

# Self-binding directives in psychiatric practice: a systematic review of reasons



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

## Introduction

Over the past two decades, international interest in mental health advance decision making (ADM) has expanded because of evidence that it can increase service user autonomy,<sup>1</sup> support human rights,<sup>2</sup> strengthen the therapeutic alliance,<sup>3</sup> and reduce involuntary admissions.<sup>4,5</sup> Increasing numbers of jurisdictions have introduced statutory support for mental health ADM.<sup>6,7</sup> The UK Government has committed to introducing statutory ADM in the form of advance choice documents in England and Wales, and is currently considering issues around their implementation.<sup>8</sup>

Self-binding directives (SBDs) are a type of advance decision making that include a clause enabling mental health service users to give advance requests for involuntary psychiatric hospital admission and treatment. SBDs are the most controversial form of ADM because they involve actively overriding a person's present expressed wishes around treatment refusal. Counter to common intuition, and the primary outcome of randomised controlled trials on ADM documents,<sup>9-11</sup> the purpose of SBDs is to request admission, rather than to avoid it. SBDs must be considered by law and policy makers as there is emerging evidence that this form of ADM is supported by service users and clinicians.<sup>12-14</sup> The Netherlands already offers legislative support for SBDs,<sup>15,16</sup> and provisions for ADM in several US states include elements of self-binding, such as the use of an advance statement to consent to mental health treatment and the irrevocability of advance statements when service users have insufficient mental capacity.<sup>17-23</sup>

A body of mostly conceptual literature on SBDs has accumulated, which explores ethical issues surrounding SBDs. However, this literature has yet to be systematically reviewed to lay the foundation for empirical research and support policy makers and practitioners. Therefore, this study aims to systematically review the reasons that have been given for and against the use of SBDs in the management of individuals with severe mental illness,

and identify implications for policy, psychiatric practice, and research.

## Methods

### Search strategy and selection criteria

We did a PRISMA-concordant systematic review of reasons according to Strehl and Sofaer.<sup>24</sup>

We included an article if it discussed the care of people with any form of severe mental illness; reported on SBDs; the SBD discussed was targeted towards mental health crisis management; the focus was on ethical reasons for or against the use of SBDs in psychiatric care; and the article was peer reviewed. We excluded an article if it was not available in English, or if it was not from an academic source.

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

The search strategy used variants of the terms advance directive and mental illness, and excluded terms such as dementia and end of life care. Searches were tailored according to the capabilities of each database. Where possible, subheadings were used and combined with basic search terms to ensure all terms in the search grid were covered. Databases were searched across all available dates and all publication types. The searches were cross-checked for reproducibility among team members (AG, LS, and MS). The full electronic search for PubMed is included in the appendix (p 1).

Articles resulting from the electronic search were compiled into a central EndNote database and duplicates were removed. Titles and abstracts were independently searched for relevance by two team members (AG and

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See Online for appendix

LS), and disagreements were discussed until consensus was reached. The full text articles were screened using the same process, and disagreements were discussed with a third team member (MS).

### Data analysis

Included articles were imported into coding software (MAXQDA and NVivo) and thematic analysis (adapted from Braun and Clark,<sup>25</sup> and Strech and Sofaer<sup>24</sup>) was used to synthesise key reasons for and against the implementation of SBDs. After reading all articles, AG and MS devised an initial coding framework. AG coded a sample of 10% of included articles, and the coding for this sample was cross-checked by LS for coding consistency. All other articles were analysed by either AG, LS, or MS. Coding disagreements were discussed among members of the research team (AG, MS, LS, and TG) until consensus was reached. All reasons for or against SBDs mentioned in included full text articles were coded, independently of whether these reasons were original or endorsed by the authors of the article, to give a sense of the relative weight of concern within the academic community about each reason. An inductive approach was used to refine and expand the initial coding framework and themes (AG, LS, and MS) through an iterative process until all articles were analysed. The final themes were presented to the entire research team, and refined until consensus was achieved.

