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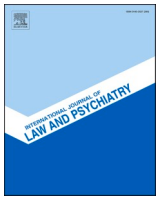

Research paper

An International Comparison of Psychiatric Advance Directive Policy: Across eleven jurisdictions and alongside advance directive policy

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ABSTRACT

The present work provides a comparative policy review of psychiatric advance directives, considering 1) variation across eleven international jurisdictions and 2) differentiation from other advance directive policy. The aim is to support well-founded legal and clinical practice when it comes to psychiatric advance directives by 1) clarifying the range of present approaches and 2) highlighting differential treatment of those with mental health conditions. Applicable statutes in England and Wales; Germany; India; the Netherlands; New South Wales (Australia), Northern Ireland, Virginia (USA); Washington (USA); Switzerland; Scotland; and Victoria (Australia) were reviewed by a team with expertise in law, clinical practice, and ethics. Policy variations were identified related to requirements for validity, activation, amendment, revocation, and override of preferences expressed. Psychiatric advance directives tend to be more strictly regulated and have less legal force than medical advance directives, with more restrictive guidelines and more conditions allowing advance preferences to be overridden. Psychiatric advance directives also tend to be less uniform across jurisdictions, sometimes reflecting varied functions of the directive and sometimes suggesting varied framing of the appropriateness of coercion in psychiatric care. More work is needed to evaluate the validity of distinct psychiatric advance directive policy. Stricter regulation and weaker legal force can serve as barriers to use, and coercion carries associated harms; psychiatric advance directive policy, especially choices that differ from other advance directive policy, should be well-justified.

1. Introduction

Advance directives are documents through which users leave written instructions outlining clinical care preferences in the event that they become incapable of consenting to, refusing, or requesting services for themselves (Gloeckler et al., 2022). Advance directives (henceforth referred to as AD) initially emerged as protection against unwanted life-sustaining interventions (Sabatino, 2010). Psychiatric advance directives (henceforth referred to as PAD) initially emerged as a way to mitigate unwanted, coercive psychiatric interventions (O'Connell, 2015; Szasz, 1982). Advance decision-making is now used more widely in both arenas to help guide treatment, and preferences expressed can often range from a description of goals and values to the establishment of specific consent or refusal regarding identified interventions. While AD and PAD are increasingly situated in broader advance care planning efforts, these formal documents have a key role as they give legal force to the preferences captured.

International human rights law upholds the value of advance decision-making, especially for vulnerable populations. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), which entered into force in 2008, promotes the equal enjoyment of human rights for people with disabilities and establishes in Art. 12(3) that parties should take appropriate measures to provide access for people with disabilities to the support they may require in exercising

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legal capacity (United Nations Convention on the Rights of Persons with Dis). Advance decision-making provides an example of such a measure, maximizing the ability of the person to secure respect for their rights, will, and preferences at a time when they are unable to make a legally determinative decision.[1]

With the CRPD as a framework, consideration is presently being given in many jurisdictions to PAD as well as the relationship between PAD and AD. The common underlying principle of respect for autonomy underpins legal and clinical justification for the use of both AD and PAD. Despite common normative underpinnings, there are legal and clinical distinctions made between AD and PAD in most jurisdictions: many jurisdictions do not have legal provisions for PAD, PAD are less widely used than AD, and the former tend to face distinct legal and clinical barriers (Braun et al., 2023; Scholten et al., 2019; Scholten et al., 2023b; Stephenson et al., 2020).

When considering the differences between PAD and AD, it is worth noting that unique decision-making challenges in mental health care have been recognized (Shields et al., 2014; Verwijmeren & Grootens, 2024). Given the nature of decision-making in the context of mental health care, PAD may be more likely than AD to come up against specific conflicts, including:

1. Conflicts between the person's preferences outlined in the document and the person's stated preferences in a mental health crisis (Brenna et al., 2023; Gergel et al., 2021)
2. Conflicts between the person's outlined preferences and clinical best judgment that the clinician feels ethically obliged to uphold, especially in the case of risk of harm to self and a precedent of paternalism in this regard (Braun et al., 2023; Hotzy et al., 2020; Quinlivan et al., 2019; Steinert & Henking, 2022; Swanson et al., 2006)
3. Conflicts between the person's outlined preferences and the legally protected interests of others in the case of risk of harm to others (Appelbaum, 2006; Gallagher, 1998; Miller, 1998; Swartz et al., 2004)

Notably, though, those creating PAD may be well-prepared to anticipate the above conflicts and consider future preferences in an informed way given their direct encounters with the mental health system and experiences with their own condition(s). PAD are especially well-suited for mental health conditions that are episodic and defined by fluctuating capacity (Gergel & Owen, 2015; Stephenson et al., 2020; Potthoff et al., 2022). As such, PAD users have often already experienced one or more acute episodes of their disorder in the past and have previously navigated relevant treatment decisions (Trachsel & Biller-Andorno, 2016). They are, therefore, especially well-positioned to predict their preferred care and anticipate future situations to inform advance statements. Conflict in the case of PAD may be well-considered. PAD users may be using these documents to give credible voice to well-informed preferences, particularly preferences that they anticipate may be challenged by clinicians or by themselves as their mental status changes.

[1] In saying this, we recognize that the UNCRPD, while advocating mechanisms such as MAD and PAD in General Comment 1 to Art. 12, at the same time denies the validity of the concept of mental capacity/competence, which is, traditionally, the dividing line between situations where the person's current decision is taken as determinative and one where reliance has to be placed on the MAD/PAD (UNCRPD, 2014). This interpretation of Art. 12 is contested (see Ruck Keene et al., 2023). For present purposes, we proceed on the basis of plain language of the CRPD. When viewed in that light, we suggest that providing for advance care planning serves as a vehicle for supporting the exercise of legal capacity within a framework that, at a treaty level, requires respect for the rights, will, and preferences of the person, and does not, itself, deny the validity of the concept of mental capacity.

For example, a person with bipolar disorder may know that, despite the slower onset of action and need for closer laboratory monitoring, lithium has worked well in the past to treat mania, whereas atypical antipsychotics have led to intolerable side effects. The person may also have experienced that, when in a manic state, clinicians have discounted this medication preference and applied strong pressure to take an atypical antipsychotic. The person may request that lithium be initiated in an outpatient setting at the earliest signs of mania. The person may recognize that he tends to refuse any medication when manic, lithium or otherwise, but that having his own words used to reason with him through the support of a specific loved one increases the likelihood that he voluntarily opts to take needed medication. Knowing that involuntary hospitalization has been necessary in the past for untreated manic episodes, he may desire involuntary hospitalization before he reaches the stage of being a harm to himself or others if he is refusing lithium and exhibiting clear signs of mania. He may want to consent to such hospitalization in advance, anticipating that he will likely object when in a state of mania. Conflict between the person's directive instructions and 1) his own stated preference in a manic state or 2) clinical judgment may not be reason to doubt the validity or utility of the directive; this conflict may, in fact, be central to the purpose of PAD. The legal force of PAD to stand in the face of conflict is highly relevant.

