Psychiatric Advance Directives, Autonomy, and Choice: An Interdisciplinary Perspective from Law, Ethics, and Medicine

Daniele Lamberto Ambrosini, B.A., B.C.L./LL.B., M.Sc.
Department of Psychiatry, McGill University, Montréal

October 2011

A thesis submitted to McGill University in partial fulfillment of the requirements
of the degree of Doctor of Philosophy

TABLE OF CONTENTS

ABSTRACT

Individuals with mental illness have a legal and ethical right to complete advance treatment planning documents in Canada. Psychiatric advance directives (PADs) are one type of legal document used in parts of the United States that enable individuals to declare their treatment preferences in the event of future mental incapacity. This dissertation consists of seven chapters that critically examine the relationship between PADs and autonomy from the perspective of Canadian mental health law. Chapter 1 argues that the operational elements of autonomy as it relates to PADs need further research. Chapter 2 argues that the self-binding nature of Ulysses contracts, where individuals make their wishes irrevocable, could be permissible under certain situations. Chapter 3 is a mixed method study involving 65 individuals with bipolar disorder, schizophrenia, or depression that examines preferences for instructional or proxy directives and the relationship to autonomy, empowerment, and recovery. The qualitative study in chapter 4 explores among 12 individuals with mental illness how factors such as trust and the strength of one's social contacts are relevant in choosing a substitute decision-maker. Chapter 5 is a comparative investigation into the legislative approaches surrounding advance treatment planning and finds there is substantial variation across Canadian jurisdictions. The relevance of mental capacity legislation (chapter 6) and civil commitment (chapter 7) are discussed in relation to advance treatment planning. For individuals with mental illness to be more involved in the process of advance treatment planning there needs to be legislative reform towards promoting autonomy, empowerment, and choice.

RÉSUMÉ

Au Canada, les personnes atteintes de maladie mentale ont le droit éthique et juridique de compléter des documents de planification de traitements anticipés. Une directive psychiatrique anticipée (DPA) est l'un des types de document juridique utilisé dans certaines régions des États-Unis qui permettent aux individus de spécifier leurs préférences de traitement advenant une incapacité mentale future. Cette thèse, constituée de sept chapitres, pose un regard critique quant au rapport entre les DPA et l'autonomie dans le contexte des lois canadiennes sur la santé mentale. Le premier chapitre argumente que l'opérationnalisation du construit de l'autonomie en lien avec les DPA nécessite plus de recherche. Le chapitre 2 argumente que l'état obligatoire des contrats d'Ulysse qui rendent les vœux des individus irrévocables devrait être permissible dans certaines circonstances. Le chapitre 3 décrit une recherche utilisant un devis de méthodologie mixte auprès de 65 individus atteints de trouble bipolaire, de schizophrénie ou de dépression. L'étude se penche sur les préférences des individus quant aux directives par instruction ou par procuration et leur relation à l'autonomie, l'autodétermination et le rétablissement. L'étude qualitative au chapitre 4 explore auprès de 12 individus atteints de maladie mentale comment des facteurs tels que la confiance et la qualité du réseau social sont pertinents dans le choix d'un décideur substitut. Le chapitre 5 présente une analyse comparative des approches législatives appuyant la planification des traitements anticipés et souligne la variabilité importante parmi les juridictions canadiennes. La pertinence de la législation qui touche à la capacité mentale (chapitre 6) et les ordonnances de traitement (chapitre 7) sont discutés en rapport avec la planification des traitements anticipés. Des réformes législatives qui favorisent l'autonomie, l'autodétermination et la primauté de choix sont souhaitables afin de permettre aux personnes atteintes de maladie mentale de s'impliquer davantage dans le processus de planification des traitements anticipés.

ACKNOWLEDGMENTS

Working on a doctoral thesis is a journey similar to training for and running a marathon - a long and lonely road, but worth every mile. I was fortunate to have many supporters cheering me to the finish.

First, and foremost, Professor Anne Crocker, my primary supervisor, has my deepest gratitude for the academic, financial, and moral support she provided throughout my graduate studies at the Master's and Doctoral level. I thank her for agreeing to act as my supervisor while I was still a law student, for believing in and promoting my research ideas, and for brokering her influence to help me obtain resources that could translate my ideas into practice. Professor Crocker taught me the value of independent scholarship and the rigours of intellectual inquiry.

I am thankful to Professor Eric Latimer, my co-supervisor, and Professor Kathleen Glass, former Director of McGill's Biomedical Ethics Unit, who kindly provided strategic advice in research methods. Without the support of Professor Mimi Israël, Chair of McGill's Department of Psychiatry, and Psychiatrist-in-Chief of the Douglas Mental Health University Institute, this research would not have been possible. Thank you.

Several research assistants helped me at various stages of this dissertation: Dörte Bemme, Elena Saimon, Joanna Rosciszewska, Laura Ravinsky, and Dominique Laferrière. Merci beaucoup. I also wish to express my appreciation to Daniel Rabouin and Yanick Charette for their assistance with statistical methods.

I wish to acknowledge financial support received through a doctoral fellowship from the Fonds de la recherche en santé Québec (FRSQ), the Abraham Fuks Fellowship in Translational Mental Health Research from the Douglas Mental Health University Institute, and the Recruitment of Excellence Fellowship from the Department of Psychiatry, McGill University. This dissertation would not

have been possible without the generous financial support of research grants from the Fondation du Barreau Québec, Psychosocial Rehabilitation Canada, and The Society for the Psychological Study of Social Issues. I am grateful to staff and research teams from the Douglas Mental Health University Institute, hospital clinics, and community mental health organizations that referred participants for this research study.

I wish to thank all those who agreed to participate in this study.

To the administrative staff from the Douglas Mental Health University Institute and the Department of Psychiatry at McGill University who provided technical and administrative support, thank you.

I wish to thank Dr. Liisa Stephenson for listening to my ideas in perpetuity, editing portions of this dissertation, and supporting me throughout the entire process. This dissertation is dedicated to the loving memory of my father, Celso Ambrosini [May 11, 1935 - May 29, 2010], who ‘ran the course to the finish’ and always told me ‘Keep going, son; you are still young.’ Every mile was for you.

INTRODUCTION

1. Overview of Study

Psychiatric advance directives (PADs) are legal documents used primarily in the United States that enable individuals with mental illness to declare treatment preferences in the event of future mental incapacity (Swanson et al., 2006). The knowledge that someone in whom you have confidence will follow your treatment preferences according to your prior capable wishes holds several benefits, not least of which is the feeling of autonomy it provides. This study examines how advance treatment planning promotes individuals' core values of autonomy, empowerment, and self-determination. Honouring the choices of individuals with disabilities when they are vulnerable and lack mental capacity is an international human rights issue that cannot be overlooked (World Health Organization, 2005; UN *Convention on the Rights of Persons with Disabilities*, 2006).

The Oxford English Dictionary (2011) defines the *state* of autonomy as "the right of self-government, of making its own laws and administering its own affairs," or "liberty to follow one's will, personal freedom," or "the Kantian doctrine of the Will giving itself its own law, apart from any object willed". Autonomy has also been equated with the ability to make independent decisions, and is particularly important when treatment preferences affect one's physical and mental integrity. Yet, the concept of autonomy is more elusive than may appear on the surface. For example, is it a state, trait, or both? How does autonomy differ from empowerment, self-determination, or dignity? Can it be operationalized and measured? How should autonomy be understood in relation to societal values? The answers to such questions are important for lawyers because they often use the principle of autonomy to argue that individuals' rights should be either honoured or limited. Judges must also decide difficult cases regarding involuntary treatment, making it important to understand the definition of autonomy and its relationship to advance treatment planning. Clinicians too are faced with daily decisions of whether individuals with mental illness are autonomous to make well-informed treatment preferences and to live independently in the community.

Research on advance treatment planning in Canada has focused primarily on the end-of-life context with relatively few empirical studies conducted in mental health. The Canadian Hospice Palliative Care Association (2010) recently launched a five-year project entitled *Advance Care Planning in Canada* aimed at establishing a national framework for the end-of-life context. The Mental Health Commission of Canada (2009) recommends in a report entitled *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy* that advance directives be disseminated and used by individuals with mental illness across the provinces and territories. This dissertation expands our current knowledge of advance treatment planning in Canadian mental health law by examining its relationship to choice and autonomy from an interdisciplinary and evidence-based perspective. One of the central arguments of this dissertation is that individuals with mental illness have a right to complete instructional advance directives based on the principle of autonomy, but have not always had the opportunity to do so. In order to ensure that Canadians' rights are safeguarded and promoted to participate fully in advance treatment planning, mental health legislation across the provinces and territories may need to be reformed.

2. Chapter Outline and Thesis Arguments

This dissertation is presented as a compilation of seven manuscripts with a unitary theme that explores the relationship between PADs, choice, and autonomy. Between each chapter is a brief connecting text that threads the common theme together. Each manuscript is intended to make a distinctive and original contribution to the field of advance treatment planning for individuals with mental illness and the state of mental health law in Canada more generally. The interdisciplinary scope of this dissertation allowed for relevant issues to be examined through multiple perspectives including: (i) theoretical and philosophical approaches; (ii) empirical methods (quantitative and qualitative) and; (iii) statutory and common-law analyses.

Chapter 1 contains a manuscript published in a peer-reviewed mental health journal that examines more closely the relationship between PADs and autonomy. Current approaches to understanding autonomy in mental health have been predominantly from ethical, legal, or philosophical perspectives, yet relatively little research has been conducted to operationalize autonomy and then test it empirically. The principle of autonomy frequently arises in courts of law and judges are asked to decide upon individuals' choices surrounding cases of assisted suicide, right to refuse medical treatment, end-of-life issues, and advance care planning. Although judges rely upon the legal principle of autonomy to make decisions regarding treatment refusals, a stronger evidence base identifying the extent of individuals' degree of autonomy based on clinical outcomes could help judges in rendering their decisions.

Chapter 2 examines the self-binding nature of Ulysses contracts and argues that the term Ulysses contract should not be used interchangeably with an advance directive. Whereas an advance directive allows individuals to record treatment preferences, a Ulysses contract permits individuals to ensure their wishes are irrevocable between Time 1 and Time 2. The chapter identifies the many terms used to describe advance directives, and argues that a Ulysses *clause* is a more fitting term than a Ulysses *contract* due to the irrevocable nature of such legal provisions. The manner in which notions of temporality relate to individuals' perception of autonomy while completing an advance directive is explored in this chapter. The legal implications of framing an advance directive as a 'will' or as a 'contract' are discussed more fully. An earlier version of this chapter was published as part of a book series for lawyers and judges in Québec.

Chapter 3 of this dissertation is a mixed methods study conducted among 65 individuals with bipolar disorder, depression, or schizophrenia-spectrum disorders who were offered a choice between two types of advance treatment planning documents. Autonomy, empowerment, and recovery were measured at baseline and at three months, after participants chose and completed either a proxy directive (mandate in case of incapacity) or an instructional directive (PAD). The majority of participants preferred PADs (76%) rather than mandates (24%).

Logistic regression analyses reveal that individuals with schizophrenia-spectrum disorders and higher insight and awareness into the need for treatment tend to choose mandates over PADs. The results of this study have significant implications for individuals drafting legislation to assist them in understanding how certain groups of individuals with mental illness may value certain types of advance directives.

Chapter 4 is a qualitative study of 12 individuals with mental illness to explore their perceptions of autonomy, medication refusal, mental capacity, recovery, the doctor-patient relationship, and the role of substitute decision-makers. The study explores how the instructions and values included in PADs correspond with how individuals narrate their experiences with mental illness. Results reveal that individuals perceive PADs as helpful documents to communicate treatment preferences and avoid side effects of medications rather than to refuse all treatment categorically. Trust and the strength of one's social network are crucial elements in whether individuals with mental illness will choose to complete an advance directive, who will act as substitute decision-maker, and perceptions of the doctor-patient relationship. Not all individuals with mental illness have the same level of trust in their doctor, which can relate to the type of mental illness one has and the level of social support received from others.

Chapter 5 is in the form of a law review article that compares mental health legislation in relation to advance treatment planning across Canadian provinces and territories. The aim of this analysis is to examine how various legislative approaches to advance treatment planning can influence the delivery of mental health services. Mental health statutes were analyzed comparatively for themes and trends including, among others, the use of instructional/proxy directives; capacity to execute advance directives; prior wishes, values, and best interests hierarchy; and whether health professionals are obligated to inquire into the existence of advance directives. Canadian courts have overridden the principle of autonomy in certain situations because it is not considered a principle of fundamental justice. Advance treatment plans could be made more accessible through electronic registries to assist in the storage, management, and retrieval of such documents during an emergency. Mental health legislation could also be reformed so that hospitals and healthcare providers must inquire whether individuals have completed an advance directive. Regional and national awareness campaigns could be undertaken to inform individuals in Canada of their legal rights to participate in advance treatment planning.

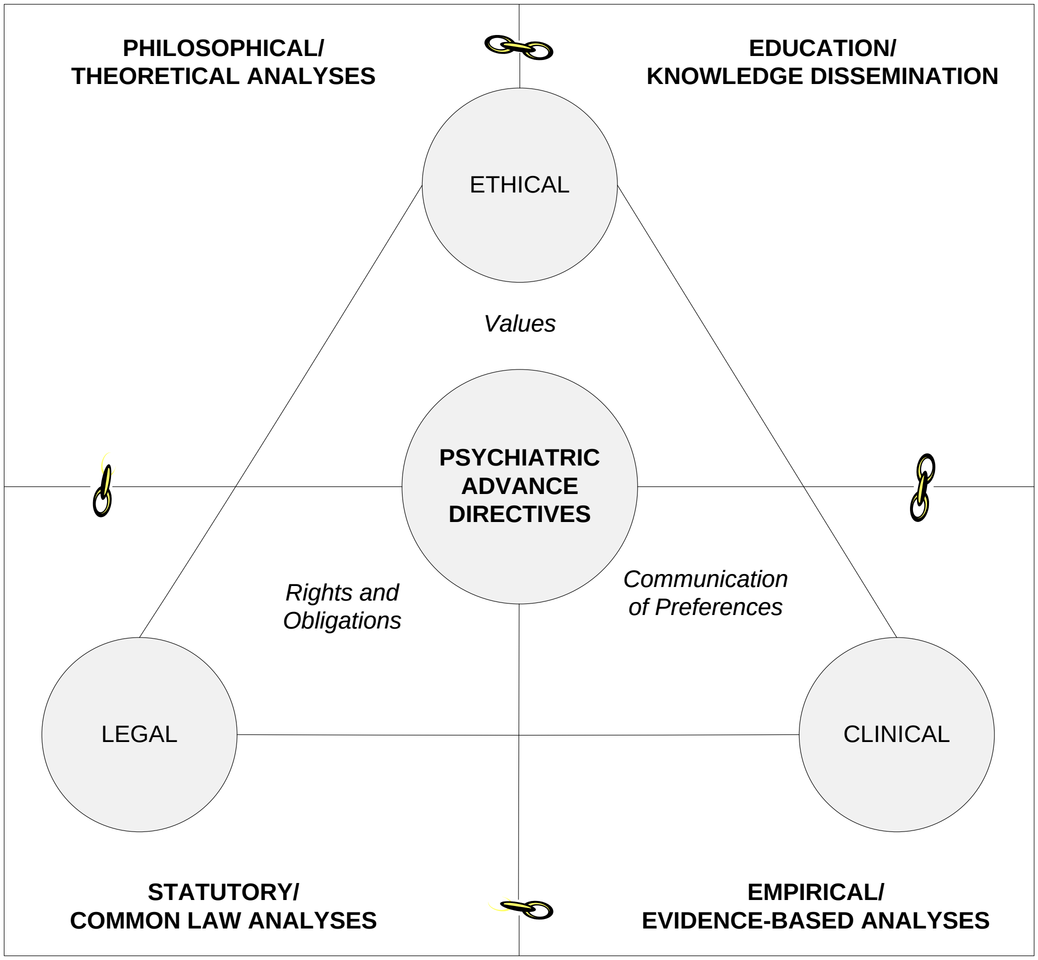
Chapter 6, submitted as a book chapter on mental health law, undertakes a comparison of legislative criteria across *Mental Health Acts* in Canada to understand how the terms “mental capacity” and “mental disorder” are defined. Mental capacity is central to the process of completing an advance directive. Several conceptual models are identified to reveal how statutory provisions within *Mental Health Acts* have been drafted. Certain legislative definitions contain residual elements of structural stigma. A uniform definition for the legislative standard of competency could help judges evaluate how capacity assessments are conducted by mental health professionals. Currently, the wide variability in how mental capacity is defined across provincial and territorial legislation can pose challenges for judges who are asked to interpret the validity of advance directives in mental health.

Chapter 7, also written for a forthcoming book chapter on mental health law, is a comparative analysis of civil commitment statutes across Canada to understand: (i) the least restrictive alternative criteria; (ii) involuntary admission criteria; (iii) danger/harm & mental/physical criteria; and (iv) civil commitment criteria. The extent to which advance directives will be honoured by health care providers will depend greatly on the type of hospitalization preferences included in such documents. For example, PADs permit individuals with mental illness to include preferences such as choice of hospital, visitation rights, instructions to staff, and refusal of treatment if mentally incapable. Ethical and legal obligations exist for hospital staff and emergency teams to remain abreast of institutional policies and legislative requirements regarding advance directives, particularly during hospital admissions.

The dissertation concludes by integrating the results of these seven chapters in order to assist lawyers and mental health professionals learn about possible future directions of advance treatment planning in Canada. Strategies are offered to overcome practical barriers associated with helping individuals execute advance directives and making the documents accessible during emergencies.

3. Framework for Advance Directives

A general framework was developed depicting four methodological and analytical approaches. Advance treatment planning can be examined through ethical (values), legal (rights and obligations), or clinical (communication of preferences) perspectives. Philosophical/theoretical analyses are adopted for chapters 1 (PADs and autonomy) and 2 (Ulysses contracts). Statutory and common law analyses are applied to chapters 5 (advance treatment planning in Canada), 6 (mental capacity), and 7 (civil commitment). Empirical and evidence-based analyses are used in chapters 3 (mixed methods research) and 4 (qualitative study). The upper right quadrant reflects the need to conduct future research that has a strong educational and knowledge dissemination component.



4. Contributions of Authors

An attestation to the relative contributions of co-authored manuscripts is provided in conformity with academic requirements of the Graduate and Postdoctoral Studies Office, McGill University. The thesis guidelines state:

> "As an alternative to the traditional thesis style, the research may be presented as a collection of papers of which the student is the author or co-author (i.e., the text of one or more manuscripts, submitted or to be submitted for publication, and/or published articles (not as reprints) but reformatted according to thesis requirements as described below). These papers must have a cohesive, unitary character making them a report of a single program of research...In the case of multiple-authored articles, the student must be the primary author, although it is expected that co-authors may have had input in revisions. The thesis must include a statement explicitly outlining the contributions of the student and all co-authors. This

statement must appear in a section entitled "Contributions of Authors" in the "Preface" of the thesis."

Chapter One: Ambrosini (90%); Crocker (10% - editing)

Ambrosini, D. L., & Crocker A. G. (2009). [Psychiatric advance directives and the role of autonomy]. *Revue Santé Mentale au Québec, 34*(2), 51-74.

Chapter Two: (100% sole)

Ambrosini, D. L. (2010). Ulysses contracts: Autonomy and the self-binding problem: legal and ethical perspectives, in *La Protection des personnes vulnérables*, Service de la formation continue du Barreau du Québec, (Cowansville: Éditions Yvon Blais) 315, 105-131.

Chapter Three: Ambrosini (70%); Crocker (15% - study design; editing); Latimer (15% - study design; editing)

Ambrosini, D. L., Crocker, A. G., & Latimer, E. Preferences for instructional or proxy advance directives in mental health: An exploratory mixed methods study. Manuscript to be submitted.

Chapter Four: Ambrosini (75%); Bemme (10% - data collection; editing); Crocker (10% - study design; editing); Latimer (5% - study design; editing)

Ambrosini, D. L., Bemme, D., Crocker. A. G., & Latimer, E. Narratives of psychiatric advance directives: qualitative study. Manuscript to be submitted.

Chapter Five: (100% sole)

Ambrosini, D. L., Legal and ethical rights of individuals with mental illness in Canada to participate in advance treatment planning, Manuscript to be submitted.

Chapter Six: Ambrosini (95%); Joncas (5%)

Ambrosini, D. L. & Joncas, L. (forthcoming). Mental health & capacity legislation across Canada, in Bloom H, Dykeman MJ (Eds.) (2nd ed.) *A Practical Guide to Mental Health, Capacity, and Consent Law in Ontario*, (Toronto: Thomson Carswell).

Chapter Seven: Ambrosini (95%); Joncas (5%)

Ambrosini, D. L. & Joncas, L. (in press). Civil commitment: a cross-country check-up, in Bloom H, Schneider R. (Eds.). *Law and Mental Disorder: A Comprehensive and Practical Approach* (Toronto: Irwin Law).

As the dissertation consists of a series of manuscripts for both mental health and legal audiences, there is only minor overlap of information between manuscripts. This was kept to a minimum and occurred to the extent that readers could understand the broader context of the analyses. Formatting of footnotes corresponds to the appropriate scholarly style of the journal to which the manuscript will be submitted to (i.e. legal or medical). The common bibliography at the end of the dissertation includes all references formatted in a single style.

CHAPTER ONE: Psychiatric advance directives and the role of autonomy

Although psychiatric advance directives (PADs) are grounded in the ethics of autonomy, the relationship between the two is unclear. PADs are legal documents that allow individuals with mental illness to record their treatment preferences should they become incompetent in the future. The relationship between autonomy and PADs has been discussed in ethical, legal, and philosophical terms, but has not been clearly operationalized for clinical purposes. Autonomy is a fundamental ethical value that can include being independent from external controlling influences and having the mental capacity to direct one's actions. Individuals with mental illness occasionally require assistance in understanding their ethical and legal rights with respect to making autonomous choices. Professional stakeholders need more education regarding the importance of autonomy for clinical practice. Competency to consent to treatment is the mental prerequisite that ensures individuals with mental illness are able to complete PADs with insight, whereas autonomy is the ethical value that empowers individuals to work towards their recovery.

Ambrosini, D. L., & Crocker A. G. (2009). [Psychiatric advance directives and the role of autonomy]. *Revue Santé Mentale au Québec, 34*(2), 51-74.

> *"In diseases of the mind, as well as in other ailments, it is an art of no little importance to administer medications properly but, it is an art of much greater and more difficult acquisition to know when to suspend or altogether omit them."*
>
> – Philippe Pinel, *Treatise on Insanity* (1806)

INTRODUCTION TO ADVANCE TREATMENT PLANNING IN CANADA

Psychiatric advance directives (PADs) are legal documents that allow competent individuals with mental illness to record their treatment preferences if they become incapable to make independent decisions in the future. Although PADs prioritize autonomy as central to the recovery process (Swartz & Swanson, 2007), the relationship between autonomy and competency, insight, attitudes toward medication, and quality of life has been less clear. PADs are contractual legal documents generally signed and witnessed by two individuals. If individuals with mental illness are given reassurance that the law will enforce their prior declarations in a PAD, and subsequently find that their wishes are honoured during a time of clinical need, this may lead to increased feelings of autonomy. Although the concept of autonomy has been discussed extensively with reference to ethical and legal rights, its relationship to patients' clinical outcomes is less clear. The aim of this chapter is to argue that in order to determine whether advance treatment-planning interventions such as PADs generate positive clinical outcomes, such as quality of life and recovery, requires that autonomy be measured empirically.

Some data suggests that only 12% of Ontarians have completed a living will (Singer et al., 1993), and that 10% of Canadians have reported filling out an advance directive within the context of end-of-life decision-making (Singer et al., 1995). Advance treatment planning for individuals with mental illness differs from end-of-life decision-making in that mentally ill individuals often experience fluctuating mental capacity, while those towards the end-of-life generally manifest a progressive loss of capacity (Samanta & Samanta, 2006). Planning for the possibility of a relapse of illness is not an easy psychological process and requires courage to consider negative future consequences in one's life. On the other hand, waiting to declare treatment preferences until after a crisis occurs also creates challenges and a level of uncertainty for patients, treatment providers, and family members.

Research studies on advance directives in Canada have focused primarily on the needs of elderly persons (Bravo, Dubois, & Paquet, 2003; Molloy et al., 2000; Patterson et al., 1997). In a systematic review and multi-level analysis of advance directives among older Canadian adults, there was widespread endorsement of the view that a major benefit of advance directives lies in their potential to preserve patient autonomy, yet there is a dearth of research in Canada examining the actual effectiveness of advance directives (Bravo et al., 2008). Elderly persons may be more inclined to complete advance directives towards end-of-life when they know their medical condition is progressively deteriorating, whereas individuals with mental illness may be reticent to do so believing they will not experience another relapse.

There is currently no national approach or federal legislation in Canada to assist individuals with mental illness to engage in advance treatment planning. It would be helpful to develop and disseminate information kits and friendly-user forms encouraging individuals with mental illness to appoint substitute decision-makers to complete advance directives (Dunbrack, 2006; Kirby, 2004). Depending on where one lives in Canada, individuals can complete an advance directive in the form of a proxy directive, whereby the person names an agent to make decisions on his or her behalf if incapable, or an instructional directive, where the individual can provide detailed statements regarding treatment preferences. Instructional directives go further than proxy directives in allowing individuals to express their autonomous choice and requiring agents to follow detailed and specific instructions. Some provinces have enabling legislation for proxy directives, but not instructional directives (namely, British Columbia, Ontario, Québec, New Brunswick, and Yukon) (Dunbrack, 2006). For example, the Ontario *Health Care Consent Act* uses powers of attorney for personal care (*HCCA*, 1996), while the *Civil Code of Québec* (*CCQ*, 1991) has legislated mandates in case of incapacity; both, however, are proxy directives. Interprovincial disparities appear to exist in mental health legislation related to proxy and/or instructional directives, creating a challenge for individuals with mental illness in knowing whether an advance directive will be upheld if they travel outside of their home jurisdiction. For example, individuals who complete an advance directive such as a power of attorney in Ontario, or a mandate in case of incapacity in Québec, and then move to another province with different governing mental health legislation confront the possibility that their document will not be considered valid. This can pose a challenge if the individual is mentally incapable at the time.

Heated debates arise between patients, psychiatrists, and family members when treatment preferences are not honoured (Joshi, 2003). Some clinicians have imposed their personal decisions regarding treatment with limited consultation from patients or family members (Goss et al., 2008). If clinicians force controversial treatment upon patients rather than negotiate alternatives, this will certainly generate feelings of powerlessness, treatment-resistant care, and a spirit of litigiousness. Alternatively, when there is transparent dialogue clinicians can offer treatment that is coherent with their patients' subjective perceptions of recovery. If individuals with mental illness feel empowered to exercise their decision-making rights, they may become more inspired to work towards their recovery goals, which requires that recovery be an operational measure (Davidson et al., 2007).

Advance treatment planning in Canada differs from the U.S. where the *Patient Self-Determination Act* (*PSDA*, 1991) mandates that health care providers develop institutional policies and educate patients about advance directives. A legal obligation exists upon U.S. medical care institutions to document the existence of advance directives in patients' medical files if one has been formulated. A similar obligation does not exist for Canadian health care institutions or hospitals. As awareness of the benefits of advance directives becomes commonplace, the ability to access them in a timely fashion will also become increasingly important (Srebnik & Russo, 2007) particularly with the advent of electronic medical records. The feasibility of developing a clearinghouse to help individuals with mental illness, health care providers, and family members to access the documents quickly needs to be explored further.

PSYCHIATRIC ADVANCE DIRECTIVES

PADs are legal documents that allow individuals with mental illness to declare their treatment preferences in the event they become incapable in the future (Scheyett, 2008). The forerunner of PADs were called psychiatric wills, documents that emerged shortly after the U.S. civil rights movement “whereby individuals could plan, while rational and sane, for how they wish to be treated in the future, should others consider them to be irrational” (Szasz, 1982). PADs differ from advance planning interventions in other countries in that they are primarily legal documents that aim to increase autonomy (Henderson et al., 2008). While PADs are used by individuals with mental illness in the U.S., joint crisis plans are employed in the United Kingdom. Each jurisdiction has its own legal requirements as to whether advance directives will be upheld by courts of law. On a spectrum from highly paternalistic to fully informed choice, treatment plans are more paternalistic than advance directives, and although they ideally involve a health care provider discussing the treatment plan with their patient this is not always done (Ashcraft & Anthony, 2006). PADs, on the other hand, allow for greater informed choice by prioritizing autonomy through the force of law (Henderson et al., 2008).

The process of sitting down and deliberating on what to include in a PAD can help individuals gain insight into their illness and develop cognitive strategies to work towards their personal recovery (Swanson et al., 2006). Some of the barriers associated with implementing PADs within hospital settings include how to share decision-making power, how they will affect hospital infrastructure, and their impact on economic resources (Amering et al., 2005). Central to whether PADs become accepted in clinical practice are the ethical values of autonomy, dignity, and self-determination (Cantor, 1992a; Ritchie et al., 1998). The law does not always provide a clear definition of autonomy, self-determination, or empowerment. Ethicists, philosophers, and legal scholars have argued that autonomy can be conceived of as in greater or lesser degrees, and it is essentially the decision to act as a free, self-directed agent, whereas self-determination is the ability to say yes or no (Somerville, 1994). The ethical principle of autonomy is broader than simply asking individuals to be responsible by taking control of their actions. The aim of this chapter is not to propose a universal definition of autonomy, but to highlight instead how challenges in operationalizing autonomy has led to a lack of clarity in defining the term. PADs allow individuals with mental illness to record their preferences towards medications, tell others how to intervene during a crisis event, or express a choice of hospital, seclusion, or restraint methods that may be perceived as overly coercive. Some choices are guided by prescriptive values (wanted treatment), while others are based on proscriptive values (unwanted treatment).

In order for treatment preferences to be valid, they must remain within the boundaries of reasonable medical care. The medical community determines what constitutes reasonable care based on commonly accepted clinical practice, so that if patients record unreasonable treatment preferences in their PADs clinicians will likely not be expected to honour such choices. Determining reasonable or unreasonable treatment preferences is not always clear. For example, in *re C* (1994), a legal case from England involving a 68 year-old psychiatric patient suffering from delusions, the court granted the patient an injunction preventing physicians from amputating his gangrenous leg, despite a 15% chance of survival if he did not undergo the surgery. Although this case is primarily relevant to health law in England, two points emerge from the court's reasons. First, it is necessary to examine whether treatment preferences of an individual with mental illness are linked to possible persecutory delusions, or the preferences are expressed as a competent and mentally sound person. Second, the court acknowledged the relationship between different degrees of autonomy and capacity stating that "[i]f the patient's capacity to decide is unimpaired, autonomy weighs heavier, but the further capacity is reduced, the lighter autonomy weighs" (*re C*, 1994). Understanding the relationship between mental capacity to consent to treatment and the degree of autonomy is important in the context of individuals who complete PADs.

When treatment preferences are negotiated through a shared decision-making approach, it is easier to identify and honour individuals' values at a future time (Grosse et al., 2004; Linhorst et al., 2002). Individuals with mental illness rarely use PADs to refuse all medical treatment (Swanson et al., 2006). Individuals who experience an acute psychotic experience should not be equated with complete loss of autonomy, as someone with psychotic symptoms can still be competent to make certain types of decisions but not others. The process of thinking reflexively about one's illness based on past treatment requires time, but can be very valuable for patients to gain insight and learn how to manage their illness (Mueser et al., 2002; Mueser et al., 2006). The question of who should be authorized to decide if an individual with mental illness is mentally capable to complete a PAD is a difficult one. Generally, a physician is able to make this determination; however, it can also include other trained professionals. In Ontario, for example, designated and trained capacity assessors can provide opinions of individuals' capacity to complete powers of attorney. There are also more objective measures to assess mental competency such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), which is a formal method to examine patients' ability level of understanding, appreciation, reasoning, and choice (Appelbaum & Grisso, 2001).

The attitudes of mental health professionals towards PADs, including those of psychiatrists, social workers, psychologists, and nurses, are critical to evaluate whether the documents will be used (Amering et al., 1999; Kim et al., 2007; O'Connell & Stein, 2005; Swartz et al., 2005; Van Dorn et al., 2006). There are still barriers to overcome before PADs will be accepted into mainstream psychiatric practice (Srebnik & Brodoff, 2003; Van Dorn et al., 2008). Individuals will be more inclined to complete PADs if clinicians are supportive of the process from the outset (Scheyett et al., 2007). For example, individuals are more likely to complete a PAD if assisted by a facilitator through a two-hour session than if they receive no assistance (Swanson et al., 2006). The demand for PADs among individuals with mental illness is relatively high. In a study across five U.S. cities involving outpatients with a mental illness, 66-77% who used mental health services reported that they would complete a PAD if given the opportunity (Swanson et al., 2006). It is particularly important to ensure that individuals with serious mental illness are competent to declare their treatment preferences, and that any statements in a PAD reflect their true selves rather than being a manifestation of their illness. Research reveals that individuals with serious mental illness are capable to complete PADs although they may need more individualized attention (Swanson et al., 2006). If many individuals with mental illness report a desire to complete PADs because they believe it may improve their medical condition, then it will be necessary to find ways to evaluate whether they are effective.

Empowerment is a value commonly associated with choosing to complete a PAD (Backlar et al., 2001). Among psychiatrists, psychologists, lawyers, and review board members in Ontario and Québec who completed a questionnaire, more than 90% reported a desire for more information about how PADs work (Ambrosini et al., 2008). Approximately 20% of legal and mental health professionals in the study reported that respect for autonomy is an advantage offered by PADs (Ambrosini et al., 2008). Although there may be differences between consumer-driven private health care in the U.S. and the public health care system in Canada, the importance of consumer choice, respect for autonomy, and recovery-oriented preventive care transcends international boundaries (Calsyn et al., 2000; Nelson, 2007). PADs do not currently exist in Canada. The provinces of Ontario and Québec currently use powers of attorney for personal care and mandates in case of incapacity, respectively. The primary difference between Canada and the U.S. is related to the type of document used. Most Canadian provinces have not adopted specific advance treatment plans for individuals with mental illness to provide detailed instructions regarding their treatment choices. The consumer recovery movement provides a valuable framework to understand better whether PADs can increase autonomy (Davidson et al., 2007; Scheyett et al., 2007).

Despite the interest in completing PADs among individuals with mental illness, 47% of psychiatrists report that they would override the document if a patient lacked the insight to make a rational decision (Swanson et al., 2007). Emergency room psychiatrists are twice as likely to override a PAD as are general clinicians even if they are aware that the documents are legally binding (Swanson et al., 2007). These findings suggest that conflicts about the right to make treatment preferences between psychiatrists and individuals with mental illness may be more real than imagined. Some clinicians have overridden validly documented PADs under the belief that they understand a patient's clinical needs better than the patient (Srebnik & Russo, 2007). While this may be justified under certain circumstances, if clinicians do not attempt to understand why individuals make certain choices then patients may come to believe that their autonomy is insignificant thereby jeopardizing the therapeutic relationship. When individuals with mental illness refuse medications due to paranoid delusions, 22% of clinicians report that they will uphold a PAD, whereas if the reason for medication refusal is related to side effects 72% of clinicians will uphold a PAD (Wilder et al., 2007). Overriding an individual's prior competent wishes creates other detrimental side effects such as loss of confidence and trust in the doctor-patient relationship. Through collaborative negotiation and knowledge of treatment preferences, it is possible for 'clinical needs' to be congruent with 'patient wants'. The limitations of PADs also require explanation and discussion between patients and clinicians. Some of these include how comprehensive treatment preferences should be, the nature of the self-binding problem, when the document can be revoked, ensuring the individual is capable when the PAD is completed, and determining what steps to take if treatment that is more effective emerges (Ambrosini et al., 2008). Gray et al. (2008) have suggested that advance directives are probably used less than is warranted due to a lack of knowledge and motivation from mental health professionals.

Adopting a collaborative strategy to complete advance directives can help clinicians and patients develop an open pathway of communication regarding treatment preferences. In England, joint crisis plans are used to encourage individuals with mental illness to negotiate treatment preferences and improve understanding of perceptions of control (Sutherby et al., 1999). Another method to increase communication is if clinicians explain to patients that advance directives can be a form of relapse prevention program (Papageorgiou et al., 2004). Some clinicians believe that during a psychiatric relapse, the onus should fall on a patient to prove to the clinician that he or she was capable at the time the PAD was documented (O'Reilly, 2008). Such a position, however, undermines respect for true autonomy. If an individual with mental illness was incapable at the time the PAD was completed, the document may not be valid from the outset. Asking someone to prove that he or she was capable when the document was completed, at a time when that individual is likely incapable, subverts any value of self-determination. If a clinician is presented a patient who has a PAD and believes that the document may have been completed while incapable, the clinician will still require strong evidence to that effect before overriding the document.

The concept of leverage in mental health refers to coercive interventions that limit autonomous choices by encouraging individuals to do what they might not otherwise do (Appelbaum & Redlich, 2006). If clinicians attempt to leverage an individual's free choice to obtain a particular medical outcome that contravenes one's autonomy, without basing it on defensible legal standards of decisional capacity, individuals will likely become distrustful towards clinicians and the psychiatric profession. Canadian law provides that forcing unwanted medical treatment on individuals with mental illness who can understand and reasonably appreciate the foreseeable consequences of their decisions can lead to medical liability (Sklar, 2007; *Starson v. Swayze*, 2003). Several psychiatric hospitals have adopted codes of ethics that advocate for patients' autonomous rights to choose a professional and/or institution from whom they wish to receive health and social services (Code of Ethics, Douglas Hospital, 2005). Regarding advance treatment planning, such codes of ethics should reflect a balance between honouring patients' autonomy rights and hospitals' obligations to provide appropriate medical care.

THE VALUE OF AUTONOMY

The loss of autonomy assumes an important role in psychiatric practice. Loss of autonomy is an indirect cost associated with deterioration of social function for long-stay hospital patients (Wagner et al., 2006). PADs have the potential to increase individuals' perception of autonomy and alleviate trauma and fear associated with loss of choice during a future psychiatric crisis (Scheyett et al., 2007; Swanson et al., 2003; van Willigenburg & Delaere, 2005). The relationship between PADs and autonomy has been researched primarily through philosophical, moral, and legal perspectives (Davis, 2008; Ritchie et al., 1998). Evidence-based ethics offers an innovative approach to understand research questions related to bioethical values through the design of experimental studies (Widdershoven, 2007). For example, empowerment in mental health has been operationalized and then tested through the development of valid and reliable psychometric instruments (Castelein et al., 2008; Rogers et al., 1997). Empowerment can be understood as a process of sharing knowledge towards the goal of giving power to help them increase their autonomy and self-determination (Schurhofer & Peschl, 2005). Another example of evidence-based ethics is the Ideal Patient Autonomy Scale (IPAS), which is a normative instrument developed to measure ideals of autonomy in the doctor-patient relationship (Stiggelbout et al., 2004). The IPAS is unique in that it aims to understand moral concepts and ideals of autonomy. For example, some individuals do not only perceive autonomy from a liberal individualist perspective, but also as a concept of procedural independence.

The term autonomy stems from the Greek words, *auto* and *nomos*, which essentially suggests that an individual has one's own law. How autonomy is defined also depends on whether one views it from a legal, clinical, philosophical, or ethical perspective (Somerville, 1994). At the most basic level, autonomy means independence from outside controlling influences while having the mental capacity to direct one's personal actions. Arriving at a single or uniform definition of autonomy is not the aim of this chapter. Yet, it is possible to distinguish between *ideals* and *preferences* of autonomy. Stiggelbout et al., (2004) state that ideals of autonomy are grounded in self-reflection, whereas preferences are more affective and refer to what one considers satisfactory. Before individuals with mental illness complete PADs it would be useful to understand not only their preferences, but also their ideals of autonomy.

Autonomy has traditionally been conceived of as a negative freedom – the right to non-intervention (Ritchie et al., 1998). A relational-based definition of autonomy differs from traditional views found in western bioethical culture where value is placed on independence and breaking free from authority (Ells, 2001; Ho, 2008; Scheyett, 2007). The concept of relational autonomy is based on social, interpersonal, and interdependent relationships, rather than seeing persons as only atomistic free agents. Relationship-based autonomy can help to nuance claims of absolute rights to refuse treatment by appreciating the value of a collective identity and understanding how choices can affect others. The degree of autonomy psychiatric patients experience can differ depending on whether one is residing in long-term care or receiving temporary acute care. Whether PADs increase autonomy also depends partly on the temporal form of autonomy one emphasizes, such as precedent or prospective autonomy (Cantor, 1992b; Davis, 2004).

Whether completing a PAD increases autonomy, and how this shapes individuals' cognitive processes, are important questions (Atkinson et al., 2004; Scheyett et al., 2007). As Geller states, "psychiatry does not need another intervention in the name of increasing patients' autonomy with no verifiable measures that the intervention actually accomplishes this end" (Geller, 2000, p. 12). A more objective measure of the relationship between PADs and autonomy could help towards designing and evaluating programs to examine the influence of PADs and their relationship to perceptions of recovery and quality of life. If individuals who complete a PAD find their wishes are upheld during crises this may lead to increases in autonomy, fewer relapses, and positive clinical outcomes. Increases in perceptions of autonomy may be related to the power to limit clinical freedom during periods of decisional incapacity (Atkinson et al., 2004).

Autonomy is a legally enforceable right. The law allows individuals with mental illness to refuse medical treatment under certain situations. At the same time, compulsory treatment can be administered legally to patients where public safety and risk of harm to oneself or others is present or in emergency medical situations. A PAD acts as a pre-emptive document allowing individuals to circumscribe the limits of what they perceive as unjustified treatment. Some mental health legislation supports the view that autonomy is more than simply an ethical value. For example, the aim of Ontario's *Health Care Consent Act* (1996) is to "enhance the autonomy of persons for whom treatment is proposed." Similarly, the *Civil Code of Québec* (*CCQ*, 1991, art. 257) provides, "Every decision relating to the institution of protective supervision or concerning a protected person of full age shall be in his interest, respect his rights and *safeguard his autonomy*." Mandates in case of incapacity are used in Québec as proxy directives to appoint an agent to protect an individual's autonomy in case of incapacity. Under a protective supervision regime, Québec courts will examine an individual's degree of autonomy (*CCQ*, 1991, art. 276). Autonomy is mentioned directly in the template forms for mandates in case of incapacity provided by Québec's Office of the Public Curator. It is fair to ask how judicial and legal actors will know if someone is experiencing full or partial autonomy. Furthermore, what efforts currently exist to safeguard and enhance the autonomy rights of individuals with mental illness through advance treatment planning? The legal relevance of autonomy for PADs was also highlighted in a U.S. appellate decision, *Hargrave v. Vermont* (2004), which upheld the validity of the documents. In the legal brief provided by *amicus curiae* for the appellant, it was argued that individuals who express autonomous choices are more likely to act with self-determination (Bazelon Mental Health Center, 2002). One reason PADs may increase autonomy is because they are legal documents that provide increased choice. Autonomy, however, is not synonymous with choice. Choice can be 'cosmetic' in that allowing patients the right to choose treatment/services do not necessarily allow them to express their true choice if not all options are made available.

Autonomy is an inalienable and universal right. Overriding someone's rights can lead to perceptions of coercion or feelings of learned helplessness. Under a formalist theory of contract law, at least two criteria are required for individuals with mental illness to formalize their treatment preferences in a PAD – a 'meeting of the minds' (*consensus ad idem*) and legal capacity to enter an agreement from the outset. Even if not all provinces and territories have legislation supporting instructional directives, PADs can nevertheless be considered legally binding documents if they are representative of the will of a party. The belief that individuals with mental illness should not be permitted to make contractual decisions because of weakness of the will, which is a form of *akrasia* (Kalis et al., 2008), or because the person would be acting against their better judgment, fails to honour autonomy. One possibility would be to consider the value of relational-based contracts, whereby close family members, friends, or health care providers can facilitate and support individual's values and choices of treatment preferences.

The value of balancing autonomy and self-determination with the need to receive effective medical treatment has been examined by Canadian courts in recent years. Individuals with mental illness have a legal right to refuse medical treatment if they are capable to *understand* and *appreciate* the reasonably foreseeable consequences of their decisions (*Starson v. Swayze*, 2003). While patients' right to refuse treatment applies across jurisdictions, psychiatric patients in Ontario cannot be found mentally incapable if they deny they have a mental illness (Sklar, 2007; *Starson v. Swayze*, 2003). Hospitals are also required to ensure that treatment plans are current, that alternative treatment options have been explored, and that physicians are reasonably accommodative of treatment preferences, particularly if current treatment is at an impasse (*Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services*, 2006). Individuals with mental illness will be required to demonstrate that they are competent to understand and appreciate the rationality of their choices before completing a PAD. However, being declared competent to consent to treatment is not identical to being found autonomous to make one's own choices (Srebnik & Kim, 2006).

Individuals can be found legally incompetent to make certain decisions, and yet retain a high measure of perceived autonomy.

Mental health policies and legislation across Canada may need to place greater emphasis on the value of autonomy in clinical practice. The Kirby Report (2004) recommends that provincial legislation barring individuals from making advance directives should be repealed if it fails to preserve patient autonomy and dignity. If a legal obligation existed for treatment providers among Canadian hospitals to ask whether individuals with mental illness have advance directives, patients may be more inclined to engage in their recovery process. Whether it is possible to adopt legislation in Canada similar to the U.S. *Patient Self-Determination Act* (*PSDA*, 1990), whereby treatment providers are required to ask patients if they have advance directives, could be explored further. The main goal of the *PSDA* was to protect the autonomy of patients, and it has helped to create an awareness of possible benefits of advance directives among treatment providers and patients. Programs have been developed to assist individuals to complete advance directives, thereby increasing national awareness of the *PSDA* among treatment providers and patients. In Canada, similar national campaigns have not been conducted to alert healthcare providers and patients to the possible advantages of advance directives. The ethic of autonomy could become a touchstone principle and catalyst to designing improved recovery-oriented advance treatment programs. In the meantime, it would be helpful to examine the types of treatment preferences that individuals with mental illness have towards instructional directives, particularly in provinces where enabling legislation only supports proxy directives.

Further research should also examine how individuals with mental illness manage their recovery process after completing a PAD. Some of the resources that could be offered to patients and family members to assist in documenting PADs include educational training kits and forms, trained facilitators who can sit down with patients and explain the process, and access to a registry system that allows individuals to obtain the documents in a timely fashion. In one study, it was found that individuals’ past and current contact with mental health care providers affects how individuals manage their anti-psychotic medications towards greater agency and self-confidence (Rogers, 2003). As voluntary choice is central to the success of advance treatment planning, it would be useful to examine to what extent making treatment preferences based on past medical experiences affects clinical outcomes (Preference Collaborative Review Group, 2008). It would also be helpful to know whether autonomy among individuals diagnosed with depression, bipolar disorder, or schizophrenia predicts one's choice to complete an instructional or proxy directive. Do individuals who complete a PAD and later experience a relapse have greater autonomy if their treatment preferences are upheld in law?

There is a need to build a solid evidence-base around whether PADs increase autonomy and lead to improved recovery. Ideally, gathering evidence of whether PADs increase autonomy would involve conducting a randomized controlled trial that compares a PAD group versus a non-PAD group, and then examining how the documents are used and influence patients' level of autonomy over time. Mediating variables of autonomy may include cognitive strategies and psychosocial perceptions of how much control individuals believe they have over their treatment preferences. However, conducting such a study poses certain ethical challenges related to randomization of participants to a legal intervention and choice of treatment. It would also be informative to examine if individuals with mental illness with varying degrees of autonomy are more likely to choose a particular form of advance directive (instructional versus proxy directives). An area of future research will require examining if individuals who complete PADs enjoy increased quality of life and how they influence one's personal views of recovery.

CONCLUSION

Canadian provinces and territories have been re-strategizing their efforts towards a national approach to address issues of stigma and recovery in mental health (Mental Health Commission of Canada, 2009). Policy-makers should not overlook the central role that autonomy has for individuals with mental illness to recover through advance treatment planning interventions such as PADs. The call for greater autonomy is echoed from the voices of individuals with mental illness, family members, and mental health care providers. If PADs are to be successful in Canada, their effectiveness will depend partly on whether they can build autonomy among users. Autonomy is more than an ethical principle; indeed, the law requires that health care providers offer mental health services to promote patient’s autonomous choices. Rather than seeing advance directives as a divisive wedge between treatment providers and patients, they can be conceptualized as therapeutic tools to empower individual with mental illness towards greater autonomy.

REFERENCES

AMBROSINI, D. L., CROCKER, A. G., PERREAULT, M., ISRAËL, M., 2008, Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec, *Journal of Ethics in Mental Health*, 3, 2, 1-12.

AMERING, M., DENK, E., GRIENGL, H., SIBITZ, I., STASTNY, P., 1999, Psychiatric wills of mental health professionals: a survey of opinions regarding advance directives in psychiatry, *Social Psychiatry and Psychiatric Epidemiology*, 34, 1, 30-34.

AMERING, M., STASTNY, P., HOPPER, K., 2005, Psychiatric advance directives: qualitative study of informed deliberations by mental health service users, *British Journal of Psychiatry*, 186, 247-252.

APPELBAUM, P. S., GRISSO, T., 2001, *MacCAT-CR MacArthur Competence Assessment Tool for Clinical Research*, Professional Resource Press: Sarasota FL.

APPELBAUM, P. S., REDLICH, A., 2006, Impact of decisional capacity on the use of leverage to encourage treatment adherence, *Community Mental Health Journal*, 42, 2, 121-130.

ASHCRAFT, L., ANTHONY, W. A., 2006, A treatment planning reality check, *Behavioral Healthcare*, 26, 2, 7-8.

ATKINSON, J. M., GARNER, H. C., GILMOUR, W. H., 2004, Models of advance directives in mental health care: stakeholder views. *Social Psychiatry and Psychiatric Epidemiology*, 39, 8, 673-680.

BACKLAR, P., MCFARLAND, B. H., SWANSON, J. W., MAHLER, J., 2001, Consumer, provider, and informal caregiver opinions on psychiatric advance directives, *Administration and Policy in Mental Health*, 28, 6, 427-441.

BAZELON CENTER FOR MENTAL HEALTH LAW, 2002, Retrieved from:
http://www.bazelon.org/issues/advancedirectives/hargrave.html

BRAVO, G., DUBOIS, M. F., PAQUET, M., 2003, Advance directives for health care and research: prevalence and correlates, *Alzheimer Disease and Associated Disorders*, 17, 4, 215-222.

BRAVO, G., DUBOIS, M. F., WAGNEUR, B., 2008, Assessing the effectiveness of interventions to promote advance directives among older adults: a systematic review and multi-level analysis, *Social Science & Medicine,* 67, 7, 1122-1132.

CALSYN, R. J., WINTER, J. P., MORSE, G. A., 2000, Do consumers who have a choice of treatment have better outcomes? *Community Mental Health Journal,* 36, 2, 149-160.

CANTOR, N. L., 1992a, Advance directives and the pursuit of death with dignity: New Jersey's new legislation, *Rutgers Law Review,* 44, 2, 335-403.

CANTOR, N. L., 1992b, Prospective autonomy: on the limits of shaping one's postcompetence medical fate, *The Journal of Contemporary Health Law Policy,* 8, 13-48.

CASTELEIN, S., VAN DER GAAG, M., BRUGGEMAN, R., VAN BUSSCHBACH, J. T., WIERSMA, D., 2008, Measuring empowerment among people with psychotic disorders: a comparison of three instruments, *Psychiatric Services,* 59, 11, 1338-1342.

CIVIL CODE OF QUÉBEC, 1991 (*CCQ*).

CODE OF ETHICS, 2005, Montréal, Douglas Mental Health University Institute. Retrieved from: http://www.douglas.qc.ca/page/ethics.

DAVIDSON, L., TONDORA, J., O'CONNELL, M. J., KIRK, T., JR., ROCKHOLZ, P., EVANS, A. C, 2007, Creating a recovery-oriented system of behavioral health care: moving from concept to reality, *Psychiatric Rehabilitation Journal,* 31, 1, 23-31.

DAVIS, J. K., 2004, Precedent autonomy and subsequent consent, *Ethical Theory and Moral Practice: An International Forum,* 7, 3, 267-291.

DAVIS, J. K., 2008, How to justify enforcing a Ulysses contract when Ulysses is competent to refuse, *Kennedy Institute of Ethics Journal,* 18, 1, 87-106.

DEWOLF BOSEK, M. S., RING, M. E., CADY, R. F., 2008, Do psychiatric advance directives protect autonomy? *JONAS Healthcare Law, Ethics and Regulation,* 10, 1, 17-24.

DUNBRACK, J., 2006, *Advance Care Planning: the Glossary Project*, Ottawa: Health Canada.

ELLS, C., 2001, Shifting the autonomy debate to theory as ideology, *The Journal of Medicine and Philosophy,* 26, 4, 417-430.

GELLER, J. L., 2000, The use of advance directives by persons with serious mental illness for psychiatric treatment, *Psychiatric Quarterly,* 71, 1, 1-13.

GOSS, C., MORETTI, F., MAZZI, M. A., DEL PICCOLO, L., RIMONDINI, M., ZIMMERMANN, C., 2008, Involving patients in decisions during psychiatric consultations, *The British Journal of Psychiatry,* 193, 5, 416-421.

GRAY, J. E., SHONE, M. A., LIDDLE, P. F., 2008, *Canadian Mental Health Law and Policy*, LexisNexis, Markham, Ontario.

GROSSE HOLTFORTH, M., REUBI, I., RUCKSTUHL, L., BERKING, M., GRAWE, K., 2004, The value of treatment-goal themes for treatment planning and outcome evaluation of psychiatric inpatients, *The International Journal of Social Psychiatry,* 50, 1, 80-91.

HARGRAVE V. VERMONT, __ F.3d __, 2003 WL 21770957 (2nd Cir. 2003).

HEALTH CARE CONSENT ACT, 1996 S.O. 1996, c. 2 Schedule A (*HCCA*).

HENDERSON, C., SWANSON, J. W., SZMUKLER, G., THORNICROFT, G., ZINKLER, M., 2008, A typology of advance statements in mental health care, *Psychiatric Services*, 59, 1, 63-71.

HO, A., 2008, Relational autonomy or undue pressure? Family's role in medical decision-making, *Scandinavian Journal of Caring Science,* 22, 1, 128-135.

JOSHI, K. G., 2003, Psychiatric advance directives, *Journal of Psychiatric Practice,* 9, 4, 303-306.

KALIS, A., MOJZISCH, A., SCHWEIZER, T. S., KAISER, S., 2008, Weakness of will, akrasia, and the neuropsychiatry of decision making: an interdisciplinary perspective, *Cognitive, Affective & Behavioral Neuroscience,* 8, 4, 402-417.

KIM, M. M., SCHEYETT, A. M., ELBOGEN, E. B., VAN DORN, R. A., MCDANIEL, L. A., SWARTZ, M. S., SWANSON, J. W., FERRON J., 2008, Front line workers' attitudes towards psychiatric advance directives, *Community Mental Health Journal*, 44, 1, 28-46.

KIRBY, M., 2004, *Mental Health, Mental Illness and Addiction: Issues and Options for Canada, Report 3*, Ottawa: Standing Senate Committee on Social Affairs.

LINHORST, D. M., HAMILTON, G., YOUNG, E., ECKERT, A., 2002, Opportunities and barriers to empowering people with severe mental illness through participation in treatment planning, *Social Work*, 47, 4, 425-434.

MAZZEI V. BRITISH COLUMBIA (DIRECTOR OF ADULT FORENSIC PSYCHIATRIC SERVICES), 2006, 1 S.C.R. 326 (Supreme Court of Canada).

MENTAL HEALTH COMMISSION OF CANADA, 2009, available at: http://www.mentalhealthcommission.ca/english/pages/default.aspx.

MOLLOY, D. W., GUYATT, G. H., RUSSO, R., GOEREE, R., O'BRIEN, B. J., BEDARD, M. ET AL., 2000, Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial, *Jama*, 283, 11, 1437-1444.

MUESER, K. T., CORRIGAN, P. W., HILTON, D. W., TANZMAN, B., SCHAUB, A., GINGERICH, S. ET AL., 2002, Illness management and recovery: a review of the research, *Psychiatric Services*, 53, 10, 1272-1284.

MUESER, K. T., MEYER, P. S., PENN, D. L., CLANCY, R., CLANCY, D. M., SALYERS, M. P., 2006, The Illness Management and Recovery program: rationale, development, and preliminary findings, *Schizophrenia Bulletin*, 32, Suppl 1, S32-43.

NELSON, W. A., 2007, The ethics of patient preferences. Autonomy has limitations when contrary to medical judgment, illegal or unethical, *Healthcare Executive*, 22, 5, 34, 36-37.

O'CONNELL, M. J., STEIN, C. H., 2005, Psychiatric advance directives: perspectives of community stakeholders, *Administration and Policy in Mental Health*, 32, 3, 241-265.

O'REILLY, R. L., 2008, The capacity to execute an advance directive for psychiatric treatment, *International Journal of Law and Psychiatry*, 31, 1, 66-71.

PAPAGEORGIOU, A., JANMOHAMED, A., KING, M., DAVIDSON, O., DAWSON, J., 2004, Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals, *Journal of Mental Health,* 13, 4, 379-388.

PATTERSON, C., MOLLOY, D. W., GUYATT, G. H., BEDARD, M., NORTH, J., HASSARD, J. ET AL., 1997, Systematic implementation of an advance health care directive in the community, *Canadian Journal of Nursing Administration,* 10, 2, 96-108.

PINEL, P., 1806, *A Treatise on Insanity*, (D. D. Davis, Trans.). Sheffield: Todd.

PREFERENCE COLLABORATIVE REVIEW GROUP, 2008, Patients' preferences within randomised trials: systematic review and patient level meta-analysis, *British Medical Journal,* 337, a1864.

RE C (ADULT: REFUSAL OF TREATMENT), [1994] 1 WLR 290, Family Division, England.

RITCHIE, J., SKLAR, R., STEINER, W., 1998, Advance directives in psychiatry: Resolving issues of autonomy and competence, *International Journal of Law and Psychiatry,* 21, 3, 245-260.

ROGERS, E. S., CHAMBERLIN, J., ELLISON, M. L., CREAN, T., 1997, A consumer-constructed scale to measure empowerment among users of mental health services, *Psychiatric Services,* 48, 8, 1042-1047.

ROGERS, A., DAY, J., RANDALL, F., BENTALL, R. P., 2003, Patients' understanding and participation in a trial designed to improve the management of anti-psychotic medication: a qualitative study, *Social Psychiatry and Psychiatric Epidemiology,* 38, 12, 720-727.

SAMANTA, A., SAMANTA, J., 2006, Advance directives, best interests and clinical judgement: shifting sands at the end of life, *Clinical Medicine,* 6, 3, 274-278.

SCHEYETT A., 2008, Psychiatric advance directives: benefits and barriers, *Current Psychiatry Reviews*, 4, 3, 137-144.

SCHEYETT, A. M., KIM, M. M., SWANSON, J. W., SWARTZ, M. S., 2007, Psychiatric advance directives: a tool for consumer empowerment and recovery, *Psychiatric Rehabilitation Journal*, 31, 1, 70-75.

SCHURHOFER, M., PESCHL, M., 2005, Autonomy: starting point and goal of personal and social change: a constructivist perspective on knowledge management in empowerment processes, *Kybernetes*, 34, 1/2, 261.

SINGER, P.A., CHOUDRY, S., ARMSTRONG, J., 1993, Public opinion regarding consent to treatment, *Journal of the American Geriatrics Society*, 41, 2, 112-116.

SINGER, P.A., CHOUDRY, S., ARMSTRONG, J., MESLIN, E.M., LOWY, F.H., 1995, Public opinion regarding end-of-life decisions: influence of prognosis, practice and process, *Social Science & Medicine*, 41, 11, 1517-1521.

SKLAR, R., 2007, *Starson v. Swayze*: The Supreme Court speaks out (not all that clearly) on the question of “capacity”, *Canadian Journal of Psychiatry,* 52, 6, 390-395.

SOMERVILLE, M.A., 1994, Labels versus contents: variance between philosophy, psychiatry and law in concepts governing decision-making, *McGill Law Journal*, 39, 179-199.

SREBNIK, D., BRODOFF, L., 2003, Implementing psychiatric advance directives: service provider issues and answers, *The Journal of Behavioral Health Services & Research*, 30, 3, 253-268.

SREBNIK, D., KIM, S. Y., 2006, Competency for creation, use, and revocation of psychiatric advance directives, *The Journal of the American Academy of Psychiatry and Law,* 34, 4, 501-510.

SREBNIK, D., RUSSO, J., 2007, Consistency of psychiatric crisis care with advance directive instructions, *Psychiatric Services,* 58, 9, 1157-1163.

STARSON V. SWAYZE, 2003, 1 S.C.R. 722 (Supreme Court of Canada).

STIGGELBOUT, A. M., MOLEWIJK, A. C., OTTEN, W., TIMMERMANS, D. R., VAN BOCKEL, J. H., KIEVIT, J., 2004, Ideals of patient autonomy in clinical decision making: a study on the development of a scale to assess patients' and physicians' views, *Journal of Medical Ethics,* 30, 3, 268-274.

SWANSON, J. W., SWARTZ, M., FERRON, J., ELBOGEN, E., VAN DORN, R., 2006, Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. *The Journal of the American Academy of Psychiatry and Law,* 34, 1, 43-57.

SWANSON, J. W., SWARTZ, M. S., ELBOGEN, E. B., VAN DORN, R. A., FERRON, J., WAGNER, H. R. ET AL., 2006, Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness, *American Journal of Psychiatry,* 163, 11, 1943-1951.

SWANSON, J. W., SWARTZ, M. S., HANNON, M. J., ELBOGEN, E. B., WAGNER, H. R., MCCAULEY, B. J. ET AL., 2003, Psychiatric advance directives: a survey of persons with schizophrenia, family members, and treatment providers, *International Journal of Forensic Mental Health,* 2, 1, 73-86.

SWANSON, J. W., VAN MCCRARY, S., SWARTZ, M. S., VAN DORN, R. A., ELBOGEN, E. B., 2007, Overriding psychiatric advance directives: factors associated with psychiatrists' decisions to preempt patients' advance refusal of hospitalization and medication, *Law and Human Behavior,* 31, 1, 77-90.

SWARTZ, M. S., SWANSON, J. W., 2007, Commentary: psychiatric advance directives and recovery-oriented care, *Psychiatric Services,* 58, 9, 1164.

SWARTZ, M. S., SWANSON, J. W., FERRON, J., ELBOGEN, E. B., VAN DORN, R., KIM, M. ET AL., 2005, Psychiatrists' views and attitudes about psychiatric advance directives, *International Journal of Forensic Mental Health,* 4, 2, 107-117.

SUTHERBY, K., SZMUKLER, G.I., HALPERN, A., ALEXANDER, M., THORNICROFT, G., JOHNSON, C. ET AL., 1999, A study of 'crisis cards' in a community psychiatric service, *Acta Psychiatra Scandinavica,* 100, 1, 56-61.

SZASZ, T. S., 1982, The psychiatric will - A new mechanism for protecting persons against "psychosis" and psychiatry, *American Psychologist,* 37, 7, 762-770.

VAN DORN, R. A., SWANSON, J. W., SWARTZ, M. S., ELBOGEN, E., FERRON, J., 2008, Reducing barriers to completing psychiatric advance directives, *Administration and Policy in Mental Health*, 35, 6, 440-448.

VAN DORN, R. A., SWARTZ, M. S., ELBOGEN, E. B., SWANSON, J. W., KIM, M., FERRON, J. ET AL., 2006, Clinicians' attitudes regarding barriers to the implementation of psychiatric advance directives, *Administration and Policy in Mental Health*, 33, 4, 449-460.

VAN WILLIGENBURG, T., DELAERE, P., 2005, Protecting autonomy as authenticity using Ulysses contracts, *The Journal of Medicine and Philosophy,* 30, 4, 395-409.

WAGNER, L. C., FLECK, M. P., WAGNER, M., DIAS, M. T., 2006, Autonomy of long-stay psychiatric inpatients, *Revisita de Saude Publica*, 40, 4, 699-705.

WIDDERSHOVEN, G. et al., 2007. *Empirical Ethics in Psychiatry,* Oxford University, Oxford.

WILDER, C. M., ELBOGEN, E. B., SWARTZ, M. S., SWANSON, J. W., VAN DORN, R. A., 2007, Effect of patients' reasons for refusing treatment on implementing psychiatric advance directives, *Psychiatric Services,* 58, 10, 1348-1350.

CHAPTER TWO: Ulysses contracts: Autonomy and the self-binding problem: legal and ethical perspectives

Ulysses contracts are intended to advance the autonomous rights of individuals with mental illness. The term Ulysses contract should not be used interchangeably with an advance directive, and the expression Ulysses clause should be used instead. Advance directives offer mentally competent individuals the opportunity to make a declaration regarding their treatment preferences in the event they become incapable to make independent decisions in the future. Ulysses type contracts are intended specifically to allow individuals to make their wishes irrevocable. One of the challenges courts have in deciding whether to honour a Ulysses contract is how to determine the legal and moral weight that should be given to a self-binding declaration intended to be irrevocable and made while competent. One possible argument is that even if an individual makes a prior competent wish at Time 1, it is too difficult to honour it later, at Time 2, when the person is now incompetent. This chapter canvasses theoretical and practical issues related to Ulysses contracts as they apply in different legal jurisdictions. Understanding issues of pre-commitment, autonomy, preference reversals, mental capacity, and self-identity can help courts in deciding whether to uphold such documents. Whether a Ulysses contract can be better thought of as a contract or a will requires an understanding of the legal relationship between the individual completing the document and his agent and physician. Finally, the concept of *akrasia*, weakness of the will, is explored to understand why some individuals choose to opt-in to a Ulysses contract.

Ambrosini, D. L. (2010). Ulysses contracts: Autonomy, and the self-binding problem: legal and ethical perspectives, in *La Protection des personnes vulnérables*, Service de la formation continue du Barreau du Québec, (Cowansville: Éditions Yvon Blais) 315, 105-131.

TABLE OF CONTENTS

‘And if I implore you and call you to untie me
Then constrain me yourselves in further fastenings’…
Homer, The Odyssey

I. ULYSSES CONTRACTS AND THE ODYSSEY

In Homer’s epic novel, *The Odyssey*, Ulysses sails with his crew past the island of Aiaia where they encounter the Sirens who attempt to lure them into the dangerous waters with their seductive music.[1] In anticipation of their encounter with the Sirens, Ulysses commands his crew to bind him to the ship’s mast while the crew places beeswax in their ears to avoid listening to the music. As Ulysses hears the Sirens’ beautiful voices, he commands his crew to unbind him from the mast. The crew is faced with an important ethical dilemma - should they honour Ulysses’ prior competent wishes or release him based on his present command? The crew’s unfailing commitment to Ulysses’ prior competent wishes allows them to travel safely past the Sirens and continue on their voyage.

Homer’s account has led to the wide use of the term Ulysses contracts in mental health, which are documents completed by individuals with mental illness to declare their prior competent wishes in the event they may become incompetent at some point in the future. The Ulysses metaphor, however, does not neatly parallel the experiences of individuals with mental illness. First, Ulysses did not have an underlying mental illness and he was instead influenced by external forces of the Sirens who encouraged him to act outside of his personal control. It is often much more difficult for individuals with mental illness to determine whether an expressed wish is a reflection of their true sense of identity. Second, as captain of his own ship, Ulysses was in a position of authority with his crew, and could therefore command them to tie him to the mast and respect his later wishes. Individuals with mental illness do not have the same level of authority and often seen as a vulnerable group and without equal bargaining power.

If we were members of Ulysses’ crew, deciding whether we would follow Ulysses’ wishes might depend on several factors that can teach us about the nature of agency and fiduciary relationships. For example, how would we react if

---

[1] Cook, A. (1967). *The Odyssey,* New York: W.W. Norton & Company.

Ulysses asked to be released because the bonds were choking him? Alternatively, might we react differently if Ulysses' relationship with the crew had already been fractured before the critical moment when he was tied to the mast? Trust and confidence between individuals with mental illness and their agents and clinicians are based on fiduciary responsibilities, which is essential for a Ulysses contract to be effective. Ulysses contracts can be structured as mutual commitments by a treatment provider that affects how an individual chooses future contingencies.[2] The agreement that Ulysses entered into with his crew was never recorded in a written contract unlike those used today. Ulysses contracts in mental health raise concerns of whether individuals should be permitted to write self-binding contracts and how third parties, namely clinicians, should deal with them.

Understanding the moral, ethical, and legal authority for Ulysses contracts is important for patients, treatment providers, and legal professionals. Although Ulysses contracts closely resemble advance directives for individuals with mental illness, the amount of legal weight they are given depends on the jurisdiction where they are used and who is authorized to make the final decision related to incompetency. Québec has adopted mandates in case of incapacity, Ontario uses powers of attorney for personal care, and there has been a proliferation in the use of psychiatric advance directives (PADs) in the United States. This chapter addresses, from an ethical and legal perspective, whether individuals should be permitted to adopt self-binding strategies in the form of Ulysses contracts.

A. Ulysses contracts: defining their limits

Ulysses contracts have been proposed for individuals with different types of mental illnesses[3] including self-destructive addictive behaviour.[4] Psychiatrist Thomas Szasz first developed the expression psychiatric will to refer to a

---

[2] Widdershoven G. & Berghams, R. (2001). Coercion and pressure in psychiatry: lessons in psychiatry. *Journal of Medical Ethics*, 33, 560-563.

[3] Rhoden, N.K. (1982). Can a subject consent to a 'Ulysses Contract'? *The Hastings Center Report*, *12*(4), 26-28 [*Rhoden*].

[4] Andreou, C. (2008). Making a clean break: addiction and Ulysses contracts. *Bioethics*, *22*(1), 25-31 [*Andreou*].

document that could be used to refuse certain forms of treatment.[5] For Professor Dresser, a psychiatric will does not have the same meaning as a Ulysses contract.[6] Indeed, just because a document is referred to as a Ulysses contract does not mean that it will be enforced under the principles of traditional contract law. The documents have also been called Ulysses commitment contracts,[7] Odysseus transfers,[8] and Ulysses directives.[9] The most general expression used is an advance directive,[10] but as shown in Table 1 there are many closely related terms that occasionally become conflated. It is important for individuals completing a Ulysses contract to understand whether they are more accurately completing a contract or a will. Nevertheless, when individuals with mental illness choose to complete a Ulysses contract, it is often their intention to provide a firm and determinative declaration that their current wishes should remain irrevocable for the future. Conversely, one can also choose to complete an advance directive without making an irrevocable declaration.[11] Individuals can declare specifically that their advance directive be made revocable, often at the discretion of a third party, or they can record their intention to make the document irrevocable. In this sense, an advance directive can have a different meaning than a Ulysses contract.

Ulysses contracts have been termed mental health advance directives.[12] Andreou states, "Ulysses contracts differ significantly from both traditional

---

[5] Szasz, T. S. (1982). The psychiatric will. A new mechanism for protecting persons against "psychosis" and psychiatry. *American Psychologist, 37*(7), 762-770 [*Szasz*].

[6] Dresser, R. S. (1982). Ulysses and the psychiatrists: a legal and policy analysis of the voluntary commitment contract. *Harvard Civil Rights-Civil Liberties Law Review, 16*(3), 777-854 [*Dresser*]; Dresser, R. (1984). Bound to treatment: the Ulysses contract. *Hastings Center Report, 14*(3), 13-16; See also, Howell, T. et al., (1982). Is there a case for voluntary commitment? In Beauchamp T. et al., (Eds). *Contemporary Issues in Bioethics*, California: Wadsworth Publishing Company, 163-167 [*Howell*].

[7] Dresser, *Ibid*.; Howell, *Ibid*.

[8] Macklin, A. (1987). Bound to freedom: the Ulysses contract and the psychiatric will. *University Toronto Faculty Law Review, 45*(1), 37-68 [*Macklin*].

[9] Ritchie, J., Sklar, R., & Steiner, W. (1998). Advance directives in psychiatry. Resolving issues of autonomy and competence. *International Journal of Law and Psychiatry, 21*(3), 245-260.

[10] Atkinson, J.M. (2007). *Advance Directives in Mental Health: Theory, Practice and Ethics*, London: Jessica Kingsley Publishers, at 39-55.

[11] One example of this can be found in a psychiatric advance directive where the person completing the document can make their document revocable.

[12] Davis, J. K. (2008). How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. *Kennedy Institute of Ethics Journal, 18*(1), 87-106 [*Davis*].

advance directives and standard contracts."[13] Some individuals complete advance directives with the intention of anticipating and thwarting actions that may contravene their wishes. Others' intentions in completing the documents are to communicate their wishes. Advance directives have been referred to as "Ulysses arrangments" to reflect a special type of document that intentionally refrains from using the term "contract" due to its legal connotations, and the expression "statement" reflects a one-sided document.[14] Others prefer the term "pre-commitment directives"[15] to highlight the importance of one's earlier prior competent wishes. Ulysses contracts have also been called "opt-in" arrangements because individuals can contemplate what they choose as acceptable medical treatment.[16] The term "psychiatric advance directive" is ubiquitous in the U.S., and has been used interchangeably with a Ulysses contract.[17]

The irrevocable nature of a Ulysses contract often depends on whether a specific provision has been included in the document, making it more appropriate to call it a "Ulysses clause" instead of a Ulysses contract. The term advance directive is broader than a Ulysses contract, which allows for treatment preferences, wishes, and statements to be included. Where an individual includes a Ulysses clause in their advance directive they are essentially requesting that the document be irrevocable and that their wishes will be honored. Unlike a Ulysses clause that makes an individual's intentions irrevocable, advance directives provide general guidance to treatment providers regarding preferences and values. The values included in an advance directive should be followed, but do not necessarily carry the same degree of enforceability a Ulysses clause can have where an individual intentionally chooses to make the document irrevocable.

---

[13] *Andreou, supra* note 4.

[14] Gremmen, I., Widdershoven, G., Beekman, A., Zuijderhoudt, R., & Sevenhuijsen, S. (2008). Ulysses arrangements in psychiatry: a matter of good care? *Journal of Medical Ethics, 34*(2), 77-80.

[15] Van Willigenburg, T., & Delaere, P. (2005). Protecting autonomy as authenticity using Ulysses contracts. *Journal of Medicine and Philosophy, 30*(4), 395-409 [*Van Willigenburg*].

[16] Atkinson, J. M. (2004). Ulysses' crew or circe? The implications of advance directives in mental health for psychiatrists. *Psychiatric Bulletin, 28*, 3-4.

[17] Widdershoven, G., & Berghmans, R. (2001). Advance directives in psychiatric care: a narrative approach. *Journal of Medical Ethics, 27*(2), 92-97 [*Widdershoven*]; Spellecy, R. (2003). Reviving Ulysses contracts. *Kennedy Institute of Ethics Journal, 13*(4), 373-392 [*Spellecy*].

II. TYPES OF ADVANCE DIRECTIVES IN MENTAL HEALTH

Although there are commonalities in how advance directives are used across jurisdictions, there is also uncertainty in whether they will be upheld as a matter of law. Some Canadian provinces have enabling legislation that allows for proxy or instructional directives.[18] Ontario has drafted a provision in its legislation that resembles a Ulysses clause by providing a foundation for the irrevocability of advance directives.[19] Although there has been some research on advance directives for mental health in Canada,[20] a brief comparison of how different jurisdictions handle the issue of revocability in advance directives would be informative. The legal forms and legislation will be contrasted between two Canadian provinces, Québec and Ontario, and the U.S.

A. Mandates in case of incapacity – Québec

Mandates are used in Québec to assist an individual (mandator) who may become incapable in the future to appoint another person (mandatary) to administer his or her property and/or to handle personal care decisions.[21] The form and structure of a mandate is governed by chapter IX of the *Civil Code of Québec* (*CCQ*),[22] which provides that a mandator can empower a mandatary to represent him or her in the event of incapacity, whereas the power and writing

---

[18] For a report on advance directives across Canada, see Dunbrack, J. (2006). *Advance care planning: the Glossary project*. Ottawa: Health Canada [*Dunbrack*]; See, Sweatman, M.J. (2002). *Guide to Powers of Attorney,* Aurora: Canada Law Book, at 101 which states, "There are two forms of advance directives: an "instruction directive (or a living will) and a "proxy directive" (or a power of attorney for personal care)." [*Sweatman*]

[19] *Substitute Decisions Act*, 1992, S.O. 1992, c.30, s. 50 [*SDA*].

[20] Ambrosini, D. L., & Crocker, A. G. (2007). Psychiatric advance directives and the right to refuse treatment in Canada. *Canadian Journal of Psychiatry, 53*(6), 397-401; Ambrosini, D. L. & Crocker, A. G. (2009). Psychiatric advance directives and the role of autonomy. *Santé Mentale au Qué*bec (in press) [*Ambrosini*]; Ambrosini, D. L., Crocker, A. G., Perreault, M., & Israel, M. (2008). Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec. *Journal Ethics in Mental Health, 3*(2), 1-12.

[21] For a discussion of mandates in case of incapacity see, Deleury E. & Goubau D. (2002). (3rd Edition), *Le Droit Des Personnes Physiques,* Cowansville, Québec: Les Éditions Yvon Blais, 601-636 [*Deleury*].

[22] *Civil Code of Québec*, S.Q. 1991, c. 64 [*CCQ*]

evidencing it are referred to as a power of attorney.[23] A mandator can only empower a mandatary to make decisions if he or she is considered mentally capable, which can be either partial or total capacity. Assessing the degree of a mandator's capacity at the time of executing a mandate poses challenges leading some to suggest that the assessment should be audio-recorded or videotaped.[24] The Québec Court of Appeal has ruled that if a mandator is partially capable when executing a mandate the document need not be homologated.[25] It is unclear, however, how courts determine whether an individual is sufficiently autonomous to make mentally capable decisions. In many cases, the court will rely upon the appointed mandatary who must act according to a standard of prudence, diligence, honesty, and faithfulness in the best interests of the mandator.[26]

While the *CCQ* provides that a mandate is a contract, individuals can obtain the legal document from the Office of the Public Curator, complete it independently, and have it witnessed by two individuals, which makes the process appear more like a will than a contract. Of course, a will is used as a planning device for after death, unlike a mandate that is intended for future mental incapacity. In Québec, there is no obligation for the mandator to inform the mandatary that he or she has been appointed to make decisions on his or her behalf, although in practice a mandator often chooses and informs a close family member. There is also no obligation upon the mandator to negotiate the terms of the mandate with the mandatary. Instead, a mandate is a proxy directive because the mandator appoints the mandatary to act on his or her behalf.[27] In this respect, the form of a mandate differs from instructional directives where individuals are empowered to provide detailed instructions about their choices.[28]

Although it is possible to include a specific provision in a mandate to make it irrevocable, the *CCQ* does not address specifically how such a provision would

---

[23] *CCQ, ibid* art. 2130. The *Civil Code of Québec* refers to a power of attorney, but it does not have the same meaning as in Ontario.
[24] Gauthier S. (2001). Comment déterminer l'aptitude du mandant?, dans S.B.P.B.Q., *Les mandats en cas d'inaptitude : une panacée?* Cowansville, Éditions Yvon Blais, 71.
[25] *L.P. c. F.H.*, [2009] J.Q. no 4771 (C.A.).
[26] *CCQ, supra* note 22 at art. 2138.
[27] *Dunbrack, supra* note 18.
[28] Emanuel, L. (1993). Advance directives: what have we learned so far? *The Journal of Clinical Ethics*, *4*(1), 8-16.

be interpreted by courts. One must therefore look to jurisprudence whereby Québec courts will ultimately make the final decision of whether a mandate will be irrevocable or not. The uncertainty of whether a judge will honour treatment preferences recorded in a legal document that is still in the *form* of a mandate may be an impediment for individuals with mental illness to complete them.[29] Québec could strengthen its legislation by making it clear to what extent it will honour the prior competent wishes of an individual completing a mandate.[30] This remains difficult partly because there is no explicit definition of mental capacity in the *CCQ*.

The concepts of empowerment and autonomy are central under Québec law. Article 2130 of the *CCQ* provides that a mandator empowers a mandatary to represent him, and if the mandatary accepts, he binds himself to exercise the power, referred to as the power of attorney.[31] The *CCQ* also provides that all decisions related to protective supervision must be made in a manner that respects individuals' rights and safeguards their autonomy.[32] When a court examines applications to institute protective supervision, including wishes expressed in a mandate that have not been homologated, it should consider the degree of autonomy of the person.[33] In assessing an individual's level of autonomy, courts should be careful not to construct it as only a functional disability and fail to understand that it also an ideal.[34] Although individuals may be mentally incapable to make certain decisions at certain points in time, they may retain an ideal of their personal autonomy. To presume that a mentally incapable person has no autonomy would be erroneous.

---

[29] Brown, K., & Murphy, E. (2000). Falling through the cracks: the Québec mental health system. *McGill Law Journal, 45*, 107-1079.
[30] *Ibid*.
[31] *CCQ, supra* note 22 at art. 2130.
[32] *CCQ, supra* note 22 at art. 257.
[33] *CCQ, supra* note 22 at art. 276.
[34] Autonomy as an ideal can differ from autonomy as a preference, see Stiggelbout, A. M., Molewijk, A. C., Otten, W., Timmermans, D. R., van Bockel, J. H., & Kievit, J. (2004). Ideals of patient autonomy in clinical decision-making: a study on the development of a scale to assess patients and physicians' views. *Journal of Medical Ethics, 30*(3), 268-274.

B. Powers of attorney for personal care – Ontario

In Ontario, an individual can complete a power of attorney for personal care (POA) or a continuing power of attorney for property or financial matters.[35] A POA for personal care addresses the possibility of future incapacity whereby the grantor appoints an agent, known as an attorney, to act on his behalf. Prior to the *Substitute Decisions Act* (*SDA*, 1992), POAs did not exist because the common law did not allow substitute decision-making once a person became incapable.[36] Now, individuals are presumed capable to make a POA for personal care if they understand that the proposed attorney (refers to the proxy not a lawyer) has a genuine concern for their welfare, and if they appreciate that the attorney may need to make decisions on their behalf.[37] In order for a POA for personal care to be valid, the grantor must be of legal age, capable, and signed by two witnesses.

A POA for personal care is a type of advance directive based on a fiduciary relationship rather than on principles of trust or a contractual relationship.[38] Similar to Québec's mandates in case of incapacity, a POA is "a one-sided instrument, an instrument which expresses the meaning of the person who makes it".[39] An Ontario judge has stated that a Ulysses contract under Ontario law is a special type of POA for personal care under section 50 of the *SDA*.[40] As described in the case of *A.M. v. Benes*,

> The *Substitute Decisions Act, 1992,* as amended, provides a means whereby a person, while capable, may choose who will be his or her S.D.M. [substitute decision-maker] in the event that the person becomes incapable. The mechanism is a power of attorney for personal care ("P.O.A./P.C"). Such a power of attorney must be created in accordance with procedures set out in the *S.D.A.* A very powerful type of P.O.A./P.C. (nicknamed a "Ulysses contract") that, among other things, allows a person to waive his or her rights under the Act, may be entered into, but only in strict compliance with s. 50 of the *S.D.A.*[41]

Section 50 of the *SDA* authorizes an attorney "to use force that is necessary and reasonable in the circumstances to take the grantor to any place for care or treatment, to admit the grantor to that place and to detain and restrain the grantor

---

[35] *Sweatman, supra* note 18.
[36] *Sweatman, supra* note 18 at 97.
[37] *SDA, supra* note 19 at s. 47(1).
[38] *Sweatman, supra* note 18 at 4.
[39] *Sweatman, supra* note 18 at 5.
[40] *A.M. v. Benes* [1998] O.J. No. 4333.
[41] *Ibid*.

in that place during the care or treatment."[42] The grantor must, however, make a statement that he or she understands the effect of the provision, and within 30 days after the POA has been executed, an assessor must have assessed the grantor's capacity and be of the opinion that he or she understands the provision.[43]

Macklin has explored issues of private ordering and enforceability for Ulysses contracts and psychiatric wills under Ontario law.[44] She concludes that Ulysses contracts are acceptable and commendable as a theoretical construct but are unworkable, unwieldy, and dangerous as a legal construct.[45] Although she recognizes it may be unfair to deny individuals the opportunity to enter Ulysses contracts, her position is based on the view that the practical and legal problems of inequality of bargaining power, coercion, and informed consent are insurmountable.[46] As a result, she suggests that a Ulysses contract should not be upheld if challenged in a court of law.[47]

A POA for personal care is based on the principle that self-determination and autonomy should be respected.[48] Section 1 of the *Health Care Consent Act* provides that one of the purposes of the legislation is to "enhance the autonomy of persons for whom treatment is proposed".[49] While a POA for personal care can be used to express one's preference for greater privacy and freedom from coercive interference with autonomy, as a core value of Canadian society,[50] it also offers predictability and certainty of medical treatment. When courts are faced with a decision to order a capacity assessment that involves a POA for personal care, they should consider the interplay between promoting autonomy and protecting vulnerability.[51]

---

[42] *SDA, supra* note 19 at s. 50(2).
[43] *SDA, supra* note 19 at s. 50(1).
[44] *Macklin, supra* note 8.
[45] *Macklin, supra* note 8 at 68.
[46] *Macklin, supra* note 8.
[47] *Macklin, supra* note 8 at 68.
[48] *Sweatman, supra* note 18 at 187.
[49] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 1.
[50] *Kischer v. Kischer*, [2009] O.J. No. 96 (Ont. S.C.).
[51] *Abrams v. Abrams*, [2008] O.J. No. 5207 (Ont. S.C.).

