Statutory Review of the Mental Health Act 2014: Literature Review of Advance Health Directives

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1. Project plan

This literature review will commence by outlining the general function of advance health directives[1] within the broader context of advance care planning.

It will then identify the key themes of the review as extrapolated from the literature. This is aimed at providing important context and background.

The next part will explore those key themes in more detail. This will include ethical discourse, human rights instruments and points of distinction associated with psychiatric advance health directives.

The following section will detail the Western Australian regulatory framework relevant to advance health directives in the mental health context. This will reference statutory instruments and broader policy guidance.

The penultimate section will be dedicated to a review of the position in other jurisdictions – both within Australia and globally, referencing back to the key themes identified at the outset.

The conclusion will provide a summary and some suggested recommendations.

2. Decision-making principles in Health Care

Advance health directives are part of advance care planning more generally. Within Australia there are different forms and terminology associated with this. It has been said that advance decision-making is a 'codification' of what Ronald Dworkin[2] termed 'precedent autonomy'. Personal autonomy is expressed in law and policy as the principle of self-determination[3] and is exercised through the laws on consent.[4] It extends autonomous decision-making to a time when the person lacks decisional capacity. Given the connection between advance care planning and the laws in connection with consent it is appropriate to begin with a short summary of the basic principles underlying the legality of health care treatment.

2.1 Valid consent to and refusal of treatment

Given that the validity of an advance health directive rests in the law relating to the consent to treatment it is important to set out key points in relation to the law around consent. A valid consent provides justification for the bodily interference which would otherwise constitute the basis for a civil law claim in trespass to the person, or a criminal law action in assault. Persons 18 years and over are presumed to have decisional capacity to consent to health care treatment. This is a well-established principle in the common law[5] and has been recognised in Western Australia.[6] This presumption may

[1] Note that the term Advance Health Directive is used throughout to refer to the execution of a document referencing specific wishes regarding advance health treatment. While the term Advance Care Directives is more commonly used in Australia, the Western Australian legislation refers to Advance Health Directives, and the subject of the review bears this title.
[2] R Dworkin, Life's Dominion (Harper Collins, 1990), p226
[3] *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 at 129-30
[4] *Re MB* [1997] 2 FLR 426
[5] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290
[6] *Brightwater Care Group v Rossiter* (2009) WASC 229.

be rebutted where there is evidence of a lack of capacity. Legal definitions of capacity vary, but the emphasis is on cognition:

> '…capacity is usually considered to be comprised of the abilities (or combination thereof) to: understand the specific situation, relevant facts or basic information in relation to the decision and choices that may be made; evaluate reasonable implications or consequences regarding the decision and choices that may be made; evaluate reasonable implications or consequences regarding the decision and choices that may be made; use reasonable processes to weight the risks and benefits; and communicate relatively consistent or stable decisions and/or choices.'[7]

In the main Western Australian authority on the refusal of healthcare treatment, *Brightwater Care Group v Rossiter,* Martin CJ adopted English common law authority on the legal test for capacity finding that there was clear evidence that Mr Rossiter had 'the capacity to comprehend and retain information given to him in relation to his treatment,… the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.'[8] Capacity is considered to be decision and context specific[9], and therefore a person's capacity to decide may vary according to the task in question. For the purposes of health care treatment, therefore, decisional capacity may depend upon the complexity of the proposed treatment. It is important to emphasise that a person's mental illness or disability does not affect the presumption of capacity. In *PBU v NJE v MHT* [2018] VSC 564, a case involving the issue of the capacity of two persons being involuntarily treated under Victoria's mental health legislation, this point was reiterated:

> 'In particular, a person does not lose the benefit of the presumption of capacity upon the basis of their status as a person with a mental disability, under the Mental Health Act, or otherwise. It applies equally to the person despite that status. Under human rights law, without compelling justification, it would be contrary to the principle of equality before the law for it to be otherwise.'[10]

A valid consent or refusal to health care treatment requires that a person have decisional capacity, and have exercised that decision voluntarily. Where treatment has been physically forced on a patient this is clearly involuntary; it is more difficult to assess voluntariness where the decision appears to have been made freely, but there are grounds to suspect that this has been influenced by other factors. Persuasion may render a decision involuntary, particularly where the source of the persuasion is a close relative with particular beliefs.[11] The health care setting itself raises particular concerns around voluntariness, especially considering the power differential which often exists between practitioner and patient:

> 'The tone of voice and other aspects of the practitioner's manner of presentation can indicate whether a risk of a particular kind with a particular incidence should be considered serious…Health practitioners who are aware of the effects of such minor variations can choose their

[7] S Allan and M Blake, 'Australian Health Law', (Lexis Nexis, 2018) at p191
[8] *Brightwater Care Group v Rossiter* (2009) WASC 229 at para [13].
[9] *Gibbons v Wright* (1954) 91 CLR 423.
[10] *PBU v NJE v MHT* [2018] VSC 564 at para [145]
[11] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 (influence exerted by patient's mother who was a devout Jehovah's witness)

> language with care; if during discussions, they can adjust their presentation of information accordingly…Because many patients are often fearful and unequal to their physicians in stature, knowledge and power, they may be particularly susceptible to manipulations of this type.'[12]

Importantly for the purposes of this review, it has been argued that persons living with mental illness are susceptible to these influences.[13]

A further requirement of a valid consent or refusal is that the treatment administered is within the scope of that consent or refusal. A consent to one procedure is therefore not consent to a fundamentally different procedure.[14] Clearly the information which a person is given about the treatment will affect the validity of the consent or refusal – a person must understand the 'broad nature' of what is proposed.[15] If the person being treated is unaware of the essential character of the act then this will nullify the validity of any consent, notwithstanding that the person has decisional capacity and has given consent voluntarily. For example in *Dean v Phung*[16]*, a* dental patient sought treatment for small chips on four teeth but over a year the dentist performed root canal therapy and fitted crowns on all teeth. It was held by the court that the patient consented to therapeutic treatment but this did not include treatment beyond this which was done for the purpose of financial gain.

Treatment administered in a situation where consent is required, and where that consent is invalidated, may result in a claim in the tort of trespass to the person in civil law. In *Dean v Phung,* for example, the patient's claim in trespass succeeded.

It is important to clarify a number of points in relation to consent to treatment.

Firstly, where a person is claiming that the health practitioner did not inform them of risks associated with treatment, and that risk has materialised, this does not result in a claim in trespass, but rather in the tort of negligence.[17]

Secondly, where a person refuses treatment in a situation which requires consent, and that treatment is nonetheless given, a claim for trespass to the person will not arise if the refusal is not a valid one. For example, in *Re MB*[18] a woman in labour refused a caesarean section on the basis of her fear of the needle required to administer the anaesthetic. The clinicians carried out the caesarean section on the basis that this was necessary to save her life and the life of her unborn child. When she subsequently brought an action in battery (a form of trespass to the person), the court found that her refusal was invalid as her needle phobia resulted in her lacking the capacity to refuse the treatment. As such the treatment was lawful as it was necessary in her best interests. Best interests is the traditional legal test associated with the treatment of persons who do not have decisional capacity to make a particular treatment decision, and is discussed further below.

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[12] President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioural Research: *Making Health care Decisions* (US) (1983) at 67.
[13] P S Appelbaum, *'Missing the Boat: Competence and Consent in Psychiatric Research*' (1998) 155 Am J Psychiatry 1486-8
[14] *Murray v McMurchy* [1949] 2 DLR 442 where the person consented to a caesarean section, but was also sterilised during the procedure.
[15] *Chatterton v Gerson* [1981] 1 All ER 257
[16] [2012] NSWCA 223
[17] *Rogers v Whittaker* (1992) 175 CLR 479
[18] [1997] 2 FLR 426

Thirdly, where a person's refusal of treatment is valid, then this must be respected, even if the consequence of that is the person's death.[19]

2.2 Advance Care Planning

Advance care planning should be distinguished from what is commonly referred to as substituted decision making – where a person makes a decision on behalf of another person.[20] Advance care planning involves a person, while they have decisional capacity, executing documentation or otherwise indicating their preferences for health care and often broader lifestyle wishes, in the event that they experience decisional incapacity. In this respect it privileges the autonomous wishes of a person; while the person has decisional capacity he, she or they may express either specific wishes in relation to a particular treatment or treatments, or more general preferences about broader lifestyle and health care. The range of advance planning therefore may involve much more than medical treatment decisions, including preferences as to where treatment occurs and who gives the treatment.

The rationale in personal autonomy is important both ethically and legally as it is aligned with the narrative of human rights as a way of promoting personal choices and preferences. The promotion of the rights, will and preferences of a person who lacks decisional capacity applying the traditional common law tests described above, was a central theme of the Australian Law Reform Commission Report, Equality, Capacity and Disability in Commonwealth Laws[21], which examined the landscape of Australian laws in response to the United Nations Convention on the Rights of Persons with Disabilities.

In Western Australia advance care planning may or may not be legally binding. For example, the *Guardianship and Administration Act 1990* (WA) (GAA (WA)) provides the legal structures for decision-making in relation to adults who have lost decisional capacity. Pursuant to this legislation a person may execute an advance care directive (AHD) which identifies 'treatment decisions' which the person wants implemented if the specified circumstances arise. A person, while they have decisional capacity, may also exercise an Enduring Power of Guardianship (EPG) under this Act, identifying a person or persons who they would like to take health care decisions (or broader personal lifestyle decisions) on their behalf should they lack decisional capacity. If these are validly executed and apply to the circumstances in question, they will be legally binding, and can only be disregarded in limited circumstances. A more detailed explanation of advance health directives follows later in this report. A person may also execute what is commonly called an 'anticipatory refusal of treatment' at common law, although these are more difficult to establish as legally binding.[22] A person may indicate their values and preferences in a non-binding statement – sometimes referred to as an advance statement of wishes, although these are limited in their effectiveness because of difficulties with implementation.[23]

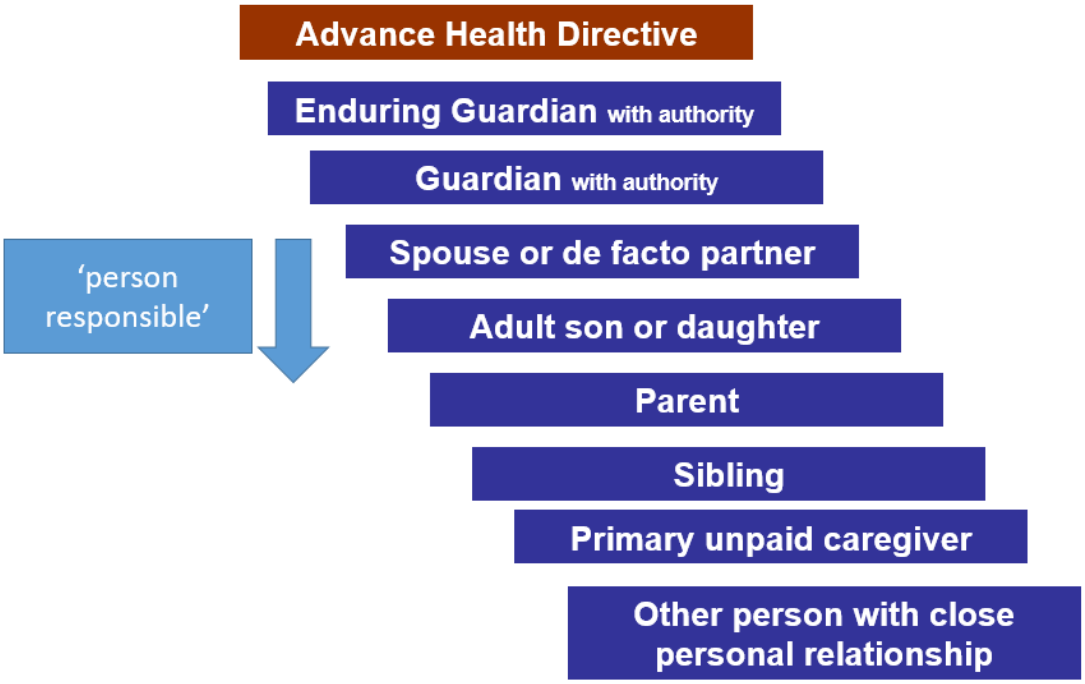
An AHD represents the most powerful indicator of a person's autonomous wishes in the event of decisional incapacity. This is clear from the diagram below which indicates the legal hierarchy of

[19] *Brightwater Care Group v Rossiter* (2009) WASC 229.
[20] Substituted decision-making is associated with the guardianship regime which has been traditionally tied to the legal test of 'best interests'.
[21] ALRC Report 124 (August 2014)
[22] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95
[23] G Thornicroft et al, *'Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial',* The Lancet (2013) 381, 9878, pp 1634-1641.

decision-making in relation to adults lacking decisional capacity. Advance Health Directives will be more specifically discussed later in part 6 of this review. For present purposes it should be noted that:

- The Health Department (WA) has introduced a new AHD form as well as educational and support materials. This includes a non-binding statement of wills and preferences;
- Advance Care Planning has traditionally focused on end-of-life decision-making, not on the mental health context. This raises questions as to whether the forms associated with advance care planning under the GAA (WA) are fit for the mental health context.

