Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette

Marcus Sellars^{a,b}, Rachael Fullam^c, Catherine O'Leary^a, Rachel Mountjoy^a, Daveena Mawren^d, Penelope Weller^e, Richard Newton^{f,g}, Lisa Brophy^{h,i}, Troy McEwan^c and William Silvester^a

^aRespecting Patient Choices, Austin Health, Melbourne, Australia; ^bSydney Medical School, University of Sydney, Australia; ^cCentre for Forensic Behavioural Science, Swinburne University of Technology and Forensicare, Melbourne, Australia; ^dOrygen, the National Centre of Excellence in Youth Mental Health, Melbourne, Australia; ^eGraduate School of Business and Law, RMIT University, Melbourne, Australia; ^fMental Health CSU, Austin Health, Melbourne, Australia; ^gDepartment of Psychiatry, University of Melbourne, Australia; ^hCentre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Australia; ⁱMind Australia, Melbourne, Australia

This study examines whether Australian psychiatrists would support requests in a psychiatric advance directive (PAD) and the reasons underlying their decisions in response to a hypothetical vignette. An online survey was completed by 143 psychiatrists. Fewer than 3 out of 10 psychiatrists supported the patient to create a PAD which requested cessation of pharmacotherapy (27%) or remaining out of hospital and not being subject to an involuntary treatment order (24%) should their depression condition deteriorate. A thematic analysis showed that patient autonomy was the strongest theme among those who supported the patient to create a PAD, whereas the clinical profile of and risk to the patient and the professional or ethical imperative of the psychiatrist were strongest among those who were unsure about supporting the patient or who did not support the patient. These findings provide a challenge about how to fulfil obligations under the United Nations Convention on the Rights of Persons with Disabilities (2006).

Key words: advance directives; advance care planning; human rights; international precedent; law reform; mental health; psychiatry; psychiatric advance directive.

Introduction

Recent revisions to mental health legislation in a number of Australian jurisdictions have included provision for some form of advance care planning (ACP) for mental health consumers. This article investigates whether or not such procedures are well understood by Australian psychiatrists and how they might respond if faced with a client who has capacity but wishes to make an advance care plan that involves refusing treatment. ACP is the term given to a process of planning for future

healthcare whereby a person's values, beliefs and treatment preferences are made known to health professionals and family members or carers. The objective of ACP is to use a person's documented wishes to guide clinical decision-making at a future time when he or she is unable to communicate his or her decisions. Internationally, ACP is more commonly discussed in medical treatment settings; however, ACP has also been incorporated into mental health treatment settings. In mental health care, psychiatric advance

Correspondence: Marcus Sellars, Respecting Patient Choices Program, Austin Hospital, PO Box 5555, Heidelberg, Melbourne, VIC 3084, Australia. Tel.: +03 9496 5660. Email: mse15428@uni.sydney.edu.au

directives (PADs) have emerged as legal documents that set out a person's preferences for future mental health treatment and care in the event that he or she is no longer able to make decisions for him or herself, such as during a period of acute psychiatric illness (Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008; Weller, 2010). Mental health law in the United States, New Zealand, England, Wales, and Scotland, as well as in parts of Canada and Australia, have been revised to give formal recognition to PADs (Henderson et al., 2008; Jankovic, Richards, & Priebe, 2010; Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006; Weller, 2010).

Following the introduction of the United Nations (UN) Convention on the Rights of Persons with Disabilities (2006), significant international attention has been paid to improving the uptake and recognition of PADs within mental health services. PADs are recognised as an important mechanism for enabling supported decision-making and therefore fulfilling obligations under the convention (Weller, 2008, 2010). To date some of the demonstrated benefits of PADs in the literature include: improved communication of patient wishes (Swanson et al., 2003), improved therapeutic relationships between patients and service providers (Thornicroft et al., 2013) and a reduction in involuntary admissions (Henderson et al., 2004; Swanson et al., 2008). There is also evidence to suggest that having a PAD leads to care consistent with patient wishes in crisis situations (Srebnik & Russo, 2007), does not increase the frequency of death resulting from suicide (Campbell & Kisely, 2009; Henderson et al., 2004; Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002), reduces coercion and increases patient satisfaction with treatment (Jankovic et al., 2010; Nicaise, Lorient, & Dubois, 2013). A randomised controlled trial evaluating the effectiveness of PADs found that although having a PAD did not significantly alter the treatment received, having a PAD did significantly improve therapeutic relationships (Thornicroft et al., 2013).