C. Psychiatric advance directives – United States

Psychiatric advance directives (PADs) are legal documents used in approximately 30 U.S. states that enable individuals with mental illness to declare detailed treatment preferences if they become incapable.[52] Unlike mandates in case of incapacity or POAs for personal care, PADs are designed specifically for mental health. Some suggest PADs closely resemble Ulysses contracts because individuals can declare detailed choices regarding treatment preferences and can make their wishes irrevocable.[53] PADs are instructional directives because they allow individuals to go beyond appointing a proxy, agent, or attorney to make decisions on their behalf. Individuals can make specific instructions including consent to medications; how they prefer medication to be administered (liquid, pill, injection); preferences regarding their physicians; instructions regarding restraint and seclusion; who to appoint as agent; and willingness to undergo electroconvulsive therapy.[54]

The U.S. *Patient Self-Determination Act* (*PSDA*) was passed in 1991 as federal legislation that obligates hospitals and health care institutions to ask individuals whether they have an advance directive.[55] As a result, PADs have emerged as legal documents to help inform healthcare providers of individuals' treatment preferences. In the U.S. case of *Hargrave v. Vermont*, the second circuit court held that the state of Vermont could not discriminate against individuals with psychiatric disabilities by preventing them from making binding preferences in a PAD regarding their treatment if they become incapable in the future.[56] Where individuals have previously completed a durable power of attorney or a

---

[52] Swanson, J., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A. et al., (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*(3), 255-267; Srebnik, & Russo, J. (2008). Use of psychiatric advance directives during psychiatric crisis events. *Administration and Policy in Mental Health and Mental Health Services Research, 35* (4), 272-282; Appelbaum, P. S. (2004). Law & psychiatry: Psychiatric advance directives and the treatment of committed patients. *Psychiatric Services, 55*(7), 751-752, 763.

[53] *Spellecy, supra* note 17.

[54] For a case involving electroconvulsive therapy and advance directives see, *In the Matter of A.A., An Alleged Incapacitated Person*, 381 N.J. Super. 334; 885 A.2d 974; 2005 N.J. Super. LEXIS 331 (New Jersey Superior Court, 2005).

[55] *Patient Self-Determination Act* of 1991 (PSDA), Pub. L. No. 101-508, 104 Stat. 1388-115, 1388-204 (1990) (codified as amended in scattered sections of 42 U.S.C.).

[56] *Hargrave v. Vermont*, 340 F.3d 27; 2003 U.S. App. LEXIS 15423 [*Hargrave*].

health care proxy, and there is no reason to believe they were mentally incapable at the time, courts will generally honour those wishes.[57] Where a statute empowers an individual with mental illness to complete a PAD, and there is a subsequent ordinance by a health care provider to follow a prescribed treatment plan that may contravene the document, at least one U.S. court has honoured the wishes in the PAD because the legislation superseded the ordinance.[58] *Hargrave* also suggests that some U.S. courts may uphold the irrevocable nature of a PAD as a valid and binding document.[59] Individuals have a choice in making their PAD revocable or irrevocable when completing the document[60] and can declare that it be revoked, suspended, or terminated if the governing law permits them to do so.[61]

III. THE SELF-BINDING PROBLEM

A. Self-binding: overly liberal or too restrictive?

Self-binding refers to the process of making plans in the present to restrict choices for the future.[62] In the context of advance directives, some health care providers are concerned that encouraging individuals to bind themselves to future medical decisions could encourage choices that are overly emotional or irrational.[63] Contrary to popular belief, it is possible that many individuals with mental illness who make advance directives take the necessary time to think about their decisions closely before completing such a document. The law in most jurisdictions recognizes individuals' right to bind themselves to important decisions. For example, capable individuals are free to enter legally binding contracts such as leases or wills. Making an advance directive, whether it is

---

[57] *Matter of Kufeld*, 51 A.D.3d 483, 859 N.Y.S.2d 119 (N.Y. App. Div. 1st Dep't, 2008).

[58] *Prot. Advocacy v. City of Albuquerque*, 2008 N.M. LEXIS 533 (N.M., Sept. 19, 2008).

[59] *Hargrave, supra* note 56.

[60] For an example of a psychiatric advance directive document that includes a revocability clause see, Bazelon Center for Mental Health Law, "Advanced Psychiatric Directives," online: http://www.bazelon.org/publications/advanceddirectives/.

[61] *Ibid*.

[62] Cuca, R. (1993). Ulysses in Minnesota: first steps toward a self-binding psychiatric advance directive statute. *Cornell Law Review*, *78*(6), 1152-1186.

[63] Elster, J. (2000). *Ulysses Unbound*, Cambridge: Cambridge University Press, at 8.

revocable or not, gives individuals a level of certainty and predictability of how others will deal with them in the event of incapacity.

Rather than focusing on character or personality to explain whether someone should be permitted to self-bind through a Ulysses contract, it is more useful to listen to their reasons based on personal values and prior experiences. Ulysses contracts are more likely to be honoured if individuals have given family members, treatment providers, and others a justifiable reason for why they want to complete the document.[64] Some individuals may choose to bind themselves while capable because they realize based on their prior experiences that there might be a time when their will is too weak, and they want reassurance that they will not regret making poor choices if incapable. On the one hand, self-binding may restrict one's degree of autonomy in the future; on the other hand, it can increase one's sense of empowerment and autonomy immediately through a willingness to cooperate with others.[65]

B. Temporality and decision-making: balancing the past, present, and future

When an individual is in the process of completing an advance directive, there is a complex relationship between autonomy, awareness of time, and decision-making capacity.[66] First, it is generally accepted that an individual must be capable to understand and appreciate the decisions they are about to enter at the time of executing an advance directive. Second, when individuals are contemplating the content of what to include in the document they are engaging in a mental task of making present choices by looking to future contingencies based on past values. As this is not an easy decision to balance, it should not be rushed into by signing an advance directive prematurely. Completing an advance directive does not necessarily mean that a person's decision at one point in time (when mental capacity is clear) is necessarily more important than at a subsequent

---

[64] Lavin, M. (1986). Ulysses contracts. *Journal of Applied Philosophy, 3*(1), 89-101 [*Lavin*].

[65] Duxbury, N. (1996). Liberalism, self-interest, and precommitment. *Canadian Journal of Law and Jurisprudence*, 9, 2, 383-395.

[66] Quante, M. (1999). Precedent autonomy and personal identity. *Kennedy Institute of Ethics Journal, 9*(4), 365-381 [*Quante*].

point in time (during a crisis episode).[67] If an individual's past values have been recorded, along with the reasons why the advance directive was completed, it is easier to see how present wishes will correspond with future goals.

The process of completing an advance directive, and the knowledge that the document exists, have the potential to build an individual's confidence that the law will require healthcare providers to uphold those wishes. There are several reasons why healthcare providers may be reluctant to honour an advance directive. They may believe the individual was incapable when the document was completed based on their personal knowledge of the person's psychopathology. Alternatively, they may argue on moral grounds that that they should not be forced to honour prior competent wishes that offend their professional autonomy. Others may suggest that by signing the document individuals actually decrease their level of autonomy because they cannot later change their minds. It should be remembered, however, that the reason for choosing to bind oneself at Time 1 is to increase the probability of carrying out another decision at Time 2.[68] Davis argues for what he calls "diachronic justification," the idea that respecting an agent's autonomy does not depend on assessing retrospective desires, but instead looking prospectively to whether what occurs to the person over time is consistent with their wants.[69]

During the process of completing an advance directive, it is useful for individuals to think about and record how their past values affect their current views of future medical treatment. Indeed, where someone refuses treatment and there was no advance directive established, courts may look to the individual's values to determine if they are congruent with current wishes.[70] Often, past values may be all that courts have to rely on in determining whether one's current wishes are the most authentic manifestation of their will. Authenticity in the decision-making process has been referred to as examining the decision that is most

---

[67] *Widdershoven, supra* note 17.

[68] *Davis, supra* note 12.

[69] *Davis, supra* note 12.

[70] Peters, C., & Chiverton, P. (2003). Use of a values history in approaching medical advance directives with psychiatric patients. *Journal of Psychosocial Nursing & Mental Health Services, 41*(8), 28-36.

congruent with a person's life history.[71] An advance directive that incorporates values of an individual will decrease ambiguity surrounding the enforceability of the document. If it is evident to a court that someone has decided to make the document irrevocable because the person has already had negative experiences with medications, electroconvulsive treatment, or hospitalization, they may be more likely to uphold the document as valid.

C. Pre-commitment and identity theory

The idea of making a commitment today to ensure that a particular action will be taken tomorrow is known as pre-commitment.[72] The term is often used interchangeably with self-binding. As Brock highlights, a simple commitment is a promise or a contract whereby one person undertakes an obligation to another person to act in a certain way in the future.[73] A pre-commitment does not necessarily involve a reciprocal undertaking by another individual.[74] Pre-commitment involves a process of controlling future events by prioritizing decisions at Time 1 to reduce options at Time 2.[75] The example proposed by Brock includes someone who decides to stop smoking, and then tells his friends of his wish in the hope that the declaration will strengthen his or her will.[76] In this case, the individual has not undertaken a commitment or obligation to any particular individual to quit smoking, but has made an expression of a strong intention to follow through on an action. In other words, the decision to stop smoking does not necessarily require the intervention of others. The issue is slightly different where an individual makes a 'pre-commitment contract', signed and sealed by two witnesses, which would impose a positive obligation upon health care providers to follow the person's wishes in a particular manner.

---

[71] Appelbaum, P. (1982). Can a subject consent to a 'Ulysses Contract'? *The Hastings Center Report*, 12 (4), 26-28.

[72] Brock, D. W. (2003). Precommitment in bioethics: some theoretical issues. *Texas Law Review, 81*(7), 1805-1821, at 1808 [*Brock*]; Robertson, J. A. (2003). Precommitment issues in bioethics. *Texas Law Review, 81*(7), 1849-1876 [*Robertson*]; Dresser, R. (2003). Precommitment: a misguided strategy for securing death with dignity. *Texas Law Review, 81*(7), 1823-1847.

[73] *Brock, ibid.*

[74] *Brock, ibid*. at 1808.

[75] *Robertson, supra* note 72.

[76] *Brock, supra* note 72 at 1808.

Robertson states that an individual's *pre-commitment* differs from a *commitment* because during the pre-commitment process the individual is involved in an intentional change in payoffs at Time 2 not contemplated during the commitment process.[77] In other words, a pre-commitment imposes a cost or a penalty if the person deviates from the path. Making a pre-commitment requires an inner resolution that one's current decisions and choices will remain the same in the future. The reality is that individuals frequently change their minds based on new information and experiences, and not only because of mental incompetence, weakness of the will, coercion, or fraud.[78] Although some individuals may be more prone to change their minds than others are, the law should not disallow individuals from committing themselves if it is clear they understand what is in their own best interests. Take the example of an individual who decides to complete a PAD and, in the process, is asked by a facilitator if there are any medications they have tried in the past but do not want in the future. The individual confidently and adamantly states that he never wants to be on the drug Seroquel again because it made him "feel like a zombie." He can describe his past symptoms under the medication, and these concerns have already been expressed to his clinician in the past. In this case, it is hard to see why he should not be permitted to record this instruction in a PAD as a means of informing other physicians. When an advance directive is brought to the attention of a treating psychiatrist, there should be a positive obligation upon treatment providers, at the minimum, to explore the reasons for such prior competent wishes.

Pre-commitment also raises issues about when individuals change their mind between Time 1 (mentally capable) and Time 2 (mentally incapable). An individual may want to change their advance directive, not because of the mental illness but due to changes in their values. It is important, therefore, for individuals to be able to distinguish between values and interests, and to clearly articulate and justify the reasons for any changes. To understand and appreciate the core values of individuals with mental illness it is necessary to discuss their authentic and true

---

[77] *Robertson, supra* note 72.

[78] Radden, J. (1994). Second thoughts: revoking decisions over one's own future. *Philosophy and Phenomenonological Research*. LIV (4), 787-801 [*Radden*].

preferences.[79] It is equally important to consider whether an individual's decision to change their advance directive is based on a fluctuating psychological state or a consistent personality trait.[80]

IV. THE GATE-KEEPING ROLE OF CAPACITY AND COMPETENCY

A. **C***apacity and competency: interrelated yet distinct*

The constructs of mental capacity and competence for individuals with mental illness needs to be disentangled; the difference between them is not only one of semantics.[81] Capacity is a medical construct generally assessed by trained health professionals, whereas competence is a legal construct used by legal professionals.[82] When mental health professionals assess individuals' mental capacity, they are examining one's cognitive abilities to understand, appreciate, express a choice, and reason.[83] On the other hand, when a lawyer is trying to determine if someone is able to sign a legal document such as an advance directive, contract, or will he or she is examining the person's competence. Competence assessments are also conducted by judges who examine an individual's mental capacity retrospectively at the time of the decision, and review statutory criteria or common law principles. Mental capacity should be used primarily as a medical term whereas competence is a legal one.

---

[79] *Widdershoven, supra* note 17.

[80] La Guardia, J. G., & Ryan, R. M. (2007). Why identities fluctuate: variability in traits as a function of situational variations in autonomy support. *Journal of Personality*, *75*(6), 1205-1228.

[81] *Atkinson, supra* note 10 at 76

[82] Fisher, M. S. (2009). Psychiatric advance directives and the right to be presumed competent. *Journal of Contemporary Health Law & Policy, 25*, 386-405; Srebnik, & Kim, S. Y. (2006). Competency for creation, use, and revocation of psychiatric advance directives. *The Journal of American Academy of Psychiatry and the Law, 34*(4), 501-510; Leo, R. J. (1999). Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians. *Primary Care Companion to the Journal of Clinical Psychiatry, 1*(5), 131-141.

[83] For a trilogy of studies on the development of a measure of competency around these criteria see, Appelbaum, P. S., & Grisso, T. (1995). The MacArthur Treatment Competence Study. I: Mental illness and competence to consent to treatment. *Law and Human Behavior, 19*(2), 105-126. Grisso, T., Appelbaum, P. S., Mulvey, E. P., & Fletcher, K. (1995). The MacArthur Treatment Competence Study. II: Measures of abilities related to competence to consent to treatment. *Law and Human Behavior, 19*(2), 127-148; Grisso, T., & Appelbaum, P. S. (1995). The MacArthur Treatment Competence Study. III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior, 19*(2), 149-174.

Despite these terminological distinctions, one of the most challenging issues is how to assess mental capacity. This is particularly the case for individuals with fluctuating capacity who have been diagnosed with bipolar disorder or who suffer from recurring acute psychotic episodes.[84] Even where individuals occasionally make erratic or sudden decisions that do not appear to reflect their authentic selves, it is still possible to identify moments of time when a lucid declaration has been made. Determining whether an individual's wishes are authoritative and authentic requires examining whether they were stated during a "cool moment."[85] It also requires determining whether past behaviour is prognostic of current prior competent wishes. If there is a reasonable suspicion that a declaration was made by someone while incapable, it will likely not be upheld by law.[86]

Not all mental health statutes are drafted to reflect a legal presumption that individuals with mental illness are competent to consent to treatment.[87] The law in most jurisdictions presumes individuals are capable to declare their choices in an advance directive, unless shown otherwise, with the exception of minors who are presumed incapable to make decisions regarding their personal care until they reach the age of majority.[88] This legal presumption can be displaced by the presence of duress, coercion, undue influence, or other reasons to believe decision-making ability was interfered with. In some situations, it will not take long for a mental health or legal professional to identify whether someone lacks mental capacity to complete an advance directive. However, although individuals may be competent for some decisions, they may also be incompetent for others. Legal professionals who meet with individuals with mental illness to complete

---

[84] Khazaal, Y., Richard, C., Matthieu-Darekar, S., Quement, B., Kramer, U., & Preisig, M. (2008). Advance directives in bipolar disorder, a cognitive behavioural conceptualization. *International Journal of Law and Psychiatry, 31*(1), 1-8.

[85] *Widdershoven, supra* note 17.

[86] Although individuals with mental illness are presumed legally competent, there may be a "cloud of suspicion" regarding whether they are capable to make their own decisions. See Srebnik, Appelbaum, P. S., & Russo, J. (2004). Assessing competence to complete psychiatric advance directives with the competence assessment tool for psychiatric advance directives. *Comprehensive Psychiatry, 45*(4), 239-245;

[87] *Fisher, supra* note 82.

[88] For a recent Supreme Court of Canada decision dealing with the capacity of minors to make decisions regarding their medical care and advance medical directives, see *A.C. v. Manitoba (Director of Child and Family Services),* [2009] S.C.J. No. 30.

advance directives should ensure that there are no “suspicious circumstances” surrounding their decisions much in the same way that an estate lawyer verifies that a testator has testamentary capacity.[89]

Several myths continue to linger regarding decision-making capacity of individuals with mental illness. One of them is that individuals are either capable or incapable, and there is no middle ground of partial incapacity. Radden states that many psychiatric cases involve “contestable competence,” which raises the issue of whether competence is an “all or none” construct or as a scalar and relative concept.[90] Québec law recognizes that individuals who complete mandates in case of incapacity may want to retain a certain degree of autonomy if they are partially incapable.[91] Individuals do not always need to be *fully* capable in order to make decisions regarding treatment refusal or hospital confinement.[92] A second, and interrelated myth, is that when individuals lose their mental capacity they no longer have any autonomy to make independent choices. Autonomy may be similar to mental capacity in that it lies on a spectrum that can be measured; it is likely not a binary construct. When individuals choose to complete advance directives, they are essentially making a choice that reflects their degree of autonomy.

An individual who writes a will is required by law to have testamentary capacity, which is recognized as the highest form of capacity compared to the level of mental capacity required to enter other contracts.[93] Capacity assessments are conducted to ensure that individuals with mental illness understand and appreciate the reasons for making critical choices. As such, mental capacity assumes a gate-keeping role in that individuals can only make advance directives

---

[89] See *Vout v. Hay*, [1995] S.C.J. No. 58 where the Supreme Court of Canada held, in the context of wills and the doctrine of suspicious circumstances, that “if the suspicious circumstances relate to mental capacity, the propounder of the will reassumes the legal burden of establishing testamentary capacity”.

[90] *Radden, supra* note 78.

[91] See *CCQ, supra* 22 at art. 258, “The court institutes tutorship to a person of full age if it is established that the incapacity of that person to care for himself or to administer his property is partial or temporary and that he requires to be represented in the exercise of his civil rights.”

[92] *Davis, supra* note 12.

[93] Howard S. Black, (2009). *Wills and Estates Cases, Text, and Materials*, Toronto: Emond Montgomery, at 22-23 [*Black*].

if they are considered capable. Performing valid capacity assessments can pose specific challenges with certain groups such as individuals with Alzheimer’s disease where capacity is slowly deteriorative, and differs from assessments with individuals with bipolar disorder.[94]

V. ETHICS OF ULYSSES CONTRACTS

A. Medical paternalism and advance treatment planning

Historically, the field of mental health has been governed by a desire among individuals with mental illness to break free from unwanted medical paternalism.[95] Some perceive advance directives as legal instruments that allow patients to oppose a historical tradition of medical paternalism.[96] Individuals with mental illness are keenly aware of the unequal bargaining power that can exist in making decisions with their physicians. Advance directives could be seen as a pre-emptive tool to avoid unwanted medical treatment, yet willingness to use advance directives could involve a collaborative process between patients and physicians to plan for future contingencies in the event of relapse.[97] In this regard, a participatory model of advance directives that encourages shared-decision-making and replaces paternalistic compliance models could be introduced.[98]

Some argue that individuals completing Ulysses contracts are actually engaged in self-paternalism, different from the state’s paternalistic power to

---

[94] Bravo, G., Dubois, M. F., & Paquet, M. (2003). Advance directives for health care and research: prevalence and correlates. *Alzheimer Disease and Associated Disorders, 17*(4), 215-222; Dukoff, R., & Sunderland, T. (1997). Durable power of attorney and informed consent with Alzheimer's disease patients: a clinical study. *American Journal of Psychiatry, 154*(8), 1070-1075.

[95] Rich, B. A. (2006). Medical paternalism v. respect for patient autonomy: the more things change the more they remain the same. *Michigan State University College of Law Journal of Medicine and Law*, *10*, 87; Falkum, E., & Forde, R. (2001). Paternalism, patient autonomy, and moral deliberation in the physician-patient relationship. Attitudes among Norwegian physicians. *Social Science and Medicine, 52*(2), 239-248.

[96] Sass, H. M. (2003). Advance directives for psychiatric patients? Balancing paternalism and autonomy. *Wien Med Wochenschr*, *153*(17-18), 380-384.

[97] Rosenson, M. K., & Kasten, A. M. (1991). Another view of autonomy: arranging for consent in advance. *Schizophrenia Bulletin, 17*(1), 1-7 [*Rosenson*].

[98] Amering M. & Schmolke, M., (2009). *Recovery in Mental Health Reshaping Scientific and Clinical Responsibilities*, Chichester, England; Hoboken, NJ: Wiley-Blackwell, at 15.

intervene.[99] Any paternalistic intervention, whether imposed upon oneself or by the state, still requires justification.[100] For example, the law does not give individuals an unbridled right to harm themselves through suicide,[101] and in many jurisdictions, the law limits assisted dying.[102] Some of the justifications used for completing an advance directive take the form of "best interests," "would have wanted," or "will want" arguments.[103] Whether the degree of paternalism is strong or weak is an important consideration, with some arguing that enforcing a Ulysses contract through weak paternalism can be justified.[104]

B. Autonomy's relationship to advance directives

The moral authority for advance directives lies in respect for patient autonomy.[105] In the process of completing a Ulysses contract, individuals are able to exercise a certain degree of autonomy.[106] Although autonomy is a foundational ethical principle,[107] it is also a legal principle closely related to theories of choice.[108] The principle of autonomy can be traced back to mental health legislation and jurisprudence from the early beginnings of psychiatry.[109] While autonomy is fundamental to protect the rights of individuals with mental illness, courts have declared that it has reasonable limits and is not absolute.[110] How autonomy's relationship to advance directives is interpreted depends on our

---

[99] *Dresser, supra* note 6.

[100] Radden, J. (1996). *Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality*, Cambridge, Mass.: MIT Press, at 143 [*Radden*].

[101] Lemmens, T. (1996). Towards the right to be killed? Treatment refusal, assisted suicide and euthanasia in the United States and Canada. *British Medical Bulletin, 52*(2), 341-353.

[102] *Ibid*.

[103] *Radden, supra* note 100 at 155-159.

[104] *Spellecy, supra* note 17.

[105] *Widdershoven, supra* note 2.

[106] *Rosenson, supra* note 97; See also Varekamp, I. (2004). Ulysses directives in the Netherlands: opinions of psychiatrists and clients. *Health Policy, 70*(3), 291-301 [*Varekamp*].

[107] Beauchamp, T. L., & Childress, J. F. (2001). (6th Edition). *Principles of Biomedical Ethics.* New York: Oxford University Press.

[108] Emanuel, L. L., Emanuel, E. J., Stoeckle, J. D., Hummel, L. R., & Barry, M. J. (1994). Advance directives: stability of patients' treatment choices. *Archives of Internal Medicine, 154*(2), 209-217. See also *Ambrosini*, *supra* note 20 arguing that autonomy and choice is not synonymous.

[109] Pellegrino, E. D., & Thomasma, D. C. (1987). The conflict between autonomy and beneficence in medical ethics: proposal for a resolution. *The Journal of Contemporary Health Law and Policy, 3*, 23-46.

[110] See, for example, *Schloendorff v. Society of the New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914); *Starson v. Swayze*, [2003] 1 S.C.R. 722.

understanding of philosophical issues of temporality, pre-commitment, precedence, dispositionality, and prospectiveness.[111] Some rely on concepts of "rational autonomy" or "sick autonomy."[112] Depending on how courts frame the concept of autonomy, they will be more or less likely to grant individuals the right to choose or refuse treatment in an advance directive.[113]

Autonomy has been referred to as a law of self-governance.[114] Although distinguishing the ability to govern oneself from the ability to bind oneself may be difficult, they share a commonality in that both are grounded on the principle of autonomy. Most courts will at least indirectly examine how autonomous an individual was at the time an advance directive was completed. Autonomy can be understood differently depending on when one is examining it. For example, Table 2 shows a list of terms that have been used to describe autonomy's relationship to advance directives. Precedent autonomy, executional autonomy, or prospective autonomy each emphasize a different moment in time – past, present, and future – and therefore may produce different understandings of the term. Some health care providers place greater weight on dispositional autonomy, an expression referring to autonomy in the present time, over precedent or prospective autonomy. Objections against Ulysses contracts based on a critique of precedent autonomy need to consider the importance of identity and biographical information of the person making the document.[115] While an individual's personality may be consistent over time, one's level of autonomy can vary according to circumstances.

---

[111] Davis, J. K. (2002). The concept of precedent autonomy. *Bioethics, 16*(2), 114-133. Dworkin, R. (1986). Autonomy and the demented self. *The Millbank Quarterly, 64*(Suppl. 2), 4-16; Somerville, M. A. (1994). Labels versus contents: variance between philosophy, psychiatry and law in concepts governing decision-making. *McGill Law Journal, 39*, 179.

[112] Tauber, A. I. (2003). Sick autonomy. *Perspectives in Biology and Medicine, 46*(4), 484-495.

[113] See *Fleming v. Reid*, (1991), 4 O.R. (3d) 74 (C.A.) where the court stated regarding involuntary patients, "Until they are found incompetent, they hold the same rights as any other competent patient in the facility. Indeed, they hold the same rights as competent persons elsewhere in the province whose consent must be obtained before they can be the subject of medical treatment. Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments."

[114] Tauber, A. I. (2001). Historical and philosophical reflections on patient autonomy. *Health Care Analysis, 9*(3), 299-319.

[115] *Quante, supra* note 66.

In determining whether individuals are trying to limit their prospective autonomy, it is important to examine if any instructions reflect the most authentic manifestation of their will. A mental disorder can certainly compromise an individual's level of authenticity and independence at a particular moment in time, making it difficult to determine whether the pre-commitment reflects one's genuine choice.[116] While it may be difficult to justify a Ulysses contract based on an overarching concept of sovereign autonomy (governing or managing oneself), a distinction exists between individuals who make an authentic wish versus an autonomous choice.[117] Authenticity refers to being true to oneself, whereas an autonomous choice generally limits the involvement of others to some extent.

Autonomy is also connected to concepts of agency and self-legislation.[118] Lavin states, "First, moral agency is inseparably linked with autonomy. In so far as agents act morally they act autonomously."[119] In this respect, Ulysses contracts are able to protect autonomy as authenticity. The choice to self-bind through an advance directive is essentially freedom now for loss of freedom later. What should an individual do if they regret binding themselves to the authority of an advance directive? Alan Stone's thank-you theory has been invoked when discussing Ulysses contracts.[120] Stone's theory was proposed originally in the context of civil commitment, yet can also apply to the context of decisions involving treatment refusals. Stone argued that individuals with mental illness would be thankful to their physician for treatment imposed upon them, even against their will, as long as they later recover from their illness. One could extend this logic by suggesting that individuals will also be thankful to their physician if, after completing an advance directive, it was honoured by the physician and the individual recovered from a temporary relapse. On the other hand, a Ulysses contract could reduce the need for a strong version of the thank-you theory where the person chose to engage in private ordering of his or her own

---

[116] *Van Willigenburg, supra* note 15.
[117] *Van Willigenburg, supra* note 15.
[118] *Van Willigenburg, supra* note 15.
[119] *Lavin, supra* note 64.
[120] *Macklin, supra* note 8; Stone, A. (1975). *Mental Health and Law: A System in Transition*, Rockville, Md.: National Institute of Mental Health, Center for Studies of Crime and Delinquency.

medical decision-making. The choice to opt-out of a traditional route and opt-in to an advance directive can occasionally create clashes between physicians' professional autonomy and patients' autonomy when the time comes to honour the document.[121]

VI. LAW OF ULYSSES CONTRACTS

A. Use of contracts in mental health

It is not always clear whether a Ulysses contract is better perceived as a legal document that is more akin to a contract or a will. Some may believe that an advance directive is better construed as a formal contract that requires health care providers, or the agent acting on behalf of the individual, to follow through on their end of the bargain. In many cases, it is difficult to identify a Ulysses contract as a true contract. For example, first year law students quickly learn that a promise is not the same as a contract. MacNeil has defined a promise as a "present communication of a commitment to engage in a reciprocal measured exchange."[122] A promise can be created by communicating an intention to undertake an obligation,[123] which can also be considered a self-binding strategy. A contract, on the other hand, is a group of related promises, the purpose of which is to limit one's future choices to some degree.

Contracts in mental health have been used to help individuals govern behaviour in situations where there may lack a sense of control. For example, the no-suicide contract (also termed a no-harm contract) has been used to assist individuals with mental illness to prevent themselves from engaging in dangerous behaviour.[124] Contract-like arrangements have been used to help individuals stop smoking[125] and to follow physical therapy programs.[126] Individuals with mental

---

[121] *Varekamp, supra* note 106.
[122] MacNeil I., (1980). *The New Social Contract: An Inquiry Into Modern Contractual Relations,* New Haven: Yale University Press, at 7.
[123] Smith, S.A., (2009). The Limits of Contract, In Neyers, J.W., Bronaugh, R.. & Pitel, S.G. *Exploring Contract Law*, Oxford; Portland, Oregon: Hart Pub., at 20.
[124] Range, L. M., Campbell, C., Kovac, S. H., Marion-Jones, M., Aldridge, H., Kogos, S. et al., (2002). No-suicide contracts: an overview and recommendations. *Death Studies, 26*(1), 51-74.
[125] See *Spellecy, supra* note 17.

illness often make a statement to someone else about a course of behaviour they will agree to follow. A contract should be distinguished from a reward-based system where individuals with mental illness are given a token reward for reaching a particular milestone. This too may not be a contract. A formal contract requires *agreement* from both parties to be valid, which is unlike a testamentary will where an individual makes a unilateral statement.

One of the benefits of having an advance directive is that it formalizes expectations, creates certainty, and reduces unpredictability. Although Ulysses contracts are occasionally construed as formal contracts, originally they were known as psychiatric wills.[127] It is necessary to clarify the legal implications of referring to the document as a Ulysses *contract*, which were intended as legal tools for individuals with mental illness to engage in private ordering. Macklin highlights this distinction by stating that a Ulysses contract is one where there are contractual obligations at work, whereas a psychiatric will often involves a unilateral refusal of treatment.[128] Macklin also argues that the two documents are fundamentally different from each other, with the Ulysses contract giving psychiatrists more power to act than they currently have, whereas a psychiatric will decreases psychiatrists' power as it is generally a unilateral declaration regarding treatment refusal.[129] While the law may be flexible enough to uphold a traditional psychiatric will, Macklin suggests that this would not be the case for a Ulysses contract.[130]

Use of the term Ulysses contract may also wrongly convey the idea to individuals that the document has an overly legalistic tone, which may discourage non-litigious individuals from using it. Individuals could involve an independent facilitator to help them complete the document. This would encourage the person to declare his or her genuine preferences without sensing possible undue influence or coercion. On the other hand, if the treating psychiatrist and individual are able

---

[126] See Heinssen, R. K. (2002). Improving medication compliance of a patient with schizophrenia through collaborative behavioral therapy. *Psychiatric Services, 53*(3), 255-257, where contractual-like therapy sessions are used to encourage medication compliance.
[127] *Szasz, supra* note 5.
[128] *Macklin, supra* note 8.
[129] *Macklin, supra* note 8.
[130] *Macklin, supra* note 8.

to negotiate treatment preferences in a spirit of shared decision-making, there will be mutual understanding for the reasons underlying a particular medical decision. Ulysses contracts should not be drafted as complex legal contracts,[131] but instead as agreements that reflect one's values towards long-term recovery.

B. Theoretical reflections on Ulysses contracts

The doctor-patient relationship is primarily based on a fiduciary relationship, and has not traditionally been assessed under principles of contract law.[132] As mentioned, use of the term Ulysses contract may lead some to believe that there is a contractual relationship with a doctor even if he or she is completely unaware of the document. Unless a Ulysses contract contains all the essential elements of a contract it should not be referred to as a contract. Freedom of contract, as a classical model of legal theory, was grounded on ethical, political, economic, and legal goals.[133] It assumed that contracting parties were of equal bargaining power, which is rarely the case for vulnerable individuals with mental illness.[134] The classical model also held that individuals were bound to the contract not because they made a promise but because they made a bargain. As individuals with mental illness rarely have bargaining power, completing an advance directive can help to equalize the extent to which patients' voices are heard. In contrast to the classical model, will theory suggested that a contract could not be presumed valid unless all parties voluntarily agreed to it without coercion.[135]

A longstanding legal principle has been that contracts require a "meeting of the minds" between two individuals.[136] The essential elements of a contract include offer and acceptance, consideration, and performance or delivery. These

---

[131] Winston, E & Winston S.M. (1982). Can a subject consent to a 'Ulysses Contract'? *The Hastings Center Report*, 12 (4), 26-28.

[132] *Macklin*, *supra* note 8.

[133] Mulcahy, L. (2008). (5th Edition). *Contract Law in Perspective*, London; New York: Routledge Cavendish, at 25-35.

[134] *Ibid*. at 29.

[135] For a theoretical account of will theory see Kennedy, D. (2000). From the will theory to the principle of private autonomy: Lon Fuller's "Consideration and Form". *Columbia Law Review,* 100 (1), 94-175.

[136] See *Murphy v. McSorley*, [1929] S.C.J. No. 36; *Landeryou v. Campbell Jr.* [1952] S.C.J. No. 58

rarely exist in Ulysses contracts. Although an agency relationship may exist between the declarant making the advance directive and the agent appointed to act on their behalf, there is rarely a meeting of minds between the declarant and physician. From a legal persepctive, if a Ulysses contract does not contain all the features of a true contract, it may be difficult to uphold its legal validity.[137] Contracts frequently involve a negotiation process. Some have reported that the most important consideration is for clients to know, beforehand, which agreements are binding and which are not.[138] Ulysses contracts rarely involve negotiated consent with the individual who will be asked to enforce it. To avoid semantic confusion, it would be preferable to adopt the term Ulysses *clause* instead of Ulysses *contract*. By referring to the provision in the document as a Ulysses clause, attention is drawn to the fact that the advance directive has a specific provision in it whereby an individual has made their wishes irrevocable. There may be situations where individuals want their wishes to be revocable, in which case the document could still be referrred to as an advance directive.

A will does not resemble a contract, or for that matter most other forms of legally binding documents, and is revocable by a testator during his or her lifetime.[139] Before the term Ulysses contract was used to refer to advance directives, Szasz developed the psychiatric will as an instrument for unilateral refusal of treatment.[140] The expression psychiatric will may be more reflective of what some individuals intend to make when completing an advance directive. Although the term living will has been used interchangeably with advance directive, many in Canada prefer the latter.[141] *Akrasia* is what some philosophers have referred to as weakness of the will and may explain why some individuals

---

[137] *Rhoden, supra* note 3.

[138] *Varekamp, supra* note 106.

[139] *Black, supra* note 93 at 13.

[140] *Szasz, supra* note 5.

[141] See Fagerlin, A., & Schneider, C. E. (2004). Enough. The failure of the living will. *Hastings Center Report, 34*(2), 30-42 where the term living will is referred to as an advance directive. Others suggest that the term ‘living will’ refers to the expression of a wish to be kept alive for an indefinite period with artificial life support, see *Black, supra* note 93 at 269. According to Dunbrack, the term living will may be passing out of use in favour of advance directives, see *Dunbrack, supra* note 18.

choose to complete Ulysses contracts.[142] Where individuals feel they do not have the ability to resist temptations or internal struggles, but are prone to succumb to a weak will much in the same way that Ulysses was when tied to the mast, they may be inclined to bind themselves to an earlier prior competent wish.[143] Ulysses clauses are sometimes signed as a means of preventing *akrasia* by granting treatment providers the permission to follow through on a course of treatment originally proposed.[144]

C. Legal remedies for breach of a Ulysses clause

The main reason for including a Ulysses clause into an advance directive is to make one's document irrevocable. However, an advance directive should only include a Ulysses clause if the aim of the person is to create safeguards that ensure one's wishes will not be revoked. It is also possible to include a sunset clause in an advance directive, where the document is binding for a defined period, rather than indefinitely, and allows for periodic review.[145]

Health care professionals often inquire about the legal consequences of overriding an advance directive, particularly one that includes a Ulysses clause. Individuals who make their document irrevocable should be informed from the outset, wherever possible, that any judicial outcomes will ultimately depend on how a court interprets the governing law in the jurisdiction where the advance directive was executed. Very few courts will uphold unreasonable requests included in advance directives that contravene best medical practice. The question remains whether a physician could override an advance directive that contains a Ulysses clause without impunity in non-emergency situations. As advance directives in mental health are a relatively new phenomena it is difficult to say with certainty how Canadian courts will respond, however they will likely draw upon legal cases of advance directives from non-mental health settings.[146]

---

[142] *Radden, supra* note 78 at 68.
[143] *Radden, supra* note 78 at 68.
[144] *Spellecy, supra* note 17.
[145] *Rhoden, supra* note 3.
[146] *Malette v. Shulman*, [1990] O.J. No. 450 (C.A.).

Individuals who devise a will essentially become self-legislators. What legal remedies might a court consider where a health care provider overrides an advance directive? Where the agent initially agreed to act in a certain way, but then chose not to follow the individual's wishes found in an advance directive, one could argue that the agent failed to act with diligence in the same manner that an estate trustee neglects to follow instructions in a will. The court may examine whether there was a fiduciary responsibility upon the agent in acting against the individual's prior competent wishes. Where an individual was unduly influenced to include a specific instruction in an advance directive the document could be rendered null and void, as coercion can be considered a violation of an individual's freedom.[147] Where there is an unequal bargaining power between an individual and clinician, depending on the facts, courts may find that a fiduciary obligation was breached and set the document aside on grounds of unconscionability. It is unclear how courts will deal with the possible situation of an individual who completes an advance directive without their physician's knowledge or assistance, and decides not to honour the document. One could argue that in this case physicians should be less accountable given that they were not engaged in any negotiation about the document, and can rely on a defence of acting in the individual's best interests. Dresser argues that although a possible remedy for breaching a Ulysses contract is specific performance, courts are unlikely to enforce this remedy because it entails a close personal relationship[148] and a contract of personal services.[149] How courts choose to interpret advance directives in mental health will depend ultimately on the facts of each case. Individuals with mental illness should be encouraged to voice their treatment preferences to their clinicians. Advance directives, particularly those in the form of instructional directives, may offer a promising avenue to promote autonomy and choice among individuals with mental illness.

---

[147] *Widdershoven, supra* note 2.
[148] *Dresser, supra* note 6 at 792-793.
[149] *Macklin, supra* note 8.

CONCLUSION

The self-binding problem of Ulysses contracts is handled differently depending on the legal jurisdiction where they are completed. Various terms have been used to identify advance directives that may contribute to uncertainty about the documents. When discussing the irrevocability of advance directives, the term Ulysses clause could be adopted rather than Ulysses contract. A Ulysses clause refers to a specific provision included within an advance directive to record one's instructions to ensure their wishes are irrevocable in the event of future mental incapacity. Although advance directives are not considered wills (despite being referred to as 'living wills'), in some jurisdictions how they are completed in practice and how they are referred to in legislation obfuscates this distinction. In Québec, for example, mandates are referred to as a contract and yet a mandatary may not realize they have been appointed by the mandator to perform the role. Whether an advance directive looks more like a will or a contract may influence the legal remedies sought if the document is overridden by health care professionals. Ontario has incorporated a strong version of a Ulysses clause in its legislation, namely section 50 of the *Substitute Decisions Act*, where an individual can include an irrevocable declaration forcing them to be taken to a place of treatment if mentally incapable in the future. The complex relationship between autonomy and notions of temporality may be one reason that individuals are more or less likely to complete such documents. Just as Ulysses' crew honoured his prior capable wishes through a turbulent storm, helping individuals with mental illness to plan for future crises can offer greater predictability and certainty.

Table I – Terms and Descriptions of Advance Directives

TERM	DESCRIPTION
Advance agreement	Term used by the English *Mental Health Act* Legislation Committee to describe a plan of care between patient and treatment provider.
Advance directive	General term of document where an individual can direct future wishes of what should happen if mentally incapable.
Advance health care directive	Document used in Newfoundland and Labrador and Prince Edward Island.
Advance refusal	A stronger version of an advance directive as it highlights *refusals*.
Advance statement	A weaker version of an advance directive in that wishes are *stated* rather than directed.
Authorization	Document previously used in Nova Scotia until replaced by term personal directive in legislation.
Health care directive	Document used in Manitoba and Saskatchewan.
Joint crisis plan	Document used in the United Kingdom where facilitator and producer of document negotiate an agreement.
Living will	Term widely used in the U.S. to highlight that document is used while individual is alive.
Mandate in case of incapacity	Document used in Québec that is framed in legislation as a contract.
Mill's will	Term used in reference to John Stuart Mill's philosophical views of liberty rights.
Nexum contract	Advance agreement that follows a contractual model that is inherently bilateral.
Odysseus contract, pact, or transfer	Greek term used instead of Ulysses contract.

Personal directive	Document used in Alberta, Northwest Territories, and Nova Scotia.
Power of attorney (continuing, durable, enduring, springing)	Document used in New Brunswick and Ontario.
Pre-commitment contract	Highlights an earlier commitment that involves making a choice.
Psychiatric advance directive	Documents used primarily in the U.S. for individuals with mental health and are premised on the value of autonomy.
Psychiatric will	Original term proposed by psychiatrist Thomas Szasz to protect patients from coercion or neglect.
Representation agreement	Document used in British Columbia.
Ulysses commitment contract	Term used to reflect a commitment to follow through on a self-binding contract.
Ulysses contract	Roman term used where individual makes self-binding wishes.
Ulysses clause	Term reflecting a legal provision included in an advance directive to make the document irrevocable.
Ulysses directive	Term specifically avoids reference to contractual relationship.
Ulysses statement	A one-sided statement that is less strong than a Ulysses directive or contract.
Voluntary commitment contract	Term highlights that document is not entered into under undue influence or coercion.

Table II –Relationship between Autonomy and Temporality

FORMS OF AUTONOMY	DESCRIPTION	TEMPORALITY
Decisional	Ability to make immediate decisions about choices independently.	Present
Dispositional	Focuses on one's character and life as a global whole.	Present
Emotional	Grounded in human feelings.	Present
Executional	Implementation of one's decisions.	Present
Functional	Engagement in activities of daily living and mobility.	Present
Precedent	Precedence over competing interests.	Past
Prospective	Looking forward from the perspective of the individual.	Future
Rational	Grounded in logic and reason (subjective or objective).	Present
Relational	Reliance on others in decision-making.	Present
Value	Independent views that align with personal value system.	Present

CHAPTER THREE: Preferences for instructional or proxy advance directives in mental health: an exploratory mixed methods study

Psychiatric advance directives (PADs) are instructional documents that allow individuals to detail their treatment preferences in the event of future mental incapacity. Mandates in case of incapacity, in contrast, are proxy directives used in Québec whereby a mandator (maker) appoints a mandatary (proxy) to make decisions related to administration of property and finances and/or personal care matters. Several Canadian jurisdictions have legislation that enables the use of only proxy directives and not instructional directives. Little is known about the factors that lead individuals with particular forms of mental illness to choose instructional or proxy directives. A mixed methods study is used to examine predictive factors such as autonomy, empowerment, and recovery associated with choice of document involving 65 individuals with schizophrenia-spectrum disorder, major depression, or bipolar disorder. Phase I consists of qualitative interviews, PAD completion, and a follow-up interview with six participants. In Phase II, 59 participants completed questionnaires measuring autonomy, empowerment, and recovery, completed a PAD or mandate, and returned at three months for follow-up measures. Phase III involved interviews among six participants who completed a PAD at phase II. The majority of participants chose to use a PAD (76%) rather than a mandate (24%). A logistic regression analysis reveals that men, individuals with a schizophrenia-spectrum disorder, and greater awareness and insight into the need for treatment are associated with choice of mandates rather than PADs. Participants' degree of autonomy, empowerment, and recovery were stable over a three-month period. The implications of these results are discussed in light of the results from qualitative phases I and III.

When individuals with mental illness experience a crisis, they may receive treatments that differ from their preferences had they been able to express them at the beginning of a crisis. Two types of legal documents have been proposed to allow individuals' preferences to be known in the event of mental incapacity. Psychiatric advance directives (PADs) are instructional directives used in some U.S. states that allow individuals to include detailed instructions regarding their treatment preferences (Srebnik et al., 2005). Mandates in case of incapacity are proxy directives used specifically in Québec that allow individuals to appoint a trusted third party, such as a family member, to make decisions in the event of mental incapacity (*Civil Code of Québec*, 1991). Some jurisdictions allow individuals to complete both types of documents. In this embedded mixed methods study, we examine the factors associated with individuals' choosing an instructional directive (PAD) or a proxy directive (mandate).

Information is empowering. Individuals with mental illness who are mentally capable to complete a PAD may feel more empowered and become more assertive in articulating their treatment preferences after the process (Wilder, Elbogen, Moser, Swanson, & Swartz, 2010). In Canada, mental health organizations and government agencies are becoming interested in the future of advance treatment planning (Mental Health Commission of Canada, 2009; Dunbrack, 2006; Kirby, 2004). While mental health legislation in all provinces and territories, except Nunavut, enable individuals to complete proxy directives, only six jurisdictions have statutory provisions that enable the use of instructional directives (Dunbrack, 2006). In the province of Québec, for example, mandates in case of incapacity are proxy directives whereby a mandator (maker) can appoint a mandatary (proxy) to make decisions regarding the administration of property and/or personal care matters (*Civil Code of Québec*, 1991). We explore factors associated with treatment preferences of individuals with bipolar disorder, depression, or schizophrenia spectrum-disorder to complete an instructional directive (PAD) or a proxy directive (mandate).

Instructional Advance Directives (PADs)

There are three types of advance directives: instructional, proxy, and a hybrid that combines both (Appelbaum, 1991; Gallagher, 1998). Instructional directives allow individuals to include detailed preferences regarding their medical treatment in order to “memorialize the subjective intent” (Gallagher, 1998). Individuals who do not have others to rely on may be more likely to use instructional than proxy directives (Pellegrino, 1992). In the U.S., instructional directives also tend to receive greater constitutional protection than proxy directives (Winick, 1996). Although some suggest that instructional directives promote autonomy (Dunbrack, 2006), others argue “instructional directive legislation gives a veneer of protecting patient autonomy” and does “nothing towards protecting patient autonomy” (Clough, 2006). These divergent views of whether instructional directives promote autonomy, in relation to proxy directives, warrant closer examination.

Individuals who have been coerced into medical treatment are more likely to report a desire for greater autonomy (La Fond & Srebnik, 2002). Decreasing coercion can lead to greater autonomy, which may be why some individuals with mental illness have a strong desire to complete PADs if they start with a belief that the document promotes autonomy (Swanson et al., 2008). As instructional directives, PADs provide individuals the opportunity to inform family, friends, and health care staff of their treatment preferences while retaining a measure of control in decision-making (Amering, Denk, Griengl, Sibitz, & Stastny, 1999; Scheyett, Kim, Swanson, & Swartz, 2007; Swanson, Swartz, Elbogen et al., 2006; Swartz & Swanson, 2007). When treatment preferences recorded in a PAD are subsequently honoured, this can increase individuals’ subjective perceptions of autonomy (Scheyett et al., 2007) and empowerment (Backlar, McFarland, Swanson, & Mahler, 2001). On the other hand, if individuals are not consulted regarding their treatment preferences before the onset of a crisis, there is a risk of making decisions against one’s true wishes (Goss et al., 2008; Szmukler & Dawson, 2006).

PADs can be considered a self-management strategy that helps individuals towards greater control, symptom recovery, and autonomy (Davidson et al., 2007). Of course, respect for autonomy to make independent choices has reasonable limits that require knowledge of one's level of mental capacity, which can fluctuate with episodes or psychosis or mood, particularly among certain groups such as people with bipolar disorder (Backlar, 1998; Ritchie, Sklar, & Steiner, 1998). Contrary to common belief, individuals who complete PADs rarely use the documents to refuse all medical treatment (Swanson, Swartz, Elbogen et al., 2006). Nonetheless, some physicians and lawyers may be reluctant to promote PADs because they believe the documents will be used to refuse all treatment and that they do not build autonomy. In a survey conducted among legal and mental health professionals in Ontario and Québec, 90% of the sample reported that PADs have the potential to promote autonomous choice (Ambrosini, Crocker, Perreault, & Israël, 2008). Members of some professional groups, such as social workers, may face greater struggles than other groups in supporting the principle of autonomy through PADs as they weigh other considerations such as non-adherence to treatment (Scheyett, 2009; Scheyett et al., 2008). Although it is often said that PADs promote autonomy, there remains a dearth of empirical research on the relationship between PADs and autonomy, which may be due in part to the difficulty in operationalizing autonomy and thus the lack of instruments to measure it (Geller, 2000).

Proxy Directives (Mandates)

Proxy directives are, in the present context, documents that allow people with mental illness to appoint an agent to make decisions for them in the event of mental incapacity. Unlike instructional directives, proxy directives are less constrained by unforeseeable events although agents need to be informed of the values of the person they are representing ahead of time (Appelbaum, 1991; Pellegrino, 1992). In Québec, a civil law jurisdiction, such mandates are legal documents (Brown & Murphy, 2000; *Civil Code of Québec*, 1991). Neither Québec, New Brunswick, Ontario, British Columbia, nor the Yukon, in contrast, have legislation that enables the use of instructional directives (Dunbrack, 2006; Tapp, 2006). The relevance of mandates in Québec is particularly salient as the National Assembly of Québec (2010) recently completed a series of public consultations in the province to hear perceptions of end-of-life, euthanasia, and palliative care issues for elderly individuals.

Some have challenged instructional directives because they do not always allow individuals such as family and friends to control treatment decisions towards the end of life (Ditto et al., 2001). Unfortunately, however, some individuals who complete proxy directives do not discuss their treatment preferences with their agents (Gillick, 2006), which can reduce the accuracy with which one’s treatment preferences are expressed and will be known in a crisis (Kirschner, 2005). One of the critiques of advance directives is that individuals’ preferences may change over time. Among a non-mentally ill aged population, research indicates that from the time an advance directive is completed to one and two years, later preferences for life-sustaining medical treatment remain relatively stable (Ditto et al., 2003). Given the nature of mental disorders, the stability of preferences and values among individuals with mental illness may fluctuate more than among individuals in the end-of-life context.

Preferences for Instructional or Proxy Directives

A proxy directive combined with an advisory statement in the form of an instructional directive may have the greatest influence in guiding decisions that truly reflect an individual’s wishes if they were mentally capable (Emanuel, 1993). Alternatively, people who are more autonomous from the outset may tend to choose instructional directives over proxy directives. A stronger evidence base is required to understand the factors associated with one’s choice of instructional or proxy directives before any reform of mental health legislation (Brown, 2003). Individuals with certain mental disorders may be more inclined to choose a certain type of document if they feel that it promotes greater autonomy, choice, and control (Campbell & Kisely, 2009; DeWolf Bosek, Ring, & Cady, 2008). For example, individuals may prefer PADs because they increase subjective perceptions of autonomy (Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008) or because they limit health care professionals' freedom (Atkinson, Garner, & Gilmour, 2004). The odds of wanting a PAD are significantly higher among individuals who feel pressured to take medication and lower among individuals who report a higher degree of personal autonomy (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006); however, it is unclear whether individuals prefer instructional to proxy directives because they want to refuse treatment (Fagerlin & Schneider, 2004).

Prior research examining the relationship between autonomy and choice for instructional or proxy directives has done so primarily through a philosophical or legal approach (Clough, 2006; Davis, 2008; Ritchie et al., 1998; van Willigenburg & Delaere, 2005; Winick, 1998). Autonomy can be distinguished from related ethical values such as empowerment and self-determination (Schurhofer & Peschl, 2005; Somerville, 1994). For example, self-determination has been referred to as the ability to express one's wishes, such as saying “yes” or “no” (Somerville, 1994), whereas empowerment is the process of gaining information that can lead to increased autonomy and control in one's life (Schurhofer & Peschl, 2005). Another approach to understanding autonomy has been to construct it as a normative and ethical *ideal* that one strives towards, rather than as a functional value (Stiggelbout et al., 2004). Unlike empowerment that can involve a process of one person sharing information to empower someone else, autonomy can be understood as a self-referential and internally generated state or trait (Schurhofer & Peschl, 2005).

Some legal scholars have recommended standardizing instructional and proxy directive forms across Canada (Downie, 1992). Before taking such steps, it would be helpful to understand the reasons why individuals prefer certain types of documents. This study is important on several fronts. First, although exact figures are unknown, among Canadians for whom advance directives are most relevant very few have completed one and those who have, have done so primarily in the end-of-life context (Bravo, Paquet, & Dubois, 2003; Molloy, Guyatt, Alemayehu, & McIlroy, 1991; Molloy, Harrison, Farrugia, & Cunje, 1993; Molloy et al., 2000;

Patterson et al., 1997; Sam & Singer, 1993). Second, as mentioned above, currently six Canadian jurisdictions do not have enabling legislation for instructional directives (Dunbrack, 2006). If the demand for instructional directives is high among certain groups of individuals with mental illness, it may be desirable to pass legislation that would give greater legal force to such documents. Third, as there is a strong impetus towards promoting a national mental health strategy across Canada, greater knowledge of preferences for advance treatment planning should precede legislative reform (Mental Health Commission of Canada, 2009; Kirby, 2004).

Goal of Present Study

The purpose of this study is to determine preferences for instructional or proxy directives among individuals with depression, bipolar disorder or schizophrenia, and to explore the factors associated with choice of document. An embedded mixed methods design using quantitative and qualitative components is used to examine the relationship between level of autonomy, empowerment, and recovery and choice of document.

Hypotheses

We developed four *a priori* hypotheses to be tested using quantitative or qualitative methods.

Quantitative.

(1) Individuals with higher levels of autonomy, empowerment, and recovery are more likely to choose instructional directives (PADs) over proxy directives (mandates). This hypothesis was based on previous literature that PADs promote consumer choice and autonomy more than other forms of advance treatment planning documents (Henderson, Swanson, Szmukler, Thornicroft & Zinkler, 2008).

(2) Individuals with schizophrenia-spectrum disorder are more likely to choose instructional directives (PADs) than individuals with depression or bipolar disorder who would choose proxy directives (mandates). This

hypothesis was based on the belief that individuals with schizophrenia-spectrum disorders may be more interested in medication refusal, which is addressed specifically in a PAD.

(3) The degree of autonomy, empowerment, and recovery of individuals who completed a PAD will increase over a three-month period more than among individuals who completed a mandate. Although preferences for life-sustaining treatment are moderately stable over one and two years among older adults (Ditto et. al., 2003), this hypothesis was based on the belief that when individuals can reflect on the benefits PADs have on mental health, more generally, their autonomy, empowerment, and recovery will likely increase.

Qualitative.

(4) How do individuals' values and experiences with mental illness, as communicated before and after completing a PAD, align with the instructions included and reasons for choosing an instructional directive? How individuals narrate their experiences with mental illness may be shaped by the process of completing a legal document, such as a PAD. Therefore, individuals were interviewed both before and after completing the document.

Methods

Study Design

Mixed Methods. An embedded mixed methods study design was used to synthesize quantitative and qualitative results to provide a robust understanding of reasons for participants' choices (Creswell & Plano-Clark, 2003). Mixed methods research has been used in mental health to examine delivery of services (Robins et al., 2008), management of anti-psychotic medication (Rogers, Day, Randall, & Bentall, 2003), acceptability of assertive community treatment programs (Killaspy et al., 2008), and coping strategies (Kartalova-O'Doherty & Doherty, 2008). The flowchart in figure 1 depicts how qualitative phases of the study (I and III) were embedded into the primary quantitative phase (II).

Preference Trial. Although random allocation enables an internally valid comparison between the effects of two treatments, it does not take into account patients' preferences for treatment (Bowling & Rowe, 2005). Some have advocated for the greater use of preference trials to evaluate how choices affect treatment outcomes (Tilbrook, 2008), which can lead to a greater appreciation for how voluntariness affects outcomes in the delivery of mental health services (Howard & Thornicroft, 2006). This study addresses factors that motivate choice between PADs as instructional directives or mandates as proxy directives.

Participants

Participants were 65 individuals with serious mental illness living in Montréal, Québec. Participants were required to: (i) have a diagnosis of bipolar disorder, schizophrenia-spectrum disorder, or major recurrent depression (with or without psychosis); (ii) be 18-65 years old; (iii) be able to understand and speak English; (iv) be capable of providing informed consent; (v) be followed by a psychiatrist. People who were incompetent to consent; under public curatorship; or had already completed an advance directive were excluded from participation in the study.

Recruitment

Participants were referred to the study from clinics associated with the Douglas Mental Health University Institute (DMHUI) in Montréal, a teaching hospital affiliated with McGill University, as well as from community mental health organizations in the Montréal area. Psychiatrists, case managers (or their delegates), and staff from the DMHUI and community mental health organizations asked eligible participants if a member of the research team could phone them to explain the research study. Recruitment took place from December 2009 to December 2010.

Interventions

Psychiatric advance directive (PAD). A PAD contains provisions to appoint an agent/proxy (although in some jurisdictions this is optional), to include instructions regarding treatment, to share contact information, and to declare when it should be revoked (Swanson, Tepper, Backlar, & Swartz, 2000). A copy of a PAD was obtained from the Bazelon Center for Mental Health Law (2010) in the U.S., which was adapted for use in this study under Canadian law. A Montreal lawyer who was independent from the research study verified that the PAD follows the general format required under Québec law that two witnesses are required to witness the signing of the document. Three additional pages were included in the PAD to allow participants to write detailed instructions regarding: physical symptoms, crisis situations, acceptable and unacceptable medications, allergies, hospitalization preferences and objections, emergency contacts, stressors and triggers of crisis, wellness factors, helpful support, recovery, therapies, personal assistance, and instructions to hospital staff. In our version of the PAD, participants were able to appoint a proxy (but did need to do so). Under Québec law, individuals have the right to choose a professional or institution from whom they wish to receive health or social services (*An Act Respecting Health and Social Services*, 2002). Individuals were able to use a PAD to record their preferred hospital where they wished to receive care, but were also informed that the availability of their choice would depend on available resources. PADs are not generally used to record detailed preferences regarding administration of property or finances.

Mandate in case of incapacity. Mandates are proxy directives used in the province of Québec and governed under articles 2130-2174 of the *Civil Code of Québec* (1991). A mandate enables individuals to appoint another trusted person to make decisions in anticipation of mental incapacity regarding administration of finances and property and personal care issues. A copy of the mandate was obtained from the website of the Office of the Public Curator who provides such a document to the public for free (Public Curator of Québec, 2009). A PAD also allows the designation of an agent/proxy; unlike PADs, however, mandates can be used to designate an individual with the right to administer finances and property and/or personal care (i.e. housing, consent to care, clinical trials, and last wishes) in the event of mental incapacity. Participants were informed that under Québec law mandates need to be homologated if a mandator becomes incapable (which often takes time), a process whereby a court confirms the individual's mental incapacity, verifies the mandate, and validates the presence of witnesses. Mandates do not generally focus on mental health issues in the same way as do PADs.

Measures

Mental competence. The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) was used to measure competence to consent to clinical research (Appelbaum & Grisso, 2001; Candilis, Fletcher, Geppert, Lidz, & Appelbaum, 2008). The MacCAT-CR is a semi-structured interview to examine decision-making competence as it relates to four factors: understanding ability, appreciation ability, reasoning ability, and expressing a choice (Kovnick, Appelbaum, Hoge, & Leadbetter, 2003). The instrument has good inter-rater reliability with kappa coefficients previously calculated for measures of understanding (.69), reasoning (.53), and appreciation (.79) (Kovnick, Appelbaum, Hoge, & Leadbetter, 2003). The instrument included questions that were relevant to completing this study on advance directives. Each question is scored on a scale of 0 to 2 with the following ranges: understanding (0 to 26); reasoning (0 to 8); appreciation (0 to 6); expression of choice (0 to 2).

Autonomy. Autonomy was measured using two instruments. The first was the Ideal Patient Autonomy Scale (IPAS), a 14-item normative instrument on a 5-point Likert scale format (from 'disagree' to 'agree') that examines how ideals of autonomy in clinical practice align with alternative conceptions of autonomy found in the ethics literature (Stiggelbout et al., 2004; Stiggelbout et al., 2008). A higher score on the IPAS reflects greater agreement that patient autonomy is desirable. The IPAS was originally developed to guide doctor-patient relationships and to understand patients' perceptions of the clinical decision-making process. The IPAS contains four subscales of autonomy: (i) doctor knows best (e.g. It is better that the doctor rather than the patient decides which is the best treatment); (ii) patient should decide (e.g. It goes too far when the doctor decides which treatment is best for the patient); (iii) right to non-participation (e.g. Patients should have the right not to be involved in the decision on the treatment); and (iv) obligatory risk information (e.g. The patient has to be informed on all the risks involved in an operation) (Stiggelbout et al., 2004). Although the IPAS has not been validated for test-retest reliability in a psychiatric population, a review of 65 instruments measuring clinical judgment suggests it shows special promise as it is closely linked with ethical theory (Redman, 2006).

The Autonomy Preference Index (API) was used as an alternate measure of autonomy and incorporates two subscales: (i) six items on decision-making (e.g. You should go along with your doctor’s advice even if you disagree with it) and (ii) eight items measuring information-seeking preference (e.g. It is important for you to know all the side effects of your medication) (Ende, Kazis, Ash, & Moskowitz, 1989). Responses are recorded using a 5-point Likert-scale from ‘strongly disagree’ to ‘strongly agree’. Test-retest reliability for the decision-making sub-scale is 0.84 and the information-seeking sub-scale is 0.83 (Ende et al., 1989). On the decision-making preference scale of 0 to 100, a 0 score indicates a very low and 100 indicates a very high preference for decision-making, whereas 50 is a neutral attitude. For the preference for information seeking scale ranging 0 to 100, a 0 refers to strong disagreement with statements favouring patient’s being informed, 50 is neutral, and 100 is strong agreement.

Empowerment. The Making Decisions Empowerment Scale is a 28-item instrument on a 4-point Likert format (from ‘strongly agree’ to ‘strongly disagree’) designed to measure subjective feelings of personal empowerment among individuals with mental illness (Rogers, Chamberlin, Ellison, & Crean, 1997). The total score ranges from 28 to 112, with a higher score indicating higher empowerment. The Empowerment Scale contains five subscales: (i) self-esteem and self-efficacy (e.g. I have a positive attitude toward myself); (ii) power-powerlessness (e.g. Usually I feel alone); (iii) community activism and autonomy (e.g. People have a right to make their own decisions even if they are bad ones); (iv) optimism and control over the future (e.g. I can pretty much determine what happens in my life) and; (v) righteous anger (e.g. Getting angry about something never helps) (Rogers et al., 1997). The scale has good reliability in terms of internal consistency (Cronbach's α = 0.83) (Hansson & Bjorkman, 2005; Rogers et al., 1997; Wowra & McCarter, 1999).

Recovery. The Recovery Assessment Scale (RAS) is a 41-item scale rated on a 5-point Likert format (from 'strongly disagree' to 'strongly agree') used to measure recovery (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004). The RAS contains five factors: (i) personal confidence and hope (e.g. I am hopeful about my future); (ii) willingness to ask for help (e.g. I am willing to ask for help); (iii) goal and success orientation (e.g. I have my own plan for how to stay or become well); (iv) reliance on others (e.g. I have people I can count on) and; (v) symptom coping (e.g. Coping with my mental illness is no longer the main focus of my mental illness) (Corrigan et al., 2004). The RAS has good internal consistency (Cronbach's α = 0.93) (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999), and each factor has satisfactory internal reliability (Cronbach's α = 0.73 to 0.91) (McNaught, Caputi, Oades, & Deane, 2007).

Insight. The Insight and Treatment Attitudes Questionnaire (ITAQ) was used to measure participants' awareness of illness and insight into the need for treatment (McEvoy, Applebaum, Apperson, Geller, & Freter, 1989; McEvoy, Freter, Merritt, & Apperson, 1993). The ITAQ consists of 11 items phrased as open-ended responses scored as 0 (no insight), 1 (partial insight), or 2 (good insight). Total scores range from 0 to 22. Patients with a score of 15 or higher are defined as having good insight, 8-14 as fair insight, and 7 or lower as poor insight. Sample items include, Do the medications do you any good? Will you take the medication? The ITAQ has been shown to have good test-retest reliability at one year follow-up ($r = 0.70$) (McEvoy et al., 1993).

Coercion. Coercion was measured using the MacArthur Perceived Coercion Scale (MPCS), a scale that includes 5 true/false items to assess perceptions of freedom, influence, control, and treatment choices (Gardner et al., 1993). In its original form, participants were asked about coercion related to their medication and to clinical treatment in relation to their hospital admission (Rain, Steadman, Robbins, 2003). The five items include: I feel free to do what I want about getting treatment; I chose to get treatment; It was my idea to get treatment; I had a lot of control over whether I got treatment, and; I had more influence than anyone else on whether I got treatment. On the MPCS, each 'true' was scored 0 and each 'false' scored 1. Scores were dichotomized into low (0-2) or high coercion (3-5) for analyses.

Psychopathology. The expanded Brief Psychiatric Rating Scale (BPRS-E) is a 24-item scale measuring participants' severity of psychiatric symptoms over the past two weeks (Lukoff, Nuechterlein, & Ventura, 1986). Each item in the BPRS-E consists of a 7-point scale ranging from 'not present' to 'extremely severe.' The BPRS-E has been demonstrated to have good internal consistency among outpatients in three diagnostic groups (bipolar disorder, schizophrenia, and depression), and has a stable four-factor structure: (i) depression/anxiety; (ii) psychosis; (iii) negative symptoms (retardation); and (iv) activation (Velligan et al., 2005). Although an earlier version of the BPRS has been shown to have a four-factor model that includes thought disturbance, anergia, affect, and disorganization (Mueser, McHugo, Curran, 1997), the more recent version of the BPRS-E was used because it too has a stable four-factor structure making it useful as a clinical outcome measure (Velligan et. al., 2005). The research assistant who administered the BPRS-E received specialized training over several weeks on how to administer the instrument from qualified clinicians.

Attitude toward medication. The Hogan Drug Attitude Inventory (DAI-30) was used to measure participants' subjective attitudes towards medication (Hogan, Awad, & Eastwood, 1983). The DAI-30 is a 30-item true/false instrument with seven factors: (i) subjective positive (e.g. For me, the good things about medication outweigh the bad); (ii) subjective negative (e.g. I feel weird, like a 'zombie' on medication); (iii) health/illness (e.g. It is unnatural for my mind and body to be controlled by medication); (iv) physician (e.g. It is up to the doctor when I go off medication); (v) control (e.g. I take medication of my own free choice); (vi) prevention (e.g. By staying on medication, I can prevent getting sick); (vii) harm (e.g. Medication is a slow-acting poison). The DAI-30 consists of 15 items dealing with positive attitudes and 15 items addressing negative attitudes. Total scores were calculated by producing a score ranging from -30 to 30 where a positive total score indicated an overall positive subjective response, and a negative total score reflected an overall negative subjective response. The DAI-30 has good internal consistency (Cronbach's α = 0.84) (Kuroda et al., 2008).

Preferences for advance directives. The Preference for Advance Directives Scale (PAD Scale) is 10-item scale measured on a 5-point Likert format (from 'strongly disagree' to 'strongly agree') developed by one of the authors (DA) to explore preferences for advance directives. The PAD scale was used in another study to examine preferences of PADs among social work students (Ambrosini, Lach, Charette, & Crocker, under review). A principal components exploratory factor analysis with Varimax rotation resulted in a four-factor model with good sample adequacy (KMO = 0.65). The four factors are: (i) choice (e.g. I want to write down detailed instructions about my treatment choices in an advance directive; (ii) interpersonal/individualism (e.g. I want my family to help me decide my treatment choices with my doctor before completing an advance directive); (iii) doctor involvement (e.g. I trust my doctor to help me decide which treatment choices to include in an advance directive); (iv) self-trust (e.g. I trust my own judgment regarding treatment choices to include in an advance directive). Data on the test-retest reliability of this scale are not available from this study.

Study Procedures

Phase I: Qualitative. Maximal variation sampling was used to recruit an equal representation of individuals who were purposefully selected across type of mental disorder and gender (Creswell, 2003; Whitley & Crawford, 2005). Sample size for the interviews was intentionally kept small to provide an in-depth understanding of participants' responses rather than obtain a breadth of information (Creswell, 2003). An experienced interviewer conducted and audio-recorded interviews in the homes of six participants (n = 1, bipolar; n = 2, depression, n = 3, schizophrenia). On average, these six interviews lasted 58 minutes. A second member of the research team, trained as a lawyer (DA), met with participants at the DMHUI approximately two days later to facilitate the completion of a PAD. The initial interviewer then returned to participants' homes one month later for a follow-up interview that averaged 30 minutes. Additional details of the study design and results are presented in chapter 4.

Phase II: Quantitative. An interviewer administered questionnaires, and laminated sheets showing participants the response options were used as supports during the interview. The time of baseline interviews was not measured but averaged between 75 to 90 minutes according to the interviewer. When participants returned to the DMHUI two to three days later, they met a member of the research team (DA) who gave them a choice between completing a PAD or mandate. Participants were provided two laminated sheets explaining in bullet format the differences between each document. In order to ensure that participants understood each document, they were asked to recite similarities and differences before expressing a choice. All participants wrote their own instructions in the document. It took participants an average of 121 minutes (SD = 30) to complete the PAD, and 94 minutes (SD = 18) to complete the mandate. To create the document, it was formally witnessed by two independent persons from the hospital. The original document was given back to participants who were advised to keep it in a secure location. Participants who named a mandatary in their mandate were encouraged to inform the individual that they completed such a document. Participants who named an agent in their PAD were also advised to inform the agent of the document. A second copy of the document was provided to hospital clinics (depression, bipolar, schizophrenia) to include in patients' files; a third copy was retained for research purposes.

Approximately three months later, participants were telephoned by a member of the research team (DA) and asked to return to the DMHUI for a brief follow-up visit. Participants completed four questionnaires previously administered at baseline measuring their degree of autonomy (IPAS, API), empowerment (Empowerment Scale), and recovery (RAS). Participants discussed advantages and disadvantages of the document, and were asked whether they wanted to revoke or retain it. These sessions lasted an average of 30 minutes.

Phase III: Qualitative. Six participants from phase II who chose and completed a PAD were purposively selected, based on equal representation of sex and mental disorder (n = 2, bipolar; n = 2, depression; n = 2 schizophrenia), for a follow-up interview at the DMHUI. Purposive sampling involves having one or more predefined groups in mind and in this case involved an equal representation of sex and type of mental disorder (Creswell, 2003; Whitley & Crawford, 2005). These interviews were conducted and audio-recorded by an interviewer (DA) and averaged 48 minutes.

Mixed Methods Integration Procedure

Integration of data occurred in several ways during the collection, analyses, and interpretation of the study (Creswell & Plano Clark, 2007). Data was collected from participants using qualitative interviews before and after questionnaires were administered during the quantitative phase. Additionally, qualitative data was collected during the quantitative phase II as participants were asked to provide reasons for choosing a PAD or mandate. During the analyses, transformation methods were used to transform qualitative data into quantitative results that could be numerically coded and interpreted. A modified form of extreme case analysis was used in phase III to integrate participants' values, expressed during the qualitative interviews, with quantitative outlier scores to identify points of convergence or divergence (Caracelli & Greene, 1993). The six individuals for the modified form of extreme case analysis were already selected based on sex and type of mental disorder and not on their individual outlier scores.

Ethics Approval

The study was approved by the Research Ethics Board of the Douglas Mental Health University Institute (DMHUI). All participants provided written informed consent and were given the following compensation: Phase I ($20); Phase II ($20 for the first visit, $20 for the second visit, and $10 for the third visit); Phase III ($10).

Results

The manner in which results are presented in a mixed methods study can vary (Creswell & Plano Clark, 2007). As this study was designed as an embedded mixed methods study prioritizing quantitative methods, the quantitative phase II results are presented first followed by qualitative results from phases I and III (Creswell & Plano Clark, 2007).

Sample Characteristics

Ninety-one individuals were referred to the study: 35% (n = 32) from community mental health organizations and 65% (n = 59) from clinics associated with the hospital. Among the 91, 4 individuals could not be reached by telephone, and 6 individuals were referred to participate in phase I. Among the remaining 81 individuals screened at phase II, 27% (n = 22) chose not to participate for reasons including: time constraints (n = 11), psychological barriers (n = 5), language issues (n = 4), and no reason provided (n = 2). Among the remaining 59 participants, 8% (n = 5) were mentally incapable to complete an advance directive, 4 of whom had a schizophrenia-spectrum disorder.

Participants' average age was 45 years (SD = 10.6) with a range between 27 and 64 years. Table 1 reveals the sample was 50% female, 54% (n = 29) had never been married, and 65% (n = 35) did not have children. Forty-four percent of participants had a diagnosis of major depression, 28% bipolar disorder, and 28% had a schizophrenia-spectrum mental disorder. Among the sample, 34% (n = 20) of participants lived alone in an apartment and 58% (n = 34) were not working. Regarding source of income, 31% (n = 18) received welfare, 22% (n = 13) received disability insurance, and 20% (n = 12) received payment for work. Fourteen percent had not completed high school.

The mean score on the BPRS was 41.8 (SD = 9.7) indicating moderate symptom severity. The mean score on the ITAQ was 13.7 (SD = 2.3) which, according to norms, reveals a fair level of awareness and insight and awareness into the need for treatment. The mean score on the MacArthur Perceived Coercion Scale (MPCS) was 3.5 (SD = 1.4) with the responses suggesting a high perception of coercion related to issues of medication and clinical treatment. Table 1 shows that 70% of participants reported at least one psychiatric hospitalization in their lifetime. However, 70% stated that they were not hospitalized against their wishes and 83% did not receive involuntary treatment. At the same time, among the sample, approximately one-third (34%) reported the use of hospital restraints, and another one-third (32%) stated that isolation or seclusion had been used against them in the past. Interestingly, 83% provided written authorization for a research team member to verify their information with their medical file, although these were not verified.

Hypothesis 1: Autonomy, empowerment, and recovery as predictors of choice of document

Consistent with our first hypothesis, we found that 76% (n = 41) of individuals with mental illness chose an instructional directive (PAD) and 24% (n = 13) preferred a proxy directive (mandate). However, a simple univariate logistic regression was conducted and we did not find that individuals with higher levels of autonomy, empowerment, or recovery were more likely to choose instructional directives (PADs) over proxy directives (mandates). We did find that individuals who chose a PAD were significantly more likely than those who chose a mandate to have higher levels of subjective negative perceptions towards medications (OR = 1.3, 95% CI: 1.0-1.6). Although not directly related to our hypothesis, it should be noted that several participants reported to the interviewer that they would have preferred to complete both documents – the mandate for administration of finances and property and the PAD for mental health issues.

Results from phase II helped to explain reasons underlying participants' choice of document in line with our goal of exploring reasons for choosing instructional directives. When participants reported why they chose a PAD (n = 41), before actually completing the document, their qualitative responses were coded into themes and transformed into frequencies. Among the coded responses, 51% (n = 21) reported that a PAD allowed them to provide detailed instructions, 39% (n = 16) believed it gave them greater control, and 39% (n = 16) stated it provided greater choice. When participants returned three months later and were asked about the advantages of PADs, the most frequent responses were that the document allows them to have greater trust in whom they choose as their substitute decision-maker (n = 10), provides security and peace of mind (n = 7), and allows them to control their own decisions (n = 7). Among the nineteen coded advantages reported by participants were that a PAD allows them to have a voice; feel empowered; be glad to have a written document; and that it provides greater choice. Among the twenty-five coded disadvantages of PADs, participants stated that it is difficult to choose an appropriate agent (n = 4); that it deals only with mental health issues (n = 4); and that the document may not be accessible during a crisis (n = 4).

Eighty-three percent of respondents who chose a PAD in phase II (n = 34) recorded that in a crisis they preferred to receive treatment at a specific hospital. Among this group, ten participants also objected to a specific hospital based on past mistreatment (n = 6); language barriers (n = 2); personal/family reasons (n = 1); and a lack of hospital funding (n = 1). PADs allow individuals to specify their preferred intervention to be used in the event of an emergency. Among those who completed this provision of the PAD (n = 39), 62% reported their first choice of emergency intervention was medication in pill form, 15% wanted medication by injection, and 15% requested seclusion. The reason participants chose an emergency intervention was then coded into one of three factors: (i) medication is effective; (ii) trying to avoid coercion from the social involvement of others; or (iii) unclear response. We found that 45% reported that the reason for their choice of emergency intervention was based on effectiveness of medication, 35% related their choice to some form of social coercion involving others, and 20% of responses were unclear.

> ‘This choice is based on past experiences that proper medication has been most effective for me.’ (Effectiveness)
>
> ‘Because medication has always worked for me in past.’ (Effectiveness)
>
> ‘Fearful memories of seclusion and restraints in the past.’ (Social coercion)
>
> ‘I prefer medication first because if I’m being aggressive or fighting I don't need seclusion or physical restraints.’ (Social coercion)

In addition, 56% (n = 23) of respondents who included a refusal of at least one medication in their PAD. The medications most commonly refused were Seroquel (n = 7), Lithium (n = 7), and Haldol (n = 5). When individuals were asked in an open-ended question to provide a reason for refusing medications, responses were coded as quantitative data as the ability to provide a specific reason related to medical symptoms (83%) or to a general reason (17%).

> ‘Lithium: I have taken this drug with very difficult side effects: somnolence, tremors, impotence, excessive sleeping, increased appetite, profound dimness of mind.’ (Specific reason)
>
> ‘Lithium: Bad side effects. Never felt like myself while on it.’ (General)

Among the seventeen participants who refused to consent to medications that gave them unwanted side effects, the most frequently cited were tremors (n = 9), weight gain (n = 7), and motor restlessness (n = 5).

Among participants who included wellness factors in their PAD (n = 37), after coding responses into themes, we found that 38% reported that they wanted to be outdoors, 32% stated they wanted to be active, and 30% stated that music helps. Other wellness factors include having a social life, reading books, animal therapy, hobbies, watching television, closeness to family, and religious activities.

At three months, participants were asked what they thought about the PAD. Responses reflected a strong appreciation for the PAD with only one participant who chose to revoke the document.

> ‘Kind and imperative tool to help ill person get better using active support of family and friends and medical practitioners. Most important strength is that it creates hope of a healthy recovery without fear of being abused. Have someone to help me without fear of someone abusing me.’ (Individual with bipolar disorder)

> ‘Makes more sense than delegating power to someone else. Gives more power as to what can happen in the future. More comfortable that things will be taken care of according to principles in life.’ (Individual with depression)
>
> ‘Never heard of it before. Good to know something can be planned for future and that things will be looked after. Provides reassurance. Was not difficult to understand and gave a lot of options so could be able to include more detail if wanted. Have power to help yourself in the future.’ (Individual with depression)
>
> ‘I feel a bit safer about my future in case something happens. Had friend at work who could not function. Someone had to take care of it.’ (Individual with schizophrenia)

Among participants in phase II who completed a mandate (n = 13), 46% (n = 6) stated that they chose the document because they trusted others, 39% (n = 5) reported that it deals with both mental and physical/financial matters, and 31% (n = 4) stated that mandates were recognized as legal documents in Québec. When asked about the advantages of mandates, participants reported that they offer greater control over one’s decisions (n = 3), provide peace of mind (n = 2), and allow for greater trust with their mandatary (n = 3). The disadvantages of mandates were that their mandatary could die (n = 3), they are giving a measure of control away to someone else (n = 2), and they need to have complete trust in their mandatary (n = 2). When participants were asked at three months what they thought about mandates, responses were consistent with earlier reasons.

> ‘Document is good in that it handles bodily illness but also material/financial issues. Being able to say which percentage goes to whom. When someone has faculties, have say. Someone will know that when sick I have appointed someone. Brought the mandate to job and intentionally left the document on desk and boss thought it was stupid. Ask questions when sick.’ (Individual with depression)
>
> ‘Good thing to sign up for the document because if an emergency occurred someone could take over my finances and personal health issues. Did have some wealth that would want to be taken care of.’ (Individual with schizophrenia)

Hypothesis 2: Type of mental disorder and choice of document

There was a significant association between choice of document (PAD or mandate) and type of mental illness (bipolar disorder, depression, schizophrenia) (Fisher’s exact test, two sided, $p < 0.01$) (Table 1). However, we did not find support for our second hypothesis that individuals with schizophrenia spectrum disorders would be more likely to choose instructional directives (PADs) than proxy directives (mandates). Instead, all individuals with bipolar disorder, three-quarters of individuals with depression, and approximately half of individuals with schizophrenia chose a PAD (Table 1). Table 2 depicts the development of a multivariate logistic regression model. To identify variables that could be entered into the multivariate logistic regression analyses, bivariate correlation analyses using SPSS 17.0 (2008) was performed to assess which variables were significantly correlated at a $p < 0.25$ level and could be included as candidate variables into the multivariable model (Hosmer & Lemeshow, 2000). The predictor variables were age, sex, insight and awareness into the need for treatment, not currently working, and type of mental illness. Due to the small sample size, we were limited to five variables to include in the model and we chose to compare schizophrenia-spectrum disorders as a psychotic disorder to bipolar disorder and depression as mood disorders. Table 2 shows the logistic regression coefficient, Wald test, and odds ratio for each of the predictors. Employing a .05 criterion of statistical significance, sex (male) (6.9 [1.07-44.99]), insight and awareness into the need for treatment (0.57 [0.33-0.97]), and schizophrenia-spectrum psychotic disorder (0.02 [0.002-0.25]), had significant partial effects. In order to provide a context for interpreting the meaning of non-significant coefficients, a post-hoc power calculation was conducted using SAS software (PROC power) based on the sample size used in this study, and to achieve 80% power the sample size required is a minimum of 75 participants.

Hypothesis 3: Stability of autonomy, empowerment, and recovery over time

In line with our third hypothesis, we examined the stability of participants' autonomy, empowerment, and recovery over three months to determine whether these changed more among individuals who completed a PAD than those who completed a mandate. Figure 2 reveals that participants' responses remained relatively stable over time from baseline to three months on measures of autonomy (IPAS), empowerment (Empowerment scale), autonomy (API), and recovery (RAS). Additionally, we performed a paired t-test among the full sample (PAD and mandate combined) to examine any significant differences over time for the mean score. No such difference was found for the IPAS (t = -.432 (48), *p* =

n.s.), Empowerment scale (t = -.176 (48), *p* = n.s.), API (t = -1.509 (48), *p* = n.s.), and the RAS (t = -.918 (48), *p* = n.s.). However, when the sample was separated by the group who chose PADs from the group who chose mandates, there was a significant difference (small increase) over time on the API for participants from the PADs group (t = -2.7 (36), *p* = .01). Among participants in phase II who returned at three months, only two individuals (N = 59) asked to change a specific provision within their PAD and in both cases it involved replacing the agent. The reasons were that the agent was no longer well enough to act or that they no longer trusted whom they initially chose.

Hypothesis 4: Phase I – Attitudes and experiences with mental illness before completing PADs

In phase I, we explored participants' attitudes and experiences with mental illness before they completed a PAD, and then examined these in relation to instructions included in the document to identify points of convergence or divergence. Four out of six participants initially interviewed agreed to complete a PAD. One female with depression during the initial interview reported feelings of anxiety, isolation, and tension with her spouse.

> Well, when I went in [hospital], it was more or less away from anybody. I was at the very end of the hall in the very end room, so I had privacy. And the whole time, the two months, the last day I shared a room with two people, with three people. I was very afraid, I kept a chair by the door…I think I would like to negotiate but sometimes a person's looks don't correspond with their mental capacity…I would like to get along better with my husband. Sometimes he makes me nervous. He has no patience. So when he has no patience that's when I feel anxiety. We used to be close and we are not very close these days. (Individual with depression)

This participant did not appoint her husband to be the primary agent in her PAD but rather another family member, and included in the document that one of her stressors or triggers of crisis was her husband. After the first interview this participant was re-hospitalized but then stated during the second interview regarding her husband, "He came almost every night to the [hospital] and sat with me for a while and we talked…he was a big support." On the second interview she had a difficult time locating her PAD among all her papers.

A male with depression emphasized during the first interview how he trusted implicitly his spouse, whom he chose as agent, and that he and his doctor were working to discover the cause or causes of his depressive symptoms. He stated, “I’m an open book...I don’t have mistrust in the medical system.” He appointed his wife as agent in the PAD, but included virtually no written instructions other than that music was an important wellness factor for him. During the second interview, he stated,

> I read it over and sat down with my wife. We looked at it, and I don’t think there’s anything in there that was written that I would change...I found it to be a very good thing because especially in this sector of medicine it’s important to have some kind of appropriate documentation in case something happens, and you would like to have someone have access to this to follow what was decided...I think we pretty well know each other inside out, we don’t withhold or hide any information about each other...she was like reading it and going like “Yeah this is what I thought you would say”...she made the same observation “I would have never thought of documenting this question”...so we had a good conversation and we know this document is put away for good safe-keeping and we made a scan of it to keep in our computers; you know it’s easy to lose a piece of paper. (Individual with depression)

Another male with bipolar disorder discussed, during the first interview, the genetic contribution he believed his family members could have had in his mental disorder, and discussed several coping strategies he used to circumvent the onset of a crisis, including the use of music. Then he chose to document in his PAD a limited refusal of lithium (unless necessary), and included wellness factors others should know about if mentally incapable (i.e. music, animals, parks). He suffered a minor heart attack before returning for the second interview, and stated how glad he was that his partner was named as an alternate agent because she handled his physical health crisis so well.