Both of these points will be discussed in more detail in Parts 5 and 6 of this review.



3. Key Themes

The literature indicates the relevance of several key points in discussing advance health directives.

3.1 The human rights context.

Respect for autonomous decision-making is reflected in the law on consent and, as such, denotes a mandate for the lawful treatment of a person. The impact of the Convention on the Rights of Persons with Disabilities (CRPD) – which Australia is a full signatory to – has specifically pushed the rights and preferences of persons living with disability to the centre of the narrative around health-care decision-making. Article 12 of the CRPD distinguishes between 'mental capacity' and 'legal capacity', and further establishes the right of persons living with disability to support in decision-making.[24] The relationship between supported decision-making and advance health directives is therefore important to recognise.

[24] M Blake et al, '*Supported Decision-Making for People Living with Dementia: An Examination of Four Australian Guardianship Laws*', (2021) 28 JLM 389 at 391-395

3.2 Traditional Advance Health Directives: End-of-life focus

The literature and broader research acknowledges that advance health directives (and advance care planning) have been most associated with end-of-life decision-making. There is considerably less data associated with psychiatric advance health directives, which raise some distinct issues. The latter are associated most frequently with the management of incapacity as a result of fluctuations – periods of illness from which recovery ensues. The episodic nature of the incapacity is therefore not associated with declining physical health and terminal illness, but rather the treatment of significant mental decline with the aim of returning to stable mental health. This distinction between physical AHDs and psychiatric AHDs is therefore important to address, as is the issue of the cycle of illness and recovery, as opposed to the management of terminal physical decline.

3.3 Traditional Advance Health Directives: refusal of treatment focus

Traditionally AHDs are associated with the refusal of life-saving or sustaining treatment whereas the psychiatric AHD raises the prospect of requesting treatment.[25] The prospect of the use of restraint or force in delivering requested treatment raises significant ethical and legal issues. Mental health consumer advocates have identified that the use of restrictive and coercive practices in caring for people living with mental health conditions are not consistent with the CRPD.[26] It is important that where a person living with a fluctuating mental health condition requests treatment in the event of an episodic illness, that the potential ramifications of administering this treatment be made explicit. The ethical issues involved in anticipatory decision-making involving unwanted treatment and force are significant.

3.4 Understanding the Relevant Statutory Frameworks

A consideration of psychiatric AHDs raises legal issues requiring engagement with the relevant complex statutory frameworks at play. In Western Australia the primary legislation is the *Guardianship and Administration Act 1990* (GAA) and the *Mental Health Act 2014* (MHA), but there is also additional legal considerations to be aware of including the clinician's duty of care at common law and under the *Civil Liability Act 2002* (CLA). The first part of the review of the legal frameworks will unpack the West Australian regulatory landscape while the second part will explore the laws in other jurisdictions, both within Australia and globally. It will become evident that there are differences in the degree to which AHDs are binding, and in the location of psychiatric advance directives (PADs) in terms of the respective governing regulatory frameworks.

4. Human Rights Considerations

[25] C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australasian Psychiatry, 2017, Vol 25(6), 574-577 at 574.
[26] National Mental Health Consumer and Carer Forum, Restrictive Practices in Mental Health Services (nmhccf.org.au)

Advance heath directives (AHDs), and more broadly advance care planning, seek to prioritise the personal autonomy of the person engaged in the planning. As an ethical principle, autonomy was developed principally within deontological ethics[27] but latterly identified as one of the four pillars of the Beauchamp and Childress principlist ethical approach.[28] While initially concerned with an individual perspective, later, largely feminist, conceptions of the principle have placed it in a more relational context that is, conceiving of the promotion of personal autonomy through the lens of relations with others.[29] Relational autonomy is associated with shared and supported models of decision-making which seek to prioritise the preferences and wishes of those persons who lack decisional capacity according to the common law and statutory tests.[30] The role that AHDs may play for those experiencing mental illness can therefore potentially benefit from this shift.

Developments in global human rights law for persons living with disability more broadly have focused on prioritising their rights, will and preferences in decision-making. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) seeks to ensure that they are afforded the same protections as all other persons under the law. The CRPD does not therefore create new rights but rather mandates the extension of existing rights to this cohort. Article 12 is at the heart of the Convention in stating that all persons living with disability enjoy legal capacity equal with others. It places the person with a disability's own will and preferences at the heart of decision-making by separating mental capacity from legal capacity. Supported decision-making, and the eradication of substituted decision-making, is integral to the State parties' obligations under Article 12.[31]

Australia was an early signatory to the Convention, and has also signed the Optional Protocol meaning that individuals are able to directly petition the UN Committee on the Rights of Persons with Disabilities.[32] The Australian Law Reform Commission's Report on Equality, Capacity and Disability in Commonwealth Laws[33] investigated Australian laws compliance with the CRPD, and made recommendations as to how Australian legal frameworks should respond to its requirements, particularly Article 12. The Report develops National Decision-Making Principles and its' main recommendation is that legal frameworks be guided by these. The Principles focus on the provision of support in decision-making, a reduction in substituted decision-making and the promotion of a person's will and preferences where supported decision-making is not possible. The Report makes reference to the test of 'best interests' as the traditional basis of substituted decision-making, notably as part of guardianship regimes, and acknowledges that this principle is 'seen to reflect the ethical tenet of beneficence, in which the 'primary imperatives were for doing good for the patient, the avoidance of harm and the protection of life.'[34] The UN Committee on the Rights of Persons with Disabilities has rejected best interests as a credible decision-making principle, and the ALRC Report is aligned with this approach in privileging wills and preferences. It should be noted, however, that while the UN Committee's interpretation of Article 12 does not accommodate substituted decision-making,

[27] S Allan and M Blake, Australian Health Law, (2018), Lexis Nexis, Chapter 2.
[28] T Beauchamp and J Childress, Principles of Bioethics (8th ed.) OUP. Also see Medicine and Philosophy, Vol 45, August 2020, Issue 4-5.
[29] S Mohapatra and LF Wiley, 'Feminist Perspectives in Health Law', Journal of Law, Medicine and Ethics, (2019) , Vol 47, Issue S4, 103-115.
[30] G Richardson, 'Mental Disabilities and he Law: From Substitute to Supported Decision-Making', Current Legal Problems , Vol 65, Issue 1 (2012), 333-354
[31] P Weller, 'Reconsidering Legal Capacity: radical Critiques, Governmentality and Dividing Practices' (2014) 23 Griffith Law review 498.
[32] Australia ratified the Convention on the 17 July 2008 and the OP on the 30 July 2009.
[33] https://www.alrc.gov.au/news/equality-capacity-and-disability-in-commonwealth-laws-alrc-report/
[34] Ibid at p 49-50 citing M Donnelly, Healthcare Decision-Making and the Law – Autonomy, Capacity and the Limits of Liberalism (Cambridge University Press, 2010), 11.

Australia has reserved the right to implement substitute decision-making 'as a last resort and subject to safeguards'[35], although there is no indication as to what circumstances might constitute a 'last resort'. Substitute decision-making is a reality for many persons living with a disability, including those with mental illness, despite the strong concerns reflected in the ALRC report.[36]

While the discussion around the implementation of the Convention has centred on persons living with intellectual disability, those with mental illness and dementia have been a more recent focus in the literature.[37] Gill and others[38] note that the CRPD has been the impetus for the reformation of mental health legislation across jurisdictions[39], highlighting the attendant focus on the shift away from involuntary treatment. They identify advance directives and joint decision-making as two of the tools which can assist in this shift.[40] Advance care planning is seen as facilitating supported decision making,[41] while the process of supported decision-making has been identified as a way to specifically enable those living with mental illness.[42]

The adoption of a human rights lens in relation to the treatment of mental illness is integral given the emerging evidence of the therapeutic benefits of optimising human rights. In this respect it is notable that Australia lacks national human rights legislation and that only Victoria, the ACT and Queensland have passed such legislation.[43] PADs, as a key mechanism for enabling supported decision-making[44] - they have been referred to as 'the most promising initiative in Australian efforts to institute a supported decision-making model in mental health'[45] – represent a key opportunity to further the human rights of those living with mental illness, by privileging their wills, preferences and lived experience in treatment decisions. It has been noted, though, that the CRPD 'implies that careful attention be given to the principles and objectives that underpin the introduction of psychiatric

[35] Australian Government, Submission to the UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12 of the Convention–Equal Recognition before the Law, 2014 [5].
[36] https://www.alrc.gov.au/news/equality-capacity-and-disability-in-commonwealth-laws-alrc-report/ Chapter 2
[37] See C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australian Psychiatry, 2017, Vol 25(6), 574-577; P Weller, 'Psychiatric Advance Directives and Human Rights', (2010), Psychiatry, Psychology and Law, 17:2, 218-229; R Kokanovic et al, 'Supported decision-making from the perspectives f mental health service users, family members supporting them and metal health practitioners', Australian and New Zealand Journal of Psychiatry, 2018, Vol 52(9), 826-823
[38] N Gill et al, 'Human rights implications of introducing a new mental health act – principles, challenges and opportunities', Australian Psychiatry, 2020, Vol 28(2), 167-170
[39] N Gill et al, 'Human rights implications of introducing a new mental health act – principles, challenges and opportunities', Australian Psychiatry, 2020, Vol 28(2), 167-170 at 167
[40] N Gill et al, 'Human rights implications of introducing a new mental health act – principles, challenges and opportunities', Australian Psychiatry, 2020, Vol 28(2), 167-170 at 168
[41] R James et al, 'Advance Statements within the Victorian Mental Health Setting: A Contextual and Legislative Global Comparison', Issues in Mental Health Nursing, 2020, Vol 41, No 4, 355-365 at p358
[42] C Roper and P Weller, 'Supported decision making as a strategy and approach for recovery focused practice', The Australian Journal on Psychosocial Rehabilitation, Autumn/Winter (2013).
[43] Victorian Charter of Human Rights and Responsibilities Act 2006; Human Rights Act 2004 (ACT); Human Rights Act 2019 (Qu)
[44] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 62.
[45] C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australian Psychiatry, 2017, Vol 25(6), 574-577 at 575 citing S Callaghan and C J Ryan, 'An evolving revolution: evaluating Australia's compliance with the Convention on the Rights of Persons with Disabilities in mental health law', UNSW Law J, 2018; 39, 596-624.

advance directives.'[46] It is therefore imperative that PADs be construed in the context of international human rights obligations.

5. The Distinct Nature of Psychiatric Advance Health Directives

Advance planning was first discussed in the mental health context by Thomas Szasz; his 1982 paper argued that psychiatric or living wills were associated with the human rights of patients, not treatment.[47]

There have been a variety of approaches to the notion of a living will as proposed by Szasz, including the concept of a Ulysses agreement (binding on both parties)[48] which provides for advance consent, and Mills Wills[49] which cover both advance refusals and advance consents; the main difference between the two being that the Mills Will is triggered in the event of the patient posing a significant harm to others. The difference in nomenclature associated with advance planning in psychiatry is recognised as problematic in terms of impeding understanding and enforcement.[50] For the purposes of this paper the term 'psychiatric advance directive' (PAD) will be used, a term which emerged through legislative enactments in the United States, and one which is frequently referenced in the Australian literature.[51]

PADs have been championed as a way of enabling a person to 'exercise their rights to self-determination, state their wills and preferences and…at least theoretically, PADs minimise the need for traditional paternalistic models'.[52] The privileging of individual will and preferences which PADs are claimed to enable, is, as noted above, founded in the ethical value of respect for personal autonomy, and is at the basis of the appeal of advance care planning more generally. Advance directives in the psychiatric space, however, present challenges which differentiate them from the more traditional advance health directives. Legislation facilitating advance directives, and advance care planning more generally, originated with a focus on end-of-life decision-making.[53] They are therefore traditionally associated with declining physical health, and are used as a way of declining treatments of efforts to prolong life which patients perceive as burdensome.[54] Consequently, they are most usually associated with the withdrawal or cessation of treatment, not with requests for

[46] P Weller, 'Psychiatric Advance Directives and Human Rights', Psychiatry, Psychology and the Law, Vol 17, No.2, May 2012, 218-229 at 219.
[47] Szasz TS, 'The psychiatric will: A new mechanism for protecting persons against 'Psychosis' and psychiatry', Am Psychol. 1982;37:62-70
[48] See T Howell et al, 'Is there a case for voluntary commitment' in T Beauchamp and L Waiters (eds), Contemporary Issues in Bioethics, Belmont, Wandsworth, 1982.
[49] J A Rogers & J B Centifanti, 'Beyond 'self-paternalism': Response to Rosenson and Kasten, Schitzophrenia Bulleting, Vol 17(1), 1991, 9-14.
[50] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law 1,
[51] See, eg., C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australian Psychiatry, 2017, Vol 25(6), 574-577; P Weller, 'Psychiatric Advance Directives and Human Rights', (2010), Psychiatry, Psychology and Law, 17:2, 218-229.
[52] C Ouiliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental health legislation', Australasian Psychiatry, 2017, Vol 25(6) 574-577 at 575.
[53] K Del Villar and CJ Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent', MJA212(5), 2020, 208-2011 at p208
[54] K Thomas, B Lobo and K Detering, Advance Care Planning in End of Life Care, 2018, OUP

treatment; indeed courts have consistently found that they will not force health professionals to provide treatment which the professionals have decided is not in the best interests of the patient.[55]