### Results

3426 articles were identified through the systematic search (figure). Four articles were identified through expert consultation and four via snowball search. Six additional articles were identified by updated searches. Of the total identified articles, 50 met the inclusion criteria. Two articles met the inclusion criteria but were not coded in the summary table of reasons, as their content focused on specific models of SBDs.

The included studies are summarised in the appendix (pp 2–13). Of the included articles, 11 (22%) are from an authorship team with a legal background,<sup>18,23,27–35</sup> seven (14%) philosophical,<sup>19,36–41</sup> 13 (26%) ethical,<sup>15,17,42–52</sup> two (4%) psychological,<sup>53,54</sup> one (2%) anthropological,<sup>55</sup> nine (18%) psychiatric,<sup>12,56–63</sup> and seven (14%) interdisciplinary.<sup>13,26,64–68</sup> The earliest article was published in 1981; seven articles were published in the 1980s, 11 in the 1990s, 14 in the 2000s, 12 in the 2010s, and seven in the 2020s. Most of the included articles were conceptual or normative, with only one containing a full clinical case study and only seven (14%) articles including empirical evidence for their conclusions.

Definitions of SBDs included at least one, but typically more, of the following elements: (a) a type of advance decision-making document, which (b) provides advance request for treatment in a future mental health crisis, (c) instructs clinicians to override treatment refusals and arrange involuntary treatment in a future mental health crisis, and (d) cannot be revoked in the situation for which it is written (appendix pp 2–13). There is considerable variation in the literature on whether SBDs are understood as including only advance requests for treatment, or also advance refusals of treatment, and whether SBDs apply only when service users do not have mental capacity, or also when they have mental capacity. The primary findings of this systematic review were synthesised, and reasons were organised into categories for and against SBDs. Six broad themes emerged for SBDs and six against (tables 1, 2).

Most articles (38 [76%] of 50; table 1) argued for SBDs because they promote service user autonomy, which could occur in several ways. These ways included investing in the person to empower them, improving their sense of self with a more holistic life narrative, allowing them to describe indicators of impaired capacity for independent decision making, and enhancing the role of others in their care. SBDs were thought to enhance autonomy by promoting the decisions made by the authentic (ie, well) self and as a tool that operationalised precedent autonomy (ie, giving priority to the capacitous past self's wishes over the incapacitous present self's wishes). One author argued that the irrevocability of SBDs was important to enhance autonomy because it protected against so-called weakness of will when unwell. Several authors argued that SBDs are such a powerful tool in promoting autonomy that opposition to their use is counter to ethical principles.