Nevertheless, evidence regarding the impact of PADs on patient outcomes is minimal (Nicaise et al., 2013), and although the majority of patients support PADs and would want the opportunity to complete one (Backlar, McFarland, Swanson, & Mahler, 2001; Srebnik, Russo, Sage, Peto, & Zick, 2003), as well as family members and clinicians generally being supportive of PADs (Swanson et al., 2003), the majority of patients in jurisdictions with the relevant legislation do not complete one (Swanson et al., 2006). This may be due to a number of barriers, including a lack of support from mental health services and staff (Backlar et al., 2001; Swanson et al., 2003).

In addition, specific preferences in PADs can legally be overridden by the treating psychiatrist in most jurisdictions, and a number of studies suggest that this override provision would commonly be used. In one United States study, almost half (47%) of surveyed psychiatrists indicated that they would override a valid, competently-completed PAD that refused hospital admission and medication (Swanson, Van McCrary, Swartz, Van Dorn, & Elbogen, 2007). Another United States study demonstrated that psychiatrists are more likely to follow a PAD if it was completed when the patient was not experiencing symptoms consistent with psychosis, despite the fact that psychotic symptoms do not necessarily impact upon competency to create a PAD (Wilder, Elbogen, Swartz, Swanson, & Van Dorn, 2007). The ease and frequency with which PADs might be overridden may mean that completing one becomes less attractive to patients. This in turn creates a significant barrier to the successful implementation of PADs in Australian mental health services (Srebnik et al., 2003; Swanson et al., 2003, 2006).

No study to date has examined the attitudes of Australian psychiatrists towards supporting or enacting a PAD. The reasons why psychiatrists choose not to support or enact PADs in

some situations also remain poorly understood. The present study was undertaken to address this gap in the literature and examine whether or not Australian psychiatrists are likely to support a competent patient in completing a PAD that refused treatment, along with their reasons for their decisions in this scenario.

Method

Study Design and Participants

An invitation to participate in an online survey was distributed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in their Australian newsletter. The RANZCP is the peak organisation for psychiatrists and trainees. The survey was open from March to August 2012. Ethical approval for the study was obtained from the Austin Hospital Human Research Ethics Committee (approval no. H2012/04597).

The Survey Tool

The vignette and associated questions were part of a larger survey studying the attitudes, knowledge and practices of Australian mental health clinicians regarding PADs. The research invitation included a brief description of PADs and similar instruments:

Internationally, a number of legal instruments and care planning processes such as psychiatric advance directives (PADs), advance statements, advance instructions, advance agreements (including joint crisis plans) and 'Ulysses' contracts, have been used to enable individuals, whilst competent, to communicate their preferences for future mental health treatment/care. As with advance directives for medical treatment, these preferences are used in the event that individuals are no longer able to make decisions for themselves, for example during a period of acute psychiatric illness.

The vignette was developed based on a scenario used in a previous United States survey (Swanson et al., 2007), with a focus on

depression rather than psychosis, in collaboration with an expert reference group which comprised consumers, psychiatrists, psychologists, health professionals and researchers. It was designed to assess whether, in a clear-cut case, where treatment options were limited, and the patient had current capacity, clinicians would support the patient in refusing treatment in the event of a loss of capacity. At the time of the survey development there was no Australian legislation in place to support PADs or define the conditions upon which they could be overridden. The vignette focused on clinician support for the requests that the patient wished to be communicated in a PAD rather than the likelihood that clinicians would override the requests in a PAD. The clinical characteristics of the patient described in the vignette were based on the experience of a senior psychiatrist involved with the study. The vignette was designed to make it clear that the depression experienced by the patient was resistant to treatment and that the patient had the capacity to formulate a PAD at the time of the discussion. The vignette and associated questions are presented in [Figure 1](#).

Data Analysis

The data analysis was largely descriptive. The primary outcome variable was the level of support for the patient to complete a PAD containing a request to stop pharmacotherapy or a request to remain out of hospital and not to become subject to an involuntary treatment order in the event that his or her depression deteriorated. Frequencies for the level of support for a PAD are reported. In addition, Chi square analyses were completed to examine the relationship between supporting the requests in the PAD from the vignette and psychiatrists' clinical practice characteristics, as well as the overall perceived value of PADs.

Thematic analysis was used to explore and categorise open-ended responses (Braun & Clarke, 2006) about the reasons respondents chose their level of support for a PAD.

Imagine that you have a patient who has had severe unremitting depression for five years. Their depression is extremely distressing to them, and is associated with a very low quality of life. Your patient has no history of self-harm. Independent reports from a number of specialist psychiatrists indicate that the patient has had repeated trials of all available treatments including ECT, a range of psychotherapies, as well as a range of pharmacological approaches to management.