By way of contrast, PADS are tools which often identify 'what *to do'*,[56] rather than to refrain from treatment. Moreover, the episodic nature of many psychiatric illnesses means that the treatment decision is not one in the context of managing terminal illness, but rather of returning the patient to stable mental health. This is referred to as 'fluctuating capacity', and is recognised as symptomatic of, for example, bipolar disorder. Eden and Maylea[57] discuss the particular issue of mania associated with bipolar disorder, and the consequent 'fluctuating capacity.' They note that patients experiencing mania almost always lose their treatment decision-making capacity, and that this is associated with two primary characteristics – a loss of insight (clinically meaning a self-awareness of mental state change and illness[58]), and loss of appreciation (a legal construct referencing the ability to apply information to one's own situation). They note that while with most hospital patients it is the loss of cognitive abilities which is most common,[59] the patient experiencing a psychosis is not necessarily affected in this way. They argue that capacity assessments should be able to consider more than cognitive abilities and should extend to all decision-making abilities that have been recognised by the law.[60] This is consistent with the view expressed by Gergel and Owen[61] who note that a person experiencing mania will lack insight that they are unwell and be unaware of the risks of their behaviour. '[62] Kisely et al also refer to the 'variations of insight' associated with some forms of mental illness; they suggest that it is precisely these variations which make advance directives 'well suited to mental health settings.'[63] A recent case involving capacity determinations in relation to two people being involuntarily treated under Victoria's mental health legislation, however, warns of the need to guard against assumptions around assessing capacity in patients experiencing mental illness:

> 'The way in which lack of belief or insight in respect of the illness and the need for treatment is considered when assessing capacity is a matter of importance to people with mental disability. This is because it is not uncommon, for various personal, social and medical reasons, for a person with mental disability to deny or diminish the illness and the need for treatment, or to choose non-advised treatment. Nor is it uncommon, for various personal, social and medical reasons, for persons not having

[55] See Burke, but also note cases like *Northridge v Central Sydney Health Service* [2000] declared treatment to go ahead where the conclusion is that the life-sustaining treatment was in the best interests of the patient.
[56] C Ouiliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental health legislation', Australasian Psychiatry, 2017, Vol 25(6) 574-577 at 574
[57] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law, 1
[58] G S Owen et al, 'Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study', Psychol Med 2009, Aug 1:39(8); 1389-98
[59] T Hindmarch et al, 'Depression and decision-making capacity for treatment or research: a systematic review', BMC Medical Ethics (2013), 14:54
[60] P Lepping, 'Overestimating patients' capacity', Br J Psychiatry, 2011 Nov; 199(5): 355-6.
[61] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 94
[62] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 94
[63] S Kisely et al, 'Motivational aftercare planning to better care: Applying the principles of advanced directives and motivational interviewing to discharge planning for people with mental illness.' International Journal of Mental Health Nursing, (2017), 26, 41-48 at p42.

> mental disability to deny or diminish illness or the need for treatment, or to choose non-advised treatment. In neither case does this mean of itself that the person lacks capacity.'[64]

But while the literature evidences strong support for the value of PADs, there is also substantial recognition that the current options for advance decision making are 'not a good fit"[65] for people living with some types of mental illness as they have been developed in the context of end-of-life decision-making and dementia.

One form of PAD which is commonly discussed in the literature is the notion of a 'self-binding directive' in the context of episodic severe psychosis associated with some types of mental illness. This is also referred in the literature as a Ulysses directive or agreement. It takes its name from the Greek hero Ulysses (also known by the Greek translation Odysseus) depicted in Homer's poem, the Odyssey.

Gergel and Owen note that:

> 'In Book 12 of Homer's Odyssey, Odysseus (Ulysses) tells his crew to bind him to the mast of his ship, so that he can experience the irresistible song of the Sirens without being drawn to self-destruction by abandoning his mission and wasting away on their island, bewitched by the sublime pleasure and enlightenment they offer.'

This conception of an SBD predicates the use of force or restraint as part of a PAD. As indicated earlier, this raises complex ethical questions around the scope of therapeutic interventions, as well as legal issues around compatibility with the CRPD, which rejects the use of coercion as well as the concept of incapacity.

Although the SBD was first raised as a psychiatric tool by Thomas Szasz, it subsequently fell out of favour.[66] Gergel and Owen attribute the 'recent revival of interest in SBDs' to their potential impact for persons living with recurrent illnesses such as schizophrenia or bipolar disorder.[67] They observe that for persons who experience acute episodes of mental illness with periods of good health SBDs are helpful as they promote autonomy and facilitate earlier intervention which may reduce treatment time.[68] Others have noted that for those who experience episodic illness, there is value in their understanding of their own illness – the 'buy-in into their recovery plans has the potential to improve how people engage with their treatment…'[69]; moreover the enhancement of self-management, in the sense of recognising that people living with mental illness while well understand their own symptoms and triggers through a reflective process, has been recognised as very important to the recovery

[64] *PBU v NJE v MHT* [2018] VSC 564 at para [195]
[65] K Del Villar and C J Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent.' MJA 212 (5), March 2020 208 at 209.
[66] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law, 1 at 2
[67] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101
[68] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 96
[69] S Kisely et al, 'Motivational aftercare planning to better care: Applying the principles of advanced directives and motivational interviewing to discharge planning for people with mental illness'. International Journal of Mental Health Nursing (2017) 26, 41-48 at 47.

process.[70] Halpurn and Szmukler[71] also note that SBDs give a person the opportunity to use his or her past experiences of acute mental illness to inform the timing and sort of treatment in the event of the onset of another episode of acute illness. Gergel and Owen point to the potential for reduced coercive measures in response to an acute psychotic episode through the better crisis management resulting from the implementation of an SBD based on patients' past experiences and preferences'.[72] Other authors have identified the building of trust which an SBD can produce, which might in turn 'lessen the level of perceived or actual coercion within treatment' in this context.[73]

Improvements in the patient/clinician relationship have been identified as one of the benefits of completing an SBD in that it creates an opportunity for 'detailed reflection and engagement between the patient and their clinical team':

> 'A condition like bipolar, where capacity can fluctuate, where a person can truly gain experience of the difference between their preferences when manic and when not, and where they can be in a position to evaluate that difference, seems eminently suited to precedent autonomy. SBDs could be one way towards making treatment for severe psychiatric illness more harmonious with the broad aspirations of the CRPD.'[74]

SBDs, as a particular form of PADs, however, raise not insignificant ethical, legal and clinical concerns. Given that the enforcement of SBDs contemplate the application of force to a resistant patient, it directly confronts the idea that 'coercion and care do not easily go together'.[75]

As Gergel and Owen note:

> 'The notion of voluntarily committing ones conscious and often very lucid self to being treated involuntarily can seem shocking, especially to those unacquainted to living with mania.'[76]

The prospect of clinical staff actively forcing treatment on a patient who is refusing it can clearly be distressing for patients and staff. In this sense SBDs have been described as an attempt to reconcile two seemingly irreconcilable issues – patient autonomy with the prospect of involuntary treatment agreed upon in advance.[77] Moreover, while Szasz use the myth of Ulysses as a tool in psychiatry, he does not recognise, as Dresser points out, that Ulysses enters into a bipartite contract with his crew,

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[70] J Cook et al, 'Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning', Schizophrenia Bulletin, (2012), 38, 881-891.

[71] A Halpern and G Szukler, 'Psychiatric advance directives: reconciling autonomy and non-consensual treatment', Psychiatr Bull, 1997; 21: 323-327

[72] Referencing C Henderson al, 'Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial', BMJ (2004), 329, 136; J Swanson et al, Psychiatric advance directives and reduction of coercive crisis interventions, (2008), Journal of Mental Health, 17, 255-267.

[73] I Varekamp, 'Ulysses directives in the Netherlands: Opinions of psychiatrists and clients', (2004), Health Policy (Amsterdam, Netherlands), 70, 291-301.

[74] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 96

[75] I Gremen et al, 'Ulysses arrangements in psychiatry: A matter of good care?', JME (2008), 34(2), 77-80.

[76] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 93

[77] A Sarin, 'On psychiatric wills and the Ulysses clause: The advance directive in psychiatry, Indian Journal of Psychiatry, (2012), 54, 206-207.

the Ulysses clause in psychiatry represents a tripartite contract between the individual, the medical profession and the state, raising further complications.[78]

Another key concern is that an SBD may request the use of compulsory treatment at an earlier stage of the illness than would usually meet the criteria for involuntary treatment, leading to accusations that they are used while the person still has existing capacity to make treatment decisions.[79] This point links back to that made earlier about the nature of the incapacity experienced by patients who live with episodic psychosis. As noted earlier, that incapacity is often more associated with lack of insight and therefore inability to refrain from engagement in activities which the individual recognises when well, as harmful to him or her, and potentially life-threatening. This alludes to the disjunct between the common law and mental health legislative approaches to assessment of capacity with the nature of the mental incapacity experienced in these sorts of cases.

The instruction to apply an SBD prior to the criteria for involuntary treatment being satisfied alludes to the contested relationship between the legal frameworks associated with advance care planning and those with the treatment of mental illness. Even when the criteria for involuntary admission is met, this may not satisfy the trigger for involuntary treatment of the disorder for which the person has been admitted. It has been commented that this legal 'grey zone' has resulted in considerable variation between jurisdictions as to the (a) existence of and (b) enforceability of SBDs.[80] In particular, the applicability of SBDs may depend upon whether the criteria for involuntary treatment has been met, in which event treatment may be applied in accordance with the mental health legislation. If that criteria are not met, there may or may not be discretion to apply the SBDs.[81]

The challenges identified in relation to SBDs exist more generally in advance care planning in the psychiatric context. The contested relationship between the different legal frameworks is not confined to SBDs and indeed have been experienced in relation to the refusal of treatments by those experiencing mental illness, albeit in a context not involving a PAD.[82] Moreover, there are additional challenges with advance care planning in relation to psychiatric care due to 'widespread confusion about the nomenclature' associated with advance planning in the mental health context, in particular the difference between legal instruments and clinical tools.[83] Edan and Maylea refer to the confusion being not limited to terminology, but being also due to the different functions and principles of documents. They note that some authors have referred to psychiatric advance directives and advance statements, equating these with joint crisis plans, wellness recovery action plans, wellness recovery action plans, and crisis plans.[84] Therefore while there is evidence that mental health advance

[78] R Dresser 'Bound to treatment: The Ulysses contact', Hastings Cent Rep 1984; 14:13-6

[79] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 95

[80] Discussed in K Del Villar and C J Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent.' MJA 212 (5), March 2020 208 at 210.

[81] [81] K Del Villar and C J Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent.' MJA 212 (5), March 2020 208 at 210.

[82] *Re Langham & Ors* [2005] QSC 127

[83] V Edan et al, 'Advance Planning in Mental Health Care: The trouble with terminology', Journal of Law and Medicine, (2021), 28(3), 655-662.

[84] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law, 1 at 2 referencing C Henderson et al, 'A typology of advance statements in mental health care', Psychiatric Services (Washington D.C.), (2008), 59(1), 63-71.

statements are an identified strategy to reduce unwanted clinician interventions,[85] there is also an acknowledgement that there are a variety of terms used across jurisdictions to describe documents associated with the expression of individual preferences for future mental health treatment, with implications for the completion and effectiveness of advance directives in the psychiatric context.[86]

A further challenge in this context relates to clinical attitudes towards PADs. Eden and Maylea, in relation to SBDs, have noted that there is considerable lower clinical receptiveness to this form of PAD where it is enshrined in legislation.[87] Clinician wariness towards PADs more generally appears to be a common theme in the literature. The time and resources challenges which the drafting of a PAD presents, for example, have been identified.[88] Perhaps more significantly at a conceptual level, it has been recognised that the process of drafting and implementing a PAD involves a change to the clinician/patient dynamic, in which the relationship reflects a shared decision-making model. While this allows the clinician more insight into the patient's underlying personality (or 'subjective personhood'[89]), other writers have raised concerns about the possibility of increased influence of the clinician on the patient's decision-making, exacerbating an existing balance of power.[90] Other concerns relate to the 'uncomfortable process for both patients and clinicians'[91] which the application of PADs, and therefore the reluctance of clinician's to formalise PADs on a legal basis, with a preference for an informal process.

Clinical resistance to PADs has been demonstrated by Sellars et al, who undertook the first published national survey to examine Australian psychiatrists' response to a PAD documenting a preference to refuse treatment, and the reasons for their decisions.[92] Their survey showed that most would not support the execution of a PAD which contained a request to cease pharmacology or not become the subject of an involuntary treatment order should their severe depression persist and deteriorate.[93]

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[85] R James et al, 'Advance Statements within the Victorian Mental health Setting: A Contextual and Legislative Global Comparison', Issues in Mental Health Nursing, 2020, Vol 41, No 4, 355-365.

