King's College London

King's Research Portal

DOI:
10.1016/S2215-0366(23)00221-3

Document Version
Peer reviewed version

Link to publication record in King's Research Portal

Citation for published version (APA):
Stephenson, L., Owen, G., Gergel, T., Astrid, G., Scholten, M., & Jakov, G. (2023). Self-binding directives in psychiatric practice: a systematic review of reasons. *The Lancet Psychiatry*, *10*(11), 887-895. https://doi.org/10.1016/S2215-0366(23)00221-3

Citing this paper
Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights
Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

•Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
•You may not further distribute the material or use it for any profit-making activity or commercial gain
•You may freely distribute the URL identifying the publication in the Research Portal

Take down policy
If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 09. Jan. 2024

Should self-binding directives be implemented in psychiatric practice?: A systematic review of reasons

Dr Lucy Stephenson PhD[1], Dr Astrid Gieselmann MD[2,4], Dr Tania Gergel PhD[1], Dr Gareth Owen PhD[1], Dr Jakov Gather MD[2,3], Dr Matthé Scholten PhD[2],

1. Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London
   16 De Crespigny Park
   London
   SE5 8AB
   United Kingdom

2. Institute for Medical Ethics and History of Medicine
   Ruhr University Bochum
   Malakowturm
   Markstraße 258a
   44799 Bochum
   Germany

3. Department of Psychiatry, Psychotherapy and Preventive Medicine, LWL University Hospital, Ruhr University Bochum
   Alexandrinenstr. 1-3
   44791 Bochum
   Germany

4. Department of Psychiatry and Psychotherapy,
   Campus Benjamin Franklin,
   Charité Universitätsmedizin Berlin
   Berlin,
   Germany

Correspondence to:
Dr Lucy Stephenson[1]
lucy.a.stephenson@kcl.ac.uk

Summary

Self-binding directives (SBDs) are an ethically controversial type of advance decision making involving advance requests for involuntary treatment. This study systematically reviewed the academic literature on psychiatric SBDs to elucidate reasons for and against the use of SBDs in psychiatric practice. Full texts were thematically analysed within the international, interdisciplinary authorship team to produce a hierarchy of reasons. We found 50 eligible articles. Reasons for SBD use were: promoting service user autonomy, promoting well-being and reducing harm, improving relationships, justifying coercion, stakeholder support and reducing coercion. Reasons against were: diminishing autonomy, unmanageable implementation issues, issues with assessing mental capacity, challenging personal identity, legislative issues, and causing harm. A secondary finding was a clarified concept of a capacity-sensitive SBD. Future pilot implementation projects are required which operationalise the clarified definition of capacity-sensitive self-binding with safeguards around informed consent, capacity assessment, support for drafting and independent review. (145 words)

Funding
JG and MS report funding from the German Federal Ministry of Education and Research (SALUS; grant number 01GP1792). LS, TG, GO report funding from Wellcome; grant number 203376

Keywords
Psychiatric advance directive, ethics, mental health, advance decision, advance choice, Ulysses contract

1 **Panel: Research in context**

2

3 *Evidence before this study*

4 This is the first systematic review and synthesis of ethical reasons for and against mental
5 health self-binding directives (SBDs). SBDs are a type of advance decision making document
6 which includes a clause that mental health service users can use to provide advance request
7 for involuntary hospital admission and treatment in a future mental health crisis. Other
8 systematic reviews have been undertaken evaluating empirical evidence for the use of
9 general mental health advance decision making (ADM) - e.g. psychiatric advance directives,
10 joint crisis plans. The primary outcome of interest for these reviews has been the
11 quantitative impact on reducing hospital admission.

12

13 *Added value of this study*

14 This study reviews ethical reasons for and against self-binding as the most controversial
15 form of ADM and one where service users request admission. SBDs must be considered by
16 policy makers as it is clear that at least a sub-group of service users highly endorse it and it
17 has been discussed in clinical ethics literature since the early 1980s. This study provides
18 comprehensive analysis to enable policy makers and practitioners to come to more
19 informed, higher quality decisions around implementation.

20

21 *Implications of all the available evidence*

22 SBDs are considered by most authors as an important tool in supporting service user
23 autonomy. However, there are significant ethical concerns that they could in fact diminish
24 autonomy and increase coercion. These ethical concerns could be addressed by attention to
25 implementation; in particular using a capacity-sensitive model of SBDs and resourcing
26 appropriate safeguards around drafting the document and application in crisis.

27

28

29

30

31

32

Introduction

Over the last two decades, international interest in mental health advance decision-making (ADM) has expanded because of evidence that it can increase service user autonomy (1), support human rights (2), increase therapeutic alliance (3) and reduce involuntary admissions (4, 5). Increasing numbers of jurisdictions have introduced statutory support for mental health ADM (6, 7). Government in England and Wales has committed to introducing statutory ADM in the form of Advance Choice Documents and is currently considering this issue (8).

Self-binding directives (SBDs) are a type of advance decision-making document which includes a clause enabling mental health service users to give advance request for involuntary psychiatric hospital admission and treatment.

Self-binding is the most controversial form of ADM because it involves actively overriding a person's present expressed wishes around treatment refusal. Counter to common intuition and the primary outcome of randomised controlled trials on ADM documents (9-11), the purpose of SBDs is to request admission rather than to avoid it. SBDs must be considered by law and policy makers as there is emerging evidence that this form of ADM is supported by service users and clinicians (12-14). The Netherlands already offers legislative support for SBDs (15, 16) and provisions for ADM in several US states include elements of self-binding, notably the opportunity to use an advance statement to consent to mental health treatment in advance and the irrevocability of advance statements when service users lack mental capacity (17-23)

A body of mostly conceptual literature on SBDs has accumulated which explores ethical issues surrounding SBDs. However, this literature has yet to be systematically reviewed to lay the foundation for empirical research and support policy makers and practitioners.

Therefore, this study aims to:

1. Systematically review the reasons that have been given for and against the use of SBDs in the management of individuals with serious mental illness (SMI)
2. Identify implications for policy, psychiatric practice and research

Methods

Search strategy and selection criteria

We carried out a PRISMA (24) concordant systematic review of reasons according to Strech and Sofaer (25). This is a method of systematically reviewing argument-based literature with the aim of improving the quality of ethical decisions in the domains of policy, practice and research (25).

Eligibility criteria

We included a paper if:

1. The paper discussed the care of people with any form of severe mental illness, and
2. The paper reported on SBDs, and
3. The SBD discussed in the paper was targeted towards mental health crisis management, and
4. The main focus of the paper was on ethical reasons for or against the use of SBDs in psychiatric care, and
5. The paper was peer reviewed

We excluded a paper if:

1. The paper was not available in English, or
2. The paper was not from an academic source

Information sources

Experts in psychiatry (GO), law (Alex Ruck Keene) and philosophy (MS, TG) were consulted about specialist databases. The following databases were searched from inception to 22/03/2022: SCOPUS, CINAHL, Cochrane, EMBASE, Medline, PsychINFO, PubMed, Web of Science, Heinonline. Further experts in psychiatry, law, philosophy and service user research were contacted to identify additional literature. The snowball method was used to detect any other papers.

Search strategy

The search strategy used variants of the terms 'advance directive' and 'mental illness' found in key texts and excluded terms such as 'dementia' and 'end of life care'. Searches were tailored according to the capabilities of each database. Where possible, subheadings were used and combined with basic search terms to ensure all terms in the search grid were covered. Databases were searched across all available dates and all publication types. The searches were cross checked for reproducibility amongst the team. The full electronic search for Pub Med is included in supplementary material.

Study selection

Papers resulting from the electronic search were compiled into a central EndNote database and duplicates removed. Titles and abstracts were independently searched for relevance by two team members (AG and LS). Disagreements were discussed until consensus was reached. The full texts were screened using the same process and disagreements were discussed with a third team member (MS).

Data analysis

Included papers were imported into coding software (MAXQDA and NViVO) and thematic analysis (adapted from Braun and Clark 2006 and Strech et al (2012)) was used to synthesise key reasons. After reading all articles, an initial coding framework was devised (AG and MS). One member of the research team (AG) coded a sample of 10% of included papers, and the coding for this sample was cross checked by another researcher (LS) for coding consistency. All other articles were analysed by either AG, LS or MS. Coding disagreements were discussed amongst members of the research team (AG, MS, LS, TG) until consensus was reached. All reasons for or against SBDs mentioned in included full texts were coded, independently of whether these reasons were original or whether they were endorsed by the authors of the article. This was to give a sense of the relative weight of concern within the academic community about particular reasons. An inductive approach was used to refine and expand the initial coding framework and themes through an iterative process until all articles were analysed. The final themes were presented to the entire research team and refined until consensus was achieved.

Role of funding source

The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.

Results

A total of 3426 articles were identified through the systematic search. Four articles were identified through expert consultation and four via snowball search. Of the total identified papers, 50 met inclusion criteria. There were 2 papers which met inclusion criteria but were not coded in the summary table of reasons as their content focussed on specific models of SBDs (26)

The search is summarised in figure 1.