Your patient is willing to continue with her current course of pharmacotherapy. However, she would like to write a PAD specifying that if her depression deteriorates, she wants to stop all pharmacotherapy, to be allowed to remain out of hospital, and for the treating team to not enforce involuntary treatment either with crisis assessment and treatment teams or in-patient psychiatry. At the time of this discussion your patient is self-reflective, aware of her prognosis and clearly meets tests of capacity.

Would you support the patient to create a PAD containing....

- A. A request to stop pharmacotherapy in the event that her depression deteriorates?
(Yes/No/Unsure)
- B. A request to remain out of hospital and not to become subject to an involuntary treatment order in the event that her depression deteriorates? (Yes/No/Unsure)

Please give an explanation for your response:

Figure 1. Clinical vignette and associated questions.

The free-text responses were read and coded by two of the authors independently (COL & MS), who compared and discussed their individual coding choices and resolved any disagreement by discussion. Following the development of a preliminary coding scheme, it was reviewed by an additional author (RF) against the raw data, and codes were reconciled where necessary. Through a process of analysis and comparisons, categories of descriptive themes were inductively developed for the data.

Results

Demographics of Respondents

Of the 143 psychiatrists who completed the survey, 56% were male and 78% were aged 40 years or older. All Australian jurisdictions were represented apart from the Northern Territory (Table 1).

The majority of the respondents ($n = 125$) were fellows of the RANZCP, 6% ($n = 8$) were exemption candidates and 6% ($n = 8$) were trainees, while 2 respondents indicated

Table 1. Demographic profiles.

	<i>n</i> (%)
Gender:	
Male	80 (55.9)
Female	63 (44.1)
Age (years):	
< 40	32 (22.4)
40–59	89 (62.2)
≥ 60	22 (15.4)
Location of practice:	
ACT	10 (7.0)
NSW	22 (15.4)
SA	15 (10.5)
QLD	27 (18.9)
NT	0 (0.0)
WA	4 (2.8)
TAS	9 (6.3)
VIC	59 (41.3)

Note: ACT = Australian Capital Territory; NSW = New South Wales; NT = Northern Territory; QLD = Queensland; SA = South Australia; TAS = Tasmania; VIC = Victoria; WA = Western Australia.

they were medical officers. The majority (66%) had worked as a psychiatrist for 10 years or more, with most practising in community care (52%). Most respondents (62%) reported that at least one quarter of their patients had previously experienced an episode of psychosis, and 36% reported that at least one quarter of their patients were currently on an involuntary treatment order (Table 2).

Clinical Decision-making

Responses to the clinical vignette revealed that fewer than 3 out of 10 respondents clearly indicated that they would support the patient in creating a PAD that requested stopping pharmacotherapy (27%) or remaining out of hospital and not being subject to an involuntary treatment order (24%) in the event that their depression deteriorated (Table 3). In addition, 12% (*n* = 17) indicated that they would support both preferences highlighted in the clinical vignette and 32% (*n* = 46) indicated that they would oppose both preferences.

Table 2. Practice profiles.

	<i>n</i> (%)
Years working as a psychiatrist:	
≤1	6 (4.2)
2–9	42 (29.4)
10–14	22 (15.4)
15–29	53 (37.1)
≥ 30	20 (13.9)
Level of care for majority of current practice:	
Primary	33 (23.1)
Secondary	52 (36.4)
Tertiary	58 (40.6)
Setting for majority of current psychiatric practice:	
Inpatient (mental health unit)	31 (21.7)
Inpatient (forensic unit)	12 (8.4)
Community care	74 (51.8)
Medical hospital emergency department	2 (1.4)
Medical hospital department – other	11 (7.7)
Private practice	6 (4.2)
Other	8 (5.6)
Percentage of caseload who have experienced an episode of psychosis:	
< 10%	19 (13.3)
10–25%	36 (25.2)
26–50%	25 (17.5)
51–75%	41 (28.7)
76–100%	22 (15.4)
Percentage of current caseload on involuntary treatment orders:	
< 10%	63 (44.1)
10–25%	29 (20.3)
26–50%	19 (13.3)
51–75%	16 (11.2)
76–100%	16 (11.2)

A comparison between participants' decisions to support one or both of the requests in the vignette and their clinical practice characteristics revealed no significant association between clinical practice setting, patient characteristics and/or self-reported PAD knowledge and experience (Table 4).

Regarding psychiatrists' overall perception of PADs, 73% (*n* = 104) believed they were

Table 3. Psychiatrists’ decisions about supporting a PAD containing requests regarding pharmacotherapy and hospitalisation (*n* = 143).