In mental health care, there is a growing recognition of the important role of self-determination in recovery and avoidance of harms caused by treatment (Ellison et al., 2018; Piltch, 2016; Tinland et al., 2022). Evidence suggests that PAD promote autonomy and empowerment while reducing perceived coercion (Braun et al., 2023; Gergel et al., 2021; Kumar et al., 2013; Lasalvia et al., 2023; Potthoff et al., 2022; Scholten et al., 2019; Scholten et al., 2023b; Tinland et al., 2022). Specifically, it has been demonstrated that PAD reduce the rate of involuntary hospital admissions (de Jong et al., 2016; Molyneaux et al., 2019; Tinland et al., 2022). A systematic review of the contents of PAD showed that PAD typically contain clear and clinically useful preferences that are compatible with practice standards (Gaillard et al., 2023). Studies indicate that potential users have favorable opinions of PAD (Braun et al., 2023; Pathare et al., 2015; Potthoff et al., 2022; Scholten et al., 2019) and tend to call for PAD that have strong legal force, both when it comes to binding clinicians to the preferences outlined (Braun et al., 2023; Scholten et al., 2019) and when it comes to binding themselves to the statements made at the time of creating the PAD (Gergel et al., 2021; Scholten et al., 2019; Scholten et al., 2023b; Stephenson et al., 2020). While someone creating an AD is speaking *for* their future self, someone creating a PAD may also be speaking *to* their future self, i.e. seeking to guide their own decision-making as their mental health status changes and their insight or judgment becomes compromised.

The foundational similarities and contextual differences between AD and PAD raise questions: To what extent are legal differences between PAD and AD necessary? To what extent are they just? Currently, there is no common language for analyzing provisions for PAD and AD across jurisdictions. An effort to categorize and review policy is needed in order to facilitate international discussion about whether current differences reflect different needs requiring different responses or, rather, should be reconsidered as relics of unfair treatment of people with mental health conditions. The primary aim of the present work is to carry out a comparative review of PAD legislation with a focus on how PAD legislation (1) compares to AD legislation in the same jurisdiction and (2) varies across jurisdictions. The goal is to provide an overview for reflection that supports the development of well-founded legal and clinical practice regarding PAD.

2. Methods

The first step in carrying out this work was to gather a team of experts capable of reviewing relevant AD and PAD law with an eye towards analysis that considered ethical and clinical implications. This team included scholars with legal, clinical, and ethics backgrounds in the

jurisdictions under review.

Jurisdictions were selected for inclusion to (1) represent the range of types of PAD legislation and (2) highlight the variability of the legal status of PAD within countries, since, in some countries, PAD legislation differs from one jurisdiction to another. The ultimate aim in selecting jurisdictions was to support the ability to draw revealing contrasts and comparisons. For the sake of feasibility, the study did not perform a comprehensive review that included all jurisdictions with PAD policy.

The next step was to consolidate and review applicable statutes for both AD and PAD considering:

1. Their legal standing and force
2. The requirements for **validity** (factors such as decision-making capacity, age requirements, signature requirements, registration requirements)
3. The requirements for **activation** (factors such as assessing decision-making capacity, involvement of a legally authorized representative, and the extent to which the person can self-describe activation criteria)
4. The requirements for **amendment** and **revocation** (factors such as assessing mental capacity, waiting periods, and other necessary formalities)

The review then led to further categorization by the experts of the jurisdictions for the purpose of discussion. See Table 1 for terms used in categorization.

3. Results

3.1. Legal Force of AD and PAD

Eleven jurisdictions were included in the review: England and Wales (taken as one jurisdiction in the United Kingdom since materially the same statutory provisions apply), Germany, India, the Netherlands, New South Wales (Australia), Northern Ireland (United Kingdom), Virginia (United States), Washington (United States), Switzerland, Scotland (United Kingdom), and Victoria (Australia). The applicable laws in Germany, India, Netherlands and Switzerland are national laws with relevant regulations that pertain to the whole country, whereas Australia, the United Kingdom, and the United States have differences between the legal provisions for AD and PAD in different regions. All the jurisdictions under review have legal provisions in place for some form of PAD except Northern Ireland and New South Wales, which were included to highlight the significant variability that can exist within a single country. A list of the jurisdictions included, along with references to the relevant statutes and abbreviations, can be found in Table 2. For a brief historiography and overview of PAD policy by jurisdiction, see Supplement 1.

In Virginia and Germany, AD and PAD are legally treated as one, whereas in most jurisdictions AD and PAD are governed by separate pieces of legislation. Of the 11 jurisdictions, all except Scotland, Northern Ireland, and New South Wales have statutory legal provisions for AD; in these three jurisdictions, AD are recognized in common law. In India, AD only apply in the case of terminal illness or treatment futility and have an emphasis on refusing life-sustaining treatment. In all the jurisdictions under review, AD can be used to refuse life-sustaining treatment.

AD tend to be binding, especially treatment refusals, if they meet validity requirements and apply to the situation at hand, although: (1) clinicians are not obliged to provide legally, ethically, or clinically inappropriate care, so requests for treatment may not be followed, (2) AD are not designed to override the preference of people who can indicate their wishes to some extent, and (3) AD can be formally challenged if there is reason to doubt the validity, interpretation, or applicability (Weller, 2017; Gurnham, 2006).

The same conditions generally apply to PAD, although (1) PAD are often overridden to provide emergency care to prevent imminent harm to the person or others, so there are more far-reaching limits on the right to treatment refusal, and (2) in certain cases, PAD have some role in challenging the expressed preferences of a person with impaired decision-making capacity at the time of treatment decision-making (Gergel & Owen, 2015; Swanson et al., 2006).

Not all PAD and AD are designed with the aim of binding actors to specific preferences outlined. Articulation of treatment preferences is an important part of both PAD and AD to inform clinical decision-making (Sudore et al., 2017; Swanson, Tepper, Backlar, & Swartz, 2000). In this form, AD and PAD elicit information regarding values and goals that serve to guide treatment decision-making, but are not designed to bind actors – clinicians, legal representatives, or users themselves – to a specific course of action (e.g. Values directives under the Medical Treatment Planning and Decisions Act 2016 (Victoria) and Advance Statements under the Mental Health and wellbeing Act 2022 ss57–60).

Fig. 1 below presents a scale that orders the jurisdiction according to the legal force of their PAD. On one end of the scale are jurisdictions where PAD guide treatment decision-making but do not bind actors to the preferences indicated (e.g. Victoria). On the other end of the spectrum are jurisdictions where PAD are designed to have binding legal force: in some jurisdictions, the legal terms bind clinicians to the users' expressed preferences, commensurate with AD (e.g. Germany); in some jurisdictions, the legal terms bind users to their own expressed preferences, specifically advance consent to treatment (e.g. Netherlands, Washington). In the middle of the scale are jurisdictions where there are clear methods to override the PAD under reasonable objection (e.g. India and Scotland), and, particularly, to provide emergency treatment in the case of involuntary hospitalization according to the applicable law (e.g. England, Wales, Switzerland, and Virginia).

3.2. Validity requirements

Traditionally, decision-making capacity is a central requirement for completing valid AD and PAD. Typically, decision-making capacity is presumed, while allowing that the presumption may be formally rebutted. For example, the MCA 2005 (England and Wales) states the principle that "A person must be assumed to have capacity unless it is established that he lacks capacity" (MCA s1(2)).

Some jurisdictions do require confirmation that the person has decision-making capacity at the time AD or PAD are created in order to

Table 1
Terms as used in the present paper.
Table 1 presents terms used throughout the paper for categorization and their corresponding definitions.

Term	Definition
Advance Directives (AD)	Documents used to declare preference for treatment in the event of future loss of decision-making capacity
Psychiatric Advance Directives (PAD)	Same as the above, but specifically for use in the case of treatment related to mental health conditions
Valid AD/PAD	AD/PAD that meet the requirements necessary for the document to hold legal force
AD/PAD creation	The process of drafting an AD/PAD
Decision-making capacity	A person's ability to understand, appreciate, reason, and express their preferences in relation to a specific treatment decision
AD/PAD activation	The point at which treatment decision-making is based on preferences outlined in a valid AD/PAD.
AD/PAD amendment	User-made alterations to the content of the AD/PAD
AD/PAD revocation	User-led overturning or annulling of AD/PAD in their entirety
Overriding AD/PAD	Not following the preferences outlined in a valid AD/PAD for some specified reason
AD/PAD that are guiding	Preferences outlined inform treatment decision-making, but need not be followed
AD/PAD that are binding	Preferences outlined must be followed in treatment decision-making

Table 2
Jurisdictions, psychiatric advance directive statutes, abbreviations, and links.
Table 2 presents the jurisdictions included in the present review alongside the applicable psychiatric advance directive statutes for the respective jurisdiction, the abbreviations used for the statute(s), and URL links to the statutes.