A male with schizophrenia described his experiences with hallucinations and delusions, being isolated, the hospitalization of his father, and spirituality as a coping strategy. He also detailed the negative experiences of being physically restrained by four hospital staff against his wishes. In his PAD, he recorded that his mother, whom he lived with, should act as an agent; refusal of certain medications that caused him to lose his thinking ability; and to be in a hospital room alone rather than to be physically restrained. When asked what comes to mind the most about the PAD during the second interview he stated, “The thing I remember is that they could avoid the medication.” Two females with schizophrenia living independently in the community described at length how they perceived the doctor-patient relationship. One of the female participants trusted her treatment team implicitly describing them as closer than family; the other distrusted the medical profession. Both chose not to complete a PAD.

These interviews can be integrated into a few general results. First, although participants often discuss their experiences with mental illness in relation to their family members, not all participants are necessarily comfortable in letting their family members know they have completed a PAD. This may vary depending on the level of trust in family. Second, after completing the PAD and a crisis event occurred, some participants found that their choice of agent was reinforced because that person supported them through the crisis. Third, some individuals with schizophrenia may be less likely to recall the detailed instructions in their PAD, which may be due to the nature of the mental disorder.

Phase III– Modified extreme case analysis

In phase III, we explored six individuals' reasons for choosing PADs (advantages/ disadvantages) using a variant of extreme case analysis to identify convergent (congruent) and divergent (discrepant) findings. Table 3 depicts a joint display analysis of the integration of questionnaire data (Time 1), PAD instructions, reasons for choice, questionnaire data (Time 2), and interviews. A joint display is a table that allows both quantitative and qualitative data to be directly compared. Along the vertical dimension of Table 3 are the six participants (by mental disorder), and the horizontal dimension shows the quantitative/qualitative results in the sequential order they were obtained. Extreme outlier categories were generated using box plots to examine cases at baseline and 3 months where the six participants were outliers (compared to all phase II participants) on quantitative measures. The six participants were recorded as outliers after the fact because the goal was to explore how later qualitative interviews converged or diverged with earlier recorded extreme outlier scores. Participants were recorded as high or low outliers if they fell in the lower or upper quartiles of 1.5 - 3.0 or > 3.0, respectively.

Participants’ outlier scores generally converged with qualitative expressions during the interviews and reasons for choosing a PAD. A male participant with depression scored in the lower quartile on his level of involvement he wanted from his doctor regarding advance directives and the degree of reliance on others towards recovery. During the qualitative interview, he described in depth an extremely negative experience with a clinician from a psychiatric hospital, how he felt alone since his parents died, without any support other than his brother, and his fear of hospitalization. A female participant with depression initially chose a PAD, but explained during the qualitative interview that she was currently experiencing medical issues that made it difficult for her to choose between the mandate and PAD. She was the only participant who revoked her PAD.

A male participant with bipolar disorder was in the upper quartile on his degree of autonomy and stated that he chose the PAD because he can control his decision-making. During the qualitative interview, he described how he left home from a young age, and experienced problems with his mother who had him involuntarily hospitalized. As a result, he chose his sister to act as agent rather than his mother. A female participant with bipolar disorder was in the upper quartile on the level of doctor involvement that she preferred regarding advance directives and willingness to ask for help towards recovery. She had experienced numerous hospitalizations from an early age, which was an overriding reason for her choice of PAD over mandate. Both the female and male individual with bipolar disorder discussed the value of finances and living independently as indicators of their degree of autonomy.

A male participant with schizophrenia stated that he chose a PAD because when he was first admitted to a hospital involuntarily by his mother several years earlier he disagreed with the decision. Although he had several siblings, he chose a friend to act as his agent because he felt alienated from his family due to his mental illness. His score in the upper quartile score of optimism and control over the future, as a sub-factor of empowerment, could be explained by his extensive involvement in mental health advocacy and strong belief in the defence of legal rights. This participant also stated that his reason for choosing a PAD over a mandate was that it provides greater freedom and choice. A female with schizophrenia who scored in the upper quartile on the measure of psychopathology (psychosis and negative symptoms), was at the same time in the lower quartile on the degree of information she sought from her doctors regarding advance directives. She stated that she chose a PAD because she understood it better than the mandate. She was one of the few individuals who agreed to the administration of electroconvulsive therapy in her PAD because it helped her in the past. During the qualitative interviews she expressed not having control of her life; which was generally planned for her but that she had strong family support.

Discussion

There has been uncertainty and some debate as to whether instructional or proxy directives should be promoted (Emanuel, 1993; Fagerlin & Schneider, 2004). The findings in this study suggest, according to individuals' preferences, that both instructional and proxy directives have an important role for mental health. The demand for instructional directives among individuals with mental illness is not being fully met as evidenced by provinces such as Québec where proxy directives are promoted almost exclusively. Many individuals with mental illness have not been offered the opportunity to complete advance directives specifically related to mental health. Provincial and territorial mental health legislation deals with instructional and proxy directives in a patchwork manner (Dunbrack, 2006). In the end-of-life context, national frameworks are being established to promote advance treatment planning (Canadian Hospice Palliative Care Association, 2010). To our knowledge, this is the first study to examine preferences among individuals with mental illness for instructional or proxy directives.

Preferences for Instructional or Proxy Directives

The finding that three-quarters (76%) of individuals with mental illness in this study prefer instructional directives (PADs) over proxy directives (mandates) suggests there is a need to examine more closely the value of making independent decisions regarding treatment and appointing a proxy agent. Preferences of individuals towards end-of-life are of a different nature than those of individuals with mental illness who may regain their mental capacity (Appelbaum, 2005; Foti, Bartels, Van Citters, Merriman, & Fletcher, 2005). In Québec, mandates in case of incapacity are proxy directives with a strong emphasis on appointing a mandatary to administer one's finances and property (*Civil Code of Québec*, 1991). The reality is that individuals with mental illness often have low income and limited assets, and instead depend on disability benefits or their families to care for them financially. Indeed, this may be one of the reasons that having a schizophrenia-spectrum psychotic disorder predicts choice of mandates if such individuals are more likely to rely upon others for social support. It is not surprising that, overall, individuals with mental illness preferred PADs to mandates as they allow individuals to voice their clinically relevant treatment preferences. Although the results from this study were obtained from Québec, several other Canadian jurisdictions have only proxy directive legislation.

The qualitative in-depth interviews helped to explain why individuals made certain choices. For example, we found that individuals who chose PADs often had greater knowledge of their mental illness and wanted to include details that gave them control over their illness. Conversely, individuals who chose a mandate often stated that they trusted others, preferred the simplicity of the document, and had a lack of knowledge about their mental illness. These results fit with findings from the logistic regression that individuals with higher levels of insight and awareness into the need for treatment, as measured using the ITAQ, predict choosing a mandate. Individuals who chose instructional directives often had good knowledge of symptoms around their mental illness, which does not align completely with the notion that patients lack knowledge to make good treatment decisions (Clough, 2006). The reason individuals choose not to complete instructional directives such as PADs does not appear to be related to disinterest (Clough, 2006). Instead, it may be that they have not been given the opportunity to choose a relevant document. Consequently, several participants mentioned they would have preferred to complete both documents.

Stability of Preferences over Time

One of the challenges that can arise with advance directives is to ensure individuals' preferences remain stable over time (Foti et al., 2005). Some question the value of instructional directives on the basis that they may not reflect one's current wishes (Clough, 2006). Undoubtedly, preferences regarding medications and treatment may, and should, change over time. Whereas identities may be more constant, preferences are dynamic in nature. Even if individuals change their preferences over time, this alone is not a compelling argument to negate one's right to use instructional directives in the event of mental incapacity. Prior research has suggested that treatment choices included in advance directives remain moderately stable over time in non-mentally ill populations (Emanuel, Emanuel, Stoeckle, Hummel, & Barry, 1994). It is important to recognize that proxy studies differ from stability studies, in that they compare either agreement between people or agreement over time, respectively (Emanuel, Emanuel, Stoeckle, Hummel, & Barry, 1994). This study takes a preliminary step to extend previous findings for mentally ill individuals in two ways. First, as shown in Figure 2, results indicate that level of autonomy, empowerment, and recovery remained stable over three months on responses to the four questionnaires, for which we hypothesized there would be changes. We also found that among all participants who completed a PAD, only one requested to change a single provision of their document three months later, suggesting that treatment preferences may be relatively stable over the short-term. Furthermore, the change that was made by this single participant was specifically related to who should be appointed as agent, and not the content of instructions. Over three months, participants informed an average of 2.7 persons that they had a document that included friends, family members, work colleagues, or a member of their treatment team. Several participants stated "just knowing the document was there" provided peace of mind. We were unable to determine to what extent family members reinforced or discouraged participants' choice of document, other than through comments expressed by participants.

Autonomy, Empowerment, and the Doctor-Patient Relationship

It has often been stated that PADs may promote autonomy (DeWolf Bosek et al., 2008; Emanuel, 1993; Scheyett, 2009). It is possible that individuals feel empowered after completing instructional directives such as PADs (Wilder et al., 2010) and three months is insufficient time to assess such changes. The hypothesis that individuals with schizophrenia would be more likely to choose PADs than did individuals with bipolar disorder or depression was completely contradicted. We also did not find support for the hypothesis that individuals with depression would be more likely to choose mandates than would individuals with bipolar disorder or schizophrenia. However, a significant finding was that type of mental illness is associated with choice of document. The preference individuals with schizophrenia have for mandates may be related primarily to whether there is a trust relationship with one's doctor and agent rather than level of autonomy (Laugharne & Priebe, 2006). The fact that half of individuals who chose a mandate had a schizophrenia-spectrum psychotic disorder suggests there is need to examine closely the social support individuals have when choosing a document.

Although individuals with mental illness may not use the term autonomy, as few people do, many described PADs as giving them greater control and choice. Individuals with higher levels of empowerment were significantly less desirous of having their doctor involved in discussing choices related their advance directive, and they had higher scores of reasoning ability. This raises concerns about the changing face of the doctor-patient relationship in psychiatry and, more specifically, the level of trust and autonomy participants have with their physicians (Dworkin, 2003; Tauber, 2003). It is possible that the more mentally capable individuals are, the greater the empowerment they will experience, and greater likelihood of wanting to make independent choices regarding treatment. Teaching individuals how to negotiate their treatment preferences and choices with physicians may be an important element to promote autonomy and empowerment (Botelho, 1992; Drake, Deegan, & Rapp, 2010).

Mental Illness, Capacity, and Insight

Level of insight into one's mental illness and need for treatment is related to completion of a PAD (Swanson, Swartz, Ferron et al., 2006). Type of mental illness is a relevant factor in the choice between instructional or proxy directives (Khazaal et al., 2008). Our finding that every participant with bipolar disorder, two-thirds of people with depression, and just over half of individuals with schizophrenia chose a PAD suggests that type of mental disorder is important. One possible explanation is that individuals with schizophrenia, who often have increased symptoms of psychopathology influencing their mental capacity and insight, prefer mandates because they are more likely to rely on a proxy agent to help them make decisions; it is possible that they have been socialized into a role of dependency. Certain sub-groups of individuals with mental illness may perceive certain types of advance directives as more effective in opening the lines of communication with their doctors (Ditto et al., 2001). Future research should explore to what extent individuals with depression, bipolar disorder, and schizophrenia perceive only social and family support as helpful towards completing advance directives. The relationship individuals with schizophrenia have with their doctors may be markedly different from those with mood disorders, which may also influence how advance treatment planning will be perceived by physicians.

Medication, Hospitalization, and Coercion

Some individuals complete PADs in order to limit doctors' freedom to make decisions (Atkinson et al., 2004). Some individuals in this study may have chosen a particular document because they were not given enough time to consult their doctor or family member prior to completing the document. The degree to which participants want their doctor involved will depend partly on the level of trust and power dynamics of earlier experiences (Laugharne & Priebe, 2006). The qualitative responses reveal that several participants may have also chosen PADs because they were afraid of being coerced into involuntary hospitalization.

In the simple univariate logistic regression analysis we found that individuals who had a subjective negative attitude towards medications predicted choice of mandate. One of the items on the subjective negative sub-scale of the Hogan Drug Attitude Inventory was ‘I feel weird, like a zombie on medication.’ During in-depth interviews, five participants mentioned that medications made them feel like a zombie, and some participants included the term in their PAD. We found that the medications individuals were most likely to refuse included Seroquel, Haldol, and Lithium, which is similar to results reported elsewhere (Wilder et al., 2010). Participants’ strong reactions to side-effects of medication raises questions about the extent to which our mental health system over-relies on medications (Whitaker, 2010), and may spend too much on them relative to other psychosocial interventions. Despite strong reactions from participants towards negative side effects of medications during the interviews, individuals who completed PADs did not use the documents to refuse all treatment as was found in the Swanson et al. (2006) study. Instead, individuals with mental illness are often well informed of which medications are effective for them. Consequently, 86% of respondents agreed that the medications they were currently taking were good for them, and they often showed judiciousness, reasonableness, and restraint in what to include in their document. Perceived coercion is positively correlated with participants’ self-reports of whether they will adhere to injected medications (Rain, Steadman, & Robbins, 2003). Our finding that perceived coercion was significantly associated with negative perceptions of medication, and that participants want to retain control in managing their medications, helps explain individuals’ concerns with side effects from medication.

Limitations

This study presents several limitations. First, the sample size limits the generalizability of the findings. Second, there may have been a selection bias among participants who refused to participate in this study due its legal component. Third, the instructional directive (PAD) was of a hybrid nature in that participants could also appoint an agent while including detailed instructions in the document. Therefore, it is difficult to know to what extent individuals made their choices based on being able to include either an agent or mandatary in their directives. Fourth, the results need to be interpreted in light of the fact that the facilitator who assisted participants to complete the advance directives was trained as a lawyer, which can lead to a strong experimenter's bias affecting individuals' responses, choices, and instructions.

Future Directions

Based on our sample, there is a strong response from individuals with mental illness to complete instructional directives in conjunction with proxy directives. Yet, more research is needed to determine how these findings would apply if other types of proxy directives are used. Currently, not all provinces and territories have legislation that specifically enables the use of instructional directives (Dunbrack, 2006). It has been suggested that, in Québec, living wills could be used in the form of instructional directives under article 12 of the *Civil Code of Québec* (*CCQ*, 1991; National Assembly of Québec, 2010). In practice, unless alternatives are offered, it is likely that most individuals will simply rely on template legal documents provided by governments in their jurisdiction (Public Curator of Québec, 2009); others may seek the assistance of a lawyer to help them draft a specific document if they have the financial means. The origin of mandates derived from a curatorship system primarily focused on protecting individuals' finances and property; PADs represent a new approach that allow individuals with mental illness to make independent choices regarding treatment preferences. Individuals with mental illness do not have the concerns as individuals towards the end-of-life who frequently experience diminishing or deteriorative mental capacity.

Another policy issue that will need to be addressed in future research is how to make advance treatment plans accessible during a time of crisis (Srebnik & Russo, 2008). Several participants acknowledged that accessibility to such documents in a time of crisis is important otherwise they may be pointless documents. The development of electronic health records provides an opportunity to ensure that PADs will be visible whenever a provider consults a service user’s records. As provincial and federal agencies begin to contemplate the value of advance treatment planning on a national scale, it would be useful for provinces and territories to examine to what extent their mental health legislation promotes autonomy, empowerment, and self-determination.

Figure 1. Flowchart of Embedded Mixed Methods Study Design

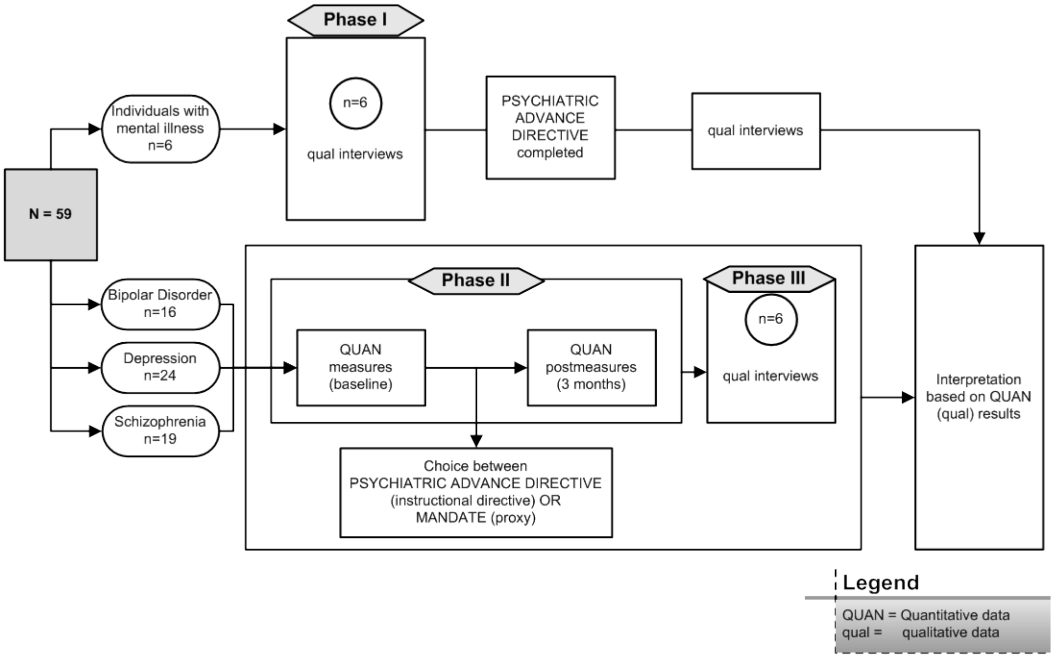


Table 1. Demographic and Clinical Characteristics of Respondents Choosing Psychiatric Advance Directive or Mandate in Case of Incapacity (N=54)

	TOTAL	PAD		MANDATE		
	N (%) or mean (SD)	N	% or mean (SD)	N	% or mean (SD)	p-value[+]
Type of mental illness						**p <0.007**
Depression	24 (44.4)	18	75.0	6	25.0	
Bipolar	15 (27.8)	15	100.0	0	0	
Schizophrenia	15 (27.8)	8	53.3	7	46.7	
Age	45 (10.6)	41	45.5 (10.4)	13	46.6 (10.6)	0.746
Gender						0.526
Female	27 (50)	19	70.0	8	30.0	
Male	27 (50)	22	81.4	5	18.6	
Civil status						0.652
Married/remarried	8 (14.8)	7	87.5	1	12.5	
Never married	29 (53.7)	22	75.9	7	24.1	
Legally divorced	7 (13)	6	85.7	1	14.3	
Separated	3 (5.6)	2	66.6	1	33.3	
Living as married	7 (13)	4	57.1	3	42.9	
Children						1.000
Yes	19 (35.2)	14	73.7	5	26.3	
No	35 (64.8)	27	77.1	8	22.9	
Number of children	54	41	.61 (.919)	13	.92 (1.44)	0.609[*]
Prior psychiatric hospitalization						0.493
Yes	38 (70.4)	30	80.0	8	20.0	
No	16 (29.6)	11	68.8	5	31.2	
Number of hospitalizations	37	29	4.5 (7.4)	8	4.3 (3.1)	0.536
Involuntary hospitalization						1.000
Yes	16 (29.6)	12	75.0	4	25.0	
No	38 (70.4)	29	76.3	9	23.7	
Hospital restraints						0.076
Yes	18 (34)	15	83.3	3	16.7	
No	31 (58.5)	24	77.4	7	22.6	
No response	4 (7.5)	1	25.0	3	75.0	
Isolation or seclusion						0.063
Yes	17 (32.1)	13	76.5	4	23.5	
No	32 (60.4)	26	81.3	6	18.7	
Unsure	4 (7.5)	1	25.0	3	75.0	
Involuntary treatment						0.740
Yes	8 (15.1)	7	87.5	1	12.5	
No	44 (83.0)	33	75.0	11	25.0	
Unsure	1 (1.9)	1	100.0	0	0	

[+] Fisher Exact Test
[*] Mann-Whitney Test

Table 2. Logistic Regression Model of Factors Associated with Choosing a Psychiatric Advance Directive over a Mandate in Case of Incapacity (N = 54)

Variable	**Coefficient (β)**	**Wald χ^2**	**p value**	**Odds Ratio (95% CI)**
Age	-.038	.979	.375	0.96 (.89, 1.05)
Sex (Male)	1.934	4.12	**.042**	6.93 (1.07, 44.99)
Schizophrenia-spectrum psychotic disorder	-3.92	9.14	**.002**	0.02 (0.002, 0.25)
Not currently working	-1.12	1.71	.191	0.963 (0.89, 1.05)
Insight and awareness into need for treatment (ITAQ scale)	-.57	4.22	**.040**	0.57 (0.33, 0.97)
Intercept	12.30	6.36	.012	

*Cox and Snell R^2 = 0.30.

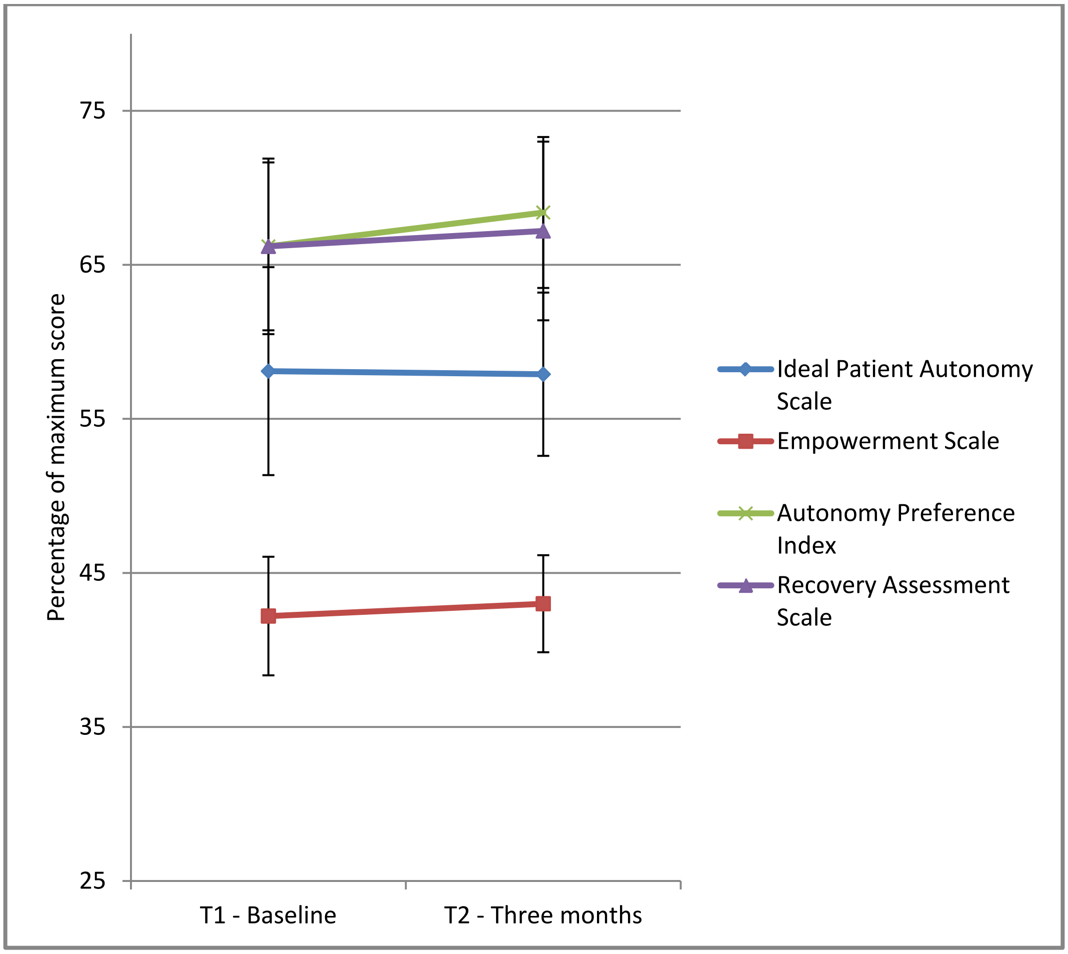
Table 3. Joint Display Analysis of Integration of Quantitative/Qualitative Data with Extreme Case Analysis in Phase III participants (N = 6)

Mental Disorder (Gender)	Extreme Outlier Baseline	Reasons for Choice of PAD		PAD Instructions	Extreme Outlier 3 Months	Qualitative Interviews ≈ 1 Month Later
		Advantages	**Disadvantages**			
Depression (male)	↑Depression/anxiety (BPRS)$^{\bullet}$ ↓Reliance on others (RAS)$^{\bullet}$ ↓Doctor involvement (PAD scale)*	-Broader scope than mandate -Deals with daily situations -Lots of options	-Mandate involves court process and PAD does not	-Agent: Brother -Refuse Seroquel because side effect of acute confusion -Refuse ECT	↓Goal and success orientation (RAS)$^{\bullet}$ ↓Reliance on others (RAS)$^{\bullet}$	“I get the right to live my life...to be forced into a hospital, that’s not autonomy to me. That’s not being able to live your life the way you choose...At some point you have to make your own decisions...I know enough about drugs that that they’re not the answer to everybody.”
Depression (female)	↑Depression/anxiety (BPRS)$^{\bullet}$	-Deals with mental health issues	-No alternative to include instructions in mandate	-Agent: Son -Side effects of medication -Refuse ECT	**CHOSE TO REVOKE PAD	“It might very well be that there is a stigma still even with the people that are closest to you with regards to mental illness, or maybe you have lost it, maybe they’re reacting to a change, so you’re maybe giving up autonomy...I’m more convinced than ever that the mandate has to involve both medical and mental.”
Bipolar disorder (male)	↑Autonomy (IPAS)$^{\bullet}$	-Can control decision-making and be involved	-Afraid of mandate because mother had him involuntarily hospitalized	-Agent: Sister -Side effect from medication (weight gain) -Refuse ECT	↑Autonomy (IPAS)$^{\bullet}$	“I had told my doctor that there’s diabetes in my family and I find that Zyprexa I’m taking it made me gain some weight. Since I took Zyprexa I’ve gained maybe 60 pounds... [autonomy means] my well-being...I’ve been doing that since I ran away from my mom. I was 13... I always managed to find a job and have a place to live. I was never on the street... I always had a job and a place to live.”

Bipolar disorder (female)	↑Activation (BPRS)• ↑Willingness to ask for help (RAS) • ↑Doctor involvement (PAD scale)• ↓Self-trust (PAD scale)*	-More things can choose herself -Very important to chose as hospitalized many times	-Mandate is more general and simple -Does not give choice of hospitals	-Agent: Father -Refusal of medications: Seroquel, Zyprexa, Lithium, Zeldoz, Clozapine -No ECT	↑Optimism and control over future (Empowerment Scale)•	"Autonomy is when you can, be on your own, have access to your own money, have access to a car if you can afford it... I believe [a PAD] gives my family the right to be part of my life... I could actually choose as well as my parents if I should be in a hospital and for how long I should be able to stay."
Schizophrenia (male)		-When first admitted at 18 didn't have a choice -Gives more freedom and choice		-Agent: Friend -Refusal of medications: Largactil, Paxil, Prozac ("These drugs make me feel suicidal thoughts") -No ECT	↑Optimism and control over future (Empowerment Scale)•	"At least I know there is going be somebody looking after me...I was given a voice of what I need, not what the hospital, the doctors wanted to do with me...it's like not signing your life away but you know there's somebody who'll look after you no matter what happens...there's some value in being able to tell your story to others."
Schizophrenia (female)	↓Reasoning ability (MacCAT-CR)• ↑Psychosis (BPRS)* ↑Negative symptoms (BPRS)• ↓Information-seeking preference (API)• ↓Autonomy (API)•	-Understands it better		-Agent: Father -Refusal of medications: Seroquel, Risperdal, Celexa ("Didn't relieve my symptoms") -Yes ECT	↓Obligatory risk information (IPAS)*	"Sometimes I think my life is planned already. I think he's like someone I'm going to be with later and in a way don't feel like I like I chose it."

• = Outlier from 1.5 to 3.0 * = Outlier above > 3.0

Figure 2. Stability of Responses to Questionnaires over Time among Participants Choosing PADs and Mandates (N=59)



References

An Act Respecting Health and Social Services, R.S.Q. 2002, c. S-4.2.

Ambrosini, D. L., Bemme, D., Crocker, A., & Latimer, E. Narratives around psychiatric advance directives: a qualitative study. Manuscript in preparation to be submitted for publication.

Ambrosini, D. L., Lach, L. M., Charette, Y., & Crocker, A. (2010) Perceptions of psychiatric advance directives and autonomy among social work students. Manuscript submitted for publication.

Ambrosini, D. L., Crocker, A. G., Perreault, M., & Israël, M. (2008). Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec. *Journal Ethics in Mental Health, 3*(2), 1-12.

Amering, M., Denk, E., Griengl, H., Sibitz, I., & Stastny, P. (1999). Psychiatric wills of mental health professionals: A survey of opinions regarding advance directives in psychiatry. *Social Psychiatry and Psychiatric Epidemiology, 34*(1), 30-34.

Appelbaum, P. S. (1991). Advance directives for psychiatric treatment. *Hospital & Community Psychiatry: A Journal of the American Psychiatric Association, 42*(10), 983-984.

Appelbaum, P. S. (2005). Advance directives: Stigma strikes again. *Psychiatric Services, 56*(5), 515.

Appelbaum, P. S., & Grisso, T. (1995). The MacArthur Treatment Competence Study. I: Mental illness and competence to consent to treatment. *Law and Human Behavior, 19*(2), 105-126.

Appelbaum, P. S., & Grisso, T. (2001). *MacCAT-CR - MacArthur Competence Assessment Tool for Clinical Research*. Sarasota: FL: Professional Resource Press.

Atkinson, J. M., Garner, H. C., & Gilmour, W. H. (2004). Models of advance directives in mental health care: Stakeholder views. *Social Psychiatry and Psychiatric Epidemiology, 39*(8), 673-680.

Backlar, P. (1998). Anticipatory planning for research participants with psychotic disorders like schizophrenia. *Psychology, Public Policy, and Law, 4*(3), 829-853.

Backlar, P., McFarland, B. H., Swanson, J. W., & Mahler, J. (2001). Consumer, provider, and informal caregiver opinions on psychiatric advance directives. *Administration and Policy in Mental Health*, *28*(6), 427-441.

Bazelon Center for Mental Health Law. (2010). Psychiatric advance directive. Retrieved January 18, 2011, from http://www.bazelon.org.

Botelho, R. J. (1992). A negotiation model for the doctor-patient relationship. *Family Practice*, *9*(2), 210-218.

Bowling, A., & Rowe, G. (2005). “You decide doctor”. What do patient preference arms in clinical trials really mean? *Journal of Epidemiology Community Health, 59*(11), 914-915.

Bravo, G., Paquet, M., & Dubois, M. F. (2003). Knowledge of the legislation governing proxy consent to treatment and research. *Journal of Medical Ethics*, *29*(1), 44-50.

Brown, K., & Murphy, E. (2000). Falling through the cracks: The Québec mental health system. *McGill Law Journal*, *45*, 107-1079.

Brown, M. (2003). The law and practice associated with advance directives in Canada and Australia: Similarities, differences and debates. *Journal of Law and Medicine*, *11*(1), 59-76.

Canadian Hospice Palliative Care Association. (2010, February). *Advance care planning in Canada: National framework for consultation*. Ottawa: Canadian Hospice Palliative Care Association.

Campbell, L. A., & Kisely, S. R. (2009). Advance treatment directives for people with severe mental illness. *Cochrane Database of Systematic Reviews,* 2009(1), Article No.: CD005963. Retrieved January 18, 2011 from http://www.thecochranelibrary.com/view/0/index.html.

Candilis, P. J., Fletcher, K. E., Geppert, C. M., Lidz, C. W., & Appelbaum, P. S. (2008). A direct comparison of research decision-making capacity:

Schizophrenia/schizoaffective, medically ill, and non-ill subjects. *Schizophrenia Research*, *99*(1-3), 350-358.

Caracelli, V. J. & Greene, J. C. (1993). Data analysis strategies for mixed-method evaluation designs. *Educational Evalutation and Policy Analysis, 15*(2), 195-207.

Civil Code of Québec, L.R.Q. c. (1991).

Clough, E. (2006). A critique of advance directives and advance directives legislation. *Appeal: Review of Current Law and Law Reform*, *11*, 16-38.

Corrigan, P. W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal*, *35*(3), 231-239.

Corrigan, P. W., Salzer, M., Ralph, R. O., Sangster, Y., & Keck, L. (2004). Examining the factor structure of the recovery assessment scale. *Schizophrenia Bulletin, 30*(4), 1035-1041.

Creswell, J. W., & Plano-Clark, V. L. (2003). *Designing and conducting mixed methods research*. Thousand Islands: Sage Publications.

Davidson, L., Tondora, J., O’Connell, M. J., Kirk, T., Jr., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23-31.

Davis, J. K. (2008). How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. *Kennedy Institute of Ethics Journal*, *18*(1), 87-106.

DeWolf Bosek, M. S., Ring, M. E., & Cady, R. F. (2008). Do psychiatric advance directives protect autonomy? *JONAS Healthcare, Law, Ethics, and Regulation, 10*(1), 17-24; quiz 25-16.

Ditto, P. H., Danks, J. H., Smucker, W. D., Bookwala, J., Coppola, K. M., Dresser, R. et al., (2001). Advance directives as acts of communication: A randomized controlled trial. *Archives of Internal Medicine, 161*(3), 421-430.

Ditto, P. H., Smucker, W. D., Danks, J. H., Jacobson, J. A., Houts, R. M., Fagerlin, A. et al., (2003). Stability of older adults’ preferences for life-sustaining medical treatment. *Health Psychology*, *22*(6), 605-615.

Downie, J. (1992). “Where there is a will, there may be a better way”: Legislating advance directives. *Health Law in Canada, 12*(3), 73-80, 89.

Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal, 34*(1), 7-13.

Dunbrack, J. (2006, August). *Advance care planning: The Glossary project*. Ottawa: Health Canada. Retrieved January 18, 2011 from http://www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2006-proj-glos/index-eng.php.

Dworkin, R. B. (2003). Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship. *Health Matrix: The Journal of Law-Medicine, 13*(2), 235-296.

Emanuel, L. (1993). Advance directives: What have we learned so far? *Journal of Clinical Ethics, 4*(1), 8-16.

Emanuel, L. L., Emanuel, E. J., Stoeckle, J. D., Hummel, L. R., & Barry, M. J. (1994). Advance directives. Stability of patients’ treatment choices. *Archives of Internal Medicine, 154*(2), 209-217.

Ende, J., Kazis, L., Ash, A., & Moskowitz, M. A. (1989). Measuring patients’ desire for autonomy: Decision making and information-seeking preferences among medical patients. *Journal of General of Internal Medicine, 4*(1), 23-30.

Fagerlin, A., & Schneider, C. E. (2004). Enough. The failure of the living will. *Hastings Center Report, 34*(2), 30-42.

Foti, M. E., Bartels, S. J., Van Citters, A. D., Merriman, M. P., & Fletcher, K. E. (2005). End-of-life treatment preferences of persons with serious mental illness. *Psychiatric Services, 56*(5), 585-591.

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.

Gardner, W., Hoge, S. K., Bennett, N., Roth, L. H., Lidz, C. W., Monahan, J. et al., (1993). Two scales for measuring patients’ perceptions for coercion during mental hospital admission. *Behavioral Sciences & the Law, 11*(3), 307-321.

Geller, J. L. (2000). The use of advance directives by persons with serious mental illness for psychiatric treatment. *Psychiatric Quarterly, 71*(1), 1-13.

Gillick, M. R. (2006). The use of advance care planning to guide decisions about artificial nutrition and hydration. *Nutrition in Clinical Practice, 21*(2), 126-133.

Goss, C., Moretti, F., Mazzi, M. A., Del Piccolo, L., Rimondini, M., & Zimmermann, C. (2008). Involving patients in decisions during psychiatric consultations. *British Journal of Psychiatry, 193*(5), 416-421.

Hansson, L., & Bjorkman, T. (2005). Empowerment in people with a mental illness: Reliability and validity of the Swedish version of an empowerment scale. *Scandinavian Journal of Caring Sciences, 19*(1), 32-38.

Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services, 59*(1), 63-71.

Hogan, T. P., Awad, A. G., & Eastwood, R. (1983). A self-report scale predictive of drug compliance in schizophrenics: Reliability and discriminative validity. *Psychological Medicine, 13*(1), 177-183.

Hosmer, D. C. & Lemeshow, S. (2000). *Applied Logistic Regression* (2nd ed.) New York: John Wiley & Sons.

Howard, L., & Thornicroft, G. (2006). Patient preference randomised controlled trials in mental health research. *British Journal of Psychiatry, 188*, 303-304.

Kartalova-O’Doherty, Y., & Doherty, D. T. (2008). Coping strategies and styles of family carers of persons with enduring mental illness: A mixed methods analysis. *Scandinavian Journal of Caring Sciences, 22*(1), 19-28.

Khazaal, Y., Richard, C., Matthieu-Darekar, S., Quement, B., Kramer, U., & Preisig, M. (2008). Advance directives in bipolar disorder, a cognitive behavioural conceptualization. *International Journal of Law and Psychiatry, 31*(1), 1-8.

Killaspy, H., Johnson, S., Pierce, B., Bebbington, P., Pilling, S., Nolan, F. et al., (2009). Successful engagement: A mixed methods study of the approaches of assertive community treatment and community mental health teams in the

REACT trial. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 532-540.

Kirby, M. (2004). *Mental Health, Mental Illness and Addiction: Issues and Options for Canada, Report 3*. Ottawa: Standing Senate Committee on Social Affairs

Kirschner, K. L. (2005). When written advance directives are not enough. *Clinics in Geriatriac Medicine, 21*(1), 193-209.

Kovnick, J. A., Appelbaum, P. S., Hoge, S. K., & Leadbetter, R. A. (2003). Competence to consent to research among long-stay inpatients with chronic schizophrenia. *Psychiatric Services, 54*(9), 1247-1252.

Kuroda, N., Sun, S., Lin, C. K., Morita, N., Kashiwase, H., Yang, F. et al., (2008). Attitudes toward taking medication among outpatients with schizophrenia: cross-national comparison between Tokyo and Beijing. *Environmental Health and Preventive Medicine, 13*(5), 288-295.

La Fond, J. Q., & Srebnik, D. (2002). The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions. *International Journal of Law and Psychiatry, 25*(6), 537-555.

Laugharne, R., & Priebe, S. (2006). Trust, choice and power in mental health: A literature review. *Social Psychiatry and Psychiatric Epidemiology, 41*(11), 843-852.

Lukoff, D., Nuechterlein, K. H., & Ventura, J. (1986). Manual for the expanded BPRS. *Schizophrenia Bulletin, 12*, 594-602.

McEvoy, J. P., Applebaum, P. S., Apperson, L. J., Geller, J. L., & Freter, S. (1989). Why must some schizophrenic patients be involuntarily committed? The role of insight. *Comprehensive Psychiatry, 30*(1), 13-17.

McEvoy, J. P., Freter, S., Merritt, M., & Apperson, L. J. (1993). Insight about psychosis among outpatients with schizophrenia. *Hospital & Community Psychiatry, 44*(9), 883-884.

McNaught, M., Caputi, P., Oades, L. G., & Deane, F. P. (2007). Testing the validity of the Recovery Assessment Scale using an Australian sample. *Australian and New Zealand Journal of Psychiatry, 41*(5), 450-457.

Mental Health Commission of Canada. (2009, January). *Toward recovery & well-being: A framework for a mental health strategy for Canada.* Ottawa: Mental Health Commission of Canada, Retrieved January 18, 2011 from http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf.

Molloy, D. W., Guyatt, G., Alemayehu, E., & McIlroy, W. E. (1991). Treatment preferences, attitudes toward advance directives and concerns about health care. *Humane Medicine, 7*(4), 285-290.

Molloy, D. W., Harrison, C., Farrugia, M. C., & Cunje, A. (1993). The Canadian experience with advance treatment directives. *Humane Medicine, 9*(1), 70-77.

Molloy, D. W., Guyatt, G. H., Russo, R., Goeree, R., O'Brien, B. J., Bedard, M. et al., (2000). Systematic implementation of an advance directive program in nursing homes: A randomized controlled trial. *JAMA, the Journal of the American Medical Association, 283*(11), 1437-1444.

Mueser, K. T., McHugo, G. J., Curran, P. J. (1997). Factor structure of the brief psychiatric rating scale in schizophrenia. *Psychological Assessment, 9*(3), 196-204.

National Assembly of Québec (2010, May). *Dying with dignity*. Québec: Government of Québec. Retrieved January 18, 2011 from http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/actualite-21205.html.

Patterson, C., Molloy, D. W., Guyatt, G. H., Bedard, M., North, J., Hassard, J. et al., (1997). Systematic implementation of an advance health care directive in the community. *Canadian Journal of Nursing Administration, 10*(2), 96-108.

Pellegrino, E. D. (1992). Ethics. *JAMA, the Journal of the American Medical Association*, *268*(3), 354-355.

Public Curator of Québec, (2009). *My mandate in case of incapacity*. Québec: Government of Québec. Retrieved January 18, 2011 from http://www.curateur.gouv.qc.ca/cura/publications/mandatE.pdf.

Rain, S. D., Steadman, H. J., & Robbins, P. C. (2003). Perceived coercion and treatment adherence in an outpatient commitment program. *Psychiatric Services, 54*(3), 399-401.

Redman, B. K. (2003). Review of measurment instruments in clinical and research ethics. *Journal of Medical Ethics, 32*(3), 153-156.

Ritchie, J., Sklar, R., & Steiner, W. (1998). Advance directives in psychiatry. Resolving issues of autonomy and competence. *International Journal of Law and Psychiatry, 21*(3), 245-260.

Robins, C. S., Ware, N. C., dosReis, S., Willging, C. E., Chung, J. Y., & Lewis-Fernandez, R. (2008). Dialogues on mixed-methods and mental health services research: Anticipating challenges, building solutions. *Psychiatric Services, 59*(7), 727-731.

Rogers, Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services, 48*(8), 1042-1047.

Rogers, A., Day, J., Randall, F., & Bentall, R. P. (2003). Patients' understanding and participation in a trial designed to improve the management of anti-psychotic medication: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 38*(12), 720-727.

Sam, M., & Singer, P. A. (1993). Canadian outpatients and advance directives: Poor knowledge and little experience but positive attitudes. *Canadian Medical Association Journal, 148*(9), 1497-1502.

Scheyett, A. (2009). Autonomy and the use of directive intervention in the treatment of individuals with serious mental illnesses: A survey of social work practitioners. *Social Work in Mental Health, 7*(4), 283-306.

Scheyett, A., Kim, M., Swanson, J., Swartz, M., Elbogen, E., Van dorn, R. et al., (2008). Social workers' familiarity with psychiatric advance directives:

Implications for education, practice, and research. *Families in Society: The Journal of Contemporary Social Services*, *89*(2), 228-236.

Scheyett, A. Kim, M. M., Swanson, J. W., & Swartz, M. S. (2007). Psychiatric advance directives: A tool for consumer empowerment and recovery. *Psychiatric Rehabilitation Journal, 31*(1), 70-75.

Schurhofer, M., & Peschl, M. (2005). Autonomy: Starting point and goal of personal and social change: A constructivist perspective on knowledge management in empowerment processes. *Kybernetes*, *34*(1/2), 261.

Somerville, M. A. (1994). Labels versus contents: variance between philosophy, psychiatry and law in concepts governing decision-making. *McGill Law Journal, 39*, 179.

SPSS Inc. (2008). SPSS Base 17.0 for Windows User’s Guide. SPSS Inc., Chicago IL.

Srebnik, D., & Russo, J. (2008). Use of psychiatric advance directives during psychiatric crisis events. *Administration and Policy in Mental Health, 35*(4), 272-282.

Srebnik, D., Rutherford, L. T., Peto, T., Russo, J., Zick, E., Jaffe, C. et al., (2005). The content and clinical utility of psychiatric advance directives. *Psychiatric Services, 56*(5), 592-598.

Stiggelbout, A. M., Molewijk, A. C., Otten, W., Timmermans, D. R., van Bockel, J. H., & Kievit, J. (2004). Ideals of patient autonomy in clinical decision making: A study on the development of a scale to assess patients’ and physicians’ views. *Journal of Medical Ethics*, *30*(3), 268-274.

Stiggelbout, A. M., Molewijk, A. C., Otten, W., Van Bockel, J. H., Bruijninckx, C. M., Van der Salm, I. et al., (2008). The impact of individualized evidence-based decision support on aneurysm patients’ decision making, ideals of autonomy, and quality of life. *Medical Decision Making*, *28*(5), 751-762.

Swanson, J. W., Swartz, M., Ferron, J., Elbogen, E., & Van Dorn, R. (2006). Psychiatric advance directives among public mental health consumers in five U.S. cities: Prevalence, demand, and correlates. *Journal of the American Academy of Psychiatry and the Law, 34*(1), 43-57.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Ferron, J., Wagner, H. R. et al., (2006). Facilitated psychiatric advance directives: A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *American Journal of Psychiatry, 163*(11), 1943-1951.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A. et al., (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*(3), 255-267.

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.

Swartz, M. S. & Swanson, J. W. (2007). Commentary: Psychiatric advance directives and recovery-oriented care. *Psychiatric Services, 58*(9), 1164.

Szmukler, G., & Dawson, J. (2006). Commentary: Toward resolving some dilemmas concerning psychiatric advance directives. *Journal of the American Academy of Psychiatry and the Law, 34*(3), 398-401.

Tapp, A. (2006). Advance directives. *Canadian Nurse, 102*(2), 26.

Tauber, A. I. (2003). Sick autonomy. *Perspectives in Biology and Medicine, 46*(4), 484-495.

Tilbrook, H. (2008). Patients’ preferences within randomised trials: Systematic review and patient level meta-analysis. *British Medical Journal, 337*, a1864.

van Willigenburg, T., & Delaere, P. (2005). Protecting autonomy as authenticity using Ulysses contracts. *Journal of Medicine and Philosophy, 30*(4), 395-409.

Velligan, D., Prihoda, T., Dennehy, E., Biggs, M., Shores-Wilson, K., Crismon, M. L. et al., (2005). Brief psychiatric rating scale expanded version: How do new items affect factor structure? *Psychiatry Research, 135*(3), 217-228.

Whitaker, R. (2010). *Anatomy of an epidemic: magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishers.

Whitley, R. & Crawford, M. (2005). Qualitative research in psychiatry. *Canadian Journal of Psychiatry, 50*(2), 108-114.

Wilder, C. M., Elbogen, E. B., Moser, L. L., Swanson, J. W., & Swartz, M. S. (2010). Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. *Psychiatric Services, 61*(4), 380-385.

Winick, B. J. (1996). Advance directive instruments for those with mental illness. *University of Miami Law Review, 51*(1), 57-95.

Winick, B. J. (1998). Foreword: Planning for the future through advance directive instruments. *Psychology, Public Policy, and Law, 4*(3), 579-609.

Wowra, S. A., & McCarter, R. (1999). Validation of the empowerment scale with an outpatient mental health population. *Psychiatric Services, 50*(7), 959-961.

CHAPTER FOUR: Narratives of psychiatric advance directives: qualitative study

Little is known about the values of individuals with specific mental disorders who complete psychiatric advance directives (PADs). This qualitative study explores how individuals narrate their perceptions and experiences of mental illness and PADs in relation to autonomy; mental capacity; medications; involuntary treatment; doctor-patient relationship; substitute decision-makers; and recovery. Before and after completing PADs, semi-structured interviews were conducted with individuals in the community living with schizophrenia, depression, and bipolar disorder (N = 12). Content analysis and transformation methods were used to yield emergent, or new, themes. Findings from the study suggest that trust and level of one's social network with family members and friends are two factors that can help explain the reason for choosing a particular substitute decision-maker if mentally incapable. This study expands on previous research showing that individuals perceive PADs as useful to improve communication, avoid side effects, and prevent involuntary treatment. PADs should be offered as documents that promote trust in the doctor-patient relationship.

Psychiatric advance directives (PADs) are legal documents in which individuals can provide detailed instructions regarding treatment preferences in the event of mental incapacity (1-2). Although Canadian research on advance directives has focused on the end-of-life context (3), PADs could be implemented in Canada for individuals with mental illness (4-5). As little is known about how individuals' values correspond with the instructions included in PADs, listening to the narratives of mental illness can help provide meaning (6). PADs are based on the principle of autonomy because they allow individuals to make independent choices regarding treatment preferences (7). Autonomy relates closely to how individuals perceive their mental capacity (8), involuntary treatment (9), and who will act as substitute decision-makers (10). Instructions included in PADs may be related to self-perceptions of the recovery process (11), and the relationship one has with their doctor (9, 12). The aim of this study is to explore how individuals narrate their perceptions and experiences with PADs in relation to their mental illness.

Methods

Qualitative interviews were conducted with individuals with mental illness affiliated with the Douglas Mental Health University Institute (DMHUI) in Montréal between December 2009 and December 2010. These qualitative results are part of the larger study presented in the previous chapter (13).

Study design and recruitment

Figure 1 shows the semi-structured interview guide used, which was developed *a priori* around eight themes: autonomy, advance directives, mental capacity, medications, doctor-patient relationship, involuntary treatment, substitute decision-makers, and recovery. In phase I, an interviewer (DB) conducted and audio-recorded interviews in the homes of six individuals with mental illness (n = 1 bipolar disorder; n = 2 depression; n = 3 schizophrenia) and gender (female = 3; male = 3). During this first visit, the six interviews averaged 58 minutes. A lawyer (DA) met with participants at the DMHUI approximately two days later to facilitate completion of PADs. Only four out of six participants completed a PAD. The two participants who chose not to complete a PAD were individual females with a schizophrenia-spectrum psychotic disorder. An interviewer (DB) conducted an interview with participants approximately one month later to explore perceptions of PADs and the aforementioned themes. The four completed interviews averaged 30 minutes.

Phase II involved recruiting 59 participants to complete questionnaires to examine whether level of autonomy, empowerment, and recovery predict choice between an instructional directive (PAD) and a proxy directive (mandate). Results from phase II study are discussed elsewhere (13), although certain elements of participants' instructions included in PADs are reported here.

In phase III, an interviewer (DA) purposefully selected and interviewed six additional participants from phase II who completed a PAD and were representative of mental illness diagnoses (n = 2 bipolar; n = 2 depression; n = 2 schizophrenia) and sex (female = 3; male = 3). The interviews were conducted at the DMHUI averaging 48 minutes.

Participants were referred to the study by clinics from the DMHUI and by community mental health organizations in Montréal. All twelve participants lived in the community. Purposeful sampling was used to represent the twelve individuals across mental illness diagnoses (n = 3 bipolar; n = 4 depression; n = 5 schizophrenia) and sex (n = 6 male; n = 6 female) (15).

Data collection and analysis

Data from the interviews was audio-recorded and transcribed into textual format by a trained research assistant. After coded themes were developed, both inductively and deductively, the software program ATLAS.ti (2010) was used by two coders to analyze the data concurrently for inter-rater reliability (14). The content and meaning of individuals' narratives were analyzed in relation to their perceptions and experiences of mental illness and instructions included in PADs (15). Enumerative approaches and transformation methods were used to convert qualitative responses into quantitative numeric counts.

Ethical issues

This research study was approved by the DMHUI Research Ethics Board. Informed consent was obtained from participants prior to enrolment and $20 compensation was provided for phase I and $20 for phase III of the study. All key identifying variables have been omitted in the results to protect participants' anonymity.

Results

Results have been grouped and presented by interview themes. Two female individuals with schizophrenia enrolled in phase I chose not to complete a PAD after being interviewed.

Psychiatric advance directives

Participants described PADs as useful if they were mentally incapable by comparing the document to another person speaking for them if they could not do so themselves.

> 'What if both of us couldn't make the decision…There's no one left. This document would be almost invaluable in that respect. It's like having an extra person there in case.' (Male: depression)

> 'At least I know there's going to be somebody…there'll be somebody looking after me...I won't be just left alone.' (Male: schizophrenia)

When participants were asked about possible advantages of PADs they reported greater safety and "peace of mind." They also stated that PADs are helpful to avoid certain medications, communicate with others, and make independent treatment decisions.

> 'It will give me peace of mind that I know if I get to the point that I can't say anything, there's something in place that can represent myself.' (Male: bipolar disorder)

> 'It just saves me time…before telling what I dislike. It should save me time. They'll know it before and if I am not able to tell them they'll know it.' (Male: schizophrenia)

> 'I was given a voice of what I need, not what they, the hospital, the doctors wanted to do with me. It was a little bit of freedom…I thought it would give me more independence.' (Male: schizophrenia)

> 'I believe it gives my family the right to be part of my life, even though they are part of my life…in a deeper way…because if something does happen they won't be afraid that I will make the wrong choices...' (Female: bipolar disorder)

Participants who had not been hospitalized emphasized that PADs are useful to avoid future hospitalization, whereas those who were previously hospitalized saw PADs as useful to avoid unwanted medications. This demonstrates that perceptions of a PAD may be grounded in specific individual experiences.

Autonomy

We were interested in how participants understand the meaning of autonomy and its relationship to PADs. To account for individual ways of discussing or conceptualizing personal values, interviewers adapted their wording to participants' manner of expressing themselves. Instead of using the abstract term "autonomy," participants often framed it as "being able to make one's own decisions." Participants' ideas of autonomy often emerged from concrete personal experiences. For example, several participants associated the desire for more independence with the ability to control their personal finances.

> 'That's one of my struggles at the moment. I've always been very autonomous, always taken care of things in spite of my, my alcoholism...So my autonomy is, I wouldn't say it's gone, but it's not that I don't feel the autonomy, it's just I have problems dealing with day to day responsibility at the moment…it's nothing major that I have to do, it's just I just don't feel like doing it anymore. As if everything, I've done before I've given 110% and I just can't give anymore. So that is sort of like, excuse the expression, screws up my autonomy because I've always been autonomous I've never really had any problems with that...except that I have problems dealing with responsibility for accepting or wanting to do things...autonomy is good, it's always been good, at the moment it's not as good as it was and I'm sure it'll come back.' (Male: depression)

> 'I think when the medical and mental become very intertwined, then I think you have to give up autonomy. So I can see myself giving up autonomy when I can't move anymore…if I'm incapable of making my own decision because that's what it implies, I think it takes away from the image we have of ourselves to be self-sufficient…I think the thing that makes you feel most autonomous is to have enough financial resources.' (Female: depression)

> ‘Autonomy is when you can be on your own, have access to your own money, have access to a car.’ (Female: bipolar disorder)

Overall, we found that when participants discussed autonomy, or associated terms, they referred to it as a dynamic rather than static quality that can be increased or decreased, lost or regained.

Medications and treatment

Most participants expressed mixed feelings regarding medications. Although participants believed medications were good for them, there was a deep concern with the effects of medication changes, not receiving adequate information, and harmful side effects.

> ‘Hopefully they would have the best interest for me and not just sell medication like a lot of doctors do, unfortunately.’ (Male: bipolar disorder)
>
> ‘They give medication. They don’t give advice. They don’t know what to do in these situations…He’ll say, ‘We help some people by giving this kind of medication so we have no choice. Only thing we can do is suggest you take medication and it’s going to calm you down…they try too many medications.’ (Male: schizophrenia)
>
> ‘The doctor told me, ‘I’m giving you this medication. If you’re going to get ill effects, give me a call. Stop the medication. I’ll see you again. We’ll try something else’…I mean, after three or four months of taking medications, if there’s no improvement I don’t think there will be.’ (Male: depression)
>
> ‘I took it very sparingly because I think all my life I never really believed in anti-depressants, drugs that could actually control your mental activity. So I didn’t take it for a while, but after I started seeing the psychiatrists and after a bit of therapy I decided to go under the anti-depressants…I didn’t think they would hurt me in any way. They couldn’t hurt me more than I was hurting, so I thought that I would start taking them and I’ve been taking them ever since…but with this particular drug it sort of takes away all my energy.’ (Female: depression)
>
> ‘Unfortunately, in order to be healthy I have to take this medication…medications are very helpful when you need them. I unfortunately need to take 22 pills a day, 7 different pills, 9 different medications, but in total 22 a day, and that includes 11 sleeping pills…sometimes they make you feel like a zombie…I don’t have very much choice. I don’t control my medication. I give that to my doctors to do.’ (Female: bipolar disorder)

Participants reported that family members often encouraged them to increase or decrease their medication based on the symptoms they observed.

Doctor-patient relationship

Although participants expressed the desire to make independent choices, some participants also mentioned that 'doctors know best' about which medications to take. Having trust in one's doctor and enough time to discuss their medications were prevailing themes.

> 'I don't control my medication. I give that to my doctors to do, my psychiatrist, because he is the one who knows best. I don't know what to take.' (Male: depression)
>
> 'Some psychiatrists will only take five minutes and think they have the problem solved. Take this medication.' (Male: bipolar disorder)
>
> 'The psychiatrist came sometimes once in two weeks. You have five minutes with him. You ask a little bit of questions…I would like them to be respectful.' (Male: schizophrenia)
>
> 'I'm giving all my trust in the doctor completely because he knows what he's doing…they're the experts…the doctor has a lot more information in order to do the job…I'm a patient whereas the person on the other side has a lot more information.' (Male: depression)
>
> 'I do trust them…there are some doctors who put you on medication without even consulting with you…he's very thorough and very informative when it comes to changing drugs.' (Male: bipolar disorder)
>
> 'My trust is complete…all my trust is there…I don't have mistrust in the medical system.' (Male: depression)
>
> 'Even though you trust your doctors, I don't think it's safe to just give it up to a doctor. It would have to be somebody who cares for you as a person.' (Female: depression)
>
> 'They are the best doctors…I trust them with my life.' (Female: bipolar disorder)
>
> 'He's a really open doctor…I trust him without a doubt. I would refer him to other people that might need a doctor.' (Male: bipolar disorder)
>
> 'There are some doctors who put you on medication without even consulting you. My doctor, he does not do that. He talks about the drug maybe two to three weeks before he finally gives it to you…He doesn't just put you on a drug, but with a lot of information along with that.' (Male: bipolar disorder)

> 'Because when you go in there they give you a doctor and then you are stuck with that doctor. So you can have Doctor A, B, C, or D, so you have to be lucky to have the doctor that you find that you like.' (Female: depression)

Two female individuals with schizophrenia chose not to complete a PAD. One made the decision because she trusted her doctor and treatment team implicitly; the other chose not to complete the PAD because she perceived it as part of the health care system that she did not trust.

Involuntary treatment and medication refusal

Table 1 reveals that seven out of the ten participants who completed a PAD included the name of a medication they would refuse if mentally incapable. Seven out of these same ten persons also did not consent to electroconvulsive therapy. One participant who refused medications described how his treatment team coerced him into taking a medication by telling him that he would not be permitted to leave the hospital until he did so. Others expressed treatment practices they viewed as coercive:

> 'I don't want the electroshock treatment because I've seen how it works. My sister had it. It did marginal good for a short term and then it regressed.' (Male: bipolar disorder)
>
> 'The doctor was saying that he could force me into hospital. He had mentioned ECT or something. It's like a two-headed monster, you don't want to know nothing about it. I certainly hope that should it ever come to that…I'm terrified of ECT.' (Male: depression)
>
> 'They shot me with an injection…for no reason against my will. They turned me on the bed and it wasn't really enjoyable…I could be really mad…but I forgive.' (Male: schizophrenia)
>
> 'I took the medication every time I was supposed to. I wanted to get out of there.' (Female: depression)
>
> 'When you refuse they find a way for you to accept it and say that, 'You won't get out of here unless you take your medication'. So everybody finally ends up taking the medication.' (Male: schizophrenia)

All participants were concerned with side effects from medications, with the most commonly cited being weight gain and inability to think clearly. One male individual with schizophrenia described how he was sure the side effects of medications caused him to attempt suicide.

> ‘During 1998, when I had this episode I was on Paxil or Prozac. I don’t remember but it was on one or the other and the suicide attempt was way over the top for me…took the knife and I injured myself and I cut my intestines right in half…no drinking, no alcohol, nothing…I was asking to get off that stuff.’ (Male: schizophrenia)
>
> ‘I was shaking, spitting, and I wasn’t able to stay 15 minutes in the same place. I had to move all the time. It was torture to get that medication.’ (Male: schizophrenia)
>
> ‘I waited ten years to get medication because I was afraid of the side effects.’ (Female: depression)
>
> ‘It’s very hard to lose the weight with those medications…these medications all put weight on you.’ (Female: depression)
>
> ‘This new medication…I was walking into walls. I couldn’t even go out to run an errand…before I take the medication, first of all, I always read the profile of the medication to know what the possible side effects are…I mean, I can take medications that has certain side effects but I also have to be able to function to a certain extent. If I can’t even talk on the phone, that’s pretty bad.’ (Male: depression)
>
> ‘I’ve gained about 100 pounds which is very depressing, very sad to me…But that’s caused by the medication…The first question that pops out of my mouth when he gives me a medication or a new medication is, ‘Is this going to cause weight gain?’’(Female: bipolar disorder)
>
> ‘Since I took Zyprexa I’ve gained maybe 60 pounds…I says, ‘Isn’t there another drug I could take that doesn’t have side effects such as weight gain’…I said, ‘I’m not going to take these pills anymore’, so I stopped taking them. And I lost another 10 pounds, but not taking these pills were making me more crazy.’ (Male: bipolar disorder)

Participants did not attempt to include instructions in their PADs to refuse all medications, but only those they perceived to have harmful side effects.

Mental capacity

Table 1 reveals that eight out of ten participants completing a PAD signed a self-binding clause in the document that if they became mentally incapable their substitute decision-maker should follow their instructions rather than any changed wishes. Participants often attributed past episodes of incapacity to their illness, side effects of medication, or both.

> ‘I would like to negotiate but…sometimes a person’s looks don’t correspond with their mental capacity.’ (Female: depression)

> ‘It’s very unclear as to whether it’s the drugs sometimes or whether you lost it…I’m not sure all the time as to whether the decisions I’m making are due to drug symptoms or whether after all this time my mind has evolved, and it certainly has dulled part of my brain cells on the way.’ (Female: depression)
>
> ‘Now they put me on Seroquel once, forget it. I can’t take this drug. This is like out of this world crazy…I would wake up confused and I didn’t know where I was…it took me like two minutes to become aware of where I am...it was just a side effect of that drug.’ (Male: depression)

Five participants used the expression ‘zombie’ in relation to mental incapacity, often related to medications, or a term used by family members about them.

> ‘Sometimes they can be very sedative or make you feel like a zombie…Maybe they need a higher dose to be stabilized, but if it’s going to cause them to walk around like a zombie and not have a life and live in a hospital...’ (Female: bipolar disorder)
>
> ‘Like they’d say, ‘Oh, pill popper’, ‘zombie’, ‘you’re addicted’…any anti-depressant…I didn’t take it…I just felt they made me zombie-like…I didn’t want to be a zombie. I just looked around here and I’d see so many people…my father would say, ‘You got to get off this medication. It’s going to kill you’…like you’re walking around like a zombie.’ (Male: schizophrenia)
>
> ‘My mom would be like, ‘You’re a zombie.’ She didn’t like what the medication was doing to me.’ (Female: schizophrenia)
>
> ‘I tried a lot of medication for depression and things like that and the results were always, it doesn’t work or the medication puts me in such a state of zombieness that I can’t keep taking it.’ (Male: depression)
>
> ‘Some of them walked around like zombies.’ (Female: depression)

Substitute decision-makers (SDM)

Participants living at home with parents often choose one of them to be a SDM. Table 1 reveals that nine out of ten participants included a family member as their primary SDM, and six out of ten individuals selected an alternate SDM. Choice of SDM is related to the quantity and quality of social contacts. Figure 2 reveals that participants (N = 46) from phase II informed an average of 2.7 persons that they completed a PAD. Figure 3 shows that 63% of persons whom participants told about the PAD had positive reactions, 25% were neutral, and 12% were less than positive.

> ‘Well they knew about it and my father was like, ‘Wow, you did that?’ I said, ‘Yes, dad’...I’m not going to ask my grandmother, she’s 75 or 80 years old. So my dad’s very happy that I did that because at least now he has security...he has the right to say no.’ (Female: bipolar disorder)

Recovery

We explored how individuals describe the meaning of recovery. We found that recovery had different meanings for different persons.

> ‘Recovery means that I’d be able to function properly in a social and personal environment. By function, I mean to achieve and contribute to a situation and an environment in some way. It means being productive. That I think is recovery. Vegetating the way I am is not recovery.’ (Female: depression)
>
> ‘No such thing…there is no recovery for bipolar disorder…there’s only maintenance…it takes time. It’s a process…I define recovery as maintenance.’ (Female: bipolar disorder)
>
> ‘To be functional…to be emotionally stable and to come to terms with what happened with my parents…to regain my friends.’ (Male: depression)
>
> ‘It means being part of the community and a productive citizen.’ (Female: schizophrenia)

When participants were asked what could assist them to recover from their illness, responses ranged from listening to music, learning about their illness, engaging in productive work, and regular use of medications. We found considerable overlap between interviewees’ responses with results from phase II where participants included wellness factors in their PAD (Figure 4).

> ‘With my manic stages I need to come down so I get a little bit depressed with music…I put on a piece of music…sometimes quiet is a way of coping with a certain type of mood…sometimes I can steer myself out of it before it gets too serious.’ (Male: bipolar disorder)
>
> ‘Not working all of this time isolates yourself…no matter what problem you’re working on, more information you have about the problem the more you are able to solve the problem…you’ve given me a lot more to work with because the whole process and everything brought up things that would never have come to imagination, and for me it’s an ace in my pocket, in my recovery.’ (Male: depression)
>
> ‘Keep busy, keep active, get involved with research. Try to understand mental health more. That’s what I’ve been trying to do. Understanding all aspects, not just mine…Recovery? Live happy without hurting yourself and inflicting pain on yourself and not always feeling blue…it’s getting the message across that we’re not alone.’ (Male: schizophrenia)

Recovery appears closely related to obtaining information that would allow individuals to learn about their mental illness.

Discussion

Although individuals with mental illness may not use the language of autonomy, they are familiar with associated terms such as choice, independence, and control. Most participants did not want others to assume complete control over their choice of treatment if they became mentally incapable. The level of trust an individual has with their doctor, along with the quantity and quality of social contacts, are likely to affect whether a PAD is completed and who is appointed as SDM. Figure 5 reflects an inverted U-relationship of how these variables may interact. It is possible that individuals with low social network and a moderate level of trust are the most likely to complete PADs. On the other hand, individuals with high social network (numerous family members and friends) and high levels of trust in their physicians are less likely to complete PADs because they can rely on others to make decisions on their behalf if they become mentally incapable. Alternatively, individuals with high social network and low trust may be less likely to complete PADs because they distrust the mental health system more generally. Further research is needed to test this hypothetical model, which arises out of analysis of data from a small sample of individuals.

Ideally, PADs are more than simply legal documents completed at a single point in time, but involve a *process* that engages personal values over time (16). Autonomy can be a value, right, or ideal in the context of the doctor-patient relationship (7, 9, 17). When individuals with mental illness use expressions such as independence, choice, control, or freedom, they appear to be referring to autonomy as a state that can change over time while still understanding the value of relying on others. The foundation of the empowerment process has been described as “the cognitive change of being powerless to the point where expectation of controllability arises” (18). Individuals with mental illness can be empowered when they are given sufficient information to make independent decisions (19). For individuals in this study, autonomy was associated with practical concerns such as control of finances, meaningful work, and the knowledge they would not be alone during a crisis.

Individuals must be mentally capable before completing a PAD (8). We found divergent responses in how individuals with schizophrenia, bipolar disorder, and depression monitor their mental illness and their degree of capacity. Whereas individuals with schizophrenia appear to be higher self-monitors in evaluating their mental capacity while around others, individuals with depression and bipolar disorder were more concerned with identifying the triggers of incapacity.

Prior research shows that individuals with mental illness perceive PADs as a tool to communicate medication preferences (20) and as a self-management tool (21). Participants did not perceive PADs as documents to refuse all medications, yet expressed concern that psychiatrists do not provide enough follow-up information regarding medication. Irregular patterns of use and non-compliance with medication may be due to lack of knowledge of one’s illness in an effort to prevent negative side effects. Individuals may perceive value in PADs primarily because they offer some protection from unwanted side effects.

Trust and some degree of empowerment through the physician are important in that they allow individuals to discuss treatment preferences openly (22). PADs provide individuals with mental illness an opportunity to reflect on the level of trust they have with their doctors and mental health institutions (22). PADs can also be seen as a type of collaborative contract to protect oneself from unwanted treatment (7). An open line of communication between doctors and patients can help clinicians to learn about PADs (9). In listening to participants, we found that a positive perception of their doctors is independent of their views towards hospitals. Future research should explore whether prohibitive instructions included in PADs are primarily related to the doctor-patient or hospital-patient relationship.

Some individuals see PADs as a tool to refuse involuntary treatment (9) such as side effects of medication (23). Comments raised by participants in this study suggest that the primary reason for refusing treatment may not be to increase autonomy generally, but instead to avoid certain medications. Individuals with mental illness rarely use PADs to refuse all medications (7), and often describe their medication-taking behavior in terms of personal ownership and self-confidence (24). The 70% of participants who refused electroconvulsive therapy, which is similar to figures in a 2007 study by Van Citters, Naidoo, & Foti where refusal of ECT hovered around 60% (25), were able to provide rational reasons for the refusal. Some argue that patients' choice to refuse psychotropic medications upon discharge from hospitals is primarily a manifestation of their mental illness and does not reflect autonomous functioning (26). These qualitative results suggest that another reason for refusals may be fear of side effects from medications (26).

Although individuals want to rely on family members as substitute decision-makers (10, 27), not all participants can do so if it is impractical or strained family relationships exist. Some participants did not want to burden their family or friends with the responsibility. Others attributed the cause of their mental illness to one or both parents, which is likely a factor in who is selected as SDM. PADs could have a unifying effect in building relationships between family members during a crisis (28), as expressed by one participant who stated, "I believe [the PAD] gives my family the right to be part of my life."

Recovery from mental illness can mean, among other things, being free to make choices, working closely with health care providers, or being able to return to work (11). PADs can help individuals achieve their recovery goals through advance treatment planning (29) as they develop insight, gain information, and become empowered through the process (30). Prior research shows that an important part of the recovery process involves engaging in meaningful work (11), yet some participants had a palpable fear that returning to work could trigger a relapse in their illness. Based on what participants stated in this study, workplace stress as a trigger towards relapse could be valuable to include in PADs to inform others of such limitations. Future research should examine whether individuals completing PADs may be more likely to achieve their recovery goals than those who do not complete the document.

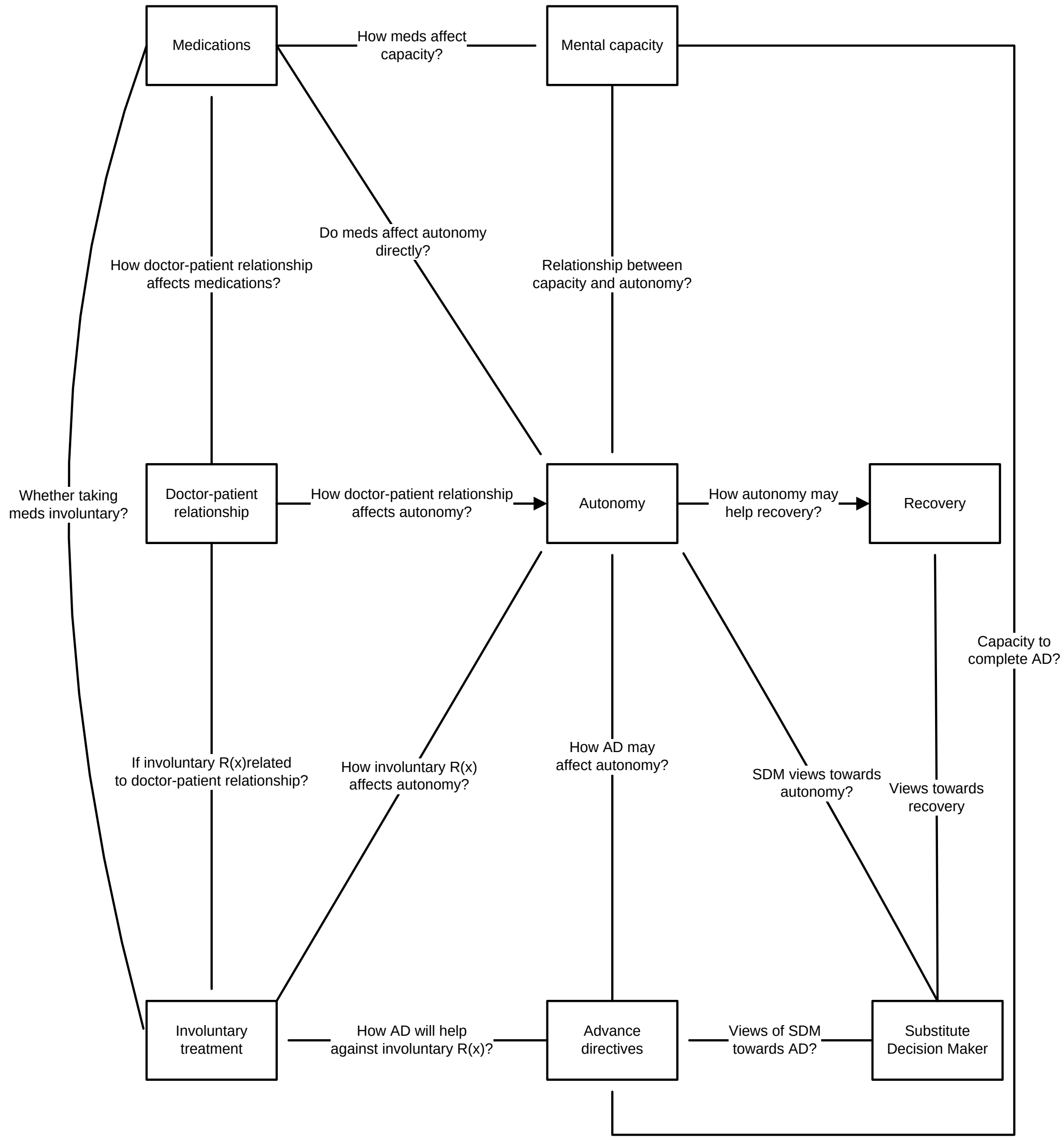
Limitations of study

One limitation of this study is that data was collected and interpreted from only twelve individuals. Nevertheless, qualitative research allows for in-depth analysis and meaning into issues such as autonomy and the meaning of PADs, rather than providing broad generalizations. A second limitation is that interviews were conducted by two different individuals, one of whom was trained as a lawyer, which could generate different responses from interviewees between the two sets of interviews.

Conclusion

Listening to the narratives of mental illness can help explain why individuals include certain preferences in PADs. Autonomy and empowerment are fundamental to making independent choices. Our findings suggest that most individuals with mental illness desire a stronger voice in negotiating medication and hospitalization preferences with their doctors through a shared decision-making approach (22). Trust and social support are critical to understanding the content of instructions included in a PAD. Future research should explore to what extent PADs can improve the lines of communication between doctors, hospital staff, patients, and family. Several participants also identified the issue of accessing PADs during a crisis as important; otherwise, they would hardly be useful. PADs may not only be helpful to communicate preferences but also to assist individuals re-examine their own values, develop insight into mental health and wellness, and improve trusting relationships between doctors, families, and friends.

Figure 1. Qualitative Interview Guide*



* The above Guide was used by interviewers to inform the types of questions asked during interviews. Generally, the seven themes (medication, mental capacity, doctor-patient relationship, recovery, involuntary treatment, advance directives, and substitute decision-makers) were tied to the central theme of autonomy.

Table 1. Participants' Instructions in PADs during Phases I and III (N=12)

PARTICIPANTS	PRIMARY AGENT (FAMILY/FRIEND)	ALTERNATE AGENT (Y/N)	MEDICATION REFUSAL	NUMBER OF INSTRUCTIONS (/18)	CONSENT TO ECT (Y/N)	NUMBER OF CONTACTS	SELF-BINDING REVOCATION
PHASE I INTERVIEWS							
Male, Bipolar disorder	Family	Yes	Yes	6/18	No	2	Yes
	I prefer not to take lithium; only as last resort (medication preferences); Making sure I'm eating well; positive reinforcement (helpful support).						
Female, Depression	Family	Yes	Yes	11/18	Yes	2	No
	Would like affection and compassion shown in time spent together (wellness factors); I would like a private room because I feel I don't have anything in common with other people (instructions to hospital staff).						
Male, Depression	Family	No	No	2/18	No	1	Yes
	Music (wellness factor).						
Male, Schizophrenia	Family	No	Yes	3/18	No	1	Yes
	Loxapac: I'm shaking, spitting, uncomfortable all the time. Have to move frequently (medication refusal); When I do sports I feel more awake and able to think clearly. Listening to music could be a good therapy (wellness factors); Prefer to be in a room alone if possible (instructions to hospital staff).						
Female, Schizophrenia				-			
Female, Schizophrenia				-			
PHASE III INTERVIEWS							
Male, Bipolar disorder	Family	Yes	No	4/18	No	2	Yes
	Before a psychiatric episode I often repeat my words not knowing I had just said them already (crisis symptoms); If hospitalized I would want visits from my clergy (wellness factor).						
Female, Bipolar disorder	Family	Yes	Yes	6/18	No	3	Yes
	Music, reading, visitors, going outdoors (wellness factors); Medication (recovery of control); Need my agent to pay my monthly expenses from my disability pay cheque (personal assistance).						
Male, Depression	Family	No	Yes	4/18	Yes	1	No
	I am more comfortable and feel safer when alone (emergency intervention); I have an extreme sensitivity to any form of criticism which triggers a crisis (stressor/trigger of crisis); I would like the ability of going out for a walk for a breath of fresh air (wellness factors).						
Female, Depression	Family	Yes	No	3/18	No	3	Yes
	Group therapy, contact with others with same symptoms (helpful support).						
Male, Schizophrenia	Friend	No	Yes	11/18	No	2	Yes
	Do not overmedicate me to the point of loss of touch with reality (medication preferences); Prefer to have my own room if possible because fearful of others (hospitalization preferences); Please do not use restraints. Have had negative experiences with this (hospitalization objections).						
Female, Schizophrenia	Family	Yes	Yes	6/18	Yes	4	Yes
	Seroquel: I tried it and it didn't relieve my symptoms (reason for refusal); Listening to music makes me happy (wellness factors).						