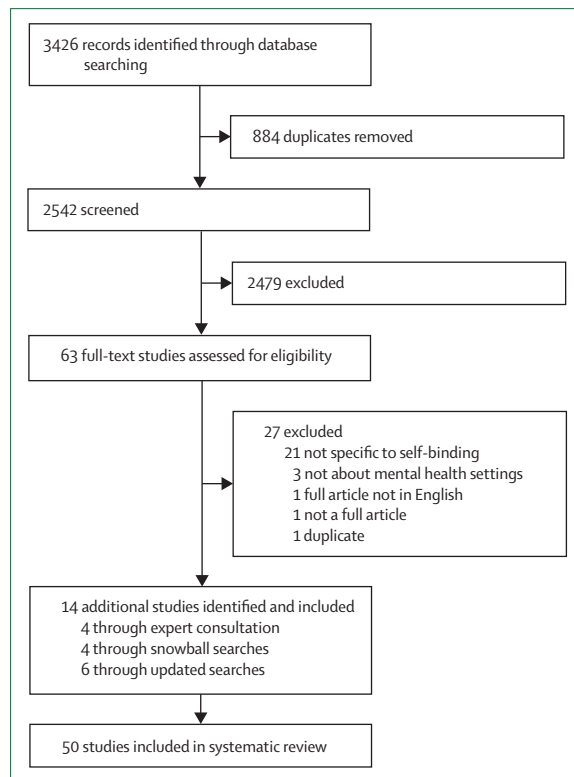


Figure: Study selection

|  | Articles that included reason (N=50)                                |
|--|---|
| <b>Broad reason 1: promoting service user autonomy, because SBDs increase the actual or perceived autonomy of service users</b>  | <b>38 (76%)</b>   |
| SBDs advance the autonomy of individuals   | 26 <sup>12,13,15,18,28-34,36-39,42,43,46-49,53,55,57</sup>          |
| SBDs promote decision making by the authentic self   | 18 <sup>27-30,35-37,39,43-45,48-50,55,56,67,68</sup>                |
| SBDs are empowering for service users  | 11 <sup>13,28,38,39,44,55-57,59,61,65</sup>                         |
| Not allowing people to use SBDs is paternalistic   | 7 <sup>27,29,30,45,55,59,68</sup>                                   |
| SBDs support precedent autonomy  | 5 <sup>12,28,30,43,65</sup>   |
| SBDs facilitate self-defined indicators for loss of capacity   | 3 <sup>44,64,65</sup>   |
| SBDs can support continuity in personal identity by creating a narrative   | 2 <sup>43,44</sup>  |
| SBDs protect against so-called weakness of will  | 2 <sup>19,38</sup>  |
| SBDs facilitate relational autonomy  | 2 <sup>44,57</sup>  |
| <b>Broad reason 2: promoting wellbeing and reducing harm, because drafting and applying SBDs can reduce harm from illness and unhelpful treatments</b>   | <b>24 (48%)</b>   |
| Involuntary treatment based on an SBD helps to avoid harms to service users  | 20 <sup>13,18,19,27,29,30,33,34,36,38,42-44,49,56,57,59,64,65</sup> |
| SBDs enable early intervention in mental health crises   | 12 <sup>15,18,30-34,37,49,59,64,65</sup>                            |
| Drafting an SBD can have a positive therapeutic effect   | 5 <sup>15,30,33,44,64</sup>   |
| Rapid treatment based on an SBD can reduce episode severity  | 4 <sup>43,56,57,65</sup>  |
| SBD instructions can improve the quality of care   | 3 <sup>13,30,64</sup>   |
| SBDs can reduce the cost of illness to society   | 1 <sup>18</sup>   |
| <b>Broad reason 3: improving relationships, because drafting and applying SBDs could improve the quality of relationships between service users and health professionals or other informal supporters (eg, family members and friends)</b> | <b>15 (30%)</b>   |
| SBDs improve therapeutic alliances between service users and professionals   | 12 <sup>12,15,26,28,29,42,56-58,61,64,65</sup>                      |
| SBDs improve relationships between service users and family members and friends  | 5 <sup>15,42,56,61,64</sup>   |
| SBDs improve communication between service users and professionals   | 3 <sup>44,45,60</sup>   |
| <b>Broad reason 4: justifying coercion, because SBDs can render involuntary treatment ethically justifiable due to earlier consent</b>   | <b>14 (28%)</b>   |
| Involuntary treatment based on an SBD is a form of self-paternalism  | 8 <sup>19,29,39,49,50,56,60,68</sup>                                |
| Using SBDs can make involuntary treatment more ethically acceptable  | 4 <sup>39,42,51,57</sup>  |
| Involuntary treatment based on an SBD is a form of soft or weak paternalism  | 3 <sup>19,38,49</sup>   |
| Involuntary treatment based on an SBD is justified because of the person's previous competent request  | 3 <sup>42,46,49</sup>   |
| Involuntary treatment based on an SBD is justified because of distorted thinking when unwell   | 1 <sup>13</sup>   |
| <b>Broad reason 5: stakeholder support, because the people most likely to be involved in and affected by drafting and applying SBDs are keen to do so</b>  | <b>6 (12%)</b>  |
| Service users support SBDs   | 3 <sup>12,13,64</sup>   |
| SBDs use service user expertise  | 3 <sup>36,64,68</sup>   |
| Psychiatrists support SBDs   | 1 <sup>29</sup>   |
| <b>Broad reason 6: reducing coercion, because the use of SBDs can reduce the overall amount of coercion or perceived coercion</b>  | <b>5 (10%)</b>  |
| SBDs can reduce formal coercion  | 3 <sup>31,42,65</sup>   |
| SBDs can reduce perceived coercion   | 2 <sup>52,65</sup>  |
| SBDs can reduce the duration of involuntary treatment  | 1 <sup>15</sup>   |