[insert figure 1 about here]

The included studies are summarised in table 1 (Appendix). Of the included papers, 11 (22%) are from an authorship team with a legal background, 6 (12%) philosophical, 14 (27%) ethical, 2 (4%) psychological, 1 (2%) anthropological, 9 (18%) psychiatric and 7 (14%) interdisciplinary. The earliest article was written in 1981. 7 articles were written in the 1980's, 11 in the 1990's, 14 in the 2000's, 12 in the 2010's and 7 in the 2020's. The majority of the included papers are conceptual or normative, with 1 case study and only 7 of 50 (14%) papers including empirical evidence for their conclusions.

A secondary finding of this review deserving early mentioning for conceptual reasons is variability in the definition of SBDs. An overview of these definitions can be found in table 1 (Appendix). Definitions included at least one but mostly more of the following elements: SBDs: (a) are a type of advance decision making document, which (b) provide advance request for treatment in a future mental health crisis, (c) instruct clinicians to override treatment refusals and arrange involuntary treatment in a future mental health crisis, and (d) cannot be revoked in the situation for which they are written. There is considerable variation in the literature on whether SBDs are understood as including only advance request for treatment, or also advance refusals of treatment; and on whether SDBs are

understood as applying only when service users lack mental capacity, or also when they have mental capacity.

The primary findings of this review were synthesised and reasons were organised into categories for and against SBDs. Six broad reason themes emerged for SBDs and six against. These are discussed below and outlined in table 2 and 3.

[insert table 2 and 3 about here]

Reasons for SBDs

Most papers (38/50, 76%) argued for SBDs because they *promote service user autonomy*. There were several strands of thought on how this occurs. These included investing in the person to empower them, improve their sense of self with a more holistic life narrative, allow them to describe the thresholds of capacity for independent decision making and enhance the role of others in their care. SBDs were thought to enhance autonomy by promoting the decisions made by the authentic (i.e. well) self and as a tool which operationalised precedent autonomy (i.e. giving priority of capacitous past over incapacitous present wishes). One author argued that the irrevocability of SBDs was important to enhance autonomy because it protected against 'weakness of will' when unwell. Several authors argued that SBDs are such a powerful tool in promoting autonomy that opposition to their use is counter to ethical principles.

The second most common reason (24/50, 48%) was that SBDs can *promote service users' well-being and reduce harms*. Personal well-being could be enhanced through the therapeutic drafting process and improved, personalised crisis care. Societal benefit could be found by reducing length and therefore costs of admission. SBDs could reduce harms, including self-defined harms, through initiation of early involuntary treatment, preventing episode escalation and containing risky behaviours.

There were 15 references to *improving relationships* through using SBDs. This included relationships between service users, health professionals and family members by increasing therapeutic alliance and improving communication during drafting and crisis.

Fourteen papers discussed the potential of SBDs in *justifying coercion* i.e. to make psychiatric involuntary treatment less ethically problematic. These arguments rested upon SBDs as a tool to avoid particular forms of paternalism. Eight papers discussed SBDs as a tool that enables 'self-paternalism', arguing that self-paternalism is ethically acceptable because paternalistic intervention is guided by the person themselves. Three papers argued that applying SBDs involves morally permissible 'soft' paternalism (i.e. overriding non-capacitous choices in the person's best interests) rather than morally impermissible 'hard' paternalism

1 (i.e. overriding capacitous choices in the person's best interests). Three papers draw on
2 arguments around precedent autonomy to conclude that SBDs justify the use of coercion.
3
4 Six papers referenced *stakeholder support* for SBDs as a reason to use them. The empirical
5 literature that surveyed stakeholders confirmed service user endorsement of SBDs.
6
7 Five papers claimed that SBDs should be used because they can *reduce coercion* on three
8 fronts. Firstly through the use of early intervention to prevent actual formal coercion,
9 secondly through reducing the intensity of perceived coercion through greater service user
10 involvement in care, thirdly through early, personalised treatment reducing the length of
11 involuntary admissions.
12
13 *Reasons against SBDs*
14 The most commonly cited concern (26/50 52%) was that although SBDs might be intended
15 as a tool to increase service user autonomy, they would ultimately *diminish autonomy*.
16 Referring to Mill's 'slavery exception' (i.e. slavery contacts are void), authors argued that
17 SBDs are void and non-enforceable because in the SBD service users would forfeit the very
18 liberty that underlies the validity of the document. Service users may also be more
19 vulnerable to experiencing unnecessary involuntary treatment when in crisis due to poor
20 judgement about applying their SBD, or they may commit to treatment based on their
21 experience of internalised stigma.
22
23 Other autonomy related concerns revolved around reliance on expired consent to apply
24 SBDs, the need to allow for treatment refusals as well as requests, reliance on
25 hypothesised rather than actual risks which may be inaccurately predicted, the increased
26 likelihood of rapid escalation in physical coercion needed to enforce an SBD and the
27 increased power SBDs offer psychiatrists to detain people earlier.
28
29 The second most prominent concern was *unmanageable implementation issues* (21/50,
30 42%). Overarching issues were the limited availability of resources to implement SBDs in a

way that minimises harms, the risk of clinical liability if there are adverse events and the lack of justification for implementation given lack of empirical evidence for effectiveness.

Other implementation concerns can be divided into three categories: issues with drafting, accessing, and applying SBDs. Concerns about drafting SBDs included challenges around raising service user awareness and the risk of undue influence and unmanageable distress during drafting. If SBDs are drafted, there is the challenge of providing infrastructure to ensure accessibility in a crisis. Concerns around applying SBDs included lessons from the Dutch experience that complex procedures and long time frames for obtaining legal authorisation for applying an SBD make them redundant in a crisis. Clinician-centric application concerns were around the difficulties of correctly predicting and planning for future mental health crises plus the issue that the document may limit the reach of their clinical judgement. User-centric concerns were that the person may be unable to communicate a legitimate change of mind during a crisis, the document would expire, trusted staff may not be available when needed during a crisis and there may be poor communication between services.

There were 18/50 papers that discussed *issues with assessing mental capacity* both at the point of drafting and applying an SBD. Critics argued the construct of mental capacity is problematic and its assessment is unreliable. Accordingly, SBDs may be made by a service user when they do not have the capacity to write an SBD and hence fail to reflect their authentic wishes. In addition, there is the concern that if mental capacity is wrongly judged at the time of SBD application, the service user may be wrongfully detained when they have mental capacity. Interestingly a survey of service users found most respondents did recognise the concept of mental capacity but held differing views of the impact of illness on thinking. The majority (411/565 89%) both endorsed SBDs and thought thinking is distorted when unwell. A minority (38/565) believed they retained capacity when unwell and most of this group (26/38) did not endorse SBDs (13).

There were also 18/50 papers discussing concerns around SBDs *challenging personal identity* as they rely on problematic conceptual assumptions around continuity of personal

identity. There were 15 references to the challenge of identifying one ‘self’ as having authority over another ‘self’. These arguments draw on the philosophical tradition of questioning the possibility of a personal identity persisting over time when there is limited psychological continuity between the past and present self. Three authors drew attention to the difficulty in determining whether past or present wishes represent the person’s most ‘authentic’ preferences.

There were 17/50 papers which raised concerns that *legislative issues* around SBDs would be too complex. This is largely supported by authors writing about the situation in the US and the Netherlands; jurisdictions which have the most experience with drafting ADM legislation including elements of self-binding. The major concern is about the complexity of the legislation that would be required to implement SBDs while retaining the right balance of personal autonomy versus coercion. In the USA, key concerns are also around the risk of liability for those involved in supporting the service user to draft and use an SBD. Three US authors raised the issue that legislation for SBDs may conflict with constitutional principles.

Three papers expressed concerns about SBDs *causing harm*. One of the oldest papers on SBDs raised a concern about the inherent stigma of having an SBD. Interestingly, one harm expressed by service users was that implementing an SBD might prevent someone from experiencing the benefits of mania. Stakeholders questioned in a focus group study raised concerns about the risk that if a document is not taken seriously in a crisis, the service user is likely to disengage in future.

Discussion

This is the first systematic review of reasons for and against SBDs. It has identified a developing international and interdisciplinary evidence base that is largely conceptual. Over the last 5 years, however, some important empirical work has been completed which includes service user and other stakeholder perspectives (1, 13, 27-29). The results indicate the most commonly cited ethical reason in favour of using SBDs is the promotion of service user autonomy, while the most common objection is the converse – that SBDs

will diminish service user autonomy. Other reasons for using SBDs, in order of prominence in the literature, are: promoting well-being/reducing harm, improving relationships, justifying coercion, stakeholder support and reducing coercion. Other concerns are: unmanageable implementation issues, issues with assessing mental capacity, challenging personal identity, legislative issues, and causing harm.