Figure 2. Persons Informed of Advance Directives among Phase II Participants (N = 46)

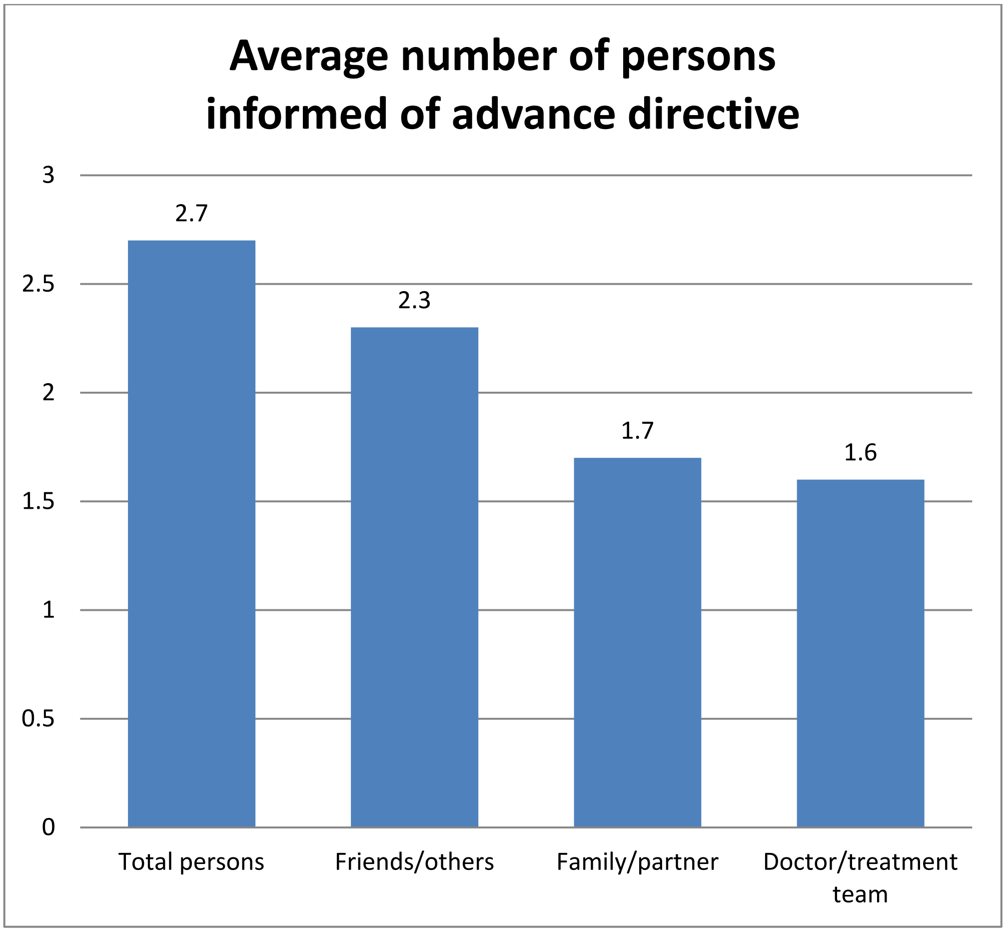


Figure 3. Perceptions of PADs by Persons Informed of Documents by Phase II Participants (N = 46)

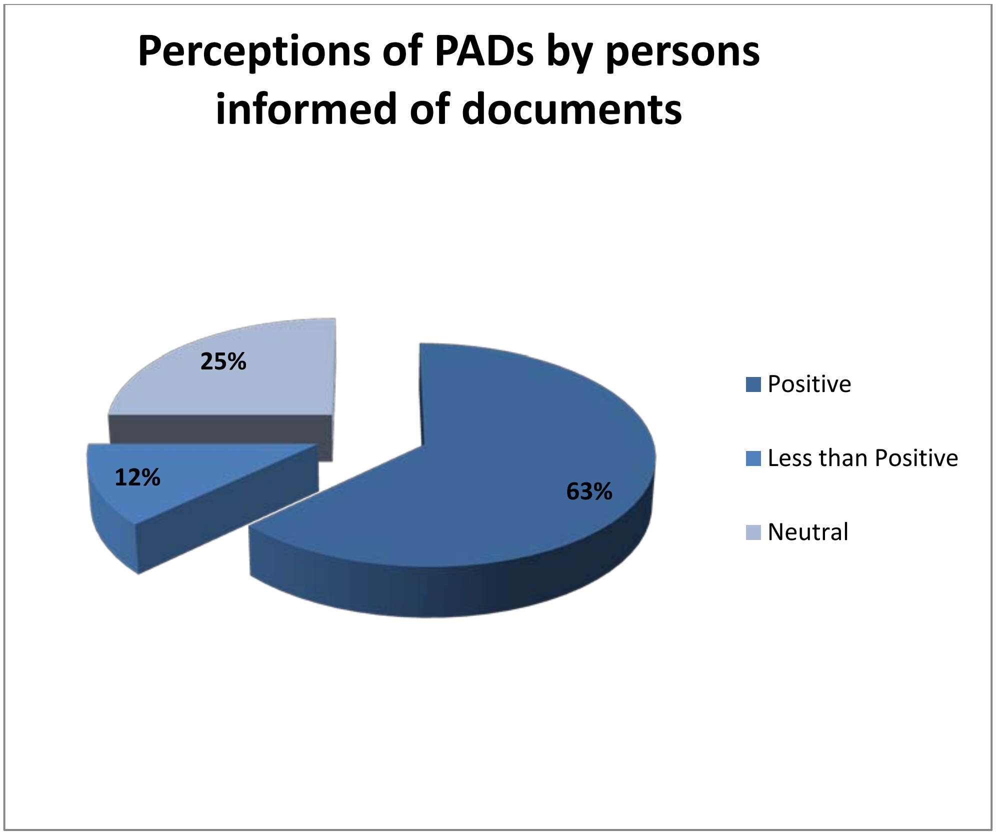


Figure 4. Wellness Factors Included in PADs by Phase II Participants (N=37)

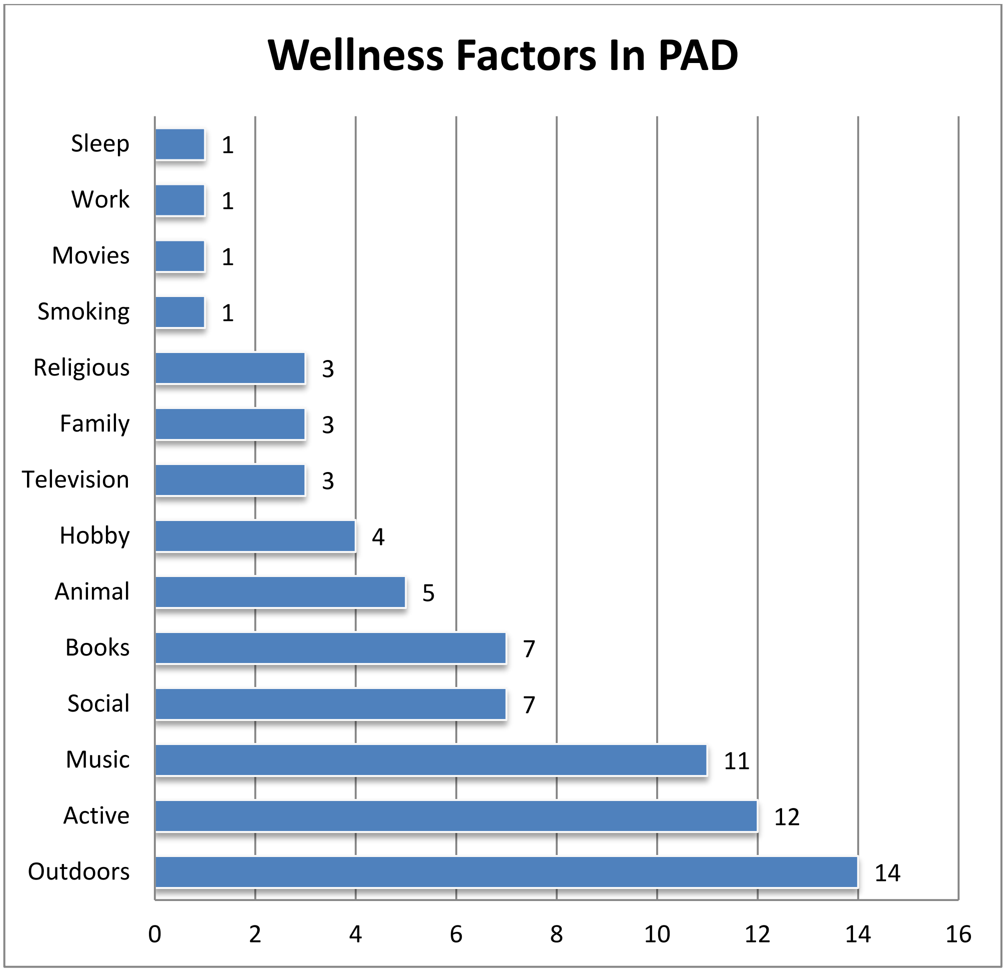
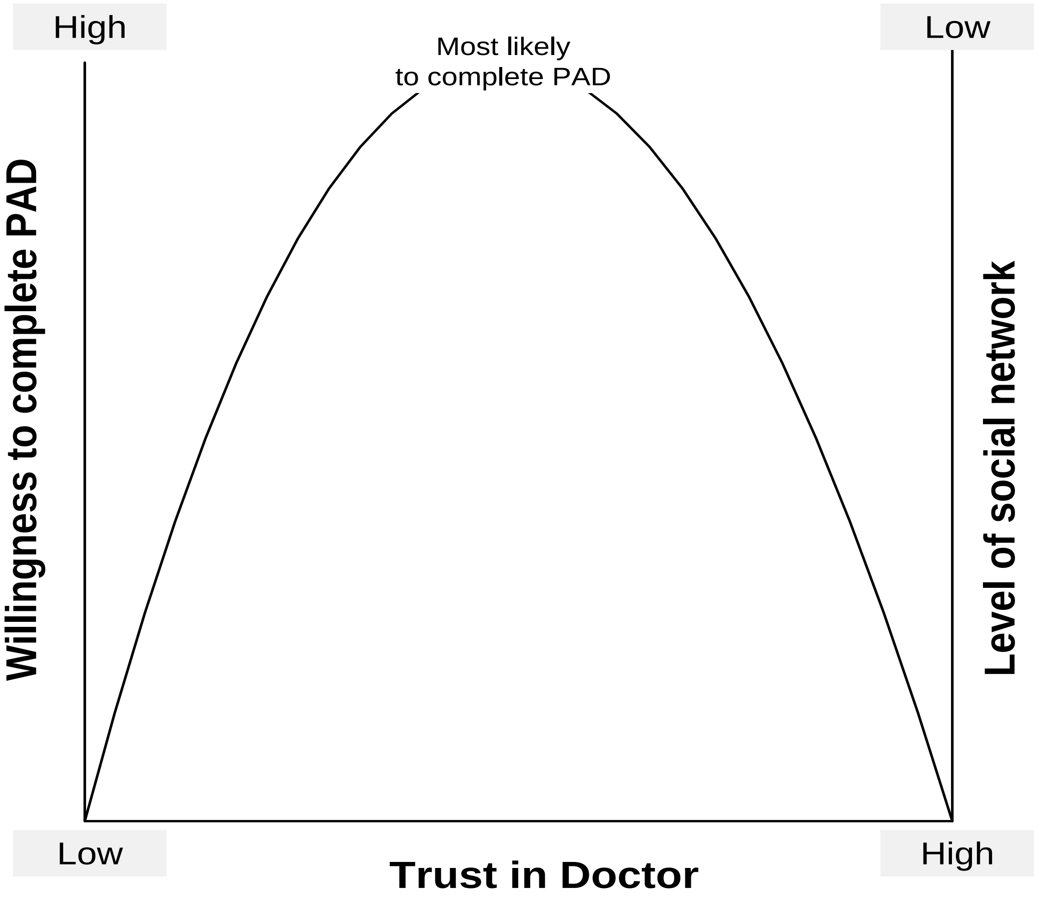


Figure 5. Hypothesized Model of Willingness to Complete PADs Based on Trust and Social Network



References

1. Appelbaum PS. Law & psychiatry: psychiatric advance directives and the treatment of committed patients. *Psychiatr Serv* 2004; **55**: 751-2, 63.
2. Swanson, Tepper MC, Backlar P, Swartz MS. Psychiatric advance directives: an alternative to coercive treatment? *Psychiatry* 2000; **63**; 160-72.
3. Bravo G, Dubois MF, Wagneur B. Assessing the effectiveness of interventions to promote advance directives among older adults: a systematic review and multi-level analysis. *Soc Sci Med* 2008; **67**; 1122-32.
4. Ambrosini DL, Crocker AG. Psychiatric advance directives and the right to refuse treatment in Canada. *Can J Psychiatry* 2007; **53**: 397-401.
5. Ambrosini DL, Crocker AG. Psychiatric advance directives and the role of autonomy. *Sante Ment Que* 2009; **34**: 51-74.
6. Kielstein R, Sass HM. Using stories to assess values and establish medical directives. *Kennedy Inst Ethics J* 1993; **3**: 303-25.
7. Amering M, Stastny P, Hopper K. Psychiatric advance directives: qualitative study of informed deliberations by mental health service users. *Br J Psychiatry* 2005; **186**: 247-52.
8. Silberfeld M, Nash C, Singer PA. Capacity to complete an advance directive. *J Am Geriatr Soc* 1993; **41**:1141-3.
9. Kim MM, Van Dorn RA, Scheyett AM, Elbogen EE, Swanson JW, Swartz MS et al., Understanding the personal and clinical utility of psychiatric advance directives: a qualitative perspective. *Psychiatry* 2007; **70**: 19-29.
10. High DM. Families' roles in advance directives. *Hastings Cent Rep* 1994; **24**: S16-8.
11. Davidson L, Ridgway P, Kidd S, Topor A, Borg M. Using qualitative research to inform mental health policy. *Can J Psychiatry* 2008; **53**: 137-44.
12. Goss C, Moretti F, Mazzi MA, Del Piccolo L, Rimondini M, Zimmermann C. Involving patients in decisions during psychiatric consultations. *Br J Psychiatry* 2008; **193**: 416-21.

13. Ambrosini DL, Crocker, AG, Latimer E. Preferences for instructional or proxy directives in mental health: an exploratory mixed methods study. 2011; Manuscript to be submitted.

14. Creswell JW, Plano-Clark VL. *Designing and Conducting Mixed Methods Research*. Sage Publications, 2003.

15. Gribich C. *Qualitative Data Analysis: An Introduction*. Sage Publications, 2007.

16. Peters C, Chiverton P. Use of a values history in approaching medical advance directives with psychiatric patients. *J Psychosocial Nurs Mental Health Serv* 2003; **41**: 28-36.

17. Stiggelbout AM, Molewijk AC, Otten W, Timmermans DR, van Bockel JH, Kievit J. Ideals of patient autonomy in clinical decision making: a study on the development of a scale to assess patients' and physicians' views. *J Med Ethics* 2004; **30**: 268-74.

18. Kane RJ. Information is the key to patient empowerment. *Ann Health Law* 2002; **11**: 25-44.

19. Linhorst DM, Hamilton G, Young E, Eckert A. Opportunities and barriers to empowering people with severe mental illness through participation in treatment planning. *Social Work* 2002; **47**:425-34.

20. Wilder CM, Elbogen EB, Moser LL, Swanson JW, Swartz MS. Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. *Psychiatr Serv* 2010; **61**: 380-5.

21. Bilsker D, Goldner EM, Jones W. Health service patterns indicate potential benefit of supported self-management for depression in primary care. *Can J Psychiatry* 2007; **52**: 86-95.

22. Laugharne R, Priebe S. Trust, choice and power in mental health: a literature review. *Soc Psychiatry Psychiatr Epidemiol* 2006; **41**: 843-52.

23. Greenberg WM, Moore-Duncan L, Herron R. Patients' attitudes toward having been forcibly medicated. *Bull Am Acad Psychiatry Law*. 1996; **24**: 513-24.

24. Rogers A, Day J, Randall F, Bentall RP. Patients' understanding and participation in a trial designed to improve the management of anti-psychotic

medication: a qualitative study. *Soc Psychiatry Psychiatr Epidemiol* 2003; **38**: 720-7.

25. Van Citters AD, Naidoo U, Foti ME. Using a hypothetical scenario to inform psychiatric advance directives. *Psychiatr Serv* 2007; **58**: 1467-71.

26. Schwartz HI, Vingiano W, Perez CB. Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication. *Hosp Community Psychiatry* 1988; **39**:1049-54.

27. Ho A. Relational autonomy or undue pressure? Family's role in medical decision-making. *Scand J Caring Sci* 2008; **22**: 128-35.

28. Ambrosini DL, Crocker AG, Perreault M, Israel M. Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec. *Journal Ethics in Mental Health*. 2008; **3**: 1-12.

29. Swartz, Swanson JW. Commentary: psychiatric advance directives and recovery-oriented care. *Psychiatr Serv* 2007; **58**:1164.

30. Bisson JI, Hampton V, Rosser A, Holm S. Developing a care pathway for advance decisions and powers of attorney: qualitative study. *Br J Psychiatry* 2009; **194**: 55-61.

CHAPTER FIVE: Legal and ethical rights of individuals with mental illness to participate in advance treatment planning

Individuals with mental illness in Canada have a legal right to complete advance treatment plans when they are mentally capable. Many individuals, however, are unaware of the legal avenues that allow them to assume greater control of their decision-making ability. A comparative analysis of Canadian mental health legislation was conducted to examine legal rights and ethical values such as autonomy and self-determination associated with advance treatment planning. This research reveals that legislation governing advance directives is disparate across several Canadian jurisdictions. The advantages and disadvantages of instructional and proxy directives are discussed in the context of mental health legislation. If mental health professionals fail to conduct valid and reliable capacity assessments, judges will find it difficult to make accurate decisions regarding individuals' competence. Canadian courts have not offered a precise definition of autonomy as a legal principle, making it unclear which deprivations are justifiable under the principles of fundamental justice. Implementing electronic registries across provinces and territories can have an important role to store, access, and disseminate advance treatment plans in a timely manner during an emergency. Finally, legislative provisions could be enacted that mandate hospitals and health care providers to inquire whether individuals with mental illness have an advance directive.

Introduction

I. Background To Advance Treatment Planning
- A. Rights, Values, and Obligations in Mental Health
- B. Defining Autonomy: A Value or Right?
- C. Types of Advance Directives
- C. Legislative Disparity across Provinces and Territories

II. Mental Capacity and Competence
- A. Mental Capacity: Objectivity and Reliability
- B. Legal Competence: Role of Judges

III. Accessing Advance Directives
- A. Access through Electronic Registries
- B. Overriding Advance Directives
- C. The Top-Down Approach: Enacting Legislation
- D. The Bottom-Up Approach: Training Hospital Staff and Lawyers

Conclusion

Introduction

I. Background to Advance Treatment Planning

The recovery movement in mental health arose from the civil rights movement,[1] which has been defined as a "journey rather than a cure."[2] During the civil rights movement of the 1970's activists claimed that their fundamental rights were being denied. Individuals with mental illness expressed a desire for greater choice and independence regarding treatment. All journeys, whether long or short, require at least some planning and foresight. Advance treatment planning is a *process* that enables individuals to express their preferences in the event of future mental incapacity.[3] The act of making a decision related to personal care or administration of finances, and then relying on others to ensure that the decision is followed, requires a high degree of confidence and trust.[4] Yet, many individuals prefer to self-manage their mental illness because it promotes greater autonomy and empowerment.

Mental health legislation related to advance treatment planning is highly fragmented across Canadian provinces and territories.[5] Rather than analyzing such legislation intra-jurisdictionally, dominant themes and trends are analyzed comparatively across provinces and territories. The majority of research on advance directives has focused on end-of-life decision-making,[6] with the

---

[1] Larry Davidson, "What Happened to Civil Rights?" (2006) 30:1 Psychiatric Rehabilitation Journal 11-14; Larry Davidson et al., "Creating a Recovery-Oriented System of Behavioral Health Care: Moving From Concept to Reality" (2007) 31:1 Psychiatric Rehabilitation Journal 23-31.

[2] Patricia E. Deegan, "Recovery and Empowerment for People with Psychiatric Disabilities" (1997) 25:3 Social Work in Mental Health: Trends & Issues, 11-24.

[3] Canadian Hospice Palliative Care Association, "Advance Care Planning in Canada: National Framework" (February, 2010) online: http://www.chpca.net/projects/advance_care_planning/advance_care_planning_index.html [*CHPCA*].

[4] Larry R. Churchill, "Trust, Autonomy, and Advance Directives" (1989) 28:3 Journal of Religion and Health 175-183.

[5] Janet Dunbrack, "Advance Care Planning: The Glossary Project" (22 August 2006), online: Health Canada http://www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2006-proj-glos/index-eng.php [*Dunbrack*].

[6] In the end-of-life context, individuals often progressively lose their mental capacity to understand or appreciate the information provided to them, whereas in mental health individuals experience fluctuating degrees of lucidity. The public interest in advance directives may stem from a fear many have towards discussing end-of-life issues. See Gerald B. Robertson, "Living Wills/Advance Directives - A Legal View" (1991) 1:1 Health Law Review 3-6 [*Robertson*];

Canadian Hospice Palliative Care Association recently launching a national framework for advance care planning.[7] Although there are important clinical distinctions in advance treatment planning between a hospice and mental health care setting, there are also fundamental similarities. More broadly, these include the right to make choices, respect for autonomy and self-determination, legislative frameworks for assessing mental capacity, and how advance directives will be disseminated. The Mental Health Commission of Canada identified advance directives as a priority issue within their national framework,[8] and the Government of Alberta recently implemented a provincial-wide electronic registry for Albertans to store information involving personal directives.[9]

Autonomy is one of the most prominently cited ethical values in support of advance directives.[10] From a human rights perspective, mentally capable individuals have a legal right to make independent choices regarding treatment preferences. The United Nations' *Convention on the Rights of Persons with Disabilities*, a human rights instrument Canada ratified in 2010, recognizes the value of respecting persons with disabilities' dignity, autonomy, and freedom to make independent choices.[11] Courts, nonetheless, have occasionally limited the principle of autonomy by distinguishing it from related concepts such as dignity and liberty. Indeed, it would appear that respect for dignity receives universal

---

Living wills were originally used for refusal of artificial or mechanical means. See, Bernard M. Dickens, "A Response to the Papers by Molloy and Colleagues (Canada) and Cranford (United States) on Advance Directives" (1993) 9:1 Humane Medicine 78-84 [*Dickens*]; Patricia Backlar, "Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning For End-Of-Life Care" (2004) 33:4 Community Mental Health Journal 261-268.

[7] *CHPCA, supra*, note 3.

[8] Mental Health Commission of Canada, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (Ottawa: Mental Health Commission of Canada, 2009 at 33, 60, 71) online: http://www.mentalhealthcommission.ca/English/Pages/default.aspx [*MHCC*].

[9] Christie McLaren, "Alberta Creates Electronic Registry for Personal Directives" (2009) 180:7 Can Med Assoc J at 708 [*McLaren*]; See also, *Government of Alberta Seniors and Community Supports, Personal Directives Registry* (2010) online: http://www.seniors.alberta.ca/opg/registry/.

[10] Janet Ritchie, Ron Sklar & Warren Steiner, "Advance Directives in Psychiatry. Resolving Issues of Autonomy and Competence" (1998) 21: 3 Int'l J L & Psychiatry 21: 3 245-260 [*Ritchie*]; Anna Scheyett et al., "Autonomy and the Use of Directive Intervention in the Treatment of Individuals with Serious Mental Illnesses: A Survey of Social Work Practitioners" (2009) 7:4 Social Work in Mental Health at 283-306.

[11] UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106, available at: http://www.unhcr.org/refworld/docid/45f973632.html [*UN Convention Rights*]

acknowledgment as a legal principle worthy of protection,[12] whereas autonomy is more readily limited by courts. In a recent public consultation document from Québec, *Dying with Dignity*, the term dignity was defined as "one's value as a person and the respect one is due, while integrity applies to one's physical and psychological protection."[13] Although some may suggest autonomy and dignity are identical values, not all courts have adopted such a view.

Advance treatment planning documents in Canada are referred to differently depending on where they are used,[14] and can be either a *document* or a *process* of planning for future contingencies regarding personal care and/or financial administration of property in the event of mental incapacity.[15] Ontario employs powers of attorney (POA) for personal care or for property;[16] British Columbia refers to them as representation agreements;[17] Alberta has adopted the term personal directives;[18] Newfoundland and Labrador calls them advance directives;[19] and Québec uses mandates in case of incapacity.[20] The term "living will" is an umbrella term for a document whereby individuals can provide detailed instructions regarding their treatment preferences, which are often in written form. In 1993, it was estimated that 10-12% of Canadians completed an advance treatment plan of some type,[21] although the majority of these were likely

---

[12] The Supreme Court of Canada has held that the purpose of section 15 (1) of the *Charter of Rights and Freedoms* is to prevent the violation of human dignity and freedom which is often associated with discrimination. See *Lavoie v. Canada* [2002] 1 S.C.R. 769; In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, the court held that section 7 encompasses notions of personal autonomy and basic human dignity [*Rodriguez*]; See Daryl Pullman, "The ethics of autonomy and dignity in long-term care" (1999) 18:1 Canadian Journal of Aging at 26-46.

[13] Québec, *Dying with Dignity: Consultation Document* (Québec: National Assembly of Québec Select, 2010) online: http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/actualite-21205.html [*Dying with Dignity*].

[14] See, Table 1 - Advance Treatment Planning Documents across Canadian Provinces and Territories [*Table 1*].

[15] The *process* of advance treatment planning often results in the production of documents including an advance directive, living will, or power of attorney.

[16] *Substitute Decisions Act*, 1992, S.O. 1992, c. 30 [*Substitute Decisions Act*].

[17] *Representation Agreement Act*, R.S.B.C. 1996, c. 405 [*Representation Agreement Act*].

[18] *Personal Directives Act*, R.S.A. 2000, c P-6 [*Personal Directives Act*].

[19] *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1 [*Advance Health Care Directives*].

[20] *Civil Code of Québec*, L.R.Q. c. C-1991 [*C.C.Q.*].

[21] Peter A. Singer, Sujit Choudry & J. Armstrong, "Public Opinion Regarding Consent to Treatment" (1993) 41: 2 Journal of the American Geriatrics Society at 112-116; Peter A. Singer et

used in the end-of-life context. Some individuals may be reluctant to complete advance directives for reasons that include not believing they will become mentally incapable; fear of signing anything legal; poor awareness of issues around legal rights; concern that the document may further stigmatize them; barriers from within the legislation or delivery of health care services; or insufficient access to legal services.

The role of advance directives for individuals with mental illness is being studied in other countries. For example, psychiatric advance directives (PADs) are used in more than thirty U.S. states where they have the potential to increase individuals' autonomy at a time when they are most vulnerable.[22] In Britain, joint crisis cards are being promoted to declare individuals' treatment preferences, but differ from PADs in that they are completed with a treatment provider and do not carry legal force.[23] Additionally, Australian states have initiated reforms to their mental health legislation to accommodate PADs for individuals with mental illness.[24] The aim of this article is to compare advance treatment planning documents across Canadian provinces and territories, offering suggestions towards possible reform of mental health legislation and greater accommodation for instructional directives. Mental health legislation can inadvertently contain elements of structural stigma that limit advance treatment plans and prevent them from reaching their full potential.[25] An important distinction lies between the role of mental health professionals to conduct capacity assessments from judges who

---

al., "Public Opinion Regarding End-of-Life Decisions: Influence of Prognosis, Practice and Process" (1995) 41:11 Social Science & Medicine at 1517-1521.

[22] Claire Henderson et al., "A Typology of Advance Statements in Mental Health Care" (2008) 59:1 Psychiatric Services at 63-71 [*Henderson*]; Anna M. Scheyett et al., "Psychiatric Advance Directives: A Tool for Consumer Empowerment and Recovery" (2007) 31:1 Psychiatric Rehabilitation Journal at 70-75 [*Scheyett*].

[23] *Henderson, supra* note 22.

[24] Tony Bogdanoski, "Psychiatric Advance Directives: The New Frontier in Mental Health Law Reform in Australia? (2009) 16:5 Journal of Law and Medicine at 891-904.

[25] See Patrick W. Corrigan et al., "Structural Stigma in State Legislation" (2005) 56: 5 Psychiatric Services at 557-563 where the authors argue that mental health legislation can be stigmatizing by confusing definitional terms such as incompetence and mental illness.

make final declarations of incompetency based on legislative criteria and assessments proffered to the court.[26]

Advance directives are founded on ethical principles of autonomy, empowerment, and self-determination, as expressed by consumers, clinicians, lawyers, courts, and governmental bodies.[27] An often-overlooked advantage of advance treatment planning is that the process of completing such documents allows individuals to become more insightful and learn how to self-manage their mental illness.[28] The knowledge that someone has an advance directive can also provide a sense of well-being,[29] and bridge potential communication gaps between doctors and patients.[30] Indeed, advance directives could be considered a form of health service that promotes mental health and fosters recovery in line with the *Canada Health Act*.[31] To what extent, however, *should* the law promote such documents in mental health? How far *will* the law go to ensure individuals' rights recorded in such documents are honoured?

---

[26] Others have referred to the distinction between mental capacity and competence by using the expression "factual competence" versus "legal competence." See, for example, Margaret A. Somerville, "Labels Versus Contents: Variance between Philosophy, Psychiatry and Law in Concepts Governing Decision-Making" (1994) 39 McGill LJ at 179.

[27] For example, the Mental Health Commission of Canada reports that "even when mental illness is at its most debilitating, service providers, families, and others – employing advanced directives and designating substitute decision-makers where necessary – can work together to support the greatest degree of self-determination and dignity possible…There must be a firm commitment to offer services in the least intrusive and least restrictive way possible and to ensure that mechanisms such as advanced directives are in place for people when their decision-making ability may be compromised." See *MHCC, supra* note 8 at 33, 71.

[28] Individuals with depression are better able to deal with their illness when they are engaged as active participants rather than merely asked to comply with treatment, see Dan Bilsker, Elliot M. Goldner & Wayne Jones, "Health Service Patterns Indicate Potential Benefit of Supported Self-Management for Depression in Primary Care" (2007) 52:2 Canadian Journal of Psychiatry at 86-95.

[29] The concept of 'well-being' in mental health contains three elements: self-determination, equality, and democratization, see Stephanie Wilson, "Consumer Empowerment in the Mental Health Field" (1996) 15:2 Canadian Journal of Community Mental Health at 69-85; In *Scardoni v. Hawryluck*, [2004] O.J. No. 300, an Ontario court examined the term "well-being" in section 21 (2)(c) of the *Health Care Consent Act* and held that it encompasses several considerations including quality of life.

[30] N.S. Wenger & J. Halpern, "The Physician's Role in Completing Advance Directives: Ensuring Patients' Capacity to Make Healthcare Decisions in Advance" (1994) 5:4 Journal of Clinical Ethics at 320-323.

[31] *Canada Health Act*, R.S.C, 1985, c. C-6, preamble.

A. Rights, Values, and Obligations in Mental Health

Autonomy needs to be balanced with other potentially incommensurable values[32] such as the need to protect individuals from harming themselves or others. From a rights perspective, autonomy claims can arise from the desire to act as an independent agent and must be consistent with communal and societal expressions of freedom. While advance directives allow individuals to assert their legal rights by expressing their treatment preferences, they also give individuals an opportunity to reveal their fundamental values to others. Individuals with mental illness have been treated historically in a highly paternalistic manner where the freedom to make personal choices was uncommon,[33] rights were curtailed by detention in asylums,[34] and patients were locked under restraints and seclusion[35] while forced to undergo controversial treatments.[36]

Historically, psychiatric patients did not have the right to make independent choices regarding treatment because they were presumed mentally incapable. This presumption was based on a belief that if an individual was diagnosed with a mental disorder, they lacked the mental capacity to make reliable choices. In the U.S., however, the delivery of mental health care services has moved towards providing patients greater choice.[37] The strong desire and frequency in which humans make choices is so fundamental that some argue it is both innate and learned from birth.[38] The expression of choice, even if it cannot always be

---

[32] Edward M. Hundert, "A Model for Ethical Problem Solving in Medicine, With Practical Applications" (1987) 144:7 American Journal of Psychiatry at 839-846. It is common for the value of autonomy to weigh in on both sides of an ethical dilemma.

[33] Roberto Cuca, "Ulysses in Minnesota: First Steps toward a Self-binding Psychiatric Advance Directive Statute" (1993) 78:6 Cornell L. Rev at 1152-1186; See also Lester J. Perling, "Health Care Advance Directives: Implications for Florida Mental Health Patients" (1993) 48 U Miami L Rev 193 [*Perling*].

[34] Jeffrey L. Geller, "Rights, Wrongs, and the Dilemma of Coerced Community Treatment" (1986) 143:10 American Journal of Psychiatry at 1259-1264.

[35] Jeffrey M. Levine, "Historical Notes on Restraint Reduction: The Legacy of Dr. Philippe Pinel" (1996) 44:9 Journal of the American Geriatrics Society 1130-1134.

[36] Elizabeth A. Williams, "Gags, Funnels and Tubes: Forced Feeding of the Insane and of Suffragettes" (2008) 32:4 Endeavour at 134-140.

[37] Alain Enthoven, "Connecting Consumer Choice to the Healthcare System" (2006) 39:3 Journal of Health Law at 289-305; Paul Barreira et al., "Choice of Service Provider: How Consumer Self-Determination Shaped a Psychiatric Rehabilitation Program" (2008) 31:2 Psychiatric Rehabilitation Journal at 202-210.

[38] Sheena Iyengar, *The Art of Choosing* (New York: Hachette Book Group, 2010).

honoured, builds autonomy because individuals understand it to be a fundamental human right.[39]

In 2003, the Supreme Court of Canada case of *Starson v. Swayze*[40] reinforced the autonomy rights of individuals with mental illness to make treatment choices when the majority of the court stated that the patient was entitled to make a choice to continue therapy rather than take anti-psychotic medication. Several years earlier, in the 1991 Ontario Court of Appeal case of *Fleming*,[41] Justice Robins relied on the doctrine of informed consent to declare that patients, not doctors, have the freedom to make choices and ultimately decide whether treatment is to be administered. Individuals with mental illness often want to decide issues related to finances, personal care matters, type of therapy and medical treatment, hospitals, and emergency interventions. These choices are often based on personal experiences with managing their illness. Whereas choices made at the end-of-life often have a sense of finality to them, individuals with mental illness know they will regain their mental capacity and are able to recall whether their rights, values, and preferences were honoured.

The legal obligation to follow instructions included in an advance directive stems from both legislation and the common law.[42] Even if an advance directive does not comply entirely with the governing mental health legislation, individuals' instructions can still reflect an expression that guides legal decision-making.[43] As Dickens states about advance directives, "Although [an advance directive] may fail because of some legislative technicality, it will not fail because

---

[39] See, for example, article 23 (1) of the *Universal Declaration of Human Rights*, GA Res 217 (III), UNGAOR, 3d Sess, UN Doc A/810, (1948), which provides that everyone has the right to free choice of employment.

[40] *Starson v. Swayze*, [2003] 1 S.C.R. 722; 2003 SCC 32 [*Starson*]; See Monique W. Dull, "Starson v. Swayze, 2003-2008: Appreciating the Judicial Consequences" (2009) 17 Health LJ 51 for a survey of 13 cases that have been influenced by Starson in Ontario, Québec, and Nova Scotia.

[41] *Fleming v. Reid*, [1991] O.J. No. 1083; 4 O.R. 93d 74 [*Fleming*]

[42] *Dickens*, *supra* note 6.

[43] *See Ibid*. where Dickens explains the common mistake of believing that once a legislature recognizes one means of protecting an individual's treatment preferences there are no other avenues of protection. Statutory rights do not reduce constitutional or common-law rights, which can be another basis for legally enforcing preferences and obligations in advance directives. See also Wolfe et. al., "Sources of Concern about the Patient Self-Determination Act" (1991) 325 New Eng J Med at 1666-1671.

it was not a valid expression of preference made prospectively by a competent individual. As such, the statement has legal force even outside the protection of the legislation that inspired it."[44] Consequently, if someone makes an oral or written statement that does not comply entirely with the operating legislation, courts may still enforce the individual's wishes by looking to the pre-existing common-law outside of the protection offered by legislation. Therefore, any values, preferences, or beliefs included in an advance directive must be examined closely in order to determine whether correlative obligations exist from legislation or common law.

B. Defining Autonomy: A Value or Right?

Autonomy is foundational as an ethical principle,[45] but "what we do to honour autonomy is determined by our definition of it."[46] Indeed, whether the principle of autonomy will be upheld by courts as a liberal democratic right or as a fundamental human value deserves scrutiny. A strong argument is possible that individuals have the freedom to contract into making an advance directive based on private law principles underpinning autonomy.[47] Freedom to contract into an advance treatment plan based on autonomy is only one pillar; two others include a constitutional right to "life, liberty, and security"[48] and obligations arising from the UN *Convention on the Rights of Persons with Disabilities* that recognizes the autonomy and independence of individuals with disabilities.[49]

The principle of autonomy, or variants with the same meaning, can be found in mental health legislation and jurisprudence from the early history of medico-

---

[44] See *Dickens, ibid* at 39.

[45] See Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics, 6th ed. (New York: Oxford University Press, 2009); Tom L. Beauchamp, Standing on Principles: Collected Essays (New York: Oxford University Press, 2010).

[46] Charles W. Lidz & Robert M. Arnold, "Rethinking Autonomy in Long Term Care" (1993) 47 U Miami L Rev 603-623 [*Lidz*].

[47] Treatment contracts were framed in a legalistic manner to emphasize their contractual component. These contracts were seen as more than a business agreement and included a written statement of the elements in a therapeutic alliance. See B. Rosen, "Written Treatment Contracts: Their Use in Planning Treatment Programmes for In-patients" (1978) 133 British Journal of Psychiatry 410-415.

[48] *Canadian Charter of Rights and Freedoms*, s.7, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11 [*Charter*].

[49] *UN Convention Rights, supra* note 11.

legal psychiatry.[50] Although mental health legislation may not be the main repository for principles of autonomy, such legislation nevertheless has the aim of promoting autonomy by ensuring that mental health services are accessible and preventing inappropriate restrictions on autonomy and liberty within hospitals. Yet, courts rarely declare autonomy as absolute.[51] Therefore, understanding the limits of autonomy in making treatment preferences is important to appreciate whether advance directives will be upheld.

The Ontario Court of Appeal's 1990 decision in *Malette v. Shulman,*[52] a case not involving mental illness, continues to have an important role for advance directives. A 57-year old woman, Georgette Malette, was involved in a head-on car collision and rushed to an emergency room hospital in an unconscious state. Her husband was killed in the accident. As a Jehovah's Witness, Mrs. Malette carried an advance directive in her wallet stating that due to her religious convictions she opposed blood transfusions. At the hospital, the nurse on duty discovered an advance directive in her purse and showed it to the attending physician. As it happened, the document was signed but not dated or witnessed. A few hours later Mrs. Malette's daughter and an elder from the local church arrived at the hospital and informed Dr. Shulman of her wishes to refuse blood. Notwithstanding the objection to blood transfusions, Dr. Shulman viewed it as his professional responsibility that Mrs. Malette should receive a blood transfusion. His belief was based on several assumptions including that she may have changed her religious beliefs before the accident; the advance directive could have been completed due to family or peer pressure; she was not fully informed of the risks of refusing blood transfusions; and she might have changed her mind to avoid death if she were conscious.[53] When Mrs. Malette recovered from her injuries, she

---

[50] Edmund D. Pellegrino & David C. Thomasma, "The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for A Resolution" (1987) 3 J Contemp Health L & Pol'y 23-46.

[51] *Schloendorff v. Society of the New York Hospital,* 211 N.Y. 125, 105 N.E. 92 (1914); *Starson, supra* note 40.

[52] *Malette v. Shulman,* [1990] O.J. No. 450; 72 O.R. (2d) 417 [*Malette*].

[53] It should be noted that the Ontario Court of Appeal has stated, albeit in a decision where the appeal was considered moot, that an advance directive where someone refuses blood transfusions may not always represent their current intention and true expression of their wishes, see *Van Wijngaarden v. Tzalalis,*[1997] O.J. No. 2408.

successfully sued Dr. Shulman for $20,000 in damages under the tort of battery claiming intentional non-consensual touching and the court called it an offense against “her reasonable sense of dignity.”[54] However, Justice Robins made a point of distinguishing this case from one where an advance directive or a living will may have been completed in the end-of-life context.[55]

The same year that *Malette* was decided, the U.S. Supreme Court released a landmark ruling, *Cruzan v. Director of Missouri Department of Health,*[56] involving a young woman Nancy Cruzan who was also involved in a serious car accident and left her in a persistent vegetative state. In a split 5-4 decision, the Court ruled that competent persons have the right to refuse medical treatment.[57] Shortly after this decision, federal legislation was enacted in the form of the *Patient Self-Determination Act*[58] that mandates U.S. hospitals and treatment providers to ask patients whether they have advance directives and obligates them to provide educational materials to assist patients to learn about them.

In *Malette*, Justice Robins highlighted the importance of dignity in relation to advance directives,

> A doctor is not free to disregard a patient’s advance instructions any more than he would be free to disregard instructions at the time of the emergency...On these facts, we are not concerned with a patient who has been diagnosed as terminally or incurably ill who seeks by way of advance directive or “living will” to reject medical treatment so that she may die with dignity; neither are we concerned with a patient in an irreversible vegetative state whose family seeks to withdraw medical treatment in order to end her life; nor is this a case in which an otherwise healthy patient wishes for some reason or other to terminate her life. There is no element of suicide or euthanasia in this case.[59]

Justice Robins begins from the position that free choice, self-determination, and autonomy all are fundamental constituents of life, and to deny these would be to

---

[54] *Malette, supra* note 52 at par 17.
[55] *Ibid* at par. 31; For a discussion of Malette see also *Robertson*, *supra* note 6.
[56] See *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) where Justice O’Connor was prepared to protect advance directives under the 14th amendment. For a discussion of *Cruzan* and advance directives in the United States see Bruce J. Winick, “Advance Directive Instruments For Those With Mental Illness” (1996) 51:1 U Miami L Rev 7-95.
[57] *Cruzan, ibid*.
[58] *Patient Self-Determination Act* of 1991 (PSDA), Pub. L. No. 101-508, 104 Stat. 1388-115, 1388-204 (1990) (codified as amended in scattered sections of 42 U.S.C.) [*PSDA*].
[59] *Malette, supra* note 52 at pars 24, 31.

lessen the value of life.[60] In the 1991 case of *Fleming*,[61] the Ontario Court of Appeal had an opportunity to discuss the relationship between autonomy and the right to make advance instructions for individuals with mental illness. Justice Robins acknowledged that the right to be free from non-consensual treatment is not an absolute right, and autonomy and self-determination both have important roles as principles of fundamental justice,

> A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to treatment. A doctor is not free to disregard such advance instructions, even in an emergency. These traditional common law principles extend to mentally competent patients in psychiatric facilities…Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments…Indeed, in my view, the common law right to determine what shall be done with one's body and a constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.[62]

The fact that someone is mentally incapable does not necessarily mean the person lacks autonomy. A functional test of capacity does not presume that individuals with specific types of disabilities lack legal capacity (status attribution), and does not base the evaluation on the decision made (outcome test). Instead, a functional test of legal capacity is based on an individual's ability to perform a specific function.[63] To illustrate, in the 1994 English case of *Re C*[64] an individual with chronic paranoid schizophrenia refused to have his gangrenous leg

---

[60] *Ibid* at pars 35, 41; See *ibid* at par 36 where Robins J. states, "The patient's right to determine her own medical treatment is, however, paramount to what might otherwise be the doctor's obligation to provide needed medical care. The doctor is bound in law by the patient's choice even though that choice may be contrary to the mandates of his own conscience and professional judgment"; Compare *Malette* with the English decision *Re T (Adult: Refusal of Treatment)* [1992] 3 W.L.R. 782 where the court also states, "Every adult has the right and capacity to refuse medical treatment, even if such refusal may risk his death or permanent injury to his health."

[61] *Fleming v. Reid*, [1991] O.J. No. 1083; 4 O.R. 93d 74 [*Fleming*]; In *R. v. Swain*, [1991] 1 S.C.R. 933; S.C.J. No. 32 the Supreme Court has stated, "The mentally ill have historically been the subjects of abuse, neglect, and discrimination in our society. The stigma of mental illness can be very damaging."

[62] *Fleming*, *ibid* at par 32-34, 39.

[63] Michael Bach & Lana Kerzner, A New Paradigm for Protecting Autonomy and the Right to Legal Capacity (Ontario: Law Commission of Ontario, 2010) at 19 [*Bach*].

[64] *In Re C (Adult: Refusal of Treatment)*, [1994] 1 WLR 290; [1994] 1 All ER 819; See J O A Tan & J R McMillan, "The Discrepancy Between the Legal Definition of Capacity and the British Medical Association's Guidelines" (2004) 30 Journal of Medical Ethics 427-429 to understand the legal criteria to show mental capacity established in *Re C*.

amputated by doctors. The court ruled that his mental capacity was not so impaired to render him incapable to understand the nature, purpose, and effects of the treatment and his right of self-determination had not been displaced.[65] Justice Thorpe, in granting an injunction against the amputation the court stated, "If the patient's capacity to decide is unimpaired, autonomy weighs heavier, but the further capacity is reduced, the lighter autonomy weighs."[66] Simply because someone is declared partially or wholly mentally incapable does not mean that individual necessarily has less autonomy than before. Indeed, autonomy may be less associated with one's cognitive capacities, and more related to an intrinsic property of all humans, similar to dignity.

In *Starson v. Swayze*,[67] Chief Justice McLachlin of the Supreme Court of Canada stated in dissent that "[o]rdinarily at law, the value of autonomy prevails over the value of effective medical treatment…however, where the individual is incompetent, or lacks the capacity to make the decision the law may override his or her wishes and order hospitalization."[68] The majority decision in *Starson* stood for the principle that individuals with mental illness who are capable of making their own decisions have a right to refuse medical treatment and that clinicians should not consider a patient's best interests in determining mental capacity.[69] It would be interesting, to consider how the judicial reasoning in *Starson* may have changed if he had previously completed an advance directive while capable.[70] Justice Major, in writing for the majority, referred to the principles of autonomy and dignity stating, "The right to refuse unwanted medical treatment is

---

[65] *Ibid*.

[66] *Ibid*.

[67] *Starson*, *supra* note 40.

[68] *Ibid* at par 7.

[69] For two perspectives on the *Starson* decision see Ron Sklar, "Starson v. Swayze: The Supreme Court Speaks Out (Not All That Clearly) On The Question Of "Capacity"" (2007) 52:6 Canadian Journal of Psychiatry 390-395 and John E. Gray & Richard L. O'Reilly, "Supreme Court of Canada's "Beautiful Mind" Case" (2009) 32:5 Int'l J L & Psychiatry 315-322.

[70] See *Starson, supra* note 40 par 98 where the majority stated that "there was no evidence that the proposed medication was likely to ameliorate Professor Starson's condition." To what extent can a valid advance directive stating that a certain treatment has been ineffective act as evidence for treatment refusal? Advance directives deserve consideration as one piece of evidence that can reflect an individual's earlier wishes and weighed among other factors, See Stuart J. Eisendrath & Albert R. Jonsen, "The Living Will. Help or Hindrance?" (1983) 249:15 Journal of American Medical Association 2054-2058 [*Eisendrath*].

fundamental to a person's dignity and autonomy ... unwarranted findings of incapacity severely infringe upon a person's right to self-determination."[71] McLachlin CJ., on the other hand, focused more closely on the relationship between autonomy and mental capacity,

> The HCCA preserves the value of individual autonomy. Mental illness is not conflated with incapacity. Mental illness without more does not remove capacity and autonomy. Only where it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision can treatment be imposed.[72]

If mental illness alone does not remove mental capacity or autonomy, then why do some courts assume that incapacity removes autonomy? What exactly is the relationship between mental illness, capacity, and autonomy?

Fundamental freedoms have an impact on *Charter* values such as liberty, human dignity, equality, autonomy, and democracy.[73] What does autonomy look like as a *Charter* value? As a matter of law, should autonomy be treated differently from dignity or equality? Pellegrino states, "[h]uman beings are owed respect for their autonomy because they have an inherent dignity. They do not have dignity because they are autonomous. Human beings who lack or who have lost the capacity for autonomous actions are nonetheless humans who retain their inherent dignity."[74] Can autonomy be elevated to the level of respect accorded to the principle of dignity? The Supreme Court of Canada has stated that mature adolescents "have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is justified by the difficulty of defining and identifying 'maturity'."[75] One way to limit autonomy, as the Supreme Court has done, is to frame it as an evolving concept, "Best interests must in turn be interpreted so as to reflect and respect the adolescent's developing

---

[71] *Starson, supra* note 40 at par 75.

[72] *Ibid* at par 10.

[73] *Alberta v. Hutterian Brethren of Wilson Colony* [2009] 2 S.C.R. 567; S.C.J. No. 37.

[74] Edmund D. Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship" (1994) 10 J Contemp Health L & Pol'y 47 at 49.

[75] *A.C. v. Manitoba (Director of Child and Family Services)* [2009] S.C.J. No. 30 at par 82. For a critique of how autonomy is addressed by Canadian courts when the competing values involve religious rights see, Shawn H.E. Harmon, "Body Blow: Mature Minors and the Supreme Court of Canada's Decision in *A.C. v. Manitoba*" (2010) 4:1 McGill JL & Health 83 at 89 stating, "As the case demonstrates, we find ways to circumvent the exercise of autonomy when we consider it just or expedient."; See also Robert P. Kouri, "Le mineur et les soins médicaux, A.C. c. Manitoba: de l'autonomie au meilleur intérêt, une limite bien floue" (2010) 4:1 McGill JL & Health 65-81.

autonomy interest."[76] In the same ruling, Justice Binnie, in dissent, arrived at a different outcome, which may be related to his understanding of the relationship between choice and autonomy,

> Whether judges, doctors and hospital authorities agree or disagree with C's objection, the decision belongs to her, as the *Charter* is not just about the freedom to make the wise and correct choice; it also gives her the individual autonomy and the religious freedom to refuse forced medical treatment, even where her life or death hangs in the balance, regardless of what the judge thinks is in her best interest.[77]

Making a *Charter* claim to liberty as a principle of fundamental justice is very similar to someone who asserts his or her right to autonomy. Section 7 of the *Charter* provides that "everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[78] Can autonomy be elevated so that it is worthy of protection as a principle of fundamental justice? How has section 7 of the *Charter* been interpreted in the non-criminal sphere? In the 1985 decision of *Singh v. Canada (Minister of Employment and Immigration)*,[79] Madam Justice Wilson held that the "principles of fundamental justice" include a right to fair procedures that are informed by common law principles governing procedural fairness. The Supreme Court of Canada established in *Motor Vehicle Act*[80] that the "principles of fundamental justice" are not purely procedural protections and include the basic tenets of our legal system, such as the right to be governed by laws that are not overbroad, vague, or arbitrary. In *Rodriguez*,[81] Justice Sopinka stated, "principles of fundamental justice must not, however, be so broad as to be no more than vague generalizations about what society considers to be ethical or moral." Indeed, Justice Sopinka was concerned that such principles could be identified with precision, yield an understandable result, and be a legal principle.

---

[76] *Ibid* at summary; The problem that arises when treatment choices are based on a best interests standard is that two reasonable persons can, and often do, disagree about choices.

[77] *Ibid* at summary; It is not that the *Charter* that gives someone autonomy, per se; instead, everyone has an inherent right to autonomy and that the *Charter* gives individuals an ability to express this autonomy through choices.

[78] *Charter, supra* note 48 at s 7.

[79] [1985] 1 S.C.R. 177 at 205, 17 D.L.R. (4th) 422.

[80] *Reference re: s. 94(2) of the Motor Vehicle Act (British Columbia)*, [1985] 2 S.C.R. 486.

[81] *Rodriguez, supra* note 12.

What is unclear, however, is how broadly courts will adopt a definition of "liberty" and "security of the person" outside of the criminal sphere,[82] and specifically for liberty rights of individuals with mental illness. In *Blencoe*,[83] Justice Bastarache appears to have adopted the position in *Godbout v. Longeuil*, where the meaning of "liberty" in section 7 encompasses "the right to an irreducible sphere of personal autonomy wherein individuals may make inherently private choices free from state interference." Yet, Justice Bastarache also stated in *Blencoe* that "[a]lthough an individual has the right to make fundamental personal choices free from state interference, such personal autonomy is not synonymous with unconstrained freedom."[84] Until the *Chaoulli*[85] ruling in 2005, courts have adopted a very narrow and restrictive interpretation of the meaning of "liberty" and "security of the person" within the meaning of section 7 of the *Charter*.

The case of *Deacon*[86] involved a pedophile individual with a long history of sexual offences against children who was declared a long-term offender. The issue that arose in *Deacon* was his refusal to take medications, prompting the court to say, "The appellant is at liberty to refuse to take the prescribed medication. However, if he does, there will be consequences for such a refusal…,"[87] and then added, "the absolute right to refuse unwanted medical treatment is <u>not a principle of fundamental justice</u> under section 7 of the *Charter*." The court went even further by stating that neither dignity nor autonomy is a principle of fundamental justice,

> The right of a competent adult to refuse unwanted medical treatment is clearly "fundamental to a person's dignity and autonomy" (*Starson v. Swayze*, at paragraph 75). However, respect for human dignity and autonomy is not itself a principle of fundamental justice (*Rodriguez*, at page 592). Moreover, although the right to refuse treatment may well be a right "deeply rooted in our common law" (*Fleming v. Reid*,

---

[82] Philip Bryden, "Section 7 of the Charter Outside the Criminal Context" (2005) 38 U.B.C.L. Rev. 507 at 518.

[83] *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 190 D.L.R. (4th) 513, 2000 SCC 44.

[84] *Ibid.* at para. 54.

[85] See *Chaoulli v. Québec (Attorney General)*, [2005], 1 S.C.R. 791 where the Supreme Court ruled in a narrow decision that the *Québec Health Insurance Act* and *Hospital Insurance Act* violated Quebecker's right to life and security of person under the *Québec Charter of Human Rights and Freedom*. Three of the seven judges also found the laws violated section 7 of the *Canadian Charter of Rights and Freedoms*.

[86] *Deacon v. Canada (Attorney General)* [2006] F.C.J. No. 1153.

[87] *Ibid* at par 40.

> at page 85), it is recognized that "[a] mere common law rule does not suffice to constitute a principle of fundamental justice" (*Rodriguez*, at page 590). The principles of fundamental justice are also not simply "vague generalizations about what our society considers to be ethical or moral" (*Rodriguez*, at page 591): significant social consensus is required … Contrary to the appellant's assertion, I do not think the requisite broad societal consensus is present concerning an absolute right to refuse unwanted medical treatment in every situation for the latter to be recognized as a principle of fundamental justice. Rather, the right to refuse medical treatment, while perhaps accepted as the general rule, is also recognized as properly subject to limitations in certain contexts.[88]

Deacon is not wholly consistent with the view of autonomy expressed by Justice Robins in *Fleming* where he stated that "[i]t is plainly contrary to the principles of fundamental justice to force a patient to take anti-psychotic drugs in his or her best interests without providing the patient, or the patient's substitute, any opportunity to argue that it is not the patient's best interests but rather his or her competent wishes."[89] It appears, therefore, that Canadian courts have struggled with how to define autonomy and whether it is a principle of fundamental justice or simply a fundamental right. It would be useful to distinguish how autonomy may differ from principles of dignity and liberty.

C. Types of Advance Directives

The different types of advance directives can be understood on a spectrum containing three reference points: (i) on the far left, treatment plans are highly paternalistic with very little choice; (ii) in the middle, individuals can complete documents through a shared decision-making approach; and (iii) on the far right are documents entirely driven by personal choice.[90] Treatment plans allow doctors to stipulate which treatment preferences patients are to follow without consultation. A shared decision-making approach involves physicians and patients discussing treatment preferences either before or during the process of completing an advance directive. The least paternalistic are advance directives completed by individuals independently of physicians. Individuals prefer different types of advance directives based on numerous considerations, not least of which is the severity of one's mental disorder. In the 2006 criminal case of *Mazzei*, the

---

[88] *Ibid* at pars 70, 71.
[89] *Fleming, supra* note 41 at par 53.
[90] *Henderson, supra* note 22.

Supreme Court of Canada ruled that review boards have a supervisory role over hospitals to ensure they are successful in meeting their goals, and this can involve questioning whether a treatment plan is effective.[91] Treatment plans differ from advance directives in that they are not legally binding, rarely require a signature,[92] and treatment teams can impose some conditions without patients' consent.[93]

Some have recommended adopting standardized forms of advance directives across Canada[94] in order to bridge provincial and territorial differences. Advance planning tools can also include do not resuscitate orders, organ donation cards, and wills. A testamentary will is not an advance directive; hence, the reason for the term "living will" is often used in reference to advance directives.[95] Some jurisdictions recommend financial and property issues should be documented separately from personal care issues;[96] others permit the two documents to be merged into one.[97]

A key distinction regarding advance directives is whether they are proxy or instructional in nature. Some jurisdictions allow for a hybrid form where proxy and instructional directives act as a single document.[98] Essentially, a proxy directive allows individuals to appoint an agent to make decisions on their behalf in the event of mental incapacity. In a proxy directive, the grantor is able to entrust decision-making authority to the proxy/agent who is less constrained in

---

[91] *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)* [2006] 1 S.C.R. 326; See also Peter Carver & Cherie Langlois-Klassen, "The Role and Powers of Forensic Psychiatric Review Boards in Canada: Recent Developments" (2006) 14 Health LJ 1.

[92] Lori Ashcraft & William A. Anthony, "A Treatment Planning Reality Check" (2006) 26:2 Behavioral Healthcare 7-8. Both a subjective and objective process can occur in making an advance directive. The subjective process permits individuals to develop greater insight into their illness, while the objective process requires a signature of the document, neither of which is present with treatment plans.

[93] *Ibid*.

[94] Jocelyn Downie, "Where There Is a Will, There May Be a Better Way: Legislating Advance Directives" (1993) 12:3 Health Law in Canada 73-80, 89 [*Downie*].

[95] *Eisendrath, supra* note 70.

[96] This is the case for powers of attorney for property and personal care under Ontario's *Substitute Decisions Act*, 1992, S.O. 1992, c. 30.

[97] *Representation Agreement Act, supra* note 17 at s 7.

[98] John Q. La Fond & Debra Srebnik, "The Impact of Mental Health Advance Directives on Patient Perceptions of Coercion in Civil Commitment and Treatment Decisions" (2002) 25:6 Int'l J L & Psychiatry 537-555.

their decision-making ability and permitted to substitute their judgment,[99] whereas an instructional directive (i.e. "living will") enables the grantor him or herself to record personalized and detailed instructions for others to follow. All provinces and territories, except for Nunavut, have enabling legislation that allows individuals to appoint an agent in a proxy directive.[100]

One of the advantages of proxy directives is that they are not constrained by unforeseeable events allowing agents the discretion to make decisions about a grantor's personal care or financial matters. In this respect, they offer greater flexibility than instructional directives.[101] However, the grantor should already have discussed their values and preferences with the agent, ideally someone in whom they have trust and confidence. A disadvantage of proxy directives is that they can occasionally include vague and imprecise language making it difficult to interpret expressions such as "not wanting extraordinary heroic means."[102] Without knowing an individual's values or beliefs, such an expression could be interpreted very broadly. Another disadvantage of proxy directives is that not everyone has someone they would choose to rely on to make important decisions in the event of mental incapacity. Others choose not to burden friends or family with the responsibility of decision-making. Proxy directives are generally perceived as less autonomy-supportive than instructional directives.

In 1991, provincial and territorial mental health legislation began to include provisions supporting of instructional directives,[103] which have been described as a type of advisory statement[104] for individuals to include details about their treatment preferences. The main advantage of instructional directives is they promote autonomy by allowing individuals to control their treatment preferences.

---

[99] Paul S. Appelbaum, "Advance Directives for Psychiatric Treatment" (1991) 42:10 Hospital & Community Psychiatry: A Journal of the American Psychiatric Association 983-984 [*Appelbaum*].

[100] *Table 1, supra* note 14.

[101] Edmund D. Pellegrino, "Ethics" (1992) 268:3 Journal of American Medical Association 354-355; *Appelbaum, supra* note 99; Elizabeth M. Gallagher, "Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals" (1998) 4:3 Psychol Pub Pol'y & L, 746-787 [*Gallagher*].

[102] Glenn G. Griener, "Living Wills/Advance Directives - An Ethicist's View" (1991) 1 Health Law Review 6-9 [*Griener*]; *Robertson, supra* note 6.

[103] *Downie, supra* note 94.

[104] Linda Emanuel, "Advance Directives: What Have We Learned So Far? (1993) 4:1 Journal of Clinical Ethics 8-16 [*Emanuel*].

Even those who may have reservations about the use of instructional directives acknowledge that they support autonomy[105] and offer greater certainty and predictability.[106] There are notable similarities and differences across provincial and territorial mental health legislation on the use of instructional and proxy directives that affect the delivery of mental health care.[107] In the following section, a comparative analysis of Canadian mental health legislation is conducted to identify some of these disparities.

D. Legislative Disparity across Provinces and Territories

As shown in Table 1, every Canadian province and territory, other than Nunavut, has mental health legislation governing some type of advance treatment planning for personal care.[108] Yet, there are wide disparities in how mental health legislation is applied in practice with numerous calls for reform to move away from the medical model.[109] The aim of this section is to analyze comparatively the dominant themes and trends regarding advance treatment planning.

(a) Proxy, Instructional, or Hybrid Directives

Seven Canadian jurisdictions have legislation that enables the use of instructional directives and every province, other than Nunavut, has proxy directive legislation. In Alberta, an enduring power of attorney (POA) enables an attorney (the individual appointed as proxy and not the lawyer) to handle financial matters, whereas an agent refers to someone who handles personal care issues that within the scope of a personal directive.[110] B.C.'s legislation provides mentally capable persons a right to be involved to the greatest degree possible in their care

---

[105] Angela Fagerlin & Carl E. Schneider, "Enough - The Failure of the Living Will" (2004) 34:2 The Hastings Center Report 30-42 [*Fagerlin*]; Emily Clough, "A Critique of Advance Directives and Advance Directives Legislation" (2006) 11 Appeal 16-38 [*Clough*].

[106] John A. Robertson, "Second Thoughts on Living wills" (1991) 21:6 The Hastings Center Report 6-9.

[107] John E. Gray & Richard L. O'Reilly, "Clinically Significant Differences among Canadian Mental Health Acts" (2001) 46:4 Canadian Journal of Psychiatry 315-321; Ann Tapp, "Advance Directives" (2006) 102:2 Canadian Nurse 26.

[108] *Table 1*, *supra* note 14.

[109] H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health LJ 139.

[110] *Powers of Attorney Act*, R.S.A. 2000, c. P-20.

planning and decision-making,[111] and representation agreements are used to deal with health care matters.[112] Unlike personal directives in Alberta, representation agreements in B.C. are proxy directives and there is no legislation enabling the use of instructional directives.[113] Representation agreements also differ from personal directives in Alberta in that the latter are strictly for non-financial matters.[114] Representation agreements, on the other hand, allow individuals to declare to whom they want to give authority regarding their financial and personal care matters,[115] while enduring power of attorneys deal exclusively with financial issues.[116] Representatives appointed as proxies in B.C. can include another adult, the Public Guardian and Trustee, or even a credit union or trust company as long as the appointed individual does not deal with health care or personal care.[117]

Both instructional and proxy directives are used in Newfoundland and Labrador. The *Advance Health Care Directives Act* provides that a person can declare instructions regarding health care treatment or make general principles regarding type of health care provided.[118] Similarly, Northwest Territories' legislation enables the use of both instructional and proxy directives. In Saskatchewan, the *Health Care Directives and Substitute Health Care Decision Makers Act* allows for either proxy or instructional directives, but does not require someone to name a proxy.[119] In Prince Edward Island both instructional and

---

[111] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, s 4(e) [*Health Care and Care Facility Act*].

[112] *Representation Agreement Act*, *supra* note 17; See *Allan v. Patterson*, [2000] B.C.J. No. 2791; 2000 BCSC 1525 where the court held that if a representation agreement was used prior to the legislation coming into force, and complied with the procedures, it would qualify as an agreement. Conversely, however, a power of attorney would not be deemed a representation agreement.

[113] Joan Rush, *Stillborn autonomy: why the Representation Agreement Act of British Columbia fails as advance directive legislation* (LLM Thesis, University of British Columbia, 2005) [unpublished].

[114] *Personal Directives Act*, *supra* note 18 at s 1.

[115] *Representation Agreement Act*, *supra* note 17 at s 2.

[116] A review of enduring powers of attorney and representation agreements was undertaken by A. J. McLean, Q.C., Attorney General of the Province of British Columbia, Review of Representation Agreements and Enduring Powers of Attorney (British Columbia: Ministry of Attorney General, 2002).

[117] *Representation Agreement Act*, *supra* note 17 s 5(1).

[118] *Advance Health Care Directives Act*, supra note 19 at s 3(1).

[119] *Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001 [*Health Care Directives Act*]; In Saskatchewan, the *Powers of Attorney Act*, 2002, S.S. 2002, c. P-20.3 does not apply to health care directives, and health care directives and wills are excluded from the application of the *Electronic Information and Documents Act*, 2000, S.S. 2000, c. E-7.22.

proxy directives can be used. Health care directives in PEI were developed primarily for end-of-life decision-making, which is clear from the legislation stating that notwithstanding any instructions in the directive a physician may prescribe medication to reduce pain and suffering.[120] In Manitoba, both proxy and instructional directives are permitted under the *Health Care Directives Act* where the maker of a directive can either express their health care decisions or appoint a proxy to make such decisions.[121] Nova Scotia recently repealed the *Medical Consent Act*, which allowed for proxy directives (termed an authorization),[122] and replaced this with the *Personal Directives Act* to permit both instructional and proxy directive legislation.[123]

Other jurisdictions have legislation enabling only proxy directives, although this does not necessarily prohibit one from writing detailed instructions in a living will. For example, Ontario's *Substitute Decisions Act* allows proxy directives to be completed as a POA for personal care,[124] but there is nothing prohibiting someone from drafting it in the form of a living will. Although a POA for personal care can include which decisions the attorney is authorized to make,[125] the document is essentially a proxy directive.[126] Under the *Infirm Persons Act* in New Brunswick, POA for personal care are proxy directives,[127] with no legislation recognizing living wills. The person who completes a POA for personal care is termed a principal[128] and the individual making decisions is the proxy.

---

[120] *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 1988, c. C-17.2, s 29 [*Consent to Treatment and Health Care Directives Act]*.

[121] *The Health Care Directives Act*, C.C.S.M. c. H27, s 5 [*Health Care Directives Act*]; It appears that few Manitobans have actually completed a health care directive, see Manitoba Law Reform Commission, Substitute Consent to Health Care (Manitoba: Law Reform Commission, 2004) at 11.

[122] *Medical Consent Act*, R.S.N.S. 1989, c. 279, s. 1.

[123] *Personal Directives Act*, S.N.S. 2008, c. 8 [*Personal Directives Act*].

[124] *Substitute Decisions Act*, *supra* note 16; See *Dunbrack, supra* note 5 at 26.

[125] *Substitute Decisions Act*, *supra* note 16 at s 46(7).

[126] *Dunbrack, supra* note 5.

[127] *Infirm Persons Act*, R.S.N.B. 1973, c. I-8 [*Infirm Persons Act*].

[128] *Dunbrack, supra* note 5 at 29 states that the term "donor" is used to refer to the person making a power of attorney, but the term appears to only be used in the *Mental Health Act* R.S.N.B. 1973, c. M-10, s 38 (3) and the *Property Act*, 1973, R.S.N.B., Chap – P 19, s 58.2 (1).

In Québec, mandates in case of incapacity are governed by the *Civil Code of Québec* (*CCQ*) where a mandator (grantor) can appoint a mandatary (agent) to make decisions regarding their personal care and/or administration of property.[129] As proxy directives, mandates are considered a contract[130] even if the mandatary is unaware such a document was completed.[131] Individuals cannot be forced to undergo care or treatment unless they provide their consent but if they are incapable, the mandatary will make decisions.[132] Article 12 of the *CCQ* provides that a person who provides consent be bound to act in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed.[133] The phrase "as far as possible" has been broadly interpreted as allowing for instructional advance directives.[134]

Yukon's legislation enables individuals to make proxy directives whereas instructional directives are not formally recognized.[135] Treatment plans in the Yukon are referred to as care plans under the *Care Consent Act*,[136] which are developed by a health care provider and detail health problems someone is likely to experience in the future and the possibility to withhold or withdraw health care.[137] A directive, on the other hand, names or appoints someone to give or refuse consent to care for a maker.[138] Representation agreements in the Yukon are unique in that they are not valid unless two representatives are appointed,[139] both of whom are required to provide a signed declaration of their relationship to the

---

[129] See arts 2130-2185 *C.C.Q.*, *supra* note 20; The mandator is the grantor who is completing the mandate and the mandatary is the agent who will make decisions for the mandator.
[130] Art. 2130 *C.C.Q*, *supra* note 20.
[131] Although it is preferable for a mandator to inform their mandatary that they have completed the document, it is possible for someone to download a mandate from the website of the Public Office of the Curator and after completing it have it signed and witnessed by two persons or by notarial deed. See art. 2166 *C.C.Q., supra* note 20; See also Katherine Brown & Erin Murphy, "Falling through the Cracks: The Québec Mental Health System" (2000) 45 McGill Law Journal 107-1079.
[132] Art. 11 *C.C.Q., supra* note 20.
[133] Art. 12, *C.C.Q., supra* note 20.
[134] Art. 12, *C.C.Q., supra* note 20; See also *Dying with Dignity*, supra note 13 at 30-31.
[135] *Dunbrack, supra* note 5.
[136] *Care Consent Act*, S.Y. 2003, c. 21, Sch. B, s 1 [*Care Consent Act*].
[137] *Ibid.*
[138] *Ibid.*
[139] *Decision-Making Support and Protection to Adults Act*, S.Y. 2003, c. 21, s 17(1) (a); Section 22 provides that a representation agreement can provide for an alternate representative to act in circumstances as specified in the agreement [*Decision-Making Support and Protection to Adults Act*].

individual stating their willingness to act and acknowledge their duties.[140] The Nunavut Government has not yet enacted advance directive legislation, and currently there is only a POA for property and financial matters pursuant to the *Powers of Attorney Act*.[141]

(b) Mental Capacity to Execute Advance Directive

Courts have held that individuals with mental illness can still maintain the testamentary capacity to make a will.[142] Similarly, there is a presumption that individuals with mental illness have the capacity to execute an advance directive. B.C.'s legislation provides that how an individual communicates is not grounds for deciding the person is incapable to understand how to make a representation agreement.[143] Capacity is not an all-or-nothing concept.[144] In B.C., adults can make representation agreements even though they may be incapable of making other contracts, or managing their health care, personal care, legal matters, financial affairs, business, or assets.[145] The test of capacity to complete a representation agreement is the ability to: (i) communicate a desire to have a representative help with making decisions; (ii) demonstrate choices and preferences and express feelings of approval or disapproval; (iii) recognize that the representative can make or stop making decisions or choices, and; (iv) have a relationship of trust with the representative.[146] Manitoba's legislation was originally designed with the aim of developing living will legislation to protect the wishes of competent individuals unable to make their own decisions.[147] As a

---

[140] *Ibid*, at s 17(2).

[141] *Powers of Attorney Act*, S.Nu 2005, c. 9.

[142] See *Re Weidenberger Estate (Re)* [2002] A.J. No. 1157; 2002 ABQB 861 where Justice Clark states, "The Court must afford the mentally ill the benefit of being treated with dignity and respect by allowing them the right to manage their own affairs to the extent to which they are capable."

[143] *Representation Agreement Act*, *supra* note 17 at s 3(2).

[144] Linda Ganzini et al., "Ten Myths about Decision-Making Capacity" (2004) 5:4 Journal of the American Medical Directors Association 263-267 [*Ganzini*].

[145] *Representation Agreement Act*, *supra* note 17 at s 8(1).

[146] *Ibid* at s 8(2); The *Adult Guardianship Act*, R.S.B.C. 1996, c. 6 s 3 also provides that until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care, health care, legal matters irrespective of way of communicating.

[147] See *Manitoba (Director of Child and Family Services) v. A.C.* [2007] M.J. No. 26; 2007 MBCA 9; The groundwork for the HCDA is found in Manitoba Law Reform Commission, *Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Manitoba: Law Reform

result, Manitoba's legislation gives substantial weight to decisions in a health care directive stating that they are as effective "as if the maker had capacity to make the decision."[148]

(c) Age of Maker/Agent

The age to complete an advance directive or to act as a substitute decision-maker can vary depending on the jurisdiction. In Alberta, adults who are 18 years or older are presumed capable of understanding the nature of making a personal directive.[149] In Manitoba, mentally capable individuals may complete a health care directive if they are 16 years old.[150] Similarly, individuals are required to be 16 years of age in Ontario,[151] PEI,[152] Saskatchewan[153] (where the proxy must be 18 years),[154] and the Yukon.[155] Manitoba and Saskatchewan's legislation is similar to Newfound and Labrador in that the maker of a directive must be 16 years old;[156] however, the substitute decision-maker in Newfoundland and Labrador is required to be 19 years old.[157] In the NWT, the *Personal Directives Act* permits a director who is 19 years of age to make personal decisions in a directive regarding treatment.[158] Québec has the lowest statutory age to complete a mandate, where individuals are required to be of "full age," which is 14 years.[159]

Commission, 1991) at 41 which recommended the law be reformed to create a mechanism that gives legal effect to the expression of future health care wishes in a situation where a previously capable person became incapacitated.

[148] *Health Care Directives Act*, *supra* note 121 at s 7(1).

[149] *Personal Directives Act*, *supra* note 18 at s 3(2).

[150] *Health Care Directives Act*, *supra* note 121 at s 4(2); See also section 12, which states that a proxy must be "apparently" mentally competent and at least 18 years of age.

[151] *Substitute Decisions Act*, *supra* note 16 at s 44.

[152] *Consent to Treatment and Health Care Directives Act*, *supra* note 120 at s 20(1).

[153] *Health Care Directives Act*, *supra* note 119 at s 3.

[154] *Ibid.* at s 9; Section 11 allows a proxy who is married to the person making the directive to be below the age of 18 if he or she is capable to make health care decisions.

[155] *Care Consent Act*, *supra* note 136 at s 27(1).

[156] *Advance Health Care Directives Act*, *supra* note 19 at s 7(b).

[157] *Advance Health Care Directives Act*, *supra* note 19 at s 3(2).

[158] *Personal Directives Act*, S.N.W.T. 2005, c.16 at s 1 [*Personal Directives Act*].

[159] Art. 14 *C.C.Q.*, *supra* note 20.

(d) Mental Capacity Assessments

Although it is not essential that a formalized capacity assessment be performed before completing a personal directive, individuals must nevertheless be mentally capable to ensure their document is valid. In Alberta, being mentally capable to make a personal directive is defined as "the ability to *understand* the information that is relevant to the making of a personal decision and the ability to *appreciate* the reasonably foreseeable consequences of the decision."[160] Alberta recently discontinued the process of having two physicians issue a certificate of incapacity for residents of facilities,[161] and established a new protocol whereby incapacity is determined using standardized assessment tools and a regulated form.[162] Individuals qualified to assess mental capacity can include physicians, nurses, psychiatric nurses, social workers, or occupational therapists.[163] One of the primary challenges in assessing capacity among individuals with mental illness is determining whether the maker suffers from fluctuating episodes of mental capacity. If this occurs in Alberta agents are required to consult with the service provider to determine whether there has been a "significant change" in the individual's mental capacity.[164] Health care providers in Alberta also have a continuing duty to make reasonable efforts to determine whether the maker of a personal directive lacks mental capacity *each time* before they offer a personal service.[165] In contrast to Alberta, there is no legislation in Québec defining mental capacity and judges make the final determination of whether someone will be declared mentally incapable.[166]

Some courts have adopted a competency test from advance directive legislation even where an advance directive was never completed. For example, in

---

[160] *Personal Directives Act, supra* note 18 s 1(b).

[161] Alberta Justice and Alberta Seniors Community Supports, *Legislative Review of the Dependents Adults Act and the Personal Directives Act: Stakeholder Consultations Summary* (January 2007) online: http://www.seniors.alberta.ca/services_resources/opg/leg_review/StakeholderConsultations.pdf [*Alberta Legislative Review*].

[162] *Ibid* at 14.

[163] *Ibid* at 15.

[164] *Personal Directives Act, supra* note 18 at s 10.1(1).

[165] *Ibid* at s 21 (1).

[166] Of course, as in other provinces, judges rely on the medical and psychosocial assessments of psychiatrists and other health professionals to determine whether someone is considered capable.

a case from Newfoundland and Labrador, *Eastern Regional Integrated Health Authority v. B.A.H.*,[167] a patient with mental illness refused to believe she had ocular melanoma that if left untreated would threaten her life, despite the diagnosis of two ophthalmologists. Although the patient had not completed an advance directive, the court recognized that individuals with mental illness have a right to assert their autonomy and self-determination to refuse treatment and relied upon the competency test found in the *Advance Health Care Directives Act*.[168] The court held that the competency test in the legislation should be applied because the statutory language was similar to that found in the Supreme Court's decision of *Starson v. Swayze*.[169] This is emblematic of the uncertainty among legal professionals of legislative definitions involving mental capacity.

Northwest Territories' legislation provides that a person is considered mentally incapable if two persons, either a medical practitioner or a psychologist, jointly or separately, assess the director and make a written declaration of incapacity.[170] In Ontario, individuals are considered incapable of personal care if they do not understand information relevant to making decisions concerning their health care, nutrition, shelter, clothing, hygiene, or safety, or cannot appreciate the reasonably foreseeable consequences of a decision or lack of decision.[171] Nova Scotia's legislation states that if someone has made a personal directive, and there is a reasonable belief the maker lacks the capacity to make a decision to leave the province, a police officer may use necessary and reasonable force to prevent the person from doing so until a capacity assessment has been completed.[172]

(e) Permissible and Prohibitive Instructions

The types of instructions that are permitted or prohibited in an advance directive differ across provincial and territorial legislation. For example, in Newfoundland and Labrador individuals are permitted to include instructions in

---

[167] *Eastern Regional Integrated Health Authority v. B.A.H. et al.*, [2007] N.J. No. 48; 2007 NLTD 30.
[168] *Advance Health Care Directives Act*, *supra* note 19 at s 14.
[169] *Starson*, *supra* note 40.
[170] *Personal Directives Act*, *supra* note 158 at s 9(2).
[171] *Substitute Decisions Act*, *supra* note 16 at s 45.
[172] *Personal Directives Act*, *supra* note 123 at s 11(1).

their advance health care directive regarding the disposition of their body after death,[173] an unusual provision given that legislation in other jurisdictions deals exclusively with treatment and personal care issues only while alive. In the NWT, individuals are prohibited from including anything in their personal directive related to transfer of property or management of financial affairs.[174] In PEI, individuals can authorize or refuse certain types of treatment, procedures, or medications; circumstances around experiencing a natural death; appointment of proxy; when the directive should spring into effect; or "any other directions concerning the health care or treatment of the maker."[175]

Québec law states that individuals are entitled to receive health and social services with continuity and in a personalized and safe manner that is scientifically, humanly, and socially appropriate.[176] Under Québec law an attending physician can transfer a patient to another institution he considers better able to meet the person's needs, but he must first obtain the person's consent and reason for the decision which must also be recorded in their medical file.[177] If individuals can make choices allowing them to participate in the development of their intervention or individualized service plans,[178] it follows that they could be permitted to make reasonable choices regarding treatment and hospitalization. Notwithstanding one's legal right to choose a health care professional or institution one wants,[179] honouring such choices will depend on institutional resources.[180]

In Alberta, the *Personal Directives Act* allows individuals to include instructions *and* to appoint an agent within a personal directive to ensure that the

---

[173] *Advance Health Care Directives Act*, *supra* note 19 at s 21(1); Many lawyers who assist their clients in drafting wills advise against including directions concerning how to dispose of bodily remains after death.

[174] *Personal Directives Act*, *supra* note 158 at s 5(2).

[175] *Consent to Treatment and Health Care Directives Act*, *supra* 120 at s 20(2).

[176] *An Act Respecting Health and Social Services*, R.S.Q. c. S-4.2, s 5 [*Health and Social Services Act*].

[177] *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or Others,* R.S.Q. c. P-38.001, s 11.

[178] *Health and Social Services Act, supra* note 176 at s 10.

[179] *Ibid*, s 4.

[180] *Ibid*, s 13.

instructions are followed in the event of mental incapacity.[181] A distinctive provision of Alberta's legislation is an explicit prohibition against including instructions dealing with assisted suicide or euthanasia.[182] Under B.C.'s *Representation Agreement Act*, adults can authorize a representative to refuse consent to health care treatment such as life-supporting care,[183] but cannot authorize their representative to refuse consent to professional services, care, or treatment under the *Mental Health Act* if the person is detained in a hospital.[184] Yet, under B.C.'s *Health Care and Care Facility Act*, mentally capable individuals have a right to provide or refuse consent on any grounds, including moral or religious factors, even if refusal will result in death.[185] Similarly, Yukon legislation allows mentally capable individuals to give consent or refuse consent on any grounds, moral or religious, "even if the refusal will result in death."[186]

(f) Wishes, Values, or Best Interests Hierarchy

A primary reason for promoting advance treatment plans is to give individuals the ability to express a wide range of choices that reflect their value of autonomy,[187] and to provide support networks to help them make decisions that

---

[181] *Personal Directives Act*, *supra* note 18; Prior to the *Personal Directives Act* becoming law, in *M.B. v. Alberta (Minister of Health)*, [1997] A.J. No. 649; 149 D.L.R. (4th) 363, the court stated that "when a mental health patient can neither express their consent nor their objection to a proposed course of treatment, that person should not be deemed to be objecting to the treatment…Where an individual objects to one form treatment, in this case electroconvulsive therapy, but prefers neuroleptic medication even though it carried side effects, health care providers must follow the wishes. The role of the courts to act in their *parens patriae* power should not be confused with a paternalistic role." The court added that, "where the treatment is invasive, and there are important side effects (either because they are very serious or because while not exceptionally serious they are permanent or long-lasting or psychologically discomforting, for example) the state should refrain from over-riding the mental health patient's objection to treatment."

[182] *Personal Directives Act*, *supra* note 18 at preamble.

[183] *Representation Agreement Act*, *supra* note 17 at s 9(1) (c).

[184] *Representation Agreement Act*, *supra* note 17 at s 11 (c).

[185] *Health Care and Care Facility Act*, *supra* note 111 at s 4(a).

[186] *Care Consent Act*, *supra* note 136 at s 3.

[187] *Alberta Legislative Review, supra* note 161; See Albert Law Reform Institute & The Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Health Care* (March 1993) online: http://www.law.ualberta.ca/alri/docs/fr64.pdf for an earlier report stating, "One of the principal aims of law in this area should be the protection and promotion of individual autonomy, dignity and self-determination, and this can be achieved by giving people greater control over decisions affecting their own healthcare after they become mentally incompetent."

enhance their self-determination.[188] However, honouring an individual's prior capable wishes and values needs to be balanced with providing treatment in the best interest of individuals. In Saskatchewan, the *Health Care Directives and Substitute Health Care Decision Makers Act* provides that a proxy must act according to a person's expressed wishes *or* their best interests.[189] The conjunctive nature of this provision differs from Ontario's *Health Care Consent Act* where one must *first* consider one's prior expressed wishes and then turn to the best interests test.[190]

In Alberta, an individual who makes a personal directive can appoint an agent to ensure that his or her personal instructions are followed as long as the agent is mentally capable.[191] Where there are no specific instructions in the personal directive, the agent can make decisions that he or she believes the maker would have made by first considering that person's *wishes, beliefs, and values*, and if these are unascertainable, the agent can make the decision in the person's best interests.[192] Health care providers must also follow any clearly stipulated wishes, beliefs, and values recorded in a personal directive,[193] even where they may be contrary to recommended treatment.[194] Generally, agents should not

---

[188] *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. 1996, c. V90 preamble; This *Act* differs from the *Mental Health Act* in that the latter applies to patients in psychiatric facilities, and where there is a conflict between Manitoba's *Mental Health Act* and *The Health Care Directives Act,* the latter will prevail, *ibid*, s. 3, 4.

[189] *Health Care Directives Act*, *supra* note 19 at s 12.

[190] See, for example, Ontario's *Health Care Consent Act*, 1996, S.O. 1996, c.2, Sch. A., s 21 [*Health Care Consent Act*].

[191] *Personal Directives Act, supra* note 18 at s 1; A personal matter is defined as a non-financial issue including health care, accommodation, with whom the person may live and associate, participation in social, educational and employment activities, or legal matters, see *Personal Directives Act, supra* note 18 at s 1(k.1) (l); An agent has limited powers to make decisions for an individual if they are incapable to make decisions regarding psychosurgery, sterilization, tissue removal, or experimental studies, see *Personal Directives Act*, supra note 18 at s 15.

[192] *Ibid*, at s 14 (3).

[193] *Ibid*, at s 19 (1).

[194] See *Sweiss v. Alberta Health Services*, [2009] A.J. No. 1303; 2009 ABQB 691, where the court found that even though a declaration made by the plaintiff did not meet the requirements of a personal directive pursuant to the *Personal Directives Act*, there was nevertheless a clear indication of the person's wishes. Justice Ouellette stated, "Thus, as the law currently stands, it appears that if a personal directive directs that all possible measures be taken to keep the patient alive, whether or not he is brain dead or no longer breathing on his own, the direction must be followed despite the fact that life support may be required for an indefinite period of time… In determining what is in the patient's best interest, consideration should be given to such matters as the patient's actual medical condition, the recommended treatment program, the patient's wishes

impose their own wishes, beliefs, and values in lieu of those of the maker. Nova Scotia's legislation states that a delegate should follow any instructions in a personal directive, *unless* circumstances would have caused the maker to set out different instructions had the circumstances been known based on the values and beliefs of the maker and any other written or oral instructions.[195]

In B.C., the appointed representative has an obligation to act in good faith and honestly[196] and is required to consult individuals' current wishes to the extent reasonable.[197] Where current wishes cannot be ascertained, or it is not reasonable to comply with them, the appointed representative must follow instructions or wishes expressed while capable.[198] If an individual's instructions are unknown, then the representative must act on the adult's known beliefs and values and, where these are unknown, in the adult's best interests.[199] B.C.'s legislation contains a unique provision whereby a monitor must be appointed in a representation agreement under certain situations[200] to ensure the representative complies with his or her duties.[201]

The primary aim of reforming Ontario's mental health legislation has been to preserve the value of patient autonomy.[202] Section 19(2) of the *Health Care Consent Act* (*HCCA*) allows a court to order treatment where it is satisfied that it will substantially improve the condition of a person or the condition is likely to deteriorate substantially or rapidly without treatment.[203] In *S.R. v. Hutchinson*,[204] an individual refused anti-psychotic medication and mood stabilizers on religious

---

and beliefs, and what is just and equitable. These factors should be weighed and balanced with a view to arriving at what is in the patient's best interest without any specific factor being determinative. Moreover, I do not purport to have created an exhaustive list of considerations, but rather a starting point for the analysis in these matters. Although I have held that no one factor should be treated as paramount, this conclusion may not apply where a valid personal directive exists which runs contrary to the proposed medical treatment program. In cases where a personal directive is found to exist, it would appear that, pursuant to the authority in the *Personal Directives Act*, the wishes, beliefs and values of the patient "must" be followed."

[195] *Personal Directives Act*, *supra* note 123 at 15 (2)(iii).

[196] *Representation Agreement Act*, *supra* note 17 at s 16(1).

[197] *Ibid*, at s 16(2).

[198] *Ibid*, at s 16(3).

[199] *Ibid*, at s 16(4).

[200] *Ibid*, at s 12(1).

[201] *Ibid*, at s 20(1).

[202] Michel Silberfeld, "Sacrificing Patient Autonomy?" (1995) 16:1 Health L Can 14-16.

[203] *Health Care Consent Act*, supra note 190 at s 19(2).

[204] *S.R. v. Hutchinson*, [2009] O.J. No. 516; 177 A.C.W.S. (3d) 499.

grounds requesting to remain in hospital, despite his attempts at suicide when not taking his medications. The lawyer representing the individual with mental illness argued that according to section 1 of the *HCCA* there was an obligation to enhance the patient's autonomy for which treatment was proposed,[205] while opposing counsel relied on section 19 to force treatment because it would improve his condition. The court ruled that although enhancing autonomy is one of the stated purposes of the *HCCA* it is not the sole purpose.[206] How, then, do courts evaluate the degree of an individual's autonomy, self-determination, or empowerment? In Québec, although the *CCQ* provides that a mandator can empower the mandatary with a mandate,[207] there is little discussion of how a mandator empowers him or herself to become an autonomous agent. Indeed, if someone comes under an institution of protective supervision Québec courts will consider, among other factors, the person's wishes expressed in a mandate and their degree of autonomy.[208] Yet, how courts evaluate autonomy is far from clear.

(g) Agents' Duty to Consult

In jurisdictions such as Alberta, agents have an ongoing duty to consult the maker of a personal directive regarding their decisions.[209] The duty to consult a maker, even when the individual may be mentally incapable, reflects a fundamental respect for the dignity of individuals. Agents in Alberta also have an obligation to provide a copy of a personal directive to the maker, the maker's lawyer and legal representative, or any other agent with decision-making authority.[210] In the NWT, a director can include decisions in a personal directive that reflect their values, beliefs, wishes, and instructions in the event of future incapacity.[211] The designated agent has a responsibility to make every reasonable

---

[205] *Ibid*.

[206] *Ibid*.

[207] Art. 2130 *C.C.Q., supra* note 20.

[208] Art. 276 *C.C.Q., supra* note 20; The template for mandates in case of incapacity that are provided on the website of the Office of the Public Curator specifically refer to the relationship between autonomy and partial incapacity.

[209] *Personal Directives Act, supra* note 18 at s 13.

[210] *Ibid*, at s 17(1) (2).

[211] *Personal Directives Act, supra* note 158 at s 5(1).

effort to notify the director's nearest relative,[212] and before an agent makes a personal decision they have a 'best efforts' duty to consult with the director regarding the decision and are permitted to seek advice and assistance from others.[213] Agents in the NWT are obligated to keep a record of all decisions made under the personal directive for at least two years.[214] Where an individual in Saskatchewan lacks the mental capacity to make a health care decision and is a member of a religious group prescribed in the regulations,[215] an ecclesiastical member of the group can make decisions for the person if he or she has not included instructions in their directive, has not appointed a proxy, or the proxy is unwilling or unavailable to act.[216]

In the Yukon, supported decision-making agreements allow individuals to appoint trusted friends or relatives to act as associate decision-makers to express decisions, obtain and explain relevant information, ascertain wishes, and ensure that decisions are implemented.[217] These types of agreements allow individuals to describe the nature of their difficulty to communicate decisions, to name someone as associate decision-maker, and to detail which decisions one is authorized to make.[218] There is an obligation to consult individuals regarding their current wishes in the Yukon,[219] although representation agreements cannot be used to authorize a representative to give or refuse consent to care within the meaning of the *Care Consent Act*.[220] Consequently, if individuals' current wishes cannot be determined representatives must comply with instructions or wishes expressed in the representation agreement[221] and, if these are unknown, to the individual's beliefs and values followed by a decision in their best interests.[222]

---

[212] *Ibid*, at s 9(4).
[213] *Ibid*, at s 15(1).
[214] *Ibid*, at s 17(1).
[215] *Health Care Directives and Substitute Health Care Decision Makers Regulations*, R.R.S. c. H-0.001 Reg. 1, s 3.
[216] *Health Care Directives Act*, *supra* note 119 at s 17.
[217] *Decision-Making Support and Protection to Adults Act*, *supra* note 139 at ss 4, 5, 6.
[218] *Ibid*, at s 9(1).
[219] *Ibid*, at s 23(1).
[220] *Ibid*, at s 15(3).
[221] *Ibid*, at s 23(3).
[222] *Ibid*, at s 23(4).

