, followed. Some of this may reflect professionals' anxieties over loss of clinical freedom and seeking ways round this [22].

A co-operative approach may be a way forward in overcoming some of the conflicts with 'right to treatment' and has been explored in various guises through crisis plans [9, 23] and 'preference of care' [8]. It was the approach in the Mental Health Bill in England and Wales through 'advance agreements' [4]. Scotland opted for the more neutral 'advance statements' [12, 19].

Opt-in and opt-out

Opt-out is usually synonymous with refusal of treatment, while opt-in usually indicates a person's willingness to accept treatment. The opt-in model was seen as potentially destigmatising if it meant detention could be avoided. Some respondents were less happy about patients opting-in to treatment, having regard for the need to protect patients against its misuse. It is assumed that an opt-in patient would be treated as a voluntary patient and not, therefore, have the safeguards of any legislation. These difficulties have been addressed, but not necessarily resolved, in the American literature where opt-in is often known as a Ulysses contract [18, 24, 25]. Opting-in may have more relevance where the mental health legislation has less concern for harm to self than in Britain [26].

Since advance refusals (opt-out) in general medicine are accepted as having the same status as contemporaneous refusal in the UK [27], then, if opt-in (or advance acceptance) is not, the reasons why need explaining and this position made transparent.

Knowledge of the law

The responses differed in respect of people's current understanding of the law and also the practical issues involved in implementing current provisions of mental health legislation and day-to-day patient management. Perhaps predictably, psychiatrists and MHOs seemed most familiar with the law, although some responses from trusts also demonstrated a good knowledge of the law.

Research suggests that mental health professionals' knowledge of the law may not always be clear [28, 29]. This was reflected in not all respondents understanding that patients in the UK can currently make advance directives under common law in respect to treatment, although there are existing guidelines [27]. Those who saw Model I as destigmatising because it conveyed the same rights on psychiatric patients as medical/surgical patients may have been misled.

Proxies

Consideration of the use of proxy decision-makers was restricted to Model IV and the need to limit the length of the questionnaire restricted the detail that respondents were asked to consider. Whilst there was some interest in proxies, the assumption appeared to be that they would be expected to make 'best interest' rather than 'substituted judgement' decisions. The difficulties of giving proxies authority in circumstances where the adult is mentally ill, but not necessarily permanently incapable, are considerable and thoroughly explored in the context of the United States by Sales [30]. The Adults with Incapacity (Scotland) Act 2000 [31], which includes the use of proxy decision-makers, bases all actions on behalf of the patient on the principle that they must benefit the patient and take into consideration the wishes and feelings of the patient and their significant others bearing in mind the least restrictive alternative and the need to respect and support the patient in the exercise of their remaining capacities.

Conclusions

Across and within stakeholder groups, there was a wide variety of views. The difficulty of achieving a balance between promoting patient autonomy and minimising risk and allowing for clinical judgement was recognised by some and led to apparently contradictory statements by others. There was, however, widespread recognition of the problems to be overcome in implementing advance directives. This suggests a need for a more widespread intersector debate on the place of advance directives.

Appendix

Full description of the models of advance directives used in the questionnaire sent to stakeholders

Below are descriptions of some of the things that people have described as their preferred advance directive. Please comment in the boxes below them on your views of these models.

All models expect that the patient would be competent when the advance directive was written.

Model I Patient initiated

A person writes down their wishes regarding any future treatment and social care. Copies of the document are given to those Psychiatrists, Community Psychiatric Nurses and GPs, etc. with whom they are most likely to be in touch in the event of any future illness. The document could cover a range of medical and social issues:

- any treatments the patient wishes to refuse
- which treatments are preferred
- who should be told about the patient's treatment, who should look after children in the event of the parent's hospitalisation, what should be done regarding financial matters such as credit cards.

The document may or may not be discussed with mental health service staff. The person may write it alone, with friends, with professional health workers or with a solicitor.

It is possible that advance treatment refusals by voluntary patients if made when competent could be judged to have weight in law. Detained patients may, with safeguards and restrictions, be treated involuntarily even with treatments that have been competently refused in advance.

Requests for treatment are not legally binding. Nor can an advance directive bind anyone to act illegally. In this model nobody has a duty to help patients make this sort of document. It would be good practice for treatment teams to consider such a document when making treatment decisions for that patient.

Someone who has not experienced a mental illness could draw up this sort of advance directive.

Model II Co-operative arrangement between patient and doctor to be described and promoted by a code of practice

This is a plan drawn up between the psychiatrist or other member of the mental health team and the patient that notes the agreed preferences and any disagreements about anticipated future care. It could cover a wide range of issues:

- any medical treatments the patient wishes to refuse
- which treatments are preferred
- who should be told about the patient's treatment, who should look after children in the event of the parent's hospitalisation, what should be done regarding financial matters such as credit cards.

This process would be for patients who had already experienced a mental health problem and are likely to experience one again.

The law would remain broadly as it is now regarding ability to enforce treatments that a patient refuses as described in Model I above.

These advance directives would most likely be seen as a way of complementing rather than substituting for the normal process of clinical decision-making. There would be an expectation that any such advance directive would be taken into account. There would also be an expectation that mental health service staff would have a responsibility to prepare such a document with a wide range of their patients.

Model III Legally binding opting-out of treatment

This advance directive could cover as wide a range of issues as described in Models I and II above and may or may not be agreed with a mental health professional. Although it could not compel a doctor to give a treatment that he or she did not think clinically appropriate, it could prevent the doctor giving such a treatment even if the patient was detained under mental health legislation. Some advance directive models honour treatment refusals even if the patient was at risk of death due to untreated mental illness.