Data are n (%) or n<sup>reference</sup>. SBD=self-binding directive.

**Table 1: Reasons for the use of SBDs**

The second most common reason in favour of SBDs (24 [48%] of 50 articles; table 1) was that they can promote service users' wellbeing and reduce harms. Personal wellbeing could be enhanced through the therapeutic drafting process and improved, personalised crisis care. Societal benefit could derive from reducing the length, and therefore cost, of admission. SBDs could reduce harms, including self-defined harms, through initiation of early involuntary treatment, preventing episode escalation and containing risky behaviours.

There were 15 references to improving relationships by use of SBDs (table 1). The relationships were between

service users, health professionals, and family members in a three-way relationship, and the improvement occurred by strengthening therapeutic alliance and improving communication during drafting and crisis.

14 articles discussed whether SBDs could justify coercion (table 1); or at least make psychiatric involuntary treatment less ethically problematic. These arguments rested on SBDs as a tool to avoid specific forms of paternalism. Eight articles discussed SBDs as a tool that enables self-paternalism, arguing that self-paternalism is ethically acceptable because the paternalistic intervention is guided by the person themselves. Three

|   | Articles that included reason (N=50)                                |
|---|---|
| Broad reason 1: diminishing autonomy, because even SBDs designed to enhance service user autonomy might actually undermine it and increase coercion   | 26 (52%)  |
| SBDs are paternalistic tools  | 17 <sup>15,19,23,27-29,31,33,34,36-38,40,43,57-59</sup>             |
| SBDs might be used to exert undue influence on service users to accept treatment or admission   | 13 <sup>13,15,27,29,36,50-52,57,59,60,65,68</sup>                   |
| SBDs do not provide valid consent   | 3 <sup>15,31,51</sup>   |
| SBDs should include the option of treatment refusals as well as treatment requests  | 3 <sup>45,57,67</sup>   |
| Predictions about the escalation of risk during a mental health crisis cannot be made accurately, which might result in people being admitted unnecessarily   | 2 <sup>33,34</sup>  |
| Physically enforcing SBDs implies an escalation of coercive measures because the power of the state must be evoked  | 2 <sup>33,34</sup>  |
| SBDs give psychiatrists increased power to instigate involuntary treatment  | 1 <sup>29</sup>   |
| Broad reason 2: unmanageable implementation problems, because SBDs are too complex to implement successfully  | 21 (42%)  |
| General problems  |   |
| Resources to support drafting, accessing, and applying SBDs are limited   | 6 <sup>29,36,57,58,62,64</sup>                                      |
| SBDs need safeguards to prevent mistakes and abuse  | 5 <sup>31,34,43,46,68</sup>   |
| Risk of professional liability if serious adverse events occur due to following or not following the SBD  | 2 <sup>50,64</sup>  |
| Lack of empirical evidence for the effectiveness of SBDs  | 2 <sup>60,62</sup>  |
| Problems with drafting SBDs   |   |
| Others might exert undue influence on service users during the drafting process   | 10 <sup>13,15,29,33,34,43,57,60,64,65</sup>                         |
| Drafting SBDs takes time and effort and can be distressing  | 7 <sup>13,15,42,57,60,64,68</sup>                                   |
| Low awareness of SBDs among service users, family, friends, and professionals   | 2 <sup>56,68</sup>  |
| Problems with accessing SBDs  |   |
| Difficulties faced by clinicians in accessing SBDs during a crisis  | 4 <sup>13,62,64,68</sup>  |
| Problems with applying SBDs   |   |
| Overly complex legal regulations make SBDs unfeasible to apply  | 4 <sup>15,43,56,58</sup>  |