Name of the Jurisdiction	Name of the applicable Statute(s) or Case(s)	Abbreviation	URL Link
England and Wales	Mental Health Act 1983, 1983	MHA	https://www.legislation.gov.uk/ukpga/1983/20/contents
	Mental Capacity Act 2005, 2005	MCA	
Germany	Guardianship Law (*Betreeuungsrecht*), part of the German Civil Code (*Bürgerliches Gesetzbuch*)	BGB	https://www.gesetze-im-internet.de/bgb/_1814.html
India	Mental Healthcare Act 2017, 2017	MHCA	https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf
	Mental Healthcare (Central Mental Health Authority) Regulations 2020		https://thc.nic.in/Central%20Governmental%20Regulations/Mental%20Healthcare%20(Central%20Mental%20Health%20Authority)%20Regulations,%202020..pdf
The Netherlands	Medical Treatment Agreement Act (*Wet op de geneeskundige behandelinsovereenkomst*), part of the Dutch Civil Code (*Burgerlijk wetboek*)	WGBO	https://wetten.overheid.nl/BWBR0005290/2023-07-01/#Boek7_Titeldeel7_Afdeling5
	Compulsory Mental Healthcare Act (*Wet verplichte geestelijke gezondheidszorg*)	BW Wvggz	https://wetten.overheid.nl/BWBR0040635/2023-10-01/0
New South Wales (Australia)	Hunter and New England Health Service v A [2009] NSWSC 761, 2009.	N/A	acd-form-info-book.pdf (nsw.gov.au)
Northern Ireland	Mental Capacity Act (Northern Ireland) 2016, 2016	MCA(NI)	https://www.legislation.gov.uk/nia/2016/18/contents/enacted
Scotland	Mental Health (Care and Treatment) (Scotland) Act 2003, 2003	MH(*CT*)A	https://www.legislation.gov.uk/asp/2003/13/contents
Switzerland	Swiss Civil Code (Zivilgesetzbuch) (1907)	ZGB	https://www.fedlex.admin.ch/filestore/fedlex.data.admin.ch/eli/cc/24/233_245_233/20220701/en/pdf-a/fedlex-data-admin-ch-eli-cc-24-233_245_233-20220701-en-pdf-a-2.pdf
Victoria (Australia)	Medical Treatment Planning and Decisions Act 2016 (Vic) (2016)	MTPD	Medical Treatment Planning and Decisions Act 2016 (Vic), 2016 | legislation.vic.gov.au
	Mental Health and Wellbeing Act 2022 (Vic) (2022)	MHWB	Mental Health and Wellbeing Act 2022 (Vic), 2022 | legislation.vic.gov.au
Virginia (USA)	Health Care Decisions Act	HCDA	https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2981/
Washington (USA)	Revised Code of Washington (Natural Death Act and Mental Health Advance Directives)	RCW	https://app.leg.wa.gov/RCW/default.aspx?cite=70.122.010

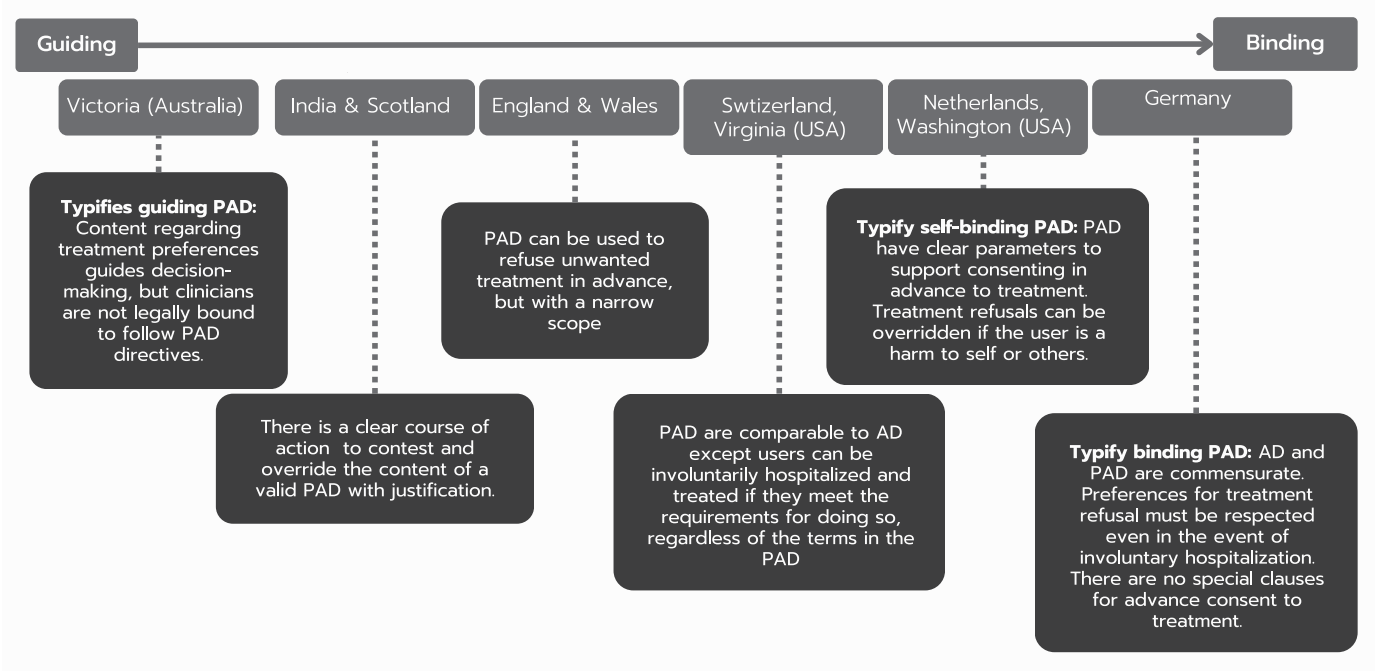

Fig. 1. Legal force of psychiatric advance directives.
Fig. 1 *presents the jurisdictions along a spectrum from those that have psychiatric advance directives with weaker legal force, where instructions are more so guiding, to those that have psychiatric advance directives with greater legal forces, where instructions are more so binding.*
Northern Ireland and New South Wales: N/A as they do not have legal provisions in place for PAD.

be valid; often, the burden to demonstrate decision-making capacity is higher for PAD than for AD. For example, in the Netherlands, while assessment of decision-making capacity is not explicitly required for an AD to be valid, an independent consultant who certifies capacity is required for a PAD to be valid (Wvggz Art. 4:1.7). Such clinician certification of capacity is also required for PAD in Scotland (MH(CT)A s275 (2)(e)) and India, although, in India, no such formal capacity assessment is required for AD, rather the notary and two signing witnesses must attest that the person had full understanding of all the relevant information and consequences (Government of India, 2020). Victoria is unique in having more stringent requirements in the case of AD than PAD. In Victoria, a medical doctor and another witness must attest that an adult completing a binding AD appeared to have decision-making capacity and that the decision was made freely and voluntarily (MTDA s17). When it comes to PAD in Victoria, which are only guiding, it is sufficient to have a witness attest that the person appears to understand what the PAD is, what the consequences of making it are, and how it can be revoked (MHWBA s58). In Virginia, if a person chooses to use an AD or PAD to consent to treatment over future objection when incapacitated, then certification is required by a healthcare provider that the person understands the meaning of this action (HCDA s54.1–2983).