Would you support the patient to create a PAD containing:	Yes, <i>n</i> (%)	No, <i>n</i> (%)	Unsure, <i>n</i> (%)
A request to stop pharmacotherapy in the event that her depression deteriorated?	39 (27.3)	70 (49.0)	34 (23.8)
A request to remain out of hospital and not to become subject to an involuntary treatment order in the event that her depression deteriorates?	34 (23.8)	74 (51.7)	35 (24.5)

Note: PAD = psychiatric advance directive.

Table 4. Associations between supporting the requests regarding pharmacotherapy and hospitalisation and clinical practice characteristics (*n* = 143).

		Support for one or both requests, <i>n</i> (%)	Not supportive or unsure, <i>n</i> (%)	χ^2	<i>p</i>
Setting of majority of care	Inpatient	17 (39)	39 (44)	0.39	.534
	Outpatient	27 (61)	49 (56)		
Percentage of current caseload with current or history of psychosis	< 25	18 (37)	37 (39)	0.94	.759
	> 25	31 (63)	57 (61)		
Percentage of current caseload who are involuntary	< 10	19 (39)	44 (47)	0.84	.358
	> 10	30 (61)	50 (53)		
Self-reported level of knowledge about PADs	Low	23 (45)	52 (55)	0.91	.341
	Moderate to high	26 (53)	42 (45)		
Having previously had a patient with a PAD (or similar instrument)	No	31 (63)	70 (74)	1.95	.163
	Yes	18 (37)	24 (26)		

Note: PAD = psychiatric advance directive.

useful or were sometimes useful in a crisis and 80% (*n* = 114) believed they had a positive effect on mental health care in their jurisdiction. Psychiatrists who perceived PADs as useful or sometimes useful in a psychiatric crisis were twice as likely to support either one or both of the requests in the PAD (*OR* = 2.522, 95% *CI* = 1.055 to 6.026). However, there was no association between the perceived effect of PADs on mental health care in their jurisdiction and the decision to support one or more requests on the PAD (Table 5).

Reasons for Decisions in Response to the Vignette

The majority of respondents who completed the survey provided an explanation for their

responses to the clinical vignette (73%, *n* = 104). The following themes were identified in the analysis of respondents’ explanations: autonomy of the patient, clinical profile of the patient, professional obligations and/or ethical or moral imperative, risks associated with the decision, and a palliative approach to treatment (Table 6). These are now examined in turn.

Autonomy

The strongest theme among those who indicated that they would support the patient in documenting one or both of the treatment preferences within the PAD concerned the patient’s conditional autonomy in the clinical decision-making process. As detailed in the examples below, respondents commonly

Table 5. Associations between supporting the requests regarding pharmacotherapy and hospitalisation and perceived value of PADs ($n = 143$).

		Support for one or both requests, n (%)	Not supportive or unsure, n (%)	χ^2	p
Perceived usefulness of PADs in a psychiatric crisis	No/unsure	8 (16)	31 (33)	4.50	.034
	Yes/sometimes	41 (84)	63 (67)		
Perceived effect of PADs on mental health care in their jurisdiction	Negative	6 (12)	23 (25)	2.98	.084
	Positive	43 (88)	71 (75)		

Note: PAD = psychiatric advance directive.

indicated that, although they believed that patients should have autonomy in treatment decisions (by completing a PAD), this should only occur under certain conditions (for example, provided the risk to the patient and others remained low, that the patient would accept other care, in the case that other supports were available to the patient, if plans were out in place in the event of deterioration of patient condition, if the patient did not lose capacity in the future or that the PAD could be overruled where necessary):

I would respect the patient choice and monitor the situation. I would intervene to overturn the patient's wishes when capacity had deteriorated, significant risk existed and there was support for intervention from family or carers. (ID59, male)

This patient has a chronic illness which is not responding to any treatment. It is important to check her capacity to make these decisions, and in this case the PAD would have to be very rigorously set up to ensure as much as possible that clinicians adhere to it. There appears low risk of harm to self or others, and I am of the opinion that if the

Table 6. Thematic analysis of respondents' free text explanation for choices regarding support of a PAD requesting no medication and/or to stay home when unwell.

Theme	Subtheme
Autonomy	Conditional support for the autonomy of the patient. Unconditional support for the autonomy of the patient.
Clinical profile of the patient	Depression is most likely treatable, now or in the future. Illness trajectory is unpredictable. Capacity is questionable at the time of writing the PAD or it is inappropriate to use the PAD.
Professional obligation/ imperative	To uphold legal and clinical duty of care to treat, to do no harm and/or not to prolong suffering and to act in the patient's best interest. To preserve life, avoid passive euthanasia/assisted suicide. To maintain hope for the patient.
Risk	Adverse patient outcomes, including neglect of self-care/nutritional sustenance, self-harm, suicide and death. Adverse professional outcomes, including legal ramifications.
Palliative approach	Consideration of a palliative approach to mental health treatment.