(h) Obtaining Legal Advice

Some jurisdictions require individuals to obtain legal advice before completing an advance directive. For example, representation agreements in B.C. allow adults to appoint a representative with standard powers, and legal consultation to complete the document is not required.[223] However, provisions giving representatives additional powers are referred to as a section 9 representation agreement and a lawyer needs to be consulted.[224] A section 9 agreement is considered invalid unless the maker has consulted a lawyer who is bound to issue a certificate.[225] In New Brunswick, a POA for personal care is given under seal, which suggests that a lawyer may be required.[226] Health care directives in PEI also require certification of a lawyer.[227] It is not obligatory to have a lawyer assist in making a health care directive in Saskatchewan, however if a lawyer has done so he or she has a professional obligation to ensure it is kept in a safe location.[228]

In Québec, if a mandator becomes mentally incapable the mandatary is obligated to have the court homologate the mandate,[229] which involves a judge granting an order declaring the person truly incapable. Although lawyers are often required for the homologation procedure, it is not necessary for a lawyer or notary to assist in completing the mandate if two witnesses were present for the signing of the document. A distinctive feature of directives in the Yukon is that a proxy or proxies are required to sign them.[230] The maker of a directive in the Yukon could include in it that if he or she became mentally incapable the appointed proxy can physically restrain or manage him,[231] with the caveat that they have first consulted

---

[223] *Representation Agreement Act*, *supra* note 17 at s 7. The kinds of decisions that can be included into a section 7 representation agreement include personal care, financial affairs, major and minor health care, and legal services.

[224] *Ibid*, at s 9.

[225] *Ibid*, at s 9(2).

[226] *Infirm Persons Act*, *supra* note 127 at s 40(1).

[227] *Consent to Treatment and Health Care Directives Act*, *supra* note 120 at s 34(3).

[228] *Rault v. Law Society of Saskatchewan*, [2009] S.J. No. 436; 2009 SKCA 81.

[229] Art. 2166 *C.C.Q.*, *supra* note 20.

[230] *Care Consent Act*, *supra* note 136 at s 28(1) (e).

[231] *Ibid*, at s. 30(1) (a).

and obtained legal advice from a lawyer or a member of the Law Society.[232] In turn, Yukon lawyers must provide a certificate of legal advice.[233]

(i) Conformity with Statutorily Prescribed Forms from Other Jurisdictions

Completing an advance directive according to the statutorily prescribed form in one's jurisdiction does not mean that it will always be accepted in other jurisdictions. Some jurisdictions have included provisions in their legislation to account for the possibility of inter-jurisdictional travel. In Manitoba, there is no mandatory prescribed form required.[234] Similarly, a POA for personal care in Ontario does not require it to be in a prescribed form.[235] Nova Scotia's legislation accepts advance directives if they were made outside of the province according to their governing legislation.[236] Individuals who reside outside of Alberta can complete an advance directive with the assurance that the *Personal Directives Act* will uphold the document as valid, given that it complies with formal requirements of a personal directive.[237] Similarly, directives made outside of the Yukon are deemed valid only if they are made pursuant to the governing legislation;[238] directives may be in the prescribed form but it is not mandatory.[239] In PEI, advance directives made extra-provincially will be recognized as long as they meet the formal requirements of the governing legislation or were established under legislation where the directive was made.[240]

(j) Multiple Advance Directives and Proxies

Another challenging issue can arise if there is more than one advance directive. Alberta's legislation is unique in that it allows a single individual to

---

[232] *Ibid*, at s 30(2) (a).
[233] *Ibid*, at s 30(2) (b).
[234] *The Health Care Directives Act*, *supra* note 121 at s 11.
[235] *Substitute Decisions Act*, *supra* note 16 at s 46(8).
[236] *Personal Directives Act*, *supra* note 123 at s 24.
[237] *Personal Directives Act*, supra note 18 at s 7.3.
[238] *Care Consent Act*, *supra* note 136 at s 34.
[239] *Ibid*, at s 36.
[240] *Consent to Treatment and Health Care Directives Act*, *supra* note 120 at s 34(1); For example, PEI would recognize a health care directive made in Ontario if it is certified by a lawyer whereas Ontario may only recognize a directive made in PEI if it follows its own prescribed regulations.

create more than one personal directive.[241] Caution is required with this approach because two personal directives can create the potential to frustrate a maker's wishes if conflicting instructions are included in each.[242] In Nova Scotia, individuals are permitted to make more than one personal directive but if they cannot be reconciled, the latter will prevail.[243] Individuals in Nova Scotia can also combine a personal directive with a POA into a single document,[244] which is similar to the NWT where a personal directive can be combined with a POA for property and finances into a single document.[245] In New Brunswick, a POA for personal care and a POA for financial matters can be in two separate documents or integrated as one.[246]

Occasionally individuals want to appoint more than one person to act as an agent on their behalf. In BC, for example, individuals can assign more than one representative as long as each person has authority over different areas.[247] This is similar to the Yukon where it is possible to appoint more than one proxy in a directive as long as each person has different authority.[248] However, New Brunswick's legislation does not allow a principal to name more than one proxy.[249] Saskatchewan's legislation allows two proxies to act either successively or jointly[250] and where a majority decision cannot be reached, the proxy appointed first in the directive makes the decision.[251]

---

[241] *Personal Directives Act*, supra note 18 at s 6; *Dunbrack*, *supra* note 5.

[242] See *Serdahely Estate (Re)*, [2005] A.J. No. 1620; 2005 ABQB 861, where the doctrine of frustration is discussed in the context of someone completing a will, enduring power of attorney, and personal directive. The court mentions that it is commonplace for these documents to be executed at the same time yet there is no support for the proposition that if one of the documents does not succeed the others become inoperative; See also *Bolt v. Popke*, [2003] A.J. No. 613; 2003 ABCA 156 where the issue was whether a personal directive was connected to a second will.

[243] *Personal Directives Act*, *supra* note 123 at s 4(1)(2).

[244] *Ibid*, at s 23.

[245] *Personal Directives Act*, *supra* note 158 at s 7.

[246] *Infirm Persons Act*, *supra* note 127 at s 41.

[247] *Representation Agreement Act*, *supra* note 17 at s 5(2).

[248] *Care Consent Act*, *supra* note 136 at s 32(3).

[249] *Dunbrack*, *supra* note 5 at 35.

[250] *Health Care Directives Act*, *supra* note 119 at s 13.

[251] *Ibid at* s 13(3).

(k) Override Principle

In Alberta, courts have overridden an agent's authority in a personal directive if the agent was no longer mentally capable to assume the role.[252] Before the *Personal Directives Act* was enacted in Alberta, it was less clear to what extent individuals could refuse treatment such as electroconvulsive therapy and whether doctors were required to honour such wishes;[253] however, the Supreme Court's decision in *Starson* allows for refusal of treatment rights to be interpreted broadly.[254] If an individual is in an emergency and it is not possible to locate an advance directive in sufficient time, health care providers may be permitted to provide emergency care without the individual's consent if necessary to preserve life.[255] However, if the advance directive can be located the ability to override prior competent wishes is much more limited. Section 50 of Ontario's *Substitute Decisions Act* contains a strong anti-override provision allowing individuals to strengthen their resolve in a POA for personal care in what is commonly known as a Ulysses clause where individuals can self-bind to earlier instructions.[256] There are very few provisions in Canadian mental health legislation that are quite as explicit in promoting autonomy as a section 50 Ulysses clause.

(l) Good Faith and Professional Immunity Clauses

Alberta's legislation provides that an individual cannot commence an action against an agent for an action or omission if it was done in good faith.[257] However, if an agent wilfully destroys, conceals, or alters a personal directive, without the consent of the maker, they may be liable to a fine of $10,000.[258] The fine for persons in Saskatchewan is $1000 and/or imprisonment for three months

---

[252] *S.C. v. M.B.*, [2008] A.J. No. 1093; 2008 ABCA 336.

[253] See *M.B. v. Alberta (Minister of Health)*, [1997] A.J. No. 649; 149 D.L.R. (4th) 363 where the court states that even if the *Personal Directives Act* was proclaimed into force and the patient had objected to the use of electroconvulsive therapy it is not clear that her wishes would have been respected.

[254] *Starson*, *supra* note 40.

[255] *Care Consent Act*, *supra* note 136 at s 21(1).

[256] *Substitute Decisions Act*, *supra* note 16 at s. 50. See also, D. Winninger & L. Pineau, "Incapacity and Autonomy: Striking a Balance" (1995) 15:3 Health L Can 59-64. *Dunbrack*, *supra* note 5 at 26.

[257] *Personal Directives Act*, *supra* note 18 at s 28(1).

[258] *Ibid*, at s 31.

if they wilfully conceal, obliterate, damage, alter, falsify, or forge a directive.[259] Additionally, coercing or unduly influencing someone in Saskatchewan to make a directive carries a similar offence.[260] In Newfoundland and Labrador, the *Act* provides that anyone who wilfully conceals, obliterates, damages, alters, falsifies, or forges an advance health care directive is guilty of an offence.[261] In the Yukon, an associate decision-maker will not be held liable for injury, death, or financial loss if he or she acts in good faith and in the best interests of the adult with the care, diligence, and skill of a reasonably prudent person.[262] Unlike supported decision-making agreements, representation agreements are also used in the Yukon to allow "two or more trusted friends or relatives" to make limited decisions regarding personal care or financial matters.[263]

Saskatchewan's legislation incorporates an immunity clause that no liability can be attached to a treatment provider who, acting in good faith, provides or refrains from providing treatment contrary to a health care directive if they did not know it existed or believed it was revoked.[264] A similar provision is found in Nova Scotia's legislation that no action lays against a health-care provider if they did not know of the existence of the personal directive.[265] In other jurisdictions, such as New Brunswick and Québec, the legislation does not offer protection for health care providers against potential lawsuits who make treatment decisions even if done in good faith.

(m) Inquiry into Existence of Advance Directives

The legal standard for whether clinicians must inquire if an advance directive exists varies across jurisdictions. In the NWT, health care providers must make reasonable efforts to determine if a personal directive was made, obtain a copy of it, and determine whether it is valid before assisting the director in

---

[259] *Health Care Directives Act*, *supra* note 119 at s 24(1).
[260] *Ibid*, at s 24(2).
[261] *Advance Health Care Directives Act*, *supra* note 19 at s 24; unlike other jurisdictions, the legislation does not provide what the punishment is for such offences.
[262] *Decision-Making Support and Protection to Adults Act*, *supra* note 139 at s 13(1).
[263] *Ibid*, at s 14.
[264] *Health Care Directives Act*, *supra* note 19 at s 22(1).
[265] *Personal Directives Act*, *supra* note 123 at s 20.

making a decision.[266] They also have an obligation to identify the agent,[267] follow any relevant instructions included in the document,[268] and make reasonable efforts in determining whether the director continues to lack capacity.[269] If the directive does not contain relevant instructions, or a copy is not reasonably available in an emergency, health care providers can provide necessary medical services.[270] Health care practitioners in PEI are also required to make reasonable inquiries into whether a health care directive exists,[271] although they may be more likely to inquire into who will make decisions for the person.[272]

Newfoundland and Labrador's legislation provides that health care professionals must make reasonable attempts to determine whether a patient has an available substitute decision-maker,[273] but does not impose an obligation upon health care professionals to ask whether a directive exists. Individuals who make health care directives have an obligation to ensure the documents are known to health care professionals.[274] Only where someone is mentally incapable upon admission to a facility are health care professionals required to make reasonable inquiries into the existence of a document.[275] In Manitoba, there is no onus on clinicians to inquire into the existence or revocation of a directive.[276] This position is reinforced by the *Mental Health Act*, which states that there is no obligation on physicians to inquire if patients have appointed a proxy or completed a health care directive.[277] The rationale for not inquiring into the existence of a health care directive is difficult to understand, particularly given that courts will inquire into whether one was made.[278] Nova Scotia has adopted a

---

[266] *Personal Directives Act*, *supra* note 158 at s 19.
[267] *Ibid*, at s 19(2).
[268] *Ibid*, at s 21.
[269] *Ibid*, at s 22(1).
[270] *Ibid*, at s 24(1).
[271] *Consent to Treatment and Health Care Directives Act*, *supra* note 120 at s 23.
[272] *Ibid*, at s 11(2).
[273] *Advance Health Care Directives Act*, *supra* note 19 at s 9(1).
[274] *Ibid*, at s 18(1).
[275] *Ibid*, at s 18(2).
[276] *The Health Care Directives Act*, *supra* note 121 at s 21.
[277] *Mental Health Act*, C.C.S.M. c. M110, s 28(8).
[278] *Ibid*, at s. 75(4).

position that health care providers must inquire whether a directive was made,[279] however in an emergency they would not be required to obtain information from their delegate or decision-maker.[280]

II. Mental Capacity and Competence

Although mental capacity and competence are terms often used interchangeably, and on the surface may appear identical, they could be treated differently from a legal perspective.[281] Mental capacity assessments are conducted by qualified health professionals to examine the degree of individuals' cognitive abilities. Competence, on the other hand, is assessed by judges who, after reviewing legislative standards and the capacity assessments performed by mental health professionals, arrive at a retrospective decision of whether someone has met the legal test of competency.[282] The capacity/competence distinction has been acknowledged by Manitoba's Law Reform Commission.[283] A recent report prepared for the Law Commission of Ontario also refers to the cognitive aspects of making capable decisions as "mental capacity" and the legal determination as "legal capacity."[284] Arbolda-Florez & Weisstub describe the distinction as one where "[a] determination of *capacity* is a *medical act*. However, the factor taken into account most often when considering the mentally disordered is competency, which involves the ability to understand and appreciate the nature and consequences of one's decisions. *Competence* is a *legal categorization*."[285] In the

---

[279] *Personal Directives Act*, *supra* note 123 at s 18(1).
[280] *Ibid*, at s 19.
[281] Dallas M. High, "Surrogate Decision Making. Who Will Make Decisions For Me When I Can't?" (2004) 10:3 Clinics in Geriatric Medicine 445-462.
[282] See Jessica Wilen Berg, Paul S. Appelbaum, & Thomas Grisso, "Constructing Competence: Formulating Standards of Legal Competence To Make Medical Decisions" (1996) 48:2 Rutgers L Rev 345 at 348 where the authors state, "Competence is a legal construct: in most jurisdictions only a court can decide if a person is incompetent. Assessments of capacity, on the other hand, are relegated to medical or mental health professionals."
[283] Manitoba Law Reform Commission, Substitute Consent to Health Care (Manitoba: Law Reform Commission, 2004) at 2.
[284] *Bach*, *supra* note 63 at 15-16.
[285] J. Arboleda-Florez & D. N. Weisstub, "Ethical Research with Vulnerable Populations: The Mentally Disordered" in D. N. Weisstub (ed), *Research on Human Subjects: Ethics, Law, and Social Policy* (Oxford: Pergamon, 1998) at 433.

following section, the two processes associated with each term are discussed further.

A. Mental Capacity: Objectivity and Reliability

Being in a state of mental incapacity can be a rollercoaster experience for individuals with mental illness, which makes the evaluation process difficult for mental health professionals.[286] In the early English case of *Banks v. Goodfellows,*[287] the court considered what degree of mental disturbance would be necessary to negate the testamentary capacity of someone to make a will. The testator was in a mental hospital because he experienced delusions but wanted to make a will nevertheless. The court found that although the testator suffered delusions at the time of executing his will they had no influence on him in disposing his property, based on a distinction the court drew upon between total and partial unsoundness of mind. Deciding if someone was influenced by delusions at the time of making a will requires that all the circumstances be considered;[288] delusions alone may not influence a testator's will.[289]

Similarly, having a mental disorder does not preclude someone from the ability to provide consent or refuse treatment.[290] Although mental illness can

---

[286] *Appelbaum, supra* note 99; *Ritchie, supra* note 10.
[287] *Banks v. Goodfellows*, 1870 L.R..5 Q.B. 549; For a discussion of situation-specific factors that are relevant to assess testamentary capacity and the role of expert assessors in line with *Banks v. Goodfellows*, see Kenneth I. Shulman, Carole A. Cohen & Ian Hull, "Psychiatric Issues in Retrospective Challenges of Testamentary Capacity" (2005) 20:1 International Journal of Geriatric Psychiatry 63-69.
[288] *Ouderkirk v. Ouderkirk*, [1936] S.C.R. 619; S.C.J. No. 42.
[289] *O'Neil v. Brown Estate*, [1946] S.C.R. 622; S.C.J. No. 31; See also *Pike v. Stone*, [1999] N.J. No. 217 where a patient in a mental hospital suffering from chronic paranoid schizophrenia wanted to make a will. His psychiatrist assessed his competency and found that he understood the purpose of the interview while on the same day he manifested bizarre behaviour. A solicitor later met with the patient to take instructions to complete a will and was satisfied that he understood the nature of the will, which was contested 10 years later by the now deceased's brother. Despite the behaviour of the patient, the court held that at the time the testator had testamentary capacity to execute a valid will.
[290] *See Starson, supra* note 40; *Crewe (Re),* 2007 NSSC 322; See also, *Strong (Re)* [1993] N.J. No. 83 where the court distinguishes the 'substituted judgment' test from the 'best interests' test which is a more paternalistic approach. Green J. cites the Supreme Court's decision in *Eve* as having rejected the substituted judgment test stating, "In every case, therefore, the pre-condition to the exercise of jurisdiction that will result in an interference with the principles of autonomy and self-determination should only be made when it has been established that the person for whom the decision is proposed to be made does not have the ability to appreciate and understand the medical

vitiate one's level of mental capacity to process information, many individuals are still able to make rational[291] and independent choices.[292] The clinical standard of mental capacity is always context-dependent,[293] and never all-or-nothing.[294] Non-compliance to treatment, on its own, is also not evidence of mental incapacity although it may signal the need to perform a capacity assessment.[295] Reasons for noncompliance to treatment can be due to sides of effects of medication; the expense of paying for treatment; value judgments based on cultural and religious beliefs; or coping styles associated with denial of mental illness. Nevertheless, if noncompliance with treatment appears to be related to an underlying mental disorder there is a need to conduct a formal capacity assessment. Similarly, a persistent refusal to take anti-psychotic medications is not necessarily a manifestation of mental illness or reflective of a choice made due to psychosis.[296] A psychotic break may erode one's ability to think clearly but it can also leave one's perception of autonomy untouched.[297] Awareness and insight are often required to make independent choices.[298] When there is a decline in mental capacity, the primary purpose of providing medication is to restore that person's capacity.[299] Medication is perhaps wrongfully, in many cases, used for other

---

condition being experienced, the treatment options available (including the option of non-treatment) and the risks inherent in the choices of those various options."

[291] George J. Annas & Joan E. Densberger, "Competence to Refuse Medical Treatment: Autonomy vs. Paternalism" (1984) 15:2 U Tol L Rev 561-596 [*Annas*]; Bruce J. Winick, "Competency to Consent to Treatment: The Distinction Between Assent and Objection" (1991) 28:1 Hous L Rev 15-61 [*Winick*].

[292] Dan W. Brock, "Precommitment in Bioethics: Some Theoretical Issues" (2003) 81:7 Tex L Rev 1805-1821 [*Brock*].

[293] See *A.B. v. C.D.* [2009] B.C.J. No. 914; BCCA 200 where the court held that the standard of capacity to leave a marriage when it appears that the individual is suffering from a delusional disorder is not identical to the capacity to manage one's own affairs or instruct counsel. The Court of Appeal endorsed the partner's right to leave the marriage on the basis that she had the personal autonomy to make her own decision.

[294] *Ganzini, supra* note 144.

[295] *Brock, supra* note 292.

[296] Harold I. Schwartz, William Vingiano & Carol Bezirganian Perez, "Autonomy and The Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication" (1998) 39:10 Hospital & Community Psychiatry: A Journal of the American Psychiatric Association 1049-1054.

[297] *Ibid*.

[298] Matthew Hotopf, "The Assessment of Mental Capacity" (2005) 5:6 Clinical Medicine 580-584 [*Hotopf*].

[299] Thomas G. Gutheil & Paul S. Appelbaum, "The Substituted Judgment Approach: Its Difficulties and Paradoxes in Mental Health Settings" (1985) 13:2 Law Medicine & Health Care 61-64.

purposes such as control or reduction of risky behaviour. What effect does forced treatment, even where it restores mental capacity, have on an individual's perception of autonomy? This is perhaps a question for further empirical research. However, as Bernard Dickens has stated, "Patients should not be considered incompetent simply because they adopt inappropriate choices or directives that seem out of character" and "autonomy imports the power to exercise badly."[300]

If mental capacity assessments are performed in a valid and reliable manner, courts will be better able to ensure the tests of legal competence are met.[301] As one judge stated, "It is important to resist the temptation to order an assessment based on the argument 'it can't hurt.' It can hurt. Privacy and freedom from coercive interference with one's physical and mental autonomy are core values of Canadian society."[302] Some clinicians have relied on hunches, intuitions, and vague recollections of conversations with clients to determine one's mental capacity. In *Petrowski*, the court heard from a mental health expert who stated there is a need to look at both internal and external consistency factors when conducting capacity assessments.[303] Internal consistency, according to the expert, refers to the ability to make the same choice over time, whereas external consistency is the relationship between choices, values, and goals more broadly.[304] Often, it is difficult to know whether capacity assessments have criterion validity,[305] yet if an assessment measures what it intends to then it is said to have face validity. If the assessment correlates with cognitive impairment then it has predictive validity.[306] Although some guidelines were developed in 1993 to distinguish if someone has mental capacity to complete an advance directive from consent to treatment and capacity to make a will,[307] it may be necessary to generate current empirical research based on broader consensus.

---

[300] *Dickens, supra* note 6.
[301] *Kischer v. Kischer* [2009] O.J. No. 96.
[302] *Ibid.*
[303] *Petrowski v. Petrowski*, [2009] A.J. No. 353 [*Petrowski*].
[304] *Ibid.*
[305] *Hotopf, supra* note 298.
[306] *Ibid*.
[307] M. Silberfeld, C. Nash & P. A. Singer, "Capacity to Complete an Advance Directive" (1993) 41:10 Journal of the American Geriatrics Society 1141-1143.

B. Legal Competence: Role of Judges

Unlike mental capacity, which is not an all-or-nothing concept, legal competence is a binary decision made by judges who interpret legislation. After judges review the capacity assessments performed by mental health professionals and the relevant legislative criteria to determine legal competence, their judicial decision is otherwise final under the law. Some judges may be inclined to make this assessment based only on an individual's outcome, status, or functioning.[308] They should instead examine the *process* of how individuals actually made their decisions, rather than rely exclusively on an outcome standard based on the content of one's choice.[309] Competence assessments by judges are inevitably a normative decision embedded with cultural, social, political, and legal values.[310] Essentially, when judges declare someone legally incompetent they are retrospectively examining prior evaluations of mental capacity and determining whether these evaluations should be upheld as a matter of law.

Experts are occasionally relied upon to assist judges to determine if someone had mental capacity at the time of making a decision. Although experts can provide opinion evidence from a clinical perspective on how mental capacity should be assessed, they are not permitted to determine whether a lawyer fulfilled their responsibility in determining a client's testamentary capacity.[311] Some experts have argued that elderly persons who score above a certain threshold on a cognitive impairment questionnaire are mentally capable to complete an advance directive.[312] In *Petrowski*, the court stated that "precisely because persons of advanced years are not as 'sharp' as they were when they were younger, the court must be very careful not to presume loss of testamentary capacity simply because

---

[308] *Annas, supra* note 291.

[309] Dan W. Brock, "Surrogate Decision Making for Incompetent Adults: An Ethical Framework" (1991) 58:5 The Mount Sinai Journal of Medicine 388-392, 398-402.

[310] *Winick, supra* note 291.

[311] *Petrowski, supra* note 303.

[312] See *Canada (Minister of Citizenship and Immigration) v. Fast* [2001] F.C.J. No. 1730 where the expert doctor's opinion was that completing an advance directive is a more complex task than standing trial. The court did not agree stating, "It appears that completing an advance directive requires the subject to learn about various medical procedures and the effects of accepting or refusing such treatment, in light of various medical conditions."

they are frailer."[313] Where individuals with mental illness cannot recognize that their views are the delusional manifestations of their mental condition, courts are likely to find the person legally incompetent.[314] Ironically, however, if that same individual recognizes and firmly asserts that his or her views may be objectively real delusions, but then states that he would prefer to live in that state rather than receive treatment this would qualify as evidence of mental capacity.[315]

III. Accessing Advance Directives

A. Access through Electronic Registries

As noted earlier, mental health legislation in some jurisdictions obligates physicians to include the nature and extent of someone's incapacity in a patient's medical record,[316] and if an advance directive is found it too should be included in the medical file.[317] In many cases, advance directives are not retrieved quickly enough, if at all. If emergency physicians do not inquire or obtain access to a copy of an advance directive during an emergency, they are permitted to provide treatment in the individual's best interests[318] but at the risk of contravening that person's fundamental values and beliefs. This raises one of the main barriers in implementing advance directives – how to access the documents in a crisis when individuals require them the most.[319] Some have expressed legitimate concerns that if advance directives are not accessible by physicians during an emergency they will not be of much help.[320] Similarly, any efforts to help individuals complete such documents will be pointless if they are kept in a locked vault or

---

[313] *Petrowski, supra* note 303 at par 292.
[314] *Afemui v. Pearce*, [2009] O.J. No. 2397.
[315] *Ibid.*
[316] *Advance Health Care Directives Act*, *supra* note 19 at s 15(1).
[317] *Ibid*, s 17.
[318] *Malette, supra* note 52.
[319] Robert E. Astroff, "Who Lives, Who Dies, Who Decides?: Legal and Ethical Implications of Advance Directives" (1997) 7 Windsor Rev Legal Soc Issues 1-33 [*Astroff*]; *Scheyett, supra* note 22; Richard A. Van Dorn et al., "Clinicians' Attitudes Regarding Barriers To The Implementation of Psychiatric Advance Directives" (2006) 33:4 Administration and Policy in Mental Health and Mental Health Services Research 449-460 [*Van Dorn*].
[320] *Clough, supra* note 105; John Monahan et al., "Mandated Community Treatment: Beyond Outpatient Commitment" (2001) 52:9 Psychiatric Services 1198-1205 [*Monahan*].

cabinet where no one knows they exist.[321] Some suggest keeping a wallet-sized document on their person;[322] others have recommended encoding scanned information on health cards.[323] These steps, although positive, will not guarantee that the document will be found in a crisis.

One approach to address the access issue is to use a centralized web-database or electronic registry that could store, retrieve, and disseminate advance directives.[324] One example is the U.S. Living Will Registry© that maintains a database that stores advance directives, organ donor information, and emergency contact information, which are accessible to health care providers through a 24-hour automated computer-facsimile system.[325] There is a one-time fee for lifetime membership to register the documents, and health care providers can receive the information quickly upon the consent of treatment providers or agents. Registrants receive annual updates to ensure their advance directive remains current, which becomes a useful reminder to update one's medication and treatment preferences.

In Canada, a national web-based resource center or central clearinghouse for advance care planning documents has been recommended in a report by Health Canada.[326] In Québec, the local Bar Association and Chamber of Notaries have created a registry to store mandates in case of incapacity after they have been homologated.[327] The mandate itself is not stored in the registry and the Public Curator only keeps a register of all homologated mandates,[328] which indicates the name of the testator or grantor, occupation, address, date, and lawyer's contact

---

[321] Elizabeth Ann Rosenfeld, "Mental Health Advance Directives: A False Sense of Autonomy for the Nation's Aging Population" (2001) 9 Elder LJ 53-81.

[322] *Malette, supra* note 52.

[323] *Astroff, supra* note 319.

[324] *Scheyett*, *supra* note 22; David N. Weisstub & Anne Moorhouse, "Advance Directives For Research: Ethical Guidelines" (1996) 17:1 Health L Can 3-10; Patricia Backlar, "Anticipatory Planning For Psychiatric Treatment Is Not Quite The Same As Planning For End-Of-Life care" (2004) 33:4 Community Mental Health Journal 261-268; See also *Dunbrack, supra* note 5.

[325] US Living Will Registry® (November 27, 2010), online: US Living Will Registry® http://www.uslivingwillregistry.com/.

[326] *Dunbrack, sup*ra note 5.

[327] See the Registres des dispositions testamentaires et des mandats du Québec (November 27, 2010), online: Registres des dispositions testamentaires et des mandats du Québec http://www.rdtmq.org where there is a fee of approximately $40 (plus tax) to perform the search in the registry.

[328] *Public Curator Act*, R.S.Q. c. C-81 at s 54.

information.[329] The drawback of Québec's registry system is that mandates are only accessible after they have been homologated, which can take several months. Additionally, the registry was not designed for treatment providers to obtain mandates during the type of crises that would be relevant to individuals with mental illness.

In 2008, the Alberta Government developed a registry system for individuals to store personal directives voluntarily and at no cost.[330] The *Personal Directives Act* provides that if a personal directive or agent cannot be found in an emergency, or if a personal directive does not provide specific instructions on how to deal with a situation, health care practitioners can provide emergency medical services without the maker's consent.[331] Downie & McEwen provide a legal definition of an emergency as, "situations in which treatment is immediately necessary to preserve the life or health of the patient and the patient (or surrogate) is unable (or unavailable) to give consent (and there must not be a valid advance directive indicating that he or she would not want the emergency treatment). Treatment given in emergency situations must be limited to that needed to preserve life or health. Non-emergency treatment must be postponed until consent can be obtained."[332] Alberta's progressive registry system allows individuals to register their personal directives in a common registry where they can confirm their instructions.[333] Similar to Québec, however, Alberta's registry does not keep a copy of the personal directive,[334] and only includes names, dates, and contact information of the agent.[335]

---

[329] According to the *Regulation respecting the application of the Public Curator Act*, R.R.Q. c. C-81, r. 1, at s 7, the registry maintains the name of the mandator and mandatary, date of completion, type and scope of mandate, date and number of judgment, and the end date of the mandate.

[330] *McLaren*, *supra* note 9.

[331] *Personal Directives Act*, *supra* note 18 at s 24(1).

[332] Jocelyn Downie & Karen McEwen, "The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution" (2009) 17 Health L.J. 115-137.

[333] Although no individual can be compelled to make a personal directive, the *Personal Directives Regulations*, Alta Reg 99/2008 s 3 empowers the Minister to establish a registry to store certain information about such documents.

[334] *Ibid*.

[335] *Ibid* at s 4(1).

There are several advantages to implementing registries under the umbrella of one entity for documents such as PADs. It would provide individuals peace of mind that their advance directive will be accessible during a crisis event. It allows individuals to receive periodical reminders to ensure their document is kept up-to-date and reflects current medical preferences. Additionally, a registry would prevent health care providers, family, and others from wasting time by searching for the document during a crisis. Upon the consent of patients, or their substitute decision-makers, emergency physicians would be reassured with the knowledge that they can obtain an advance directive any time. Such a registry system could be used in conjunction with a wallet-size document or a bracelet system to assist health care providers learn about the document.[336] Another advantage of a registry system is that it represents a step forward in harmonizing legislation on advance directives across jurisdictions, in the event a province or territory wanted to verify the document was in prescribed form.[337] It would be helpful if inter-provincial agreements were developed so that individuals who were temporarily hospitalized while living outside of their jurisdiction could authorize release of the document to clinicians.

B. Overriding Advance Directives

When psychiatrist Thomas Szasz first proposed the idea of a ‘psychiatric will’ some argued that it was primarily intended to protect patients from unwanted psychiatric interventions;[338] others stated the documents would lead to a litigation

---

[336] Not everyone prefers to use a bracelet system that would openly self-identify oneself as having mental health problems. Drawing an analogy between health care bracelets and “dog bracelets” should be avoided to ensure that individuals with mental illness are not inadvertently stigmatized.

[337] *Astroff, supra* note 319.

[338] See Thomas S. Szasz, “The psychiatric will. A New Mechanism for Protecting Persons against “Psychosis” And Psychiatry” (1982) 37:7 American Psychologist 762-770 were he suggested that a psychiatric will would have a dual function of protecting psychiatrists from worrying about being sued; See also Thomas Szasz, “Parity For Mental Illness, Disparity For The Mental Patient” (1998) 352:9135 Lancet 1213-1215 where he states, “I proposed such an advance psychiatric directive – or, as I called it, “psychiatric will” – in 1982, crafting it especially for the needs of mental patients who face the prospect of future involuntary treatment. The intent of the directive was to transcend the problems created by psychiatric crises or emergencies – situations in which the patients’ involuntary treatment is justified by their being deemed dangerous to themselves or others.”

feast for lawyers;[339] others believed physicians would become fearful of being sued in malpractice if they either failed to uphold it or unilaterally override it.[340] Swanson et al. described the term "legal defensiveness" in the context of advance directives as a general concern and perceived threat of legal sanctions in civil and criminal law matters regarding treatment decisions made by patients.[341] There is no single or determinative criterion of when it is acceptable to override a competent person's wishes in an advance directive with impunity.[342] One must look to the mental health statute for possible override provisions. The aim of many statutes is to respect an incapable person's well-being and dignity, particularly if that person's consent to treatment cannot be established.[343] There are also generally accepted medical standards and practices regarding treatment preferences that would not likely be upheld by the law. Legal defensiveness may be more prevalent in those jurisdictions where health care providers are not obligated to inquire if an advance directive exists or where there is no good faith immunity for doctors.[344]

Some jurisdictions have included good faith clauses in their mental health legislation in order to protect physicians if they treat patients in their best interests.[345] If physicians have made reasonable inquiries into the existence of an advance directive, a good faith clause could be invoked. What benefit is there to

---

[339] Paul Chodoff & Roger Peele, "The Psychiatric Will of Dr. Szasz" (1983) 13:2 The Hastings Center Report 11-13.

[340] *Griener, supra* note 102; The problem with relying on only a conversation between an individual and their doctor rather than a signed and witnessed document is that there are very few ways to empower or enforce a conversation.

[341] See Jeffrey W. Swanson & S. Van McCrary, "Medical Futility Decisions and Physicians' Legal Defensiveness: The Impact of Anticipated Conflict On Thresholds For End-Of-Life Treatment" (1996) 42:1 Social Science & Medicine 125–132; S. Van McCrary et al., "Physicians' Legal Defensiveness In End-Of-Life Treatment Decisions: Comparing Attitudes and Knowledge In States With Different Laws" (2006) 17:1 Journal of Clinical Ethics 15–26; Jeffrey W. Swanson et al., "Superseding Psychiatric Advance Directives: Ethical And Legal Considerations" 34:3 (2006) The Journal of the American Academy of Psychiatry and the Law 385-394; *Van Dorn, supra* note 319.

[342] Søren Holm, "Autonomy, Authenticity, or Best Interest: Everyday Decision-Making and Persons with Dementia" (2003) 4:2 Medicine, Health Care and Philosophy 153-159.

[343] *M. (A.). v. Benes*, (1996), 46 O.R. (3d) 271.

[344] *Table 1, supra* note 14.

[345] *Health Care Directives Act, supra* note 119 at s 22(1); *Personal Directives Act, supra* note 123 at s 20; See also, Gerald B. Robertson, "Ontario's New Informed Consent Law: Codification or Radical Change?" (1994) 2 Health LJ 88-98.

impose an obligation on doctors to inquire about an advance directive if it cannot be accessed in a timely manner? If a physician fails to inquire about an advance directive in the face of a statutory obligation to do so, and then proceeds to disregard that person's prior competent wishes recorded in the advance directive, they may not be immune from liability.[346] To this end, mental health legislation needs to clarify to what extent health care providers will be immune from liability if they override advance directives.[347]

C. The Top-Down Approach: Enacting Legislation

The aim of federal legislation in the U.S., namely the *Patient Self-Determination Act* (*PSDA*), was to encourage hospitals and health care providers to ask patients if they have an advance directive.[348] The focus of the *PSDA* was to promote self-determination and autonomy,[349] to encourage individuals to complete advance directives,[350] and to foster sharing of medical information.[351] The *PSDA* fell short by not specifying the content of what physicians should discuss with their patients,[352] by not distinguishing different types of advance directives,[353] and by imposing only administrative requirements upon hospitals that were not implemented adequately.[354] The *PSDA* did not include enforcement mechanisms leaving it as a statute that was largely precatory in scope.[355] Nonetheless, U.S. health care providers and hospitals are obligated to inquire whether advance directives exist, to record patients' preferences in their medical

---

[346] *Malette, supra* note 52.

[347] Debra Srebnik & Lisa Brodoff, "Implementing Psychiatric Advance Directives: Service Provider Issues and Answers" (2003) 30:3 Journal of Behavioral Health Services & Research 253-268.

[348] *PSDA, supra* note 58; The PSDA was an acknowledgment that a purely voluntary approach to advance directives was unsuccessful, see Peter J. Greco et al., The Patient Self-Determination Act And The Future Of Advance Directives" (1991) 115:8 Annals of Internal Medicine 639-643 [*Greco*].

[349] *Lidz, supra* note 46.

[350] The *PSDA* does not force patients to complete advance directives.

[351] Steven K. Hoge, "The Patient Self-Determination Act and Psychiatric Care" (1994) 22:4 Bulletin of American Academy of Psychiatry and the Law 577-586.

[352] *Greco, supra* note 348.

[353] *Perling, supra* note 33.

[354] *Gallagher, supra* note 101.

[355] *Ibid*.

records, to develop institutional policies, and to provide written materials about institutional policies.[356]

There has been some U.S. research examining the merits of advance directives after the *PSDA.*[357] Some have criticized the legislation for failing to achieve its goal of increasing the number of patients who have executed advance directives.[358] Others suggest that the national incremental start-up cost for hospitals to establish an advance directive program is between $43,625,114 to $101,569, 922, and the total implementation cost for a single hospital upwards of $114,528.[359] Asking individuals whether they have an advance directive during admission to a hospital differs from assisting individuals to complete a document when they are feeling well.[360] The issue of completing advance directives would likely be best upon hospital discharge rather than during admission.

In Canada, there is no federal legislation dealing with advance directives, unlike in the United States.[361] Some suggest that the lack of success with the *PSDA* in the U.S. means that analogous federal legislation in Canada mandating health care providers to inquire into advance directives would not be useful.[362]

---

[356] *Greco, supra* note 348.

[357] Joanne Lynn & Joan M. Teno, "After the Patient Self-Determination Act: The Need for Empirical Research on Formal Advance Directives" (1993) 23:1 The Hastings Center Report 20-24.

[358] Edward J. Larson & Thomas A. Eaton, "The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act, 32 Wake Forest L Rev. 249; *Fagerlin, supra* note 105; Nancy M. King & Arlene M. Davis, "End-Of-Life Decision-making. The Patient's Right To Choose" (1996) 57:6 North Carolina Medical Journal 381-384.

[359] See Jeremy Sugarman et al., "The Cost of Ethics Legislation: A Look at the Patient Self-Determination Act" (1993) 3:4 Kennedy Institute of Ethics 387 at 396 where the authors state, "the *PSDA* was enacted without adequate evidence that its provisions would accomplish its intended goals."

[360] In *Mullins v. Levy,* [2009] B.C.J. No. 23; 2009 BCCA 6, British Columbia's Court of Appeal heard a case where an individual brought a *Charter* challenge against a hospital in an effort to clear his name from the stigma of mental illness. The individual was brought to a psychiatric hospital because of a panic attack he was experiencing, and while waiting in the emergency ward he wrote several pages of notes including his direction not to be medicated, that he did not like the medical care he was receiving, and that he was entitled to leave the hospital. When the physician later reviewed the notes, it was found that they presented an illogical theme and were difficult to follow. The Court of Appeal held that due to his mental disorder he did not have mental capacity at the time to complete the document despite his staunch denial of ever having a mental disorder; Advance directives should not be made at the point of admission to a hospital, see *Dickens, supra* note 6.

[361] *Astroff, supra* note 319; *Dunbrack, supra* note 5.

[362] Alistair Browne & Bill Sullivan, "Advance Directives in Canada" (2006) 15:3 Cambridge Quarterly of Healthcare Ethics 256-260; Others do not advocate for legislation similar to the

Although the *PSDA* may not have achieved all of its intended aims, it continues to have an important role in sensitizing the U.S. public to the value of advance treatment planning.[363] The major hurdle with the *PSDA* was operational, specifically that a national strategy to access the documents in a timely manner was not considered from the outset. Furthermore, the *PSDA* was primarily a legislative response to cases involving end-of-life, whereas issues affecting individuals with mental illness are different. The *PSDA* also did not stipulate who should educate patients about advance directives, whether a clerk, lawyer, ethicist, social worker, or another designated hospital staff. Individuals with mental illness rarely want to discuss making advance directives during their admission to hospitals when they may be mentally incapable.[364] Outreach programs could be created to educate individuals about advance directives after recovering from a crisis or upon discharge from the hospital. In Canada, the delivery of mental health services falls under provincial jurisdiction. Enacting federal legislation to mandate hospitals and health care providers to provide information about advance directives may be a difficult threshold to meet. Nonetheless, provinces and territories could consider modeling their mental health legislation dealing with advance directives after a uniform statute under the Uniform Law Conference in Canada.

D. The Bottom-Up Approach: Training Hospital Staff and Lawyers

If advance directives will be implemented successfully, training programs are necessary for hospital staff, community mental health organizations, and legal professionals. In the past, training manuals explaining advance directives were too lengthy and complicated for individuals to understand.[365] The bottom-up approach involves designing effective training programs for mental health staff and hospitals to offer educational toolkits to patients transitioning into the community

---

PSDA in Canada, but cite it as an example that can be used to a greater extent, see *Downie, supra* note 94.

[363] Dan Brock, "Advance Directives: What Is It Reasonable To Expect From Them?" (1994) 5:1 Journal of Clinical Ethics 57-60.

[364] *Emanuel, supra* note 104.

[365] Robert D. Fleischner, "Advance Directives for Mental Health Care: An Analysis of State Statutes" (1998) 4:3 Psychol Pub Pol'y & L 788-804.

upon discharge from the hospital.[366] Before widely disseminating advance directives, it would be useful to start with educational programs in mental health[367] that could include workshops for psychiatrists, psychologists, social workers, lawyers, and judges. Health care professionals could receive certification through continuing medical education as they learn about ethical, legal, and clinical issues involving advance directives.[368]

The combination of clinical and legal education is important to ensure that advance directives are well understood.[369] Hospitals and treatment providers could help in this regard by encouraging persons to have their advance directives registered.[370] Lawyers could help to ensure the documents conform to provincial and territorial rules,[371] although this may not always be necessary. Additionally, provincial and territorial Bar Associations should encourage estate-planning lawyers to inform their clients of the value of making advance treatment planning documents at the same time they are making wills.[372] Eventually, it will be necessary to market the process of advance treatment planning more systematically,[373] as was done in New York State when it embarked on a $1 million campaign by distributing over 20,000 copies of the documents.[374]

Conclusion

As a human rights issue, advance treatment planning is an autonomy-building process that promotes the legal rights and values of individuals with mental illness. In order to ensure that advance directives are implemented

---

[366] *Greco, supra* note 348.

[367] See, for example, a booklet developed in Ontario was the Let Me Decide tape that was targeted towards geriatric patients; see William Molloy, *Let Me Decide: The Health Care Directive That Speaks For You When You Can't* (Toronto, Penguin Books, 1992).

[368] Tara Rayne Shewchuk, "Completing Advance Directives for Health Care Decisions: Getting To Yes" (1998) 4:3 Psychol Pub Pol'y & L 703-718.

[369] Debra S. Srebnik & John Q. La Fond, "Advance Directives for Mental Health Treatment" (1999) 50:7 Psychiatric Services 919-925.

[370] *Greco, supra* note 348.

[371] Peter A. Singer, Gerald Robertson & David J. Roy, "Bioethics for Clinicians: 6. Advance Care Planning" (1996) 155:12 Canadian Medical Association Journal 1689-1692.

[372] *Greco, supra* note 348.

[373] Robert Allan Pearlman, "Are We Asking The Right Questions?" (1994) 24:6 Hastings Center Report S24-27.

[374] *Monahan, supra* note 320.

effectively, government policies and mental health legislation needs to be aligned with the UN *Convention on the Rights of Persons with Disabilities,* the *Canadian Charter of Rights and Freedoms,* and empirical research. Canadian jurisprudence permits mentally capable individuals to express their autonomous choices regarding their treatment preferences. Yet, all claims to autonomy have reasonable limitations particularly when societal values and interests are at stake. The legal framework in Canada needs to find ways to balance increasing patient autonomy while offering the best medical treatment possible.

There are substantial differences across provincial and territorial legislation that influence how advance treatment plans are currently used. For example, not all jurisdictions permit the use of instructional directives and certain sub-groups of individuals with mental illness are more inclined to complete instructional over proxy directives. Some provinces have adopted a formalized approach to assess mental capacity, whereas others are more likely to rely on subjective assessments by mental health professionals. Jurisdictions also vary in the age to complete an advance directive, age to appoint a substitute decision-maker, an agent's duty to consult the maker, whether to obtain legal advice, and how to deal with multiple advance directives. Another issue among certain jurisdictions is the lack of good faith immunity clause for treatment providers when there is no advance directive. Placing an obligation on health care providers to inquire into the existence of an advance directive is an excellent step forward to verify whether any prior capable wishes have been made in writing. To this end, electronic registries offer an innovative avenue in mental health making advance directives accessible during a crisis event. At the same time, greater thought should be given to the possibility of reforming provincial and territorial legislation to impose a positive obligation on hospitals and health care providers to inquire whether individuals have an advance directive. Education training courses could be offered to help others learn about such documents and increase their use. Advance treatment planning for individuals with mental illness offers a promising avenue to honour patient autonomy, decision-making capacity, and freedom of choice as fundamental values.

Table 1. Advance Treatment Planning Legislation across Provincial and Territorial Jurisdictions

Jurisdiction	Governing Legislation	Instructional Directive	Proxy Directive	Age		Obligation to Inquire	Good Faith Immunity	Lawyer Required	Witnesses Required
				Maker[+]	Agent[*]				
Alberta	Personal Directives Act (2000)	Personal Directive	Personal Directive	18	18	_	Y	N	Y (one)
British Columbia	Representation Agreement Act (1996)	_	Representation Agreement	19	19	_	Y	Y	Y (two)
Manitoba	Health Care Directives Act (1993)	Health Care Directive	Health Care Directive	16	18	N	Y	N	Y (one)
New Brunswick	Infirm Persons Act (1973)	–	POA for Personal Care	–	–	–	N	Under seal	Y (one)
Newfoundland & Labrador	Advance Health Care Directives Act (1995)	Advance Health Care Directive	Advance Health Care Directive	16	19	Y	Y	N	Y (two)
Northwest Territories	Personal Directives Act (2005)	Personal Directive	Personal Directive	19	19	_	Y	N	Y (one)
Nova Scotia	Personal Directives Act (2010)	Personal Directive	Personal Directive	19	19	Y	Y	N	Y (one)
Nunavut	–	–	–	–	–	–	–	–	–
Ontario	Substitute Decisions Act (1992)	_	POA for personal care	16	16	_	N	N	Y (two)
Prince Edward Island	Consent to Treatment and Health Care Directives Act (1988)	Advance Health Care Directive	Advance Health Care Directive	16	_	Y	Y	N	Y (one)
Québec	Civil Code of Québec (1991)	_	Mandate	14	_	N	N	N	Y
Saskatchewan	Health Care Directives and Substitute Health Care Decision Makers Act (1997)	Health Care Advance Directive	Health Care Advance Directive	16	18	_	Y	N	Y (one)
Yukon	Decision Making Support and Protection to Adults Act (2003)	_	Representation Agreements	16	19	_	Y	N	Y (one)

[+] Other jurisdictions call a maker a principal or mandator.

[*] Other jurisdictions call an agent a representative, proxy, attorney, substitute decision-maker, or mandatary.

CHAPTER SIX: Mental health and capacity legislation across Canada

Mental health legislation across Canadian provinces and territories differs in how mental disorder and mental capacity are defined. This chapter presents a historical overview of the development of mental capacity laws, along with several conceptual models to show how mental health legislation is drafted around mental capacity and mental disorder. Individuals with mental illness and their family members have become increasingly frustrated with health care providers disputing the validity of capacity assessments. Some individuals with mental illness categorically deny that they are mentally incapable or have a mental disorder. A statutory analysis across Canadian jurisdictions reveals there is a lack of uniformity in *Mental Health Acts* of the definition of mental capacity and mental disorder. The capacity threshold to complete advance directives differs depending on the nature of the decision, whether it be financial, lifestyle, or medical. Mental capacity is important for advance directives at three distinct periods: (i) when the document is initially completed to ensure it is valid; (ii) when the document is used to challenge health care decisions; and (ii) when the document is revoked. If advance directives are to be useful in clinical practice, it is necessary to ensure that capacity assessments are reliable and valid.

Ambrosini, D. L. & Joncas, L. (forthcoming). Mental health & capacity legislation across Canada, in Bloom H, Dykeman MJ (Eds.) (2nd ed.) *A Practical Guide to Mental Health, Capacity, and Consent Law in Ontario*, (Toronto: Thomson Carswell).

TABLE OF CONTENTS

INTRODUCTION

Mental health and capacity legislation has undergone substantial changes in Canada over the past twenty years. The catalyst for many of these changes is grounded on individual and societal values of autonomy, empowerment, and recovery. Just as mental health professionals must remain knowledgeable of governing legislation to guide their clinical practice, similarly legal professionals require an understanding of how clinical practice and research can shape their legal practice. The diverse *Mental Health Acts* across Canadian provinces and territories is due to mental health services falling under provincial rather than federal jurisdiction as provided under the *Constitution Act*,[1] which makes obtaining a national overview of mental health legislation a challenging task for even the most well informed lawyer.

The aim of this chapter is to provide a comparative overview of *Mental Health Acts* across the provinces and territories, and to understand how the legislative definitions of “mental disorder” and “mental capacity” can vary. Currently, statutory definitions of mental illness, mental disorder, capacity, and competence are highly disparate. Although the causes and manifestations of mental incapacity can vary among individuals with different mental illnesses, legislative definitions could be more uniform. Capacity assessments conducted by mental health professionals are not identical to assessments of legal competence performed by judges. The purpose of performing capacity assessments and the role of courts in declaring someone legally incompetent is explained and illustrated through a comparative statutory analysis. This chapter discusses the relevance of mental capacity assessments for individuals who choose to complete advance directives. Currently, highly disparate criteria of mental capacity across provincial and territorial legislation have the potential to create vastly different outcomes in how individuals’ capacity to complete an advance directive is assessed.

---

[1] See *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3 reprinted in R.S.C. 1985, App. II, No. 5, s. 92(7).

I. HISTORICAL REFLECTIONS ON MENTAL CAPACITY

The Canadian Psychiatric Association's 2005 Position Statement on the role of mental health legislation stated, "Mental health legislation should attempt to strike a balance between a citizen's right to live safely in society and a person's right to liberty and autonomy."[2] Psychiatry is unique from most other medical disciplines in that it has been guided by detailed mental health legislation from the earliest beginnings.[3] Indeed, as far back as *The Twelve Tables* under ancient Roman law, an insane person (*cura furiosi*) came under the curatorship of his closest relative unless the person was considered dangerous, in which case he fell under the care of someone who was his keeper.[4] In modern times, law has adopted a more nuanced approach to address dangerousness through risk assessments and management; nevertheless, there will always be a need to ensure definitions in mental health legislation remain socially and culturally sensitive.

Several historical terms have been used to refer to mental disorder in the legislation. Ontario's *Lunacy Act* of 1909[5] referred to individuals as "lunatics" and mental institutions were described as "lunatic asylums." The term "lunatic" was closely associated with a folklore hypothesis that the lunar phase of the moon was related to abnormal behaviour.[6] A "lunatic" referred to someone who had mental capacity but then lost it, whereas the term "idiot" applied to someone who was mentally incapable from birth. In 1935, Ontario physician and lawyer Kenneth Gray stated, "it has been unnecessary to use the terms 'insane,'

---

[2] Grainne Neilson, "The Role of Mental Health Legislation" (2005) 50 (11) Canadian Journal of Psychiatry at 1.

[3] Jacob Margolin & Eliezer Witztum, "Mental Health Legislation: An Unavoidable Necessity or a Harmful Anachronism" (2006) 43 (3) The Israel Journal of Psychiatry and Related Sciences 219-227.

[4] Under Roman law forms of disability were not differentiated from each other, see Gershon Berkson, "Mental Disabilities in Western Civilization From Ancient Rome to the Prerogativa Regis" (2006) 44 (1) Mental Retardation 28-40.

[5] *Lunacy Act*, S.O. 1909, ch. 37.

[6] Research was conducted examining whether more inpatients were disruptive during a hospital inpatient stay, whether there was any relation between homicides, suicides, and suicide attempts and the lunar cycle, and the number of consecutive admissions to an inpatient service at a psychiatric hospital. See Carlos E. Climent & Robert Plutchik, "Lunar Madness: An Empirical Study" (1977) 18 (2) Comprehensive Psychiatry, 369-374; Donald I. Templer & David M. Veleber, "The Moon and Madness: A Comprehensive Perspective" (1980) 36 (4) Journal of Clinical Psychology 865-868; Alina Iosif & Bruce Ballon "Bad Moon Rising: The Persistent Belief in Lunar Connections to Madness" (2005) 173 (12) CMAJ 1498-1500.

'insanity,' and 'idiot' throughout the act and these terms are no longer applied to any patient of the commitment forms."[7] A "mentally ill" person was defined in Ontario's legislation as someone "other than a mental defective who is suffering from such a disorder of the mind that such person requires care, supervision and control for his own protection or welfare, or for the protection of others."[8] Definitions and terms applied in mental health can shift according to the prevailing views in society.

Another definition that has undergone legislative changes is mental capacity. When the *Lunacy Act* (1845) in England and Wales was amended in 1890, mentally ill individuals were referred to as patients and were no longer treated as prisoners.[9] Before the *Lunacy Act* (1890) was enacted, the hallmark of lunacy was the inability to manage one's affairs. Over time, however, it was found that being declared mentally incapable to manage one's personal property is not equivalent to being incapable to direct one's personal care, and courts adopted a nuanced appreciation for mental capacity. It eventually became clear that "memory alone is not synonymous with soundness of mind."[10] There was a time when measuring the degree of unsoundness of mind to make a testamentary will involved assessing whether a testator could hold in their memory the natural objects of their bounty. Ontario's *Lunacy Act* (1914) provided these criteria to determine mental incapacity,

> The powers and provisions of the *Lunacy Act*, relating to management and administration shall apply to every person not declared to be a lunatic with regard to whom it is proved, to the satisfaction of the Court, that he is, through mental infirmity, arising from disease, age, or other cause, or by reason of habitual drunkenness or the use of drugs, incapable of managing his affairs.[11]

Under Ontario's *Mental Incompetency Act* (1937) the term "mental incompetent" referred to an individual, whose mental condition required supervision and control for his or her own protection and the protection of their

---

[7] Kenneth G. Gray, "The Mental Hospitals Act, 1935 (Ontario)" (1937) 2 University of Toronto Law Journal, 103 at 110.
[8] *Ibid*. at 110.
[9] *Lunacy Act*, 1845 (8 & 9 Vict.), c. 100; *Lunacy Act*, 1890, (53 & 54 Vict.), c. 5.
[10] *Fraser (Re)*, [1911] O.J. No. 67.
[11] *Lunacy Act*, R.S.O. 1914, ch. 68, s. 37.

property.[12] Manitoba's *Lunacy Act* (1940) stated that a mentally incompetent person "includes every person who is or who is deemed to be mentally diseased or a mental defective."[13] Irrespective of changes in the legislative definition of competence, presenting evidence before the court to support facts and circumstances of an individual's incompetence has required the production of affidavits and medical reports and not merely stating an opinion.[14] Well-documented legal evidence of mental incapacity through a valid and reliable capacity assessment is often required by judges.

II. MODELS OF MENTAL HEALTH LEGISLATION

How mental health legislation is drafted can be a highly variable and contextual process that reflects political, cultural, and societal values. Legislative drafting requires policymakers to balance perspectives and values from multiple stakeholders. The aim of this section is to identify various conceptual models that have been used either implicitly or explicitly in drafting mental health legislation. A theoretical understanding of these models can help to contextualize the reasons for certain statutory provisions. No single model is recommended over another; the reality is that legislation often incorporates several.

Custodial Model

A custodial model represents drafting mental health legislation around concepts of dependency, maintenance, and need.[15] As such, a custodial model emphasizes the importance of economic resources in society, and measures morale through satisfaction with mental health services received. In the late 1800's and early 1900's, asylums were considered places of custody and detention rather than treatment centers; doctors were perceived as custodians rather than treatment providers. A vestige of the custodial approach can still be

---

[12] *Mental Incompetency Act*, R.S.O. 1937, c. 110.

[13] *Lunacy Act*, R.S.M. 1940, c. 124.

[14] *re Bulger*, (1911) 1 W.W.R. 248.

[15] The reference to a custodial model is taken from the field of organizational behaviour in management. See Keith Davis, "Evolving Models of Organizational Behaviour" (1968) 11 (1) The Academy of Management Journal 27-38.

found in legislation. For example, Alberta's *Mental Health Act* provides that two physicians may issue a community treatment order where individuals have on 2 or more occasions, or for a total of at least 30 days, "been in an approved hospital or been lawfully detained in a *custodial institution*."[16] Should hospitals be perceived as custodial institutions or treatment centers? Some legislation adopts criminological terminology such as the expression that individuals will be "taken into custody" by a peace officer as found in Manitoba's *Mental Health Act*, where a peace officer may also take an individual "into custody as soon as possible, and then promptly to a hospital."[17] What effect does taking an individual "into custody" have on public perceptions towards the criminalization of individuals with mental illness? Ontario's legislation also provides that "[a] police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner."[18] The problem with the custodial approach to mental health legislation is that patients are not motivated to reach their full capacity or to self-actualize, and may believe there is no need to move towards something better.

Medical/Biological Model

Under the medical/biological model of mental health legislation, the focus is on drafting legislation targeted at providing medical treatment of illness. Such legislation could be criticized if it overemphasizes the delivery of treatment in a manner that is overly mechanistic. Additionally, such legislation could be critiqued if it fails to provide sufficient mention of values such as autonomy, recovery, and well-being. The World Health Organization (WHO) has associated the terms "mental illness" and "mental patient" with a medical model of mental illness, and favours the term "mental disorder."[19] The International Classification

---

[16] *Mental Health Act*, R.S.A. 2000, c. M-13, s. 9(1)(b)(i)(B).

[17] *Mental Health Act*, C.C.S.M. c. M110, s. 9 (1), 12 (1).

[18] *Mental Health Act*, R.S.O. 1990, c. M.7, s. 33.

[19] World Health Organization, *WHO Resource Bok on Mental Health, Human Rights and Legislation*, (Geneva: Switzerland, 2005) at 21, online: World Health Organization. http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf.

of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) both adopt the term mental disorder to avoid problems with terms such as disease and illness. The WHO further states,

> The term "mental disorder" can cover mental illness, mental retardation (also known as mental handicap and intellectual disability), personality disorders and substance dependence. Not everyone considers all of these to be mental disorders; yet many legislative issues that pertain to conditions such as schizophrenia and bipolar depression apply equally to other conditions such as mental retardation, and therefore a broad definition is preferred.[20]

For the most part, provincial and territorial legislation have adopted the term mental disorder although mental illness does appear occasionally such as in Alberta's *Mental Health Act*.[21] Additionally, other legislation closely associated with *Mental Health Acts* continues to use the term mental illness.[22]

Prevention Model

The prevention model of mental health legislation focuses less on remediation and rehabilitation and more on preventing common mental health problems that interfere with adequate functioning. This model extends beyond legislation that prevents individuals from harming themselves with the use of hospital restraints. Instead, it emphasizes prevention by actively promoting health to reduce costs in healthcare and improve clinical outcomes. An example of a legislative provision around health promotion is found in New Brunswick's *Mental Health Services Act* where the preamble states, "It is one of the purposes of mental health services to promote self-reliance and lessen dependence on formal systems of care."[23] The Minister of Health in most provinces and territories has an obligation to ensure that prevention programs are established. For example, the Minister of Health and Wellness in PEI is responsible for

---

[20] *Ibid*. at 21.

[21] *Mental Health Act*, R.S.A. 2000, c. M-13, s. 49(1)(c)(i); See also *The Eden Mental Health Centre Incorporation Act*, R.S.M. 1990, c. 48, s. 3 (c); *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, R.S.Q. c. P-38.001, s. 9.

[22] See, for example, *Decision-Making Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 53(1)(c); See s. 15(1) of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, which uses the term "mental disability."

[23] *Mental Health Services Act*, S.N.B. 1997, c. M-10.2, preamble.

ensuring there are public education, research, and illness-prevention programs.[24] Similarly, in Saskatchewan, the Minister can do what he considers advisable to prevent circumstances that may lead to mental disorder in order to promote and restore mental health and well-being.[25]

Justice Models

Several examples of justice models have been used to guide the drafting of mental health legislation. One approach commonly associated with U.S. mental health legislation is the *parens patriae* power, which is the public policy power of the state to intervene on behalf of individuals in need of protection. British Columbia's *Representation Agreement Act* provides that there is nothing in its legislation to limit the inherent jurisdiction of the court to act in a *parens patriae* capacity.[26] Other types of justice models found in mental health legislation are those emphasizing dangerousness standards[27] and/or community protection. Most mental health legislation provides that individuals can be detained if they suffer from a mental disorder or are likely to cause serious harm to themselves or others.[28] Some legislation states explicitly that its primary purpose is to "protect persons from dangerous behaviour caused by a mental disorder."[29] Therapeutic jurisprudence is another justice model that aims to examine the effects laws can have on behaviour, emotions, and mental health through an interdisciplinary approach.[30]

---

[24] *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 2(c).

[25] *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 3.

[26] *Representation Agreement Act*, R.S.B.C. 1996, c. 405 s. 37(a); see also the *Adult Guardianship and Co-decision-making Act*, S.S. 2000, c. A-5.3, s. 28(2).

[27] For example, U.S. legislation was developed around the Stone-Roth Model of civil commitment based on the paternalistic power of the state to care for individuals who could not do so for themselves. See John Monahan, Mary Ruggiero & Herbert Friedlander, "Stone-Roth Model of Civil Commitment and the California Dangerousness Standard" (1982) 39 Archives of General Psychiatry 1267-1271.

[28] *Mental Health Act*, C.C.S.M. c. M110, s. 5(2).

[29] *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 1.1; See also *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 3(1)(a); See *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, R.S.Q. chapter P-38.001, s. 1.

[30] David B. Wexler & Bruce J. Winick, *Essays in Therapeutic Jurisprudence* (Durham, NC: Carolina Academic Press, 1991).

Evidence-Based Models

Evidence-based models of drafting legislation are those that incorporate the need to provide services and programs to individuals based on scientific research methods and findings. Through an iterative process of consensus building between mental health professionals and legislators, mental health services could be based on empirically valid research. PEI's *Mental Health Act* is a good example by providing that one of the functions of the Director of Mental Health for the province is to "initiate research designed to improve the provision of mental health services in the province."[31]

Recovery Models

The recovery movement occupies a central role towards the development of a national framework for mental health across Canada.[32] Although recovery is often discussed in the context of social models of disability, it is also a highly individualistic construct. Recovery is often associated with hope, the self, well-being, and has been described as a "deeply personal process."[33] Canadian mental health legislation needs to be more explicit in how it aims to assist individuals with mental illness to recover. Québec law provides that individuals admitted to a hospital for close treatment have a right to require physicians to notify family or caregivers of the measures taken to hasten that person's recovery.[34] However, the meaning of recovery in this legislative context may differ from the recovery model commonly associated with mental health. Some provinces empower the Minister of Health to do anything that will restore the "well-being" of individuals.[35]

---

[31] *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 3(c); see also, for example, the *Mental Health Act*, R.S.Y, 2002, c. 150, s. 2(1)(d); *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 3(d); see New Brunswick's *Mental Health Services Act*, S.N.B. 1997, c. M-10.2, s. 2(c) for types of programs of research that the Minister may ensure are conducted in the province.

[32] Mental Health Commission of Canada, *Toward Recovery and Well-being: a Framework for a Mental Health Strategy for Canada* (Ottawa: Canada, 2009) online: Mental Health Commission of Canada http://www.mentalhealthcommission.ca.

[33] Patricia E. Deegan, (1988) "Recovery: The Lived Experience of Rehabilitation" (1988) 11 (4) Psychosocial Rehabilitation Journal 11-19.

[34] *Regulation Respecting the Application of Section 27 of the Mental Patients Protection Act*, R.Q. c. P-41, r.1, s. 2(b).

[35] *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 3.

Consumer Choice Models

There is a growing appreciation in the mental health community for the value of giving individuals with mental illness greater choice in making decisions about their medical treatment. For example, most mental health legislation empowers mentally capable individuals to choose and authorize a substitute decision-maker to make decisions on their behalf in the event of mental incapacity. An important choice that has not always existed for individuals with mental illness is to admit oneself voluntarily into a hospital. In Québec, there is presumption that individuals who have been confined to a hospital are allowed to communicate freely and confidently with whom they choose, unless an attending physician prohibits or restricts such communication.[36]

III. MENTAL CAPACITY & LEGAL COMPETENCE

Performing assessments of mental capacity of individuals has been an intensely debated issue that may stem partly from how mental health legislation is drafted.[37] When an individual is declared legally incompetent, this can raise strong reactions by the individual or family members who may not believe the decision accurately reflects their true level of capacity.[38] Although incapacity and incompetence are terms often used interchangeably, a more nuanced understanding suggests that "incapacity reflects a clinical period of compromised decision-making ability, while incompetency is a legal term referring to court-ordered periods where consumers are unable to make reasoned decisions."[39] Capacity assessments are performed by qualified mental health professionals to examine cognitive abilities and deficits to make actual decisions. Although mental

---

[36] *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, R.S.Q. chapter P-38.001, s. 17; Such a prohibition regarding communication is temporary, must be in writing and contain reasons, be given to the person, and noted in his record.

[37] Matthew Hotopf, "The Assessment of Mental Capacity" (2005) 5 (6) Clinical Medicine 580-584.

[38] *P.H. v. Eastern Regional Integrated Health Authority*, [2010] N.J. No. 59.

[39] Debra Srebnik & Lisa Brodoff, "Implementing Psychiatric Advance Directives: Service Provider Issues Answers" (2003) 30 (3) Journal of Behavioural Health Services & Research, 253-268.

health professionals often use their own interpretation to determine whether an individual is capable, more objective capacity assessments have been proposed.[40] Whereas capacity assessments by mental health professionals are based on individuals' present status, judges base competence on legislative criteria and mental status retrospectively.

Mental capacity needs to be evaluated relative to the task or decision and is no longer viewed as a global characteristic.[41] Some individuals with mental illness manifest *continuous* psychotic symptoms that make it difficult to be capable regarding treatment decisions even for a brief period. Others experience intermittent or fluctuating psychosis that affects mental capacity and decision-making abilities during specific crisis events. The loss of mental capacity to make treatment decisions should never be assumed even if someone has been admitted to a hospital as an involuntary patient. Instead, clinicians need to be mindful that the issue of "consent" is very much alive even where individuals with mental illness accept their medication. Substituted consent is provided for in all provincial and territorial legislation. In those cases where no one is authorized by law, and no family member or spouse is able to provide consent, solutions vary. For example, section 31 of British Columbia's *Mental Health Act* provides that "treatment authorized by the director is deemed to be given with the consent of the patient."[42]

The *Hospitals Act* in Nova Scotia provides criteria that should be examined in establishing whether an adult in a psychiatric facility is mentally capable:

> In determining whether or not a person is capable of consenting to treatment, the examining psychiatrist shall consider whether the person understands and appreciates: (a) the condition for which the treatment is proposed; (b) the nature and purpose of the specific treatment; (c) the risks and benefits involved in undergoing the specific treatment; and (d) the risks and benefits involved in not undergoing the treatment. In determining a patient's capacity to make a treatment decision, the

---

[40] For example, see the website of the UK Mental Health Foundation, "Assessing Mental Capacity" online: http://www.amcat.org.uk where mental health professionals can audit the quality of their capacity assessment.

[41] Mona Gupta, "All Locked Up with Nowhere to Go: Treatment Refusal in the Involuntary Hospitalized Population of Canada" in Kate Diesfeld & Ian R. Freckelton I (Eds.): *Involuntary Detention and Therapeutic Jurisprudence* (Burlington: Ashgate Publishing Limited, 2003) 155-178.

[42] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31.

> psychiatrist shall also consider whether the patient's mental disorder affects the patient's ability to appreciate the consequences of making the treatment decision.[43]

These criteria from Nova Scotia's legislation were adopted in the 1994 Québec Court of Appeal case of *Institut Philippe Pinel de Montréal v. Gharavy,*[44] where the Court held that dangerousness should not be a consideration in determining mental capacity.

Informed consent is a central tenet in the doctor-patient relationship, but consent can only be valid if an individual is first mentally capable. Although there is no universally agreed upon definition of mental capacity, a widely accepted operational criteria rests upon the pioneering work of Grisso and Appelbaum.[45] These scholars proposed four functional cognitive abilities underlying mental capacity to provide informed consent: ability to *express a choice* about treatment, to *understand* the information provided about the treatment(s); to *appreciate* the personal implications of the information and decision; and to *reason* through the consequences of accepting or refusing treatment.[46] As mental capacity and its underlying functional abilities can vary along a continuum, there is no established threshold or cut-off to determine whether someone is capable or not. On this continuum, however, reasoning ability is a more stringent criterion than the ability to express a choice. In Canada, for the most part, mental health legislation has adopted the understanding and appreciation ability criteria, although other criteria are mentioned occasionally.

IV. MENTAL HEALTH ACTS ACROSS CANADA

One factor that may contribute to heated disputes surrounding mental capacity is the lack of uniformity in how to define it. How mental disorder and

---

[43] *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52 (2A) (2B).

[44] *Institut Philippe Pinel de Montréal v. Gharavy*, [1994] J.Q. no 837.

[45] See the research studies found in Paul S. Appelbaum & Thomas Grisso, "The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment" (1995) 19 (2) Law and Human Behavior, 105-126; Thomas Grisso & Paul S. Appelbaum, "The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments" (1995) 19 (2) Law and Human Behavior, 149-174; Thomas Grisso *et al.*, "The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment" (1995) 19 (2) Law and Human Behavior, 127-148.

[46] *Ibid*.

mental capacity is defined in legislation can affect access to and use of mental health services by individuals.[47] Legislative definitions may also change due to judicial interpretation. For example, the term "guilty by reason of insanity" is no longer found in the *Criminal Code* and has been replaced with the expression "not criminally responsible on account of mental disorder."[48] Yet at least one *Mental Health Act* continues to use the outdated term "not guilty by reason of insanity."[49] In the 2003 Supreme Court of Canada case of *Starson v. Swayze,*[50] the Court distinguished the term "illness" from "condition" revealing the need for sensitivity in how definitions can influence the outcome of cases.[51]

Previous efforts have made towards developing a uniform approach to drafting provincial and territorial mental health legislation. For example, when the Uniform Law Conference of Canada adopted the *Uniform Mental Health Act*[52] in 1987, they proposed a definition of "mental disorder" and "mental competence" adopted by some provinces and territories:

> "Mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.
>
> For the purposes of consent under this Act, a person is mentally competent if the person is able to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or refusing consent, and, where the consent relates to a proposed treatment for the person, the subject-matter is the nature of the persons illness and the nature of the proposed treatment.

The language adopted in mental health legislation can inadvertently foster discriminatory stereotypes and fail to promote civil liberties if it is not technically precise.[53] Taskforce members of the DSM-IV-TR acknowledge problems inherent with defining a single term such as "mental disorder,"

---

[47] Marcia C. Peck & Richard M. Scheffler, "An Analysis of the Definitions of Mental Illness Used in State Parity Laws" (2002) 53 Psychiatric Services 1089-1095.
[48] *Criminal Code*, R.S.C. 1985, c. C-46, s. 672.1 (1).
[49] See, for example, the *Mental Health Act*, R.S.A. 2000, c. M-13, s. 3.
[50] *Starson v. Swayze*, [2003] 1 S.C.R. 722.
[51] *Conway v. Darby*, [2008] O.J. No. 4205.
[52] Uniform Law Conference of Canada, *Uniform Mental Health Act*, (Ottawa: Uniform Law Conference of Canada, 1987) online: http://www.chlc.ca/en/us/index.cfm?sec=1&sub=1m1.
[53] Piere Beaumont & Terry Carney, "Can Psychiatric Terminology be Translated into Legal Regulation? The Anorexia Nervosa Example" (2004) 38 Australian and New Zealand Journal of Psychiatry 2004 819-829.

> The problem raised by the term "mental" disorders has been much clearer than its solution, and unfortunately, the term persists in the title of the DSM-IV because we have not found an appropriate substitute…no definition adequately specifies precise boundaries for the concept of "mental disorder"…lacks a consistent operational definition that covers all situations…in most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder", "mental disability", "mental disease" or "mental defect". In determining whether an individual meets a specified legal standard (e.g. for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.[54]

Review Boards across Canada who adjudicate criminal cases for individuals with mental illness must be careful in whether they adopt a broader definition, as found in federal legislation such as the *Criminal Code*, or a more narrow definition found in provincial and territorial *Mental Health Acts*. The *Criminal Code* defines "unfitness to stand trial" as,

> ...unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel.[55]

The definition and criteria to find someone "unfit to stand trial" is not identical to a determination of mental capacity found in mental health legislation. Although terms such as mental and physical disability may occasionally overlap, they too are not identical and need to be distinguished carefully.

Mental health legislation from other Commonwealth countries has attempted to balance the duty of care and protection with the right to self-determination.[56] In a study comparing thirty-two Commonwealth *Mental Health Acts*, researchers found that there is widespread deviation from standards found in the *Universal Declaration of Human Rights*, which may be partly due to a failure to remain current with changing attitudes.[57] In the study, legislation was reviewed and coded along five axes based on guidelines from the WHO (diagnosis, therapeutic aim, risk, capacity, review process), and then given an autonomy score (minimum=6; maximum=30). No *Mental Health Acts* were compliant with all of

---

[54] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* 4th ed. (Washington, DC: American Psychiatric Association, 2000) at xxx.

[55] *Criminal Code*, R.S.C. 1985, c. C-46, s. 2.

[56] E.C. Fistein *et al.*, "A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions" (2009) 32 (3) International Journal of Law and Psychiatry 147-155.

[57] *Ibid*.

the WHO's guidelines, and five Canadian provinces did not meet the stringent criteria for monthly reviews.[58] Table 1 is a reproduced summary of autonomy scores found in the study across Canadian provinces and territories. In the following section, a more in-depth statutory analysis of Canadian mental health acts is conducted to explore use of the terms mental disorder and mental capacity.

Alberta

The term mental disorder is defined in Alberta's *Mental Health Act* as a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life."[59] Under this definition, which is identical to that found in the *Uniform Mental Health Act*, an individual with a substantial disorder of orientation that grossly impairs their ability to meet the demands of life could qualify as having a mental disorder.

Alberta's *Mental Health Act* prefers the term mental competence to mental capacity stating, "a person is mentally competent to make treatment decisions if the person is able to understand the subject-matter relating to the decision and able to appreciate the consequences of making the decisions."[60] Section 1 of the *Personal Directives Act*, on the other hand, defines capacity as "the ability to *understand* the information that is relevant to the making of a personal decision and the ability to *appreciate* the reasonably foreseeable consequences of the decision." Notice that the criteria to determine mental capacity to make treatment decisions under the *Mental Health Act* involves appreciation of the consequences of making the decision, whereas a determination of capacity to make personal decisions has an additional criteria of reasonable foreseeability.

British Columbia

The *Mental Health Act* in British Columbia defines a person with a mental disorder as someone "who has a disorder of the mind that requires treatment and

---

[58] *Ibid*.
[59] *Mental Health Act*, R.S.A. 2000, c. M-13, s. 1 (g).
[60] *Mental Health Act*, R.S.A. 2000, c. M-13, s. 26.

seriously impairs the person's ability to (a) to react appropriately to the person's environment, or (b) to associate with others."[61] A patient is defined in the *Act* as someone "who is received, detained or taken charge of as a person with a mental disorder or as *apparently a person with a mental disorder*."[62] Police officers can rely on their personal observations or information received from others to apprehend and take to a physician for examination an individual who is "apparently a person with a mental disorder."[63] Notice the provision in the *Act* provides that the officer would need to ensure that the person is also acting in a manner likely to endanger one's own safety or the safety of others.

B.C.'s *Mental Health Act* does not provide a definition of competence.[64] However, the *Health Care (Consent) and Care Facility Act* states that every adult is presumed capable to give, refuse or revoke consent to health care, and to apply to or move out of a health care facility.[65] Section 7 of the *Consent Act* states that incapacity is assessed by a health care provider who bases the decision on whether the individual understands the information they are provided and that the information applies to the situation of the adult.[66] The *Adult Guardianship Act* contains a rebuttable presumption that "every adult is presumed to be capable of making decisions about personal care, health care, legal matters or about the adult's financial affairs, business or assets."[67] Adults are able to make representation agreements in B.C. even if they are incapable of making a contract or managing their health care, personal care, legal matters, financial affairs, business, or assets.[68] Yet an adult's manner of communicating with others is not, by itself, grounds for deciding that a person is incapable of understanding.[69]

---

[61] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
[62] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
[63] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 28.
[64] *Mental Health Act*, R.S.B.C. 1996, c. 288.
[65] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 3.
[66] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 7.
[67] *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 2.
[68] *Representation Agreement Act*, R.S.B.C. 1996, c. 405, s. 8. The relevant factors in examining incapacity involve examining whether the adult can communicate a desire to have a representative, if there is an ability to demonstrate choices and preferences, is aware that the representative may make or stop making decisions or choices, and whether there is a relationship of trust with the representative.
[69] *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 3.

Manitoba

Manitoba legislation draws a distinction between mental disorder and mental disability. Mental disorder is defined in the *Mental Health Act* as “a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include a disorder due exclusively to a mental disability as defined in *The Vulnerable Persons Living with a Mental Disability Act.*”[70] The *Vulnerable Persons Living with a Mental Disability Act*, on the other hand, defines mental disability as, “significantly impaired functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder....”[71] As the *Vulnerable Persons Act* does not apply to individuals who have a mental disorder exclusively, one is left to wonder whether the level of vulnerability may really differ between these groups based on age.

The *Vulnerable Persons Act* defines a vulnerable person as an adult living with a mental disability who needs assistance to meet their basic needs with regard to personal care or management of property.[72] The legislation provides that a person is considered incapable of personal care if they are not able to *understand* information that is relevant to making a decision concerning their health care, or regarding their own emotional, psychological, residential, educational, vocational or social needs, or if the person is not able to *appreciate* the reasonably foreseeable consequences of a decision.[73] The *Powers of Attorney Act* defines the term mental incompetence as the inability “to manage his or her affairs by reason of mental infirmity arising from age or a disease, addiction or cause.”[74] Although the legal criteria for incapacity of personal care under the *Vulnerable Persons Act* is framed disjunctively as the ability to understand information <u>*or*</u> appreciate reasonably foreseeable consequences, section 2 of *The*

---

[70] *Mental Health Act*, C.C.S.M. c. M110, s. 1.
[71] *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 1 (1).
[72] *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 1 (1).
[73] *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 46.
[74] *Powers of Attorney Act*, C.C.S.M. c. P97, s. 1 (1).

Health Care Directives Act defines capacity conjunctively as the ability to understand information *and* appreciate the reasonably foreseeable consequences.[75]

New Brunswick

The definition of mental disorder in New Brunswick's *Mental Health Act* differs slightly from Manitoba's *Mental Health Act.*[76] The difference lies in that Manitoba's legislation separates individuals with a mental disorder from those with a mental disability, whereas New Brunswick's *Mental Health Act* states that it "does not include the disorder known as mental retardation."[77] The *Infirm Persons Act* can apply to someone who is not declared mentally incompetent by physical infirmity but is incapable to manage his or her affairs or personal care due to habitual drunkenness or the use of drugs.[78]

The *Mental Health Act* in New Brunswick further provides that a person is mentally competent to give or refuse consent to a proposed treatment if the person can understand the subject matter and appreciate the consequences of giving or refusing to give consent.[79] The *Infirm Persons Act* defines mental incompetency as "a condition of mind or physical incapacity of a mentally incompetent person."[80] How mental incompetency could be construed as a condition of physical incapacity is not clear. The legislation elaborates that a "mentally incompetent person means a person (a) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or (b) who is suffering from such a disorder of the mind."[81]

---

[75] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 2.
[76] *Mental Health Act*, R.S.N.B. 1973, c. M-10.
[77] *Mental Health Act*, R.S.N.B. 1973, c. M-10. Interestingly, New Brunswick's *Mental Health Services Act*, S.N.B. 1997, c. M-10.2 defines mental disorder differently from the *Mental Health Act*, R.S.N.B. 1973, c. M-10 and makes no reference to mental retardation.
[78] *Infirm Persons Act*, R.S.N.B. 1973, c. I-8, s. 39.
[79] *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 1 (2).
[80] *Infirm Persons Act*, R.S.N.B. 1973, c. I-8, s. 1.
[81] *Infirm Persons Act*, R.S.N.B. 1973, c. I-8, s. 1.

Newfoundland and Labrador

Mental disorder in Newfoundland and Labrador's *Mental Health Care and Treatment Act* is defined as "a disorder of thought, mood, perception, orientation, or memory that impairs (i) judgment or behaviour, (ii) the capacity to recognize reality, or (iii) the ability to meet the ordinary demands of life, and in respect of which psychiatric treatment is advisable."[82] The legislation is unique from other provinces and territories in that the definition of mental disorder is explicitly connected to whether "psychiatric treatment is advisable."[83] Notably, the criteria of judgment and behaviour are grouped under the same sub-clause unlike, for example, Alberta's *Mental Health Act*. The *Mentally Disabled Persons' Estate Act* also provides that an individual can be classified as a mentally disabled person whether or not they have been committed to a hospital under the *Mental Health Care and Treatment Act*."[84]

The *Mental Health Care and Treatment Act* does not offer a clear definition of mental capacity or competence. Yet, the *Advance Health Care Directives Act* provides that a maker of an advance health care directive is considered competent to make the document when they understand the information to making a health care decision and are able to appreciate the reasonably foreseeable consequences.[85] With respect to financial matters and capacity, the *Mentally Disabled Persons' Estates Act* states that where a court is satisfied that an individual is incapable to manage his affairs it may declare this without necessarily making a declaration of mental disability.[86]

Northwest Territories

The *Mental Health Act* in the Northwest Territories defines mental disorder as "a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life but mental retardation or

---

[82] *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 2 (1) (k).
[83] *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, s. 2 (1) (k).
[84] *Mentally Disabled Persons' Estates Act*, R.S.N.L. 1990, c. M-10, s. 2 (f).
[85] *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1, s. 14.
[86] *Mentally Disabled Persons' Estates Act*, R.S.N.L. 1990, c. M-10, s. 17 (1).

a learning disability does not of itself constitute a mental disorder."[87] There has been a move away from use of the term "mental retardation" in legislation towards "intellectual disability" as the preferred and more authoritative term.[88]

The *Mental Health Act* defines being mentally competent as "having the ability to understand the subject-matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent."[89] The *Personal Directives Act*, on the other hand, includes the criteria of appreciating reasonably foreseeable consequences of making a personal decision.[90] It is also notable that the *Mental Health Act* presumptively defines mental competence rather than incompetence, which is similar to New Brunswick's *Infirm Persons Act*.[91] The *Powers of Attorney Act* defines mental incapacity as "the inability of a person, by himself or herself or with assistance to (a) understand information that is relevant to making a decision concerning his or her financial affairs, or (b) appreciate the reasonably foreseeable consequences of a decision concerning his or her financial affairs or the lack of such a decision."[92] The definition of mental capacity to complete a power of attorney is notable in that it has a social element to it by including a reference to receiving assistance from others.