[86] Ibid

[87] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law, 1.

[88] Identified as a problem with the Dutch model, and regarded as responsible for the low take-up of PADs in that jurisdiction – R Berghmans and M van der Zanden, 'Choosing to limit choice: Self-binding directives in Dutch mental health care', Int J Law Psychiatry, 2012, Jan-Feb; 35(1): 11-8.

[89] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 argue that it is imperative to distinguish between 'subjective' and 'objective' personhood. The former they refer to as 'personal identity, 'the psychological continuity of values and beliefs', whereas the latter constitutes a conception of a 'legal individual entitled to human rights'. Importantly this notion of objective personhood is not dependent upon self-determination. The consequence is that when there is an episodic loss of mental capacity (that is, subjective personhood is compromised), the individual, through the application of the PAD, remains entitled to the protection of their human rights. They note that this subjective/objective approach to personhood helps to address the notion of universal legal capacity, and the separation of legal and mental capacity, found in the CRPD, and is therefore more aligned with the human rights imperative identified above.

[90] S Kiesley et al, 'Motivational aftercare planning to better care: Applying the principles of advanced directives and motivational interviewing to discharge planning for people with mental illness', International Journal of Mental Health Nursing (2017), 26, 41-48 at 42.

[91] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 99

[92] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73.

[93] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 69

The authors note that the results were similar to those of a survey of US psychiatrists which revealed that nearly half would override a PAD, responding to a vignette which raised concerns about the patient's well-being.[94] Perhaps unsurprisingly, the thematic analysis indicated that of most concern to those resisting following the PAD were the patient's clinical profile and concerns about the psychiatrist's duty of care, whereas the interest in the patient's autonomy was strongest in those supporting the completion of the PAD.[95] Significantly they note that their findings indicate the latent mistrust of patients' capacity by some psychiatrists at the time of making the PAD or at the point of its enactment, and link this to earlier studies which note that the non-adherence to PADs 'act as a barrier to their perceived utility' and therefore patient uptake.[96] Those studies referred to the 'significant association between legal defensiveness on the part of psychiatrists and the likelihood that they would override the patient's PAD'.[97]

Lenagh-Glue et al also refer to clinician hesitancy around PADS, specifically the concern that specific medications could be refused, and the uncertainty of the legality of overriding these.[98] They note that this affects uptake because the clinicians' hesitancy to support PADs feeds into a reluctance on the part of the users to utilise PADs.[99]

International studies have indicated that the strongest themes for those psychiatrists not supporting PADs is concern for capacity (both at the time of making of the PAD and at the time it was enacted), the level of harm to the patient an others and whether the patient was willing to accept other treatments in place of that being offered.[100] These findings directly link support for making the PAD to the ability to override it later if required.

Sellars et al note, relevantly for the Western Australian position (see below) that:

> In jurisdictions where PADs can be override, such mistrust draws the utility of completing a PAD into serious question.[101]

[94] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 69

[95] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 70

[96] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 70 referencing J Swanson et al, 'Overriding psychiatric advance directives: Factors associated with psychiatrists' decisions to pre-empt patients' advance refusal of hospitalization and medication', Law and Human Behaviour (2007), 31, 77-90.

[97] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 70

[98] J Lenagh-Glue et al, 'Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand.', Australian and New Zealand Journal of Psychiatry, 2022 1

[99] J Lenagh-Glue et al, 'Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand.', Australian and New Zealand Journal of Psychiatry, 2022 1 at 2

[100] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 71 referencing P Nicaise et al, 'Psychiatric advance directives as a complex and multistage intervention: A realist systematic review', Health & Social Care in the Community (2013), 21, 1-14.

[101] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 71 at 70

Therefore, while the 'selling point' for psychiatrists'[102] support for PADs has been the principle of autonomy, these survey, vignette-based studies indicate that most clinicians privilege the value of clinical outcomes where the PAD precludes the treatment that the psychiatrist is able to offer. This is valuable evidence when coming to interrogate the Western Australian framework around PADs.

Further complications can arise in relation to the psychiatrists' responsibilities where there is an overlap between psychiatric and palliative care, a point which has been recognised in the literature but not explored.[103] The limited case law in relation to this overlap has exposed these complexities although not in the context of AHDs.[104]

Conclusion on PADS

A review of the literature clearly reveals the practical and conceptual challenges associated with PADs; these resonate in the ethical, clinical and legal perspectives. These will always be difficult to reconcile as Gergel and Owen acknowledge in their arguments in support of SBDs for people living with Bipolar Disorder. They advocate to situate the PAD in the clinical space, while attempting to address the ethical concerns through the assurance that:

- Free and informed consent is present at the time of *making the PAD* because it is 'based upon the patient's own prior experience of both the condition and the treatment.' They address concerns about the 'coercion context' arguing that this is more present in relation to the risk-based mental health laws as well as inaccurate public perceptions about mental illness;[105]
- In relation to enforcing an SBD, their argument is that there are sufficient moral grounds for the person with bipolar, when well, to exercise precedent autonomy over themselves when manic[106]. As such it is ethically untenable to not follow the SBD as it risks denying to the patient, who has personal experience of mania, the authority to know what represents their own interests with respect to compulsory treatment.[107]

There is no doubt that the problems besetting advance health directives in the psychiatric context reflect a broader issue; Berghmans & van der Zanden, for example, identify the 'lack of attention to the patient's underlying values and beliefs' as an issue with advance directives in general and they instead propose supplementing it with a 'values-history'. [108]

There is also no doubt that PADs are associated with particular ethical, clinical and legal challenges, reflecting unhelpful preconceptions about mental illness and the continuing stigma around this. Gergel and Owen usefully summarise these in relation to SBDs:

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[102] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 71

[103] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73 at 72.

[104] *Australian Capital Territory v JT* [2009] ACTSC 105; *Re D* (1997) 41 BMLR 81

[105] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 97

[106] Referencing A Sarin, 'On psychiatric wills and the Ulysses clause: The advance directive in psychiatry, Indian Journal of Psychiatry, (2012), 54, 206-207.

[107] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 97-98.

[108] R Berghmans and M van der Zanden, 'Choosing to limit choice: Self-binding directives in Dutch mental health care', Int J Law Psychiatry, 2012, Jan-Feb; 35(1): 11-8.

> 'Discussions of SBDs often draw on the misleading parallels taken from discussions of precommitment as a means to control 'weakness of will' or akrasia, such as Christmas savings accounts which impose penalties on an unrestrained spender for early withdrawal or Elster's well-known example of the lecherous academic, who takes his wife to a faculty party, so that he will be discouraged from too much drink or flirtation (Elster, 2000, p 11). Not only do such examples misrepresent the impact of mania, they depend upon the presence of rational contemplation and dissuasion.[109] Yet the notion of mania invoked within an SBD is more akin to the overwhelming bewitchment of the Sirens, which leaves its listener utterly powerless to resist being lured towards destruction or to recollect their ordinary values and priorities in a way which could function on some type of rational disincentive.'[110]

While they acknowledge that SBDs are problematic given that the CRPD rejects coercion as a form of treatment, they submit that SBDs:

> 'could represent an ethically coherent means of enhancing self-determination which is consistent with the broadly worded aims of enablement and empowerment espoused within the CRPD itself.'[111]

The theoretical premise of PADs in this sense is beyond question. More broadly, PADs represent an important development in terms of Australia's international legal obligations under the CRPD; its whole purpose is to achieve equality for persons living with disability, therefore where it is possible to make a binding advance directive for a physical health condition but it is not possible to do so for a mental health condition, this is discriminatory[112] and therefore a potential breach of the CRPD. One author has argued that effective law reform in Australia must 'pay close attention to the principles expressed in the Convention on the Rights of Persons with Disabilities', particularly given that:

> 'The long-standing association of psychiatric advance directives with the aspirations of the consumer and anti-psychiatry movements has injected psychiatric advance directives with a strong human rights flavour'.[113]

That attention must include addressing the dual interests of respecting wills and preferences and that avoiding the use of coercion and force in mental health treatment.

While there is strong evidence in the literature to support PADs on human rights grounds, there is less evidence of the effectiveness of PADs. The Cochrane Review[114] (the Review) identified and analysed

[109] Aristotle says 'the akratic acts on account of passion, even though he knows it is wrong' (NE 1145b13).
[110] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 98.
[111] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 93.
[112] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law, 1 at 5
[113] P Weller, 'Psychiatric Advance Directives and Human Rights', Psychiatry, Psychology and the Law, Vol 17, No.2, May 2012, 218-229 at 219 referencing T S Szasz.
[114] LA Campbell and SR Kisely, 'Advance treatment directives for people with severe mental illness (Review), 2012, The Cochrane Collaboration (Wiley & Sons)

studies of randomised controlled trials (RCTs) involving adults with severe mental illness who were being treated in a community setting and where an advance directive[115] was in place and/or applied. Their review of their studies found that there were no significant conclusions that could be drawn from the use of an advance directive, except that the need for social workers was reduced and fewer violent acts were carried out by patients.[116] In relation to joint crisis planning instruments, in particular, there was no differences in the proportion of voluntary admissions but patients were less likely to be hospitalised and less likely to engage in violence. The Review concludes that, for persons with severe mental illness:

> 'Evidence for the effects of mental health advance directives is limited by the paucity of data available from randomised controlled trials. In a non-randomised study examining the effects of advance directives on working alliance and treatment satisfaction, participants in the intervention group showed significantly greater improvement in their working relationship with their clinicians…'[117]

While The Review acknowledged that 'more intensive interventions, such as joint crisis planning' may benefit clinicians in terms of reduction of involuntary admissions, it again pointed to the lack of data available as affecting its' ability to make stronger recommendations to policy makers.[118] Given that The Review is now ten years old, it is important to consider any specific evidence relating to the uptake and effectiveness of PADs in other jurisdictions; we do this in section 7.

6. The Current Western Australian Regulatory Framework

6.1 The Guardianship and Administration Act 1990 (WA)

Advance care planning in WA is, as previously noted, legislated through the *Guardianship and Administration Act 1990* (WA) (GAA). The *Acts Amendment (Consent to Medical Treatment) Act 2008* introduced changes to the GAA and the *Criminal Code* (WA) which recognised the formal Advance Health Directive and the Enduring Power of Guardianship. In the Second Reading Speech given in support of the Bill, the Hon Jim McGinty MLA (the Health Minister at the time) stated:

> 'The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition, including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance heath directive and or alternatively treatment decisions can be made by an enduring guardian chosen by them…The bill, however, will not change the

[115] Interpreted broadly to include advance directives, joint crisis planning, advance crisis planning, anticipatory psychiatric planning and Ulysses directives)

[116] LA Campbell and SR Kisely, 'Advance treatment directives for people with severe mental illness (Review), 2012, The Cochrane Collaboration (Wiley & Sons) at 10.

[117] LA Campbell and SR Kisely, 'Advance treatment directives for people with severe mental illness (Review), 2012, The Cochrane Collaboration (Wiley & Sons) at 11

[118] LA Campbell and SR Kisely, 'Advance treatment directives for people with severe mental illness (Review), 2012, The Cochrane Collaboration (Wiley & Sons). Also see G Davidson et al, 'Supported decision making: A review of the international literature, International Journal of Law and Psychiatry, 38 (2015) 61-67 at 66

> position at common law whereby a health professional is under no obligation to provide treatment that is not clinically indicated. In other words, although a patient, or someone on the patient's behalf, will be entitled to refuse lawful treatment, there will be no legal entitlement by a patient to demand treatment.'[119]

In Western Australia, Advance Health Directives are located in Part 9B of the GAA. Advance Health Directives refer to '**treatment decisions** in respect of the person's future treatment'. They are therefore limited by the meaning of 'treatment' and 'treatment decisions' in the GAA section 3. They do not extend to lifestyle decisions (for example, such as directions as to the place of habitation).

Treatment (s3) –

(a) Means[120] -
- (i) Medical or surgical treatment, including a life-sustaining measure or palliative care; or
- (ii) Dental treatment; or
- (iii) Other health care;

Treatment also includes (for the purposes of Part 9B (AHDs) and 9E (medical research) only), medical research. This provision was included in 2020 amendments to enable research to be carried out on persons lacking decisional capacity. It brings the GAA in alignment with the *NHMRC Statement on Ethical Research on Humans*[121], and some other Australian jurisdictions.

A treatment decision (s3):

(a) Means[122] a decision to consent or refuse consent to the commencement or continuation of any treatment of the person; and

(b) In part 9B – includes a decision to consent or refuse to consent to the commencement or continuation of the person's participation in medical research.

Medical research is defined in section 3AA, and includes[123], inter alia, the administration of pharmaceuticals, the use of equipment or a device and 'providing health care that has not yet gained the support of a substantial number of practitioners in that field of health care'.