Our analysis of the data showed variation in the definition of SBDs (see Table 1 Appendix). Many definitions do not specify whether the treatment requests in the SBD override only treatment non-capacitous refusals or also capacitous refusals. The former type can be called ‘capacity-sensitive SBDs’, the latter type ‘capacity-insensitive’ SBDs (30). It is not always clear to which of these types of SBDs included papers refer, even if the overview of SBD definitions (Table 1 Appendix) provides some orientation. This should be considered when interpreting the findings because some reasons for SBDs seem to apply only to capacity-sensitive SBDs (e.g. facilitating self-defined indicators of loss of capacity and SBDs as soft-paternalistic instruments), whereas some reasons against SBDs seem to apply only to capacity-insensitive SBDs (e.g. concerns relying on the analogy with Mill’s slavery exception, including concerns about paternalism and the priority of past over present wishes). Implementing capacity-sensitive SBDs within a broader capacity framework (7, 31) can thus address, or at least mitigate, some of the fundamental concerns about SBDs.

A finding that requires explanation is that “promoting service user autonomy” is the most frequently given reason for the use of SBDs, while “diminishing service user autonomy” is the most frequently given reason against their use. These findings need not be contradictory. One possible explanation is that multiple concepts of autonomy are presupposed in the debate around SBDs. According to one prominent conception, autonomy involves acting according to one’s own highest-order desires (32), evaluative judgments (33) or long-term plans (34). According to a more everyday conception, it involves what philosophers after Berlin call “negative liberty”(35), namely, having the ability to do what one wants at a given point of time. If a person’s current treatment refusal is overridden based on her SBD, this diminishes her autonomy in the latter sense, while at the same time promoting her autonomy in the former sense (7). Accordingly, a crucial question for those considering drafting an SBD is which type of autonomy they find more important.

While most of the included articles employed exclusively conceptual methods, some papers included empirical data on stakeholders' attitudes towards SBDs (12, 13, 28, 36-39). The papers on stakeholders' attitudes tended to focus less on fundamental concerns about SBDs (e.g., those repeating to personal identity and paternalism) and more on personal benefits and practical challenges. Although the empirical data on stakeholders' attitudes to SBD is still too limited to draw solid conclusions, it does suggest that reasons against SBDs may be raised less often by stakeholders with familiarity of SMI. Papers written in the Netherlands, a jurisdiction where SBDs were legally binding at the time of publication (15, 40), tended to focus more on policy and implementation issues, in particular on validity criteria for SBDs and the process for obtaining legal authorisation of involuntary treatment based on an SBD.

The implementation of general mental health ADM documents is notoriously difficult. Surveys in several jurisdictions have identified high endorsement but low uptake (27, 41) and barriers to implementation have been identified at systemic, health professional and service user levels (42). Given the controversial nature of SBDs, it is unsurprising that implementation has been identified as a significant hurdle. Future research should involve piloting and evaluating SBDs with service users and health professionals and include capturing stakeholder attitudes. Using the findings from this systematic review, it is possible to clearly identify the challenges that researchers and policy makers seeking to implement SBDs may face. These are outlined below along with suggested ways to address some of these challenges drawn from the results of this study and wider literature on general mental health ADM.

1. Diminishing autonomy

To address concerns that SBDs may diminish autonomy, several safeguards could be employed in the design of the SBD document and process of making it. Firstly, as discussed above, a capacity-sensitive model can allay concerns about paternalism and the priority of past over present wishes. To this end capacity assessment should be undertaken at the time of drafting the SBD and when it is applied (43-46). Secondly a structured SBD template can be created which allows for treatment requests as well as refusals (38, 47, 48) and includes prompts for relevant SBD

content (e.g. conditions for involuntary treatment, preferred treatments, maximum duration of involuntary treatment and contact persons. Thirdly, to address concerns about the validity of consent, service users who want to draft an SBD must be informed of the risks and benefits of the treatment alternatives, the possibility that their wishes expressed in crises may be overridden, and the practical risks associated with SBDs.

2. Unmanageable implementation issues

Several papers included in this review highlighted the importance of involving a third party in the drafting process (43, 46, 49, 50). Empirical evidence from the wider literature on mental health ADM evidence suggests that involving a third party facilitator in the process of making documents is vital to aiding uptake and implementation (11, 51, 52). Addressing accessibility issues are less well considered in the literature. Digital formats can allow for ease of production and access. There are digital precedents to be found in physical health ADM (e.g. Coordinate My Care (53), Urgent Care Plan (54)) which have increased uptake and accessibility of ADM.

3. Issues with assessing mental capacity

The use of a clinical tool can facilitate capacity assessment in the context of ADM and yield highly reliable judgements of mental capacity (7, 55). Gergel and Owen (2015) propose, furthermore, using a personalised mental capacity assessment whereby service users document indications for capacity loss in their SBD (31). SBD templates could incorporate prompts encouraging service users to provide this kind of information.

4. Challenging personal identity

Research in progress on general mental health ADM has pointed to the importance to service users of including information about their personal identity on their documents (56). Including a biographical section in SBDs to provide a context for the interpretation of the document's content can go some way to addressing concerns about personal identity.

5. Legislative issues

The biggest learning opportunity for legislators seeking to implement SBDs is from The Netherlands. The Dutch legislation provides detailed criteria for the validity, content and application of SBDs (15, 16). A lesson learned from the Dutch

experience is that involuntary hospital admission or treatment based on an SBD should be subject to a form of independent review that does not impede intervention according to the SBD (15, 40, 57).

6. Causing harm

While in the wider literature low endorsement by clinicians has been identified as a key stumbling block for successful use of ADM documents (9, 58), the risk of disappointment on the part of the service users if their SBD is not access or followed in a crisis is significant (29, 57). . This issue points to a need for awareness raising and training amongst healthcare professionals as well as the development and evaluation of clinical implementation strategies.

Strengths and limitations

This paper is, to our knowledge, the first systematic review and synthesis of the literature on SBDs. It offers policy makers and clinicians a comprehensive analysis of reasons relevant to SBD implementation. Synthesising this body of academic literature faces limitations due to the breadth of disciplines, jurisdictions and methodologies represented. Only English language publications were reviewed with the effect that some literature from the Netherlands published in the Dutch language was excluded. A reading of the literature in Dutch by a native speaker (MS), however, revealed that the articles published in Dutch do not add substantially to the findings. The generalisability of findings is limited by the fact that the vast majority of included articles are written by authors who work in high-resource settings.

Conclusion

This systematic review of reasons for and against SBDs identified the opportunity to increase service users' autonomy as the major reason for implementing SBDs. The major concern is the removal of the right to negative liberty. The factor that may tip the balance between these two reasons is how SBDs are implemented. To test implementation, we recommend pilots of capacity-sensitive SBDs which employ the described safeguards around information, capacity assessment, support for drafting and independent review when the SBD is in use.

Word count

4000

Contributors

LS created and conducted the literature searches, extracted and analysed the data and drafted the manuscript

AG created and conducted the literature searches, extracted and analysed the data and reviewed the manuscript

TG was consulted for expert advice on literature searches and reviewed the manuscript

GO was consulted for expert advice on literature searches and reviewed the manuscript

JG was consulted for advice and reviewed the manuscript

MS was consulted for expert advice on literature searches, extracted and analysed data, contributed to manuscript drafts and reviewed the manuscript

Declaration of interest

GO is special advisor to the Royal College of Psychiatrists UK on mental health and capacity law (England and Wales)

All other authors declare no conflicts of interest

Data sharing

No new patient data was collected as part of this study

Further details of coding and analysis can be made available by making a request and contacting the first author: lucy.a.stephenson@kcl.ac.uk

Acknowledgments

JG and MS report funding from the German Federal Ministry of Education and Research (SALUS; grant number 01GP1792). LS, TG, GO report funding from Wellcome; grant number 203376

With thanks to Alex Ruck Keene KC (Hon) for advice on legal issues pertaining to self-binding in England and Wales

This paper has not been submitted to any other journal and has not been published in whole or part elsewhere previously.

References

1. Braun E, Gaillard A-S, Vollmann J, Gather J, Scholten M. Mental health service users' perspectives on psychiatric advance directives: a systematic review. Psychiatric Services. 2023 Apr 1;74(4):381-92.