Nova Scotia

Nova Scotia is the only province, other than Québec, whose legislation is not referred to as a *Mental Health Act* but rather the *Involuntary Psychiatric Treatment Act*.[93] On the surface, it may appear that mental disorder in Nova Scotia is defined similarly to Newfoundland and Labrador, yet it differs in that it must be *substantial* and *severely* impair the judgment, behaviour, capacity to

---

[87] *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 1.
[88] Robert L. Schalock et al., "The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability" (2007) 45 (2) Intellectual and Development Disabilities 116-124; In 2010, U.S. President Obama signed into law Rosa's Law that changes the language of "mental retardation" to "intellectual disability" in federal law.
[89] *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 1
[90] *Personal Directives Act*, S.N.W.T. 2005, c. 16, s.1
[91] *Infirm Persons Act*, R.S.N.B. 1973, c. I-8, s. 1.
[92] *Powers of Attorney Act*, S.N.W.T. 2001, c. 15.
[93] *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42.

recognize reality or the ability of the person to meet the ordinary demands of life.[94]

Although section 18 of the *Involuntary Psychiatric Treatment Act* contains a test of capacity to make a treatment decision,[95] there is no explicit definition of mental capacity or competence. Nevertheless, the *Act* provides that each person have the right to make treatment decisions to the extent of their capacity.[96] The *Incompetent Persons Act*, intended for custody and estate matters, defines an incompetent person as "a person, not an infant, who is capable from infirmity of mind of managing the person's own affairs."[97] This provision exemplifies how mental health legislation, more generally, could better distinguish between mental incapacity and incompetence. In the 2009 case of *Ocean v. Economical Mutual Insurance Co*,[98] Nova Scotia's Court of Appeal highlighted the confusion that can arise when mental capacity and mental competence are not clearly defined. The appellant challenged the lower court's authority to order a competency assessment, and the Court of Appeal held on a narrow issue that the *Civil Procedure Rules* could not be used to appoint a medical practitioner to ascertain the mental competence of a party to litigation where competency is not a fact in issue in the proceeding.[99]

Nunavut

Nunavut's definition of mental disorder and mental competence in the *Mental Health Act* mirrors that of the NWT.[100] Whereas mental incapacity in Nunavut's *Powers of Attorney Act* refers to the "inability of a person, due to infirmity or impaired judgment, whether arising from disease, disability, age, addiction or other cause",[101] the *Powers of Attorney Act* in the NWT does not

---

[94] *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 3.
[95] *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 18.
[96] *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42, s. 2 (b).
[97] *Incompetent Persons Act*, R.S.N.S. 1989, c. 218, s. 2 (b); See also s. 3 (b) of the *Adult Protection Act*, R.S.N.S. 1989, c. 2 where it defines an "adult in need of protection".
[98] *Ocean v. Economical Mutual Insurance Co*, [2009] N.S.J. No. 332.
[99] *Ibid.*
[100] *Mental Health Act*, R.S.N.W.T. 1988, c. M-10.
[101] *Powers of Attorney Act*, S.Nu. 2005, c. 9, s. 1.

state that causes of incapacity could possibly arise from disease, disability, or other factors.[102]

Ontario

Ontario's *Mental Health Act* defines mental disorder broadly as "any disease or disability of the mind."[103] The *Health Care Consent Act* (*HCCA*) states that mental disorder has the same meaning as found in the *Mental Health Act*.[104] The *Accessibility for Ontarians with Disabilities Act* defines a disability broadly to include physical disability, a condition of mental impairment, a learning disability, a mental disorder, or an injury for which benefits were claimed or received under an insurance plan under the *Workplace Safety and Insurance Act*.[105]

In Ontario, the Consent and Capacity Board is an administrative tribunal with expertise in adjudicating issues involving consent and capacity, civil commitment, and substitute decision-making. While mental capacity is left undefined in the *Mental Health Act*, section 4 of the *HCCA* states that it involves being able to *understand* the information that is relevant to making a decision and being able to *appreciate* the reasonably foreseeable consequences of a decision or lack of decision.[106] Section 15 of the *HCCA* provides that a person can be incapable with respect to some treatments and capable with respect to others,[107] and acknowledges the possibility of fluctuating capacity where "a person may be incapable with respect to a treatment at one time and capable at another."[108] Ontario's *Substitute Decisions Act* provides that a person 18 years of age or more is presumed capable to enter into a contract, whereas a person need only be 16 years old to give or refuse consent to personal care.[109]

---

[102] *Powers of Attorney Act*, S.N.W.T. 2001, c. 15, s. 1.

[103] *Mental Health Act*, R.S.O. 1990, c. M.7, s. 1 (1).

[104] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 2(1).

[105] *Ontario Disabilities Act*, 2001, S.O. 2001, c. 32, s. 2; See also the definition of disability as a mental disorder under the *Human Rights Code*, R.S.O. 1990, c. H.19, s. 10 (1) (d).

[106] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 4.

[107] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 15.

[108] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 15 (2).

[109] *Substitute Decisions Act*, 1992, S.O. 1992, c. 30, s. 2 (1) (2).

Prince Edward Island

Mental disorder is defined in PEI's *Mental Health Act* as "a substantial disorder of thought, mood, perception, orientation or memory that seriously impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life," but then adds that it "includes a mental disorder resulting from alcohol or drug addiction or abuse, but a mental handicap or learning disability does not itself, constitute a mental disorder."[110] The *Act* is unique in explicitly defining a mental disorder as resulting from alcohol or drug addiction or abuse. A disabled person under the *Rehabilitation of Disabled Persons Act* is defined as someone who has a physical, mental, psychological, emotional, or other impairment that impedes them from participating to the best of their ability in social and economic activities.[111]

Capacity under Prince Edward Island's *Mental Health Act* refers to the ability to make a decision to give or refuse consent to treatment.[112] Section 7 of the *Consent to Treatment and Health Care Directives Act* states that an individual is capable with respect to treatment if, in the health practitioner's opinion, the person is able to: (a) understand the information relevant to make a decision, (b) understand the information that applies to his situation, (c) understands he has a right to make a decision, (d) and appreciates the reasonably foreseeable consequences of a decision or lack of a decision.[113]

Québec

Neither the *Civil Code of Québec (CCQ),*[114] nor *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others,* [115] defines mental disorder or mental capacity in the province. Although article 11 of the *CCQ* states that if someone is incapable of giving or refusing care

---

[110] *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 1(k).
[111] *Rehabilitation of Disabled Persons Act*, R.S.P.E.I. 1988, c. R-12, s. 1(b) (i).
[112] *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1, s. 1 (f).
[113] *Consent to Treatment and Health Care Directives*, R.S.P.E.I. 1988, c. C-17.2, s. 7.
[114] *Civil Code of Québec*, L.R.Q., c. C-1991.
[115] R.S.Q. c. P-38.001.

a person authorized by law or by a mandate in case of incapacity may do so,[116] there is no explicit definition of either term. As the legislation does not provide specific criteria of mental capacity to consent or refuse to treatment, determining capacity is a question of fact and not legal status[117] and one must look to jurisprudence to determine how judges have defined it.

Saskatchewan

Saskatchewan's *Mental Health Services Act* defines mental disorder as "a thought, perception, feelings or behaviour that seriously impairs a person's judgement, capacity to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, in respect of which treatment is advisable."[118] It is not clear when or why *feelings* are associated with the definition of mental disorder. Indeed, taken to an extreme, one could argue from the basis of this legislation that if an individual experiences feelings that seriously impair their ability to associate with others this may constitute a mental disorder.

The definition of capacity under the *Health Care Directives and Substitute Health Care Decision Makers Act* includes the criteria of understanding and appreciation in addition to a person being able "to communicate a health care decision on a proposed treatment."[119] Interestingly, the same criterion of communicating a health care decision of a proposed treatment is not found in the definition of capacity in the *Adult Guardianship and Co-Decision-Making Act*.[120]

Yukon Territory

Yukon's definition of mental disorder in the *Mental Health Act* is identical to Alberta's and includes the criteria of need for a *substantial* disorder of thought that *grossly* impairs judgment, behaviour, capacity to recognize reality, or ability

---

[116] *Civil Code of Québec*, L.R.Q., c. C-1991, art. 11.

[117] Katherine Brown & Erin Murphy, "Falling Through the Cracks: the Québec Mental Health System" (2000) 45 McGill Law Journal 107-1079.

[118] *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 1(m).

[119] *Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 2 (1) (b).

[120] *Adult Guardianship and Co-Decision-Making Act*, S.S. 2000, c. A-5.3, s. 2 (c).

to meet the ordinary demands of life.[121] An individual is considered competent to consent to treatment if they understand the condition for which treatment is proposed, the nature and purpose of treatment, the risks of undergoing the treatment, and the risks of not undergoing the treatment.[122] The "capacity to recognize reality" has been used as a criterion of mental capacity by several provinces and territories, which needs to be examined carefully by mental health professionals when conducting capacity assessments. In the 2003 Supreme Court of Canada case of *Starson v. Swayze*,[123] although Scott Starson recognized that his reality differed from others, the Court held that he had the right to refuse certain forms of medical treatment.

V. ADVANCE DIRECTIVES AND CAPACITY LEGISLATION

Psychiatric advance directives (PADs) are legal documents that allow individuals to declare their treatment preferences in advance of a mental health crisis in the event of mental incapacity to make decisions.[124] There has been an increased interest in understanding how advance directives for mental health could be implemented across Canada and their relationship to autonomy.[125] The *Kirby Report*, a federal report produced in 2006 to reform Canada's mental health system, recommended that all provinces and territories empower mentally capable persons through legislation by appointing substitute decision-makers and using

---

[121] *Mental Health Act*, R.S.Y. 2002, c. 150, s. 1.

[122] *Mental Health Act*, R.S.Y. 2002, c. 150, s. 19.

[123] *Starson v. Swayze*, [2003] 1 S.C.R. 722; see also *D'Almeida v. Barron*, [2008] O.J. No. 2945.

[124] Jeffrey W. Swanson *et al.*, "Facilitated Psychiatric Advance Directives: a Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Severe Mental Illness" (2006) 163 (11) American Journal of Psychiatry 1943-1951; Paul S. Appelbaum, "Advance Directives for Psychiatric Treatment" (1991) 42 (10) Hospital & Community Psychiatry: a Journal of the American Psychiatric Association 983-984; Debra S. Srebnik & Joan Russo, "Consistency of Psychiatric Crisis Care with Advance Directive Instructions" (2007) 58 (9) Psychiatric Services 1157-1163.

[125] Janet Ritchie, Ron Sklar & Warren Steiner, "Advance Directives in Psychiatry. Resolving Issues of Autonomy and Competence" (1998) 21 (3) International Journal of Law and Psychiatry 245-260; Daniel L. Ambrosini & Anne G. Crocker, "Psychiatric Advance Directives and the Right to Refuse Treatment in Canada" (2007) 52 96) Canadian Journal of Psychiatry 397-402; Daniel L. Ambrosini & Anne G. Crocker, Psychiatric advance directives and the role of autonomy" (2009) 34 (2) Santé Mentale Québec 51-74; Daniel L. Ambrosini *et al.*, "Perceptions of Psychiatric Advance Directives among Legal and Mental Health Professionals in Ontario and Québec" (2008) 3 (2) Journal Ethics in Mental Health 1-12.

advance directives to access their personal health information.[126] The report further states that any provisions in legislation barring persons from giving advance directives regarding health treatment decisions should be repealed.[127]

A follow-up report released by the Mental Health Commission of Canada in 2009, *Toward Recovery and Well-Being*, recommended that, "people living with mental health problems and illnesses may choose to use advance directives to specify who will make decisions for them when they are not able to do so for themselves."[128] The Canadian Hospice Palliative Care Association released a national framework for advance care planning for the end-of-life context in 2010, noting that one of the challenges in codifying issues around mental capacity and advance care planning has been the lack of harmonization among provincial legislation,

> There are definitions of capacity or competence in some of the provincial/territorial legislation – and they differ…since laws differ across the country, professionals must know what the law says in their own province/territory and they need to address such questions as…Is there a definition of capacity or competence? What is it?[129]
>
> Provincial/territorial ministries of health develop strategies to implement advance care planning programs within their jurisdictions that are modeled after the National Framework and reflect their own legislative environments and health and social service frameworks."[130]

One barrier to implementing advance directives across the provinces and territories lies in the form and substance of policies within mental health statutes that affect the degree of social control over individuals.[131] Another barrier mental health professionals occasionally face is resistance by family members of

---

[126] Michael J.L. Kirby & Wilbert Joseph Keon, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Final Report of The Standing Senate Committee on Social Affairs, Science, and Technology) (Ottawa: Senate Canada, 2006) at 70.

[127] *Ibid*.

[128] Mental Health Commission of Canada, *Toward Recovery and Well-being: a Framework for a Mental Health Strategy for Canada* (Ottawa: Canada, 2009) online: Mental Health Commission of Canada http://www.mentalhealthcommission.ca.

[129] Canadian Hospice Palliative Care Association, *Advance Care Planning in Canada: National Framework for Consultation* (Ottawa: Canada Hospice Palliative Care Assocation, 2010) at p. 15 online: http://www.chpca.net/projects/advance_care_planning/advance_care_planning_index.html.

[130] *Ibid*. at 13.

[131] Walter R. Gove *et al.*, "Involuntary Psychiatric Hospitalization: a Review of the Statutes Regulating the Social Control of the Mentally Ill" (1985) 6 (3) Deviant Behavior 287-318; Robert D. Fleischner, "Advance Directives for Mental Health Care: an Analysis of State Statutes" (1998) 4 (3) Psychology, Public Policy, and Law 788-804.

individuals who question how mental capacity was assessed. A standardized and formal process to assess mental capacity before completing an advance directive could provide greater confidence and trust for individuals and their families that decisions are determined objectively.

Many individuals want to make independent choices regarding treatment preferences in line with the consumer choice model. Many individuals with mental illness understand that they may become incapable to make independent decisions at some point in the future. If mental capacity assessments can be shown to be valid and reliable and can be administered before completing an advance directive, why prohibit individuals from making advance decisions? Honouring individuals' prior capable wishes shows respect for choice, autonomy, and self-determination, which are all values found in legislation such as Ontario's *Health Care Consent Act*.[132] A misperception exists among some that the primary purpose of advance directives is to allow patients to use the documents to refuse involuntary treatment.[133] Research reveals that most individuals completing advance directives do not attempt to decline all treatment with the documents but use them to specify their choices of alternative treatments.[134] If advance directives are completed in a manner that respects individuals' fundamental rights to make reasonable choices when mentally capable, they have the potential to empower persons to greater recovery.

Some have expressed concern that individuals with mental illness may make an advance directive without the requisite mental capacity.[135] This is a valid concern, but it can be overcome by implementing appropriate instruments, tools, and procedures to perform capacity assessments prior to completing advance directives in some circumstances.[136] To suggest that the onus of proof should fall

---

[132] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 4.

[133] John E. Gray & Richard L. O'Reilly, "Supreme Court of Canada's "Beautiful Mind Case"" (2009) 32 (5) International Journal of Law and Psychiatry 315-322.

[134] Paul S. Appelbaum, "Psychiatric Advance Directives and the Treatment of Committed Patients" (2004) 55 (7) Psychiatric Services 751-753.

[135] Richard O'Reilly, "The Capacity to Execute an Advance Directive for Psychiatric Treatment" (2008) 31 (1) International Journal of Law and Psychiatry 66-71.

[136] See, for example, Eric B. Elbogen et al., "Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making" (2007) 31 (3) Law and Human Behavior 275-289.

upon an individual with the mental illness to demonstrate he or she was mentally capable at the time of completing an advance directive during a crisis is unrealistic. Instead, objective tools could be used to assess mental capacity from the outset as a means of promoting individual's autonomy rights.

CONCLUSION

Mental health legislation across the provinces and territories differs in the definitions applied to mental disorder and mental capacity that can influence how individuals receive personalized treatment and care. Over the years, mental health legislation has undergone substantial changes in an effort to keep abreast with innovative research and changing societal values. How mental health legislation is drafted relates to the conceptual model one begins from – whether it is a custodial, medical, prevention, justice, evidence-based, consumer choice, or recovery approach. Individuals with mental illness and families may express frustration with the uncertainty of how capacity assessments are conducted, which may be due partly to the failure of legislation to provide uniformity in the definitions. Therefore, greater effort should be directed towards uniformly defining, interpreting, and applying mental health legislation across the provinces and territories. One possibility could be to develop a Canadian Association of Consent and Capacity Boards that could guide provincial and territorial boards on best practices and guidelines. If advance directives will assume an increased role for individuals with mental illness, there is an ongoing need to ensure that capacity assessments are performed with an objective measure of reliability and validity. The outcome of such efforts will lead to individuals with mental illness perceiving they have greater autonomy to self-manage their illness and develop a long-term plan towards personal recovery.

TABLE 1 – Autonomy Scores of Canadian Mental Health Legislation[137]

Province & Territories	Autonomy rating (6-30)
Saskatchewan	18
Northwest Territories	17
Prince Edward Island	17
Alberta	17
Yukon	16
Nova Scotia	16
Ontario	16
Manitoba	15
New Brunswick	14
Newfoundland and Labrador	11
British Columbia	11
Québec	10

---

[137] Reproduced from E.C. Fistein *et al.*, "A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions" (2009) 32 (3) International Journal of Law and Psychiatry 147-155.

TABLE 2 – Theoretical Models of Drafting Mental Health Legislation

MODEL	DESCRIPTION
CUSTODIAL	Based on dependency, need, and maintenance.
MEDICAL/ BIOLOGICAL	Emphasizes the delivery of treatment and rehabilitation; overly mechanistic and dehumanizing.
PREVENTION	Focuses less on remediation and rehabilitation and more on preventing common mental health problems that interfere with adequate functioning.
JUSTICE: ***PARENS PATRIAE***	Based on benevolent intent of the State (based on police powers) to intervene and offer treatment to individuals in need of protection.
JUSTICE: DANGEROUSNESS & COMMUNITY PROTECTION	Risk to the safety of the public is paramount so that victims' rights in the community are not overlooked; based on the need to predict and prevent potential criminal violence by individuals with mental illness living in the community.
JUSTICE: **THERAPEUTIC JURISPRUDENCE**	Law's impact is used as a positive and therapeutic social force that considers the emotional and psychological well-being and outcome for individuals with mental illness.
EVIDENCE-BASED	Integration of best evidence practices through scientific research combined with clinical expertise and patient values.
RECOVERY	Focuses on individuals' personal recovery and well-being as values to strive for.
CONSUMER CHOICE	Focuses on providing individuals with greater choice to make decisions regarding treatment decisions and substitute decision-making.

TABLE 3 – Legislative Definitions of Mental Disorder across Canadian Mental Health Legislation

JURISDICTION	LEGISLATION	DEFINITION
ALBERTA	*Mental Health Act*, R.S.A. 2000, M-13	s. 1 (g): "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life.
BRITISH COLUMBIA	*Mental Health Act*, R.S.B.C. 1996, c. 288	Definitions: "person with a mental disorder" means a person who has a mental disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others.
MANITOBA	*Mental Health Act*, C.C.S.M., c. M110	s. 1: "mental disorder" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include a disorder due exclusively to a mental disability as defined in *The Vulnerable Persons Living with a Mental Disability Act*; (« troubles mentaux »);
	Vulnerable Persons Living with a Mental Disability Act, 2004, C.C.S.M. c. V90	"mental disability" means significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*.
NEW BRUNSWICK	*Mental Health Act*, R.S.N.B. 1973, c. M-10	s. 1: "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's (a) behaviour, (b) judgment, (c) capacity to recognize reality, or (d) ability to meet the ordinary demands of life, but does not include the disorder known as mental retardation.
	Mental Health Services Act, R.S.N.B. 1997, c. M-10	s. 1: "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's (a) behaviour, (b) judgment, (c) capacity to recognize reality, or (d) ability to meet the ordinary demands of life.
	Infirm Persons Act, 1973, R.S.N.B. 1973, c. 1-8	s. 1: mentally incompetent person means a person (a) in whom there is such a condition of arrested or incomplete development of the mind, whether arising from inherent causes or induced by disease or injury or (b) who is suffering from such a disorder of the mind that he requires care, supervision, and control for his protection or welfare or for the protection of others or for the protection of his property.

NEWFOUNDLAND & LABRADOR	*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	s. 2(1)(k): mental disorder means a disorder of thought, mood, perception, orientation or memory that impairs (i) judgment or behaviour, (ii) the capacity to recognize reality, or (iii) the ability to meet the ordinary demands of life, and in respect of psychiatric treatment is advisable.
	Mentally Disabled Persons' Estates Act, R.S.N.L. 1990, c. M-10	s. 2 (f): "Mentally disabled person" means a person (i) in whom there is such a condition of arrested or incomplete development of the mind, whether arising from inherent causes or induced by disease or injury, or (ii) who is suffering from a disorder of the mind, requiring care, supervision and control for the protection of his or her property, whether or not he or she has been committed under the *Mental Health Care and Treatment Act*.
NORTHWEST TERRITORIES	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	s. 1: "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, the capacity to recognize reality or the ability to meet the ordinary demands of life but mental retardation or a learning disability does not of itself constitute a mental disorder; (troubles mentaux).
NOVA SCOTIA	*Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42	s. 3 (q): "mental disorder" means a substantial disorder of behaviour, thought, mood, perception, orientation or memory that severely impairs judgement, behaviour, capacity to recognize reality or the ability to meet the ordinary demands of life, in respect of which psychiatric treatment is advisable.
NUNAVUT	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	s. 1: "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, the capacity to recognize reality or the ability to meet the ordinary demands of life but mental retardation or a learning disability does not of itself constitute a mental disorder; (troubles mentaux).
	Powers of Attorney Act, S. Nu. 2005, c. 9	s. 1: "mental incapacity", unless otherwise specified in a power of attorney, means the inability of a person, due to infirmity or impaired judgment, whether arising from disease, disability, age, addiction, or cause (a) to understand information that is relevant to making a decision concerning his property or financial interests or, (b) to appreciate the reasonably foreseeable consequence of a decision concerning his or her property or financial interests or the lack of such a decision.

ONTARIO	*Mental Health Act*, R.S.O. 1990, c. M.7	s. 1 (1): “mental disorder” means any disease or disability of the mind.
	Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A	s. 2: “mental disorder has the same meaning as in the *Mental Health Act.*
	Accessibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11.	s. 2: “disability” means (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device, (b) a condition of mental impairment or a development disability, (c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language, (d) a mental disorder, (e) an injury or disability for which benefits were claimed and received under the insurance plan established under the *Workplace Safety and Insurance Act*, 1997.
PRINCE EDWARD ISLAND	*Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1	s. 1 (k): “mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that seriously impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life and includes a mental disorder resulting;
QUÉBEC	*Civil Code of Québec*, (CCQ), S.Q. 1991, c. 64	No explicit definition. Art. 27: Where the court has serious reasons to believe that a person is a danger to himself or to others owing to his mental state, it may, on the application of a physician or an interested person and notwithstanding the absence of consent, order that he be confined temporarily in a health or social services institution for a psychiatric assessment. The court may also, where appropriate, authorize any other medical examination that is necessary in the circumstances. The application, if refused, may not be submitted again except where different facts are alleged. If the danger is grave and immediate, the person may be placed under preventive confinement, without the authorization of the court, as provided for in the Act respecting the protection of persons whose mental state presents a danger to themselves or to others.

SASKATCHEWAN	*Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1	s. 2 (m): “mental disorder” means a disorder of thought, perception, feelings or behaviour that seriously impairs a person's judgment, capacity to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, in respect of which treatment is advisable.
YUKON	*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	s. 1: “mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life but mental retardation or a learning disability does not of itself constitute a mental disorder.
FEDERAL LEGISLATION	*Criminal Code,* R.S. 1985, c. C-46	s. 2: “mental disorder” means a disease of the mind.

TABLE 4 – Legislative Standards of Competence across Canadian Mental Health Legislation

JURISDICTION	LEGISLATION	DEFINITION
ALBERTA	*Mental Health Act*, R.S.A. 2000, M-13	s. 26: A person is mentally competent to make treatment decisions if the person is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions.
BRITISH COLUMBIA	*Mental Health Act*, R.S.B.C. 1996, c. 288	No definition of capacity or competence.
	Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181	s. 3 (1): Presumption of capacity until contrary is demonstrated. s. 3 (2): An adult's way of communicating with others is not, by itself, grounds for deciding that he or she is incapable of understanding anything referred to subsection (1). s. 7: When deciding whether an adult is incapable of giving, refusing or revoking consent to health care, a health care provider must base the decision on whether or not the adult demonstrates that he or she understands (a) the information given by the health care provider under section 6 (e), and (b) that the information applies to the situation of the adult for whom the health care is proposed.
	Representation Agreement Act, R.S.B.C. 1996, c. 405	s. 8 (2): In deciding whether an adult is incapable of making a representation agreement consisting of one or more of the standard provisions authorized by section 7, or of changing or revoking any of these provisions, all relevant factors must be considered, for example: (a) whether the adult communicates a desire to have a representative make, help make, or stop making decisions; (b) whether the adult demonstrates choices and preferences and can express feelings of approval or disapproval of others; (c) whether the adult is aware that making the representation agreement or changing or revoking any of the provisions means that the representative may make, or stop making, decisions or choices that affect the adult; (d) whether the adult has a relationship with the representative that is characterized by trust.

MANITOBA	*Mental Health Act,* C.C.S.M., c. M110	s. 3: For the purpose of Part 8 and 9, a person is incapable of personal care if he or she is repeatedly or continuously unable, because of mental capacity, (a) to care for himself or herself; and (b) to make reasonable decisions about matters relating to his or her person or appreciate the reasonably foreseeable consequences of a decision or lack of decision. s. 17 (2): In determining whether a person is mentally competent to consent to a voluntary admission under clause (1) (c), the psychiatrist shall consider whether the person understands the nature and purpose of admission and whether the person's condition affects he or her ability to appreciate the consequences of giving or withholding consent. s. 27(1) (2): Except as provided in this Act, a patient of a facility has the right to consent to or refuse psychiatric and other medical treatment. In determining a patient's mental competence to make treatment decisions, the attending physician shall consider (a) whether the patient understands (i) the condition for which the treatment is proposed, (ii) the nature and purpose of the treatment, (iii) the risks and benefits involved in undergoing the treatment, and (iv) the risk and benefits involved in not undergoing the treatment; and (b) whether the patient's mental condition affects his or her ability to appreciate the consequences of making a treatment decision.
	Vulnerable Persons Living with a Mental Disability Act, 2004, C.C.S.M. c. V90	s. 46: For the purposes of this Act, a person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, or his or her own physical, emotional, psychological, residential, educational, vocational or social needs, or similar needs, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.
	Powers of Attorney Act, 2006 C.C.S.M. c. P97	s. 1: "Mental incompetence" means the inability of a person to manage his or her affairs by reason of mental infirmity arising from age or a disease, addiction or other cause.
	The Health Care Directives Act, 1993, C.C.S.M. c. H27	s. 2: For the purpose of this Act, a person has the capacity to make health care decisions if he or she is able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

NEW BRUNSWICK	*Mental Health Act*, R.S.N.B. 1973, c. M-10	s. 1(2): For the purposes of consent under this Act, a person is mentally competent to give or refuse to give consent if the person is able to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or refusing to give consent, and, if the consent relates to a proposed treatment for the person, the subject-matter is the nature of the person's illness and the nature of the proposed treatment.
NEWFOUNDLAND & LABRADOR	*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	No definition of competence or capacity.
NORTHWEST TERRITORIES	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	s. 1: "mentally competent" means having the ability to understand the subject-matter in respect of which consent is requested and the ability to appreciate the consequences of giving or withholding consent.
	Powers of Attorney Act, S.N.W.T. 2001 c.15	s. 1: "mental incapacity" means the inability of a person, by himself or herself or with assistance, to (a) understand information that is relevant to making a decision concerning his or her financial affairs, or (b) appreciate the reasonably foreseeable consequences of a decision concerning his or her financial affairs or the lack of such a decision.
	Personal Directives Act, S.N.W.T. 2005, c. 16	s. 1: "capacity" means the ability to (a) understand information that is relevant to making of a personal decision and (b) appreciate the reasonably foreseeable consequences of that personal decision.
NOVA SCOTIA	*Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42	s. 18 (1): In determining a patient's capacity to make a treatment decision pursuant to clause 17 (e), the psychiatrist shall consider whether the patient fully understands and appreciates (a) the nature of the condition for which the specific treatment is proposed; (b) the nature and purpose of the specific treatment; (c) the risks and benefits involved in undergoing the specific treatment; and (d) the risks and benefits involved in not undergoing the specific treatment; (2) In determining a patient's capacity to make a treatment decision, the psychiatrist shall also consider whether the patient's mental disorder affects the patient's ability to fully appreciate the consequence of making the treatment decision.
	Incompetent Persons Act, R.S.N.s. 1989, c. 218	s. 2: "incompetent person" includes a person, not an infant, who is incapable from infirmity of mind of managing the person's own affairs.

NUNAVUT	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	No explicit reference.
ONTARIO	*Mental Health Act*, R.S.O. 1990, c. M.7	No explicit reference.
	Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A	s. 4 (1): A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. s. 4 (2): A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.
	Substitute Decisions Act, 1992, S.O. 1992, c. 30	s. 47: A person is capable of giving a power of attorney for personal care if the person, (a) has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare, and (b) appreciates that the person may need to have the proposed attorney make decisions for the person.
PRINCE EDWARD ISLAND	*Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1	s. 1 (f): "capable" or "incapable" means mentally capable or incapable of capable of making a decision to give or refuse consent to treatment.
	Powers of Attorney Act, R.S.P.E.I. 1988, c. P-16.	s. 1: Legal incapacity" means mental infirmity of such a nature as would, but for this Act, invalidate or terminate a power of attorney and "legal incapacity" has a corresponding meaning.
	Consent to Treatment and Health Care Directives Act, R.S.P.E.I. 1988, c. C-17.2	s. 7 (1): Subject to the criteria prescribed pursuant to section 10, a patient is capable with respect to treatment if the patient is, in the health practitioner's opinion, able (a) to understand the information that is relevant to making a decision concerning the treatment; (b) to understand that the information applies to his or her particular situation, (c) to understand that the patient has the right to make a decision; and (d) to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

QUÉBEC	*Civil Code of Québec*, (CCQ), S.Q. 1991, c. 64	No explicit definition.
	An Act respecting the protection of persons whose mental state presents a danger to themselves or to others, R.S.Q. c. P-38.001	No explicit definition.
SASKATCHEWAN	*Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1	No definition.
	The Health Care Directives and Substitute Health Care Decision Makers Act, S.S. 1997, C. H-0.001	s. 2 (1): "Capacity" means the ability: (i) to understand information relevant to a health care decision respecting a proposed treatment; (ii) to appreciate the reasonably foreseeable consequences of making a health care decision respecting a proposed treatment; and (iii) to communicate a health care decision on a proposed treatment.
YUKON	*Mental Health Act*, R.S.Y. 2002, c. 150	s. 19: A person is mentally competent to consent to treatment if the person is able to (a) understand the condition for which the treatment is proposed; (b) understand the nature and purpose of the treatment; (c) understand the risks involved in undergoing the treatment; and (d) understand the risks involved in not undergoing treatment.

CHAPTER SEVEN: Civil commitment, autonomy, and advance directives: a cross-country check-up

Civil commitment, also known as confinement in Québec, is a legal process that permits individuals to be temporarily committed to a designated psychiatric facility either voluntarily or involuntarily. Current prevalence rates of the civil commitment process in Canada are not well documented. No comprehensive overview comparing the extent that civil commitment procedures conform to mental health legislation has been conducted across Canadian jurisdictions. Civil commitment procedures are considered laws of exception because there is a presumption that the liberty rights of individuals with mental illness will be honoured, although under narrowly defined exceptions they can be overridden. In this chapter, the history of civil commitment in Canada is reviewed along with how the process can influence patient autonomy. General principles are provided for clinicians of when and how to commit individuals, particularly during an involuntary admission process. Civil commitment is relevant for advance directives as individuals with mental illness often want to make their instructions known to hospital staff regarding hospitalization experiences, treatment preferences, and hospitals they wish to attend. The success of advance directives will ultimately depend on whether clinicians and health care providers can receive and review such documents in adequate time during a crisis.

Ambrosini, D. L. & Joncas, L. (in press). Civil commitment: a cross-country check-up, in Bloom H, Schneider R. (Eds.). *Law and Mental Disorder: A Comprehensive and Practical Approach* (Toronto: Irwin Law).

TABLE OF CONTENTS

INTRODUCTION

Over the past 35 years, there have been many changes to civil commitment legislation across Canada. Many of the reforms reflect an attempt to balance the civil rights of individuals through stronger procedural safeguards with the need to provide effective and timely medical care. Although psychiatric hospitals have evolved dramatically over the past one hundred years - from asylums, to detention centers, to treatment centers, to research institutes - there is an ongoing need to ensure that mental health legislation reflects societal standards. The civil liberties movement that emerged in the United States during the 1970's has also had an effect on civil commitment legislation across Canada. The aim of this chapter is to provide a comparative analysis of civil commitment legislation across Canadian provinces and territories, and to identify areas where the autonomous rights of individuals with mental illness can be strengthened.

Civil commitment is a legal process whereby individuals with a mental illness can be temporarily committed to a designated psychiatric facility where they receive medical treatment, care, or supervision. Individuals can be committed through a voluntary or an involuntary process.[1] Although this chapter primarily addresses involuntary commitment, it is important to appreciate that many individuals voluntarily admit themselves to hospitals at the encouragement of physicians, family, and friends.[2] While coercion may be less visible in the voluntary rather than involuntary process, it can still exist in subtle forms known as pressures. For many years, voluntary hospitalization was not permitted partly because there was a fear that if individuals could voluntarily commit themselves to a hospital they could also leave when they wanted, which could interfere with treatment programs.[3] There was also a myth, one that may still exist today, that individuals with mental illness are presumptively incompetent to consent to

---

[1] Winick, B.J. (2005). *Civil Commitment: A Therapeutic Jurisprudence Model*. Durham, North Carolina: Carolina Academic Press at 3-4 [*Winick*].

[2] Gray, J.E., Shone, M.A. & Liddle P.F. (2008). (2nd Edition), *Canadian Mental Health Law and Policy*. Markham, Ontario: LexisNexis Canada at 20 [*Gray*]; *Winick, supra* note 1 at 165-196.

[3] Appelbaum, P. S. & Guteil, T.S. (2007). (4th Edition). *Clinical Handbook of Psychiatry and the Law*. Philadelphia, PA: Lippencott Williams & Wilkins at 38 [*Appelbaum*].

hospitalization.[4] Receiving a diagnosis of a mental illness should not automatically be equated with an inability to make capable or autonomous choices.

Although short and long-term hospital stays are occasionally required for an individual's best interests, hospital detention over a long period can affect one's self-perception of autonomy. In the same way that forcing medical treatment can lead to perceptions that one's bodily integrity is being threatened, civil commitment can lead to feelings of being unduly detained and isolated from the greater community. Outpatient commitment (OPC) offers a greater degree of freedom than civil commitment in that individuals can live in the community contingent on following their prescribed treatment.[5] OPC is a term commonly associated with the U.S. legislation whereby individuals are mandated to follow certain treatments while living in the community. Some Canadian provinces have incorporated a similar intervention known as a community treatment order (CTO) in their mental health legislation.

Deinstitutionalization policies have also led to an increasing number of individuals receiving mental health care in the community. As a result, mental health legislation across several countries has been reformed to include community treatment rather than only hospital care.[6] Whereas individuals with mental illness were most often hospitalized and treated solely based on whether they suffered a mental illness and were in need of treatment, it is now possible under mental health legislation to re-commit someone to a hospital for failing to follow their prescribed medication.

Following due process is essential to ensure that individuals' rights are respected in civil commitment procedures, which can be evaluated during three periods: (1) during the initial assessment and admission process; (2) while someone is admitted as a short or long-term patient, or; (3) during discharge and

---

[4] *Ibid* at 38.

[5] Outpatient commitment (OPC) is a term commonly associated with United States legislation whereby individuals are mandated to follow certain treatments while living in the community. Some Canadian provinces have incorporated a similar intervention known as a community treatment order (CTO) in their mental health legislation.

[6] Anfang, S. A., & Appelbaum, P. S. (2006). Civil commitment-the American experience. *Israel Journal of Psychiatry and Related Science*, *43*(3), 209-218.

follow-up in the community. Procedural law can help ensure that effective and ethical treatment will be provided. As Chief Justice McLachlin of the Supreme Court of Canada has stated, however, "[l]aws cannot heal people; only medical professionals who provide services and treatment do that."[7] Indeed, while laws are intended to ensure that procedural safeguards protect patients' rights, they must also be flexible enough to change with societal values.

Because of the division of powers doctrine in Canada mental health falls within the competence of provincial[8] and territorial jurisdiction.[9] According to section 92 (7) of the *Constitution Act, 1867*, provinces and territories have exclusive jurisdiction to legislate on "the "establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals."[10] Because of this provincial/federal divide, offering a national perspective of civil commitment legislation is not always straightforward. Nevertheless, comparing how legislative provisions are applied across jurisdictions can help identify gaps or trends that need to be addressed. Furthermore, although provincial mental health legislation and federal legislation such as the *Criminal Code* are intended to be theoretically non-overlapping, some provinces have enacted legislation that has blurred these boundaries.[11]

---

[7] Chief Justice McLachlin, (Spring 2005). "Research views" *Alberta Heritage Foundation for Medical Research: Research News*, online: http://www.ahfmr.ab.ca/publications.html (during a lecture "Medicine and Law: The Challenges of Mental Illness" given at University of Alberta and University of Calgary).

[8] The governing provincial mental health legislation include British Columbia - *Mental Health Act*, R.S.B.C. 1996, c. 288; Alberta - *Mental Health Act*, R.S.A. 2000, M-13; Saskatchewan - *Mental Health Services Act*, S.S. 1984-85-86, c. M-15.1; Manitoba - *Mental Health Act*, C.C.S.M., c. M110; Ontario - *Mental Health Act*, R.S.O. 1990, c. M. 7; Québec – *Civil Code of Québec*, S.Q. 1991, c. 64; *An act respecting the protection of persons whose Mental State presents a danger to themselves or to the others*, R.S.Q., c. P-38.001; New Brunswick - *Mental Health Services Act*, R.S.N.B. 1973, c. M-10; Nova Scotia – *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42; Prince Edward Island - *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1; Newfoundland & Labrador - *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1.

[9] The governing legislation in the territories include Northwest Territories - *Mental Health Act*, R.S.N.W.T. 1998, c. M-10; Nunavut - *Mental Health Act*, R.S.N.W.T. 1988, c. M-10; Yukon - *Mental Health Act*, R.S.Y. 2002, c. 150

[10] *The Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, s. 91, 92.

[11] British Columbia – *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 30, 31; Alberta – *Mental Health Act*, R.S.A. 2000, c. M-13, s. 13; Saskatchewan – *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 22; Manitoba – *Mental Health Act*, C.C.S.M., c. M110, s. 24-25; Ontario – *Mental Health Act*, R.S.O. 1990, c. M.7, s. 21-23.

I. LAWS OF EXCEPTION

Before examining mental health legislation, it is important to appreciate that these are all laws of exception that need to be interpreted restrictively. Although an individual's rights can be overridden in the interests of necessary medical treatment under certain situations, such as if someone is a danger or threat to others, civil commitment is a process that interferes presumptively with an individual's constitutional rights. As Winick states, "[c]ivil commitment is basically inconsistent with our legal system's strong commitment to principles of individual autonomy and self-determination."[12]

The application of the least restrictive principle during the process of civil commitment is not new. Anand stated more than thirty years ago, "[i]t is important to realize at the outset that civil commitment represents the most significant deprivation of liberty without judicial process that is sanctioned by our society today."[13] Consequently, involuntary civil commitment should always be used as a last resort such as if patients decline voluntary commitment but pose a substantial risk of harm to oneself or others.[14]

Just as lawyers meeting clients must presume that their competence to make legal decisions is intact, similarly individuals who present themselves at a hospital should be presumed capable to make free and informed decisions. Of course, a psychiatric assessment may quickly reveal that the individual's mental capacity to make decisions is impaired or diminished. Despite lacking the capacity to make independent decisions, an individual will not necessarily lose their full autonomy. Civil commitment is considered a temporary process with a long-term goal of assisting patients to return to an autonomous life in the community.

Equally important is that although mental health legislation can restrict individuals' liberty rights, the principles found across legislation must still

---

[12] *Winick, supra* note 1 at 17.

[13] Anand, R. (1979). Involuntary civil commitment in Ontario: the need to curtail the abuses of psychiatry. *Canadian Bar Review, 57*(2), 250-280.

[14] Appelbaum, P. S., & Rumpf, T. (1998). Civil commitment of the anorexic patient. *General Hospital Psychiatry, 20*(4), 225-230. Some decisions to commit individuals to a hospital are clear whereas others will be more difficult, such as with individuals who suffer from anorexia nervosa where it appears that harm to oneself is not imminent, which may not be the case.

conform to the *Canadian Charter of Rights and Freedom*.[15] Some of these *Charter* rights include the right to counsel, the right to remain silent, to communicate with others, to receive visitors, to object to certain forms of seclusion and restraint, to request reasonable treatment, to refuse unreasonable treatment, to declare treatment preferences, and to access medical records.[16] Within the context of criminal law, section 10 of the *Charter* provides that everyone has a right to be informed promptly of the reason for an arrest or detention.[17] While hospital detention for the purpose of a psychiatric assessment under mental health legislation does not always hold the same public aim as detention in the criminal law context, their common thread lies in that both temporarily restrict individuals' rights.[18]

Most jurisdictions have incorporated into mental health legislation, as a matter of constitutional freedom, the principle that treatment should be administered in the least restrictive or least intrusive manner.[19] The Supreme Court of Canada has stated in the criminal law context that where an individual poses a risk to the public the "least onerous" and "least restrictive alternative" must be considered to protect that person's liberty interests.[20] Applying the least restrictive principle to the mental health context means that before committing someone to a hospital involuntarily, whether that person is dangerous or not, all

---

[15] See *Gray, supra* note 2 at 55-63 for an overview of the *Charter* as it applies to mental health law.

[16] For a Canadian perspective describing some of these rights and safeguards see, *Gray*, *supra* note 2 at 331-387; for an American perspective, see Miller, R.D. (1987). *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*. Springfield, Illinois: Charles C Thomas Publisher; *Winick, supra* note 1 at 197-238; *Appelbaum, supra* note 3 at 77-81 (describing the rights of inpatients).

[17] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, s. 10 [*Charter*].

[18] See *C.B. v. Sawadsky*, [2005] O.J. No. 3682 where the court stated that protections under the *Charter* do not have the same effect for detention under the *Mental Health Act* as someone detained for criminal purposes. The decision was affirmed in *C.B. v. Sawadsky*, [2006] O.J. No. 4050, and application for leave to appeal dismissed in *C.B. v. Sawadsky*, [2006] S.C.C.A. No. 479.

[19] For a discussion of the least restrictive alternative principle in the Unites States, see Slovenko, R. (2000). Civil commitment laws: an analysis and critique. *Cooley Law Review, 17*(1), 25-51.

[20] See specifically, *Pinet v. St. Thomas Psychiatric Hospital*, [2004] 1 S.C.R. 528; *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, [2004] 1 S.C.R. 498; *R. v. Demers*, [2004] 2 S.C.R. 489; See also *Criminal Code*, R.S.C.1985, c. C-46, s.672.54 [*Criminal Code*].

other reasonable alternatives must have been explored first.[21] For example, the use of diversion by problem-solving courts uses the least restrictive principle because it aims to first direct individuals to treatment programs or processes that may lead to positive clinical outcomes. Table 1 highlights how several *Mental Health Acts* have included a reference to the least restrictive principle.[22] Some provinces and territories may wish to consider how this principle can be made more explicit.

II. HISTORY OF CIVIL COMMITMENT IN CANADA

To appreciate the evolution of civil commitment in Canada it is necessary to contextualize the legislation within the historical development of psychiatric hospitals. During early settlement into North America, individuals with mental illness were primarily cared for by members of their communities.[23] As the burden of care for such individuals mounted, almshouses and jails were used to confine persons, with the law offering only limited protections and rights.[24] Among the first of the British North American colonies to make special provisions for individuals with mental illness was New Brunswick where, in 1835, a small wooden building that had been a cholera hospital was converted into an asylum.[25] Until then, it was possible for any two justices of the peace, without a medical certificate "to issue a warrant for the apprehension of a lunatic or mad person, and cause him to be kept safely locked in some secure place directed and appointed by them, and, if they deem it necessary, to be chained."[26]

During these early years, mental health legislation did not differentiate between individuals with mental illness and serious criminals. Jails were

---

[21] For example, the use of diversion by problem-solving courts uses the least restrictive principle because it aims to first direct individuals to treatment program or processes that may lead to positive clinical outcomes.

[22] The references listed in Table 1 to the least restrictive principle in mental health legislation are not intended to be exhaustive.

[23] *Appelbaum, supra* note 3 at 40-41 (where in the United States the first hospital to be established in Philadelphia back in 1751 provided treatment for physical and mental health problems).

[24] According to the Napoleonic Code of 1804, insane individuals were categorized with mad animals who were running about freely. See Burgess, T.J.W. (1905). Presidential Address - The insane in Canada, *American Journal of Insanity*, LXII, 1, 1-36 [*Burgess*].

[25] *Burgess, Ibid*.

[26] *Burgess, Ibid*.

substituted with hospitals, and those individuals who behaved in a bizarre manner were often perceived as dangerous. In 1841, the jail in York, now known as Toronto, was retrofitted as one of the first asylums, followed by Québec who opened the doors of Beauport Asylum in 1845.[27] As asylums began emerging in Kingston, London, and Hamilton,[28] by-laws and regulations were provided on how to manage more effectively individuals with mental illness. In 1853, *An Act for the Better Management of the Provincial Lunatic Asylum at Toronto* was enacted where it provided that "no person shall be received into the Institution as a Lunatic without a Certificate from three Medical Licentiates."[29] Interestingly, the legislation required the Certificate be signed by the Reeve or Mayor where the person was referred from, and required the signature of three Medical Licentiates in the presence of each other to examine the patient and inquire into all the necessary facts relating to the individual.[30] Not all provinces offered similar safeguards to protect patients' liberties during this time, with some individuals admitted into hospitals based on a single line from a doctor and, occasionally, with no recorded medical history.[31] Nevertheless, according to the Supreme Court of Canada in 1951, section 5 of chapter 61 of the 1857 Statutes of Canada provided that the Court could, on sufficient evidence, declare a person a lunatic without the delay or expense of issuing a commission, except in cases where there was a reasonable doubt.[32] In 1909, the *Lunacy Act* in Ontario repealed this earlier legislation, followed by the *Mental Incompetency Act* in 1937. By 1978, the committal criteria across all the provinces were based on a "need for treatment" model.[33]

---

[27] *Burgess, Ibid*.

[28] *Burgess, Ibid* at 5-6. In Québec, the first asylum developed was the Beauport Asylum in 1845 just outside of Québec City, followed by two others closer to Montreal, one of which was the Protestant Hospital for the Insane (Verdun Hospital) in 1890, now known as the Douglas Mental Health University Institute.

[29] *An Act for the Better Management of the Provincial Lunatic Asylum at Toronto*, (1854): Toronto: [s.n.], 1854. CIHM, microfiche, no. 53934

[30] *Ibid.*

[31] *Burgess, supra* note 24 at 1, 13-14.

[32] See *Wright v. Wright*, [1951] S.C.R. 728.

[33] *Gray, supra* note 2 at 109.

The move to strengthen mental health legislation across provinces and territories reflected a growing need to provide procedural safeguards that would protect patients' civil rights. The level of protection for patients from possible civil rights abuses has often been associated with the amount of funding hospitals received to advance psychiatric research.[34] Over the years, it became an important part of civil commitment legislation that respect for the rights and safeguards of patients while admitted to a hospital should be paramount. Some of these procedural safeguards included specifying the scope of committal criteria and treatment authorization, providing greater information to patients to make treatment decisions, ensuring renewal certificates contain checks and balances against possible abuses, and providing patients with a meaningful review and appeal process.[35]

III. PREVALENCE OF CIVIL COMMITMENT

The prevalence of individuals civilly committed across Canada is difficult to determine with systematic accuracy.[36] In 1901, there were an estimated 16,622 individuals with mental illness in Canada, 64% of who were institutionalized.[37] The length of time patients remain in hospital can depend on several factors, such as whether the admission was voluntary or involuntary. According to a 2005-2006 report, provinces with the longest average length of stay in a psychiatric hospital were B.C. (439 days), Saskatchewan (368 days), and New Brunswick (181 days).[38] Patients who are involuntarily committed for the longest period are those diagnosed with schizophrenia.[39] In 2007-2008, the three most common reasons

---

[34] See *Burgess, supra* note 24 at 1, 14, where Dr. Burgess reports, "Ontario, as the wealthiest of the Provinces, has of course been able to outstrip the others, and in it's care of the insane has always endeavoured to keep up with the advance of science."

[35] *Gray, supra* note 2 at 26-29.

[36] Crisanti, A.S. & Love, E.J. (2001). Characteristics of psychiatric in patients detained under civil commitment legislation: a Canadian study. *International Journal of Law and Psychiatry*, 24, 399 [*Crisanti*].

[37] *Burgess, supra* note at 24 at 1, 15. As of 1901, British Columbia had 94% of their patients institutionalized, whereas New Brunswick had custodial care for 52% of patients. At the time, the population of Canada was 5,371,315 individuals.

[38] Canadian Institute Health Information: Total Patient Days and Average Length of Stay Related to Mental Illness Separations, 2005-2006, online: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_source_hmhdb_e.

[39] *Crisanti, supra* note 36.

for admission to an Ontario mental health bed (whether in a general hospital or a psychiatric facility) included: (i) threat or danger to oneself (49%); (ii) an inability to care for oneself because of mental illness (35%) and; (iii) problems with addiction or dependency (27%).[40] On average, individuals from psychiatric hospitals tend to remain in hospital longer than do individuals from general hospitals before discharge.[41]

Individuals involuntarily committed are more likely to be male; have significantly longer hospital stays than those who commit themselves voluntarily; are more likely to be diagnosed with schizophrenia, and are already known to the criminal justice system.[42] The risk of subsequent criminal behaviour is higher among persons who have been detained in a psychiatric inpatient unit under civil commitment legislation compared to individuals who accept treatment.[43] One study from the Canadian Institute for Health Information showed that within one week of discharge from the hospital, 4% of individuals diagnosed with schizophrenia were re-admitted, 28% will be readmitted after six months, and 38% after one year.[44]

Recent data from epidemiological studies on the number of persons involuntarily committed across Canada would be helpful. In the meantime, however, one proxy measure to determine how significant the issue of involuntary hospitalization is can be estimated from the number of court cases dealing with the issue. More than twenty-five years ago, a quarter of all admissions to Canadian hospitals were involuntary.[45] Certainly, those figures have changed as

---

[40] Canadian Institute for Health Information, Analysis in Brief, Exploring Hospital Mental Health Service use in Ontario, 2007-2008, March 31, 2009, online: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_2813_E.

[41] Canadian Institute for Health Information, Exploring Hospital Mental Health Service use in Ontario, 2007-2008, March 31, 2009, online: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_2813_E.

[42] Crisanti A. S., & Love E.J. (2002). From one legal system to another? An examination of the relationship between involuntary hospitalization and arrest. *International Journal of Law and Psychiatry*, 25, 581

[43] *Crisanti, Ibid.*

[44] Canadian Institute for Health Information, Hospital Length of Stay and Readmission for Individuals Diagnosed with Schizophrenia: Are they Related? April 17, 2008, online: http://secure.cihi.ca/cihiweb/products/aib_los_and_readmission08_e.pdf.

[45] Riley, R., & Richman A. (1983). Involuntary hospitalization in Canadian psychiatric inpatient facilities. *Canadian Journal of Psychiatry*, 28, 536.

individuals began committing themselves voluntarily to hospitals. As of 1999, in the judicial district of Montréal alone, one advocacy group found there were 1619 motions filed for either preventive confinement (284), confinement (1159), or renewal (176), with over 85% of these motions presented before the courts without the patient present.[46] Only ten of the above-mentioned motions were rejected by the courts.[47] In 2000, there were 4504 motions filed with Québec courts requesting an order for involuntary admission and a psychiatric examination.[48] Future research should focus on obtaining prevalence rates of voluntary and involuntary civil commitment procedures across Canada and identifying how courts deal with the issue.

IV. THE ROLE OF AUTONOMY IN CIVIL COMMITMENT

By its very nature, civil commitment is a coercive process. Health care providers need to consider how coercion may be used to leverage whether individuals are admitted or discharged from a hospital, and how this influences their level of autonomy.[49] To combat negative perceptions associated with being involuntarily coerced, hospitals could implement practical strategies aimed towards increasing patient autonomy. For example, research reveals there is a difference between locking patients into crisis units where they have only a bed and window, versus permitting patients to reside in a more open living environment with a kitchen, multiple rooms, and an accessible garden, which can lead to greater reductions in psychopathology and increased treatment satisfaction.[50] Of course, offering such mental health services may be limited by economic resources, yet this research highlights the value of understanding how one's physical environment in a hospital can influence perceptions of well-being.

---

[46] Provencher C. & Hébert, A. (1999). Quand la liberté ne tient qu'à…". Étude de l'application de la loi, Région de Montréal: Action Autonomie Le Collectif pour la défense des droits en santé mentale de Montréal.

[47] *Ibid.*

[48] Dupin, F. (2003). Être protégé malgré soi. *Le Journal du Barreau du Québec*, 182, at 119.

[49] *Winick, supra* note 1 at 17-39.

[50] Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1-2), 135-144.

Civil commitment directly affects an individual's degree of autonomy. Although the principle of autonomy is generally considered a universal ethic, it also has reasonable limits. As stated by the Supreme Court of Canada in the 2003 case of *Starson v. Swayze*,

> Ordinarily at law, the value of autonomy prevails over the value of effective medical treatment. No matter how ill a person, no matter how likely deterioration or death, it is for that person and that person alone to decide whether to accept a proposed medical treatment. However, where the individual is incompetent, or lacks the capacity, to make the decision, the law may override his or her wishes and order hospitalization.[51]

Providing individuals the freedom to make reasonable choices regarding medical treatment, wherever possible, may help to foster autonomy. Section 1 of Ontario's *Health Care Consent Act* (*HCCA*) provides that one of the purposes of the legislation is "to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed."[52] However, a care facility in the *HCCA*, which refers to either a long-term care home or a care facility as defined under the *Long Term Care Homes Act*, is distinguishable from a psychiatric facility. One Ontario court has stated that although one of the purposes of the *HCCA* is to "enhance the autonomy of persons," an autonomy interest refers to "persons for whom treatment is proposed," and once there has been a finding of incapacity, the autonomy-interest purpose has been met.[53] Yet, how far does one need to go to enhance an individual's autonomy-interest? The relationship between autonomy, mental capacity, and admission to a psychiatric or care facility needs further research.

Despite the coercive nature of civil commitment procedures, some suggest that after recovering from mental illness, some patients will thank their physicians for providing them effective medical treatment. In 1975, Professor Stone proposed the "thank-you theory" of involuntary civil commitment, where he suggested that if psychiatrists focus on preventing and treating mental illness then even if patients deteriorate to the point of being involuntarily committed, they

---

[51] *Starson v. Swayze*, [2003] 1 S.C.R. 722.

[52] *Health Care Consent Act*, 1996, S.O. 1996, c.2, Sch. A. s. 1.

[53] For two cases discussing the autonomy criteria in section 1 (c) of the *Health Care Consent Act*, see *Professor Starson v. Dr. Mark Pearce*, [2009] O.J. No. 21, and *S.R. v. Hutchison*, [2009], O.J. No. 516.

would thank their doctors after recovering.[54] It should be remembered, however, that involuntary hospitalization is able to have both positive and negative effects on an individual's perceptions of autonomy. The stigma of having been institutionalized can also influence individuals' re-integration back into society. Individuals will only be thankful for medical treatment if it was effective and ethical, not if they remain hospitalized on a long-term basis with their health condition deteriorating.

V. TREATMENT UNDER CRIMINAL CODE AND MENTAL HEALTH ACTS

The boundary between treatments administered under mental health legislation and under the *Criminal Code* can occasionally become blurred.[55] The *Criminal Code* places limitations on how individuals with mental illness are dealt with in terms of assessment and treatment when someone is found to be unfit to stand trial. Section 672.58 of the *Code* is the only provision that allows for involuntary court-ordered treatment of an accused individual.[56] It is limited to treatment that will, to the satisfaction of the court, *likely* make the accused fit to stand trial within a period not exceeding sixty days.[57] In the criminal sphere, making an individual fit to stand trial is the primary objective of involuntary treatment and dangerousness does not come into consideration at this stage, although it may have a bearing on whether court-ordered assessments or treatments are performed while in or out of custody.

The criteria for a treatment disposition in the criminal context are established under section 672.59 of the *Code*, which provides that no treatment disposition should be made unless the court is satisfied based on a medical practitioner's testimony that the treatment will result in making the accused fit to

---

[54] Stone, A. (1975). *Mental Health and Law: A System in Transition*, Rockville, Md.: National Institute of Mental Health, Center for Studies of Crime and Delinquency.
[55] *Starnaman v. Penetanguishene Mental Health Centre*, [1995] O.J. 2130 (C.A).
[56] *Criminal Code*, s. 672.58; See also *Institut Philippe Pinel de Montréal v. A.M.* [2001] Q.J. No. 1554.
[57] *Criminal Code*, s. 672.59 (2) (b).

stand trial.[58] The evaluation does not have to be made by a psychiatrist because, according to section 672.1, the definition of a medical practitioner is a person entitled to practice medicine by the laws of the province.[59] A related issue that occasionally arises is identifying who is authorized to prescribe treatment. In *Mazzei*, the Supreme Court of Canada ruled that while Review Boards have the authority to make their decisions binding on hospitals, they cannot require hospitals to prescribe or impose medical treatment for someone declared not criminally responsible on account of mental disorder.[60] While not allowed to prescribe medical treatment, Review Boards have a supervisory role with respect to treatment decisions of individuals who fall under their jurisdictional care.[61]

Section 672.61 of the *Code* also prohibits courts from directing that either psychosurgery or electro-convulsive therapy be prescribed.[62] Mental health legislation across provinces and territories does not uniformly contain the same restrictions. Although electro-convulsive therapy has been authorized by courts if an individual suffers from severe and recurring depression,[63] there have been no recent cases authorizing psychosurgery. Involuntary confinement (forced hospital admission) and involuntary treatment (forced treatment such as forced electro-convulsive therapy) are distinct from one another; in both cases, however, individuals have a right to substantial procedural protections. Involuntary treatment of an accused is generally not permitted under the *Code*, with the above-mentioned exception found in section 672.58. Consequently, care must be exercised in using mental health legislation to do what was actually intended by the criminal justice system, and vice versa. An individual's first contact with the

---

[58] *Criminal Code*, s. 672.59.

[59] *Criminal Code*, s. 672.1.

[60] *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)* [2006] 1 S.C.R. 326 [*Mazzei*].

[61] *Ibid.*

[62] *Criminal Code*, s. 672.61.

[63] See *T and Board of Review for the Western Region et al.,* [1983] O.J. No. 3249, where the court stated that electroconvulsive therapy does not fall within the meaning of psychosurgery in the statute and therefore was able to be administered to an individual as involuntary treatment.

mental health or the criminal justice system can determine subsequent orientation.[64]

VI. PSYCHIATRIC GATING AND THE ROLE OF DIVERSION

There has been a long history in psychiatry of attempting to separate individuals with mental illness who engage in criminal behaviour from those who do not.[65] In the U.S., this has become evident with the proliferation of civil commitment laws for sexual predators. Research suggests that some jury-eligible citizens make decisions regarding the civil commitment of sexually violent offenders based primarily on retributive motives rather than a desire to protect society by focusing on potential recidivism.[66]

Psychiatric gating is a process used to detain convicted sexual offenders in a hospital towards the end of their criminal sentence.[67] In other words, a prisoner is certified under mental health legislation as an involuntary patient typically only days before the completion of his criminal sentence.[68] Although section 24 (2) of Manitoba's *Mental Health Act* appears to be the only provision that codifies this procedure,[69] this is a practice that occurs in other provinces in a more informal way. Concerns have also been raised regarding the use of sections 21 and 22 of Ontario's *Mental Health Act* for sentencing purposes.[70] These examples illustrate

---

[64] Dessureault, D., Côté, G., & Lesage G., (2000). Impact of first contacts with the criminal justice or mental health systems on the subsequent orientation of mentally disordered persons toward either system. *International Journal of Law and Psychiatry*, 23, 79.

[65] *Burgess, supra* note 24 at 1, 27.

[66] Carlsmith, K. M., Monahan, J., & Evans, A. (2007). The function of punishment in the "civil" commitment of sexually violent predators. *Behavioral Sciences & the Law*, *25*(4), 437-448; See also La Fond, J. Q. (2000). The future of involuntary civil commitment in the U.S.A. after Kansas v. Hendricks. *Behavioral Sciences & the Law*, *18*(2-3), 153-167 (dealing with US courts' approach to civil commitment of sexual offenders).

[67] Henry, Y. (2001). Psychiatric gating: questioning the civil committal of convicted sex offenders, *University of Toronto Faculty of Law Review*, 59 (2), 229

[68] Schneider, R. (1995). Mental disorder and the courts: psychiatric gating. *Criminal Lawyer's Association Newsletter*, 16, 18; Gagné, P., Joncas, L. Carette, D. (June 1993). The Renaissance of Custodial Psychiatry. Conference presentation at the International Academy of Law and Mental Health in Lisbon, Portugal.

[69] Manitoba *Mental Health Act*, C.C.S.M., c. M110, s. 24 (2).

[70] Ontario *Mental Health Act*, R.S.O. 1990, c. M.7, s. 21-22. For jurisprudence on these provisions see *R. v. Lenart*, 39 O.R. (3d) 55 (particularly Justice Goudge's dissenting opinion); *R. v. Simanek*, [2001] O.J. No. 4187 (it was appropriate to order a *Mental Health Act* assessment to assist in the sentencing of an accused); *R. v. Leach*, [2007] O.J. No. 5092.

how civil and criminal law procedures can occasionally become conflated, highlighting the need to divert persons to the appropriate route to avoid the revolving door phenomenon. As Geller states,

> Granted, many aspects of the functioning of state hospitals in the past have been questionable at best. But does the current role of the state hospital – in which society refuses to permit asylum to those who are unable to function without its succour while simultaneously condoning a system of care whereby some individuals are admitted more than 100 times – make any sense?[71]

The decision to divert individuals through the criminal justice or mental health system is a difficult choice and requires an early assessment. Clinicians require a basic familiarity with procedures in the *Criminal Code* and mental health legislation as they relate to psychiatric issues. In one 1998 Ontario Court of Appeal case, *R. v. Lenard*, Justice Finlayson highlighted the federal and provincial challenges of performing psychiatric assessments,

> It is conceivable that individuals through Canada could be subject to differing intensity of invasiveness, according to the provincial mental health statute in place. The notion that criminal procedure is federal law would be defeated by the development of divergent provincial regimes dealing with the remand of individuals for psychiatric assessment.[72]

Although the majority of the court upheld the constitutionality of these assessment provisions, they are not available in most Canadian jurisdictions. Therefore, when interpreting mental health legislation across provinces it is important to realize that the provisions can differ substantially from each another.

VII. THERAPEUTIC JURISPRUDENCE

Civil commitment procedures once used to be grounded in a medical model of mental illness, and deferred to the expertise of physicians without an effective process of judicial review.[73] The medical model allowed individuals to be involuntarily hospitalized when they were in need of treatment as determined by physicians. Eventually, the pendulum swung to an approach that applied highly restrictive legal standards and procedural requirements that focused on protecting

---

[71] Geller, J.L. (1992). A historical perspective on the role of state hospitals viewed from the era of the "revolving door." *American Journal of Psychiatry*, 149, 1532.

[72] *R.* v. *Lenard*, (1998)123 C.C.C. (3d) 353.

[73] See *Winick, supra* note 1.

individuals' civil liberties.[74] Both approaches can pose challenges – where one may be too paternalistic the other can be too procedural. The medical model granted too much discretion to physicians that could infringe an individual's civil liberties in the name of necessary medical treatment, whereas the legal approach occasionally neglected patients' therapeutic and medical needs.

Therapeutic jurisprudence has been proposed as a theoretical outlook that aims to balance these two approaches in the context of civil commitment.[75] A principal advocate of therapeutic jurisprudence, Professor Winick, describes it in the following manner:

> [t]herapeutic jurisprudence is an interdisciplinary approach to legal scholarship and law reform that sees law itself as a therapeutic agent…it is interdisciplinary in that it brings insights from psychology and the social sciences to bear on legal questions, and it is empirical in that it calls for the testing of hypotheses concerning how the law functions and can be improved…it seeks to ascertain whether law's anti-therapeutic effects can be reduced and its therapeutic effects enhanced without subordinating due process and other justice values.[76]

Individuals who are committed involuntarily may understand the need to be hospitalized, but object to the *way* it is done. Committal procedures need to be applied in a manner that reflects an interest in the overall clinical well-being of the person. A therapeutic approach focuses on the underlying rationale for specific criteria in mental health legislation, ensures there are public policy debates through multiple stakeholders prior to enacting legislation, and offers procedural safeguards to protect and promote individuals' long-term clinical outcomes. An example where therapeutic jurisprudence can be used is by encouraging criminal offenders who are charged with drug-related offences to participate in treatment programs that target the source of the problem.[77] Lawyers working within hospital settings would be well advised to review how

---

[74] Diesfeld K. & Freckelton I, (2003). Introduction, in *Involuntary Detention and Therapeutic Jurisprudence*, Burlington: Ashgate Publishing at 5.

[75] Wexler, D. B. and B. J. Winick (1991). Essays in Therapeutic Jurisprudence. Durham, NC, Carolina Academic Press; Wexler, D. B. (1996). Therapeutic jurisprudence in clinical practice. *American Journal of Psychiatry 153*(4), 453-455.

[76] Winick B., (2003). A therapeutic jurisprudence model for civil commitment, in Diesfield, K., Freckelton, I. (Eds.) *Involuntary Detention and Therapeutic Jurisprudence*, Burlington: Ashgate Publishing, 25.

[77] *R. v. Piamonte*, [2006] O.J. No. 2814.

institutional policies promote procedural safeguards of patients through therapeutic jurisprudence.

VIII. CIVIL COMMITMENT CRITERIA ACROSS CANADA

Civil commitment criteria was once based upon a two prong welfare test that examined whether an individual suffered from a mental disorder and if, in the opinion of the committing physician, it was in the person's interest to be hospitalized.[78] In the U.S., current involuntary civil commitment legislation varies across states in that it focuses on either the criteria of "dangerousness" or "need for treatment," with some states adopting a mix of the two.[79] Similarly, the legislative criteria adopted across Canadian provinces can create significant differences that affect how patients will be managed to receive timely treatment during a possible hospital admission.[80] Table 2 at the end of this chapter provides a summary of criteria required by each province and territory for issuing an involuntary admission certificate. Table 3 reveals how legislation can reflect a policy decision regarding involuntary admission based on whether an individual is dangerous and/or will suffer substantial mental or physical deterioration. Some provinces and territories use a perceived danger standard of physical or bodily harm, while others adopt a broader concept of dangerousness that includes the risk of serious mental, emotional, social, or financial harm.

There has been an effort to strengthen patients' rights by providing greater procedural safeguards through the appeal process and right to receive legal representation.[81] Nevertheless, committal criteria are not consistent across provinces, and occasionally create an appearance of unfairness and unreasonable care.[82] For example, the mental health legislation in only four provinces requires

---

[78] *Saskatoon Regional Health Authority v. A.B.*, [2005] S.J. No. 187.

[79] *Anfang, supra* note 6.

[80] For an overview of admission procedures and hospitalization see *Gray, supra* note 2 at 159-195; see also Gray J.E. & O'Reilly, R. (2001). Clinically significant differences among Canadian mental health acts. *Canadian Journal of Psychiatry*, *46*, 315.

[81] O'Reilly, R. (2004). Why are community treatment orders controversial? *Canadian Journal of Psychiatry*, *49*, 581.

[82] *Anfang, supra* note 6.

that a certificate of involuntary admission be filed by a psychiatrist,[83] whereas the majority of jurisdictions require that it only be done by a medical practitioner. The *Criminal Code* permits evaluations to be made by a medical practitioner or "any other person who has been designated by the Attorney General as being qualified to conduct an assessment."[84] It may be tempting in terms of cost cutting and, some may argue in terms of access to care, to allow other professionals other than qualified forensic psychologists or psychiatrists to be entitled to perform such risk assessments.

A. Admission Criteria

All provinces and territories have some form of *Mental Health Act* that provides criteria related to assessment, admission, detention, and treatment of individuals. Nova Scotia is unique in that its legislation is termed *Involuntary Psychiatric Treatment Act* rather than a *Mental Health Act*. To explore how different jurisdictions have structured their civil commitment laws, Table 4 reviews each province and territory on a "who, what, when, where, and how long" basis.

The dangerousness criterion to admit someone to a hospital is not applied uniformly across Canada. For example, Ontario, Yukon, and the NWT use an "impending serious physical danger" criterion, whereas other provinces such as Québec, Alberta, and B.C. specify that the individual is "likely to endanger himself or others." Two additional criteria that exist in the legislation among several provinces are those of mental and physical deterioration. Nunavut has legislated that a person is likely to suffer harm of physical deterioration, but not mental deterioration. In Québec, where the committal criteria involve endangerment of one's health or security, it could be argued that the possibility of mental deterioration is grounds for hospitalization. In the 1998 *Morgentaler*[85] decision, the Supreme Court of Canada interpreted the definition of health in a

---

[83] The four provinces are Manitoba, Québec, New Brunswick, and Prince Edward Island.
[84] *Criminal Code*, s. 672.1 (1).
[85] *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

federal statute to include not just physical health but also mental health. Consequently, taking this criterion of mental deterioration as grounds for hospitalization would mean that an untreated individual suffering from schizophrenia, and whose condition is likely to deteriorate gradually, could be captured by such a provision.

B. Treatment during Hospital Stay

The criteria used to assess and admit someone to a hospital differs from whether an individual can refuse medical treatment. An individual’s substantive rights to refuse medical treatment do not disappear when admitted to a hospital. The rules that govern consent to treatment in other contexts apply to those patients who have been civilly committed under the legislation. Depending on the treatment offered and the mental capacity of the patient when the treatment is offered, he may be able to refuse treatment categorically. The need to protect patients’ rights becomes more important when they are in a hospital. Some of these include the right to an interpreter; right to contact family members; right to legal counsel; right to refuse medical treatment; and the right to participate in advance treatment planning.

C. Discharge Criteria

Before being discharged from a hospital back into the community, it is necessary to ensure that an individual’s physical and mental condition has been stabilized. The lack of mental health beds among psychiatric hospitals is an ongoing problem that is relevant to when someone will be discharged.[86] At the same time, detaining someone in hospital for such lengthy periods of time that they no longer believe they are able to regain their autonomy and live independently in the community is a serious problem. Hospitals need to consider to what extent their institutional policies encourage timely discharges, and whether their practices in this regard correspond with the law. Indefinitely detaining a patient within a hospital can quickly erode hope of recovery. At the

---

[86] See the decisions of *R. v. Rosete*, [2006] O.J. No. 1608; *R. v. Rosete*, [2007] O.J. No. 3273.

same time, prematurely releasing someone from a hospital, particularly where the individual may be at risk to oneself or others can attract liability. As highlighted in the 2006 Supreme Court of Canada decision of *Mazzei*, case managers and clinicians need to ensure that patients' treatment plans are regularly examined by health care providers.[87] According to the Court, review boards across Canada have a supervisory authority to review treatment plans implemented by hospitals in the context of criminal cases in order to ensure that the overall goal of assisting individuals to recover is met.[88] Extended leaves and conditional discharges can also be effective legal tools to encourage patients to gain more autonomy and gradual reintegration into the community.

IX. FACTUAL BASIS FOR COMMITTAL DECISIONS

The decision to commit someone involuntarily to a hospital needs to be based on verifiable facts and solid medical evidence. Where an individual may engage in future dangerous criminal behaviour, the physician must first, and foremost, establish a causal link between an individual's mental disorder and the risk of dangerousness. Factual bases for decisions must be detailed within medical reports that are submitted to courts as support for committal orders. Physicians should not be deceived by the ease of using ready-made forms to determine whether an individual should be committed or not. The use of a checklist alone, without additional medical details of a patient's history, may not withstand a court's scrutiny when the physician is asked to provide evidence and reasons for the committal decision. In one Québec Court of Appeal case, a patient was ordered discharged from the hospital because two of the supporting psychiatric reports were too vague and relied on ready-made forms.[89] In this case, the physician could not demonstrate on a balance of probabilities that the patient was a danger to herself or others. Mental health legislation often specifies the content

---

[87] *Mazzei, supra* note 60.

[88] *Mazzei, supra* note 60.

[89] *D.M.* c. *Dr Prosper*, 22 décembre 2004, 500-09-015164-049, Q.C.A. « …la preuve dont nous disposons, et qui se résume à deux rapports psychiatriques sibyllins sur formulaire réimprimés, ne démontre pas de façon prépondérante que l'état de l'appelante est tel qu'il y a un danger pour elle-même ou pour autrui et nécessite de la garder en établissement ».

of what should be included in committal certificates. In Québec's legislation, a report made following a psychiatric examination must be signed by the examining physician and include,

- Confirmation that the doctor has examined the person;
- The date of examination;
- The diagnosis, even if only provisional, concerning the mental state of the person;
- In addition to what is provided in article 29 of the *Civil Code of Québec* (Statutes of Québec, 1991, chapter 64), the doctor's opinion as to the gravity and probable consequences of the person's mental state;
- Reasons and facts upon which the opinion and diagnosis are based and, among the facts mentioned, those that the doctor has directly observed and those that have been communicated to him by others.[90]

In certain cases, failing to abide by the governing legislation can lead to a fine. For example, section 80 of Ontario's *Mental Health Act* provides that contravening any provision of the legislation can lead to a fine of up to $25,000.[91] In one case, a psychiatrist was charged for issuing a commitment certificate, which would have created a situation where the patient would be detained in the hospital for an additional month, without first meeting the patient.[92] Although the charge was ultimately dismissed, the case highlights that although physicians have the authority to curtail the liberty rights of individuals in order to provide effective medical treatment, mental health legislation incorporates protections for patients who are detained in the hospital based on insufficient evidence.

X. MENTAL CAPACITY ASSESSMENTS

Civil commitment leaves intact the presumption that an individual is mentally capable. Similarly, because someone has a mental disorder does not mean that person is mentally incapable. The loss of capacity to make treatment decisions cannot be assumed simply because someone is involuntarily committed. Wherever possible, it is essential that physicians determine an individual's degree of mental capacity prior to commitment. Unfortunately, legislation has not always offered a precise definition of what it means to have a mental disorder sufficient

---

[90] *An Act respecting the protection of persons whose mental state presents a danger to themselves or to others*, R.S.Q., chapter P-38.001, sec. 3.

[91] Ontario *Mental Health Act*, R.S.O. 1990, c. M.7, s. 80.

[92] Patton L., & Simpson D. (2002). Psychiatrist charged. Online: Psychiatrist Patient Advocate Office http://www.ppao.gov.on.ca/med-pre-psy.html.

to warrant commitment.[93] Consequently, without a clear and uniform definition of mental disorder across mental health legislation, comparing how decisions are made in relation to civil commitment has produced a patchwork effect. The definition of mental disorder in mental health legislation may affect whether individuals will be subsequently committed voluntarily or involuntarily.[94]

Competency is no longer viewed as a global characteristic.[95] Instead, it must be evaluated relative to the decision-making task because individuals can be competent for one decision but not another. More formal and thorough assessments can also help determine whether an individual is making a voluntary or involuntary choice about their treatment. Physicians are permitted to administer or prescribe medication or treatment that is considered medically necessary as long as it is consistent with good medical practice.[96] Still, a doctor's discretion to provide medically necessary treatment, in line with good medical practice, does not vitiate the requirement to obtain a patient's full and informed consent wherever possible. Although patients may not be capable of understanding the information given to them at one point in time, there is an ongoing obligation for clinicians to ensure that patients will understand the information if, and when, they regain capacity.[97]

The Nova Scotia *Hospitals Act* describes the factors psychiatrists should examine in establishing whether an individual is *capable to consent to treatment*. In determining whether a person is capable of consenting to treatment, the examining psychiatrist shall consider:

a) whether the person understands the condition for which the treatment is proposed;
b) the nature and purpose of the specific treatment;
c) the risks and benefits involved in undergoing the specific treatment;
d) the risks and benefits involved in not undergoing the treatment; [98]

---

[93] Slobogin, C. (2006). *Minding Justice*. Cambridge, Massachusetts: Harvard University Press, 253-255.

[94] Brooks, R. (2007). Psychiatrists' opinions about involuntary civil commitment: results of a national survey. *Journal of the American Academy Psychiatry and the Law, 35*(2), 219-228.

[95] Gupta, M. (2003). All locked up with nowhere to go, treatment refusal in the involuntary hospitalized population of Canada, in Diesfield, K., Freckelton, I. (Eds.) *Involuntary Detention and Therapeutic Jurisprudence*, Burlington: Ashgate Publishing, 154.

[96] Saskatchewan, *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s. 25(2).

[97] British Columbia, *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.

[98] Nova Scotia, *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52 (2A).

The legislation further provides that in determining whether a patient is *capable to make a treatment decision* a psychiatrist shall consider the patient's ability to appreciate the consequences of making the treatment decision.[99] This would appear to suggest that the appreciation criterion is less relevant to capacity to consent to treatment than capacity to make a treatment decision. Compare this with section 4 of Ontario's *Health Care Consent Act* where a person is capable with respect to treatment if they are able to understand the information and able to appreciate the reasonably foreseeable consequences of a decision.[100]

Dangerousness is not relevant to a determination of mental incapacity but is relevant to decisions of confinement. Nova Scotia's legislative provisions of mental capacity were adopted by the Québec Court of Appeal in *Institut Philippe Pinel de Montréal* c. *G*., [101] which stated that dangerousness was not an element to consider when determining fitness to stand trial. Dangerousness is not mentioned in section 16 of the *Civil Code of Québec* as a factor to consider when deciding whether to impose treatment against the will of an incapable patient.[102] Article 30 of the *Civil Code of Québec* provides that a court may not authorize confinement unless there are serious reasons to believe that the individual is dangerous and confinement is necessary.[103]

XI. RENEWALS AND APPEALS

Each province and territory has specific processes and timelines to renew committal certificates. Ontario, NWT, and Nunavut allow two weeks for the first certificate; Saskatchewan, Manitoba, Québec, and Yukon provide for three weeks; the remainder of the provinces allow for approximately one month.[104] It is important for clinicians to ensure that renewals are justified and in an individual's

---

[99] Nova Scotia, *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52 (2B).
[100] Ontario, *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 4 (1)
[101] *Institut Philippe Pinel de Montréal* c. *G*., [1994] R.J.Q. 2523.
[102] *C.C.Q.*, S.Q. 1991, c. 64. art. 16.
[103] *C.C.Q.*, S.Q. 1991, c. 64. art. 30.
[104] *Gray, supra* note 2 at 184.

best interests.[105] From a patient's perspective, the right to appeal a renewal certificate is an important process that offers protection from the perception of being unduly detained. The decision to renew a certificate is often decided on the need for continued medical treatment if the individual continues to pose a danger to oneself or others. Where the motivation for renewing a certificate is suspicious, the appeal process can be an important safeguard. It is therefore important that legal and mental health professionals are familiar with renewal deadlines. Clinicians have an obligation to meet regularly with patients and provide reasons for renewing a certificate. Where tele-psychiatry is used as a means of issuing a renewal certificate without regular in-person assessments, this could raise concerns by patients they are not receiving personalized medical attention.[106]

XII. CLINICIANS' DECISIONS TO COMMIT

A. General Principles

Clinicians have difficult decisions to make in determining whether to commit someone involuntarily to a hospital. The decision often results in heated debates among families and friends of what is in a patient's best interests. Among health care professionals, psychiatrists are generally perceived as individuals who retain the most power in deciding whether someone will be committed or not.[107] Yet, they often rely on input from other front-line treatment providers such as nurses, social workers, and case managers. Psychiatrists will be able to fulfill their clinical and legal obligations if they understand the governing mental health legislation, which involves applying commitment criteria, being familiar with important times and periods, and understanding how the review process works if their decision is challenged.

Clinicians working in emergency departments of psychiatric hospitals need to be particularly conscious of protecting procedural rights, as they are often an

---

[105] *E v. Board of the Foothills General Hospital*, [2003] A.J. No. 1563 (renewal certificate was permitted); *C. L. v. Hurdalek*, [1997] O.J. No. 2572 (renewal certificate quashed and rescinded).

[106] *Gray, supra* note 2 at 181-182.

[107] Brooks, R. (2007). Psychiatrists' opinions about involuntary civil commitment: results of a national survey. *Journal of American Academy of Psychiatry and Law, 35*(2), 219-228.

individual's first line of contact within the mental health system.[108] Adopting precautionary policies can help avert potential claims in negligence,[109] particularly in cases where an individual was not committed and subsequently harmed oneself or others. Many psychiatrists support the view that the legal standard for involuntary commitment should be based on "danger to self," "danger to others," or "grave disability," with weaker support given to "illness relapse" as a ground for committal.[110] Civil commitment legislation can create duties that are broader, narrower, or different from those that appear on the face of the statute, as judicial interpretation can shift the meaning of the original intent.[111] Therefore, in evaluating whether individuals should be committed clinicians must first form a reasonable diagnostic impression and then, in some cases, assess whether the patient may become dangerous to oneself or others. Although predictions of dangerousness can be wrong,[112] one way to achieve greater accuracy is by examining whether an individual was violent in the recent past or if the act was a single occurrence.[113]

The first step in determining whether an individual should be involuntarily hospitalized involves a psychiatric assessment as part of the evaluation of one's mental condition. This preliminary assessment can take place at the request of one or two physicians, or a justice of the peace. Whether an individual is dangerous to oneself or others cannot be ignored. A judge or justice has the authority to issue a warrant that the individual undergo an assessment upon receiving a sworn statement by an interested party who meets the criteria of the relevant legislation to make a statement. Depending where one lives in Canada, an initial assessment can last anywhere from twenty-four hours to fifteen days. Several factors can

---

[108] Segal, S. P., Laurie, T. A., & Segal, M. J. (2001). Factors in the use of coercive retention in civil commitment evaluations in psychiatric emergency services. *Psychiatric Services, 52*(4), 514-520.

[109] *Villemure v. Turcot*, [1973] S.C.R. 716.

[110] Brooks, R. A. (2006). U.S. psychiatrists' beliefs and wants about involuntary civil commitment grounds. *International Journal of Law and Psychiatry, 29*(1), 13-21.

[111] Werth, J. L. (2001). Involuntary mental health commitment statues: requirements for persons perceived to be a potential harm to self. *The American Association of Suicidology, 31*(3), 348.

[112] Diamond, B. (1975). The psychiatric prediction of dangerousness, *Pennsylvania Law Review, 123*, 439.

[113] Campbell J., Stefan S., & Loder, A. (1994). Putting violence in context. *Hospital and Community Psychiatry 45*,633.

affect a psychiatrist's decision to commit an individual, including level of knowledge and familiarity with the patient, likelihood of ongoing management, along with the psychiatrist's values and philosophy towards autonomy, the right to treatment, and community safety.[114] Some psychiatrists take a "common sense" approach to involuntary commitment by balancing the patient's needs with available mental health services and potential outcomes of their decisions.

B. Risk Assessments

Where dangerousness is a committal criterion in mental health legislation, it is essential that psychiatrists perform a complete risk assessment. Research indicates that there is a cognitive "expertise bias" among psychiatrists and judges in defining dangerousness, whereby judges lean towards a definition of harm to others while psychiatrists lean towards a definition of harm to self.[115] A judge's frame of reference aims to adjudicate conflicts among or between individuals and society, whereas psychiatrists focus on providing effective treatment. Similarly, psychiatrists often make their decisions when patients are in an acute condition, whereas judges are often only able to understand dangerousness in hindsight.[116]

Clinicians who attempt to protect patients' procedural rights during their committal decisions can help reduce negative perceptions associated with coercion.[117] Patients are more likely to accept being involuntarily admitted if they perceive that their clinician's communication style is persuasive instead of threatening or forceful.[118] Patients also experience that a sense of justice has been served if they have been given all necessary information regarding their health care.[119]

---

[114] Vine, R. (2003). Decision-making by psychiatrists about involuntary detention, in Diesfeld K. & Freckelton I. (Eds.), *Involuntary Detention and Therapeutic Jurisprudence*. Burlington: Ashgate at 117.

[115] Poletiek, F. H. (2002). How psychiatrists and judges assess the dangerousness of persons with mental illness: an 'expertise bias'. *Behavioral Sciences and Law*, *20*(1-2), 19.

[116] *Ibid*.

[117] McKenna, B.G., Simpson, A. I. F., & Coverdale, J. H. (2000). What is the role of procedural justice in civil commitment? *Australian and New Zealand Journal of Psychiatry*, *34*(4), 671.

[118] *Ibid.*

[119] *Ibid*.

As clinicians evaluate and record patients' mental state in their reports, any relationship between one's pathological mental condition and associated dangerous behaviour should be included. Clinicians who offer predictions of risk of dangerousness understand that this field remains an imperfect science, and they should not distort the concept as a purely empirical notion or misrepresent their expertise by offering a normative judgment beyond their call of professional duty. The Québec Court of Appeal in *Lajoie* c. *Commission Québécoise d'examen et PGPQ*[120] in 1994 stated that dangerousness should not be evaluated in the abstract, but should take into account all pertinent circumstances including social resources available to ensure the supervision of an accused.

Clinicians are routinely asked to provide testimony regarding their committal decisions by explaining how patients' level of impairment affected their functional ability. As civil commitment legislation does not always detail how functional ability fulfills eligibility commitment criteria, clinicians should provide explanatory and descriptive testimony.[121] Courts will evaluate the evidence in light of the appropriate normative considerations in determining whether an individual is dangerous or not.