To be legally binding there would probably have to be a formal test of competency to ensure that the document was made when the person was competent and was not made under coercion. It is usual to have the same degree of formality when such a document is made, invoked, changed or revoked.

Model IV A legally binding opting-in to treatment

This would allow people with previous experience of a mental illness to opt-in to involuntary treatment sooner than they expect to receive it under the safeguards provided by the mental health legislation. They expect to refuse treatment when they need it because insight has been temporarily lost due to illness. Such a model might include the ability to nominate a proxy decision-maker who could make decisions about treatment on behalf of the patient.

As with the legally binding opting-out of treatment model there would probably need to be formal tests of competence when such a document was made, invoked, revoked or changed.

Model V Electro Convulsive Therapy *(ECT)*

This topic was raised frequently in discussions with individuals and groups in the first part of this research.

10. Would you like to see some form of legally binding advance arrangement dealing solely with ECT that enabled patients to:

a) prohibit this form of treatment on themselves even if they were detained under the mental health legislation? Yes ☐ No ☐ Don't know ☐

b) opt-in to ECT for themselves without waiting for a second opinion even if they were detained under the mental health legislation?

Yes ☐ No ☐ Don't know ☐

Acknowledgements Our thanks go to: Hilary Patrick, Honorary Fellow, Faculty of Law, Old College, University of Edinburgh and Dr. Susan Stuart, Lecturer in Philosophy, Humanities Advanced Technology and Information Institute, University of Glasgow, who were involved in the earlier stage of this research developing the models; The Nuffield Foundation for funding the research (Grant No. MNH/00015/G) and also to the many people who completed questionnaires.

References

1. Scottish Executive (2001a) Report on the Review of the Mental Health (Scotland) Act 1984. Edinburgh: Scottish Executive
2. Scottish Executive (2001b) Renewing Mental Health Law Policy Statement. Edinburgh: Scottish Executive
3. Department of Health (1999) Report of the Expert Committee, Review of the Mental Health Act. London: Department of Health
4. Department of Health and Home Office (2000) Reforming the Mental Health Act. London: Department of Health and Home Office 2000
5. Curran C, Grimshaw C (1999) Advance Directives. OpenMind 99 Sept/Oct pp 24
6. Rethink (2000) Policy Statements 25 & 26 http://www.rethink.org/news + campaigns/policies/
7. Manic Depression Fellowship (2001) Planning ahead for people with manic depression. London: Manic Depression Fellowship
8. Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Br J Psychiatry 181:513–551
9. Sutherby K, Szmukler GI, Halpern A, Alexander M, Thornicroft G, Johnson C, Wright S (1999) A study of 'crisis cards' in a community psychiatric service. Acta Psychiatr Scand 100:56–61
10. Scottish Parliament (2002) Official Report Health and Community Care Committee, Friday 4th October 2002 Edinburgh: Stationery Office
11. Scottish Parliament (2002) Official Report Health and Community Care Committee, Wednesday 30th October 2002 Edinburgh: Stationery Office
12. Scottish Parliament (2003) Mental Health Care and Treatment (Scotland) Act 2003 Edinburgh: Stationery Office
13. Department of Health (2002) Draft Mental Health Bill London: HMSO
14. Dobson R (2003) Mental health bill will be subject to pre-legislative scrutiny Br Med J 327:1304
15. Szasz TS (1982) The Psychiatric Will: a New Mechanism for Protecting Persons Against 'Psychosis' and Psychiatry. Am Psychol 37:762–770
16. Appelbaum PS (1991) Advance Directives for Psychiatric Treatment. Hosp Comm Psychiatry 42:983–984
17. Kapp MB (1994) Implications of the Patient Self-Determination Act for psychiatric practice. Hosp Comm Psychiatry 45:355–358
18. Backlar P (1997) Ethics in Community Mental Health Care: Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning for End-of-Life Care. Comm Ment Health J 33:261–268
19. Atkinson JM, Garner HC, Patrick H, Stuart S (2003) Issues in the development of advance directives in mental health care J Ment Health 12:463–474
20. Atkinson JM, Garner HC, Stuart S, Patrick H (2003) The development of potential models of advance directives in mental health care J Ment Health 12:575–584
21. Institute of Healthcare Management Yearbook 2000/2001 Stationery Office 2000
22. Atkinson JM (2004) Ulysses' crew or Circe? – the implications of advance directives in mental health for psychiatrists. Psychiatr Bull 28:3–4
23. Sutherby K, Szmukler GI (1998) Crisis cards and self-help crisis initatives. Psychiatr Bull 22:4–7
24. Winston ME, Winston SM, Appelbaum P, Rhoder N (1982) Can a Subject Consent to a 'Ulysses Contract'? Case Study Commentary. The Hastings Center Report, University of Toronto Faculty of Law Review 12:26–28
25. Dresser R (1984) Bound to Treatment: The Ulysses Contract. The Hastings Center Report, pp 13–16
26. Somerville MA (1985) Changes in mental health legislation as indicators of changing values and policies. In: Roth M, Bluglass R (eds.) Psychiatry, human rights and the law. Cambridge:Cambridge University Press, pp 156–214
27. British Medical Association (1995) Advance Statements about Medical Treatment. London: BMJ Publishing Group
28. Humphreys M (1998) Consultant psychiatrists' knowledge of mental health legislation in Scotland. Med Sci Law 38:237–241
29. Peay J, Roberts C, Eastman N (2001) Legal knowledge of mental health professionals: Report of a national survey. J Ment Health Law, pp 44–55
30. Sales GN (1993) The health care proxy for mental illness: can it work and should we want it to? Bull Am Acad Psychiatry Law 21(2):161–179
31. Scottish Parliament (2000) Adults with Incapacity (Scotland) Act 2000 Edinburgh: Stationery Office