2. Ward A. Enabling citizens to plan for incapacity: A review of follow-up action taken by member states of the Council of Europe to Recommendation CM/Rec (2009) 11 on

1 principles concerning continuing powers of attorney and advance directives for incapacity.
2 Council of Europe https://rm. coe. int/cdcj-2017-2e-final-rapport-vs-21-06 …; 2017.
3 3. Farrelly S, Lester H, Rose D, Birchwood M, Marshall M, Waheed W, et al. Improving
4 therapeutic relationships: joint crisis planning for individuals with psychotic disorders.
5 Qualitative Health Research. 2015;25(12):1637-47.
6 4. Molyneaux E, Turner A, Candy B, Landau S, Johnson S, Lloyd-Evans B. Crisis-planning
7 interventions for people with psychotic illness or bipolar disorder: systematic review and
8 meta-analyses. BJPsych Open. 2019;5(4).
9 5. de Jong MH, Kamperman AM, Oorschot M, Priebe S, Bramer W, van de Sande R, et
10 al. Interventions to reduce compulsory psychiatric admissions: a systematic review and
11 meta-analysis. JAMA psychiatry. 2016;73(7):657-64.
12 6. Owen G, Gergel T, Stephenson L, Hussain O, Rifkin L, Keene AR. Advance decision-
13 making in mental health–Suggestions for legal reform in England and Wales. International
14 journal of law and psychiatry. 2019;64:162-77.
15 7. Scholten M, Gieselmann A, Gather J, Vollmann J. Psychiatric advance directives
16 under the convention on the rights of persons with disabilities: why advance instructions
17 should be able to override current preferences. Frontiers in Psychiatry. 2019;10:631.
18 8. Draft Mental Health Bill, (2022).
19 9. Thornicroft G, Farrelly S, Szmukler G, Birchwood M, Waheed W, Flach C, et al. Clinical
20 outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a
21 randomised controlled trial. The Lancet. 2013;381(9878):1634-41.
22 10. Ruchlewska A, Wierdsma AI, Kamperman AM, Van Der Gaag M, Smulders R,
23 Roosenschoon B-J, et al. Effect of crisis plans on admissions and emergency visits: a
24 randomized controlled trial. PloS one. 2014;9(3):e91882.
25 11. Tinland A, Loubière S, Mougeot F, Jouet E, Pontier M, Baumstarck K, et al. Effect of
26 Psychiatric Advance Directives Facilitated by Peer Workers on Compulsory Admission
27 Among People With Mental Illness: A Randomized Clinical Trial. JAMA psychiatry.
28 12. Hindley G, Stephenson LA, Keene AR, Rifkin L, Gergel T, Owen G. "Why have I not
29 been told about this?": a survey of experiences of and attitudes to advance decision-making
30 amongst people with bipolar. Wellcome open research. 2019;4.
31 13. Gergel T, Das P, Owen G, Stephenson L, Rifkin L, Hindley G, et al. Reasons for
32 endorsing or rejecting self-binding directives in bipolar disorder: a qualitative study of
33 survey responses from UK service users. The Lancet Psychiatry. 2021;8(7):599-609.
34 14. Scholten M, Efkemann S, Faissner M, Finke M, Gather J, Gergel T, et al.
35 Implementation of self-binding directives: Recommendations based on expert consensus
36 and input by stakeholders in three European countries World Psychiatry. 2023;22(2):332-3
37 15. Scholten M, van Melle L, Widdershoven G. Self-binding directives under the new
38 Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a
39 proposal for reform. International Journal of Law and Psychiatry. 2021;76:101699.
40 16. Wet verplichte geestelijke gezondheidszorg (Wvggz), Art. 4:1-4:3.
41 17. Backlar P. The longing for order: Oregon's medical advance directive for mental
42 health treatment. Community Mental Health Journal. 1995;31(2):103-8.
43 18. Cuca R. Ulysses in Minnesota: first steps toward a self-binding psychiatric advance
44 directive statute. Cornell L Rev. 1992;78:1152.
45 19. Spellecy R. Reviving ulysses contracts. Kennedy Institute of Ethics Journal.
46 2003;13(4):373-92.

20. Mental Health Advance Directives, Washington State Legislature, Section 71.32.080 (2016).
21. Rights of Patients, Minnesota Statutes, Section 253B.03.6d (2022).
22. Powers of Attorney, Oregon Revised Statutes, Sections 127.700-127.737
23. Anderson N. Dr. Jekyll's waiver of Mr. Hyde's right to refuse medical treatment: Washington's new law authorizing mental health care advance directives needs additional protections. Wash L Rev. 2003;78:795.
24. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. Bmj. 2021;372:n71.
25. Strech D, Sofaer N. How to write a systematic review of reasons. Journal of Medical Ethics. 2012;38(2):121-6.
26. Widdershoven G, Berghmans R. Coercion and pressure in psychiatry: lessons from Ulysses. Journal of Medical Ethics. 2007;33(10):560-3.
27. Hindley G, Stephenson LA, Ruck Keene A, Rifkin L, Gergel T, Owen G. "Why have I not been told about this?": a survey of experiences of and attitudes to advance decision-making amongst people with bipolar. Wellcome Open Res. 2019;4:16.
28. Stephenson LA, Gergel T, Keene AR, Rifkin L, Owen G. The PACT advance decision-making template: preparing for Mental Health Act reforms with co-production, focus groups and consultation. International journal of law and psychiatry. 2020;71:101563.
29. Potthoff S, Finke M, Scholten M, Gieselmann A, Vollmann J, Gather J. Opportunities and risks of self-binding directives: A qualitative study involving stakeholders and researchers in Germany. Frontiers in Psychiatry. 2022;13.
30. Bielby P. Ulysses arrangements in psychiatric treatment: towards proposals for their use based on ‘sharing’legal capacity. Health Care Analysis. 2014;22:114-42.
31. Gergel T, Owen GS. Fluctuating capacity and advance decision-making in bipolar affective disorder—self-binding directives and self-determination. International Journal of Law and Psychiatry. 2015;40:92-101.
32. Frankfurt HG. Freedom of the Will and the Concept of a Person: Springer; 1988.
33. Watson G. Free agency. The journal of philosophy. 1975;72(8):205-20.
34. Bratman M. Intention, plans, and practical reason. The David Hume Series. CSLI Publications 1999.
35. Berlin I. Four essays on liberty. Oxford Paperbacks. 1969.
36. Gremmen I, Widdershoven G, Beekman A, Zuijderhoudt R, Sevenhuijsen S. Ulysses arrangements in psychiatry: a matter of good care? Journal of Medical Ethics. 2008;34(2):77-80.
37. Rosenson MK, Kasten AM. Another view of autonomy: Arranging for consent in advance. Schizophrenia Bulletin. 1991;17(1):1-7.
38. Varekamp I. Ulysses directives in The Netherlands: opinions of psychiatrists and clients. Health Policy. 2004;70(3):291-301.
39. Ambrosini DL. Psychiatric advance directives, autonomy, and choice: an interdisciplinary perspective from law, ethics, and medicine: McGill University (Canada); 2011.
40. Berghmans R, van der Zanden M. Choosing to limit choice: Self-binding directives in Dutch mental health care. International Journal of Law and Psychiatry. 2012;35(1):11-8.

41. Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R. Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. J Am Acad Psychiatry Law. 2006;34(1):43-57.
42. Shields LS, Pathare S, van der Ham AJ, Bunders J. A review of barriers to using psychiatric advance directives in clinical practice. Adm Policy Ment Health. 2014;41(6):753-66.
43. Macklin A. Bound to freedom: The Ulysses contract and the psychiatric will. U Toronto Fac L Rev. 1987;45:37.
44. Raphael AJ. Fluctuating Capacity and the Strategic Role of Self-Binding Directives in Preserving Autonomy. Journal of Medical Law and Ethics. 2020;8(1):15-31.
45. Ritchie J, Sklar R, Steiner W. Advance directives in psychiatry. Resolving issues of autonomy and competence. Int J Law Psychiatry. 1998;21(3):245-60.
46. Widdershoven G, Berghmans R. Advance directives in psychiatric care: a narrative approach. Journal of Medical Ethics. 2001;27(2):92-7.
47. Rogers JA, Centifanti JB. Beyond "self-paternalism": Response to Rosenson and Kasten. Schizophrenia Bulletin. 1991;17(1):9-14.
48. Dickenson D, Savulescu J. The time frame of preferences, dispositions, and the validity of advance directives for the mentally ill. Philosophy, Psychiatry, & Psychology. 1998;5(3):225-46.
49. Mester R, Toren P, Gonen N, Becker D, Weizman A. Anticipatory consent for psychiatric treatment: a potential solution for an ethical problem. Journal of Forensic Psychiatry. 1994;5(1):160-7.
50. Saks ER. Refusing care: Forced treatment and the use of psychiatric advance directives. Journal of forensic psychology practice. 2004;4(4):35-50.
51. Swanson JW, Swartz MS, Elbogen EB, Van Dorn RA, Ferron J, Wagner HR, et al. Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. American Journal of Psychiatry. 2006;163(11):1943-51.
52. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMj. 2004;329(7458):136.
53. Coordinate My Care Available from: https://www.coordinatemycare.co.uk/.
54. Urgent Care Plan Available from: https://ucp.onelondon.online/
55. Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, et al. Reliability of mental capacity assessments in psychiatric in-patients. The British Journal of Psychiatry. 2005;187(4):372-8.
56. Babatunde A, Ruck Keene A, Simpson A, Gilbert S, Stephenson L, Chua K-C, et al. Advance Statements for Black African and Caribbean people (AdStAC): protocol for an implementation study. BMC psychiatry. 2023;23(1):1-9.
57. van Melle AL, van der Ham AJ, Voskes Y, Widdershoven G, Scholten M. Opportunities and challenges of self-binding directives: An interview study with mental health service users and professionals in the Netherlands. BMC Medical Ethics. (in press).
58. Farrelly S, Lester H, Rose D, Birchwood M, Marshall M, Waheed W, et al. Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis. Health Expectations. 2016;19(2):448-58.
59. Atkinson JM. Ulysses' crew or Circe?–the implications of advance directives in mental health for psychiatrists. Psychiatric Bulletin. 2004;28(1):3-4.