<u>The Validity of AHDs</u>

The following are key aspects/requirements of making a valid AHD:

- They are limited to persons aged 18 or over (s110P);
- A valid AHD *under the GAA*[124] must (s110Q)
- be in the prescribed form (found in the attendant regulations);

[119] *Brightwater Care Group v Rossiter* (2009) WASC 229 at para [47].
[120] Limited to these practices/interventions
[121] https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018
[122] Therefore limited to these decisions
[123] S3AA(2) is not an exhaustive list, although this is limited by the meaning of medical research in s3AA(1)
[124] The GAA preserves the operation of the common law under which anticipatory refusals of treatment may be upheld (a110ZB – it does not affect the common law relating to a person's entitlement to make treatment decisions in respect of the person's future treatment)

- Be signed by the maker, or someone directed by the maker (who must be present);
- Be witnessed by 2 persons authorised to take declarations, or 1 who is authorised by law and the other who is 18 or over and not the maker/person directed by the maker;
- Be signed by the witness in the presence of the maker and (if applicable) the person directed by the maker

There is no requirement that legal or medical advice be sought by the maker, although it is encouraged (s110Q(b)). A failure to seek advice will not, therefore, invalidate the AHD (s110Q(2)), although the maker can indicate in the directive whether advice has been sought and who it was sought from (s100QA).

A treatment decision in an AHD will not be valid if (s110R):

- Ss(1) - It is not made voluntarily; or is made as a result of inducement or coercion;
- Ss(2) – if at the time it is made the maker does not understand
- The nature of the treatment decision; or
- The consequences of making the treatment decision

This generally reflects the common law in relation to the validity of health care decisions.[125] The reference to inability to understand reflects the common law approach to capacity determinations which are centred on cognition.[126]

The Operation of AHDs

The AHD becomes operative once the maker of the directive '*is unable to make reasonable judgments in respect of that treatment*' – s110S. This is the test set out in relation to the 'need for a guardian' (section 43).[127] There are three tests set out in relation to this question, and the AHD has identified that related to mental capacity (as opposed to the inability to care for one's health or safety) as the key test. There is, however, no definition of capacity in the GAA, nor is there any acknowledgement of fluctuating capacity.[128] Evidence drawn from decisions of tribunals determining guardianship suggest that the statutes are approached through the common law lens' of capacity determinations.[129]

The AHD will only apply if the specific circumstances identifies in the AHD exist (s110S(2)). Additionally it will not operate if it is assessed that (s110S(3)):

- If circumstances exist/have arisen that the maker of the directive would not reasonably have anticipated at the time of making it; and
- These would have caused a reasonable person in the maker's position to have changed his or her mind about the treatment decision.

This provision operates through an objective lens; s110S(4) provides a list of matters that may be taken into account in determining whether ss(3) applies including the period that has elapsed between the

[125] See *Brightwater Care Group v Rossiter* (2009) WASC 229
[126] *Brightwater Care Group v Rossiter* (2009) WASC 229, relying on *Re MB* [1997] 2 FLR 426 and *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95
[127] Note that the GAA contains a presumption of capacity – s4.
[128] See the discussion in Blake et al, 'Supported Decision-Making for People Living with Dementia: An Examination of Four Australian Guardianship Laws', (2021) 28 JLM 389 at 396-399.
[129] Blake et al, 'Supported Decision-Making for People Living with Dementia: An Examination of Four Australian Guardianship Laws', (2021) 28 JLM 389 at 401-404

time of making the directive and the time of operation as well as the nature of the condition and the treatment.

In addition, a treatment decision in an AHD will be regarded as revoked it the maker has changed his or her mind about the treatment subsequent to making the AHD. There is no indication in the statute as to what would constitute sufficient evidence of this change of mind. As such, it is assumed that the change of mind does not need to be formally expressed and does not require decisional capacity. It has been proffered that as a result in WA a PAD is likely to be ineffective if the person knows they will object to treatment when their mental health is declining.[130]

The GAA contains a specific provision in circumstances where the patient needs 'urgent treatment', the patient is unable 'to make reasonable judgments' in relation to the treatment, the health professional 'reasonably suspects' the patient has attempted suicide and 'needs treatment as a consequence'. Under s110ZIA (2) the health professional can provide treatment despite the patient having made an AHD containing a treatment decision inconsistent with providing the treatment or the patient's guardian or enduring guardian having made such a treatment decision.

Challenging AHDs

An application can be made to the State Administrative Tribunal to make a declaration about the validity of an AHD or a treatment decision in an AHD (s110W), and the capacity of a maker of an AHD to make reasonable judgments in respect of treatment specified in the AHD (s110X). It may also make declarations as to the construction of terms in the AHD (s110Y) and that the treatment decision has been revoked (s110Z).

Developments in Relation to AHDs

Following from the recommendations of the My Life My Choice Report (WA)[131], the Ministerial Expert Panel on Advance Health Directives was formed, delivering its Final Report in August 2019. That Report endorsed a 'new approach to community awareness and education' in relation to AHDs, and identified the importance of coordinating:

- The concept of 'having a conversation' about serious illness and death;
- Advance care planning; and
- The statutory instruments[132]

A major issue driving the recommendations was the identified low uptake of AHDs in WA as compared with other jurisdictions.[133] As such, one of the key recommendations was that the new advance health directive template provide more guidance and facilitate the inclusion of a non-binding values statement; another was the creation of a register of AHDs. Notably, while there is a specific chapter dedicated to the position of persons living with dementia, cognitive impairment and neurodegenerative diseases[134], there is no specific reference to or recommendations made in relation to persons living with mental illness. Given that the emphasis of the Report is on improving the visibility and accessibility around AHDs, this is perhaps not surprising. Moreover, the Report's focus

[130] K Del Villar and CJ Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent', MJA212(5), 2020, 208-2011 at 210.
[131] Joint Select Committee on End-of-Life Choices (Aug 2018)
[132] Ministerial Expert Panel on Advance Health Directives, Final report at p4.
[133] Ministerial Expert Panel on Advance Health Directives, Final report at p3.
[134] Ministerial Expert Panel on Advance Health Directives, Final report Chapter 6

on end-of-life decision-making is also understandable given that it was a direct product of a recommendation of the End-of-Life Choices Joint Select Committee Report.[135]

Subsequently the End of Life Care (EOLC) Programme within the Department of Health (WA) was given the task of implementing the recommendations from both of these Final Reports. Pursuant to this the WA Health's strategy for Advance Care Planning education and awareness raising for health professionals and the community was released in August 2021.[136] The strategy maps out promotion, resources, education and training, monitoring and evaluation and implementation as key areas of focus and outcome. In addition to this, the redrafting of the AHD template has been completed; it is now located in the regulations pursuant to the GAA, rather than attached as a Schedule to the Act. The Guardianship and Administration Amendment Regulations 2022 came into force on the 4th of August. The new template requires completion of Part 4 (specifying the treatment decision) but not Part 3 (the Values and Preferences Statement). While Part 4 is legally binding (to the extent that it applies to the circumstances), Part 3 is not. This will mean that responsive changes to the form will be easier to achieve.

What all of these developments indicate is that recent developments in the space of advance care planning, while welcome, have not specifically addressed the issue of advance health directives for those experiencing mental illness. It is evident that the focus has been on end-of-life decision-making, and in that respect is consistent with the general emphasis in the literature, as outlined earlier. Judicial authority on advance health directives has similarly confined to the context of end-of-life decision-making.[137]

6.2 The Mental Health Act 2014 (WA)

Background

In the Parliamentary debates of the *Mental Health Bill 2013* the aims of the new Act were explained by the Hon Helen Morton (the then Minister for Mental Health) stated in the Second Reading of the Bill in Parliamentary Council:

> 'The overall purpose of the bill is to bring mental health legislation into line with current community expectations, to codify good practice from an Australian and international perspective, and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities 2006.'[138]

In speaking to key aspects of the bill, she noted that:

> 'Patients have the right to have their wishes considered by their psychiatrist and if the patient's psychiatrist makes a decision that is inconsistent with an advance health directive or enduring power of guardianship, he or she must record this decision and the reasons for it,

[135] Ministerial Expert Panel on Advance Health Directives, Final report Chapter 1
[136] WA Health STRATEGY ACP Education Awareness FINAL.pdf
[137] *Brightwater Care Group v Rossiter* [2009] WASC 229; Hunter and New England Health Service v SA [2009] NSWSC 761
[138] Wed 7 May 2014 at p2879

> and provide a copy t the patient, the patient's support persons, the Chief Psychiatrist and the Chief Mental Health Advocate. This decision can be reviewed by the Chief Psychiatrist.'[139]

When the bill was later debated, a question was raised as to why the bill stated that the term 'must have regard to' was used, rather than 'for the purposes of ascertaining their wishes, the person or body must implement any instructions contained in an advance health directive.' The question was referencing the wording used in the GAA, and querying the distinction between the proposed operation of AHDs in the mental health context as compared to the general health care context.[140]

A debate then ensued about a proposed amendment to the bill in relation to advance health directives which would:

- Require the bill to follow the scheme of the GAA in its entirety;
- State that a psychiatrist must not act contrary to an AHD unless the State Administrative Tribunal has determined that this is permissible;
- Give the SAT jurisdiction to make a determination for these purposes, in line with the provisions in the GAA

In response to this, the Hon Helen Morton put forward this argument:

> I set out the scenario in which a person with severe depression intentionally makes an advance health directive that precludes all viable treatment options. If such a person were deemed to be at serious risk, he or she could be detained under the act but could not be treated , in effect, making the hospital a detention facility rather than a place of recovery…If a person has been detained involuntarily, but the clinicians are unable to provide treatment, that person will languish in that hospital in torment and in the situation that they are in for, I would say, forever and a day until their illness progresses to such a stage that they would be picked up under the emergency part of the legislation anyway.[141]

She further stated:

> 'A key point here is that the witnessing requirements under the Guardianship and Administration Act do not require the involvement of a person trained in the identification of mental illness and in the assessment of capacity. This is problematic because determining the capacity of a person with mental illness can be a highly complex matter. This problem is compounded by the fact that under the bill the capacity test for making an AHD is weaker than the test for establishing capacity. The result is that a person who wants to evade the safeguards of the Guardianship and Administration Act could do so without significant difficulty. The reality is that the provisions of that legislation are not appropriately adapted to the mental health context, and as such should not apply in full.

[139] Wed 7 May 2014 at p2882.
[140] See debates of Legislative Council, 11 Sept 2014 at p6074.
[141] See debates of Legislative Council, 11 Sept 2014 at p6074

> An additional consideration is that the Guardianship and Administration Act already creates an exception, in the case of attempted suicide. If it is appropriate to overrule an AHD in order to save a person who has harmed themselves, why is it not acceptable to act to prevent such harm arising in the first place?' [142]

Notably, in response the Hon Sally Talbot references another case, one which she claims had been raised with her by persons living with mental illness. It concerned the situation where a person recognises that, while experiencing a psychosis they may say something which they recognise, while well, is a product of their psychosis, not of their actual wishes. The example given is where the patient says of their mother, a primary carer 'Do not let that woman near me because she is trying to kill me', when they would actually like their mother to have a direct say in their care.[143]

While the debate on this point became complicated by that particular reference to the involvement of the mother in the treatment decision (it being correctly pointed out that treatment decisions do not involve who is involved in the care - as has been noted above) it nonetheless raises an issue around PADs which was earlier noted in the literature; that they may detail a request for treatment in circumstances where in the period of psychosis that treatment is being refused.

Ultimately the proposed amendment, which would have seen a refusal to follow an AHD automatically referred to SAT, was rejected by 19 votes to 10. A subsequent attempt to amend the bill to require the involvement of SAT was not ultimately pursued.[144]

Current Provisions

The *Mental Health Act 2014* WA (MHA) seeks to reduce the necessity for involuntary treatment orders and certain treatments. Two key legal changes were implemented with this aim in mind.

The **first** was that an involuntary patient order can only be made if the person in question lacks the capacity to consent to the treatment. Section 18 defines capacity, closely aligning this with the common law test.[145] Section 19 sets out a duty on the part of clinicians to explain the treatment in question.

18. Determining capacity to make treatment decision

A person has the capacity to make a treatment decision about the provision of treatment to a patient if another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that the person has the capacity to —

(a) understand the things that are required under section 19 to be communicated to the person about the treatment; and

(b) understand the matters involved in making the treatment decision; and

(c) understand the effect of the treatment decision; and

(d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the treatment decision; and

(e) communicate the treatment decision in some way.

[142] See debates of Legislative Council, 11 Sept 2014 at p6074
[143] See debates of Legislative Council, 11 Sept 2014 at 6075
[144] Legislative Council, 21 August 2014 at p5703.
[145] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290

19. Explanation of proposed treatment must be given

(1) Before a person is asked to make a treatment decision about the provision of treatment to a patient, the person must be provided with a clear explanation of the treatment —

(a) containing sufficient information to enable the person to make a balanced judgment about the treatment; and

(b) identifying and explaining any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effect to be predicted reliably; and

(c) warning the person of any risks inherent in the treatment.

(2) The extent of the information required under subsection (1) to be provided to a person is limited to information that a reasonable person in the person's position would be likely to consider significant to the treatment decision unless the person providing the information knows, or could reasonably have been expected to know, that the person is likely to consider other information to be significant to the treatment decision.