| There is a risk of failure to foresee all contingencies of a future mental health crisis  | 4 <sup>13,51,58,62</sup>  |
| SBDs might limit clinical judgement   | 4 <sup>13,34,53,64</sup>  |
| Service users with an SBD would be unable to communicate a change of mind   | 1 <sup>51</sup>   |
| SBDs might become out of date   | 1 <sup>13</sup>   |
| Familiar staff might not be available during a mental health crisis   | 1 <sup>57</sup>   |
| Poor communication between services   | 1 <sup>57</sup>   |
| Broad reason 3: problems with assessing mental capacity when drafting or applying an SBD  | 18 (36%)  |
| It is difficult to assess mental capacity to make decisions about treatment when drafting an SBD and deciding to apply an SBD in crisis   | 18 <sup>13,17,18,33,35,36,40,43,45,52,54,56,57,59,60,62,63,65</sup> |
| It is possible to retain mental capacity during mental health crises  | 1 <sup>13</sup>   |
| Broad reason 4: challenging personal identity, because identifying the person's most authentic preferences is complex and using these preferences to override treatment refusals during a mental health crisis is hard to justify | 18 (36%)  |
| Problematic to assume priority of wishes of past over present self  | 15 <sup>17,28,31,33,38,40,41,43,45,48,50-52,58,60</sup>             |
| Unclear what constitutes the individual's authentic self  | 3 <sup>48,51,55</sup>   |
| Broad reason 5: legislative problems, because making legal provisions for SBDs is complex and the provisions might conflict with other laws or legal principles within the jurisdiction   | 17 (34%)  |
| Legislating for SBDs is complex   | 14 <sup>13,19,28,29,32,38,43,50,51,55,58,60,62,66</sup>             |
| Legislation for SBDs might conflict with other laws or legal principles   | 3 <sup>18,33,46</sup>   |
| Broad reason 6: causing harm, because applying SBDs might cause harm to the service user  | 3 (6%)  |
| Involuntary admission and treatment based on an SBD removes the benefits of mania   | 1 <sup>13</sup>   |
| Disappointment to service users if SBDs not accessed or followed in crisis  | 1 <sup>64</sup>   |
| Stigma of having an SBD   | 1 <sup>59</sup>   |

Data are n (%) or n<sup>reference</sup>. SBD=self-binding directive.

**Table 2: Reasons against the use of SBDs**

articles argued that applying SBDs involves morally permissible soft paternalism (ie, overriding non-capacitous choices in the person's best interests) rather than morally impermissible hard paternalism (ie,

overriding capacious choices in the person's best interests). Three articles<sup>42,46,49</sup> drew on arguments around precedent autonomy to conclude that SBDs justify the use of coercion.

Six articles (table 1) referenced stakeholder support for SBDs as a reason to use them, and the empirical literature that surveyed stakeholders confirmed service user endorsement of SBDs.

Five articles (table 1) stated that SBDs should be used because they can reduce coercion on three fronts. First, by use of early intervention to prevent formal coercion; second, by reducing the intensity of perceived coercion through greater service user involvement in care; and third, through early, personalised treatment reducing the length of involuntary admissions.

The most commonly cited concern (26 [52%] of 50 articles; table 2) was that although SBDs might be intended as a tool to increase service user autonomy, they would ultimately diminish autonomy. Referring to Mill's slavery exception<sup>69</sup> (ie, slavery contracts are void), authors argued that SBDs are void and non-enforceable because service users would forfeit the very liberty that underlies the validity of the document. Service users might also be vulnerable to receiving unnecessary involuntary treatment when in crisis due to poor judgement about applying their SBD, or they might commit to treatment on the basis of their experience of internalised stigma.