Most jurisdictions reviewed require that AD and PAD be signed by the creator and, often, additional witnesses. The Netherlands, India, Virginia, Victoria, and England and Wales all have signature requirements that differ between AD and PAD. In some cases, the difference is to make an allowance for the fact that people may be physically unable to sign an AD due to serious illness or injury; in this case, conditions are set whereby another can formally sign on the person's behalf (e.g. oral AD in Virginia (HCDA s54.1–2983)). In most jurisdictions, it is not necessary for a clinician to sign an AD or PAD for the document to be valid. The notable exception is the Netherlands (Wvggz Art. 4:2.1). In the Netherlands, such sanctioning from clinicians is required for a PAD to be valid but not for an AD to be valid.

Most jurisdictions stipulate an age of maturity, either 16 or 18, for completing valid AD and PAD. There are some exceptions, though. In Victoria, any person, including minors with demonstrated capacity, can complete AD or PAD (MHWB s24, MTPD s13). In Washington, a minor at least 13 years of age may execute a PAD "if the person is able to demonstrate that they are capable of making informed decisions related to behavioral health care" (RCW s71.32.040). In India, a legal guardian may create a PAD for minors (MH(CT)A s5(4)). Neither Washington nor India have similar provisions for minors in the case of creating AD. In jurisdictions where minors can complete PAD, there are often extra stipulations. In Washington, for example, capacity is presumed if a legal adult is creating an AD or PAD, but a minor age 13 must be found to have such decision-making capacity (RCW s71.32.040). In Victoria, minors creating PAD must have at least one of the signing witnesses be a registered medical practitioner or psychologist with the prescribed training and experience s17(e).

One element related to AD and PAD validity is the use of registries. Registries are designed to ensure that AD or PAD documents are securely stored and easily available for use in clinical settings (Wilkinson et al., 2007). Most jurisdictions do not have registry options for either AD or PAD. In India, no registry exists for AD, but PAD must be registered with the Mental Health Review Board (MHCA s5). In Virginia and Scotland, such registries do exist, but their use is optional.

3.3. Content requirements

AD tend not to have specific content requirements for points that must be included, although there are some specifications in some jurisdictions. In Victoria, users indicate whether they are establishing binding directives or guiding instructions that are values-based (MTPDA s12). In India, where AD are limited to cases of terminal illness and treatment futility, AD must indicate a surrogate decision-maker who can refuse or withdraw treatment in the event of loss of capacity (Supreme Court of India, 2018). In England and Wales, when an AD is used to refuse life-sustaining treatment, the person must indicate in writing that the instruction is to take effect even if it puts life at risk (MCA s25(5) and (6)).

PAD tend to have specific content requirements, notably in Washington (RCW s70.122.030), Victoria (MHWBA (s58(2)(b)(i)–(v))), Scotland (MH(CT)A s275(1)), Netherlands (Wvggz Art. 4:1.2), and India (MHCA s5). See Table 3.

3.4. Activation requirements

Certain requirements must be met for AD and PAD to be activated and applied in treatment decision-making. In all jurisdictions reviewed, the activation requirements for AD are set by statute rather than criteria the person outlines. In all jurisdictions, the person must lack decision-making capacity for AD to go into effect. In India, and Virginia, a capacity assessment must confirm that the person lacks decision-making capacity for the AD to go into effect. In Virginia, for example, this must be made by an attending physician with confirmation by another physician or licensed clinical psychologist following personal examination (HCDA s54.1–2983.2). In the other jurisdictions, a confirmation of lack of decision-making is implied or can be inferred from the law, but a formal assessment is not explicitly required for AD to go into effect. India is unique in that AD are restricted to use in the context of a terminal condition or permanent, unconscious state. In India, within the parameters set by statute, a person can additionally specify under what conditions the AD should go into effect (MHCA s5).

In most jurisdictions, PAD come into effect as do AD, when the person lacks decision-making capacity. A specific assessment of decision-making capacity is sometimes required, for example in Virginia and India. In Virginia, such a capacity assessment is typically made by the attending clinician, with confirmation by a "capacity reviewer," another physician or licensed clinical psychologist, following personal examination (HCDA s54.1–2983). In Virginia, the user has the option to designate in their PAD that their PAD can be activated for purposes of psychiatric hospital admission upon a finding made by a single clinician who determines that the person is incapable of making an informed decision regarding such admission. In the other jurisdictions, for example England and Wales, Germany and the Netherlands, a confirmation of lack of decision-making is implied or can be inferred from the law, but a formal assessment is not explicitly required for PAD to go into effect. In Victoria, PAD come into effect when the person is involuntarily admitted to hospital.

Unlike in the case of AD, when it comes to PAD, some jurisdictions explicitly allow for the user to set their own activation criteria for when the instructions should go into effect. The Netherlands and Washington are notable for designing PAD legislation that allows the user to do so; setting activation criteria is, in fact, a requirement of valid PAD in those

Table 3
Content requirements for psychiatric advance directives.
Table 3 presents descriptions of content requirements for jurisdiction where psychiatric advance directives must include certain information.

Country	Content requirement
Victoria	Any or all of the following: Preferences relating to treatment; preferences relating to care and support; preferences as to whom may be provided with health information; the name and contact details of a nominated support person or advocate; the name and contact details of any person or organization to be informed that the person is a patient.
Washington	The criteria for PAD activation; the duration of the validity of the PAD; and the criteria for PAD revocation
Scotland	The person's treatment preferences
Netherlands	The criteria for PAD activation; the duration of the validity of the PAD; the person's treatment preferences; the duration of compulsory care; and the contact information of contact persons
India	The person's treatment preferences

two jurisdictions (Wvggz Art. 4:1.2a; RCW § 71.32.040). In such cases, the user may indicate the conditions under which interventions outlined in the PAD are necessary and/or signs that their decision-making may be compromised. In Washington, the necessity of confirming the person's lack of decision-making capacity using a capacity assessment for PAD activation depends on what activation criteria the person has indicated; some users may indicate that such formal assessment is not required and some may even decouple PAD activation from loss of decision-making capacity (RCW § 71.32.040).

Not all AD and PAD users have legally authorized representatives, a role that tends to be defined outside of AD and PAD legislation. In most of the jurisdictions reviewed, a legally authorized representative is not required to be involved for activation of AD or PAD. The exception is India, where AD particularly address treatment refusal at the end of life. In this jurisdiction, the person's legally authorized representative is required to be involved for AD activation. India does not require involvement of a legal representative, though, for activation of PAD. In Washington, for both AD and PAD, the person has the ability to make a legal representative's powers effective at any appointed time independent of decision-making capacity, but such involvement is not required. In the case of Germany, it is understood that a legal representative is only legally required to be involved if the instructions in an AD or PAD are insufficiently clear or require interpretation (Götz, 2022).

3.5. Amending and revoking

In India, Switzerland, Victoria, Virginia, and Washington, there are formal requirements for users to amend or revoke their own AD. For example, in Washington and Virginia, AD amendment must be in writing and have the signatures of the person and two witnesses to confirm the amendment; revocation can be in writing but can also be through a clear oral statement or destruction of the AD document (RCW s70.122.040; HCDA, s54.1–2985). In India, an application with the signature of two witnesses is required, attested before a notary or gazetted officer (Mental Healthcare Regulations, 2020). Switzerland requires that formal revocation or amendment be done in writing or by destroying the original document (ZGB Art. 371). The other jurisdictions reviewed did not require a formal legal act to amend or revoke AD, save that in England and Wales, an amendment that involves the refusal of life-sustaining treatment must comply with the requirements of such an AD.