The second key amendment was a more restricted definition of treatment in section 4:

> … the provision of a psychiatric, medical, psychological or psychosocial intervention intended (alone or in combination) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness and does not include bodily restraint, seclusion or sterilisation

It is important to note these provisions as the operation of AHDs under the MHA is referenced in that part of the MHA which is concerned with the treatment of involuntary patients. Currently Part 13 Division 2 of the MHA deals with the treatment of involuntary patients.

Section 179(1) states that 'the patient's psychiatrist must ensure that a medical practitioner, in deciding what treatment will be provided to the patient, has regard to the patient's wishes in relation to the provision of treatment, to the extent that it is practicable to ascertain those wishes.' Of particular relevance is s179(2)(c) which states that if the decision made by the medical practitioner 'is inconsistent with a treatment decision in an advance health directive …' the patient's psychiatrist must file a record of this detailing the reasons the decision was made. Under s179(3) a copy of the reasons must be provided 'as soon as practicable' to the patient, the enduring guardian or guardian (if the patient has one, the patient's nominated person (if the patient has one), the patient's carer (if the patient has one), the patient's close family member, the Chief Psychiatrist and the Chief Mental Health Advocate. Section 180 requires the patient's psychiatrist to, prior to seeking the patient's wishes in relation to treatment, ('to the extent that it is practicable) provide the patient with the same explanation of the treatment, give the same amount of time for consideration of the matters involved in the provision of the treatment and give the same opportunities to discuss and obtain advice in relation to the provision of the treatment.

There is a form provided on the Chief Psychiatrist's website (the Notification Form)[146] for the purposes of recording the necessary information required under s179(2)(c). There is also reference to the psychiatrist's obligation to ensure the provision of a copy of the form to the various parties identified in s179(3).

[146] https://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/treatment-decision-different-to-the-advanced-health-directive/

As it stands, therefore, an AHD, if in place under the GAA, may be disregarded if the person is the subject of an involuntary patient order under the MHA. This, of course, requires that the person be found to be lacking in capacity to make the relevant treatment decision (according to the criteria in section 18). The critical question then becomes the nature of the treatment decision which the clinician seeks to make, and that which is identified in the advance health directive. It demonstrates the way that capacity assessments operate in health care – they are decision-specific. This point is clearly illustrated by one of the main common law authorities on decisional capacity, a case which involved an elderly man living with a chronic and serious mental illness.[147] An interesting question arises as to whether circumstances could arise in which a patient who does not satisfy the criteria for an involuntary patient order, may nonetheless experience a situation in which an advance health directive could apply. The statutory landscape is complicated by the basis for the trigger for the operation of the AHD under the GAA, based as it is around the inability to make 'reasonable judgements', and not explicitly tied to the common law test for decisional capacity found in the MHA. All of these complexities have implications for the scope and validity of advance health directives for those living with mental illness.

6.3 Relevant professional duties in civil law

It is important to recognise that all health professionals are bound by more general common law and legislative rules. While these do not deal specifically with the mental health profession, they do regulate treatment and treatment decisions more generally.[148]

At common law there are duties which arise in relation to the torts of trespass to the person, and negligence.

The tort of trespass to the person comprises the actions of battery (the application of force), assault (the threat to apply force) and false imprisonment (physical confinement). The onus of proof lies on the complainant to establish the requisite elements of each action on the balance of probabilities. Lack of consent is an element of each cause of action, and it is therefore relevant to consider, for example, whether the application of force occurred with the consent of the individual in question. The elements of a valid consent have already been considered above in the context of the GAA and MHA, where it was noted that the test in the MHA is closely aligned with that at common law. If the patient is regarded as unable to provide a valid consent in common law, then the relevant provisions in the GAA and the MHA in relation to persons lacking decisional capacity and involuntary patients are likely to 'kick in'. There remains a limited defence of 'emergency' in the common law; as with the GAA the premise for the legality of the treatment in these instances is whether the treatment is in the 'best interests' of the patient.[149]

The duty of care in negligence applies to all treating health care professionals. The key questions arising at common law therefore are not whether a duty is owed but whether it is breached and whether this has caused the damage in question; and whether the damage is within the scope of the duty of care. In WA (and indeed all Australian jurisdictions), civil liability legislation now covers much of the field in relation to treatment administered by health professionals, and assessments of negligence in this context. The *Civil Liability Act 2004* (WA) (CLA) Divisions 2 and 3 set out the general principles around breach of duty and causation of damage, which are largely regarded as reflecting

[147] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290

[148] S Allan and M Blake, 'Australian Health Law', (Lexis Nexis, 2018) Chapters 6 and 7 for discussion of the law in this area.

[149] *Re D* (1997) 41 BMLR 81 which concerned the question whether continuing dialysis for a man with severe mental illness was in his best interests given his physical resistance to the treatment.

the common law. As such there are considerations of the nature of the foreseeable risk in terms of its likelihood of manifesting as well as its seriousness. In relation to causation, there is a requirement both that the breach factually caused that damage (usually resolved through the application of the 'but for' test), and that the damage is within the 'scope of liability', a question often influenced by policy considerations (and therefore referred to as a normative assessment). The CLA contains a specific defence for health professionals: S5PB(1) states that…

> An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice

The law around the disclosure of risk associated with treatment is not covered by the CLA and therefore the common law remains the source of governance. *Rogers v Whittaker*[150] holds that:

> …the law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

It is therefore important to recognise that the regulation of information given in the course of health care treatment is attached to this common law rule.

7. Jurisdictional Comparisons

7.1 Australia

Victoria

Legislative framework

Victoria was the first jurisdiction in Australia to introduce legislation that provides mental health consumers with the opportunity to document their treatment preferences by way of advance statements. The legislative scheme for advance statements in Victoria is contained in ss 19-22 of the *Mental Health Act 2014* (Vic), which apply to persons who are subject to compulsory treatment.

Advance statements are not binding. An authorised psychiatrist must only have regard to the views and preferences of the person as expressed in their advance statement when making a treatment order (ss 49(2)(b), 55(2)(b)) and in determining leave of absences (s 64(3)(b)). Further, advance statements may be overridden by an authorised psychiatrist where the advance statement is not clinically appropriate or is not a treatment ordinarily provided by the designated mental health service (s 73(1)). If an authorised psychiatrist overrides an advance statement, the psychiatrist must inform the patient and include reasons for the decision, and advise the patient that they have a right to request written reasons (s 73(2)). Consequently, in effect, the *Mental Health Act 2014* (Vic) simply

[150] (1992) 175 CLR 479.

requires psychiatrists to have regard to the views and preferences of the person as expressed in their advance statement when making treatment decisions.[151]

In addition, ss 23-27 of the *Mental Health Act 2014* (Vic) provide for the appointment of nominated persons. The role of a nominated person in relation to a patient is to provide the patient with support and to help represent the interests of the patient; to receive information about the patient in accordance with the Act; to be one of the persons who must be consulted in accordance with the Act about the patient's treatment; and to assist the patient to exercise any right that the patient has under the Act (s 23). The appointment of a nominated person appears to go some way to supporting, rather than substituting, decision-making in the mental health context.

In March 2021, the Royal Commission into Victoria's Mental Health System recommended that the *Mental Health Act 2014* (Vic) be repealed, and a new *Mental Health and Wellbeing Act* be enacted.[152] The Victorian Government subsequently introduced the new *Mental Health and Wellbeing Bill 2022* to the Victorian Parliament in June 2022.[153] Notably, advance statements may still be overridden by a psychiatrist under the proposed new law.

The mental health advance planning regime operates alongside the physical health advance planning regime in the *Medical Treatment Planning and Decisions Act 2016* (Vic). Relevantly, under Pt 2, binding advance care directives in respect of medical treatment are available for voluntary patients (that is, those that are not subject to compulsory mental health orders). The directives may be overridden on application to the Victorian Civil Administrative Tribunal.[154]

The *Charter of Human Rights and Responsibilities Act 2006* (Vic) provides for human rights in Victoria.

Uptake

There has been low uptake of advance statements in Victoria. More specifically, the proportion of adult consumers who have an advance statement only rose from 2.03% in 2015-16 to 2.94% in 2019-20.[155]

As to barriers to the update of advance statements in Victoria, in a 2018 study conducted by Maylea et al, several participants expressed the view that advance statements under the *Mental Health Act 2014* (Vic) were not accepted by clinical staff. Consequently, Maylea et al concluded:[156]

> *The lack of legal enforceability is also a likely barrier to uptake, as consumers who have not completed an advance statement, or had it ignored, may not appreciate the subtler benefits of improved communication with their treating team. For those seeking to genuinely limit the power of the treating team, a document that can be easily dismissed by a decision maker may seem pointless—a further indignity and reminder of their powerlessness.*

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[151] [151] C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australasian Psychiatry, 2017, Vol 25(6), 574, 575.

[152] Royal Commission into Victoria's Mental Health System, *Final Report: Executive Summary* (February 2021) 78..

[153] Available at https://content.legislation.vic.gov.au/sites/default/files/bills/591225bi1.pdf.

[154] See V Edan, B Hamilton and L Brophy, 'Advance Planning in Mental Health Care: The Trouble with Terminology' (2021) 28(3) *Journal of Law and Medicine* 655, 659.

[155] Victorian Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019-20* (undated) 72.

[156] C Maylea et al, 'Consumers' Experiences of Mental Health Advance Statements' (2018) 7(2) *Laws* 22, [4.4].

Similarly, the Victorian Mental Illness Awareness Council's 2018 survey revealed that 83% of respondents said that the hospital did not uphold requests in their advance statements.[157] The Council surmised that this reinforced concerns by consumers that the hospital would not respect or uphold advance statements, and constituted a barrier to the uptake of advance statements in Victoria.[158] Other perceived barriers of significance included lack of information, the level of effort required, and emotional challenges.[159] The 2021 Royal Commission into Victoria's Mental Health System also revealed that advance statements were often ignored.[160] Further, in a 2021 study conducted by Maylea et al, the overwhelming experience of consumers was that their statutory rights under the *Mental Health Act 2014* (Vic) are illusory.[161]

In the context of first-episode psychosis treatment of young people, Valentine et al's study found that such young people perceived two barriers to using advance statements: first, if they changed their preferences without updating their statement they would receive unwanted treatment; and second, if they became unwell and their treating team did not fulfil their wishes, this could damage their relations with their clinician.[162] The psychiatrists perceived that barriers included clinicians' lacking the time to discuss and implement advance statements, and perceived risk to the working relationship between clinicians and clients.[163] Finally, carers identified a range of barriers to using advance statements, including a lack of knowledge about treatment options, limited experience of treatment, and limited information provided by mental health services.[164]

In their study regarding clinicians' knowledge and attitudes towards the use of advance statements in Victoria, James et al found that the level of knowledge of advance statements among mental health clinicians remains a barrier to their use.[165] James et al surmised that training for clinicians was limited in duration and content, and half of those surveyed reported that the training received did not meet expectations, leading to a reluctance to discuss advance statements with service users and increased concerns about potential barriers and negative attitudes towards the use of advance statements.[166] Maylea et al also observe a general lack of knowledge and training regarding rights under the *Mental*

[157] Victorian Mental Illness Awareness Council, *Consumer Survey Results: Advance Statements and Nominated Persons* (2018) 8.
[158] Victorian Mental Illness Awareness Council, *Consumer Survey Results: Advance Statements and Nominated Persons* (2018) 9, 12.
[159] Victorian Mental Illness Awareness Council, *Consumer Survey Results: Advance Statements and Nominated Persons* (2018) 12.
[160] Royal Commission into Victoria's Mental Health System, *Final Report: Volume 4 – The fundamentals of enduring reform* (February 2021) 402.
[161] C Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia (2021) 78 *International Journal of Law and Psychiatry* 1, 5.
[162] L Valentine et al, '"When I'm Thinking Straight, I Can Put Things in Place for When I'm Not.' – Exploring the Use of Advance Statements in First-Episode Psychosis Treatment: Young People, Clinician, and Carer Perspectives" (2021) 57 *Community Mental Health Journal* 18, 21.
[163] L Valentine et al, '"When I'm Thinking Straight, I Can Put Things in Place for When I'm Not.' – Exploring the Use of Advance Statements in First-Episode Psychosis Treatment: Young People, Clinician, and Carer Perspectives" (2021) 57 *Community Mental Health Journal* 18, 24.
[164] L Valentine et al, '"When I'm Thinking Straight, I Can Put Things in Place for When I'm Not.' – Exploring the Use of Advance Statements in First-Episode Psychosis Treatment: Young People, Clinician, and Carer Perspectives" (2021) 57 *Community Mental Health Journal* 18, 26.
[165] R James, P Maude and A Searby, 'Clinician knowledge and attitudes of mental health advance statements in Victoria, Australia' (2022) *International Journal of Mental Health Nursing* 1, 7.
[166] R James, P Maude and A Searby, 'Clinician knowledge and attitudes of mental health advance statements in Victoria, Australia' (2022) *International Journal of Mental Health Nursing* 1, 8. See also R James, P Maude and A Searby, 'Mental health clinician training and experiences with utilization of advance statements in Victoria, Australia' (2021) 31 *International Journal of Mental Health Nursing* 25.