Note: PAD = psychiatric advance directive.

treatment is not working, what is the point of continuing with it? This individual has a human right to make choices, and as long as there is no harm to self or risk of harm to others I think this PAD should be respected. (ID106, female)

The PAD is supporting a statement of wishes and does not have a binding effect if the medical practitioner believes at the time that treatment is warranted and the PAD cannot be adhered to, e.g. if there is good reason to believe treatment or hospitalisation may lead to alleviation of the deterioration in the depression. (ID140, male)

Less common, however ($n = 6$), were responses enabling the patient to have unconditional autonomy in decisions about their treatment:

As a psychotherapist, this (impossible) situation begs relief from imposed authority and a psychotherapeutic treatment. (ID98, male)

Patient has good awareness of illness; there is no historical risk of serious self-harm; there is no convincing evidence that any specific medical treatment works well. Cooperating in this way with the patient builds a strong therapeutic alliance without obvious risk to her, giving opportunities to explore effective treatments. (ID62, male)

Clinical Profile of the Patient

The most common theme among those who did not support, or were unsure about supporting, the patient in completing the PAD concerned the perceived clinical outcomes for the patient. For example, many respondents ($n = 26$) did not support, or were unsure about supporting, the PAD because they believed that the patient's depression was treatable, either at the present time or if the condition should deteriorate in the future:

I have a patient in her 80s who has improved with careful and judicious medication and support. I don't really believe in 'treatment resistant' depression, [it] just means underlying personality stuff has not been addressed. This is a cop out for lack of

adequate resources to treat difficult and complex patients. (ID88, female)

Unlike [Not For Resuscitation] orders ..., some degree of psychiatric treatment is rarely completely futile. (ID77, male)

Depression *is* treatable, even though it may sometimes take years to find the right combination of treatments for a given patient. New medications and psychotherapeutic approaches may be available after the time of creating the PAD. A PAD in this case would only prolong this patient's suffering and halt the search for treatment that may be beneficial. (ID121, female)

The symptoms associated with depression were commonly listed as reasons for not supporting the validity of a PAD. For example, 20 respondents did not support the current PAD because of the difficulty predicting the prognosis of depression and 16 believed that the depression would compromise the patient's capacity to complete a PAD:

We play poor Gods. We cannot predict the future. I have seen people in that situation, asking for those things, recover remarkably, against my own and their beliefs about their state. (ID89, male)

The scenario implies that her view is that if her depression 'deteriorates' then all hope is lost and she should be left alone to stay depressed forever. This belief is of itself characteristic of depressive thinking and so I don't think she actually has true 'capacity' at any time: in that her thinking is distorted by the illness itself. (ID18, male)

I am not convinced that the patient would write the same PAD if in full remission and am not convinced about the patient's capacity or the validity of any 'tests' of capacity. (ID68, female)

Professional or Ethical Imperative

Themes relating to the respondent's perceived clinical, legal and/or moral duty of care (such as to do no harm and to act in the patient's best interest) are also most common among those who did not support the completion of a PAD:

... we have a duty to treat ... even if the patient does not want treatment; when they deteriorate we have a duty of care (and medico legally) to help and do no harm. Not treating in hospital or using medications is harmful. (ID111, female)

It is my task to continue to pursue treatment, not become victim to her transference, and agree. (ID126, female)

In addition, 16 respondents expanded on their perceived professional imperative, specifically stating that they would not support the PAD because it is equivalent to giving up hope that the depression could be treated and that they have an obligation to avoid 'passive euthanasia' and/or to preserve life for the patient.

We, the professional carers must maintain hope even if the patient cannot. (ID85, male)

This scenario depicts a highly contentious area of psychiatric practice – akin to passive euthanasia – should this end in the patient's suicide. (ID131, male)

To answer otherwise sanctions the potential death of a patient because of illness, which I think is rather contrary to our presumed purpose. (ID25, male)

Risk

Further highlighting the potential clinical outcomes of the decision, 28 respondents indicated that because of potential risk to the patient, they either did not support or were unsure about supporting the completion of the PAD:

There would be very serious risks to the patient if they deteriorated and were left untreated, including months of suffering, possible development of psychotic symptoms, the possibility of physical neglect/illness leading to death. (ID68, female)

Patient's safety is most important determinant of hospitalisation against their wishes. (ID119, female)

Another 4 respondents referred to the risks that they themselves may encounter

should the PAD be completed with their support:

Unpredictable self-harm risk puts me at risk if event occurs. (ID54, male)