XIII. ROLE OF ADVANCE DIRECTIVES IN CIVIL COMMITMENT

Advance directives have been recommended as a treatment-planning tool to assist individuals with mental illness to declare their preferences in the event they become incapable in the future.[122] Advance directives could be used in a greater extent within psychiatric hospitals and mental health institutes across Canada. They can be helpful in understanding individuals' preferences and wishes at the

---

[120] [1994] R.J.Q. 607, 61 (QCA).

[121] Schopp, R.F. (2001). *Competence, Condemnation, and Commitment*, Washington D.C.: American Psychological Association at 213.

[122] See Appelbaum, P. S. (1991). Advance directives for psychiatric treatment. *Hospital Community Psychiatry, 42*(10), 983-984; Brock, D.W. (1993). A proposal for the use of advance directives in the treatment of incompetent mentally ill persons; *Bioethics, 7*(2-3), 247-256; Swanson, J., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A. et al., (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*(3), 255-267; Ambrosini, D. L., Crocker, A. G., Perreault, M., & Israel, M. (2008). Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec. *Journal Ethics in Mental Health, 3*(2), 1-12.

point of admission, as an inpatient, and upon discharge. Documents such as psychiatric advance directives, joint crisis plans, crisis cards, and wellness recovery action plans are receiving increased attention in other countries.[123] Yet, there is substantial variation among Canadian provinces and territories as to how advance directives are legislated. For example, some provinces allow for only proxy directives, whereby an individual is appointed to make health care decisions on behalf of the person.[124] Other provinces adopt legislation supporting instructional directives where individuals can declare detailed treatment preferences if they become incapable in the future.[125] Depending on the province or territory, the documents are termed advance health care directives, authorization, powers of attorney for personal care, mandates in case of incapacity, health care directives, personal directives, or representation agreements.[126] Some have referred to advance directives as Ulysses contracts because they pose ethical challenges in determining whether one's prior competent wishes are self-binding and should be irrevocable.[127]

Advance directives can help to promote patient autonomy if they protect individuals against involuntary treatment or hospitalization.[128] Perhaps their most valuable contribution, however, is by giving individuals the ability to negotiate treatment preferences with health care providers. In the U.S., research has targeted decreasing barriers associated with implementing psychiatric advance directives.[129] One of the driving forces behind the growth of advance directives in

---

[123] For a comparison of different forms of mental health statements see Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services, 59*(1), 63-71.

[124] One example of a jurisdiction that uses proxy directives are mandates in case of incapacity in Québec.

[125] Dunbrack, J. (2006). *Advance care planning: the Glossary project*. Ottawa: Health Canada.

[126] For a chart identifying different forms of advance directives across Canada see Dunbrack, J. (2006). *Advance care planning: the Glossary project*. Ottawa: Health Canada.

[127] Some individuals may decide to include in their advance directive a Ulysses like clause that if they require hospitalization but are incapable to make their own wishes that their friends and family members should have the authority to decide upon hospitalization. See *Gray, supra* note 2 at 9, 317-324. An individual could request in their advance directive not to be committed to a particular hospital.

[128] *Gray, supra* note 2 at 195; see also Ambrosini, D. L., & Crocker, A. G. (2009). Psychiatric advance directives and the role of autonomy. *Revue Santé Mentale au Québec 34*(2), 51-74.

[129] Van Dorn, R. A., Swartz, M. S., Elbogen, E. B., Swanson, J. W., Kim, M., Ferron, J. et al., (2006). Clinicians' attitudes regarding barriers to the implementation of psychiatric advance

the United States has been the *Patient Self-Determination Act* enacted in 1991,[130] whereby health care institutions are required to ask individuals upon arrival at a hospital whether they have completed an advance directive. There is no counterpart Canadian federal law to the US federal legislation. In fact, some provincial mental health legislation provides that there is no onus upon health care providers to inquire whether someone has completed or revoked an advance directive.[131] Advance directives may prove to be useful in honouring individuals' treatment preferences and alerting health care providers to their wishes prior to a hospital admission, particularly where the person is not known to the treatment team. If advance directives can be made readily available, they may also be useful in informing health care providers of patients' preferences towards specific medications, treatment, and care. Upon discharge from hospitals, some patients may benefit from completing an advance directive, giving them greater predictability and continuity of care as they transition back to the community.

Greater consideration should be given to identifying how advance directives could be used by hospitals.[132] They may reduce perceptions of coercive treatment, protect the legal and ethical rights of patients, and empower individuals with greater information that allows for more engagement throughout their recovery process. While advance directives are not a panacea to the ethical and legal challenges in mental health, they are an important and underutilized tool that can reduce feelings of disempowerment, stigma, and oppression that have traditionally been associated with involuntary treatment and hospitalization.

---

directives. *Administration Policy Mental Health and Mental Health Services Research, 33*(4), 449-460; Van Dorn, R. A., Swanson, J. W., Swartz, M. S., Elbogen, E., & Ferron, J. (2008). Reducing barriers to completing psychiatric advance directives. *Administration Policy Mental Health and Mental Health Services Research, 35*(6), 440-448.

[130] *Patient Self-Determination Act* (PSDA) (1991).

[131] Manitoba, *The Health Care Directives Act*, C.C.S.M. c. H27, s. 21.

[132] La Fond, J. Q., & Srebnik, D. (2002). The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions. *International Journal of Law and Psychiatry, 25*(6), 537-555.

CONCLUSION

More than 100 years ago, Dr. Burgess, the medical superintendent of the Douglas Mental Health University Institute in Québec, as it is now known, was both critical and optimistic of psychiatric hospitals across Canada stating that,

> [w]hile with respect to custodial care and ordinary treatment, moral and medical, Canada, generally speaking, is well up to the times, she is doing little toward the solution of the many problems connected with the scientific aspects of insanity. In this respect she presents but a sorry picture when compared with the good work being done in many hospitals elsewhere. To stand still is to fall behind.[133]

Over the last century, psychiatric hospitals have changed dramatically. Many Canadian hospitals have become international centers of excellence in scientific research while at the same time remaining sensitive to the need to protect patients' rights. This is partly because hospitals are no longer perceived as asylums, detention centers, or cages to detain individuals temporarily. Despite progress, there is an ongoing obligation for hospitals to ensure that the ethical and legal rights of individuals with mental illness will be honoured. The law can play a central role by helping individuals transition from institutionalized settings back to an autonomous community life; continuing to ensure that procedural safeguards respect patients' civil liberties; and reducing stigma often associated with involuntary hospitalization. Civil commitment legislation across Canada is relied upon by physicians, patients, families, friends, and indeed all of society to protect and advance the autonomous rights of individuals with mental illness.

---

[133] *Burgess, supra* note 24 at 36.

Table 1 – Least Restrictive Alternative in Canadian Mental Health Legislation

JURISDICTION	LEGISLATION	LEAST RESTRICTIVE/INTRUSIVE ALTERNATIVE
ALBERTA	*Mental Health Act*, R.S.A. 2000, c. M-13	Sec. 24 (4): In order to determine the best interest of the formal patient in relation to treatment, a person referred to in subsection (1)(a) or (c) shall have regard to the following: (a) whether the mental condition of the patient will be or is likely to be improved by the treatment; (b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment; (c) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient; (d) whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).
BRITISH COLUMBIA	*Mental Health Act*, R.S.B.C. 1996, c. 288	No reference.
	Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181	S. 19 (3): When deciding whether it is in the adult's bests interests to give, refuse, or revoke substitute consent, the person chosen under section 16 must consider...(e) whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.
MANITOBA	*Mental Health Act*, C.C.S.M., c. M110	Sec. 28(5): In determining the patient's best interests regarding treatment, a person referred to in subsection (1) shall have regards to all the relevant circumstances, including the following:..(d) whether the treatment is the least restrictive and least intrusive treatment that meets the criteria set out in clauses (a), (b) and (c). Sec. 95: A committee of both property and personal care shall choose the least restrictive and least intrusive course of action relating to personal care that is available and is appropriate in any particular situation.
NEW BRUNSWICK	*Mental Health Act*, R.S.N.B. 1973, c. M-10.	Sec. 1.1: The purposes of Part II of this Act, as it relates to involuntary custody, detention, restraint, observation, examination, assessment, care and treatment, are (a) to protect persons from dangerous behaviour caused by a mental disorder, (b) to provide treatment for persons suffering from a mental disorder that is likely to result in dangerous behaviour, and (c) to provide when necessary for such involuntary custody, detention, restraint, observation, examination, assessment, care and treatment as are the least restrictive and intrusive for the achievement of the purposes set out in paragraphs (a) and (b).

NEWFOUNDLAND & LABRADOR	*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	Sec. 3 (1): The purpose of the Act is as follows...(c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b)... Section 35 (2): For the purpose of subsection (1), in taking into account the best interests of the involuntary patient, the attending physician or other person shall consider...(d) whether the specified treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraph (a), (b) and (c).
NORTHWEST TERRITORIES	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Preamble: Being committed to the principle that mental health services should be provided in the least restrictive manner.
NOVA SCOTIA	*Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42	Sec. 2 (c): The purpose of this Act is to ensure that issues with mental health are dealt with in accordance with the following guiding principles...(c) treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time.
NUNAVUT	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Preamble: Being committed to the principle that mental health services should be provided in the least restrictive manner.
ONTARIO	*Mental Health Act*, R.S.O. 1990, c. M.7	No reference, other than with reference to community treatment orders (s. 33 (3)).
	Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A	Sec. 21 (2) (c) (4): "n deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration...whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

PRINCE EDWARD ISLAND	*Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1	Sec. 24 (2): The Review Board shall not consider an application under subsection (1) unless it is accompanied by statements signed by the attending psychiatrist and another psychiatrist, each stating that they have examined the patient and that they are of the opinion, stating the reasons of each of them, that (d) the specified psychiatric treatment and other related medical treatment are the least restrictive and least intrusive treatments that meet the requirements of clauses (a), (b), and (c).
QUÉBEC	*Civil Code of Québec*, (CCQ), S.Q. 1991, c. 64	No reference.
SASKATCHEWAN	*Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1	No reference.
YUKON	*Mental Health Act*, R.S.Y. 2002, c. 150	Preamble: And recognizing that care and treatment of persons suffering from mental disorder should be provided in the least restrictive and least intrusive manner.

Table 2 - Involuntary Hospital Admission Criteria across Canadian Mental Health Legislation

JURISDICTION	LEGISLATION	CRITERIA FOR INVOLUNTARY ADMISSION CERTIFICATE
ALBERTA	*Mental Health Act*, R.S.A. 2000, c. M-13	Sec. 2: When a physician examines a person and is of the opinion that the person is (a) suffering from mental disorder, (b) in a condition presenting or likely to present a danger to the person or others, and (c) unsuitable for admission to a facility other than as a formal patient, the physician may, not later than 24 hours after the examination, issue an admission certificate in the prescribed form with respect to the person.
BRITISH COLUMBIA	*Mental Health Act*, R.S.B.C. 1996, c. 288	Sec. 22(1) (3) (c): Each medical certificate...must be completed by a physician...and must set out...a statement...that the physician is of the opinion that the person to be admitted...(i) requires treatment in or through a designated facility, (ii) requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and (iii) cannot suitably be admitted as a voluntary patient.
MANITOBA	*Mental Health Act*, C.C.S.M., c. M110	Sec. 8(1): When a physician examines a person and is of the opinion that he or she (a) is suffering from a mental disorder; (b) because of the mental disorder, is likely to cause serious harm to himself or to another person, or to suffer substantial mental or physical deterioration; and (c) is unwilling to undergo or is not mentally competent to consent to a voluntary psychiatric assessment; the physician may apply to the medical director of a facility for an involuntary psychiatric assessment of the person.
NEW BRUNSWICK	*Mental Health Act*, R.S.N.B. 1973, c. M-10	Sec. 7.1 (1): If a physician examines a person and is of the opinion that the person (a) may be suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of other, and (b) is not suitable for admission as a voluntary patient, the physician may issue an examination certificate in the prescribed form.

NEWFOUNDLAND & LABRADOR	*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	Sec. 17 (1): A certificate of involuntary admission shall be in the approved form and shall contain the following information...A statement by the person who has conducted the psychiatric assessment referred to in paragraph (a) that, as a result of the psychiatric assessment, he or she is of the opinion that the person who is named or described in the certificate (i) has a mental disorder, and (ii) as a result of the mental disorder (A) is likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted in a psychiatric unit as an involuntary patient, (B) is unable to appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and (C) is in need of treatment or care and supervision that can be provided only in psychiatric unit and is not suitable for admission as a voluntary patient...
NORTHWEST TERRITORIES	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Sec. 13: Where a medical practitioner examines a person and has reasonable cause to believe that the person (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself, (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her, or (c) has shown or is showing a lack of competence to care for himself or herself, and, if based on the information before the medical practitioner, the medical practitioner is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in (d) serious bodily harm to that person, (e) serious bodily harm to another person, or (f) imminent and serious bodily impairment of that person, unless the person remains in the custody of a hospital, the medical practitioner shall (g) admit the person as a voluntary patient to a hospital in accordance with section 6, or (h) apply to admit the patient as an involuntary patient to a hospital by completing and filing with the Minister an application for a certificate of involuntary admission as set out in section 15, where the medical practitioner is of the opinion that the person is not suitable for admission as a voluntary patient.
NOVA SCOTIA	*Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42	Sec. 8: Where a physician has completed a medical examination of a person and is of the opinion that the person apparently has a mental disorder and that (a) the person, as a result of the mental disorder, (i) is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so, or (ii) as the result of the mental disorder, the person is likely to suffer serious physical impairment or serious mental deterioration, or both; and (b) the person would benefit from psychiatric inpatient treatment in a

		psychiatric facility and is not suitable for inpatient admission as a voluntary patient, the physician may complete a certificate for involuntary psychiatric assessment for the person.
NUNAVUT	*Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Sec. 13: Where a medical practitioner examines a person and has reasonable cause to believe that the person (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself, (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her, or (c) has shown or is showing a lack of competence to care for himself or herself, and, if based on the information before the medical practitioner, the medical practitioner is of the opinion that that person is apparently suffering from a mental disorder of a nature or quality that will likely result in (d) bodily harm to that person, (e) serious bodily harm to another person, or (f) imminent and serious bodily impairment of that person, unless the person remains in the custody of a hospital, the medical practitioner shall (g) admit the person as a voluntary patient to a hospital in accordance with section 6, or (h) apply to admit the patient as an involuntary patient to a hospital by completing and filing with the Minister an application for a certificate of involuntary admission as set out in section 15, where the medical practitioner is of the opinion that the person is not suitable for admission as a voluntary patient.
ONTARIO	*Mental Health Act*, R.S.O. 1990, c. M.7	Sec. 20 (1.1): The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion that the patient, (a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; (b) has shown clinical improvement as a result of the treatment; (c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one; (d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; (e) has been found incapable, within the meaning of the *Health Care Consent Act*, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and (f) is not suitable for admission or continuation as an informal or voluntary patient.

PRINCE EDWARD ISLAND	*Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1	Sec. 13 (1): A psychiatrist who has received an application for an involuntary psychiatric assessment...may confirm the admission of the person as an involuntary patient...if the psychiatrist is of the opinion that the person (a) is suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and (b) is refusing or is unable to consent to voluntary admission.
QUÉBEC	*Civil Code of Québec*, (CCQ), S.Q. 1991, c. 64	Art. 27: Where the court has serious reasons to believe that a person is a danger to himself or to others owing to his mental state, it may, on the application of the a physician or an interested person and notwithstanding the absence of consent, order that he be confined temporarily in a health or social services institution for a psychiatric assessment...If the danger is grave and immediate, the person may be placed under preventive confinement, without the authorization of the court, as provided for in the Act respecting the protection of persons whose mental state presents a danger to themselves or to others.
SASKATCHEWAN	*Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1	Sec. 24 (2): Every certificate is to be in the prescribe form and is to...he has probable cause to believe that: (i) the person is suffering from a mental disorder as a result of which he is in need of treatment or care and supervision which can be provided only in an in-patient facility; (ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision; and (iii) as a result of the mental disorder, the person is likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration if he is not detained in an in-patient facility.
YUKON TERRITORY	*Mental Health Act*, R.S.Y. 2002, c. 150	Sec. 5 (1): A physician who has examined a person may recommend involuntary psychiatric assessment of the person if at least one of the following conditions applies: (a) the physician believes on reasonable grounds that the person as a result of a mental disorder (i) is threatening or attempting to cause bodily harm to themselves or has recently done so, (ii) is behaving violently towards another person or has recently done so, or (iii) is causing another person to fear bodily harm has recently done so, and the physician believes that the person as a result of the mental disorder is likely to cause serious bodily harm to themselves or to another person; (b) the physician believes on reasonable grounds that the person as a result of mental disorder shows or has recently shown a lack of ability to care for themselves and the physician further believes on reasonable grounds that the person as a result of the mental disorder is likely to suffer impending serious physical impairment.

Table 3 – Danger/Harm & Mental/Physical Deterioration Criteria across Canadian Mental Health Legislation

IF PHYSICIAN IS OF THE OPINION UNDER THE LEGISLATION:	**THAT A PERSON WITH A MENTAL DISORDER IS/WILL:**	**AND IS LIKELY TO SUFFER HARM OF:**	
		MENTAL DETERIORATION:	**PHYSICAL DETERIORATION:**
ALBERTA *Mental Health Act*, s. 2(b)	A DANGER TO ONESELF OR OTHERS		
BRITISH COLUMBIA *Mental Health Act*, s. 22(3)(a)(c)	IN NEED OF PROTECTION	X	X
MANITOBA *Mental Health Act*, s. 17(1)	CAUSE SERIOUS HARM TO ONESELF OR OTHERS	X	X
NEW BRUNSWICK *Mental Health Act*, s. 8.1 (c)	A SUBSTANTIVE RISK OF HARM AND IN THE INTERESTS OF SAFETY TO ONESELF OR OTHERS	X (imminent psychological harm)	X (imminent)
NEWFOUNDLAND *Mental Health Care and Treatment Act*, s. 3 (a), 17 (1)	CAUSE HARM TO ONESELF OR OTHERS/ RESULT IN DANGEROUS BEHAVIOUR	X	X (serious impairment)
NORTHWEST TERRITORIES *Mental Health Act*, s. 13	CAUSE SERIOUS BODILY HARM/ BEHAVING VIOLENTLY	X (imminent and serious)	X
NOVA SCOTIA *Involuntary Psychiatric Treatment Act*, s. 17	CAUSE SERIOUS HARM	X (serious)	X (serious)

NUNAVUT *Mental Health Act*, s. 13	CAUSE BODILY HARM/ BEHAVING VIOLENTLY TO OTHERS		X (imminent and serious)
ONTARIO *Mental Health Act*, s. 20 (1.1) (c)	CAUSE BODILY HARM TO ONESELF OR OTHERS	X	X (serious impairment)
PRINCE EDWARD ISLAND *Mental Health Act*, s. 6(1), 13(1)	IN INTEREST OF PERSON'S OWN SAFETY OR OTHERS		
QUÉBEC *Civil Code of Québec*, 27 *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*, s. 1, 7	A DANGER TO ONESELF OR OTHERS		
SASKATCHEWAN *Mental Health Services Act*, s. 24(2) (a)	IN NEED OF TREATMENT OR CARE AND SUPERVISION/ LIKELY TO CAUSE HARM TO ONESELF OR OTHERS	X	X
YUKON *Mental Health Act*, s. 13(1)	CAUSE SERIOUS BODILY HARM TO ONESELF OR ANOTHER	X	X

Table 4 - Civil Commitment Criteria across Canadian Mental Health Legislation

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
ALBERTA *Mental Health Act*, R.S.A. 2000, c. M-13	Sec. 2: one physician performs initial examination Sec. 5(1): separate physician on staff of facility if person detained after initial examination	Sec. 4(1): initial admission certificate Sec. 7: two admission certificates for one month from date of second admission certificate Sec. 8: renewal certificate process Sec. 27,28: treatment decisions on patient's behalf Sec. 29: if patient objects to treatment must go to review panel	Sec. 2: suffers from a mental disorder, is a danger to oneself or others, and is suitable as a formal patient Sec. 10(1): warrant for apprehension if reasonable and probable grounds person suffers from mental disorder and likely to present danger to oneself or others	Sec. 1(c): Facility defined	Sec. 2 (a): initial examination for 24 hours Sec. 8(3): renewal certificate valid for 1 month Sec. 8 (3): renewal certificate for a second month, thereafter every 6 months

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
BRITISH COLUMBIA *Mental Health Act*, R.S.B.C. 1996, c. 288	Sec. 22(1): one physician for the initial medical certificate (first 48 hours) Sec. 22 (2): another physician completes second medical certificate to detain longer than 48 hours	Sec. 22: involuntary admission procedures for initial, second, and subsequent certificates Sec. 24: review of detention	Sec. 22(3) (c) (i): requires treatment; with a mental disorder Sec. 22(3) c) (ii): requires care, supervision, and control...to prevent substantial mental or physical deterioration or for the protection of the person or others	Sec. 22(7): provincial mental health facility or psychiatric unit	Sec. 23: detained one month after admission date Sec. 24: review of detention after 1 month, 3 months, thereafter every 6 months

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
MANITOBA *Mental Health Act*, C.C.S.M., c. M110	Sec. 7: first examination by physician	Sec. 8: application process for involuntary psychiatric assessment Sec. 16: psychiatrist who applies for assessment cannot also certify Sec. 18 (2): content of what to include in involuntary admission certificate 24(1): involuntary admission under Criminal Code 22(1): renewal of certificate	Sec. 17(1): person suffers from a mental disorder and is likely to cause serious harm to oneself or others, or to suffer physical and mental deterioration	Sec. 1: designated facility for observation, assessment, diagnosis and treatment of persons who suffer from mental disorders Sec. 24 (3): definition of hospital under this section according to *Criminal Code*, s. 672.1	Sec. 19: duration of involuntary admission certificate is 21 days Sec. 20(2): release person within 72 hours from first being detained, unless admitted as a patient 21(4): renewal certificate for 3 months to detain or treat patient

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
NEW BRUNSWICK *Mental Health Act,* R.S.N.B. 1973, c. M-10	Sec. 8 (1): attending psychiatrist for examination certificate	Sec. 8(1) (c): admission as involuntary patient Sec. 8.11(2) - 8.11 (5): routine medical treatment by authorized psychiatrist without consent	Sec. 8.1(1): person suffering from a mental disorder, substantial risk of imminent physical and psychological harm to oneself or others	Sec. 8.1 (2): psychiatric facility	Sec. 13(4): first certificate not more than one month, second for two months, and third or subsequent is three months
NEWFOUNDLAND & LABRADOR *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1	Sec. 17 (2): first certificate by physician, nurse practitioner or other authorized person, second certificate by psychiatrist or another certificate Sec. 19: judge's order for involuntary assessment	Sec. 12: rights of involuntary patient Sec. 17 (1): certificate of involuntary admission Sec. 24: admission on two certificates	Sec. 17 (1) (b) (i) (ii): suffering from mental disorder, likely to cause harm to oneself or others, mental or physical impairment, unable to appreciate nature of decision, and is in need of care and treatment	2 (1) (h) : facility can include a physician's office	Sec. 22: initial assessment within 72 hours Sec. 28: admitted as involuntary patient detention for 30 days Sec. 31: renewal certificate for 30, 60, 90 days depending on which certificate ; no limits on number of certificates

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
NORTHWEST TERRITORIES *Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Sec. 8(1): medical practitioner Sec. 9(1): application to a justice or territorial judge Sec. 10: psychologist Sec. 11: peace officer Sec. 12: private person if peace officer not available Sec. 13: medical practitioner	Sec. 7: assessment procedures for Aboriginal persons Sec. 15: application to Minister to admit person Sec. 19.1: determination of competence before treatment Sec. 26: application to court for review	Sec. 14 (c): person suffering from mental disorder and will likely be serious bodily harm to oneself or another, and imminent and serious physical impairment	Sec. 1: hospital means designated medical facility within or outside the Territories for observation, care or treatment	Sec. 23(1), 16(2) (5) Sec. 16 (5): initial assessment 72 hours Sec. 23.2(1): first order for three months, second order for six months, every six months thereafter

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
NOVA SCOTIA *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42	Sec. 8: physician completes medical assessment Sec. 17: psychiatrist for admission Sec. 13: judicial order for examination	Sec. 10: two certificates for involuntary assessment Sec. 18: factors in determination of capacity Sec. 26: duty to inform patient of renewals	Sec. 17: admission as involuntary patient where person is threatening to cause harm to oneself or others	Sec. 19, 20: psychiatrist who signs involuntary admission shall decide which psychiatric facility person should be taken to	Sec. 12: 72 hours Sec. 15: detention for 24 hours for medical examination Sec. 22: time limitations for renewal of involuntary patient of one month, three months, six months
NUNAVUT *Mental Health Act*, R.S.N.W.T. 1988, c. M-10	Sec. 7 (2):consultation with elder where aboriginal person Sec. 8 (1): medical practitioner for assessment Sec. 13: medical practitioner for certificate of involuntary admission	Sec. 7: involuntary psychiatric assessment Sec. 19.1: examination to determine mental competence	Sec. 13: criteria for certificate of involuntary admission if threatening to harm oneself or others, behaving violently, or is showing lack of competence to care for oneself	Sec. 1: hospital means designated medical facility within or outside the Territories for observation, care or treatment	Sec. 8 (2): detention of person for 48 hours after initial examination Sec. 23: renewal certificates and extension of detention

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
ONTARIO *Mental Health Act*, R.S.O. 1990, c. M.7	Sec. 15(1): physician application for assessment Sec. 16(1): Justice of peace's order for examination Sec. 17: police officer's role Sec. 20(5) senior physician's report Sec. 21 (1): judge's order for examination	Sec. 15(1): application for psychiatric assessment Sec. 21: judge's order for admission where individual committed an offence (2 months)	Sec. 20(5): physician is of the opinion person suffering from a mental disorder will cause serious bodily harm to oneself or another or physical impairment	Sec. 18: psychiatric examination to be conducted at a psychiatric facility or health facility	Sec. 20(4): two weeks on a basis certificate of involuntary admission, one additional month after first certificate renewal, two additional months after second certificate renewal, three additional months after third certificate renewal
PRINCE EDWARD ISLAND *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1	Sec. 6(1): physician may make an application 13(1): psychiatrist's assessment for involuntary commitment	Sec. 7 (1): application to court for order for examination Sec. 8: police officers' powers in taking into custody Sec. 23: right to give or refuse consent to treatment	Sec. 13: psychiatrist of the opinion that person suffers from mental disorder and in requires hospitalization in the interest of safety and refuses voluntary admission	Sec. 1: psychiatric facility designated for examination, care and treatment Sec. 19: transfer or prisoner to psychiatric facility	Sec. 13 (4): release after 72 hours Sec. 15: not more than 28 days from date of certificate Sec. 16: renewal certificate thirty days, ninety days, twelve months

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
QUÉBEC *Civil Code of Québec*, (CCQ), S.Q. 1991, c. 64 (Art.) *An Act respecting the protection of persons whose mental state presents a danger to themselves or to others*, R.S.Q. c. P-38.001(Sec.)	Art. 27: application of physician or interested person for confinement Art. 28: role of second physician within 96 hours Sec. 2: psychiatrist's role for examination	Art. 26-31: confinement in institution and psychiatric assessment Sec. 7: preventive confinement Sec. 15: duty to inform patient	Art. 27: person is a danger to oneself or others Sec. 1: person whose mental state is a danger to themselves or others	Art. 27: health or social services institution for psychiatric assessment Sec. 6: facilities for preventive or temporary confinement Sec. 9: specifies type of confinement facility	Art. 28: first psychiatric assessment within 24 hours; and second psychiatric assessment within 96 hours Sec. 7: preventive confinement for 72 hours Sec. 10: 21 days from date of decision, review every three months
SASKATCHEWAN *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1	Sec. 20(1): police officer's role Sec. 24 (1): physician with admitting privileges Sec. 24(3): two physicians , one of whom is a psychiatrist Sec. 22: judge's role where person charged with offence	Sec. 19: judicial warrant for examination Sec. 23.1(1): psychiatric review if person detained under *Criminal Code* Sec. 27: duty to provide care and treatment	Sec. 24(2): admission certificate criteria whereby person suffering with a mental disorder and likely to cause harm to oneself or others	Sec. 2 (h), 4: facility means mental health centre, psychiatric ward, mental health clinic, any other designated building Sec. 22 (2) (3): designated in-patient facility if person charged with offence	Sec. 24(2) (a): initial admission 72 hours Sec. 24.1(1) long term detention orders

JURISDICTION	WHO	WHAT	WHEN	WHERE	HOW LONG
YUKON *Mental Health Act*, R.S.Y. 2002, c. 150	Sec. 5 : physician for recommendation for involuntary assessment Sec. 12 (1): two physicians to determine person's need for care and treatment	Sec. 14: one or both physicians to complete treatment plan after 120 hours after certificate Sec. 20: certificate of incompetence	Sec. 13(1): person suffers from mental disorder likely to result in harm to another or impending serious mental or physical impairment	Sec. 1: health facility means nursing station, health center, or hospital	Sec. 13(7), 16: every twenty-one days, certificates of renewal Sec. 16: renewal process of certificate

CONCLUSION

Individuals with mental illness have a strong desire to create advance treatment plans that allow them to share relevant information with others when they are most vulnerable (Swanson et al., 2008). This study has demonstrated that individuals with mental illness may be more inclined to use certain types of advance treatment plans, namely an instructional or proxy directive, depending on their illness diagnosis. Recovery from mental illness requires the coordinated support of family, friends, legal professionals, treatment teams, and government agencies (Davidson et al., 2007). This dissertation takes an interdisciplinary perspective to understand the clinical, ethical, and legal issues related to advance treatment planning for individuals with mental illness across Canada. Research from other countries has significantly advanced our knowledge of issues around advance treatment planning. In Canada, this study represents one of the first comprehensive analyses examining the relationship between advance treatment planning, autonomy, and choice as it relates specifically to individuals with mental illness. Advance treatment planning is a *process* that involves more than simply completing a document to assert one's legal right (Canadian Hospice Palliative Care Association, 2010). Encouraging individuals to participate in this process raises socio-political questions including access to justice, social exclusion, free will, and respect for civil liberties. These complex issues required analyses from multiple perspectives (i.e. empirical, legal, and philosophical).

PADs are unique in mental health because they offer individuals a practical and timely way to be heard when they are most vulnerable due to mental incapacity. Autonomy does not hold the same meaning for everyone. Nevertheless, all humans have autonomy to some degree even if it is not always manifested overtly. Rarely, however, has autonomy been examined from an evidence-based perspective. Moreover, an individual's *ideal* of autonomy can differ from their *actual* autonomy. When individuals are required to make risky choices, a relational conception of autonomy can be useful because it is premised on the view that humans are interconnected beings and not isolated rational thinkers (Ho, 2008; Hunt & Ells, 2010). Furthermore, the expression of autonomy is not identical to making choices. Whereas free choice permits individuals to select from multiple options, autonomy is more akin to an internal psychological state or trait. Giving individuals more choice does not always lead to increased autonomy, yet making a well-informed choice can be a manifestation of one's degree of autonomy. Empowerment also needs to be distinguished from autonomy (Schurhofer & Peschl, 2005). Individuals can be empowered when there is a reciprocal exchange of information between two or more persons, which may lead to feeling more autonomous. Although the law frequently constructs dignity as a legal principle and innate human right worthy of universal recognition, courts have not always given autonomy the same degree of constitutional protection. Canadian courts have limited autonomy as a principle of fundamental justice, while failing to explain clearly how it differs from dignity, liberty, or freedom. An area of future research will be to examine how courts define autonomy, and give more or less weight to the values of autonomy, dignity, liberty in different medical settings.

Choice is deeply ingrained in humans from a tender age (Iyengar, 2010). As such, individuals with mental illness are rarely indifferent about making important choices related to their medical treatment, particularly those that influence their physical well-being and emotional integrity. In the U.S., the consumer choice movement in health care has been one of the driving forces behind the impetus to implement PADs. One of the critiques of traditional psychiatry has been the degree of paternalism and coercion used to leverage choice of treatment (Sass, 2003). Although coercion may continue to have a role in psychiatry, the fundamental value of patient choice cannot be overlooked (Quill & Brody, 1996). Indeed, results from this research suggest that giving individuals with mental illness greater choice through advance treatment planning does not necessarily open the floodgates of treatment refusals. Instead, the value of providing individuals choice is that it facilitates communication between doctors and patients and allows greater room to negotiate treatment preferences. The robust demand by certain groups of individuals with certain mental illnesses to prefer

PADs (instructional directives) rather than mandates (proxy directives) may be related to the openness in which they are able to discuss medications within a trusting doctor-patient relationship. Yet, heated disputes arise between doctors and patients due to side effects from medication (Wilder et al., 2007), involuntary hospitalization (Crisanti & Love, 2001), and insufficient time to negotiate treatment preferences (Botelho, 1992). A shared decision-making approach requires enabling people with negotiation skills, which many individuals with mental illness have never learned (Drake, Deegan, & Rapp, 2010). Thus, future research could explore how training programs in negotiation could be developed to help patients feel more empowered and have better clinical outcomes related to their psychosocial well-being.

Several individuals with mental illness in this study recognized that both instructional directives (PADs) and proxy directives (mandates) offer numerous advantages. It is not surprising that many individuals with mental illness wanted to complete both. However, several jurisdictions have not enacted legislation to facilitate the wider use of instructional directives (Dunbrack, 2006). Individuals with specific forms of mental illness prefer certain types of advance directives to others. Some individuals with mental illness choose instructional directives because they do not want to relinquish all control and decision-making to a substitute decision-maker. Others do not want to burden family members with the responsibility of making all decisions. It is possible that many substitute decision-makers do not fully understand their roles when they are appointed in a proxy or hybrid instructional/proxy directive. Future research should examine whether it is possible for uniform guidelines to be developed in Canada that would allow individuals with mental illness to make both instructional and proxy directives.

Many individuals are alone in dealing with their mental illness. This research suggests that some of the factors related to feeling isolated may include stigma, a breakdown in relationships with family and friends, and not wanting to manifest publicly that one has an illness. Advance treatment planning requires a substantial degree of trust, reliance, and confidence that others will be supportive during times of increased vulnerability when one lacks mental capacity.

Completing a PAD allows individuals to reflect on whom they trust to act as substitute decision-maker and to develop greater insight and awareness into the need for treatment.

PADs are tools that have the potential to help mitigate the sense that individuals are alone, promote community involvement and education, build confidence through shared decision-making, offer peace of mind, and break down stigma barriers. This dissertation represents the first comparative study of advance directive legislation across Canada for individuals with mental illness. Some provincial and territorial legislation allows individuals to include provisions in their advance directive that would make it difficult to honour the document in another Canadian jurisdiction. Furthermore, mental health legislation in some jurisdictions does not obligate health care providers to make reasonable inquiries into whether an individual has completed an advance directive. The lack of such an obligation could be construed as closing the door on shared communication in the doctor-patient relationship. One possibility for future research is to draft a uniform statute dealing with advance directives through the Uniform Law Conference of Canada.

Accessing advance directives during a crisis when an individual is mentally incapable often requires the maker to ensure that the substitute decision-maker can find and retain the document in a timely fashion. The Governments of Québec and Alberta have established electronic registries to store basic information about an individual's advance directive. The U.S. Living Will Registry® has adopted an innovative approach to manage, store, and retain advance directives in a secure registry. During an emergency, and with the prior consent of the maker or the consent of a proxy, the Registry is able to forward a copy of the document electronically to health care providers. Alberta and Québec's registries have not incorporated similar technology that would allow for immediate transmission of an advance directive to healthcare providers. As electronic health records begin to be implemented in mental health institutions, it will be useful to consider how advance directives could be integrated into electronic medical files.

This dissertation compared how mental capacity is defined across provincial and territorial legislation and, in the process, found that there is no legislative definition for mental capacity in Québec. Additionally, the terms "mental disorder" and "mental capacity" across provincial and territorial mental health legislation are not uniform, which can lead to ambiguity in how capacity to complete an advance directive will be interpreted. There has been a longstanding myth that mentally incapable individuals do not have autonomy. This study has suggested that individuals are able to feel and act autonomously to some degree even if they are mentally incapable. The term "mental capacity" refers to individuals' cognitive abilities to make informed decisions, whereas "competence" is a term generally reserved as a legal criterion applied by judges. Individuals are required, as a matter of law, to be mentally capable to complete PADs. Currently, many capacity assessments are performed based on the subjective expertise of mental health care professionals rather than through objectively valid and reliable instruments. If individuals complete PADs when their mental capacity is questionable, without an objective assessment from the outset, the validity of such documents can be legitimately questioned. The example of Alberta introducing an evidence-based approach to mental capacity assessments is a useful approach to reduce uncertainty among patients, clinicians, and family members. Ensuring that PADs are completed voluntarily with a minimum standard of mental capacity is especially important for individuals who choose to include a Ulysses clause in their directive, thus making their wishes irrevocable.

Occasions will arise when individuals need to be hospitalized involuntarily. Among persons who consent voluntarily to hospitalization, there is often a strong preference to receive mental health treatment from particular hospitals and to be engaged in their treatment choices during their hospital stay. Based on the reassurances of Canadian common-law jurisdictions, it is likely that hospital staff and treatment teams would not be permitted to ignore instructions in a PAD that become known well before an emergency (*Malette v. Shulman*, 1991). If PADs are to become widely disseminated such that health care providers regularly consult such documents, treatment teams will need to be trained with best practice guidelines.

Advance treatment planning under Canadian law represents a new era of consumer choice and ethical treatment in psychiatry. This dissertation can help to establish a framework for future research and scholarship in the field of advance treatment planning for mental health. Autonomy, empowerment, and dignity are fundamental human values worthy of honour. The completion of a legal document, such as a PAD, requires mutual trust and collaboration between patients, legal and health care professionals, and family members. Consequently, governments who embark on drafting legislative policies for advance treatment planning should ensure that individuals' rights and values to receive ethical treatment are honoured. As Michel Foucault once said, "If governments make human rights the structure and the very framework of their political action that is well and good. But human rights are, above all, that which one confronts governments with. They are the limits that one places on all possible governments" (Foucault, 2000). Governments have the power to limit fundamental rights such as autonomy through mental health legislation, but they must also listen to the voices of members from vulnerable populations to ensure their needs are being met.

.

APPENDICES

Appendix I: Research Instruments

Chapter Three: Mixed Methods Study

Québec
Fonds de la
recherche en santé
du Québec

Douglas
INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

AUTONOMY AND ADVANCE TREATMENT PLANNING STUDY

PURPOSE OF STUDY

- To assist individuals with mental illness to complete advance directives in the event they become incapable to make their own decisions at some point in the future.

YOUR ROLE

- To meet on 3 separate visits which involve the following:
  - 1st meeting (1.5 hours) to complete questionnaires
  - 2nd meeting (1.5 hours) to complete an advance directive
  - 3rd meeting (1 hour) to complete questionnaires

ELIGIBILITY

- 18-65 years
- English-speaking
- Have a diagnosis of bipolar disorder, schizophrenia, or depression
- Competent to consent to participation in the research study
- Currently receiving follow-up treatment with a psychiatrist

COMPENSATION

- Individuals will receive compensation for participating in the study.

TO ENROLL IN THIS RESEARCH STUDY CONTACT:
Daniel Ambrosini, LLB, BCL, MSc, PhD candidate
Douglas Mental Health University Institute
Services, Policy, and Population Health Research
Psychosocial Division, Perry Pavillon
(514) 761-6131 extension : 3438
daniele.ambrosini@mail.mcgill.ca

CONSENT DOCUMENT

TITLE OF RESEARCH STUDY

Autonomy and Advance Treatment Planning Study (Phase II and III)

RESEARCHERS RESPONSIBLE FOR RESEARCH STUDY

Principal investigator (Doctoral student):	Daniel Ambrosini, LLB, BCL, MSc, PhD candidate McGill, Department of Psychiatry Douglas Mental Health University Institute
Principal co-investigator:	Dr. Anne Crocker, PhD Associate Professor, McGill University Douglas Mental Health University Institute
Principal co-investigator:	Dr. Eric Latimer, PhD, Associate Professor, McGill University Douglas Mental Health University Institute

PROTOCOL NUMBER: 09/34

NAME OF FUNDING ORGANIZATION:

Psychosocial Rehabilitation Canada; Foundation of the Barreau du Québec; The Society for the Psychological Study of Social Issues

1. INTRODUCTION

You are being invited to participate in a research study. Before agreeing to participate in this study and signing this consent form, please take the time to read, understand, and consider closely the information that follows.

This form may contain words that you do not understand. We invite you to ask all questions that you consider helpful in making your decision to the principal investigator or any member of the research team involved in this project, and to ask them to explain any words or information that are unclear.

2. PURPOSE OF RESEARCH STUDY

The aim of this study is to examine the relationship between autonomy and advance directives among individuals with mental illness. Psychiatric advance directives (PADs) are legal documents that allow individuals with mental illness to state their treatment preferences if they become incompetent to make their own choices in the future. Mandates in case of incapacity are legal documents used in Québec that allow individuals with mental illness to appoint someone else to make decisions on their behalf. PADs do not currently exist in Québec, but there is some evidence that they may help individuals with mental illness to become more autonomous. Before completing either advance directive it is important that you understand and appreciate the choice you will make.

We are inviting you to participate in this study because you are part of a group in which researchers from this study are interested in knowing more, specifically an individual with a mental illness who is affiliated with the Douglas Mental Health University Institute.

We are aiming to recruit 105 participants for this research study. The participants will be from 3 groups of 35 individuals each from the bipolar, depression, and schizophrenia clinics at the Douglas Mental Health University Institute.

3. PROCEDURES OF RESEARCH STUDY

Your participation in this project will involve an initial interview; completing an advance directive; and returning for a follow-up interview.

3.1 INITIAL INTERVIEW

You will be asked to undergo a competency assessment to ensure that you understand and appreciate the nature of participating in this research study. This assessment will take approximately 15 minutes. You will then be asked to provide some basic information about yourself and to complete several short questionnaires. The entire session will take approximately 2 hours. You will be asked to come back to the clinic the following day, where you will receive assistance to complete an advance directive.

3.2 COMPLETION OF ADVANCE DIRECTIVE

You will be given a choice to complete one of two types of advance directives: (1) a psychiatric advance directive OR, (2) a mandate in case of incapacity. You will be informed about the advantages and disadvantages of each document, and will be assisted to complete it. This session will take approximately 1.5 hours. You will receive one copy of the document, one copy will be given to your psychiatrist, and another will be kept by the investigators for research purposes.

3.3 FOLLOW-UP INTERVIEW

You will then be asked to return to the clinic 3 months after completing the advance directive to complete more questionnaires. Someone will phone you in advance to provide you a reminder. This interview will take approximately 1 hour. During these 3 months, you can ask your treatment providers to review your document at any time. You will be asked to remain in the study until the final interview, at which time a member of the research team will ask you if you want to retain your advance directive.

4. OPTIONAL PARTICIPATION IN FOLLOW-UP STUDY

At the end of the research study, a member of the research team may invite you to participate in a follow-up interview that would last 1.5 to 2 hours. If you are invited to participate in this follow-up study, you will have the opportunity to express your views of the advance directive that you selected.

5. RISKS ASSOCIATED WITH RESEARCH STUDY

There are no known harms, risks, or expected side effects associated with your participation in this research study. You will be provided ongoing information regarding any potential risks from the choices you make. If you experience any such problem with any element of advance treatment planning you should speak to a member of the research team immediately.

6. INCONVENIENCES ASSOCIATED WITH RESEARCH STUDY

Participation in this study includes the inconvenience of having to take the time to come to the clinic and participate in interviews, which were described above.

Certain questions that we will ask you regarding particular issues may appear to be sensitive. It is possible that discussing treatment around your mental illness may cause you some psychological discomfort. Nevertheless, you are not obligated to answer any question that you find overly sensitive.

7. BENEFITS

There are no known immediate benefits to you for participating in this research study. It is possible that by completing an advance directive your health care providers will become aware of who to contact in the event that you become incapable to make your own decisions. Making others aware of your treatment preferences if you are incapable may be a benefit to you if those preferences are honoured by your health care providers. It is uncertain how often your health care providers will honour your wishes as stated in an advance directive.

The results obtained from this research study will contribute to advancing knowledge in this field. Specifically, it will help us to explore the relationship between autonomy and advance treatment planning for individuals with mental illness in the future.

8. VOLUNTARY PARTICIPATION AND POSSIBILITY OF WITHDRAWAL

Your participation in this research study is voluntary. You are therefore free to refuse to participate. You can also withdraw from the project at any time, without providing reasons, by making your decision known to principal investigator or to one of the research team members associated with this study.

Your decision not to participate in this research study or your decision to withdraw will have no consequences on the quality of care or services you are entitled to receive or on your relationship with the principal investigator of the project and others involved in the study.

The principal investigator of the research study, or the Committee of the Research Ethics Board (REB) from the Douglas Mental Health University Institute may decide, at any time, to terminate your participation, without your consent, if they discover information that participation in the study is not in your best interests, if you do not respect the requirements of the research study, or if there are administrative reasons for terminating the research study.

If you withdraw or are asked to withdraw from the study, the information already obtained during the course of the research study will be preserved for as long as necessary to meet the demands of law.

All new information acquired during the procedures of the study that can affect your decision to continue in the study as a participant will be communicated to you verbally and in writing without delay.

9. CONFIDENTIALITY

During your participation in this study, the principal investigator and the research team will collect and record all information concerning you in a file. Only the necessary information to respond to the scientific objectives of the study will be collected.

This information will help understand your responses from the questionnaires, your views of medications, treatment, and hospitalization, along with other observations the interviewer may make about your well-being. Your file may also include other information such as your name, sex, date of birth, and ethnic background.

All information collected will remain strictly confidential within the limits of the law. In order to preserve your identity and confidentiality, the information you provide will be securely retained in a central computer. Access to this information will be strictly controlled, with the assistance of a security code.

The principal investigator responsible for the project will use the information you provide for research with the aim of answering the scientific objectives of the study described in this consent form. Furthermore, the information will respect applicable Québec and Canadian confidentiality laws.

Certain information provided may be published in specialized journals or presented at scientific conferences, but it will not be possible to identify you personally. Similarly, the information from the study may be used for other analyses in related projects or to explain future research.

For the purposes of quality surveillance, your research file may be consulted by a designated person of the Research Ethics Board from the Douglas Mental Health University Institute. This designated person and the organization will adhere to a strict policy of confidentiality.

For your protection, in order to contact you quickly, your first name and surname, your co-ordinates, and the beginning and end date of your participation in the study will be preserved for 5 years after the study ends in a secure computer directory maintained by the principal investigator or the organization.

You have the right to consult your research file to verify the information collected for as long as the researchers are responsible to retain the information. Nevertheless, to preserve the scientific integrity of the research study, you are not permitted to have certain information until your participation in the study has terminated.

10. FINANCING OF RESEARCH STUDY

The principal investigator responsible and the collaborators have received funding from Psychosocial Rehabilitation Canada, the Foundation of the Barreau du Québec, and the Society for Psychological Study of Social Issues for this research study.

11. INDEMNITY IN CASE OF PREJUDICE AND RIGHTS OF RESEARCH PARTICIPANT

If you undergo some prejudice which is due to your participation in this research study, you will continue to receive all the care and services required for your health, without expense on your part.

In accepting to participate in this project, you are neither renouncing any of your legal rights nor do you free the researchers, any partners, or the hospital from their civil and professional responsibilities.

12. COMPENSATION

You will receive compensation of $50 for your participation. You will receive $20 for the first visit, $20 for the second, and $10 for the third. If you are asked to withdraw from the study, or decide to withdraw before it is complete, you will receive an amount that is proportional to your participation. If you are asked and agree to participate in the follow-up interview you will be compensated an additional $20.

13. IDENTIFICATION OF KEY PERSONNEL

If you have questions concerning this research study or if you discover a problem which you believe involves your participation in the study, you can communicate with the principal investigator, Daniel Ambrosini, from the Douglas Mental Health University Institute at (514) 761-6131 ext. 3438.

For all other questions related to your rights as a research participant or for any ethical problem concerning the conditions in which this research project is being conducted, you may contact:

- Ombudsman of the Douglas Mental Health University Institute: (514) 761-6131 ext. 3287.

14. MONITORING ETHICAL ASPECTS OF THIS STUDY

The Committee of the Research Ethics Board of the Douglas Mental Health University Institute have approved this research study and will assure that it is followed. Furthermore, they will approve any revisions and modifications to this consent form and the research protocol.

For all information, you may contact the Secretariat of the Committee of the Research Ethics Board of the Douglas Mental Health University Institute at (514) 761-6131 ext. 2708.

CONSENT

I. Consent from research participant

I understand the information provided in this consent form. I acknowledge that someone explained to me the above study and answered my questions. The individual provided me sufficient time to make a decision.

I consent to participate in this research study according to the conditions as they were described.

A signed and dated copy of the consent form and my consent were provided to me.

____ ______________________

Participant signature Date

____

Name (signature)

II. Signature of the person who obtained consent

I explained to the research participant the terms of this informed consent document and have answered all the questions that were asked of me.

____ ______________________

Signature of person who explained the study Date

____

Name (signature)

III. Signature of principal investigator of research study

I certify that someone has explained to the research participant the terms of this informed consent document, that someone responded to all the participant's questions in this regard, and that it was clearly explained to the participant that he or she is free to terminate the study without prejudice. With the research team, I agree to respect the information provided in this consent form and to provide a signed copy of the document to the participant.

____ ______________________

Signature of principal investigator of study Date

____

Name (signature)

Douglas

INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

Authorization to consult a medical file

Name: ____________________________ File #: ________________________

Birthdate: _____ / ______ / ______ (dd/mm/yyyy)

I, the undersigned, ___________________________, authorize the research assistant assigned to the evaluation of files at the Douglas Mental Health University Institute to consult my medical file within the context of my participation in the research study entitled: **Autonomy and Advance Treatment Planning.**

The person responsible for the evaluation of files will verify:

1) My eligibility to participate in the research.
2) The presence of side effects related to my taking medication.
3) The validity of the information obtained about me within the context of the research.
4) The number of times I have been hospitalized.
5) The number of visits to my treatment team clinic during the research study.

I authorize the consultation of my medical file by the research assistant assigned to the evaluation of files at the Douglas Mental Health University Institute.

Signature: _____________________________________

Signed the _________________________(date), at ___________________ (city)

MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR)

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

Understanding

U-1 Disclosure (Nature of Project) - 'You have been asked to be in a research project to find out what your preferences regarding advance treatment planning are. We are asking you to participate because you have been referred to us by the bipolar/schizophrenia/depression clinic, and because an advance directive may help you. The research project will last 3 months. During this time, each person in the project will be asked to complete some questionnaires and will be asked to choose between two types of advance directives.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

a) Purpose of project

If participant fails to mention spontaneously, ask: 'What is the purpose of the research project I described to you?'

If participant fails to mention spontaneously, ask: 'What is the main purpose of what the investigators are trying to do in this study?'

b) Duration of project (Procedural element No. 1)

If participant fails to mention spontaneously, ask: 'How long will the research project last?'

c) Completing questionnaires (Procedural element No. 2)

If participant fails to mention spontaneously, ask: ' What sorts of things will be done with people who agree to be in the study?'

d) Choosing an advance directive (Procedural element No. 3)

If participant fails to mention spontaneously, ask: 'What else would be done with people who agree to be in the study?'

U-2 Disclosure (Primary purpose is research, not individualized care) - 'It is important for you to realize that the project in which you have been asked to participate is a research project. That means that its main purpose is to help researchers figure out what kinds of advance directives people with mental illness choose. The main purpose is not to find out whether it works for specific people in the study. Instead, the primary purpose is for research.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

If participant fails to mention spontaneously, ask: 'What is the main purpose of what the researchers are trying to do in this study?'

U-3 Disclosure (Effect of research methods on individualized care) - 'Because this is a research project, not an ordinary treatment procedure, the researchers will be doing things that doctors would not do in ordinary hospitals. For example, some people who are in this project will choose the psychiatric advance directive, while others will choose the mandate in case of incapacity. You will need to choose which one of the two you want to have. All participants will be assisted to complete the advance directive they have chosen. Your psychiatrist and the researcher will know which one of the two you chose. All these things are done to see which type of advance directives individuals choose.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

a) Choice of advance directive

If participant fails to mention spontaneously, ask: 'Will all people be allowed to choose which type of advance directive they want?'

b) No randomized assignment

If participant fails to mention spontaneously, ask: 'Will individuals be randomly assigned to receive an advance directive or will they be allowed to choose themselves?'

c) Blinding (none)

If participant fails to mention spontaneously, ask: 'Who will know what kind of advance directive you chose?'

U-4 Disclosure (Benefits of participation) - 'There are several benefits that could result if people agree to be in this project. First, the researchers will learn which of the two advance directives most individuals in the study prefer to use. Second, people in this project who choose one of the advance directives may discover that it works well for them.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

a) Societal benefits

If participant fails to mention spontaneously, ask: 'What might researchers learn about the treatment of mental illness if people decide to be in this research project?'

b) Personal benefit

If participant fails to mention spontaneously, ask: 'In what way might people who volunteer be better off by being in this research project?'

U-4 Disclosure (Risks/Discomforts of participation) - 'There are a few risks and discomforts to which people that are in this study will be exposed. First, completing an advance directive means that it will become your recorded legal expression of the kinds of treatment you want to receive in the event you become incapable in the future. You can change your treatment preferences later, but only if you are capable to understand your choices at that time. It is important, therefore, that you make sure that the treatment preferences are those you really want. Second, you will be asked to complete some questionnaires, which can cause some emotional discomfort for certain people.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

c) Self-binding wishes

If participant fails to mention spontaneously, ask: 'What is one possible effect of completing an advance directive for some people?'

d) Discussing mental illness (emotional discomfort)

If participant fails to mention spontaneously, ask: 'What uncomfortable things can result from being in this study?'

U-5 Disclosure (Ability to withdraw/receive ordinary care) -'No one has to be in this research study. People who agree to be in this research project can change their minds at any time. If they don't agree to be in this study or if they decide to stop, they will be referred back to the treatment clinic for the usual treatment.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

b) Personal benefit

If participant fails to mention spontaneously, ask: 'In what way might people who volunteer be better off by being in this research project?'

U-4 Disclosure (Risks/Discomforts of participation) - 'There are a few risks and discomforts to which people that are in this study will be exposed. First, completing an advance directive means that it will become your recorded legal expression of the kinds of treatment you want to receive in the event you become incapable in the future. You can change your treatment preferences later, but only if you are capable to understand your choices at that time. It is important, therefore, that you make sure that the treatment preferences are those you really want. Second, you will be asked to complete some questionnaires, which can cause some emotional discomfort for certain people.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

c) Self-binding wishes

If participant fails to mention spontaneously, ask: 'What is one possible effect of completing an advance directive for some people?'

d) Discussing mental illness (emotional discomfort)

If participant fails to mention spontaneously, ask: 'What uncomfortable things can result from being in this study?'

U-5 Disclosure (Ability to withdraw/receive ordinary care) -'No one has to be in this research study. People who agree to be in this research project can change their minds at any time. If they don't agree to be in this study or if they decide to stop, they will be referred back to the treatment clinic for the usual treatment.'

Do you have any questions about what I just said?

Can you tell me your understanding of what I just said?

Expressing a choice

As you know, you have been invited to participate in a research project looking at which type of advance directives individuals with mental illness prefer to use. Do you think you are more likely to want to participate or not want to participate?

Reasoning

R-1/R-2 (Consequential and comparative reasoning) - 'You think that you are most likely to want to (insert subject's choice to participate or not) in the study. Tell me what it is that makes that option better than the other.'

R-3(Generating consequences) - 'I told you about some of the possible benefits and risks or discomforts of participating in the research project. The benefits are that participants who receive one type of advance directive may find out that it works better for them than if they chose the other type of advance directive. The risks and discomforts of participating in this study are that the last wish you put in your advance directive is the choice doctors may follow if you become incapable. If you change your mind regarding your treatment preferences, you will need to change your advance directive. What are some ways that advance directives can affect your everyday activities if you participate in the research project?'

If participant fails to mention a consequence of either the benefits or the risks/discomforts, ask: 'How might (restate benefit or risk) affect your everyday life?'

Final choice

'A few minutes ago you told me that you favored participating/not participating in the research project. What do you think now that we have discussed everything? What do you want to do?'

Reasoning

R4 (Logical consistency of choice) - Interviewer records and explains presence or absence of logical consistency in subject's choice.

MacCAT-CR Record Form

Understanding *(Each item is rated 0-2)*

1. Nature of project
   a. __________
   b. __________
   c. __________
   d. __________

subtotal: ____________

2. Primary purpose is research

subtotal: ____________

3. Effects on individualized care
   a. __________
   b. __________
   c. __________

subtotal: ____________

4. Benefits and risks/discomforts
   a. __________
   b. __________
   c. __________
   d. __________

subtotal: ____________

5. Ability to withdraw

subtotal: ____________

TOTAL Understanding Score (0-26): ____________

Appreciation *(Each item is rated 0-2)*

1. Object not personal benefit

subtotal: _______________

2. Possibility of reduced benefit

subtotal: _______________

3. Withdrawal possibility

subtotal: _______________

TOTAL Appreciation Score (0-6): _______________

Reasoning *(Each item is rated 0-2)*

1. Consequential reasoning

subtotal: _______________

2. Comparative reasoning

subtotal: _______________

3. Generating consequences

subtotal: _______________

4. Logical consistency of choice

subtotal: _______________

TOTAL Reasoning Score (0-8):_______________

Expressing a choice *(Each item is rated 0-2)*

TOTAL Expressing a choice Score (0-2):_______________

Socio demographic Data

Today's date: ☐☐ / ☐☐ / ☐☐☐☐ (DD MM YYYY)   Participant ID: ☐☐☐☐☐   Rater ID: ☐☐

---

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐☐☐ (DD MM YYYY)   Age: ____________________

2. In what country were you born?

   ☐ Canada   ☐ Other (specify: ________________________________)

3. What is your first language?
   ☐ French
   ☐ English
   ☐ Other (Specify: ___________________________________)

4. What is your gender?
   ☐ Female   ☐ Male

5. What is your current civil status?

Alone :	**Couple :**
☐ Never married nor in common law	☐ Married/remarried
☐ Legally divorced	☐ Living as married (Specify duration:_______________)
☐ Separarted form a marriage or common law relationship	
☐ Widowed	

6. Do you have children?
   ☐ Yes   ☐ No
   If yes:
   How many? ☐☐

7. Are you currently under a protection regime?
   ☐ Yes   ☐ No

Socio demographic Data

8. Current residential setting:
   - ☐ Residence approved by hospital
   - ☐ Living at parent's home
   - ☐ Living at a relative's home (brother/sister/uncle/aunt)
   - ☐ Living with spouse
   - ☐ Living as married
   - ☐ Living at child's home
   - ☐ Sharing an apartment with an acquaintance
   - ☐ Living alone in an apartment
   - ☐ Living alone in a boarding house
   - ☐ Homeless
   - ☐ Supervised apartment
   - ☐ Foster home
   - ☐ Group home
   - ☐ Nursing home
   - ☐ Other (Specify: ____________________)

9. What is your main current source of income?
   - ☐ Own paid work
   - ☐ Partner's work
   - ☐ Pension
   - ☐ Employment insurance
   - ☐ Welfare
   - ☐ Charity (homeless)
   - ☐ Non declared work (under the table)
   - ☐ Other (Specify : ___________________________)

10. Are you currently working?
    - ☐ Regular full time work
    - ☐ Regular half time work
    - ☐ Student
    - ☐ Adapted work centre (outpatient)
    - ☐ Therapeutic workshop (inpatient)
    - ☐ Other (Specify: ______________________________)
    - ☐ Does not work

11. What is the highest grade of schooling that you have completed?
    - ☐ No formal schooling
    - ☐ High school not completed
    - ☐ High school completed (DES, DESP)
    - ☐ Cegep not completed or in progress
    - ☐ Cegep completed (DEC, DEP)
    - ☐ University not completed or in progress
    - ☐ University completed (BSc, BA)
    - ☐ University graduate studies (masters' degree, doctorate) not completed or in progress
    - ☐ University graduate studies completed (MSc, MA, PhD, MD)

---

12. Have you ever had a psychiatric hospitalization?

☐ Yes ☐ No

If yes, how many times (according to the participant): ________________

If yes, how many times (as found in the chart):________________

Age at first hospitalization (according to the participant): ________________

Age at first hospitalization (as found in the chart):________________

Did you receive a diagnosis?

☐ Yes ☐ No ☐ Don't know

If yes, what was the last diagnosis you received (participants' opinion)?______________________

If yes, what was the last diagnosis you received (found in chart)?___________________________

13. Have hospital restraints ever been used on you?

☐ Yes ☐ No ☐ Don't know

14. Have you ever been placed in isolation or seclusion while at the hospital?

☐ Yes ☐ No ☐ Don't know

15. Were you admitted to the hospital against your wishes?

☐ Yes ☐ No ☐ Don't know

16. Have you ever received medical treatment against your wishes?

☐ Yes ☐ No ☐ Don't know

17. Present medication (see file):

____

____

____

____

____

Length of the interview (in minutes) : ☐☐☐☐

Ethical follow-up

Today's date: ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

---

1. Did the participant make any statement during the interview about harming himself or others?

   ☐ Yes ☐ No

   If yes:

   a) What did he say?

   b) Did you report this information to treatment staff?

      ☐ Yes ☐ No

      If yes:

      Who did you speak to and what did you say?

      If no:

      Why didn't you report the information?

   c) Did you tell the participant that this information would be reported to the treatment staff?

      ☐ Yes ☐ No

      If yes:

      What was the participant's reaction?

      If no:

      Why didn't you tell the participant that this information would be reported?

Ideal Patient Autonomy Scale

What do you consider a good doctor-patient relationship?

Today's date: ☐☐ / ☐☐ / ☐☐☐☐ (DD MM YYYY)

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

Below are 14 statements about the relationship between doctor and patient. Try to imagine that you are going to the doctor with a serious illness. The doctor-patient relationship can take many forms. We would like you to tell us what you think is a good doctor-patient relationship, what, in your opinion, are the characteristics of a good doctor-patient relationship? What is important is ***your opinion***. It is not about how doctors and patients actually relate to each other, or how they could relate to each other. When thinking about what constitutes a good doctor-patient relationship, you therefore do not have to take into account what you think mostly actually happen in practice or what you think is feasible in practice.

We would like to know whether you agree or disagree with the content of the statement. In this process, keep in mind what you think is a good doctor-patient relationship. The question is actually: ***Do you agree with the statement: when you think about what constitutes a good doctor-patient relationship?***

EXAMPLE:

"It is better if there are no students in the consulting room."

When I think about a good doctor-patient relationship, then my reaction is to:

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

The person who filled in this example had never encountered students in the doctor's consulting room. This person knew a lot of people who have absolutely no problemwith students sitting in on a consultation. Yet, he still answered that he agreed with this statement. Because he thinks that it is in the interest of his relationship with the doctor if there are no students present. As you can see from this example, even if somebody has no experience with students in the consulting room, or if others have a different opinion, they can still say what they think makes for a good relationship between doctor and patient. **End of example.**

Please tell me whether you disagree, disagree slightly, neither agree, nor disagree, agree slightly or agree with each of the following statements.

1. If the patient does not want to receive information about risks, the doctor should respect this.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

2. It is better that the doctor rather than the patient decides which is the best treatment.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

3. The patient has to be informed on all the risks involved in an operation.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

4. Patients should have the right not to be involved in the decision on the treatment.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

5. During the conversation, the patient must submit him/herself with confidence to the expertise of the doctor.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

6. The patient him/herself must choose between the various treatments.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

7. Before a patient consents to a treatment (s)he should receive all information on the risks involved.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

8. Patients who become afraid when thinking along about treatment decision should be left in peace by the doctor.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

9. If doctor and patient cannot agree on which treatment is best, the doctor should make the final decision.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

10. The patient should, without much information on the risk involved, confidently undergo an operation.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

11. It goes too far when the doctor decides which treatment is best for the patient.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

12. The doctor can presume that the patient knows that people can die during serious operations.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

13. If a patient chooses a treatment with more health risks, the doctor should respect this treatment decision.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

14. As it concerns the body and life of the patient, the patient should decide.

☐ Disagree ☐ Disagree slightly ☐ Neither agree, nor disagree ☐ Agree slightly ☐ Agree

Making Decisions

Empowerment scale

Today's date:		Participant ID:	Rater ID:
☐☐ / ☐☐ / ☐☐☐☐		☐☐☐☐☐	☐☐
DD MM YYYY			

Below are several statements relating to one's perspective on life and with having to make decisions. Please tell me the response that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answer reflect your true feelings.

Please tell me whether you strongly agree, agree, disagree or strongly disagree with the following statements.

1. I can pretty much determine what will happen in my life.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

2. People are only limited by what they think is possible.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

3. People have more power if they join together as a group.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

4. Getting angry about something never helps.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

5. I have a positive attitude toward myself.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

6. I am usually confident about the decisions I make.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

7. People have no right to get angry just because they don't like something.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

8. Most of the misfortunes in my life were due to bad luck.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

9. I see myself as a capable person.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

10. Making waves never gets you anywhere.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

11. People working together can have an effect on their community.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

12. I am often able to overcome barriers.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

13. I am generally optimistic about the future.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

14. When I make plans, I am almost certain to make them work.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

15. Getting angry about something is often the first step toward changing it.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

16. Usually I feel alone.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

17. Experts are in the best position to decide what people should do or learn.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

18. I am able to do things as well as most other people.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

19. I generally accomplish what I set out to do.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

20. People should try to live their lives the way they want to.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

21. You can't fight city hall.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

22. I feel powerless most of the time.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

23. When I am unsure about something, I usually go along with the rest of the group.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

24. I feel I am a person of worth, at least on an equal basis with others.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

25. People have the right to make their own decisions, even if they are bad ones.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

26. I feel I have a number of good qualities.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

27. Very often a problem can be solved by taking action.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

28. Working with others in my community can help to change things for the better.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

MacArthur Perceived Coercion Scale

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

The purpose of this questionnaire is to gain some understanding of people's perceptions on freedom, influence, control, and treatment choices.
I will read you a list of statements. You must tell me whether it is **true as applied to you** or **false as applied to you**. If the statement is **false** or **usually false**, tell me False following the statement. If the statement is **true** or **usually true**, tell me True follwing the statement.
You must answer every question. If a statement is worded not quite the way you would express it yourself, decide whether it is **mostly true,** or **mostly false**. Remember to give your own opinion - there are no right or wrong answers.

1. I feel free to do what I want about getting treatment.
☐ True ☐ False

2. I chose to get treatment.
☐ True ☐ False

3. It was my idea to get treatment,
☐ True ☐ False

4. I had a lot of control over whether I got treatment.
☐ True ☐ False

5. I had more influence than anyone else on whether I got treatment.
☐ True ☐ False

Draft

BRIEF PSYCHIATRIC RATING SCALE

6

Client ID ☐☐☐☐☐☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Rater ________________

Code ☐☐☐

Indicate period (0 to 10): ☐☐

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Not Assessed	Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

Rate items 1-14 on the basis of patient's self-report during interview. Mark "N" for symptoms not assessed. Note items 7, 12 and 13 are also rated on observed behavior during the interview. **PROVIDE EXAMPLES**

1. Somatic Concern	⓪	①	②	③	④	⑤	⑥	⑦	________
2. Anxiety	⓪	①	②	③	④	⑤	⑥	⑦	________
3. Depression	⓪	①	②	③	④	⑤	⑥	⑦	________
4. Suicidality	⓪	①	②	③	④	⑤	⑥	⑦	________
5. Guilt	⓪	①	②	③	④	⑤	⑥	⑦	________
6. Hostility	⓪	①	②	③	④	⑤	⑥	⑦	________
7. Elevated Mood	⓪	①	②	③	④	⑤	⑥	⑦	________
8. Grandiosity	⓪	①	②	③	④	⑤	⑥	⑦	________
9. Suspiciousness	⓪	①	②	③	④	⑤	⑥	⑦	________
10. Hallucinations	⓪	①	②	③	④	⑤	⑥	⑦	________
11. Unusual Thought Content	⓪	①	②	③	④	⑤	⑥	⑦	________
12. Bizarre Behavior	⓪	①	②	③	④	⑤	⑥	⑦	________
13. Self-neglect	⓪	①	②	③	④	⑤	⑥	⑦	________
14. Disorientation	⓪	①	②	③	④	⑤	⑥	⑦	________

Rate items 15-24 on the basis of observed behavior or speech of the patient during the interview.

15. Conceptual Disorganization	⓪	①	②	③	④	⑤	⑥	⑦	________
16. Blunted Affect	⓪	①	②	③	④	⑤	⑥	⑦	________
17. Emotional Withdrawal	⓪	①	②	③	④	⑤	⑥	⑦	________
18. Motor Retardation	⓪	①	②	③	④	⑤	⑥	⑦	________
19. Tension	⓪	①	②	③	④	⑤	⑥	⑦	________
20. Uncooperativeness	⓪	①	②	③	④	⑤	⑥	⑦	________
21. Excitement	⓪	①	②	③	④	⑤	⑥	⑦	________
22. Distractibility	⓪	①	②	③	④	⑤	⑥	⑦	________
23. Motor Hyperactivity	⓪	①	②	③	④	⑤	⑥	⑦	________
24. Mannerisms and Posturing	⓪	①	②	③	④	⑤	⑥	⑦	________

Sources of information (check all that apply)

__ Patient
__ Parents/Relatives
__ Mental health professionals
__ Chart

Explain here if validity of assessment is questionable:

__ Underreported due to lack of rapport
__ Symptoms possibly drug-induced
__ Underreported due to negative symptoms
__ Patient uncooperative
__ Difficult to assess due to formal thought disorder
__ Other ________________________________

Confidence in assessment ☐ 1=Not at all
5=Very Confident

06/07/2000

BPRS 1/1

Recovery Assessment Scale

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

I am going to read a list of statement that describes how people sometimes feel about themselves and their lives. Please listen carefully to each one and indicate the response that best describes the extent to which you agree or disagree with the statement. For each statement, please tell me whether you strongly disagree, disagree, you are not sure, agree, or strongly agree with these statements.

1. I have a desire to succeed.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

2. I have my own plan for how to stay or become well.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

3. I have goals in life that I want to reach.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

4. I believe I can meet my current personal goals.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

5. I have a purpose in life.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

6. Even when I don't care about myself, other people do.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

7. I understand how to control the symptoms of my mental illness.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

8. I can handle it if I get sick again.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

9. I can identify what triggers the symptoms of my mental illness.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

10. I can help myself become better.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

11. Fear doesn't stop me from living the way I want to.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

12. I know that there are mental health services that do help me.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

13. There are things that I can do that help me deal with unwanted symptoms.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

14. I can handle what happens in my life.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

15. I like myself.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

16. If people really knew me, they would like me.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

17. I am a better person than before my experience with mental illness.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

18. Although my symptoms may get worse, I know I can handle it.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

19. If I keep trying, I will continue to get better.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

20. I have an idea of who I want to become.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

21. Things happen for a reason.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

22. Something good will eventually happen.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

23. I am the person most responsible for my own improvement.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

24. I'm hopeful about my future.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

25. I continue to have new interests.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

26. It is important to have fun.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

27. Coping with my mental illness is no longer the main focus of my life.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

28. My symptoms interfere less and less with my life.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

29. My symptoms seem to be a problem for shorter periods of time each time they occur.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

30. I know when to ask for help.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

31. I am willing to ask for help.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

32. I ask for help, when I need it.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

33. Being able to work is important to me.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

34. I know what helps me get better.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

35. I can learn from my mistakes.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

36. I can handle stress.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

37. I have people I can count on.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

38. I can identify the early warning signs of becoming sick.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

39. Even when I don't believe in myself, other people do.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

40. It is important to have a variety of friends.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

41. It is important to have healthy habits.

☐ Strongly disagree ☐ Disagree ☐ Not sure ☐ Agree ☐ Strongly agree

Today's date:	Participant ID:	Rater ID:
☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY	☐☐☐☐☐	☐☐

The purpose of this questionnaire is to gain some understanding of how people view the use of psychiatric medications and the nature of their experiences of these drugs. Your replies are used for research purposes only, are stricIty confidential, and will in no way affect your treatment.
I will read you a list of statements. You must tell me whether it is **true as applied to you** or **false as applied to you**. If the statement is **false** or **usually false**, tell me False following the statement. If the statement is **true** or **usually true**, tell me True follwing the statement.
You must answer every question. If a statement is worded not quite the way you would express it yourself, decide whether it is **mostly true,** or **mostly false**. Remember to give your own opinion - there are no right or wrong answers.
The medications referred to in the statements are psychiatric medications only.

1. I don't need to take medication once I feel better.
☐ True ☐ False

2. For me, the good things about medication outweigh the bad.
☐ True ☐ False

3. I feel weird, like a 'zombie' on medication.
☐ True ☐ False

4. Even when I am not in hospital I need medication regularly.
☐ True ☐ False

5. If I take medication, it's only because of pressure from other people.
☐ True ☐ False

6. I am more aware of what I am doing, of what is going on around me, when I am on medication.
☐ True ☐ False

7. Taking medication will do me no harm.
☐ True ☐ False

8. I take medication of my own free choice.
☐ True ☐ False

9. Medication make me feel more relaxed.
☐ True ☐ False

10. I am no different on or off medication.
☐ True ☐ False

11. The unpleasant effects of medication are always present.
☐ True ☐ False

12. Medication makes me feel tired and sluggish.
☐ True ☐ False

13. I take medication only when I am sick.

☐ True ☐ False

14. Medication is a slow-acting poison.

☐ True ☐ False

15. I get on better with people when I am on medication.

☐ True ☐ False

16. I can't concentrate on anything when I am on medication.

☐ True ☐ False

17. I know better than the doctor when to go off medication.

☐ True ☐ False

18. I feel more normal on medication.

☐ True ☐ False

19. I would rather be sick than taking medication.

☐ True ☐ False

20. It is unnatural for my mind and body to be controlled by medication.

☐ True ☐ False

21. My thoughts are clearer on medication.

☐ True ☐ False

22. I should stay on medication even if I feel all right.

☐ True ☐ False

23. Taking medication will prevent me from having a breakdown.

☐ True ☐ False

24. It is up to the doctor when I go off medication.

☐ True ☐ False

25. Things that I could do easily are much more difficult when I am on medication.

☐ True ☐ False

26. I am happier, feel better, when taking medication.

☐ True ☐ False

27. I am given medication to control behaviour that other people (not myself) don't like.

☐ True ☐ False

28. I can't relax on medication.

☐ True ☐ False

29. I am in better control of myself when taking medication.

☐ True ☐ False

30. By staying on medication, I can prevent getting sick.

☐ True ☐ False

Autonomy Preference Index

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

The aim of this questionnaire is to gain some understanding on people's decision making and information-seeking preferences. Please tell me whether you strongly disagree, disagree, agree, strongly agree, or feel neutral about the content of each statement.
It is important that you tell me your own opinion -- Remember that there are no right or wrong answers.
Do you have any question?

1. The important decisions should be made by your doctor, not by you.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

2. You should go along with your doctor's advice even if you disagree with it.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

3. When hospitalized, you should not be making decisions about yout own care.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

4. You should feel free to make decisions about everyday medical problems.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

5. If you were sick, as your illness became worse you would want your doctor to take greater control.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

6. You should decide how frequently you need a check-up.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

7. As you become sicker you should be told more and more about your illness.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

8. You should understand completely what is happening inside your body as a result of your illness.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

9. Even if the news is bad, you should be well informed.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

10. Your doctor should explain the purpose of your laboratory tests.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

11. You should be given information only when you ask for it.
☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

12. It is important for you to know all the side effects of your medication.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

13. Information about your illness is as important to you as treatment.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

14. When there is more than one method to treat a problem, you should be told about each one.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

Insight and Treatment Attitude Questionnaire

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

The aim of this questionnaire is to gain some understanding on people's attitudes toward previous hospitalizations, medication, and follow-up evaluations. It will also allow us to gain some information on people's views on their illness.
It is important that you tell me what you think, as honestly as possible. Remember that there are no right or wrong answers.

Have you ever been hospitalized in a psychiatric hospital before? ☐ **Yes** ☐ **No**

1. At the time of admission to this hospital, did you have mental problems that were different from most other people? Explain. *(if no previous hospitalization, write N/A).*

2. At the time of admission, did you need to come to this hospital? Explain. *(if no previous hospitalization, write N/A).*

3. Do you have mental problems now? Explain.

4. Do you need to be in this hospital now? Explain.

5. After you are discharged, it is possible you may have mental problems again? Explain.

6. After you are discharged, will you need to be followed (looked after) by a psychiatrist (mental health center)? Explain.

7. At the time of admission, did you need to be treated with medication for mental problems? Explain. *(if no previous hospitalization, write N/A).*

8. Do you need to be treated with medication for mental problems? Explain.

9. After you are discharged, will you need to take medication for mental problems? Explain.

10. Will you take the medication? Explain.

11. Do the medication do you any good? Explain.

Preferences for Advance directives Scale

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Participant ID: ☐☐☐☐☐

Rater ID: ☐☐

I will read you a series of ten statements regarding advance directives and treatment preferences. An advance directive is a legal document that allows you to record your treatment preferences if you become incapable in the future. Please tell me whether you strongly disagree, disagree, agree, strongly agree or you neither agree, nor disagree with the statements. Remember to tell me the response that is closest to how you feel about each statement. Please be honest with yourself so that your answers reflect your true feelings.

1. I want to write down detailed instructions about my treatment choices in an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

2. I want my doctor to follow my treatment choices in an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

3. I want to discuss my treatment choices with my doctor before completing an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

4. I want my family to help me decide what treatment choices I should include in an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

5. I trust my own judgment regarding treatment choices to include in an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

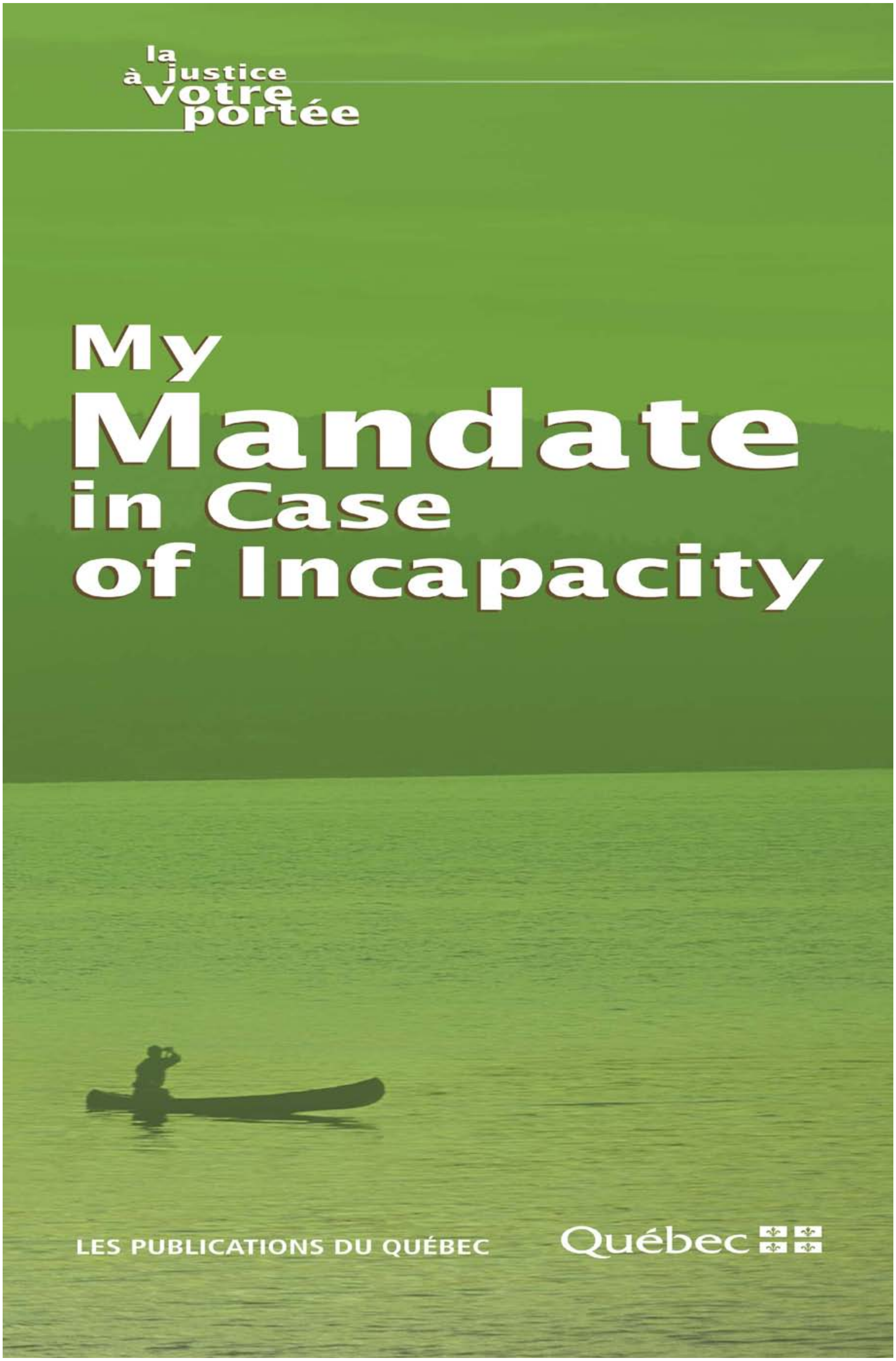
6. I want to appoint someone whom I trust to make sure my advance directive is followed.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

7. I am currently capable to make my own treatment choices.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

8. I trust my doctor to help me decide which treatment choices to include in an advance directive.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

9. My treatment choices should be left between me and my doctor.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree

10. I want the law to uphold my advance directive if I cannot decide for myself.
☐ Strongly disagree ☐ Disagree ☐ Neither agree, nor disagree ☐ Agree ☐ Strongly agree



la
à justice
votre
portée

My Mandate in Case of Incapacity

LES PUBLICATIONS DU QUÉBEC

Québec

Form
My Mandate in Case of Incapacity

PLEASE PRINT

Wherever required by the context, any word written in the singular form also includes the plural, and any word written in the masculine form also includes the feminine.

IMPORTANT

Please read the explanatory notes on pages 14 through 19 of the booklet carefully. Each section of the form has a corresponding explanatory note.

If you would like to designate **ONLY ONE MANDATARY** to care for your person and administer your property**, fill out section 1,** then go directly to section 3.

If you would like to designate **SEVERAL MANDATARIES** to care for your person and administer your property together or one to care for your person and the other to administer your property, **fill out section 2,** then go to section 3.

Please note that the administrator of your property can be someone in your family, a friend or someone else you trust, or even a company, such as a trust company or other institution authorized by law to act in this capacity.

If you need more space for any section of the form, you can add pages by numbering them so that they refer to the appropriate section.

Please initial the margin whenever you change a printed text.

1 SINGLE MANDATARY (See note 1)

This mandate cancels all previous mandates in case of incapacity and, once homologated, it terminates any power of attorney I have granted for the administration of my property.

I, the undersigned, ______________________ , born on ____ ____ ____
NAME OF MANDATOR DAY MONTH YEAR

hereby designate ______________________
NAME OF MANDATARY

____
ADDRESS

to act as mandatary responsible for protecting my person and administering my property.

Indicate your relationship to this person: ______________________

1.1 Substitute mandatary

If my mandatary is unable to act for whatever reason,

I designate ______________________
NAME OF MANDATARY

____
ADDRESS

to act as substitute mandatary.

Indicate your relationship to this person: ______________________

Initials of the mandator and witnesses ________ ________ ________

(Continued on back)

2 MULTIPLE MANDATARIES (See note 2)

This mandate cancels all previous mandates in case of incapacity and, once homologated, it terminates any power of attorney I have granted for the administration of my property.

I, the undersigned, ________________ (NAME OF MANDATOR), born on ____ (DAY) ____ (MONTH) ____ (YEAR)

hereby designate ________________ (NAME OF MANDATARY)

________________ (ADDRESS)

to act as mandatary responsible for protecting my person.

Indicate your relationship to this person: ________________

I also designate ________________ (NAME OF MANDATARY)

________________ (ADDRESS)

and (where relevant) ________________ (NAME OF MANDATARY)

________________ (ADDRESS)

to act as mandatary responsible for the administration of my property.

Indicate your relationship to this person: ________________

When several mandataries act jointly, decisions must be made:

☐ unanimously **OR** ☐ by majority

2.1 Substitute mandataries

If my mandatary is unable to act for whatever reason,

I also designate ________________ (NAME OF SUBSTITUTE)

________________ (ADDRESS)

to act as substitute mandatary responsible for protecting my person.

Indicate your relationship to this person: ________________

I also designate ________________ (NAME OF SUBSTITUTE)

________________ (ADDRESS)

to act as substitute mandatary responsible for administering my property.

Indicate your relationship to this person: ________________

Check if desired:

☐ In case of the resignation, death or legal incapacity of any of my mandataries mentioned above, the remaining mandatary will act as if he alone had been designated.

Initials of the mandator and witnesses ________ ________ ________

(Continued on back)

3 INVENTORY AND REPORT (See note 3)

3.1 Inventory

At the beginning of his functions, the mandatary responsible for the administration of my property should complete a summary inventory of all my moveable and immoveable property. This procedure must be performed in the presence of two witnesses, ideally including the person for whom the management report will be prepared, as appropriate.