Health Act 2014 (Vic) among mental health professionals in Victoria.[167] This has flow on effects and contributes to the persistent failures by mental health clinicians to facilitate access to advance statements.[168]

Queensland

Legislative framework

By Pt 3 of Ch 3 of the *Powers of Attorney Act 1998* (Qld), an adult person may make an advance health directive in respect of physical and medical treatment. Under the *Mental Health Act 2016* (Qld), an advanced health directive is a less restrictive form of treatment that must be utilised in preference to an involuntary order (ss 13(1), 18(2) and 48). This means that a person who would otherwise receive involuntary treatment may receive treatment as a voluntary patient, in accordance with their wishes.[169]

In addition, an authorised doctor must take reasonable steps to find out whether a person has made such a directive when assessing a person (s 43(4)). That is, there is an obligation for clinicians to establish the existence of an advanced health directive.[170]

However, the advanced health directive may not be followed where the authorised doctor decides to make a treatment authority despite the person having an advance health directive, or the nature and extent of the treatment and care decided by the authorised doctor is inconsistent with the views, wishes and preferences of the person expressed in the advance health directive (s 54(1)). The authorised doctor must explain to the person why such a decision has been made and record the reasons in the patient's records (s 54(2)).

Further, a person may appoint a nominated support person and may receive notices for the appointing person under the *Mental Health Act 2016* (Qld); receive confidential information relating to the appointing person; request a psychiatrist report under the Act; and act as the appointing person's support person in any tribunal hearing or represent the appointing person in the tribunal (s 224). It appears that at least some of these roles support, rather than substitute, decision-making in the mental health context.

As regards human rights, the *Human Rights Act 2019* (Qld) came into effect from 1 January 2020.

Uptake

There is no literature regarding uptake of advance health directives under the *Mental Health Act 2016* (Qld).

Australian Capital Territory

Legislative framework

[167] C Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia (2021) 78 *International Journal of Law and Psychiatry* 1, 5-6.
[168] C Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia (2021) 78 *International Journal of Law and Psychiatry* 1, 7.
[169] C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation' (2017) 25(6) *Australasian Psychiatry* 574, 575.
[170] C Ouliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation' (2017) 25(6) *Australasian Psychiatry* 574, 575.

The Australian Capital Territory has taken a different approach in the *Mental Health Act 2015* (ACT), allowing a person to either create an "advance agreement", which is not binding, or an "advance consent direction", which is binding and can only be overridden with the consent of the person or on application to the ACT Civil and Administrative Tribunal (ss 24-32).

A unique aspect of this framework is that there is a statutory obligation on the representative of the treating team to ensure that the person is told about advance agreements and advance consent directions, and given the opportunity to make either or both of them. Further, like the Queensland legislative framework, there is also a statutory obligation on the mental health professional to determine whether an advance agreement or advance consent direction is in force (s 28(1)).

As has been noticed, if a mental health professional believes on reasonable grounds that giving treatment, care or support to a person with impaired decision-making capacity in accordance with an advance consent direction is unsafe or inappropriate, the mental health profession may only give the person other treatment if both the person and their nominated guardian, health attorney or attorney gives consent, or the ACT Civil and Administrative Tribunal, on application by the mental health professional, makes an order to do so (s 28(5)).

The *Mental Health Act 2015* (ACT) also provides that a person with a mental disorder or mental illness who has decision-making capacity may nominated a person to be their nominated person (s 19). The nominated person's main function is to help the person by ensuring that the interests, views and wishes of the person are respected if the person requires treatment, care or support for a mental disorder or mental illness (s 20(1)). On one view, this function goes some way to supporting, rather than substituting, decision-making in the mental health context.

In relation to general health advance planning, the *Medical Treatment (Health Directions) Act 2006* (ACT) allows an adult to make a direction to in respect of medical treatment (ss 7-10).

As regards human rights, the *Human Rights Act 2004* (ACT) contains provisions that confer rights on individuals.

Uptake

There is no literature regarding uptake of advance agreements or advance consent directions under the *Mental Health Act 2015* (ACT).

General literature regarding uptake in Australia

Sellars et al posit that the ease and frequency within which advance directives might be overridden may mean that completing one becomes less attractive to patients, which in turn creates a significant barrier to the successful implementation of directives in Australian mental health services.[171]

James et al note that several studies have identified barriers of use and implementation of mental health advance planning tools, including a lack of ability to access documents, inadequate knowledge and awareness of the existence of advance statements, poor training opportunities, issues with communication, time constraints, willingness to share decision-making responsibilities with service uses, and clinician attitude towards advance planning tools.[172]

[171] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette' (2017) 24(1) *Psychiatry, Psychology and Law* 61, 62.
[172] R James, P Maude and A Searby, 'Clinician knowledge and attitudes of mental health advance statements in Victoria, Australia' (2022) *International Journal of Mental Health Nursing*.

Edan and Maylea observe that the difference in language (for example, advance directives and advance statements) and enforceability of these instruments across jurisdictions can lead to confusion both for consumers and clinicians.[173]

7.2 International jurisdictions

Belgium

Legislative framework

The literature indicates that there is an explicit legal provision which confers a right on persons to make advance statements in the mental health context. It is unclear whether such statements are binding.

Uptake

The available literature indicates that uptake of psychiatric advance directives in Belgium is low.[174]

Canada

Legislative framework

A number of provinces in Canada have enacted legislation that give legal force and effect to psychiatric advance statements.[175] For example, in Ontario, instructional directives regarding anticipatory treatment can be recorded and must be upheld.[176] Further, even in those parts of Canada where there is no legislation, the common law is clear that an advance directive is legally valid and must be followed.[177]

Uptake

There is no literature regarding general uptake of advance health directives in Canada.

India

Legislative framework

The *Mental Health Care Act 2017* provides for a right to a mental health advance directive, both to request and refuse treatment, and are binding except in emergencies (defined in s 94 to include treatment immediately necessary to prevent death or irreversible harm to the health of the person) or following successful applications to the Mental Health Review Board which must use specific criteria to judge the matter (ss 5-13). The Act also requires every board to maintain an online register of all advance health directives (s 7).

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[173] V Edan and C Maylea, 'A Model for Mental Health Advance Directives in the New Victorian *Mental Health and Wellbeing Act*' (2021) *Psychology and Law* 2.

[174] P Nicaise et al, 'Users' and Health Professionals' Values in Relation to a Psychiatric Intervention: The Case Outcomes of Psychiatric Advance Directives' (2015) 42, *Administration and Policy in Mental Health* 384, 384.

[175] The Canadian Encyclopedia, *Advance Directives* (Gerald Robertson, 16 December 2013) < https://www.thecanadianencyclopedia.ca/en/article/advance-directives>.

[176] D L Ambrosini and A G Crocker, 'Psychiatric Advance Directives and the Right to Refuse Treatment in Canada' (2007) 6 *The Canadian Journal of Psychiatry* 397, 400.

[177] The Canadian Encyclopedia, *Advance Directives* (Gerald Robertson, 16 December 2013) < https://www.thecanadianencyclopedia.ca/en/article/advance-directives>.

In contrast, physical healthcare advance planning is only available under common law.[178]

The Constitution of India provides for fundamental human rights, as well as the *Protection of Human Rights Act 1993*.

Uptake

Although there is no literature regarding uptake, Gowda et al note a number of factors that may influence uptake of advance directives in India, including the difficulties in communicating to patients and empowering them to make decisions in the daily practice of the family-oriented culture, and the often limited literacy of patient in mental health care.[179]

The Netherlands

Legislative framework

On 1 January 2020, the Dutch Law on Special Admissions to Psychiatric Hospitals (Bopz) was replaced by the Law on Compulsory Mental Health Care (Wvggz). Under the Wvggz, a person may make a self-binding directive as to the conditions under which compulsory care should be provided, the kind of care, the duration of compulsory care, the period of validity of the self-binding directive, and any contact persons (Art 4:1.2a-e). Self-binding directives are legally binding.[180]

Uptake

The completion rates for self-binding directives in the Netherlands is very low.[181] Scholten, van Melle and Widdershoven attribute part of this low uptake to well-known barriers to the completion of advance directives in mental healthcare, such as a lack of familiarity with advance directives and a lack of support, as well as the complexity of the legal arrangement for self-binding directives under the Bopz.[182]

Northern Ireland

Legislative framework

The *Mental Capacity Act (Northern Ireland) 2016*, which has been enacted but not yet brought substantially into force, provides for both mental and physical health advance planning. The Act has been described as "fundamentally a support decision making statute".[183] By way of brief overview, advance decisions to refuse treatment may be made by reference to the common law and are legally

[178] G S Owen et al, 'Advance decision-making in mental health – Suggestions for legal reform in England and Wales' (2019) 64 *International Journal of Law and Psychiatry* 162, 168.
[179] G S Gowda et al, 'Factors influencing advance directives among psychiatric inpatients in India' (2018) 56 *International Journal of Law and Psychiatry* 17, 18-20.
[180] M Scholten, L van Melle and G Widdershoven, 'Self-binding directives under the new Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a proposal for reform' (2021) 76 *International Journal of Law and Psychiatry* 101699, 2.
[181] M Scholten, L van Melle and G Widdershoven, 'Self-binding directives under the new Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a proposal for reform' (2021) 76 *International Journal of Law and Psychiatry* 101699, 2.
[182] M Scholten, L van Melle and G Widdershoven, 'Self-binding directives under the new Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a proposal for reform' (2021) 76 *International Journal of Law and Psychiatry* 101699, 2.
[183] Department of Health, 'Mental Capacity Act', *Department of Health* (Web Page) < https://www.health-ni.gov.uk/mental-capacity-act-background>.

binding (s 11). The Act also provides for the appointment of a nominated person, such as that available to be appointed as a named person in Scotland, but their views are not binding (ss 69-85).

The *Human Rights Act 1998* (UK) applies in Northern Ireland.

Uptake

There is no literature regarding uptake of advanced decisions in Northern Ireland.

New Zealand

Legislative framework

The Code of Health and Disability Services Consumers' Rights, which is a regulation under the *Health and Disability Commission Act 1994*, relevantly provides that every consumer may use an advance directive in accordance with the common law (right 7(5)). This right appears to extend to the making of advance health directives in respect of mental health.[184]

The literature reveals that the enforceability of advance health directives in New Zealand remains in question. The uncertainty arises because the *Mental Health (Compulsory Assessment and Treatment) Act 1992* relevantly provides that "[e]very patient who is subject to a compulsory treatment order shall … be required to accept such treatment for mental disorder as the responsible clinician shall direct", and there is no express exception carved out for treatment that would be contrary to the terms of an advance directive (s 59(1)). It follows that, on one view, an advance directive is not legally binding and will not override the ability of a clinician to authorise compulsory treatment.[185] However, another view is that it would not usually be lawful to provide treatment contrary to an advance directive because that would involve treating a person without their consent, unless an exceptional situation exists wherein the law provides a justification or authority for treating a person without their consent.[186] This uncertainty awaits resolution by legislative reform or consideration by New Zealand courts[187]

Uptake

[184] R James et al, 'Advance Statements within the Victorian Mental Health Setting: A Contextual and Legislative Global Comparison' (2020) 41(4) *Issues in Mental Health Nursing* 355, 361.
[185] Health and Disability Commissioner, 'Advance Directives & Enduring Powers of Attorney', *Health and Disability Commissioner* (Web Page) < https://www.hdc.org.nz/your-rights/about-the-code/advance-directives-enduring-powers-of-attorney/>.
[186] J Lenagh-Glue et al, 'Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand' (2022) *Australian & New Zealand Journal of Psychiatry* 1, 2.
[187] J Lenagh-Glue et al, 'Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand' (2022) *Australian & New Zealand Journal of Psychiatry* 1, 2.

The uptake of advance directives in the mental health context has been limited,[188] and consumers have reported that even if they had an advance directive they were disregarded by service providers.[189]

Scotland

Legislative Framework

Under the *Mental Health (Care and Treatment) (Scotland) Act 2003*, individuals have the right to make and withdraw advance statements (s 275). Advance statements are not binding, and the clinical decision-maker only needs to "have regard to the wishes specified in the advance statement". However, if a clinical decision-maker overrides the wishes specified in the advance statement, they must give reasons for that decision in writing to, among others, the patient and the Mental Health and Welfare Commission (s 276). Further, the Act sets up a process whereby advance statements are put with medical records and subsequently registered by the Commission must maintain a register of all advance statements (ss 276A-276B).

The *Mental Health (Care and Treatment) (Scotland) Act 2003* also provides for the appointment of a named person (ss 250-258). The named person represents and safeguards the interests of the patient but does not replace the patient in any way.[190] The named person thus has similar rights to the patient, such as appealing to the relevant tribunal, but the patient still retains their rights.[191] If a clinical decision-maker overrides the views of a named person, there is no duty to give reasons to the Commission as with advance statements, and there is no register of named person.