Palliative Approach

Lastly, 3 respondents who were unsure about supporting the PAD raised the concept of a palliative approach to mental health treatment, highlighting that palliative care (or the relief from further suffering and/or deterioration) may be considered in the context of mental health treatment in the future:

There may still be a role for pharmacotherapy to alleviate suffering even if not treating the illness, i.e. a broadly palliative approach to care. (ID79, male)

Not clear about role of palliative care in Mental Health. (ID127, female)

Discussion

This is the first published national survey to examine whether Australian psychiatrists would support the creation of a PAD by a competent patient that documents a desire to refuse treatment, and the kinds of reasoning and principles underlying their decision. The survey shows that most respondents would not support the patient in completing a PAD containing a request to stop pharmacotherapy or to not become subject to an involuntary treatment order in the event that their severe unremitting depression deteriorated. This finding is similar to a previous survey of psychiatrists in the United States which shows that almost half would also override a valid, competently-executed PAD in response to a clinical vignette in which concerns about patient well-being were at stake (Swanson et al., 2007). In addition, contrary to past findings showing that support for PADs may differ according to clinical practice characteristics (Elbogen et al., 2006; Swanson et al., 2007; Van Dorn et al., 2006), no consistent association was found in the present study

between the psychiatrist's main practice setting, the clinical profile of the majority of his or her patients, and the decision to support or not support PAD requests.

Underlying Reasons for Supporting or Not Supporting the PAD

The psychiatrists in the present study were not only similar to psychiatrists in the United States in the variation in their intent to support or not support the development of a PAD, but also in the reasoning underlying their decision-making. For example, whereas nearly half of respondents did not support the patient in completing a PAD of this nature, the remaining group was divided between supporting the patient and being unsure about supporting the patient in relation to PADs and, when asked about the perceived value of PADs generally, the majority believed they were useful in a crisis and that they had a positive effect on mental health care in their jurisdiction. Despite this, less than 3 out of 10 psychiatrists advocated supporting the patient in completing a PAD, highlighting that their beliefs about PADs generally may be different to their actions when they are faced with complex cases. Our thematic analysis shows that the clinical profile of the patient and the professional imperative regarding the psychiatrist's duty of care are the strongest themes for not supporting the patient in completing a PAD, whereas acknowledging and maintaining a sense of the patient's autonomy is the strongest theme evident in the responses of those supporting the patient in completing a PAD.

Similar to past international surveys (Elbogen et al., 2006; Swanson et al., 2007), our results reveal that psychiatrists who either did not support or were unsure about supporting the patient in completing a PAD of this nature placed considerable weight upon the clinical profile and capacity of the patient in their decision. For example, many referred to the patient's depression as being treatable, the

unpredictable nature of depression, or the belief that the patient's capacity is questionable at the time of completing the PAD as reasons not to support a PAD. Some also used additional knowledge or approaches to case conceptualisation to inform their decisions, such as the efficacy of pharmacotherapies or the role and meaning of transference in decisions about treatment. These findings are consistent with the study by Swanson et al. (2007), wherein the factors most commonly associated with decisions to override a PAD are related to the clinical profile of the patient (e.g. history of violence and suicide) and competency when completing the PAD. Although the patient in the vignette was described as clearly meeting the test of capacity, 13 respondents questioned the patient's capacity at the time of completing the PAD. For example, 3 respondents believed that because the patient was refusing pharmacotherapy and/or hospitalisation that this was indicative of their lack of capacity, and 7 mentioned that reduced capacity is an inevitability of the illness trajectory of depression. Further, 1 respondent highlighted that the validity of available methods for measuring patient capacity is questionable. Consistent with concerns that not adhering to a PAD may act as a barrier to their perceived utility and therefore uptake among patients (Srebnik et al., 2003; Swanson et al., 2003, 2006), our findings highlight that some psychiatrists may show latent mistrust of patient capacity and therefore the instructions in the PAD, either at the time of development or when it is to be enacted. In jurisdictions where PADs can be overridden, such mistrust draws the utility of completing a PAD into serious question.

The study by Swanson et al. (2007) found a significant association between measures of legal defensiveness on the part of psychiatrists and the likelihood that they would override the patient's PAD. This was not as strongly reflected in the present study. For example, respondents appeared more

concerned with upholding their legal and clinical duty of care (such as doing no harm and acting in the patient's best interest) and maintaining hope for the patient when choosing not to support the PAD. It is also noteworthy that many respondents felt that not only would supporting the patient in completing a PAD be against their own professional duty of care, it would also pose a significant risk to the patient. For example, many respondents indicated that they would not support the patient in completing a PAD because they believed it could result in serious harm to the patient as a consequence of leaving the symptoms of depression untreated.