The requirements for users to amend or revoke their PAD tend to be more stringent than those to amend or revoke MAD. Scotland and the Netherlands require that PAD amendment or revocation be done in writing (MH(CT)A s275(3) and Wvggz Art. 4:3 respectively). In Victoria, amendment is not permitted; a new PAD must be made, and revocation must be done formally (signed, dated, and witnessed) (MHWBA s59. s60). In India as well, a PAD cannot be amended by the user; it must be replaced with a new PAD, following the formal procedure to do so, and, moreover, a period of three months needs to have elapsed from when the previous PAD was issued (Mental Healthcare Regulations, 2020). In Virginia and Washington, the same fairly strict formal requirements for AD amendment and revocation apply to PAD (HDA s70.122.40 RCW s71.32.080). England, Wales, and Germany do not have formal requirements for amending or revoking PAD.

For both AD and PAD, guidelines around the necessity of assessing decision-making capacity for amendments or revocations to be valid tend not to be clearly specified. The requirements regarding confirmation of capacity as specified in the law – or lack thereof - tend to be equivalent between AD and PAD in the jurisdictions reviewed. Washington is notable in that the person must specify whether or not they can revoke the PAD even after they have been found to lack decision-making capacity (RCW s71.32.080).

4. Discussion

Whereas AD provisions are more standardized, the differences across the jurisdictions with respect to PAD provisions reflect the way different legislatures have sought to resolve the ongoing and contested debates about the appropriate scope and role of involuntary treatment of patients with mental health conditions. In comparing AD and PAD overall, there tend to be two main overarching differences: (1) PAD tend to be more stringently regulated, and (2) PAD tend to have less legal force, especially in the face of potentially life-limiting choices. These two differences are evident in that there tends to be (i) greater ability for clinicians and others to challenge PAD, (ii) more content requirements for PAD, (iii) more specificity regarding requirements around assessing decision-making capacity in the case of PAD, (iv) more possibility to set activation requirements for when the document should go into effect in the case of PAD, and (v) more stringent requirements for the user to amend or revoke PAD. Given the role and use of PAD in the various jurisdictions, sometimes these differences are more well-founded than in other instances.

For example, clinician involvement in the certification of PAD is a good case of variability in terms of stringency requirements and justification. PAD in the Netherlands and Scotland require physicians to certify decision-making capacity at the time of writing for PAD to be valid. In the Netherlands, where users may be strictly bound to the preferences they have outlined and clinicians obliged to enact advance consent to treatment, clinician involvement to certify PAD may be well-founded to the extent it (1) protects users in the face of decisions that have strong legal force over them in the future and (2) increases clinicians' confidence in the documents and, potentially, comfort adhering to them (Scholten et al., 2021; Van Melle et al., 2023). In Scotland, though, PAD do not have the self-binding force that they do in the Netherlands, and the additional stringency requirement of physician certification may be less well-founded; the burden may not be proportional to the protection conferred and, instead, serve as a barrier to use. In Victoria, documents must be signed, and a witness must certify that the person understood the effect of the document, which is a lower bar than demonstrating decision-making capacity. Given that PAD are guiding documents in Victoria, which cannot displace the decision of a treating psychiatrist, greater stringency may be less necessary and this lesser requirement proportional. Virginia law exemplifies sensitivity to the relationship between risk and precaution: certification by a health care provider is only required *if* the person uses the document (AD or PAD) to consent to treatment over future objection when incapacitated (HCDA s54.1–2983).

Another example of the above relates to ease of PAD amendment and revocation. In most jurisdictions, the process is quite controlled. In Germany, England, and Wales, though, there is relative ease to amend or revoke PAD, which may be understood in light of those documents' emphasis on treatment refusal. Allowing users to change their mind and accept treatment with relative ease seems well-founded when considering risks and benefits. In the Netherlands and Washington, formality for amendment and revocation is relevant to the document's unique function in facilitating advance consent to involuntary hospitalization and treatment; for PAD to operate in this manner, users should not be able to easily overturn them at the time the instructions might become relevant. While the policy requirements increase institutional oversight and control, they are logically coherent with the role these PAD are intended to play. In other jurisdictions, though, greater stringency around revocation and amendment suggests differential treatment of decision-making in the context of mental health than in the context of physical health. For example, in India, a PAD cannot be amended by a user; it must be replaced with a new PAD, following the formal procedure to do so, and a period of three months needs to have elapsed from when the previous PAD was issued. The same three-month waiting period does not apply, though, to AD, raising the question of whether decision-making in the case of mental health conditions should be thought of as different enough to warrant the different treatment.

Since greater stringency can serve as a barrier to use, requirements, especially those that differ from AD requirements, should be well-

justified (Maylea et al., 2021). When considering justification for more stringent regulation, PAD designed with a self-binding function stand out. Using PAD to strengthen the power of a user over their future self such that the user is bound to their PAD consent establishes a unique relationship between the PAD user and their future self. This raises ethical questions (Scholten et al., 2023b; Stephenson et al., 2023) and may justify special legal safeguards (Scholten et al., 2023a). Here, PAD content requirements, assessment of capacity at the time of creation, the need to set activation criteria, and restrictions on amendment or revocation could be seen as well-founded safeguards and necessary features for the PAD to function as intended. Some aspects of self-binding PAD, such as the right to set activation criteria and de-emphasize decision--making capacity, tie into broader debates around how PAD and AD could be reenvisioned (Flynn, 2019). Reliance on the traditional threshold requirement of mental capacity may limit the ability of PAD to align with the recognized symptomology of the person; allowing users to set tailored activation criteria may better facilitate early interventions. Self-binding advance directives particularly highlight the question of whether PAD activation should be decoupled from decision-making capacity, as proposed by the UNCRPD Committee regarding Art. 12 of the CRPD (UNCRPD, 2014).

While some PAD are designed around advance consent to treatment, others more so emphasize users' right to express respected treatment refusals. A comparison of Germany with England and Wales exemplifies the range of PAD in this second regard. Clinicians in Germany are bound to respect treatment refusals and a PAD that has been deemed valid cannot be overridden, even in the event of involuntary hospitalization. Thus, someone may be involuntarily hospitalized, specifically if they pose a risk of harm to others, but they cannot be forced to receive interventions that they have refused through their PAD. Like Germany, PAD in England and Wales also aim to reduce the harm of coercive measures by upholding advance treatment refusals. PAD in England and Wales, though, have a tight scope that focuses specifically on electroconvulsive therapy and refusals in the context of community-based treatment. This raises the questions of how to set the scope on right to treatment refusal, and, if PAD can only be used in limited ways to refuse treatment, how such limitations are justified given the broad right to treatment refusal in the case of AD.

On the point of treatment refusals, comparison with AD is illuminating. In all the jurisdictions under review, AD can be used to uphold treatment refusals that may lead to death; PAD, though, generally can be overridden when it comes to mental health interventions that are viewed as life-saving. The limited scope of PAD in this regard reflects an unresolved concern that PAD may be used as a tool to enable suicide and the debate around how to contend with this possibility in the case of mental illness (Nowland et al., 2019; Quinlivan et al., 2019). There is precedent in psychiatry for paternalistic interventions aimed at preventing harm to self (Borecky et al., 2019; Wasserman et al., 2020; Wasserman et al., 2021). People with mental health conditions have the same fundamental rights as people with physical health conditions, though, including the right to autonomy. People with mental health conditions often have preserved decision-making capacity, particularly in periods when they are stable. Good insight and judgment are necessary for the legitimacy of the preferences expressed in an advance directive: any type of advance directive is only valid when the person making it has decision-making capacity regarding the preferences outlined. As such, users would be taking on risk through PAD in an informed way commensurate with risk assumed through AD.