In Scotland, advanced decision-making does not exist in statute for physical health where, instead, the common law is relied upon.[192]

The *Human Rights Act 1998* (UK) applies in Scotland.

Uptake

There has been a general lack of uptake of advance statements in Scotland.[193] In July 2021, the Mental Welfare Commission for Scotland published a report which found that, of all people who had been detained under the *Mental Health (Care and Treatment) (Scotland) Act 2003* (Scot), only 6.6% had an

[188] Hon HA Little, 'Transforming our Mental Health Law', *Health Department* (Web Page, 2021) <https://consult.health.govt.nz/mental-health/transforming-mental-health-law-in-new-zealand/supporting_documents/Transforming%20our%20Mental%20Health%20Law.docx>; J Lenagh-Glue, 'A MAP to mental health: the process of creating a collaborative advance preferences instrument' (2018) 131 *New Zealand Medical Journal* 18, 19.

[189] J Lenagh-Glue, 'A MAP to mental health: the process of creating a collaborative advance preferences instrument' (2018) 131 *New Zealand Medical Journal* 18, 19. See also Katey Thom et al, 'Service user, whanau and peer support workers' perceptions of advance directives for mental health' (2019) 28 *International Journal of Mental Health Nursing* 1296, 1303.

[190] G S Owen et al, 'Advance decision-making in mental health – Suggestions for legal reform in England and Wales' (2019) 64 *International Journal of Law and Psychiatry* 162, 169.

[191] Scottish Government, 'Mental health law in Scotland: guide to named persons', *Scottish Government* (Web Page, 15 January 2019) <https://www.gov.scot/publications/mental-health-law-scotland-guide-named-persons/pages/2/>.

[192] G S Owen et al, 'Advance decision-making in mental health – Suggestions for legal reform in England and Wales' (2019) 64 *International Journal of Law and Psychiatry* 162, 168.

[193] A Gumley et al, 'Mental Health Professionals' Positions in Relation to Advance Statements: A Foucauldian Discourse Analysis' (2021) 31(13) *Qualitative Health Research* 2378.

advance statement, and this figure had remained the same for at least three years prior.[194] Further, among people who had an advance statement, 36.9% had been overridden.[195]

As to reasons for the low uptake, the Commission cited a lack of awareness and understanding of the process, confusion of what should be included, lack of belief that the advance statement will be upheld, and difficulty in contemplating being unwell again once in recovery.[196] Further, a 2021 study of mental health clinicians' knowledge of and experiences with advance statements revealed that the lack of uptake may be attributable to a lack of knowledge and experience on the part of clinicians, clinicians' attitudes towards advance statements (specifically, the tension between respecting autonomy and the responsibility to deliver appropriate treatment), and clinicians' high caseloads.[197]

Spain

Legislative Framework

In Spain, by Article 2 of Act 41/2002 of 14 November, every patient has the right to refuse treatment in writing. The management and implementation of advance directives is the responsibility of different provinces.[198]

Uptake

In 2020, only 0.6% of the Spanish population had filled out and registered advance directives. Herreros et al posit four reasons for low uptake: the lack of proper training for health care professionals in terms of the conceptual framework, existing legislation and legal implementation; lack of a public process to increase awareness about advance directives; excessively cumbersome bureaucratic documentation and implementation procedures; and the continued existence of a paternalistic medical culture, both among patients and health care professionals, which makes it difficult to reach shared decisions with patients and their relatives.[199]

7.3 Potential lessons from other jurisdictions

The above literature regarding other Australian and international jurisdictions reveals that the legislative framework, and its surrounding context, can influence the uptake of advance health directives in the mental health context. In our view, the literature canvasses three key legislative and contextual factors that may be particularly effective in increasing uptake.

First, there should be an option to make an advance health directive that is binding and legally enforceable. This is because the literature makes plain that a major barrier to uptake is the lack of enforceability of directives, and the consequent perception and reality that consumers' rights are illusory.

Second, significant efforts must be made to educate and raise awareness regarding advance health directives in the mental health context among both consumers and clinicians. In relation to clinicians,

[194] Mental Welfare Commission for Scotland, *Advance statement in Scotland: Statistical Monitoring* (July 2021) 4.
[195] Mental Welfare Commission for Scotland, *Advance statement in Scotland: Statistical Monitoring* (July 2021) 5.
[196] Mental Welfare Commission for Scotland, *Advance statement in Scotland: Statistical Monitoring* (July 2021) 20.
[197] A Gumley et al, 'Mental Health Professionals' Positions in Relation to Advance Statements: A Foucauldian Discourse Analysis' (2021) 31(13) *Qualitative Health Research* 2378, 2384-2385.
[198] B Herreros et al, 'Why have Advance Directives failed in Spain?' (2020) 113 *BMC Medicine and Ethics* 21.
[199] B Herreros et al, 'Why have Advance Directives failed in Spain?' (2020) 113 *BMC Medicine and Ethics* 21.

this may assist in alleviating the general lack of knowledge and training among mental health professionals that is canvassed in the literature, and reduce any consequent reluctance towards the use of advance statements.

Third, and relatedly, like in the Australian Capital Territory, there should be a statutory obligation on clinicians to ensure that persons are told about advance health directives and be given the opportunity to make one. This would further assist in educating and raising awareness among consumers, which could lead to greater uptake.

8. Conclusions and Reflections

8.1 Determinations of capacity in severe, episodic mental illness

The review has revealed the potential disjunct between the way that capacity is assessed at common law and the incapacity experienced during acute episodes of mental illness. Some literature suggests that there is currently too much of an emphasis on a narrow concept of self-determination in the psychiatric context.[200] Gergel and Owen argue that we need a 'broader understanding of self-determination, able to negotiate the challenges of advance decision-making'.[201]

Edan and Maylea propose a model based on the Victorian Commission's recommendations, based on considerations of non-discrimination and the alignment with other decision-making frameworks. The components of the model are:

1. Capacity-based assessment and support for capacity;
2. Inclusion of non-treatment preferences;
3. Tribunal review for overturning or non-compliance

This is a model which allows for the creation of both values directives and advance consent directives, proposing that these be termed 'mental health values directives' and 'mental health advance consent directives'. They point to the need to incorporate advance planning into a variety of decision-making obligations and integrate them into clinical decision-making obligations. They propose that the new Victorian mental health legislation should only allow the Tribunal to override an advance consent directive as a 'last resort' and that it is demonstrably the least restrictive way to achieve the purpose.[202]

As previously noted, Gergel and Owen regard the determinative justification for the utility of SBDs as not being the ethical or legal perspectives but the clinical context. They rebuke the 'competence insensitive' claim by proposing that the behaviours identified in the SDMs as triggers for its application are itself indicative of a lack of treatment decision-making capacity:

[200] P Lepping and B E Raveesh, 'Overvaluing autonomous decision-making', British Journal of Psychiatry (20140 204, 1-2

[201] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 93.

[202] V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law 1 at 8

'Unlike other advance directives, which are only invoked after a patent has already been judged to be lacking in DMC-T, SBDs would therefore have an informing role in the assessment of capacity, as well as directing any compulsory treatment once capacity is judged to be lost.'[203]

They suggest that SBDs could extend beyond treatment instructions to include non-treatment related aspects of care such as management of affairs, and involvement of family members, arguing that current assessment frameworks are too decontextualized and don't give sufficient weight to the individual's own understanding of their behaviours, values and beliefs.

However, it is also evident from the literature that an 'ethical protectionism'[204] continues to exist in relation to PADS; there persists a view that psychiatric patients, even when well, are particularly vulnerable in making decisions about their treatment, leading to doubts about their capacity to engage in the PAD process.[205] The wariness of the psychiatric profession in relation to PADs was very evident in the hypothetical vignette study carried out by Sellars et al.[206]

8.2 The most effective form of advance health planning more broadly in the psychiatric context

A significant issue which emerges from the review is the role of non-binding advance statements. These are discussed by James et al as a way of an individual being able to express preferences related to not only future treatments during periods of incapacity, but also inclusive of the treatment setting and instructions around the care of children, pets or property.[207] The very recent changes to the GAA, with the inclusion of a non-binding values and preferences statement, is indicative of the place that such statements have in advance care planning. The statement is intended to present an opportunity for people to address treatment preferences without feeling that these are 'set in stone'. While AHDs can be changed, the research indicates that this remains a concern for consumers.[208] The non-binding statement provides substitute decision-makers with guidance in making health care decisions for a person who has lost decisional capacity.

The different forms which future directions for care can take are discussed by Ouliaris and Kealy-Bateman who consider the ways in which consumers of mental health services can indicate preferences for the biological, psychological and social aspects of treatment,[209] with their clear preference being for the ACT model which at the time was the only form of binding PAD. The Cochrane Review also engaged with a range of instruments including instructional mental health ADs, proxy directives and hybrid directives in its study of the outcomes associated with the implementation of

[203] T Gergel and GS Owen, 'Fluctuating capacity and advance decision-making in Bipolar Affective Disorder – Self-binding directives and self-determination', International Journal of Law and Psychiatry 40 (2015) 92-101 at 95.
[204] Ibid at 97
[205] B M Sheetz, 'Choice to limit choice: Using psychiatric advance directives to manage the effects of mental illness and support self-responsibility', The University of Michigan Journal of Law Reform, 40, 401
[206] M Sellars et al, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', Psychiatry, Psychology and Law, Vol 24, No 1, 61-73.

[207] R James et al, 'Advance Statements within the Victorian Mental health Setting: A Contextual and Legislative Global Comparison', Issues in Mental Health Nursing, 2020, Vol 41, No 4, 355-365.
[208] A finding from the broad consultation undertaken in 2021 by the WA Department of Health End-of-Life Care Program (EOLCP).
[209] C Ouiliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australian Psychiatry, 2017, Vol 25(6) 574-577

these instruments.[210] Their qualitative analysis of the random controlled trials of these forms of advance care planning reported that there was a limited knowledge of these among service providers, and this directly affected their usefulness.

This identification of the importance of service provider and staff engagement with advance care planning more generally is clearly integral to the effectiveness of PADs. Kisely et al, in their consideration of the range of advance care planning processes available for psychiatric treatment, identify the implementation issues associated with joint care plans. They note the 'poor engagement and ambivalence of staff to the process of developing and implementing' these plans.[211]

8.3 Whether there should be a legally enforceable AHD

Currently in Western Australia the MHA references AHDs but gives the treating psychiatrist the ability to disregard the wishes and preferences expressed in an AHD. An AHD in relation to a physical condition, in circumstances where the AHD applies, must be respected as a matter of law. It has been noted that this represents a situation which appears to discriminate between persons who execute AHDs in relation to physical conditions and those who execute AHDs in connection with mental health treatment.[212] This would, on its face, present as a breach of the CRPD.

There is strong support for legally enforceable PADs in the literature. Del Villar and Ryan note that:

> 'The law of consent to treatment needs reform to strengthen the legal enforceability of SBDs for mental health treatment. Only then will their potential to promote both self-determination and recovery for people living with mental illness be fully realised.'[213]

This sentiment is reflected by many others in the literature,[214] with strong reference to the need to ensure that persons receiving treatment for mental health challenges are accorded equality under the law with those being treated for physical illnesses.

Final Comment

AHDs in the psychiatric context are complex from ethical, legal, professional and practical perspectives. This review has referenced the psychiatric profession's wariness in relation to a patient

[210] L A Campbell and S R Kisely, 'Advance treatment directives for people with severe mental illness', Cochrane Database of Systematic Reviews, 2009, Issue 1.
[211] S Kisely et al, 'Motivational aftercare planning to better care: Applying the principles of advanced directives and motivational interviewing to discharge planning for people with mental illness', International Journal of Mental health Nursing, (2017) 26, 41-48 at 42.
[212] P Weller, 'Psychiatric Advance Directives and Human Rights', Psychiatry, Psychology and Law, Vol 17, No. 2, May 2010, 218-229 at 225.
[213] K Del Villar and CJ Ryan, 'Self-binding directives for mental health treatment: when advance consent is not effective consent', MJA212(5), 2020, 208-211 at 211.
[214] Eg. C Ouiliaris and W Kealy-Bateman, 'Psychiatric advance directives in Australian mental-health legislation', Australian Psychiatry, 2017, Vol 25(6) 574-577; V Edan and C Maylea, 'A Model for Mental health Advance Directives in the New Victorian Mental Health and Well being Act', (2021) Psychiatry, Psychology and Law 1; [214] G S Owen et al, 'Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study', Psychol Med 2009, Aug 1:39(8); 1389-98.

executing an AHD and respecting that AHD, should the relevant circumstances arise. It has also identified the strong human rights-based foundation for AHDs in this space. As such, it is essential that the CRPD be the central source of reference for the development of PADs in Western Australia. In the absence of domestic human rights legislation, this provides the best practice source of law reform in this area. The authors would endorse the recommendation of Penny Weller that the 'principles and objectives that underpin the introduction of psychiatric advance directives' be given 'careful attention'.[215]

[215] P Weller, 'Psychiatric Advance Directives and Human Rights', Psychiatry, Psychology and Law, Vol 17, No. 2, May 2010, 218-229 at 219.