Other autonomy-related concerns revolved around reliance on expired consent to apply SBDs, the need to allow for treatment refusals as well as requests, reliance on hypothesised rather than actual risks that might be inaccurately predicted, the increased likelihood of rapid escalation if physical coercion is needed to enforce an SBD, and the increased power SBDs offer psychiatrists to detain people earlier than in the absence of an SBD.

The second most prominent concern was unmanageable implementation problems (21 [42%] of 50 articles; table 2). Overarching issues were the limited availability of resources to implement SBDs in a way that minimises harms, the risk of clinical liability if there are adverse events, and the absence of justification for implementation given insufficient empirical evidence for effectiveness.

Other implementation concerns can be divided into three categories: difficulties with drafting, accessing, and applying SBDs. Concerns about drafting SBDs included challenges around raising service user awareness, the risk of undue influence from health professionals and family members, and unmanageable distress during drafting. If SBDs are drafted, there is the challenge of providing infrastructure to ensure accessibility in a crisis. Concerns around applying SBDs included lessons from the experience in the Netherlands<sup>15,43</sup>—eg that complex procedures and long timeframes for obtaining legal authorisation for applying an SBD make them redundant in a crisis. Clinician-centric application concerns were around the difficulties of correctly predicting and planning for future mental health crises, and that the document could limit the reach of their clinical judgement. User-centric concerns were that the person might be unable to communicate a

legitimate change of mind during a crisis, the document would expire, trusted staff might not be available when needed during a crisis, and there could be poor communication between services.

18 (36%) of 50 articles (table 2) discussed issues with assessing mental capacity during drafting and applying an SBD. Critics argued the construct of mental capacity is problematic and its assessment is unreliable. Accordingly, SBDs might be made by a service user when they do not have the capacity to write an SBD and hence fail to reflect their authentic wishes. In addition, there is the concern that if mental capacity is wrongly judged at the time of SBD application, the service user could be wrongfully detained when they have mental capacity. A survey<sup>13</sup> of service users found most respondents recognised the concept of mental capacity, but held differing views of the effect of mental illness on thinking. The majority of respondents (463 [82%] of 565) endorsed SBDs and of this group the majority (411 [89%] of 463) gave the reason of distorted thinking when unwell as justification for their endorsement. A minority (38 [7%] of 565) believed they retained capacity when unwell, and most of this group (26 [68%] of 38) did not endorse SBDs. The remaining participants did not report on the theme of thinking when unwell, or were ambivalent, and were therefore not counted in this.

Another 18 (36%) of 50 articles (table 2) discussed concerns around SBDs challenging personal identity, as they rely on problematic conceptual assumptions about continuity of personal identity. There were 15 references to the challenge of identifying one self as having authority over another self. These arguments draw on the philosophical tradition of questioning the possibility of a personal identity persisting over time, when there is limited psychological continuity between the past and present self. Three references<sup>48,51,55</sup> drew attention to the difficulty in determining whether past or present wishes represent the person's most authentic preferences.

17 (34%) of 50 articles (table 2) raised concerns that legislative issues related to SBDs would be too complex. These concerns are largely supported by authors writing about the situation in the USA and the Netherlands; jurisdictions that have the most experience with drafting ADM legislation, including elements of self-binding. The major concern is about the complexity of the legislation that would be required to implement SBDs while retaining the right balance of personal autonomy versus coercion. In the USA, other key concerns are the risk of liability for those involved in supporting the service user to draft and use an SBD. Three references<sup>18,33,46</sup> raised the issue that legislation for SBDs could conflict with constitutional principles.

Three articles (table 2) expressed concerns about SBDs causing harm, including the inherent stigma of having an SBD. One type of harm mentioned by service users was that implementing an SBD might prevent someone from experiencing the benefits of mania. Stakeholders



questioned in a focus group study raised concerns about the risk that if a document is not taken seriously in a crisis, the service user is more likely to disengage with services in the future.