Germany is unique in the extent to which it upholds the right of those with mental health conditions to take on a high degree of risk of harm to self through PAD (Henking & Scholten, 2023). In all jurisdictions except Germany, PAD preferences can be overridden when the person poses a risk of harm to themself. Even in Virginia, which is the closest to Germany in that AD and PAD are legally treated as one, there is a clause allowing involuntary psychiatric hospitalization and treatment if the person meets statutory criteria for such hospitalization regardless of PAD preferences. The above suggests that, in Virginia, treatment refusals that may result in harm to self and go against clinical best judgment are treated differently for those expressing preferences related to physical health conditions and for those expressing preferences related to mental health conditions. This raises questions regarding whether preferences that may shorten life are fundamentally different in the case of mental health, and, if so, whether they are sufficiently different to justify differences in how those preferences are respected.

Whether or not PAD are binding, they contribute valuable guidance for treatment decision-making and are an important tool in efforts to provide care aligned with the person's goals, values, and wishes. An important question is whether there might be greater adoption of relatively weak PAD - those that are guiding only – and whether wide adoption might provide a significant benefit worth weighing (Swanson et al., 2006). Northern Ireland is a good example of the challenges that can emerge when trying to legally uphold ideals of parity. The Mental Capacity Act of Northern Ireland establishes that there not be any standalone mental health legislation, but, despite being established in 2016, the Act has not yet gone fully into force, perhaps reflecting the complexity of enacting such parity in practice. Where strongly binding PAD on par with AD have been enacted, unprecedented scenarios emerge that require attention. For example, in Germany, clinicians have faced a conundrum caring for those who are involuntarily committed as a risk to others but who, to honor PAD refusals, are then not treated for their condition (Gather et al., 2016). When PAD can be used as a definitive means to refuse unwanted treatment, new guidance is needed to define what care should look like in the absence of coercion. PAD with strong binding force delineate patients' rights but necessitate further reflection on the appropriate role of clinicians and institutions in response.

While weak PAD may sidestep certain difficulties, the concern that PAD may not affect treatment is given as a reason for why users do not complete them (Braun et al., 2023; Nowland et al., 2019; Zelle et al., 2015). Various nongovernmental organizations, for example *Human Right in Switzerland*, have challenged the weaker legal force of PAD relative to AD as a violation of fair treatment of those with disabilities (Humanrights.ch, 2022). Service users see value in binding PAD and call for them to have force even (or especially) in the types of emergency situations where they tend to be overridden (Belden et al., 2021; Braun et al., 2023; Stephenson et al., 2020). Service users also see the protective requirements that are sometimes put in place to regulate PAD as barriers to use (Maylea et al., 2021; Braun et al., 2023).

5. Conclusion

Policy governing AD and PAD set terms under which advance preferences are to be respected, codifying choices about how to provide care in cases where capacity poses challenges for decision-making. Divergence between PAD and AD policy in single jurisdictions reflects differential treatment of mental health conditions. Where these policy differences exist, the legal landscape reinforces the position that care in the context of mental health is different from other kinds of care and, more precisely, that decision-making for those with mental health conditions can and should, under certain circumstances, be treated differently. This carries implications that are both conceptual and practical, demanding reflection in order to avoid possible unfair treatment and bias.

The present comparative review draws out policy differences, but it does not explore the principles on which these policy choices are based and what aims these policies seek to achieve. It also does not evaluate how well these goals are met. Moreover, the study does not comprehensively include all jurisdictions with PAD policy. There is significant variation across jurisdictions regarding the policy choices that set PAD apart from AD, and the landscape continues to change. For example, advance directives covering both mental and physical health treatment came into law in the Republic of Ireland in 2023, and emerging case law

will shape practice. Determining how best to use PAD in different jurisdictions and how to structure policy to support such use remain important challenges. PAD policy should be made with an awareness of the range of possible approaches and a sound understanding of the implications of choosing one approach over another. Comparative studies that support mutual learning are valuable. To that end, the above policy comparison invites reflection and calls for further, more comprehensive, research.

Additional work is needed to support well-considered PAD policy. Two important topics of future research emerge. One valuable line of exploration is to compare the various impacts of these PAD policy choices from one jurisdiction to another to help elucidate the practical implications of adopting an approach, recognizing that social and healthcare contexts vary significantly. *How do PAD tend to play out in practice in the various jurisdictions and what connections can be made to the corresponding PAD policy?* Another valuable step is to clearly map the ethical, clinical, and legal arguments that undergird the various policy approaches. *What arguments support the different approaches and various policy decisions?* A subsequent evaluation of these impacts and arguments would help in determining whether policy differences between PAD and AD can be well-justified. Policy differences between PAD and AD that place additional burdens or restrictions for those managing mental health conditions should be revised if they are not well-founded.

Abbreviations

AD	advance directives
PAD	psychiatric advance directives
CRPD	Convention on the Rights of Persons with Disabilities
UNCRPD	United Nations Committee on the Rights of Persons with Disabilities
MCA	Mental Capacity Act 2005 (England and Wales)
MHCA	Mental Healthcare Act 2017 (India)
Wvggz	Wet verplichte geestelijke gezondheidszorg (Compulsory Mental Healthcare Act, Netherlands)
MH(CT)A	Mental Health Care and Treatment Act (Scotland)
ZGB	*Zivilgesetzbuch* (Civil Code, Switzerland)
MTPD	Medical Treatment Planning and Decisions Act 2016 (Victoria, Australia)
MHWB	Mental Health and Wellbeing Act 2022 (Victoria, Australia)
HCDA	Health Care Decisions Act (Virginia, United States)
RCW	Revised Code of Washington (Washington, United States)

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Ethical statement

The work described has not been published previously nor is the article under consideration for publication elsewhere. If accepted, the article will not be published elsewhere in the same form. The article's publication is approved by all authors, who have all made substantial contributions to the work. The authors declare no competing interests. No artificial intelligence was used in any capacity for this work. This work was supported by the Institute of Biomedical Ethics and History of Medicine at the University of Zurich and the German Federal Ministry of Education and Research (SALUS; grant no. 01GP17920). This research did not receive other specific grants from any funding agencies in the public, commercial, or not-for-profit sectors.

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References

Appelbaum, P. S. (2006). Commentary: Psychiatric advance directives at a crossroads—When can PADs be overridden? *The Journal of the American Academy of Psychiatry and the Law, 34*(3), 395–397. Retrieved from https://pubmed.ncbi.nlm.nih.gov/17032963.

Belden, C. M., Gilbert, A. R., Easter, M. M., Swartz, M. S., & Swanson, J. W. (2021). Appropriateness of psychiatric advance directives facilitated by peer support specialists and clinicians on Assertive Community Treatment teams. *Journal of Mental Health, 31*(2), 239–245. https://doi.org/10.1080/09638237.2021.1952946

Borecky, A., Thomsen, C., & Dubov, A. (2019). Reweighing the ethical tradeoffs in the involuntary hospitalization of suicidal patients. *The American Journal of Bioethics, 19*(10), 71–83. https://doi.org/10.1080/15265161.2019.1654557

Braun, E., Gaillard, A. S., Vollmann, J., Gather, J., & Scholten, M. (2023). Mental health service users' perspectives on psychiatric advance directives: A systematic review. *Psychiatric Services (Washington, D.C.), 74(4)*, 381–392. https://doi.org/10.1176/appi.ps.202200003

Brenna, C. T., Chen, S. S., Cho, M., McCoy, L. G., & Das, S. (2023). Steering clear of akrasia: An integrative review of self-binding Ulysses contracts in clinical practice. *Bioethics, 37*(7), 690–714. https://doi.org/10.1111/bioe.13197

de Jong, M. H., Kamperman, A. M., Oorschot, M., Priebe, S., Bramer, W., van de Sande, R., & Mulder, C. L. (2016). Interventions to reduce compulsory psychiatric admissions: A systematic review and meta-analysis. *JAMA Psychiatry, 73*(7), 657–664. https://doi.org/10.1001/jamapsychiatry.2016.0501

Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and definition of mental health recovery: A systematic review. *Administration and Policy in Mental Health, 45*(1), 91–102. https://doi.org/10.1007/s10488-016-0767-9

Flynn, E. (2019). The rejection of capacity assessments in favor of respect for will and preferences: The radical promise of the UN Convention on the Rights of Persons with Disabilities. *World Psychiatry, 18*(1), 50–51. https://doi.org/10.1002/wps.20605

Gaillard, A. S., Braun, E., Vollmann, J., Gather, J., & Scholten, M. (2023). The content of psychiatric advance directives: A systematic review. *Psychiatric Services, 74*(1), 44–55. https://doi.org/10.1176/appi.ps.202200002

Gallagher, E. M. (1998). Advance directives for psychiatric care: A theoretical and practical overview for legal professionals. *Psychology, Public Policy, and Law, 4*(3), 746–787. Retrieved from https://psycnet.apa.org/doi/10.1037/1076-8971.4.3.746.