60. Bell K. Thwarting the diseased will: Ulysses contracts, the self and addiction. Culture, Medicine, and Psychiatry. 2015;39(3):380-98.
61. Brock DW. A proposal for the use of advance directives in the treatment of incompetent mentally ill persons. Bioethics. 1993;7(2-3):247-56.
62. Clausen JA. Making the case for a model mental health advance directive statute. Yale J Health Pol'y L & Ethics. 2014;14:1.
63. Davis JK. How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. Kennedy Institute of Ethics Journal. 2008;18(1):87-106.
64. Del Villar K, Ryan CJ. Self-binding directives for mental health treatment: when advance consent is not effective consent. The Medical Journal of Australia. 2020;212(5):208-11. e1.
65. Dresser R. Bound to treatment: the Ulysses contract. Hastings Center Report. 1984:13-6.
66. Dresser RS. Ulysses and the psychiatrists: a legal and policy analysis of the voluntary commitment contract. Harv CR-CLL Rev. 1981;16:777.
67. Howell T, Diamond RJ, Wikler D. Is there a case for voluntary commitment? Contemporary issues in bioethics. 1982:163-8.
68. Lavin M. Ulysses contracts. Journal of Applied Philosophy. 1986;3(1):89-101.
69. Radoilska L. Autonomy and Ulysses arrangements. Autonomy and Mental Disorder. 2012:252-80.
70. Quante M. Precedent autonomy and personal identity. Kennedy Inst Ethics J. 1999;9(4):365-81.
71. Sarin A. On psychiatric wills and the Ulysses clause: The advance directive in psychiatry. Indian Journal of Psychiatry. 2012;54(3):206.
72. Spellecy RB. Ulysses contracts: Navigating the sirens of mental illness: The University of Utah; 2002.
73. Standing H, Lawlor R. Ulysses Contracts in psychiatric care: helping patients to protect themselves from spiralling. Journal of Medical Ethics. 2019;45(11):693-9.
74. Van Willigenburg T, Delaere PJ, editors. Protecting autonomy as authenticity using Ulysses contracts. The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine; 2005: Journal of Medicine and Philosophy Inc.
75. Bielby P. Ulysses arrangements in psychiatric treatment: towards proposals for their use based on 'sharing' legal capacity. Health Care Anal. 2014;22(2):114-42.
76. Lundahl A, Helgesson G, Juth N. Against Ulysses contracts for patients with borderline personality disorder. Medicine, Health Care and Philosophy. 2020;23(4):695-703.
77. Rosenson MK, Kasten AM. Another view of autonomy: arranging for consent in advance. Schizophr Bull. 1991;17(1):1-7.
78. Winston ME, Winston SM, Appelbaum PS, Rhoden NK. Can a Subject Consent to a 'Ulysses Contract'? Hastings Center Report. 1982;12(4):26-8.
79. Davidson H, Birmingham CL. Directives in anorexia nervosa: use of the "Ulysses Agreement". Eat Weight Disord. 2003;8(3):249-52.
80. Stephenson LA, Gergel T, Keene AR, Rifkin L, Owen G. The PACT advance decision-making template: preparing for Mental Health Act reforms with co-production, focus groups and consultation. International Journal of Law and Psychiatry. 2020;71.
81. Walker T. Ulysses contracts in medicine. Law and Philosophy. 2012;31(1):77-98.
82. Backlar P. Anticipatory planning for psychiatric treatment: Liberty or limitation for our future life plans? Journal of Forensic Psychology Practice. 2004;4(4):83-96.

83. Radden J. Planning for mental disorder: Buchanan and Brock on advance directives in psychiatry. Social Theory and Practice. 1992;18(2):165-86.
84. Sarin A, Murthy P, Chatterjee S. Psychiatric advance directives: potential challenges in India. Indian Journal of Medical Ethics. 2012;9(2).
85. Backlar P. The longing for order: Oregon's medical advance directive for mental health treatment. Community Ment Health J. 1995;31(2):103-8.
86. Ennis BJ. The psychiatric will: Odysseus at the mast. 1982.
87. Kane NB. Ulysses in the United Kingdom: Difficulties with a capacity-based justification for self-binding in bipolar disorder. Journal of Evaluation in Clinical Practice. 2017;23(5):1038-44.
88. Andreou C. Making a clean break: Addiction and Ulysses contracts. Bioethics. 2008;22(1):25-31.

Appendix

The full electronic search strategy for PubMed is presented below:

((((advance directive OR advance care planning[MeSH Terms])) OR (“advance decision”[Title/Abstract] OR “self-binding”[Title/Abstract] OR “psychiatric advance directive”[Title/Abstract] OR “advance agreement”[Title/Abstract] OR “advance statement”[Title/Abstract] OR “mill’s will”[Title/Abstract] OR “voluntary commitment contract”[Title/Abstract] OR “nexum contract”[Title/Abstract] OR “crisis plan”[Title/Abstract])) AND (mental disorder OR Bipolar and related disorders OR Mood disorder OR psychotic disorders OR depression OR mental health OR mentally ill persons[MeSH Terms])) NOT (dementia OR terminal care OR palliative care[MeSH Terms])

[Insert table 1 about here

Figure 1. Summary of PRISMA search

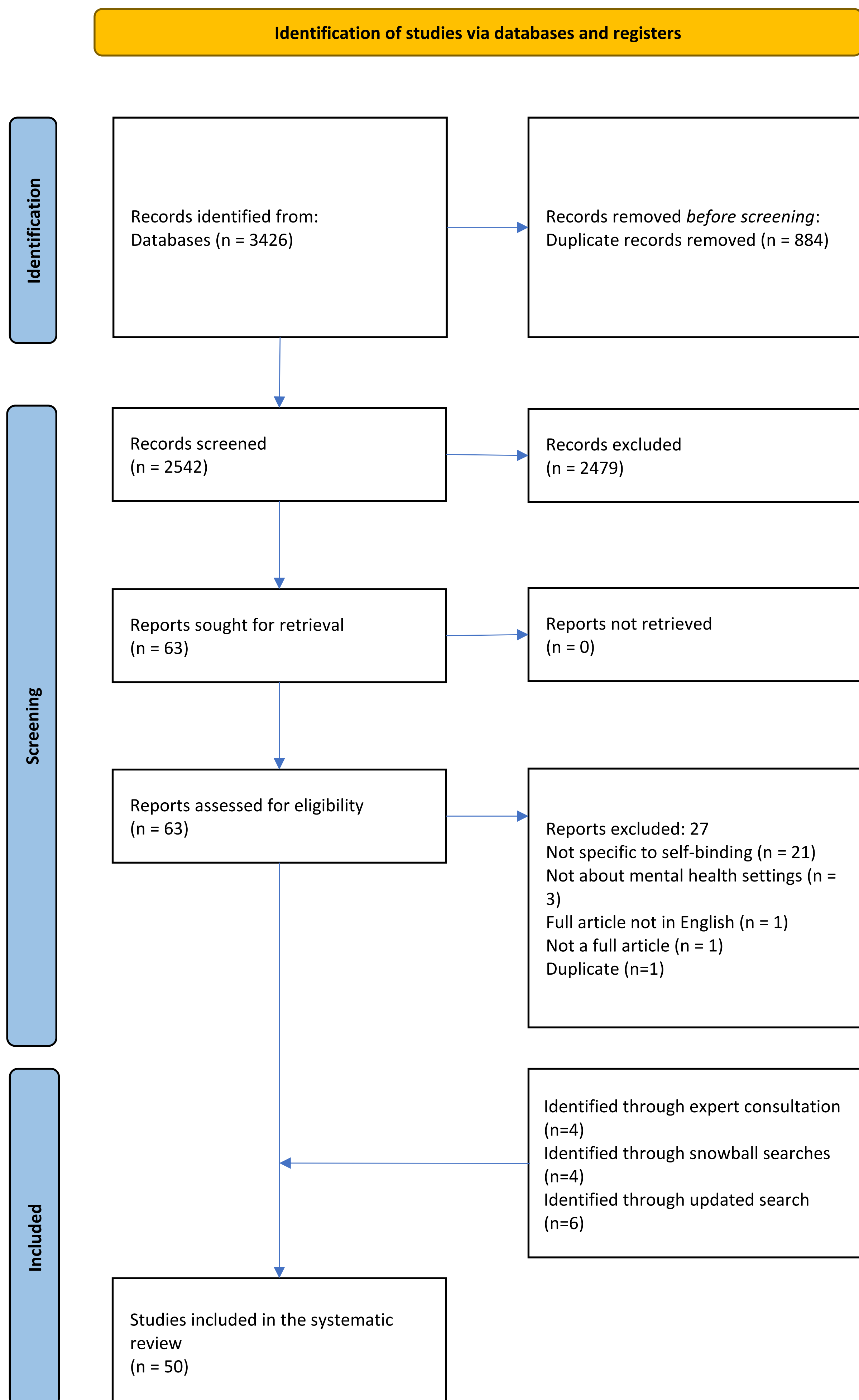

Table 1. Summary of included papers

Paper No	Authors Year Country	Academic disciplines of the authors	Methodology	Clinical context	Definition of SBD quoted	Key points addressed
1	Dresser 1981 USA	Law	Legal analysis	SMI	'The voluntary commitment contract would enable such an individual *(paper includes case study of someone with bipolar),* and person's suffering from similar disorders, to receive treatment during such foreseeable episodes. Involuntary confinement and specified forms of treatment would be authorised when the diagnostic criteria explicitly set forth in the contract were satisfied.'	Argues that SBDs do not address the problems around involuntary treatment of mental illness in that SBDs themselves are a coercive, paternalistic measure that cannot be feasibly legally enacted.
2	Ennis 1982 USA	Psycholog y	Conceptual analysis	SMI	Definition not given	Outlines several barriers to SBD use, including: difficulty of determining capacity, radical treatment refusal. But overall in support of SBDs.
3	Howell et al 1982 USA	Psychiatry	Conceptual analysis	SMI	'enable patients with recurrent psychotic illnesses to voluntarily, during periods of remission, enter into agreements with their physicians that would commit them to treatment during a relapse'	Outlines a model for an SBD including profile of a service user who it would be most useful for, key components of the document, and safeguards.