### Discussion

This systematic review is, to our knowledge, the first to discuss reasons for and against SBDs. It has identified a developing international and interdisciplinary evidence base that is largely conceptual. Over the past 5 years, however, some important empirical work has been completed, which includes service user and other stakeholder perspectives.<sup>1,12,13,64,70</sup> The results indicate that the most commonly cited ethical reason in favour of SBDs is the promotion of service user autonomy, and the most common objection is the converse—that SBDs will diminish service user autonomy. Other reasons for SBDs, in order of prominence in the literature, are promoting wellbeing and reducing harm, improving relationships, justifying coercion, stakeholder support, and reducing coercion. Other concerns are unmanageable implementation problems, difficulties with assessing mental capacity, challenging personal identity, legislative issues, and causing harm.

We found considerable variation in the definition of SBDs (appendix pp 2–13). Many definitions do not specify whether the treatment requests in the SBD override only non-capacitous treatment refusals (capacity-sensitive SBDs), or also capacitous refusals (capacity-insensitive SBDs).<sup>27</sup> The type of SBD that included articles refer to is not always clear, even if the overview of SBD definitions (appendix pp 2–13) provides some clarity. This ambiguity should be considered when interpreting the findings, because some reasons for SBDs appear to apply only to capacity-sensitive SBDs (eg, facilitating self-defined indicators of loss of capacity, and SBDs as soft-paternalistic instruments), whereas some reasons against SBDs appear to apply only to capacity-insensitive SBDs (eg, concerns relying on Mill's slavery exception, including concerns about paternalism and the priority of past over present wishes). Implementing capacity-sensitive SBDs within a broader capacity framework<sup>7,65</sup> can thus address, or at least mitigate, some of the fundamental concerns about SBDs.

A finding that requires explanation is that promoting service user autonomy is the reason most frequently given for the use of SBDs, and diminishing service user autonomy is the reason most frequently given against their use; however, these findings need not be contradictory. One possible explanation is that multiple concepts of autonomy are presupposed in the debate about SBDs. According to one prominent conception, autonomy involves acting according to one's own highest-order desires,<sup>71</sup> evaluative judgments,<sup>72</sup> or long-term plans.<sup>73</sup> According to a more everyday conception, autonomy involves what philosophers after Isaiah Berlin call negative liberty;<sup>74</sup> namely, having the ability to do

what one wants at a given point of time. If a person's current treatment refusal is overridden on the basis of their SBD, their autonomy is diminished in terms of consistency with their negative liberty, while it is also promoted in terms of their highest-order desires, evaluative judgements, and long-term plans.<sup>7</sup> Therefore, a crucial question for those considering drafting an SBD is which type of autonomy they find more important.

Although most of the included articles used exclusively conceptual methods, some articles included empirical data on stakeholders' attitudes towards SBDs.<sup>12,13,28,42,56,57,64</sup> These articles focused less on fundamental concerns about SBDs (eg, concerns about personal identity and paternalism) and more on personal benefits and practical challenges. Although the empirical data on stakeholders' attitudes to SBDs are insufficient for firm conclusions to be drawn, reasons against SBDs might be raised less often by stakeholders who are familiar with severe mental illness. Articles written in the Netherlands, a jurisdiction where SBDs were legally binding at the time of publication,<sup>15,43</sup> focused more on policy and implementation issues; in particular, on validity criteria for SBDs and the process for obtaining legal authorisation of involuntary treatment based on an SBD.

The implementation of general mental health ADM documents is notoriously difficult. Surveys in several jurisdictions have identified high endorsement, but low uptake,<sup>12,75</sup> and barriers to implementation have been identified at systemic, health professional, and service user levels.<sup>76</sup> Given the controversial nature of SBDs, it is unsurprising that implementation has been identified as a significant hurdle. Future research should involve piloting and evaluating SBDs with service users and health professionals, and include capturing stakeholder attitudes. The findings from this systematic review identify the challenges that researchers and policy makers seeking to implement SBDs might face.