Consistent with a past international survey (Elbogen et al., 2006) and the theoretical underpinnings of PADs (Nicaise et al., 2013; Weller, 2010), the strongest theme for those respondents who supported the development of PADs is respect for patients' right to autonomy. As expected, none of the respondents who did not support the PAD cited patient autonomy in their reasoning. Of those who did consider patient autonomy as a determinant of the decision to support the development of the PAD, many cited specific conditions under which autonomy would be respected. Capacity again was of concern to the psychiatrists, both at the time of making the PAD and the point at which it was to be enacted. Other limitations on respect for autonomy included the level of harm posed to self or others, whether the patient was willing to accept other treatments or care in place of the treatment being refused (such as mental health service access and monitoring), demonstrated family or carer support, and that there was no hope of recovery. Further, 6 respondents reported that they would only support the patient in completing the PAD if the preferences could be overridden later if required, again calling into question the utility of such a PAD if it is not a guarantee of subsequent treatment. Only 6 of the 104 psychiatrists who responded cited unconditional

autonomy as the rationale behind their support of the PAD.

Respecting Patient Autonomy

Until now the 'selling point' to psychiatrists for supporting PADs has been the principle of autonomy (Henderson et al., 2008; Jankovic et al., 2010; Swanson et al., 2006; Weller, 2010). This study, however, similar to Swanson et al. (2007), shows that most psychiatrists place less importance on autonomy and more on clinical outcomes and ethical considerations in cases where the PAD has the potential to affect the kind of treatment that the psychiatrist is able to offer. This makes sense when the outcome that psychiatrists are measured against and measure themselves against is whether their patient 'gets better' and whether they adhere to their duty of care, not whether or not the patient's right to autonomous decision-making was observed.

Rather than focusing on the autonomy of the patient, which is of course of primary concern to consumers advocating for change, improved uptake of and support for PADs may best be achieved by focusing on how PADs can help psychiatrists meet their ethical obligations and improve patient care. The process of completing a PAD will mean spending time with their patients discussing their treatment and care preferences when they are mentally well and supporting them to document this, facilitating communication, improving patient satisfaction and accentuating the doctor/patient therapeutic alliance. Although a randomised controlled trial showed that a significant benefit of PADs is the strengthening of therapeutic relationships (Thornicroft et al., 2013), no respondents in this study identified improved communication from PADs and only one mentioned improved therapeutic relationships in the reasons for their decision about whether to support the patient in completing a PAD or not.

Although not comprehensively addressed by the respondents in this study, three psychiatrists who were unsure about whether or not to support one or both preferences within the PAD highlighted the concept of palliative care in mental health treatment as a consideration. It is suggested that this, consistent with past available literature (Holman & Brendel, 2006; Romm, Combs, & Poeschla, 2009), reflects the need for research about psychiatrists' clinical responsibility in end-of-life situations, such as when there is overlap between psychiatric and palliative care.

Limitations and Considerations

As the survey URL link was distributed through the RANZCP newsletter, it is not possible to determine whether those who completed the survey were different from those who chose not to. Despite this, the sample is mostly representative of Australian psychiatrists, where the majority are male and aged 40 or over. One limitation, however, is that the State of Victoria is overrepresented (AIHW, 2014). This may have been because PAD legislation was under review in Victoria at the time that the survey was distributed, and this should be taken into account when interpreting these results. A further possible limitation of the study is the use of a clinical vignette, as clinicians may have had a lack of clinical details and historical information that is usually available to them – but, as highlighted by Swanson et al. (2007), this may also reflect the reality of psychiatric emergencies where clinicians are required to make decisions based on limited information.

Conclusions

The results of this study suggest that the majority of Australian psychiatrists either do not support or are unsure about supporting a patient in creating a PAD that includes preferences to refuse pharmacotherapy and/or involuntary hospitalisation in the future.

However, there is international recognition that PADs may be an important mechanism for implementing supported decision-making. This study demonstrates the tension between psychiatrists' theoretical support for patient autonomy and PADs and the clinical and ethical issues to be considered if they allow a patient to refuse treatment during an episode of depression due to concern about their clinical and ethical responsibilities. These findings, therefore, provide a challenge in Australia about how to fulfil obligations under the UN Convention on the Rights of Persons with Disabilities (2006) and warrant further research and policy attention to the issues raised. A possible solution is to emphasise to psychiatrists that PADs improve communication and build the patient/doctor therapeutic alliance. It may also be of assistance to develop frameworks and decision-making processes that can help psychiatrists resolve the ethical dilemmas that arise in supporting PADs with these kinds of preferences.