4	Winston et al 1982	Law	Conceptual analysis	SMI	'instructs others to disregard his deranged protests and to carry out what he had indicated in his competent hours to be his authentic desires'	Advocates for a specific process for creating SBDs to be created. Commentaries on the case described in the article suggests safeguards including a third party and independent review.
5	Dresser 1984 USA	Law	Legal analysis	SMI	'consenting in advance to treatment for a mental disorder and of waiving the right to refuse that treatment when it is administered'	On balance, the potential benefits of SBDs do not outweigh the costs (financial and ethical cost of 'mistaken deprivations of liberty').
6	Lavin 1986 USA	Philosoph y	Conceptual analysis	SMI	'prearrange involuntary commitments to be put into effect if the patient satisfies certain diagnostic criteria in the future'	Argues for an additional safeguard around the use of SBDs: lack of symptoms alone should not suffice to allow a service user to create an SBD. The service user should be able to offer good reasons for drafting an SBD.
7	Macklin 1987 Canada	Law	Conceptual analysis	SMI	'The Ulysses contract is a device through which an individual anticipates the impact of mental illness on his/her willingness to accept help and attempts to inoculate himself/herself against it.'	Compares SBDs with the 'psychiatric will'. Concludes that legal provision could be made for a psychiatric will but not for SBDs because they are too complex.
8	Rogers & Centifant i 1991 USA	Lived expertise/ Law	Conceptual analysis	SMI	'authorise psychiatric treatment in advance'	Advocate for 'Mill's Wills', which support requests and refusals rather than SBDs on the grounds that people with SMI should have the same right to refuse as those with physical health difficulties
9	Rosenso n & Kasten	Psychiatry	Conceptual analysis/surv ey	SMI	'a prior consent agreement'	Advocates for SBDs as a tool to promote autonomy but emphasises the importance of safeguards, monitoring and

	1991 USA		 9 service users, 12 family members, and 8 professionals			raises concerns about practical issues that make implementation challenging.
10	Radden 1992 USA	Philosoph y	Conceptual analysis	SMI	'to bind oneself ahead of time to some course of action or treatment'.	Critiques Buchanan and Brock's support for SBDs for SMI on the grounds that determining capacity is more complex for people experiencing SMI than in medical scenarios (e.g. dementia), there may be diverse reasons for people changing their mind and because of issues with Buchanan and Brock's notion of personhood
11	Brock 1993 USA	Bioethics	Conceptual analysis	SMI	'it would be possible for mentally ill persons who are currently refusing treatment to give prior consent, while competent and with their disease in remission, to treatment at a later time when they are incompetent, have become noncompliant and are refusing treatment'.	Builds on earlier models of SBDs to address criticisms to propose a new model which includes ensuring that an SBD is only applied when the person is incapacitous. Argues that prior, competent consent offers the strongest justification for involuntary treatment.
12	Cuca 1992 USA	Law	Conceptual analysis	SMI	SBDs 'allow a physician to ignore a patient's disease-induced refusal and administer medication'	Argues for SBDs as a tool to reduce emotional and financial burden of illness to individual and society and to increase service user autonomy. Outlines difficulties with the current legal support for SBDs in Minnesota.
13	Mester et al	Psychiatry	Conceptual analysis	SMI	'anticipatory consent for psychiatric treatment'	Advocates for greater use of and support for SBDs to support autonomy and build therapeutic alliance.

	1994 Israel					
14	Backlar 1995 USA	Bioethics	Conceptual analysis	SMI	'the competent person binds herself or himself to a future treatment'	Observes that the Oregon legal framework for ADM allows not only advance refusal of but also advance consent to mental health treatment. Is on balance supportive of the framework. Sees benefits if service users have mental capacity and collaborate with clinicians and relatives in the drafting process but sees disadvantages if these conditions are not fulfilled.
15	Ritchie et al 1998 Canada	Psychiatry /Law	Conceptual analysis	SMI	'allowing patients, when competent, to opt for the treatment that they might refuse when their capacity becomes impaired'	Advantages of advance decision making include increased autonomy, reduced harms, resources savings, increased therapeutic alliance. Recommends safeguards when using SBDs: capacity at the time the SBD is made must be documented and an SBD should specify whether or not a proxy decision maker could override treatment decisions in the SBD.
16	Dickenson & Savulescu 1998 Australia /UK	Ethics	Conceptual analysis	SMI	'way to facilitate the mentally ill consenting in advance to psychiatric treatment when they become incompetent'	Argues that SBDs like other forms of ADM should be respected insofar as they represent a person's dispositional preferences, past and likely future preferences. These may conflict with someone's present preferences when they are unwell. Treatment refusals as well as requests should be respected. There should not be a distinction between respecting the preferences of those who are physically vs mentally ill.
17	Quante 1999 Germany	Ethics	Conceptual analysis	SMI/neurodegenerative disease	'are of use for individuals with recurrent but treatable psychotic disorders, are puzzling because the individual is competent during the episode of disorder and will not consent to hospitalisation because the disorder causes change of personality'	Asserts that SBDs can be understood as ethically permissible tools as concerns about the reliance on precedent autonomy are caused by a mistaken understanding of personal identity, namely a conflation of persistence and biographical identity. These concerns can be addressed.

18	Widdershoven & Berghmans 2001 Netherlands	Ethics	Conceptual analysis	SMI	‘give prior authorisation to treatment at a later time when they are incompetent, have become non-compliant and are refusing care’	Advocates for the use of SBDs as a tool to reduce harm from SMI. Discusses common ethical concerns and proposes taking a narrative approach and seeing SBDs as a process in the context of a positive therapeutic relationship between service user and health professional.
19	Spellecy 2002 USA	Philosophy	Conceptual analysis	SMI	‘enable persons to commit themselves at an initial time to a course of treatment at a future time if they suspect they will not be willing or able to follow that course of treatment at that future time’	Advocates for the use of SBDs on the grounds that criticisms that SBDs are paternalistic understand SBDs in terms of a ‘desire-belief’ model of practical reasoning. The author challenges this and proposes an alternative model, ‘the planning theory of practical reason’. Drafting an SBD can be rational and applying them therefore respectful. Practical recommendations for applying of SBDs are made.
20	Spellecy 2003 USA					
21	Anderson 2003 USA	Law	Conceptual analysis	SMI with fluctuating capacity	‘mental health care advance directives that could be irrevocable’	Amendment is required to the law that supports SBDs to ensure there are sufficient safeguards. These should include a ‘rights advocate’ and a written warning in the document template.
22	Davidson and Birmingham 2003 Canada	Psychiatry	Case report	Anorexia nervosa	‘developing an agreement for the management of episodes of relapse with both the health-care provider and the patient’	Supports the use of SBDs in the treatment of Anorexia nervosa to increase control over management and support for the patient’s family/friends.
23	Atkinson 2004 Scotland	Psychology	Conceptual analysis	SMI	‘a form of opt-in to services’	Psychiatrists are often understood as members of Ulysses crew in the literature on SBDs. However, there is reason to understand the role of the psychiatrist as Circe – giving directions to Ulysses.

24	Backlar 2004 USA	Bioethics	Conceptual analysis	SMI	'mechanism by which individuals may make choices in the present about treatment they would want or not want should they, in the future, lose their capacity for decision-making'	SBDs may become coercive instruments because past wishes may not cohere with present wishes.
25	Saks 2004 USA	Lived expertise/ Law	Conceptual analysis	SMI	'patients should self-bind (i.e. give an advance directive) to care under similar circumstances as in the case of the first break – or self-bind to no treatment undertaken for the patient's own benefit'	Argues for use of SBDs to prevent harms from illness and promote autonomy. The risks of unjustified detentions are outweighed by these advantages and can be managed using safeguards; this is ultimately a decision for the person drafting the SBD. Argues that the well self should be respected over the unwell self and that self-paternalism is justified.
26	Varekam p 2004 Netherla nds	Psychiatry	Qualitative study Semi structured interviews with 18 service users, 17 psychiatrists, and 15 relatives	SMI	'a client with recurrent psychiatric episodes which are not (yet) deemed dangerous gives permission in advance for admission and treatment, thereby forfeiting the right to refuse them'	Results suggest the most important motivations for drafting SBDs is to prevent harms by facilitating early hospital admission and reducing the severity of episodes. Important concerns were potential for coercion in the process of drafting the document, premature admission to hospital and practical issues in creating and applying documents including resource constraints.
27	Van Willigen burg & Delaere	Philosoph y	Conceptual analysis	SMI	'By means of what might be termed an 'extended hand construction' the psychiatrist is authorised, in strictly defined	Support SBDs as a tool to support autonomy as authenticity rather than autonomy as sovereignty.