To address concerns that SBDs diminish autonomy, several safeguards could be applied in the design and creation of the SBD document. First, as stated earlier, a capacity-sensitive model can allay concerns about paternalism and the priority of past over present wishes. Capacity assessment should, therefore, be done when drafting the SBD and when it is applied.<sup>29,30,44,66</sup> Second, a structured SBD template can be created, which allows for treatment requests as well as refusals,<sup>45,47,67</sup> and includes prompts for relevant SBD content (eg, conditions for involuntary treatment, preferred treatments, maximum duration of involuntary treatments, and approved people to contact in a crisis). Third, to address concerns about the validity of consent, service users who want to draft an SBD must be informed of the risks and benefits of the treatment alternatives, the possibility that their wishes expressed in crises might be overridden, and the practical risks associated with SBDs.

Several articles included in this systematic review highlighted the importance of involving a third party in

the drafting process.<sup>29,44,58,68</sup> Empirical evidence from the wider literature on mental health ADM evidence suggests that involving a third party facilitator in the process of making documents is essential to uptake and implementation.<sup>11,77,78</sup> Accessibility problems are less well considered in the literature. Digital formats can facilitate production and access, and digital precedents exist in physical health ADMs (eg, Coordinate My Care and Urgent Care Plan), which have increased uptake and accessibility of ADMs.

The use of a clinical tool can facilitate capacity assessment in the context of ADM and yield highly reliable judgements of mental capacity.<sup>7,79</sup> Two of us (TG and GO) have proposed a personalised mental capacity assessment in which service users document indicators of capacity loss in their SBD.<sup>65</sup> SBD templates could incorporate prompts that encourage service users to provide this kind of information.

Ongoing research on general mental health ADM has pointed to the importance to service users of including information about their personal identity in their documents.<sup>80,81</sup> Including a biographical section in SBDs to provide context for the interpretation of the document's content could help to address concerns about personal identity.

The biggest learning opportunity for legislators seeking to implement SBDs is from the Netherlands. The Dutch legislation provides detailed criteria for the validity, content, and application of SBDs,<sup>15,16</sup> and has shown that involuntary hospital admission or treatment based on an SBD should be subject to a form of independent review that does not impede intervention according to the SBD.<sup>15,43,82</sup>

Although low endorsement by clinicians has been identified as a key barrier to successful use of ADM documents,<sup>9,83</sup> risk of disappointment on the part of the service users if their SBD is not accessed or followed in a crisis is significant.<sup>70,82</sup> Awareness raising and training among health-care professionals is needed, as well as the development and evaluation of clinical implementation strategies.

Synthesising this body of academic literature had limitations due to the breadth of disciplines, jurisdictions, and methodologies presented. Only English language publications were reviewed. A reading of the literature in Dutch by a native speaker (MS) revealed that the articles published in Dutch do not add substantially to the findings. The generalisability of findings is limited by the fact that most included articles are written by authors who work in high-resource settings.

This systematic review of reasons for and against SBDs identified the opportunity to increase service users' autonomy as the key reason for using SBDs. The major concern is the removal of the right to negative liberty, and the deciding factor could be how SBDs are implemented. To test implementation, we recommend pilots of capacity-sensitive SBDs that apply the described safeguards

around information, capacity assessment, support for drafting, and independent review when the SBD is in use.

#### Contributors

LS and AG searched the literature, extracted and analysed the data, and drafted the manuscript. TG and GO were consulted for expert advice on literature searches and reviewed the manuscript. JG was consulted for advice and reviewed the manuscript. MS was consulted for expert advice on literature searches, extracted and analysed data, contributed to manuscript drafts, and reviewed the manuscript.

#### Declaration of interests

GO is special advisor to the Royal College of Psychiatrists UK on mental health and capacity law (England and Wales). All other authors declare no competing interests.

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