Gather, J., Henking, T., Juckel, G., & Vollmann, J. (2016). Vorausverfügte Therapieablehnungen in Situationen von Eigen- oder Fremdgefährdung. Ethische und rechtliche Überlegungen zur Umsetzung von Patientenverfügungen in der Psychiatrie. *Ethik in der Medizin, 28*(3), 207–222. https://doi.org/10.1007/s00481-016-0409-5

Gergel, T., Das, P., Owen, G., Stephenson, L., Rifkin, L., Hindley, G., … Ruck Keene, A. (2021). Reasons for endorsing or rejecting self-binding directives in bipolar disorder: A qualitative study of survey responses from UK service users. *The Lancet Psychiatry, 8*(7), 599–609. https://doi.org/10.1016/S2215-0366(21)00115-2

Gergel, T., & Owen, G. S. (2015). Fluctuating capacity and advance decision-making in bipolar affective disorder—Self-binding directives and self-determination.

International Journal of Law and Psychiatry, 40, 92–101. https://doi.org/10.1016/j.ijlp.2015.04.004

Gloeckler, S., Ferrario, A., & Biller-Andorno, N. (2022). An ethical framework for incorporating digital technology into advance directives: Promoting informed advance decision making in healthcare. *The Yale Journal of Biology and Medicine, 95*(3), 349–353. Retrieved from https://pubmed.ncbi.nlm.nih.gov/36187419/.

Götz, I. (2022). § 1901a BGB. In C. Grüneberg (Ed.), *Bürgerliches Gesetzbuch*. München: C. H. Beck.

Government of India. (2020). *Mental Healthcare (Central Mental Health Authority) Regulations, 2020*. Ministry of Health and Family Welfare. Retrieved from https://thc.nic.in/Central%20Governmental%20Regulations/Mental%20Healthcare%20(Central%20Mental%20Health%20Authority)%20Regulations,%202020..pdf.

Gurnham, D. (2006). Losing the wood for the trees: Burke and the Court of Appeal. *Medical Law Review, 14*(2), 253–263. https://doi.org/10.1093/medlaw/fwl006

Henking, T., & Scholten, M. (2023). Respect for the will and preferences of people with mental disorders in German law. In C. Kong, J. Coggon, P. Cooper, M. Dunn, & A. R. Keene (Eds.), *Capacity, participation, and values in comparative legal perspective* (pp. 203–225). Bristol University Press. https://doi.org/10.51952/9781529224474.ch012.

Hotzy, F., Cattapan, K., Orosz, A., Dietrich, B., Steinegger, B., Jaeger, M., & Bridler, R. (2020). Psychiatric advance directives in Switzerland: Knowledge and attitudes in patients compared to professionals and usage in clinical practice. *International Journal of Law and Psychiatry, 68*, Article 101514. https://doi.org/10.1016/j.ijlp.2019.101514

Humanrights.ch. (2022). Établissements psychiatriques: L'usage de la contrainte reste problématique. Retrieved from https://www.humanrights.ch/fr/pfi/droits-humains/handicaps/etablissements-psychiatriques-usage-contrainte-reste-problematique.

Hunter and New England Health Service v A [2009] NSWSC 761. (2009). Supreme Court of New South Wales. Retrieved from https://www.caselaw.nsw.gov.au/.

Kumar, T. C. R., John, S., Gopal, S., Mohan, G., Joseph, J., & Rangaswamy, T. (2013). Psychiatric advance statements: An Indian experience. *International Journal of Social Psychiatry, 59*(6), 531–534. https://doi.org/10.1177/0020764012443756

Lasalvia, A., Patuzzo, S., Braun, E., & Henderson, C. (2023). Advance statements in mental healthcare: Time to close the evidence to practice gap. *Epidemiology and Psychiatric Sciences, 32*, Article e68. https://doi.org/10.1017/S2045796023000835

Maylea, C., Katterl, S., Johnson, B., Alvarez-Vasquez, S., Hill, N., & Weller, P. (2021). Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia. *International Journal of law and Psychiatry, 78*, 101737.

Medical Treatment Planning and Decisions Act 2016 (Vic). (2016). Government of Victoria. Retrieved from https://www.legislation.vic.gov.au/.

Mental Capacity Act (Northern Ireland) 2016. (2016). Northern Ireland Assembly. Retrieved from https://www.legislation.gov.uk/nia/2016/18/contents.

Mental Capacity Act 2005. (2005). United Kingdom Parliament. Retrieved from https://www.legislation.gov.uk/ukpga/2005/9/section/4.

Mental Health (Care and Treatment) (Scotland) Act 2003. (2003). Retrieved from https://www.legislation.gov.uk/asp/2003/13/contents.

Mental Health Act 1983. (1983). United Kingdom Parliament. Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/contents.

Mental Health and Wellbeing Act 2022 (Vic). (2022). Government of Victoria. Retrieved from https://www.legislation.vic.gov.au/.

Mental Healthcare Act, 2017. (2017). Government of India. Retrieved from https://egazette.nic.in.

Miller, R. D. (1998). Advance directives for psychiatric treatment: A view from the trenches. *Psychology, Public Policy, and Law, 4*(3), 728–745. https://doi.org/10.1037/1076-8971.4.3.728

Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S., & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: Systematic review and meta-analyses. *BJPsych Open, 5*(4), Article e53. https://doi.org/10.1192/bjo.2019.28

Nowland, R., Steeg, S., Quinlivan, L. M., Cooper, J., Huxtable, R., Hawton, K., … Kapur, N. (2019). Management of patients with an advance decision and suicidal behaviour: A systematic review. *BMJ Open, 9*(3), Article e023978. https://doi.org/10.1136/bmjopen-2018-023978

O'Connell, M. J. (2015). Psychiatric advance directives. In P. W. Corrigan (Ed.), *Person-centered care for mental illness: The evolution of adherence and self-determination* (pp. 103–116). American Psychological Association. https://doi.org/10.1037/14644-006.

Pathare, S., Shields, L., Nardodkar, R., Narasimhan, L., & Bunders, J. (2015). What do service users want? A content analysis of what users may write in psychiatric advance directives in India. *Asian Journal of Psychiatry, 14*, 52–56. https://doi.org/10.1016/j.ajp.2014.10.006

Piltch, C. A. (2016). The role of self-determination in mental health recovery. *Psychiatric Rehabilitation Journal, 39*(1), 77–80. https://doi.org/10.1037/prj0000176

Potthoff, S., Finke, M., Scholten, M., Gieselmann, A., Vollmann, J., & Gather, J. (2022). Opportunities and risks of self-binding directives: A qualitative study involving stakeholders and researchers in Germany. *Frontiers in Psychiatry, 13*, Article 974132. https://doi.org/10.3389/fpsyt.2022.974132

Quinlivan, L., Nowland, R., Steeg, S., Cooper, J., Meehan, D., Godfrey, J., Robertson, D., Longson, D., Potokar, J., Davies, R., Allen, N., Huxtable, R., Mackway-Jones, K., Hawton, K., Gunnell, D., & Kapur, N. (2019). Advance decisions to refuse treatment and suicidal behaviour in emergency care: 'it's very much a step into the unknown. *BJPsych Open, 5*(4), Article e50. https://doi.org/10.1192/bjo.2019.42

Ruck Keene, A., Kane, N. B., Kim, S. Y., & Owen, G. S. (2023). Mental capacity—why look for a paradigm shift? *Medical Law Review, 31*(3), 340–357.