Acknowledgements

The authors acknowledge the members of the Advance Care Planning for Mental Health Treatment Reference Group, who contributed to the design of the materials used in this study. The group consisted of mental health clinicians, researchers and consumers.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Funding

This work was funded by the Australian Government's Department of Health under the National Palliative Care Program.

References

- AIHW. (2014). *Medical workforce 2012. National health workforce series no. 8. Cat. no. HWL 54*. Canberra: AIHW.

- Backlar, P., McFarland, B. H., Swanson, J. W., & Mahler, J. (2001). Consumer, provider, and informal caregiver opinions on psychiatric advance directives. *Administration and Policy in Mental Health and Mental Health Services Research*, 28, 427–441.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Campbell, L. A., & Kisely, S. R. (2009). Advance treatment directives for people with severe mental illness. *Cochrane Database of Systematic Reviews*, 1, Article No.: CD005963.
- Elbogen, E. B., Swartz, M. S., Van Dorn, R., Swanson, J. W., Kim, M., & Scheyett, A. (2006). Clinical decision making and views about psychiatric advance directives. *Psychiatric Services*, 57, 350–355.
- Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. *BMJ*, 329(7458), 122–123.
- Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services*, 59, 63–71.
- Holman, J. B., & Brendel, D. H. (2006). The ethics of palliative care in psychiatry. *Journal of Clinical Ethics*, 17, 334–338.
- Jankovic, J., Richards, F., & Priebe, S. (2010). Advance statements in adult mental health. *Advances in Psychiatric Treatment*, 16, 448–455.
- Nicaise, P., Lorant, V., & Dubois, V. (2013). Psychiatric advance directives as a complex and multistage intervention: A realist systematic review. *Health & Social Care in the Community*, 21, 1–14.
- Papageorgiou, A., King, M., Janmohamed, A., Davidson, O., & Dawson, J. (2002). Advance directives for patients compulsorily admitted to hospital with serious mental illness. *The British Journal of Psychiatry*, 181, 513–519.
- Romm, S., Combs, H., & Poeschla, B. (2009). Psychiatry and palliative care: Thoughts on collaboration. *Journal of Hospice & Palliative Nursing*, 11, 79–81.
- Srebnik, D. S., & Russo, J. (2007). Consistency of psychiatric crisis care with advance directive instructions. *Psychiatric Services*, 58, 1157–1163.
- Srebnik, D. S., Russo, J., Sage, J., Peto, T., & Zick, E. (2003). Interest in psychiatric advance directives among high users of crisis services and hospitalization. *Psychiatric Services*, 54, 981–986.
- Swanson, J., Swartz, M., Ferron, J., Elbogen, E., & Van Dorn, R. (2006). Psychiatric advance directives among public mental health consumers in five US cities: Prevalence, demand, and correlates. *Journal of the American Academy of Psychiatry and the Law Online*, 34, 43–57.
- Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A., ... Gilbert, A. R. (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health*, 17, 255–267.
- Swanson, J. W., Swartz, M. S., Hannon, M. J., Elbogen, E. B., Wagner, H. R., McCauley, B. J., & Butterfield, M. I. (2003). Psychiatric advance directives: A survey of persons with schizophrenia, family members, and treatment providers. *International Journal of Forensic Mental Health*, 2, 73–86.
- Swanson, J. W., Van McCrary, S., Swartz, M. S., Van Dorn, R. A., & Elbogen, E. B. (2007). Overriding psychiatric advance directives: Factors associated with psychiatrists' decisions to preempt patients' advance refusal of hospitalization and medication. *Law and Human Behavior*, 31, 77–90.
- Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., ... Marshall, M. (2013). Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. *The Lancet*, 381, 1634–1641.
- United Nations. (2006). *Convention on the Rights of Persons with Disabilities*. Retrieved from <http://www.un.org/esa/socdev/enable/rights/convtexte.htm>
- Van Dorn, R. A., Swartz, M. S., Elbogen, E. B., Swanson, J. W., Kim, M., Ferron, J., ... Scheyett, A. M. (2006). Clinicians' attitudes regarding barriers to the implementation of psychiatric advance directives. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 449–460.
- Weller, P. (2008). Supported decision-making and the achievement of non-discrimination: The promise and paradox of the disabilities convention [Paper in: *International Trends in Mental Health Laws*. McSherry, Bernadette (ed.)]. *Law in Context (Bundoora, Vic)*, 26, 85.
- Weller, P. (2010). Psychiatric advance directives and human rights. *Psychiatry, Psychology and Law*, 17, 218–229.
- Wilder, C. M., Elbogen, E. B., Swartz, M. S., Swanson, J. W., & Van Dorn, R. A. (2007). Effect of patients' reasons for refusing treatment on implementing psychiatric advance directives. *Psychiatric Services*, 58, 1348–1350.