	2005 Netherlands				future situations, to do all that is necessary to help the patient, even when in future situations the patient emphatically rejects any help’	
28	Widdershoven & Berghmans 2007 Netherlands	Ethics/psychology	Conceptual analysis	SMI	‘people cannot revoke their request (like Ulysses)’	Discusses issues in the context of using coercion in the course of caring for a service user with SMI. These include managing service user and clinician emotions, elucidating desired outcomes and communication.
29	Andreou 2008 USA	Philosophy	Conceptual analysis	Addiction	‘they mandate that the ‘benefits’ due be forced onto the one to whom they are due, even if the ‘beneficiary’ clearly expresses wishes that the ‘benefits’ not be provided’	Reviews various models of how addiction may disturb behaviour. Argues that the use of SBDs can be justified to address addictive behaviour if this behaviour can be understood in terms of particular problematic preference structures.
30	Davis 2008 USA	Ethics	Conceptual analysis	SMI	‘precommit themselves to treatment’	The use of SBDs is justified because when they are enacted, health professionals are respecting service users’ autonomy diachronically and prospectively, rather than synchronically and retrospectively. As such, SBDs do allow a person’s autonomy to be respected even when overriding a capacitous treatment refusal.
31	Gremmen et al 2008 The Netherlands	Ethics	Conceptual analysis/interview study Semi structured interviews	SMI	‘an arrangement between a patient suffering from a chronic relapsing serious psychiatric illness and professional care providers, at a time when the patient is competent, about the use of involuntary admission	Argues for the use of the concept of an ‘ethic of care’ in debates about SBDs as an addition to language around autonomy and the right to non-intervention. Stipulates the importance of SBDs being made within the context of trusting relationships and continuity of care.

			with 18 service users, 12 family members/friends, 17 health professionals, and 19 legal professionals		and/or treatment during a future episode of relapse when the patient will not be competent'	
32	Ambrosini 2011 Canada	Law	Conceptual analysis and mixed methods study	SMI	'Ulysses type contracts are intended specifically to allow individuals to make their wishes irrevocable'	SBDs could be permissible under certain conditions. Legislative reform is necessary to support the involvement of service users in ADM.
33	Berghmans et al 2012 Netherlands	Ethics	Conceptual analysis	SMI	'the patient can indicate when and how mental health professionals may intervene against his or her will'	SBDs can be a helpful intervention to prevent harm to the person or others. However, too many detailed legal rules about their use in the Netherlands 'are a threat to increasing patient empowerment'.
34	Radoilska 2012	Philosophy	Conceptual analysis	SMI	'pre-commitment'	Addresses objections to the use of SBDs for SMI which rest on the potential for SBDs to undermine autonomy. Argues that there is no difference in kind between the types of pre-commitments made in every day circumstances compared to those made to manage episodes of mental disorder.
35	Sarin 2012 India	Psychiatry	Conceptual analysis	SMI	'the person may mandate treatment for anticipated incapacity'	Advocates for the use of SBDs and other forms of ADM on conceptual grounds but raises concerns about issues around assessing capacity, self-paternalism, lack of empirical evidence and ensuring service users' participation in the process of drafting an SBD.

36	Sarin et al 2012 India	Psychiatry	Conceptual analysis	SMI	'advance consent to treatment and waiving the right to refusal'	SBDs offer a solution to the conflict between well and unwell self-experience in SMI. Concludes that ADM (including SBDs) may have a role as a clinical tool to increase autonomy and improve therapeutic alliance but has significant limitations as a legal tool.
37	Walker 2012 UK	Ethics	Conceptual analysis	SMI	'at the time treatment is needed the patient will frequently be competent to refuse it. As such they would appear to authorise another at Time 2 to disregard the patient's present wishes and forcibly medicate him'	Advocates for the use of a modified SBD which would include the use of a 'safe word' to ensure that the service user could revoke the SBD if they change their mind.
38	Bielby 2014	Law	Conceptual analysis	SMI	'an agreement where a patient may arrange for psychiatric treatment or non-treatment to occur at a later stage when she expects to change her mind'	Advocates for the use of 'Ulysses Arrangements'. Distinguishes between 'capacity sensitive' and 'capacity insensitive' SBDs. Outlines legal models which would provide support mechanisms for service users in creating a capacity insensitive SBD.
39	Clausen 2014 USA	Law	Conceptual analysis	SMI	'a special type of mental health advance directive that authorises a doctor to administer treatment during a future episode even if the episode causes the individual to refuse care'	Argues for SBDs on the grounds that mental illness can having devastating effects if treatment is not enforced at an early stage in an episode. Makes a case for increased legal support for SBDs and improved safeguards against their abuse.
40	Bell 2015 USA	Anthropology	Conceptual analysis	Addiction	'Ulysses contracts instruct others to force one to do or refrain from doing something regardless of one's anticipated resistance'	The use of SBDs in addiction illuminates models of this psychopathology – they rely on the concept of there being an 'authentic' self which requires protection from a 'usurping alien force'. Self-binding involves an 'abdication' of the will which 'becomes the key to exerting it'.

41	Gergel & Owen 2015 UK	Psychiatry /Philosophy	Conceptual analysis	SMI	'Commit themselves to treatment during future episodes of mania, even if unwilling'	Argues for the use of SBDs as a tool to prevent personal harms and promote service user autonomy. Argues that patient-centred evaluation of capacity, drafting SBD within the context of a therapeutic relationship could address some ethical concerns. Refusal to support SBDs could be understood as undermining service user autonomy.
42	Kane 2017 UK	Psychiatry	Conceptual analysis	Bipolar	'a person with previous experience of mania enters into an agreement to be forcibly detained and treated if she relapses into mania even if her manic self refuses detention and treatment at time of enforcement'	Critique of Gergel & Owen 2015; argues that enacting an SBD should be justified according to personalised ideas about 'risk to self' rather than a personalised capacity assessment.
43	Hindley et al 2019 UK	Psychiatry	Survey 932 people with bipolar	Bipolar	'the individual wants the contents of their plan to be respected even if they no longer agree to it when they are unwell'	69% participants expressed an interest in SBDs; this interest was associated with experience of involuntary treatment.
44	Standing & Lawlor 2019 UK	Ethics	Conceptual analysis	SMI	'commit to a specified medical treatment at a future time under specific conditions where the patient anticipates that they may be unwilling to consent at the specified future time'	Advocates for the use of SBDs to increase service user autonomy and counters common objections around capacity, authenticity, paternalism. Concludes there is an ethical imperative to respect SBDs.
45	Del Villar & Ryan 2020 Australia	Law	Legal analysis	SMI	'a type of advance health directive used by people with mental illness to bind themselves to future treatment	Australian law needs to be reformed to strengthen the legal enforceability of SBDs for treatment. This will facilitate the use of SBDs by service users in Australia and allow SBDs to reach potential to increase autonomy.

					that is likely to be resisted at the time when it is needed’	
46	Lundahl et al 2020 Sweden	Ethics	Conceptual analysis	Borderline personality disorder	‘pre-emptive agreements to treatment and detention, and are to be implemented under certain conditions specified in the contracts’	Argues that SBDs should not be used for service users diagnosed with borderline personality disorder because detention is unlikely to be beneficial in this group and uncertainty about decision making capacity is likely to be high.
47	Raphael 2020	Law	Conceptual analysis	SMI Dementia	‘a contract by which the person commits to a future course of action by giving prior authorisation to treatment intervention and consent to override a potential refusal at a later time when they become incompetent’	Raises concern about binary definitions of capacity, which mean that those who experience fluctuating capacity have a diminished ability to exercise autonomy. Proposes a model of SBDs which addresses these issues. Also proposes expansion of the application of SBDs beyond SMI to other episodic disorders.
48	Stephenson et al 2020 UK	Psychiatry /Philosophy/Law	Focus group study and consultation process 10 service users 3 family members/friends, 19 clinicians, 3 legal experts,	Bipolar	‘an advance request for coercive treatment in acknowledgement that at the time when the treatment is required i.e. during an episode of illness, they are likely to refuse it’	Reports on key themes from 7 stakeholder focus groups and a consultation process with service user and health professional organisations as well as co-production of an ADM template which supports self-binding. Concludes that stakeholders from all groups support ADM and SBDs but significant practical barriers remain. Potential enabling factors including the ADM template were presented and discussed.