Sabatino, C. P. (2010). The evolution of health care advance planning law and policy. *The Milbank Quarterly, 88*(2), 211–239. https://doi.org/10.1111/j.1468-0009.2010.00596.x

Scholten, M., Efkemann, S. A., Faissner, M., Finke, M., Gather, J., Gergel, T., … Widdershoven, G. (2023a). Implementation of self-binding directives: Recommendations based on expert consensus and input by stakeholders in three European countries. *World Psychiatry, 22*(2), 332–333. https://doi.org/10.1002/wps.21095

Scholten, M., Efkemann, S. A., Faissner, M., Finke, M., Gather, J., Gergel, T., … Widdershoven, G. (2023b). Opportunities and challenges of self-binding directives: A comparison of empirical research with stakeholders in three European countries. *European Psychiatry, 66*(1), Article e48. https://doi.org/10.1192/j.eurpsy.2023.2421

Scholten, M., Gieselmann, A., Gather, J., & Vollmann, J. (2019). Psychiatric advance directives under the convention on the rights of persons with disabilities: Why advance instructions should be able to override current preferences. *Frontiers in Psychiatry, 10*, 631. https://doi.org/10.3389/fpsyt.2019.00631

Scholten, M., van Melle, L., & Widdershoven, G. (2021). Self-binding directives under the new Dutch Law on Compulsory Mental Health Care: An analysis of the legal framework and a proposal for reform. *International Journal of Law and Psychiatry, 76*, Article 101699. https://doi.org/10.1016/j.ijlp.2021.101699

Shields, L. S., Pathare, S., van der Ham, A. J., & Bunders, J. (2014). A review of barriers to using psychiatric advance directives in clinical practice. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(6), 753–766. https://doi.org/10.1007/s10488-013-0523-3

Steinert, T., & Henking, T. (2022). Law and psychiatry-current and future perspectives. *Frontiers in Public Health, 10*, Article 968168. https://doi.org/10.3389/fpubh.2022.968168

Stephenson, L. A., Gergel, T., Gieselmann, A., Scholten, M., Keene, A. R., Rifkin, L., & Owen, G. (2020). Advance decision making in bipolar: A systematic review. *Frontiers in Psychiatry, 11*, Article 538107. https://doi.org/10.3389/fpsyt.2020.538107

Stephenson, L. A., Gieselmann, A., Gergel, T., Owen, G., Gather, J., & Scholten, M. (2023). Self-binding directives in psychiatric practice: A systematic review of reasons. *The Lancet Psychiatry, 10*(11), 887–895. https://doi.org/10.1016/S2215-0366(23)00221-3

Sudore, R. L., Lum, H. D., You, J. J., Hanson, L. C., Meier, D. E., Pantilat, S. Z., … Heyland, D. K. (2017). Defining advance care planning for adults: A consensus definition from a multidisciplinary Delphi panel. *Journal of Pain and Symptom Management, 53*(5), 821–832.e1. https://doi.org/10.1016/j.jpainsymman.2016.12.331

Supreme Court of India. (2018, March 9). Common cause (a Regd. Society) v. Union of India & Anr., writ petition (civil) no. 215 of 2005. Retrieved from https://main.sci.gov.in/supremecourt/2005/9123/9123_2005_Judgement_09-Mar-2018.pdf.

Swanson, J. W., Tepper, M. C., Backlar, P., & Swartz, M. S. (2000). Psychiatric advance directives: An alternative to coercive treatment? *Psychiatry, 63*(2), 160–172.

Swanson, J. W., Van McCrary, S., Swartz, M. S., Elbogen, E. B., & Van Dorn, R. A. (2006). Superseding psychiatric advance directives: Ethical and legal considerations. *Journal of the American Academy of Psychiatry and the Law Online, 34*(3), 385–394. https://doi.org/10.29158/JAAPL.34.3.385

Swartz, M. S., Swanson, J. W., & Elbogen, E. B. (2004). Psychiatric advance directives: Practical, legal, and ethical issues. *Journal of Forensic Psychology Practice, 4*(4), 97–107.

Swiss Civil Code (Zivilgesetzbuch). (1907). Switzerland. Retrieved from https://www.fedlex.admin.ch/eli/cc/24/233_245_233/en.

Szasz, T. S. (1982). The psychiatric will: A new mechanism for protecting persons against "psychosis" and psychiatry. *American Psychologist, 37*(7), 762–770. https://doi.org/10.1037/0003-066X.37.7.762

Tinland, A., Loubière, S., Mougeot, F., Jouet, E., Pontier, M., Baumstarck, K., … Group, D. (2022). Effect of psychiatric advance directives facilitated by peer workers on compulsory admission among people with mental illness: A randomized clinical trial. *JAMA Psychiatry, 79*(8), 752–759. https://doi.org/10.1001/jamapsychiatry.2022.1627

Trachsel, M., & Biller-Andorno, N. (2016). Applying a double standard: The lacking binding character of advance directives of involuntary committed patients with mental disorders in Switzerland. *Ethik in der Medizin, 28*(3), 239–247. https://doi.org/10.1007/s00481-016-0372-0

United Nations Convention on the Rights of Persons with Disabilities (CRPD) Adopted 13 December 2006, GA Res 61/106, UN Doc A/Res/61/106, entered into force 3 May 2008.

United Nations Committee on the Rights of Persons with Disabilities. (2014). *UNCRPD general comment no. 1: article 12 (equal recognition before the law) 11th session, adopted 11th April 2014 (U.N. Doc. CRPD/C/GC/1)*.

Van Melle, L., van der Ham, L., Voskes, Y., Widdershoven, G., & Scholten, M. (2023). Opportunities and challenges of self-binding directives: An interview study with mental health service users and professionals in the Netherlands. *BMC Medical Ethics, 24*(38). https://doi.org/10.1186/s12910-023-00915-y

Verwijmeren, D., & Grootens, K. P. (2024). Shifting perspectives on the challenges of shared decision making in mental health care. *Community Mental Health Journal, 60*(2), 292–307. https://doi.org/10.1007/s10597-023-01170-6

Wasserman, D., Apter, G., Baeken, C., Bailey, S., Balazs, J., Bec, C., … Vahip, S. (2020). Compulsory admissions of patients with mental disorders: State of the art on ethical and legislative aspects in 40 European countries. *European Psychiatry, 63*(1), Article e82.

Wasserman, D., Carli, V., Iosue, M., Javed, A., & Herrman, H. (2021). Suicide prevention in psychiatric patients. *Asia-Pacific Psychiatry, 13*(3), Article e12450.

Weller, P. (2017). Chapter 10: Substituted decision-making. In A. M. Farrell, J. Devereux, I. Karpin, & P. Weller (Eds.), *Health law: Frameworks and context* (pp. 12–23). Cambridge University Press.

Wilkinson, A., Wenger, N., & Shugarman, L. R. (2007). *Literature review on advance directives*. U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs.gov/reports/literature-review-advance-directives-0.

Zelle, H., Kemp, K., & Bonnie, R. J. (2015). Advance directives for mental health care: Innovation in law, policy, and practice. *Psychiatric Services, 66*(1), 7–9. https://doi.org/10.1176/appi.ps.201400435