			5 service user led organisations , and 5 clinical teams			
49	Gergel, Das et al 2021	Psychiatry /Philosoph y	Empirical survey and qualitative analysis 932 individuals with bipolar	SMI	'instruct clinicians to overrule treatment refusal during future severe episodes of illness'	Results suggest that of the 565 who responded to a question about SBDs 82% endorsed SBDs. 89% of these people cited 'distorted thinking' when unwell as the key justification.
50	Scholten et al 2021 Germany /Netherl ands	Ethics	Legal analysis	SMI	'special type of psychiatric advance directive by means of which mental health service users can give advance consent to compulsory hospital admission or treatment during a future mental health crisis'	Discusses change in recent legal provision for SBDs in Dutch law. Argues that it is difficult for SBDs to achieve their potential under the new legal framework because arranging admission as requested in an SBD is too complex and takes too much time. The authors suggest a more feasible model of authorising treatment based on an SBD.

Table 2. Reasons for the use of SBDs

Narrow reasons	Number of papers which include reason	Reference details
Broad reason 1: Promoting service user autonomy (38/50 76% of papers) ***SBDs increase the actual and/or perceived autonomy of service users***		
SBDs advance the autonomy of individuals	26	(39) (59) (60) (40) (61) (62) (18) (63) (64) (65) (66) (13) (36) (27) (67) (68) (43) (69, 70) (44) (71) (15) (72) (73) (74) (38)
SBDs promote decision making by the authentic self	18	(39) (60) (40) (75) (68) (76) (43) (70) (69) (44) (77) (50) (48) (74) (46) (78) (47) (73)
SBDs are empowering for service users	11	(39) (60) (79) (13) (31) (67) (77) (72) (74) (38) (46)
Not allowing people to use SBDs is paternalistic	7	(60) (75) (67) (43) (44) (50) (48)
SBDs support precedent autonomy	5	(39) (40) (31) (27) (44)
SBDs facilitate self-defined indicators for loss of capacity	3	(46), (31) (80)
SBDs can support continuity in personal identity by creating a narrative	2	(46) (40)
SBDs protect against weakness of will	2	(19) (72)
SBDs facilitate relational autonomy	2	(38) (46)
Broad reason 2: Promoting well-being and reducing harm (24/50 48% of papers) ***Drafting and applying SBDs can reduce harm from illness and unhelpful treatments***		

Involuntary treatment based on an SBD helps to avoid harms to service users	20	(40) (75) (18) (65) (66) (31) (13) (36) (67) (68) (43) (44) (77) (50) (19) (72) (73) (80) (38) (46)
SBDs enable early intervention in mental health crises	12	(62) (18) (64) (66) (31) (67) (69) (44) (15) (73, 80) (38)
Drafting an SBD can have a positive therapeutic effect	5	(65) (44) (15) (80) (46)
Rapid treatment based on an SBD can reduce episode severity	4	(31) (36) (77) (38)
SBD instructions can improve the quality of care	3	(13) (80) (44)
SBDs can reduce cost of illness to society	1	(18)
Broad reason 3: Improving relationships (15/50 (30%) of papers) ***Drafting and applying SBDs could improve the quality of relationship between service users and health professionals as well as other informal supporters (e.g. family members/friends)***		
SBDs improve therapeutic alliance between service users and professionals	12	(39) (79) (31) (36) (27) (43) (49) (77) (15) (80) (38) (26)
SBDs improve relationships between service users and family members/friends	5	(79) (36) (77) (15) (80)
SBDs improve communication between service users and professionals	3	(71) (48) (46)
Broad reason 4: Justifying coercion (14/50 28% of papers) ***SBDs can render involuntary treatment ethically justifiable in virtue of prior consent***		
Involuntary treatment based on an SBD is a form of self-paternalism	8	(76) (43) (77) (50) (71) (19) (73) (74)
Using SBDs can make involuntary treatment more ethically acceptable	4	(36) (74) (38) (81)
Involuntary treatment based on an SBD is a form of soft/weak paternalism	3	(72) (19) (73)
Involuntary treatment based on an SBD is justified because of the person's prior competent request	3	(73) (61) (36)
Involuntary treatment based on an SBD is justified because of 'distorted thinking' when unwell	1	(13)
Broad reason 5: Stakeholder support (6/50 12% of papers) ***People likely to be most involved in/impacted by drafting and applying SBDs are keen to do so***		
Service users support SBDs	3	(27) (13) (80)
SBDs utilise service user expertise	3	(68) (50) (80)
Psychiatrists support SBDs	1	(43)
Broad reason 6: Reducing coercion (5/50 10% of papers)		

The use of SBDs can reduce the overall amount of coercion and/or perceived coercion		
SBDs can reduce formal coercion	3	(62) (31) (36)
SBDs can reduce perceived coercion	2	(82) (31)
SBDs can reduce the duration of involuntary treatment	1	(15)

Table 3. Reasons against the use of SBDs

Narrow reasons	**Number of papers which include reason**	**Reference details**
Broad reason 1: Diminishing autonomy (26/50 52% of papers) *SBDs may be designed to enhance service user autonomy but may actually undermine it and increase coercion*		
SBDs are paternalistic instruments	17	(75) (39) (23), (40) (62) (66) (65) (67) (68) (43) (49) (15), (83) (69) (19) (72) (38)
SBDs might be used to exert undue influence on service users to accept treatment/admission	13	(82) (75) (13) (31) (67) (68) (76) (43) (50) (71) (15), (38) (81)
SBDs do not provide valid consent	3	(62) (15) (81)
SBDs should include the option of treatment refusals besides treatment requests	3	(47) (48) (38)
Predictions about the escalation of risk during a mental health crisis cannot be made accurately, which may result in people being admitted unnecessarily	2	(66) (65)
Physically enforcing SBDs implies an escalation of coercive measures because the power of the state must be evoked	2	(66) (65)
SBDs give psychiatrists increased power to instigate involuntary treatment	1	(43)
Broad reason 2: Unmanageable implementation issues (21/50 42% of papers) *SBDs are conceptually attractive but too complex to implement successfully*		
Resources to support drafting, accessing and applying SBDs are limited	6	(68) (43) (49) (84) (80) (38)
SBDs need safeguards to prevent mistakes and abuse	5	(40) (61, 62) (50, 66)

Risk of professional liability if serious adverse events occur as a result of following or not following the SBD	2	(76) (80)
Lack of empirical evidence for the effectiveness of SBDs	2	(71) (84)
Issues with drafting SBDs ***Service users may face ethical and practical challenges while drafting an SBD***		
Others may exert undue influence on service users during the drafting process	10	(40) (65) (66) (13) (31) (43) (71) (15), (80) (38)
Drafting SBD takes time and effort and may be distressing	7	(13) (36) (50) (71) (15), (80) (38)
Low awareness of SBDs amongst service users, family/friends and professionals	2	(77) (50)
Issues with accessing SBDs ***Once an SBD is made, it is uncertain how it can be accessed in a crisis***		
Difficulty faced by clinicians in accessing SBDs during a crisis	4	(13) (50) (84) (80)
Issues with applying SBDs ***Applying an SBD in a crisis would be unfeasible***		
Overly complex legal regulations make SBDs unfeasible	4	(40) (49) (15, 77)
There is a risk of failure to foresee all contingencies of a future mental health crisis	4	(13) (49) (84) (81)
SBDs may limit clinical judgement	4	(59) (13) (66) (80)
Service users with an SBD would be unable to communicate a change of mind	1	(81)
SBD may become out of date	1	(13)
Familiar staff may not be available during a mental health crisis	1	(38)
Poor communication between services	1	(38)
Broad reason 3: Issues with assessing mental capacity (18/50 36%) ***Assessing mental capacity when drafting or applying an SBD is challenging***		
It is difficult to assess mental capacity to make decisions about treatment when drafting an SBD and/or deciding to apply an SBD in crisis	18	(82) (85) (40) (18) (65) (13) (31) (67) (68) (83) (77) (71) (84) (48) (38) (78) (86) (87)
It is possible to retain mental capacity even during mental health crises	1	(13)
Broad reason 4: Challenging personal identity (18/50 36% of papers) ***Identifying the person’s most ‘authentic’ preferences is complex and using these preferences to override treatment refusals during a mental health crisis is hard to justify***		
Problematic to assume priority to wishes of past over present self	15	(39) (88) (82) (85) (40) (62) (65) (76) (70) (49, 83) (71) (48) (72) (81)

Unclear what constitutes the individual's authentic self	3	(60) (70) (81)
Broad reason 5: Legislative issues (17/50 34% of papers) ***Making legal provisions for SBDs is too complex and the provisions may conflict with other laws or legal principles within the jurisdiction***		
Legislating for SBDs is complex	14	(39) (60) (40) (64) (13, 76) (43) (49) (45) (71) (84) (72) (19) (81)
Legislation for SBDs may conflict with other laws or legal principles	3	(61) (18) (65)
Broad reason 6: Causing harm (3/50 6% of papers) ***Applying SBDs may cause harm to the service user***		
Involuntary admission and treatment based on an SBD removes the benefits of mania	1	(13)
Disappointment if SBDs not accessed or followed in crisis	1	(80)
Stigma of having an SBD	1	(67)