3.2 Report

☐ My mandatary **OR** ☐ Only his substitute **OR** ☐ My mandatary and his substitute

must prepare an annual report of the actions taken with respect to my person and the administration of my property and submit it to ______________________________
NAME
____
ADDRESS
or, failing that person, to ______________________________
NAME
____
ADDRESS

4 RESPONSIBILITIES OF THE MANDATARY CONCERNING THE PROTECTION OF MY PERSON
(See note 4)

4.1 General

My mandatary is responsible for ensuring my moral and material welfare. In this sense, he is authorized to make any decisions and take any steps to meet my daily needs while respecting my wishes, my personal and religious values, my habits, my standard of living and degree of autonomy.

Wherever I live, my mandatary must ensure that I receive the care and services required by my health status.

As a general rule, I would like my mandatary to be "actively" present to the extent possible (regular visits, moral support, etc.).

4.2 Housing

If possible, I would like to live at home. However, if my health requires me to live in a setting that is safer and better adapted to my needs, my mandatary will decide according to the circumstances, while taking into account the following wishes:

____
____
____
____
____

Initials of the mandator and witnesses __________ __________ __________

(Continued on back)

4.3 Consent to care

If I am unable to consent to the care required by my health status or to refuse it, my mandatary shall do so on my behalf. In this respect, he shall act in my interest alone and take into account the wishes I have expressed to the extent possible and as provided by law. Should he be asked to consent to care, he shall use all means necessary to make a well-informed decision, as discussed with the attending physician and healthcare team. If he consents to the care suggested, it is with the conviction that it will be beneficial, despite its effects, appropriate in the context and the risks involved do not seem disproportionate given the beneficial effect targeted.

☐ Yes

OR

☐ No: I would like ______________________________ to consent to this care.
NAME OF PERSON

Indicate your relationship to this person: ______________________________

4.4 Clinical trials

I authorize my mandatary, if he feels that it is appropriate and complies with the applicable provisions of the *Civil Code of Québec*, to allow my participation in a research project or trial.

☐ Yes **OR** ☐ No

4.5 Last wishes

In all decisions concerning care required at the end of my life, my mandatary must consider:

Check the desired options:

☐ my opposition to any disproportionate diagnostic method or therapy that needlessly worsens or prolongs my suffering and death;

☐ my wish to die with dignity, with the required supportive care and comfort and proper medication to relieve my suffering, even though it may indirectly accelerate my death;

☐ other details or wishes:

____

____

____

____

____

____

____

____

____

____

____

Initials of the mandator and witnesses __________ __________ __________

(Continued on back)

5 RESPONSIBILITIES OF THE MANDATARY CONCERNING THE ADMINISTRATION OF MY PROPERTY (See note 5)

I grant my mandatary the power to administer my moveable and immoveable property according to the rules of

☐ **simple administration** in accordance with the *Civil Code of Québec*

OR

☐ **full administration** in accordance with the *Civil Code of Québec.*

Check the desired options:

☐ I would not like the following moveable and immoveable property to be sold, unless necessary:

____

____

☐ I specifically authorize my mandatary to property ________________________
NAME OF MANDATARY
to act in my place as liquidator of a succession if these duties should be given to me.

6 ACCESS TO RECORDS (See note 6)

In the exercise of his functions, it is understood, as provided by law, that my mandatary is authorized to consult my medical, personal and other records concerning my person and my property that may be useful to him.

7 REMUNERATION (See note 7)

My mandatary may reimburse himself out of my assets for all expenses that are helpful or necessary to execute his duties, including fees for the homologation of the mandate.

☐ My mandatary or his substitute will act free of charge.

OR

☐ I would like ________________________
NAME OF MANDATARY TO THE PERSON

OR

☐ I would like ________________________
NAME OF MANDATARY TO THE PROPERTY

OR

☐ I would like ________________________
NAME OF MANDATARY TO THE PERSON

AND ________________________
NAME OF MANDATARY TO THE PROPERTY

to be remunerated from my assets according to the following terms and conditions: ____________

____

____

Initials of the mandator and witnesses ________ ________ ________

(Continued on back)

8 PARTIAL INCAPACITY (See note 8)

If my incapacity is only partial:

☐ I require this mandate to be homologated with all powers specified in it.

I am fully aware that should I become partially incapable, some of the powers specified in this mandate could limit my rights and my autonomy. Nevertheless, I want this mandate to be homologated.

I consider myself the person in the best position to know my interests. I believe that my mandatary will act fully to respect my rights and protect my autonomy, even if he holds the powers of full administration.

OR

☐ I prefer that my residual capacity be taken into account in my mandate.

If I am only unable to manage my property, the mandate concerning the administration of my property must be homologated.

My mandatary will then act with powers of ☐ simple administration **OR** ☐ full administration and I will retain full autonomy in decisions about my person.

Initials of the mandator and witnesses __________ __________ __________

(Continued on back)

9 VARIOUS CLAUSES (See note 9)

Check the desired options:

☐ I would like my mandatary to use a portion of the revenues from my assets, and even some capital if necessary, in order to assume my financial obligations to my family in the same manner that I have assumed them until the homologation of this mandate. However, if these revenues have decreased considerably as a result of my incapacity, my mandatary will assume these obligations to the extent of my means.

☐ For any decision concerning my person or the administration of my property, I want to be consulted, if possible, so that I can give my opinion. If my mandatary deems it appropriate, he will consult the most significant persons among my friends and family, who are:

____________ NAME	____________ NAME
____________ NAME	____________ NAME

However, it is understood that my mandatary is entitled to make the final decision.

☐ If, at the time of the homologation of this mandate, one or more of my children are minors and must be represented, I appoint:

____
NAME

to act as tutor.

☐ The mandatary to my person must have a new medical and psychosocial assessment conducted every five (5) years after the homologation of this mandate in order to reassess my condition. After receiving these assessments, this person must make all decisions and take all necessary steps to protect my rights and ensure that my autonomy is respected.

☐ If I regain my capacity again, my mandatary shall cease to represent me and begin procedures to terminate this mandate, unless I indicate otherwise.

10 SIGNATURE OF THE MANDATOR AND DECLARATION OF THE WITNESSES (See note 10)

____
SIGNATURE OF THE MANDATOR

10.1 Declaration of witnesses

We, the undersigned, ____________ (NAME) and ____________ (NAME)
have both witnessed the signature of ____________________ (NAME OF MANDATOR).

We also declare that this person was fully capable of preparing this mandate and that we have no personal interest in it.

In witness whereof, we have signed at ____________ (PLACE) this ____ (DAY) ____ (MONTH) ____ (YEAR)

____________ SIGNATURE OF WITNESS	____________ SIGNATURE OF WITNESS
____________ NAME OF WITNESS	____________ NAME OF WITNESS
____________ FULL ADDRESS	____________ FULL ADDRESS
____________ TELEPHONE NO.	____________ TELEPHONE NO.

Initials of the mandator and witnesses ______ ______ ______

(Continued on back)

11 ACCEPTANCE BY THE MANDATARY (See note 11)

☐ The request to homologate this mandate by my mandatary will be deemed his acceptance of this office.

OR

☐ The mandatary hereby designated in this mandate:

NAME OF MANDATARY ____________________ OCCUPATION ____________________

FULL ADDRESS ____

declares the following:

1. I ______________________ acknowledge that I have read this mandate and agree to be appointed mandatary to the property or to the person or to both.

2. I agree, in case of the incapacity of ______________________ (NAME OF MANDATOR), to take the measures required by law to homologate this mandate in case of incapacity and thereafter assume the powers and obligations of my office as mandatary.

3. If at such a time I cannot assume the office of mandatary, the substitute mandatary shall carry on in my place.

4. I agree to fulfill my duties in the interest of ______________________ (NAME OF MANDATOR) and to ensure the protection of this person's rights and autonomy.

____
SIGNATURE OF ACCEPTING MANDATARY

THE CURATEUR PUBLIC MUST BE NOTIFIED

- Upon the death of the mandator, the mandatary informs the Curateur public du Québec.
- Upon the death of the mandatary, the liquidator of the succession reports the death to the Curateur public du Québec.

Please initial the margin whenever you change a printed text.

Initials of the mandator and witnesses ________ ________ ________

JUDGE DAVID L.
BAZELON
CENTER
FOR
MENTAL
HEALTH
LAW

Civil Rights and Human Dignity

PSYCHIATRIC ADVANCE DIRECTIVE

Forms to Prepare an Advance Directive for Mental Health Decisionmaking

1101 15th Street NW
Suite 1212
Washington DC 20005-5002
Voice: 202/467-5730
TDD: 202/467-4232
Fax: 202/223-0409
HN1660@handsnet.org
www.bazelon.org

www.bazelon.org/advdir.html

The Bazelon Center is the leading national legal-advocacy organization representing people with mental disabilities. Since its formation in 1972, the center has used precedent-setting litigation, public-policy advocacy and technical support for local lawyers and other advocates to define and uphold the rights of adults and children who rely on public services and ensure their equal access to community-based health and mental health care and supportive services, education, housing and employment.

The Bazelon Center also publishes issue papers, booklets and manuals explaining and interpreting major federal laws and regulations that protect the rights of and make resources available to children and adults with disabilities.

These forms for an advance directive are printed from the Bazelon Center's website: www.bazelon.org. Other pages on the site offer advocacy resources on fair housing, Medicaid, managed care, the Americans with Disabilities Act, the Individuals with Disabilities Education Act (IDEA) and other topics, along with action alerts on current policy issues and a list of our publications.

Psychiatric Advance Directive

A. Directions for Using the Forms

How to Fill Out the Forms

1. Read each section carefully.
2. Choose which sections you wish to use. Sections I and VI are required. If you are not sure whether or not you want to use section II, appointing an agent, find out if your province's law requires an agent for mental health decision-making. Sections III, IV and V are optional and cover the substance of your instructions.
3. If you decide to appoint an agent, make sure he or she understands your wishes and is willing to take the responsibility. Your agent and alternate agent(s) should sign the form to show acceptance of the responsibility.
4. Talk over your choices with your treating providers and your case manager.
5. Fill in only the choices you want in sections III, IV and V. Your advance directive should be valid for whatever part(s) you fill in, as long as it's properly signed. You may cross out and/or write in words or sentences (or rewrite, if you are editing the document on a computer).
6. To indicate which choices you want, put your initials in the blank at the beginning of a statement. If you do not want a statement to be true, leave the blank empty.
7. Add any special instructions in the spaces provided. Be sure you also put your initials in the blank at the beginning of that segment to make your choices valid. You can write additional instructions or comments on a separate sheet of paper, but be sure to write on the form that there are additional pages.
8. Complete the checklist attached to section I to show at a glance what your advance directive covers.
9. Assemble the completed sections, renumber the pages and sign section VI before two witnesses (see the list on the signature page of people who cannot be your witness). Some provinces may require a notary's signature as well; if you are not sure, it's best to have the document notarized.
10. Have copies made and give them to your doctor(s), the individual(s) you have appointed to make mental health care decisions for you, your family and anyone else who might be involved in your care. Explain your choices to each of them.

Can I change my mind?

You can revise your advance directive at any time unless you have been declared legally incompetent. However, provincial laws vary about whether you may revoke your advance directive or overrule your own agent after becoming incapacitated. Part V spells out some options describing when you want to be able to revoke, suspend or end this advance directive. A lawyer can explain your province's law in this regard.

Should I see a mental health professional before signing an advance directive?

For your advance directive to be valid, you must be legally competent when you sign it. To protect yourself against any claim that you were not competent when you signed your advance directive, you can ask a mental health professional to conduct a mental status exam and note in your medical record file that you were of sound mind at the time. Ask for a signed copy of this note, and attach it to your advance directive. This is not absolutely necessary, but it can head off future challenges.

What to do when you are finished

You want your advance directive to be an active part of your medical record. It is a good idea to discuss your choices with your case manager and treating providers. Your advance directive is more likely to be remembered and followed if you have told them about it and explained to them the choices you made, and why.

When will my advance directive take effect?

Your advance directive will become active, under most provincial laws, when a doctor, usually your treating physician, determines that you are not capable of making health care decisions on your own behalf.

Who should have copies?

Your treating professionals should have copies of your advance directive. Your agent, if you appoint one, and each alternate agent you name should have a copy. Also consider giving copies to family members, close friends, the hospitals or programs where you might be taken in an emergency, your managed care firm (if you have one) and your other service providers. If you make changes, be sure to let everyone who has a copy know. For this reason, you'll want to keep track of who has copies; a form for doing this is attached to the signature page.

If you travel, be sure to take a copy with you. And keep the original in an easily accessible place.

How will anyone know I have an advance directive?

A form that advises physicians and others of your advance directive appears below. It is designed to fit in your wallet. Complete the information on the form, cut it out, fold it in half and keep it in your wallet.

PHYSICIANS AND OTHERS PLEASE NOTE:

I have an advance directive for mental health decision-making, a legal document stating my preferences as to psychiatric hospitalization and treatment. A copy may be found at:

____

If I am incapacitated, please obtain this document and respect the choices I have registered in it.

My name: ______________________________ My SIN#:________________

I have appointed as my agent for mental health decision-making

__________________________________ who can be reached at

________________(day) or _______________ (evening). This person is authorized to make all decisions about my psychiatric treatment in the event that I am incapable of making such decisions.

Part I

STATEMENT OF INTENT

I, (your name) ____, being of sound mind, willfully and voluntarily execute this health care advance directive to assure that, during periods of incapacity or incompetency resulting from psychiatric or physical illness, my choices regarding my mental health care will be carried out despite my inability to make informed decisions on my own behalf. In the event that a guardian or other decision-maker is appointed by a court to make health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

By this document, I intend to create an advance directive for health care as authorized by provincial law to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under provincial law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect. I understand that this directive will become active and take effect upon my incapacity to make my own mental health decisions and shall continue in effect only during that incapacity.

My wishes expressed in this document should be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time of the execution of this document. If I have not named an agent, these instructions shall be binding upon whoever may be appointed as my agent or other decision-maker.

The fact that I may have left blanks in this advance directive (i.e., not completed certain sections) should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is the decision I would make if I were competent to do so.

If any part of this advance directive is invalid or ineffective under relevant law, this fact should not affect the validity or effectiveness of the other parts. It is my intention that each part of this advance directive stand alone. Even if some parts are invalid or ineffective, I desire that all other parts be followed.

I intend this mental health care advance directive to take precedence over any and all living will documents and/or durable power of attorney for health care documents and/or other advance directives I have previously executed, to the extent that they are inconsistent with this document.

NOTE TO PROVIDER: The next page is a checklist of the sections I have completed. Failure to follow the instructions in these sections (or the requests of my agent), even in emergency situations, may result in legal liability for professional misconduct and/or battery. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under provincial and federal laws, to influence decisions about the care I will receive.

Instructions Included in My Directive
Put a checkmark in the left-hand column for each section you have completed.

____ Designation of my health care agent(s).

____ Authority granted to my agent.

____ My preference as to a court-appointed guardian.

____ My preferences about no termination in the event a guardian or other agent is appointed.

____ My choice of treatment facility and preferences for alternatives to hospitalization if 24-hour care is deemed medically necessary for my safety and well-being.

____ My preferences about the physicians who will treat me if I am hospitalized.

____ My preferences regarding medications for psychiatric treatment.

____ My preferences regarding electroconvulsive therapy (ECT or shock treatment).

____ My preferences regarding emergency interventions (seclusion, restraint, medications).

____ Consent for experimental studies or drug trials.

____ Who should be notified immediately of my admission to a psychiatric facility.

____ Who should be prohibited from visiting me.

____ My preferences for care and temporary custody of my children.

____ My preferences about revocation of my health care directive during a period of incapacity.

____ Other instructions about mental health care.

____ Duration of this mental health care directive.

Go to Part II of the Advance Directive

Part II

APPOINTMENT OF AGENT FOR MENTAL HEALTH CARE

Make sure you give your agent a copy of all sections of this document.

Statement of Intent to Appoint an Agent:

I, (your name) __________________________, being of sound mind, authorize a health care agent to make certain decisions on my behalf regarding my mental health treatment when I am incompetent to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Mental Health Care Agent

A. I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Note: Make sure to list this person in Part IV of your advance directive.

Name: ____

Address: ____

____

Day Phone Number ____________________ Night Phone ____________________

B. Agent's Acceptance: I hereby accept the designation as agent for

(your name) ____

(your agent's signature) ____

Designation of Alternate Mental Health Care Agent

If the person named above is unavailable or unable to serve as my agent, I hereby appoint and desire immediate notification of my alternate agent as follows:

Name: ____

Address: ____

____

Day Phone Number ____________________ Night Phone ____________________

Note: Make sure to list this person in Part IV of your advance directive.

Alternate Agent's Acceptance: I hereby accept the designation as alternate agent for

(your name) ____

(Your agent's signature) ____

The following paragraphs will apply when you appoint an agent.

2. Authority Granted to My Agent

Initial if you agree with a statement; leave blank if you do not.

A. ________ If I become incapable of giving consent to mental health care treatment, I hereby grant to my agent full power and authority to make mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

B.________ Having named an agent to act on my behalf, I do, however, wish to be able to discharge or change the person who is to be my agent if that agent is instrumental in the process of initiating or extending any period of psychiatric treatment against my will. My ability to revoke or change agents in this circumstance shall be in effect even while I am incompetent or incapacitated, if allowed by law. Even if I choose to discharge or replace my agent, all other provisions of this advance directive shall remain in effect and shall only be revokable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

3. When Spouse Is Agent and If There Has Been a Legal Separation, Annulment, or Dissolution of the Marriage

Initial if you agree with this statement; leave blank if you do not.

__________ I desire the person I have named as my agent, who is now my spouse, to remain as my agent even if we become legally separated or our marriage is dissolved.

4. My Preference as to a Court-Appointed Guardian

In the event a court decides to appoint a guardian who will make decisions regarding my mental health treatment, I desire the following person to be appointed:

Name: ____ Relationship: ________________________
Address: ____
City, Province, Postal Code: ____
Day phone: _____________________________ Evening Phone: ____________________________

5. Powers of a Guardian

The appointment of a guardian of my estate or my person or any other decision-maker shall not give the guardian or decision-maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as specifically required by law.

BE SURE TO GIVE YOUR AGENT AND ALTERNATIVE AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT

Go to Part III of the Advance Directive

Part III

STATEMENT OF MY DESIRES, INSTRUCTIONS, SPECIAL PROVISIONS AND LIMITATIONS REGARDING MY MENTAL HEALTH TREATMENT AND CARE

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials after the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

1. My Choice of Treatment Facility and Preferences for Alternatives to Hospitalization If 24-Hour Care Is Deemed Medically Necessary for My Safety and Well-Being

A. _____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

A1. _____ I would prefer to receive 24-hour care at the following programs/facilities:

____
____
____
____
____
____
____
____

B._____ In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

____
____
____
____
____
____
____

C. _____ I do ***not*** wish to be committed to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: ______________________________
Reason: ______________________________
Facility's Name: ______________________________
Reason: ______________________________
Facility's Name: ______________________________
Reason: ______________________________

2. My Preferences Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

_____ seclusion
_____ physical restraints
_____ seclusion and physical restraint (combined)
_____ medication by injection
_____ medication in pill form
_____ liquid medication
_____ other:_______________________
____
____

Reasons for my preferences:
____
____
____
____
____
____
____
____

Initial this paragraph if you agree; leave blank if you do not agree.

__________ In the event that my attending physician decides to use medication for rapid tranquilization in response to an emergency situation after due consideration of my preferences for emergency treatments stated above, I expect the choice of medication to reflect any preferences I have expressed in this section and in Section 3. The preferences I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

3. My Preferences About the Physicians Who Will Treat Me if I Am Hospitalized.

Put your initials after the letter and complete if you wish either or both paragraphs to apply.

A. __________My choice of treating physician is:
Dr. ______________________________
Phone number ____________________
OR
Dr. ______________________________
Phone number ____________________
OR
Dr. ______________________________
Phone number ____________________

B. __________I do not wish to be treated by the following, for the reasons stated:
Dr. ______________________________
Reason: ___________________________
____
____
Dr. ______________________________
Reason:___________________________
____
____

4. My Preferences Regarding Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

A. _____ I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

B._____ I consent to and authorize my agent to consent to the administration of:

Medication Name	Not to exceed the following dosage:	OR	In such dosage(s) as determined by
____________________	________________		Dr.__________________________
____________________	________________		Dr.__________________________
____________________	________________		Dr.__________________________
____________________	________________		Dr.__________________________

C._____ I consent to the medications deemed appropriate by Dr.________________________, whose address and phone number are: ____
____

D. _____ I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand-name, trade-name or generic equivalents:

Name of Drug	Reason for Refusal
__________________	____
__________________	____
__________________	____
__________________	____
__________________	____
__________________	____

E._____ I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

F. ____ I am concerned about the side effects of medications and do ***not*** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at a 1% or greater level of incidence *(check all that apply)*.

_____ Tardive dyskinesia
_____ Loss of sensation
_____ Motor restlessness
_____ Seizures
_____ Muscle/skeletal rigidity
_____ Tremors
_____ Nausea/vomiting
_____ Neuroleptic Malignant Syndrome
_____ Other ____________________

G._____ I have the following other preferences about psychiatric medications:
____
____
____
____

5. My Preferences Regarding Electroconvulsive Therapy (ECT or Shock Treatment)

If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes regarding electroconvulsive therapy are as follows:
Initial A or B; if you check B, you must also initial B1, B2 or B3:

A._____ I do ***not*** consent to administration of electroconvulsive therapy.

B._____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only:
B1. _____with the number of treatments that the attending psychiatrist deems appropriate;
OR
B2. _____ with the number of treatments that Dr. __________________________ deems appropriate. Phone number and address of doctor:
____
____
____
OR
B3. _____for no more than the following number of ECT treatments: __________

C. _____ Other instructions and wishes regarding the administration of electroconvulsive therapy:
____
____
____
____
____
____
____
____

6. Consent for Experimental Studies or Drug Trials

Initial one of the following paragraphs.

A. _____ I do ***not*** wish to participate in experimental drug studies or drug trials.

B. _____ I hereby consent to my participation in experimental drug studies or drug trials.

C. _____ I authorize my agent to consent to my participation in experimental drug studies if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment.

Go to Part IV of the Advance Directive.

Advance Directive of (*your name*) ______________________________

ADVANCE DIRECTIVE INSTRUCTIONS

Medical symptoms: ____ (initials)

____
____
____
____
____

Desired medications: ____ (initials)

____
____
____
____
____

Crisis symptoms and instructions: ____ (initials)

____
____
____
____
____

Unacceptable medications: ____ (initials)

____
____
____
____
____

Allergies: ____ (initials)

____
____
____
____
____

Hospitalization preferences: _____ (initials)

____
____
____
____
____

Hospitalization objections: _____ (initials)

____
____
____
____
____

Emergency contacts: ____ (initials)

____
____
____
____
____

Stressors and triggers of crisis: ____ (initials)

____
____
____
____
____

Wellness factors: ____ (initials)

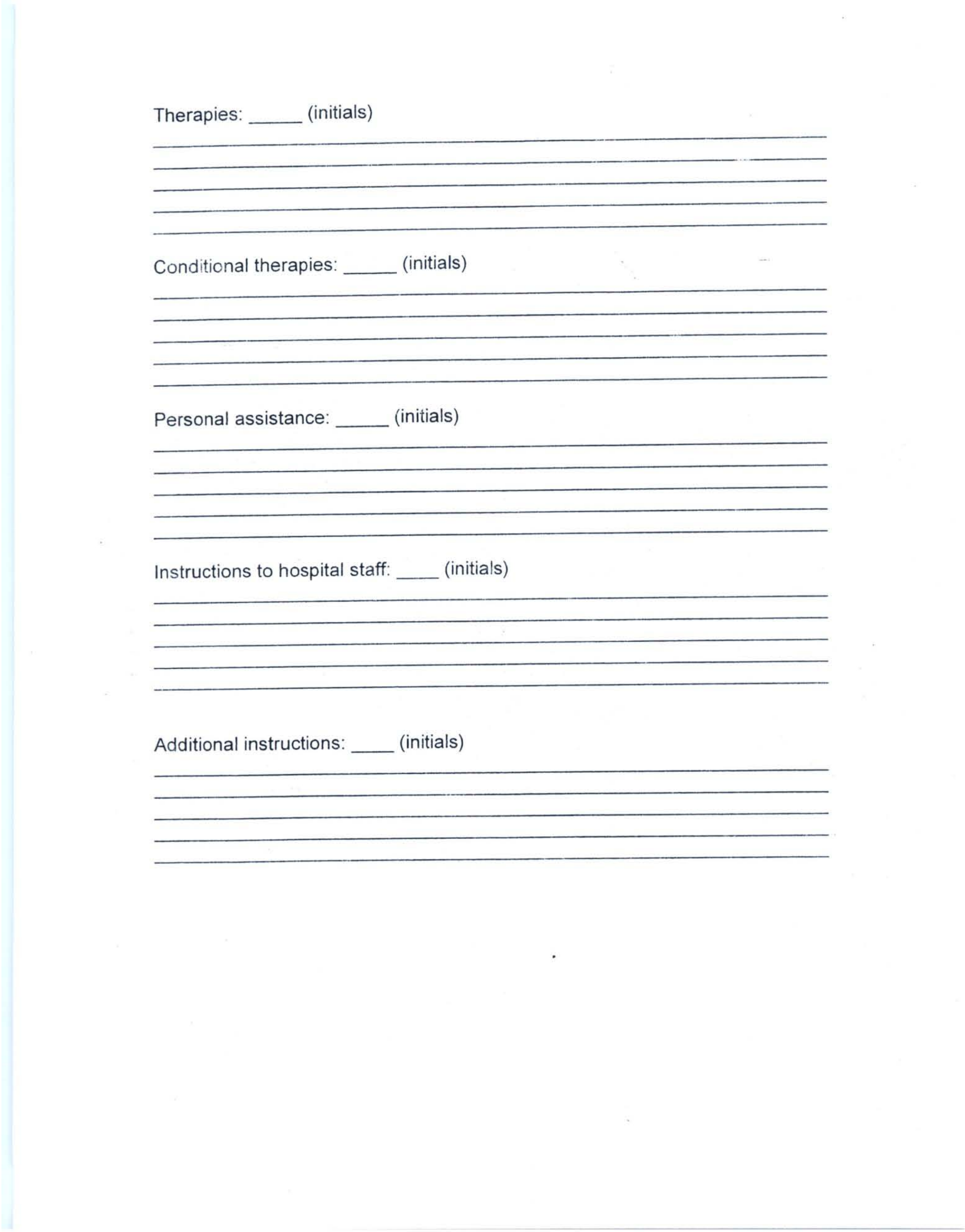
____
____
____
____
____

Helpful support: ____ (initials)

____
____
____
____
____

Recovery of control: ____ (initials)

____
____
____
____
____



Therapies: _____ (initials)

Conditional therapies: _____ (initials)

Personal assistance: _____ (initials)

Instructions to hospital staff: ____ (initials)

Additional instructions: ____ (initials)

Part IV

STATEMENT OF MY PREFERENCES REGARDING NOTIFICATION OF OTHERS, VISISTORS, AND CUSTODY OF MY CHILD (REN)

1. Who Should Be Notified Immediately of My Admission to a Psychiatric Facility

If I am incompetent, I desire staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Name:____________________
Relationship: ____________________
Address: ____________________
____
____
Phone (Day):____________________
Phone (Eve.): ____________________
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:____________________
Relationship: ____________________
Address: ____________________
____
____
Phone (Day):____________________
Phone (Eve.): ____________________
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:____________________
Relationship: ____________________
Address: ____________________
____
____
Phone (Day):____________________
Phone (Eve.): ____________________
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:____________________
Relationship: ____________________
Address: ____________________
____
____
Phone (Day):____________________
Phone (Eve.): ____________________
It is also my desire that this person be permitted to visit me: Yes_____ No _____

2. Who Should Be Prohibited from Visiting Me

I do not wish the following people to visit me while I am receiving care in a psychiatric facility:

Name	Relationship

3. My Preferences for Care & Temporary Custody of My Children

In the event that I am unable to care for my child(ren), I want the following person as my first choice to care for and have temporary custody of my child(ren):

Name: ____________________________________ Relationship: ______________
Address: ____
City, Province, Postal Code: ____
Phone number: (Day) _________________________ (Evening) _________________

In the event that the person named above is unable to care for and have temporary custody of my child(ren), I desire one of the following people to serve in that capacity.

My Second Choice	**My Third Choice**
Name: ____________________________	Name: ____________________________
Relationship: ______________________	Relationship: ______________________
Address: __________________________	Address: __________________________
___________________________________	___________________________________
___________________________________	___________________________________
Phone (Day): _______________________	Phone (Day): _______________________
Phone (Eve.): _______________________	Phone (Eve.): _______________________

Go to Part V of the Advance Directive.

Part V

STATEMENT OF MY PREFERENCES REGARDING REVOCATION OR TERMINATION OF THIS ADVANCE DIRECTIVE

Initial all paragraphs that you wish to apply to you.

1. Revocation of My Psychiatric Advance Directive

___________My wish is that this mental health directive may be revoked, suspended or terminated by me at any time, if provincial law so permits.

2. Revocation of My Psychiatric Advance Directive During a Period of Incapacity

__________ My wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my advance directive. My decision not to be able to change this advance directive while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated.

2A. __________ Notwithstanding the above, it is my wish that my agent or other decision-maker specifically ask me about my preferences before making a decision regarding mental health care, and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

3. Other Instructions About Mental Health Care

(Use this space to add any other instructions that you wish to have followed. If you need to, add pages, numbering them as part of this section.)

____
____
____
____
____
____
____
____
____
____
____

4. Duration of Mental Health Care Directive

Initial A or B.

A._____It is my intention that this advance directive will remain in effect for an indefinite period of time. OR

B._____It is my intention that this advance
directive will automatically expire two years from the date it was executed.

If my choice above is not valid under provincial law, then it is my intention that this advance directive remain in effect for as long as the law permits.

Part VI.

Signature Page

By signing here I indicate that I understand the purpose and effect of this document.

____________________	____________________
Your Signature	*Date*

The directive above was signed and declared by the "Declarant," ____________________ ____________________ , to be his/her mental health care advance directive, in our presence who, at his/her request, have signed names below as witness. We declare that, at the time of the execution of this instrument, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is: 1) a physician; 2) the Declarant's physician or an employee of the Declarant's physician; 3) an employee or a patient of any residential health care facility in which the Declarant is a patient; 4) designated as agent or alternate under this document; or 5) a beneficiary or creditor of the estate of the Declarant.

Dated at ____ *(city, province)*,

this ____________________ day of ____________________, 19____.

Witness Signatures

Witness 1:	**Witness 2:**
____________________	____________________
Signature of Witness 1	*Signature of Witness 2*
____________________	____________________
Name of Witness 1 (printed)	*Name of Witness 2 (printed)*
____________________	____________________
Home address of Witness 1	*Home address of Witness 2*
____________________	____________________
City, Province, Postal Code of Witness 1	*City, Province, Postal Code of Witness 2*

(for use by the notary):

Province of________________, City of ________________________

Subscribed and sworn to or affirmed before me by the Declarant,

____, and (*names of witnesses*)

____ and

____, witnesses, as the

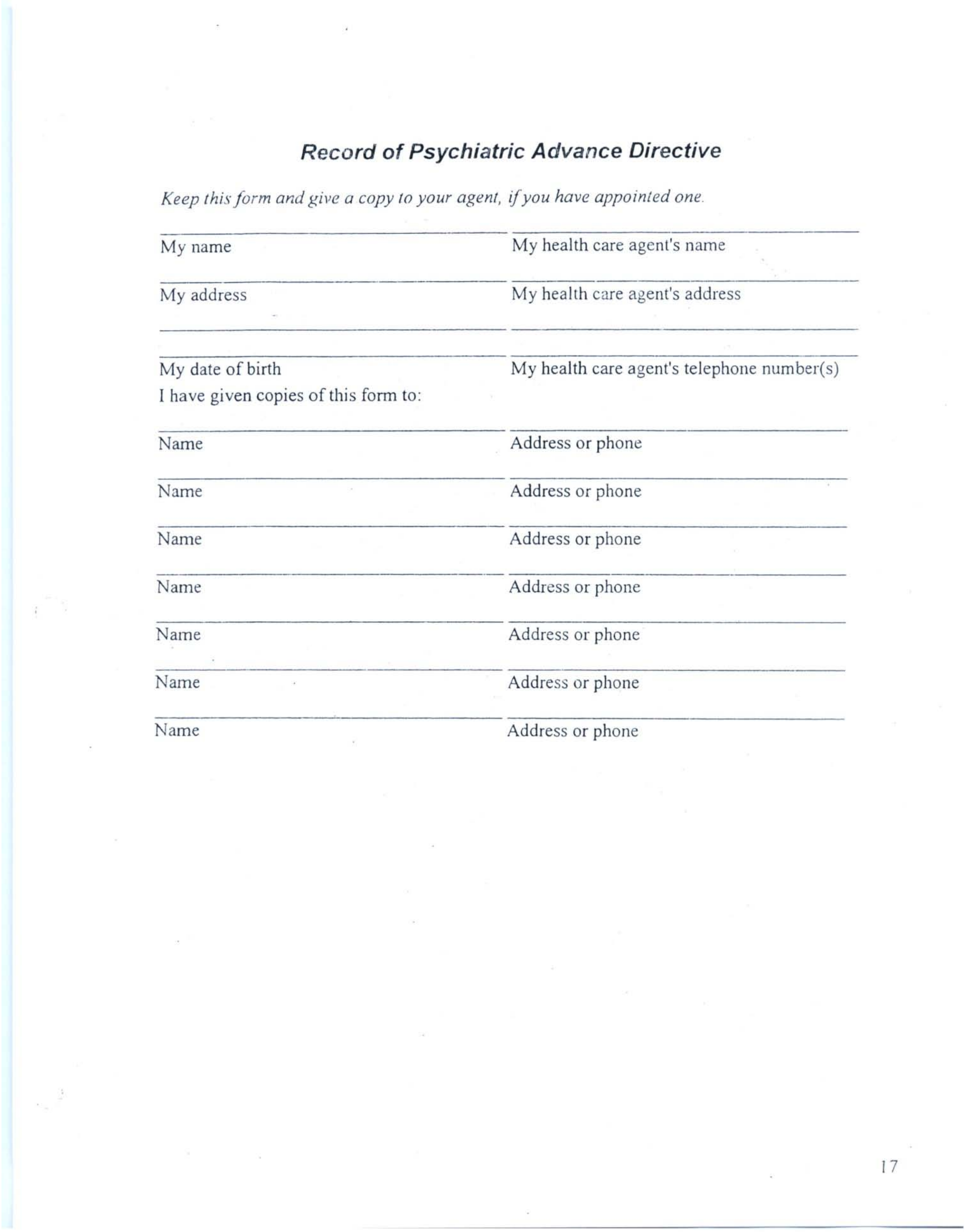
voluntary act and deed of the Declarant, this __________ day of __________, ____________.

My commission expires:

____

____
Notary Public

16



Record of Psychiatric Advance Directive

Keep this form and give a copy to your agent, if you have appointed one.

My name	My health care agent's name
My address	My health care agent's address
My date of birth	My health care agent's telephone number(s)

I have given copies of this form to:

Name	Address or phone
Name	Address or phone
Name	Address or phone
Name	Address or phone
Name	Address or phone
Name	Address or phone
Name	Address or phone

MANDATE IN CASE OF INCAPACITY

- A mandate is a legal document used in Québec to protect your personal interests if you become incapable by appointing someone else to make decisions on your behalf;

- A mandate is a proxy directive (you appoint someone else to make decisions for you if you become ill and incapable to decide your choices);

- A mandate informs your treatment providers who to contact if you become incapable;

- You can appoint one or more persons to make decisions on your behalf if you become incapable;

- You should have complete confidence in the person whom you choose to make your decisions for you;

- You will sign the mandate along with two witnesses;

- If you become incapable in the future, the mandate is given to a court who will approve the document;

- A mandate differs from a will, and can only be used while you are alive;

- If you become capable after a period of incapacity, you can decide to change or terminate your mandate if you would like.

PSYCHIATRIC ADVANCE DIRECTIVE

- A psychiatric advance directive (PAD) is a legal document that allows you to protect your own personal interests if you become incapable by documenting your treatment preferences;

- A PAD is an instructional directive (you declare your detailed instructions about the kinds of medical treatment you would like if you became incapable in the future);

- A PAD informs your treatment providers who to contact if you become incapable;

- You can appoint one or more persons to make decisions on your behalf if you become incapable;

- You are able to include your detailed preferences regarding crisis symptoms, medication, hospital choices, and instructions to treatment providers who assist you when you are incapable;

- You will sign the mandate along with two witnesses;

- A PAD differs from a will, and can only be used while you are alive;

- If you become capable after a period of incapacity, you can decide to change or terminate your mandate if you would like.

CONSENT DOCUMENT

TITLE OF RESEARCH STUDY

Autonomy and Advance Treatment Planning Study (Phase I)

RESEARCHERS RESPONSIBLE FOR RESEARCH STUDY

Principal investigator (Doctoral student):	Daniel Ambrosini, LLB, BCL, MSc, PhD candidate McGill, Department of Psychiatry Douglas Mental Health University Institute
Principal co-investigator:	Dr. Anne Crocker, PhD Associate Professor, McGill University Douglas Mental Health University Institute
Principal co-investigator:	Dr. Eric Latimer, PhD, Associate Professor, McGill University Douglas Mental Health University Institute

PROTOCOL NUMBER: 09/34

NAME OF FUNDING ORGANIZATION:

Psychosocial Rehabilitation Canada; Barreau du Québec

1. INTRODUCTION

You are being invited to participate in a research study. Before agreeing to participate in this study and signing this consent form, please take the time to read, understand, and consider closely the information that follows.

This form may contain words that you do not understand. We invite you to ask all questions that you consider helpful in making your decision to the principal investigator or any member of the research team involved in this project, and to ask them to explain any words or information that are unclear.

2. PURPOSE OF RESEARCH STUDY

The aim of this study is to examine the relationship between autonomy and advance directives among individuals with mental illness. Psychiatric advance directives (PADs) are legal documents that allow individuals with mental illness to state their treatment preferences if they become incompetent to make their own choices in the future. Mandates in case of incapacity are legal documents used in Québec that allow individuals with mental illness to appoint someone else to make decisions on their behalf. PADs do not currently exist in Québec, but there is some evidence that they may help individuals with mental illness to become more autonomous. Before completing either advance directive it is important that you understand and appreciate the choice you will make.

We are inviting you to participate in this study because you are part of a group in which researchers from this study are interested in knowing more, specifically an individual with a mental illness who is affiliated with the Douglas Mental Health University Institute.

We are aiming to recruit 6 participants for this research study. Two participants will be recruited from each of the bipolar, depression, and schizophrenia clinics at the Douglas Mental Health University Institute.

3. PROCEDURES OF RESEARCH STUDY

Your participation in this project will involve an initial interview; completing an advance directive; and returning for a follow-up interview.

3.1 INITIAL INTERVIEW

You will be asked to undergo a 1-1.5 hour interview session with a member of the research team. This interview will be audio-recorded so that the information can be transcribed for research purposes. You will be asked to come back to the clinic the following day, where you will receive assistance to complete an advance directive.

3.2 COMPLETION OF ADVANCE DIRECTIVE

You will be given asked to complete a psychiatric advance directive after being fully informed about the advantages and disadvantages of the document. This session will take approximately 1.5 hours. You will receive one copy of the document, one copy will be given to your psychiatrist, and another will be kept by the investigators for research purposes.

3.3 FOLLOW-UP INTERVIEW

You will then be asked to return to the clinic 1 month after completing the psychiatric advance directive for a 30 minute follow-up interview. A member of the research team will phone you in advance to provide you a reminder of the interview. During the one month, you can ask your treatment providers to review your document at any time. At the end of the study, a member of the research team will ask you if you want to retain your advance directive.

4. RISKS ASSOCIATED WITH RESEARCH STUDY

There are no known harms, risks, or expected side effects associated with your participation in this research study. You will be provided ongoing information regarding any potential risks from the choices you make. If you experience any such problem with any element of advance treatment planning you should speak to a member of the research team immediately.

5. INCONVENIENCES ASSOCIATED WITH RESEARCH STUDY

Participation in this study includes the inconvenience of having to take the time to come to participate in interviews, which were described above.

Certain questions that we will ask you regarding particular issues may appear to be sensitive. It is possible that discussing treatment around your mental illness may cause you some emotional discomfort. You are not obligated to answer any question that you find overly sensitive.

6. BENEFITS

There are no known immediate benefits to you for participating in this research study. It is possible that by completing an advance directive your health care providers will become aware of who to contact in the event that you become incapable to make your own decisions. Making others aware of your treatment preferences if you are incapable may be a benefit to you if those preferences are honoured by your health care providers. It is uncertain how often your health care providers will honour your wishes as stated in an advance directive.

The results obtained from this research study will contribute to advancing knowledge in this field. Specifically, it will help us to explore the relationship between feelings of autonomy and advance treatment planning for individuals with mental illness in the future.

7. VOLUNTARY PARTICIPATION AND POSSIBILITY OF WITHDRAWAL

Your participation in this research study is voluntary. You are therefore free to refuse to participate. You can also withdraw from the study at any time, without providing reasons, by making your decision known to principal investigator or to one of the research team members associated with this study.

Your decision not to participate in this research study or your decision to withdraw will have no consequences on the quality of care or services you are entitled to receive or on your relationship with the principal investigator of the project and others involved in the study.

The principal investigator of the research study, or the Committee of the Research Ethics Board (REB) from the Douglas Mental Health University Institute may decide, at any time, to terminate your participation, without your consent, if they discover information that participation in the study is not in your best interests, if you do not respect the requirements of the research study, or if there are administrative reasons for terminating the research study.

If you withdraw or are asked to withdraw from the study, the information already obtained during the course of the research study will be preserved for as long as necessary to meet the demands of law.

All new information acquired during the procedures of the study that can affect your decision to continue in the study as a participant will be communicated to you verbally and in writing without delay.

8. CONFIDENTIALITY

During your participation in this study, the principal investigator and the research team will collect and record all information concerning you in a file. Only the necessary information to respond to the scientific objectives of the study will be collected.

This information will help understand your responses from the questionnaires, your views of medications, treatment, and hospitalization, along with other observations the interviewer may make about your well-being. Your file may also include other information such as your name, sex, date of birth, and ethnic background.

All information collected will remain strictly confidential within the limits of the law. The researchers will not discuss any information about you to anyone outside the research team. In order to preserve your identity and confidentiality, the information you provide will also be securely retained in a central computer. Access to this information will be strictly controlled, with the assistance of a security code.

The principal investigator responsible for the project will use the information you provide for research with the aim of answering the scientific objectives of the study described in this consent form. Furthermore, the information will respect applicable Québec and Canadian confidentiality laws.

Certain information provided may be published in specialized journals or presented at scientific conferences, but it will not be possible to identify you personally. Similarly, the information from the study may be used for other analyses in related projects or to explain future research.

For the purposes of quality surveillance, your research file may be consulted by a designated person of the Research Ethics Board from the Douglas Mental Health University Institute. This designated person and the organization will adhere to a strict policy of confidentiality.

For your protection, in order to contact you quickly, your first name and surname, your co-ordinates, and the beginning and end date of your participation in the study will be preserved for 5 years after the study ends in a secure computer directory maintained by the principal investigator or the organization.

You have the right to consult your research file to verify the information collected for as long as the researchers are responsible to retain the information. Nevertheless, to preserve the scientific integrity of the research study, you are not permitted to have certain information until your participation in the study has terminated.

9. FINANCING OF RESEARCH STUDY

The principal investigator responsible and the collaborators have received funding from Psychosocial Rehabilitation Canada and the Barreau du Québec for this research study.

10. INDEMNITY IN CASE OF PREJUDICE AND RIGHTS OF RESEARCH PARTICIPANT

If you undergo some prejudice which is due to your participation in this research study, you will continue to receive all the care and services required for your health, without expense on your part.

In accepting to participate in this project, you are neither renouncing any of your legal rights nor do you free the researchers, any partners, or the hospital from their civil and professional responsibilities.

11. COMPENSATION

You will receive compensation of $50 for your participation: $20 for the first visit, $20 for the second, and $10 for the third. If you are asked to withdraw from the study, or decide to withdraw before it is complete, you will receive an amount that is proportional to your participation. If you are asked and agree to participate in the follow-up interview you will be compensated an additional $20.

12. IDENTIFICATION OF KEY PERSONNEL

If you have questions concerning this research study or if you discover a problem which you believe involves your participation in the study, you can communicate with the principal investigator, Daniel Ambrosini, from the Douglas Mental Health University Institute at (514) 761-6131 ext. 3438.

For all other questions related to your rights as a research participant or for any ethical problem concerning the conditions in which this research project is being conducted, you may contact:

- Ombudsman of the Douglas Mental Health University Institute: (514) 761-6131 ext. 3287.

13. MONITORING ETHICAL ASPECTS OF THIS STUDY

The Committee of the Research Ethics Board of the Douglas Mental Health University Institute have approved this research study and will assure that it is followed. Furthermore, they will approve any revisions and modifications to this consent form and the research protocol.

For all information, you may contact the Secretariat of the Committee of the Research Ethics Board of the Douglas Mental Health University Institute at (514) 761-6131 ext. 2708.

CONSENT

I. Consent from research participant

I understand the information provided in this consent form. I acknowledge that someone explained to me the above study and answered my questions. The individual provided me sufficient time to make a decision.

I consent to participate in this research study according to the conditions as they were described.

A signed and dated copy of the consent form and my consent were provided to me.

_______________________________________ ___________________________
Participant signature Date

____
Name (signature)

II. Signature of the person who obtained consent

I explained to the research participant the terms of this informed consent document and have answered all the questions that were asked of me.

_______________________________________ ___________________________
Signature of person who explained the study Date

____
Name (signature)

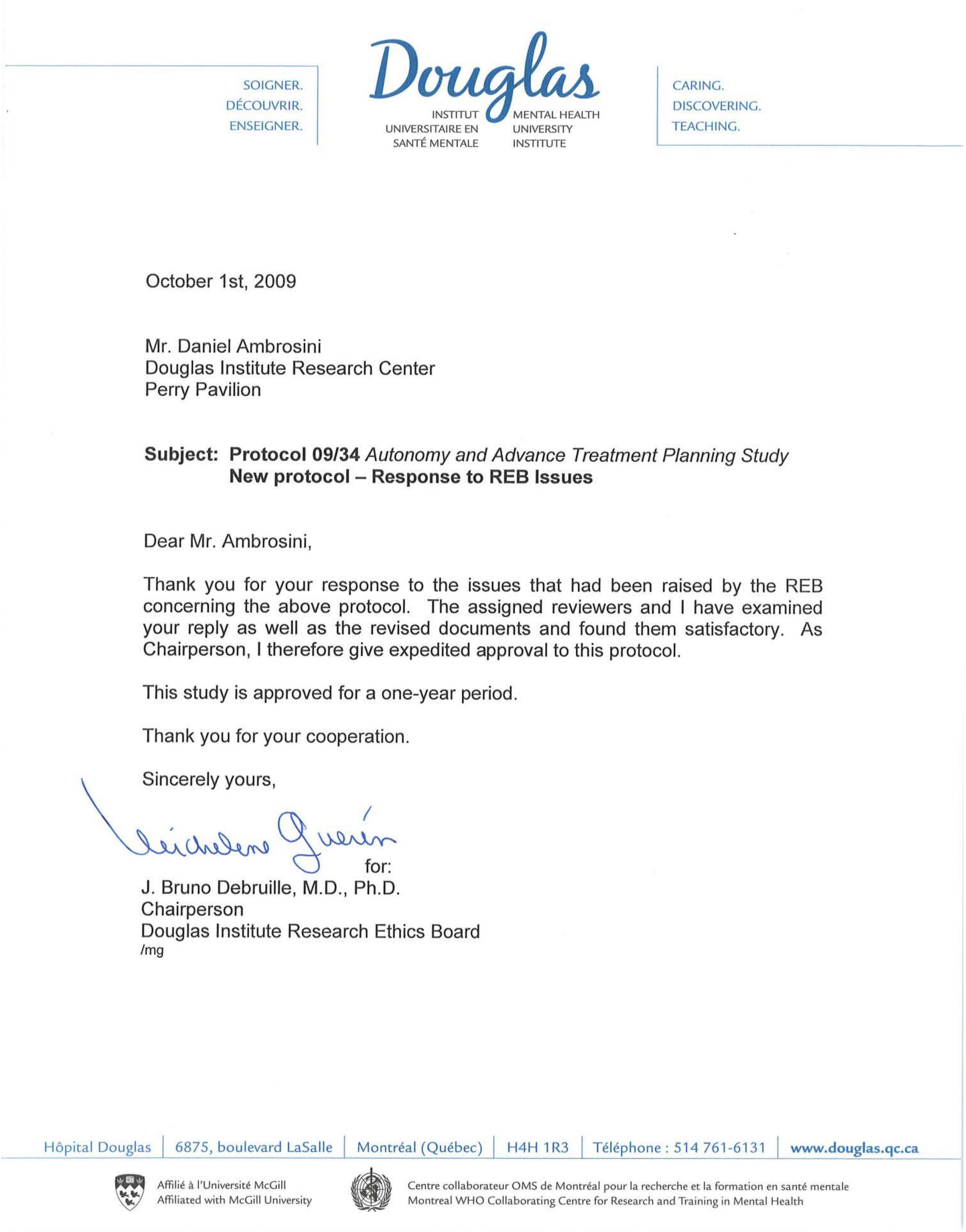
III. Signature of member of research team

I certify that someone has explained to the research participant the terms of this informed consent document, that someone responded to all the participant's questions in this regard, and that it was clearly explained to the participant that he or she is free to terminate the study without prejudice. With the research team, I agree to respect the information provided in this consent form and to provide a signed copy of the document to the participant.

_______________________________________ ___________________________
Signature of member of research team Date

____
Name (signature)

Appendix II: Research Ethics Certificates



SOIGNER.
DÉCOUVRIR.
ENSEIGNER.

Douglas
INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

CARING.
DISCOVERING.
TEACHING.

October 1st, 2009

Mr. Daniel Ambrosini
Douglas Institute Research Center
Perry Pavilion

Subject: Protocol 09/34 *Autonomy and Advance Treatment Planning Study*
New protocol – Response to REB Issues

Dear Mr. Ambrosini,

Thank you for your response to the issues that had been raised by the REB concerning the above protocol. The assigned reviewers and I have examined your reply as well as the revised documents and found them satisfactory. As Chairperson, I therefore give expedited approval to this protocol.

This study is approved for a one-year period.

Thank you for your cooperation.

Sincerely yours,

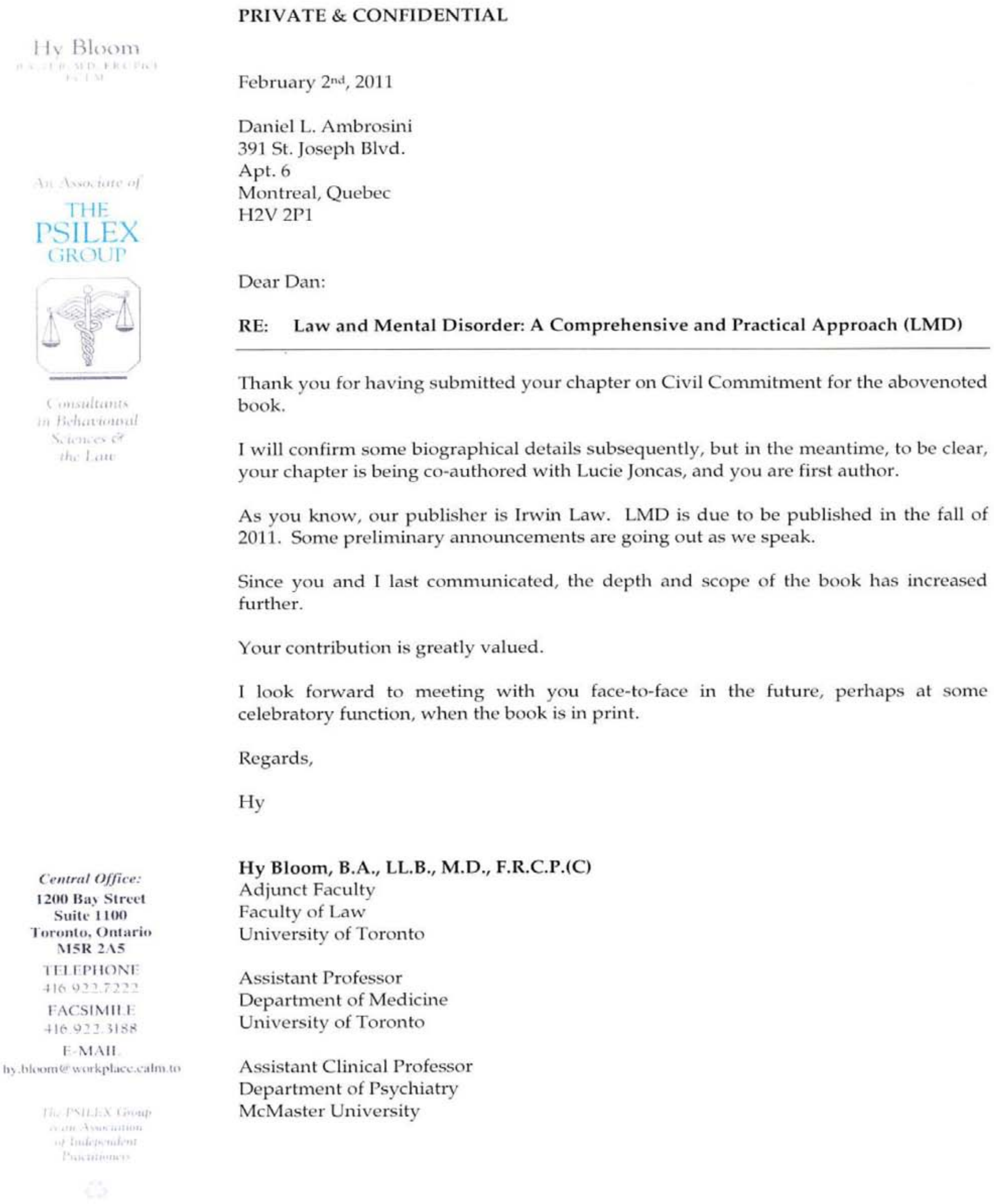
Micheline Guérin
for:
J. Bruno Debruille, M.D., Ph.D.
Chairperson
Douglas Institute Research Ethics Board
/mg

Hôpital Douglas | 6875, boulevard LaSalle | Montréal (Québec) | H4H 1R3 | Téléphone : 514 761-6131 | www.douglas.qc.ca

Affilié à l'Université McGill
Affiliated with McGill University

Centre collaborateur OMS de Montréal pour la recherche et la formation en santé mentale
Montreal WHO Collaborating Centre for Research and Training in Mental Health

Appendix III: Correspondence of Publications



PRIVATE & CONFIDENTIAL

Hy Bloom
[illegible]

An Associate of
THE
PSILEX
GROUP

Consultants
in Behavioural
Sciences &
the Law

February 2nd, 2011

Daniel L. Ambrosini
391 St. Joseph Blvd.
Apt. 6
Montreal, Quebec
H2V 2P1

Dear Dan:

RE: Law and Mental Disorder: A Comprehensive and Practical Approach (LMD)

Thank you for having submitted your chapter on Civil Commitment for the abovenoted book.

I will confirm some biographical details subsequently, but in the meantime, to be clear, your chapter is being co-authored with Lucie Joncas, and you are first author.

As you know, our publisher is Irwin Law. LMD is due to be published in the fall of 2011. Some preliminary announcements are going out as we speak.

Since you and I last communicated, the depth and scope of the book has increased further.

Your contribution is greatly valued.

I look forward to meeting with you face-to-face in the future, perhaps at some celebratory function, when the book is in print.

Regards,

Hy

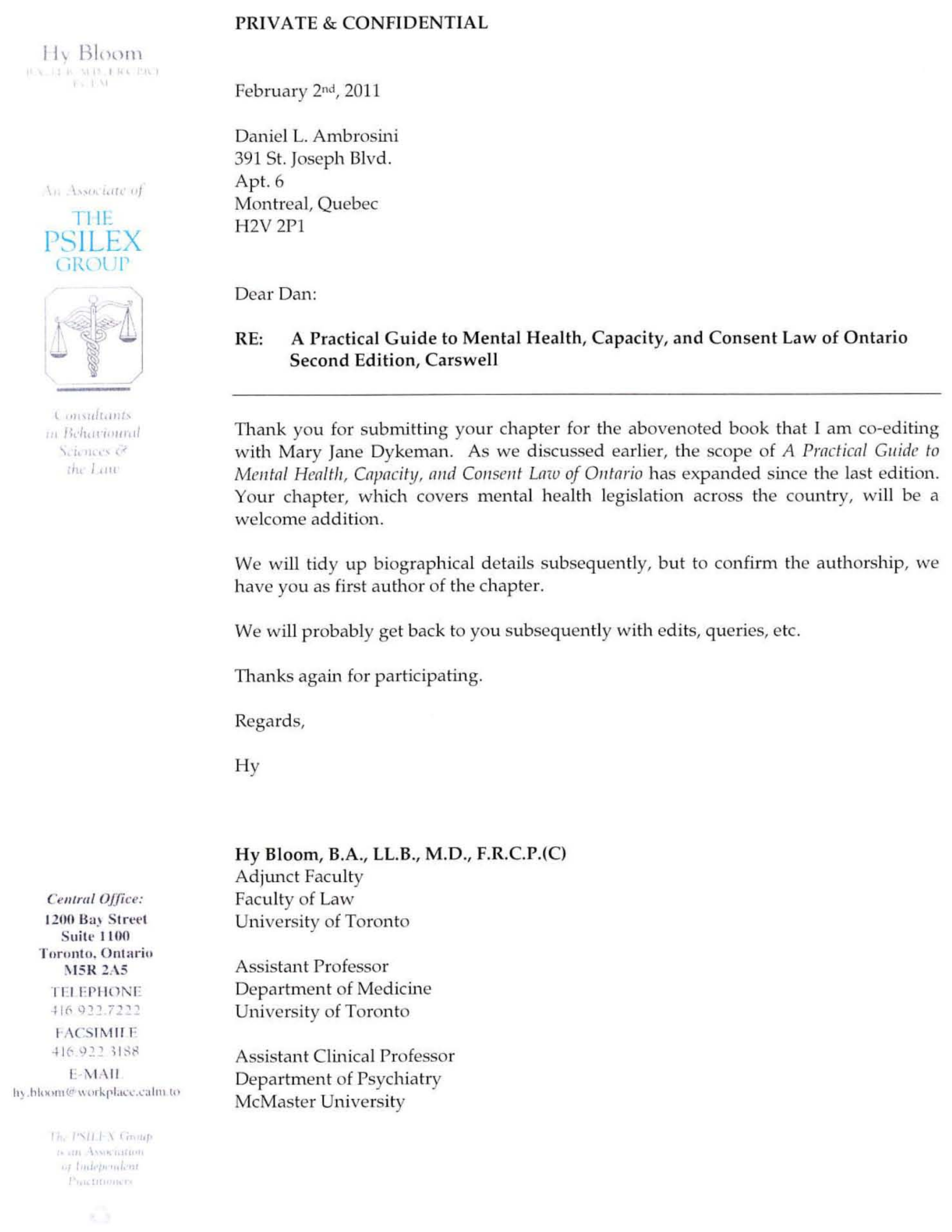
Hy Bloom, B.A., LL.B., M.D., F.R.C.P.(C)
Adjunct Faculty
Faculty of Law
University of Toronto

Assistant Professor
Department of Medicine
University of Toronto

Assistant Clinical Professor
Department of Psychiatry
McMaster University

Central Office:
1200 Bay Street
Suite 1100
Toronto, Ontario
M5R 2A5
TELEPHONE
416.922.7222
FACSIMILE
416.922.3188
E-MAIL
hy.bloom@workplace.calm.to

The PSILEX Group
is an Association
of Independent
Practitioners



Hy Bloom
B.A., LL.B., M.D., F.R.C.P.(C)
F.C.L.M

An Associate of
THE
PSILEX
GROUP

Consultants
in Behavioural
Sciences &
the Law

PRIVATE & CONFIDENTIAL

February 2nd, 2011

Daniel L. Ambrosini
391 St. Joseph Blvd.
Apt. 6
Montreal, Quebec
H2V 2P1

Dear Dan:

RE: A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario Second Edition, Carswell

Thank you for submitting your chapter for the abovenoted book that I am co-editing with Mary Jane Dykeman. As we discussed earlier, the scope of *A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario* has expanded since the last edition. Your chapter, which covers mental health legislation across the country, will be a welcome addition.

We will tidy up biographical details subsequently, but to confirm the authorship, we have you as first author of the chapter.

We will probably get back to you subsequently with edits, queries, etc.

Thanks again for participating.

Regards,

Hy

Hy Bloom, B.A., LL.B., M.D., F.R.C.P.(C)
Adjunct Faculty
Faculty of Law
University of Toronto

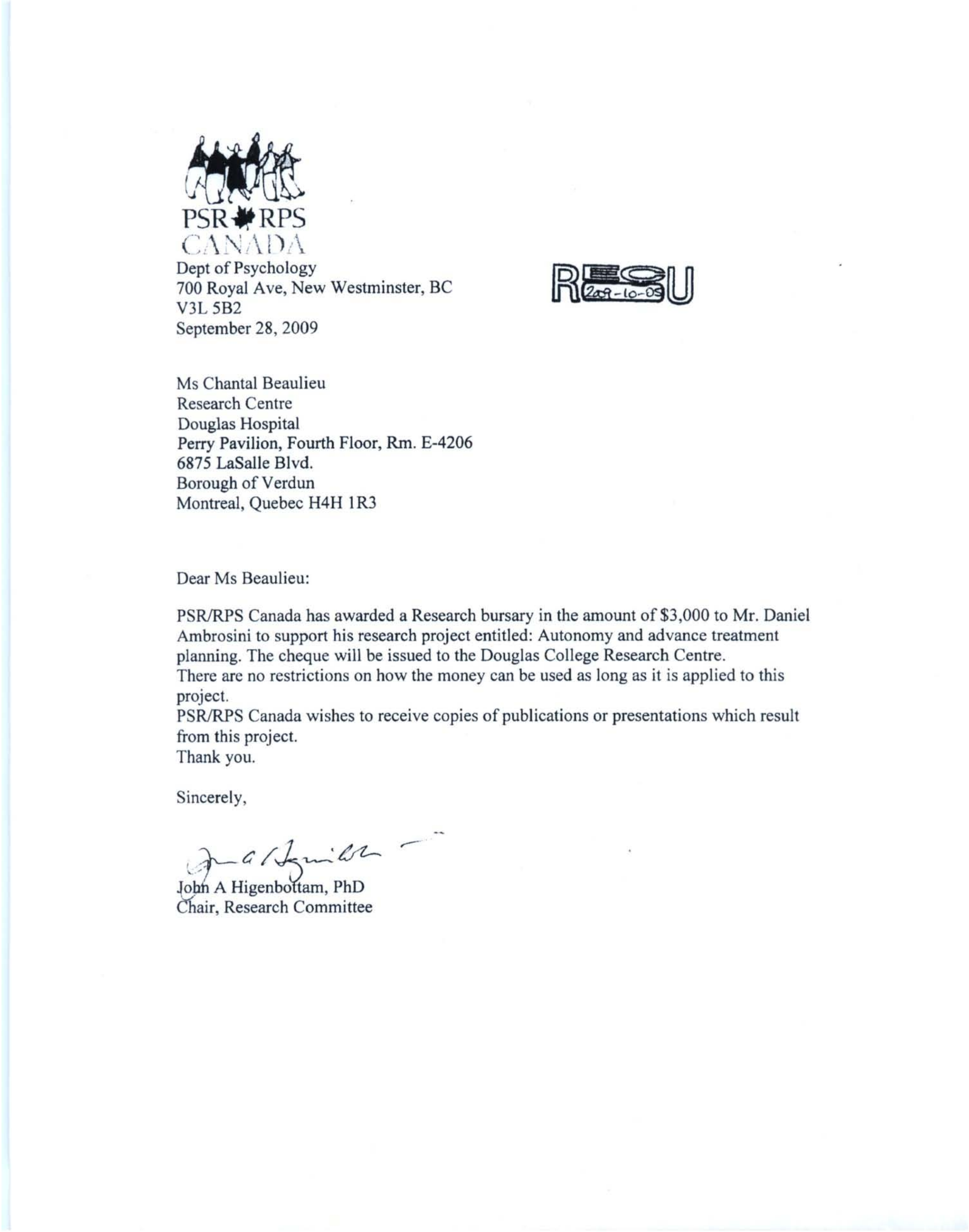
Assistant Professor
Department of Medicine
University of Toronto

Assistant Clinical Professor
Department of Psychiatry
McMaster University

Central Office:
1200 Bay Street
Suite 1100
Toronto, Ontario
M5R 2A5
TELEPHONE
416.922.7222
FACSIMILE
416.922.3188
E-MAIL
hy.bloom@workplace.calm.to

The PSILEX Group
is an Association
of Independent
Practitioners

Appendix IV: Research Grants



PSR RPS
CANADA
Dept of Psychology
700 Royal Ave, New Westminster, BC
V3L 5B2
September 28, 2009

REÇU
2009-10-05

Ms Chantal Beaulieu
Research Centre
Douglas Hospital
Perry Pavilion, Fourth Floor, Rm. E-4206
6875 LaSalle Blvd.
Borough of Verdun
Montreal, Quebec H4H 1R3

Dear Ms Beaulieu:

PSR/RPS Canada has awarded a Research bursary in the amount of $3,000 to Mr. Daniel Ambrosini to support his research project entitled: Autonomy and advance treatment planning. The cheque will be issued to the Douglas College Research Centre.

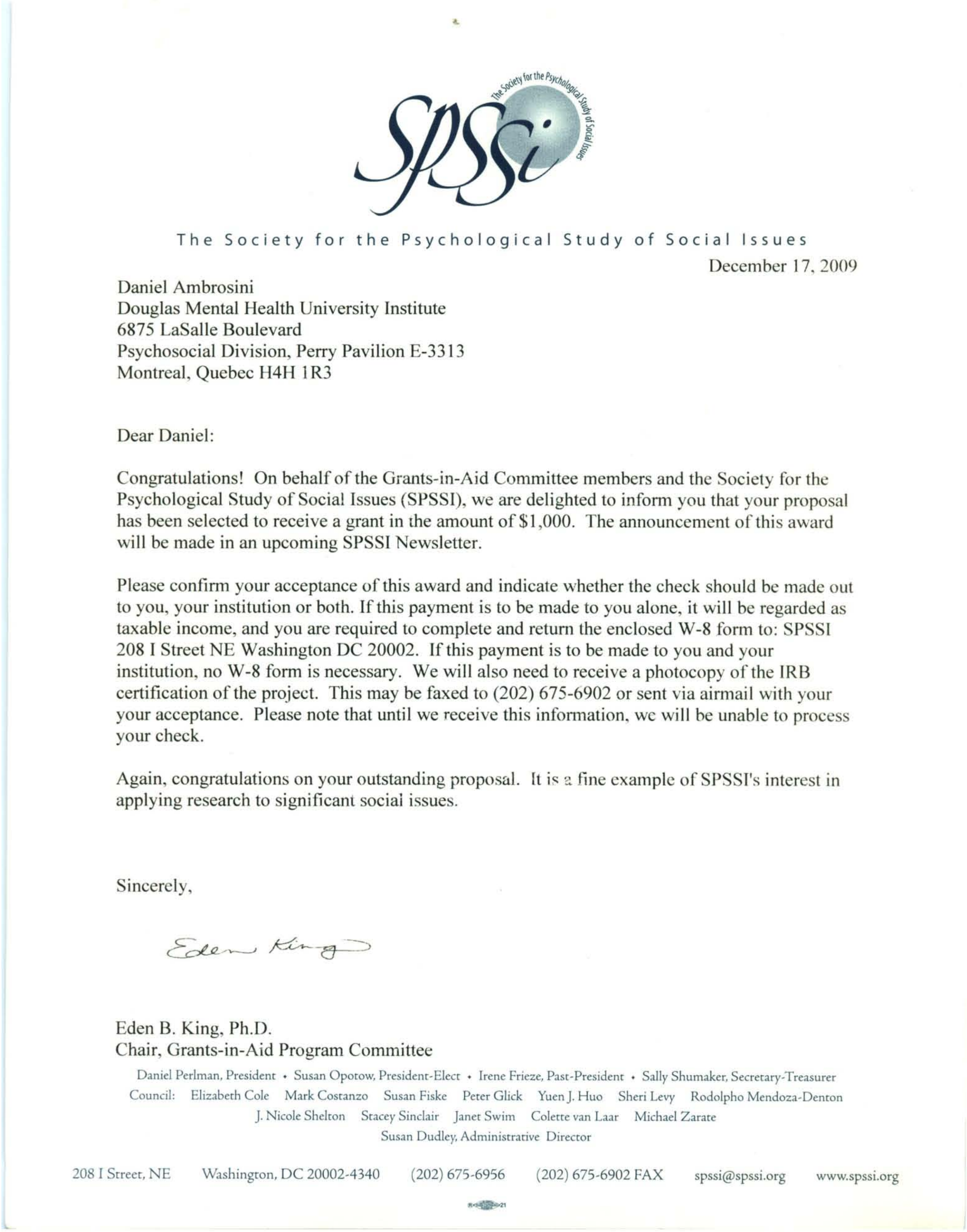
There are no restrictions on how the money can be used as long as it is applied to this project.

PSR/RPS Canada wishes to receive copies of publications or presentations which result from this project.

Thank you.

Sincerely,

John A Higenbottam, PhD
Chair, Research Committee



SPSSI
The Society for the Psychological Study of Social Issues

December 17, 2009

Daniel Ambrosini
Douglas Mental Health University Institute
6875 LaSalle Boulevard
Psychosocial Division, Perry Pavilion E-3313
Montreal, Quebec H4H 1R3

Dear Daniel:

Congratulations! On behalf of the Grants-in-Aid Committee members and the Society for the Psychological Study of Social Issues (SPSSI), we are delighted to inform you that your proposal has been selected to receive a grant in the amount of $1,000. The announcement of this award will be made in an upcoming SPSSI Newsletter.

Please confirm your acceptance of this award and indicate whether the check should be made out to you, your institution or both. If this payment is to be made to you alone, it will be regarded as taxable income, and you are required to complete and return the enclosed W-8 form to: SPSSI 208 I Street NE Washington DC 20002. If this payment is to be made to you and your institution, no W-8 form is necessary. We will also need to receive a photocopy of the IRB certification of the project. This may be faxed to (202) 675-6902 or sent via airmail with your your acceptance. Please note that until we receive this information, we will be unable to process your check.

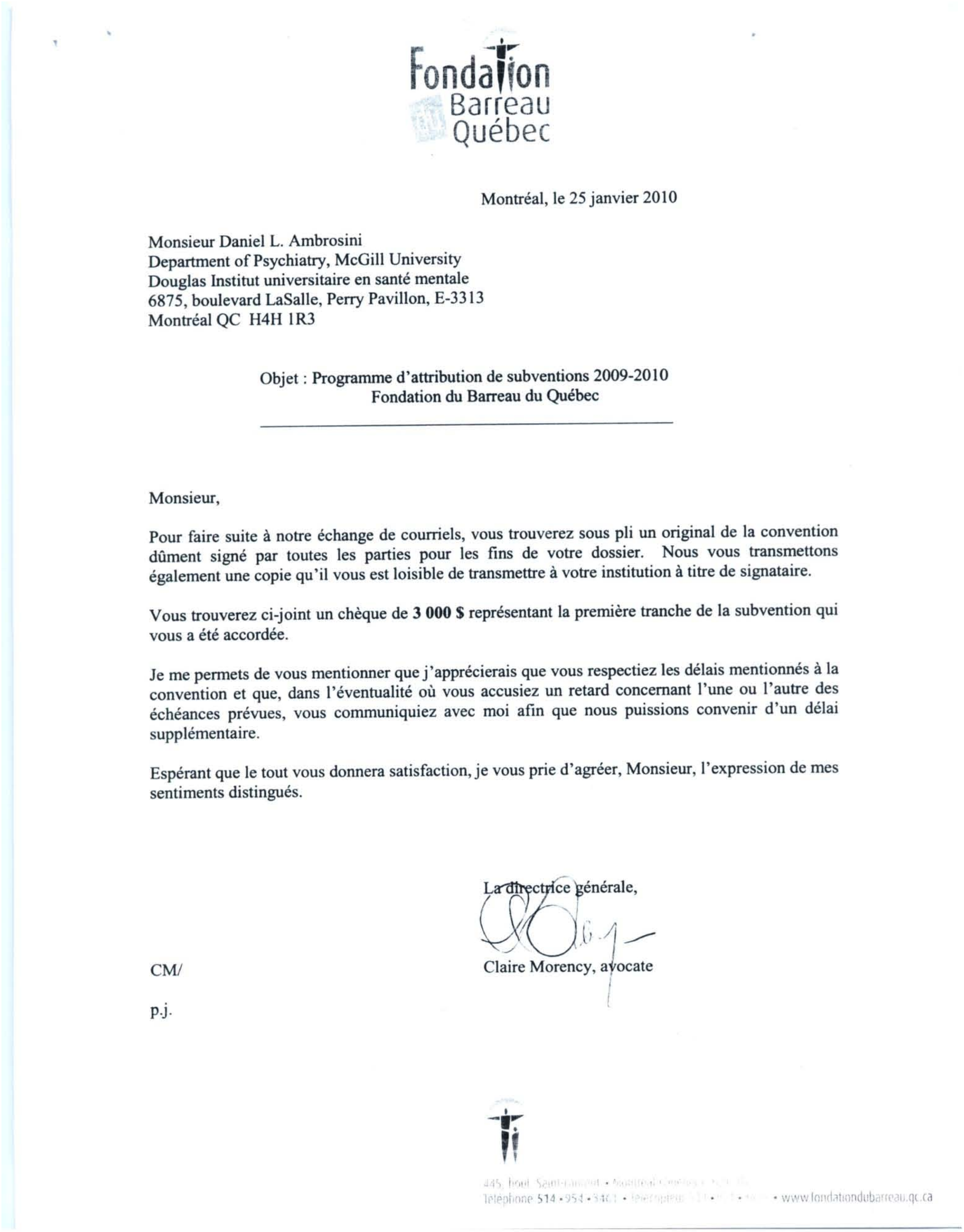
Again, congratulations on your outstanding proposal. It is a fine example of SPSSI's interest in applying research to significant social issues.

Sincerely,

Eden King

Eden B. King, Ph.D.
Chair, Grants-in-Aid Program Committee

208 I Street, NE Washington, DC 20002-4340 (202) 675-6956 (202) 675-6902 FAX spssi@spssi.org www.spssi.org



Fondation
du Barreau
du Québec

Montréal, le 25 janvier 2010

Monsieur Daniel L. Ambrosini
Department of Psychiatry, McGill University
Douglas Institut universitaire en santé mentale
6875, boulevard LaSalle, Perry Pavillon, E-3313
Montréal QC H4H 1R3

Objet : Programme d'attribution de subventions 2009-2010
Fondation du Barreau du Québec

Monsieur,

Pour faire suite à notre échange de courriels, vous trouverez sous pli un original de la convention dûment signé par toutes les parties pour les fins de votre dossier. Nous vous transmettons également une copie qu'il vous est loisible de transmettre à votre institution à titre de signataire.

Vous trouverez ci-joint un chèque de **3 000 $** représentant la première tranche de la subvention qui vous a été accordée.

Je me permets de vous mentionner que j'apprécierais que vous respectiez les délais mentionnés à la convention et que, dans l'éventualité où vous accusiez un retard concernant l'une ou l'autre des échéances prévues, vous communiquiez avec moi afin que nous puissions convenir d'un délai supplémentaire.

Espérant que le tout vous donnera satisfaction, je vous prie d'agréer, Monsieur, l'expression de mes sentiments distingués.

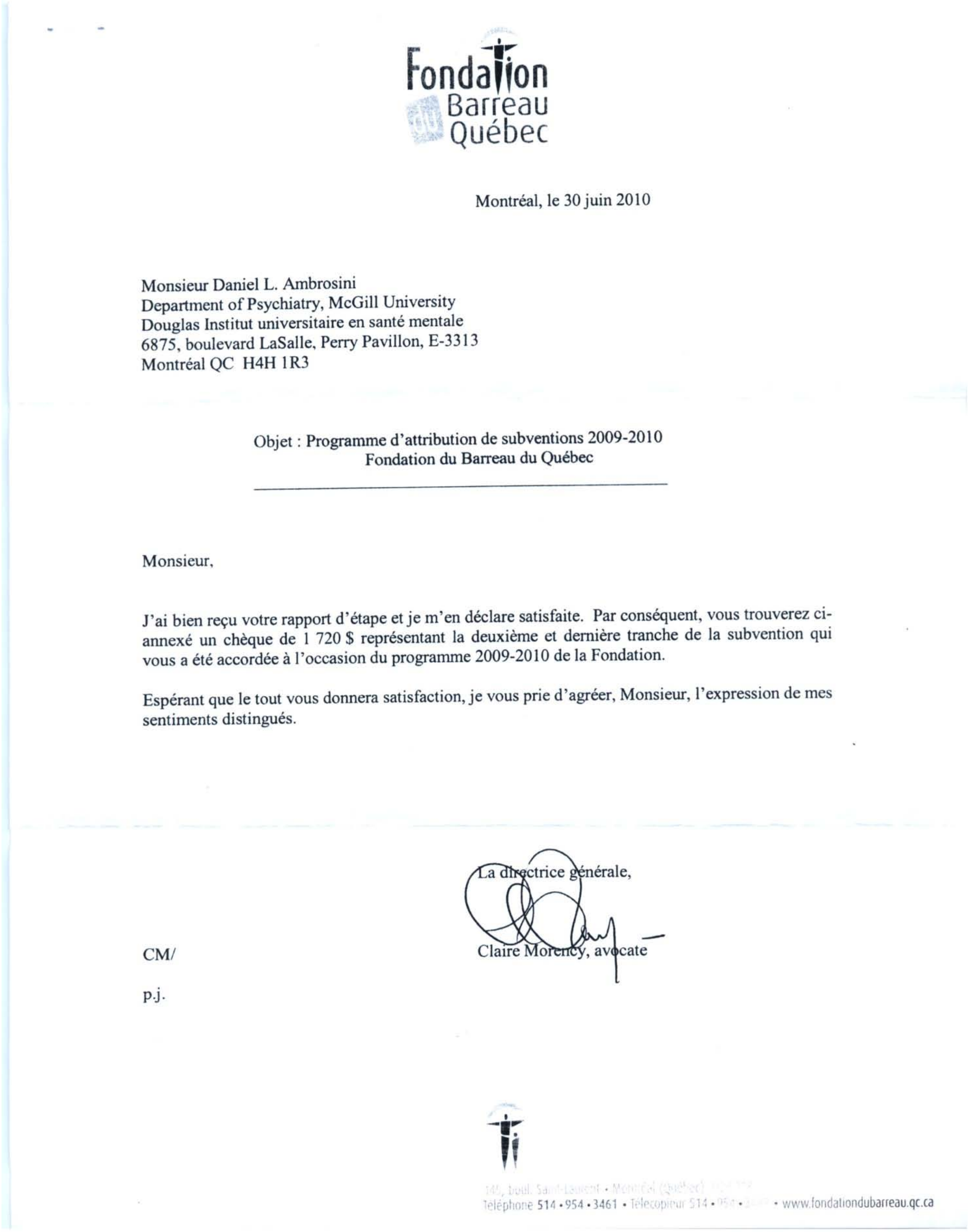
La directrice générale,

Claire Morency, avocate

CM/

p.j.

445, boul. Saint-Laurent • Montréal [illegible]
Téléphone 514 • 954 • 3461 • Télécopieur [illegible] • www.fondationdubarreau.qc.ca



Fondation
du Barreau
Québec

Montréal, le 30 juin 2010

Monsieur Daniel L. Ambrosini
Department of Psychiatry, McGill University
Douglas Institut universitaire en santé mentale
6875, boulevard LaSalle, Perry Pavillon, E-3313
Montréal QC H4H 1R3

Objet : Programme d'attribution de subventions 2009-2010
Fondation du Barreau du Québec

Monsieur,

J'ai bien reçu votre rapport d'étape et je m'en déclare satisfaite. Par conséquent, vous trouverez ci-annexé un chèque de 1 720 $ représentant la deuxième et dernière tranche de la subvention qui vous a été accordée à l'occasion du programme 2009-2010 de la Fondation.

Espérant que le tout vous donnera satisfaction, je vous prie d'agréer, Monsieur, l'expression de mes sentiments distingués.

La directrice générale,

Claire Morency, avocate

CM/

p.j.

445, boul. Saint-Laurent • Montréal (Québec) [illegible]
Téléphone 514 • 954 • 3461 • Télécopieur 514 • 954 • [illegible] • www.fondationdubarreau.qc.ca

BIBLIOGRAPHY

Journal Articles

Ambrosini, D. L. A brief history of the doctor-patient relationship in psychiatry: Foundations of autonomy. Manuscript to be submitted.

Ambrosini, D. L., Legal and ethical rights of individuals with mental illness in Canada to participate in advance treatment planning, Manuscript to be submitted.

Ambrosini, D. L. Critical review of international evidence on outpatient commitment laws. Manuscript to be submitted.

Ambrosini, D. L. (2010). Ulysses contracts: Autonomy, and the self-binding problem: legal and ethical perspectives, in *La Protection des personnes vulnérables*, Service de la formation continue du Barreau du Québec, (Cowansville: Éditions Yvon Blais) 315, 105-131.

Ambrosini, D. L., & Crocker, A. G. (2007). Psychiatric advance directives and the right to refuse treatment in Canada. *Canadian Journal of Psychiatry*, *53*(6), 397-401.

Ambrosini, D. L., Crocker, A.G., Perreault, M., & Israël, M. (2008). Perceptions of psychiatric advance directives among legal and mental health professionals in Ontario and Québec. *Journal of Ethics in Mental Health*, *3*(2), 1-12.

Ambrosini, D. L., & Crocker, A.G. (2009). Psychiatric advance directives and the role of autonomy. *Revue Santé Mentale au Québec*, *34*(2), 51-74.

Ambrosini, D. L. & Joncas, L. (forthcoming). Mental health & capacity legislation across Canada, in Bloom H, Dykeman MJ (Eds.) (2nd ed.) *A Practical Guide to Mental Health, Capacity, and Consent Law in Ontario*, (Toronto: Thomson Carswell).

Ambrosini, D. L. & Joncas, L. (in press). Civil commitment: a cross-country check-up, in Bloom H, Schneider R. (Eds.). *Law and Mental Disorder: A Comprehensive and Practical Approach* (Toronto: Irwin Law).

Ambrosini, D. L., Lach, L., Charette, Y., & Crocker, A. G. Autonomy and psychiatric advance directives: polling social work students. Manuscript submitted to *Journal of Social Work Education*.

Ambrosini, D. L., Bemme, D., Crocker, A., & Latimer, E. Narratives of psychiatric advance directives: Qualitative study. Manuscript to be submitted for publication.

Ambrosini, D. L., Crocker, A., & Latimer, E. Preferences for instructional or proxy directives in mental health: A mixed methods study. Manuscript to be submitted for publication.

Amering, M., Denk, E., Griengl, H., Sibitz, I., & Stastny, P. (1999). Psychiatric wills of mental health professionals: A survey of opinions regarding advance directives in psychiatry. *Social Psychiatry and Psychiatric Epidemiology, 34*(1), 30-34.

Amering, M., Stastny, P., & Hopper, K. (2005). Psychiatric advance directives: Qualitative study of informed deliberations by mental health service users. *British Journal of Psychiatry, 186*, 247-52.

Anand, R. (1979). Involuntary civil commitment in Ontario: The need to curtail the abuses of psychiatry. *Canadian Bar Review, 57*(2), 250-280.

Andreou, C. (2008). Making a clean break: Addiction and Ulysses contracts. *Bioethics, 22*(1), 25-31.

Anfang, S. A., & Appelbaum, P. S. (2006). Civil commitment – the American experience. *The Israel Journal of Psychiatry and Related Sciences, 43*(3), 209-218.

Annas, G., & Densberger, J. E. (1984). Competence to refuse medical treatment: Autonomy vs. paternalism. *University of Toledo Law Review, 15*(2), 561-596.

Appelbaum, P. (1982). Can a subject consent to a ‘Ulysses Contract’? *The Hastings Center Report, 12*(4), 26-28.

Appelbaum, P. S. (1991). Advance directives for psychiatric treatment. *Hospital & Community Psychiatry: A Journal of the American Psychiatric Association, 42*(10), 983-984.

Appelbaum, P. S. (2004). Law & psychiatry: Psychiatric advance directives and the treatment of committed patients. *Psychiatric Services, 55*(7), 751-753.

Appelbaum, P. S. (2005). Advance directives: Stigma strikes again. *Psychiatric Services*, *56*(5), 515.

Appelbaum, P. S., & Grisso, T. (1995). The MacArthur treatment competence study. I: Mental illness and competence to consent to treatment. *Law and Human Behavior, 19*(2), 105-126.

Appelbaum, P. S., & Redlich, A. (2006). Impact of decisional capacity on the use of leverage to encourage treatment adherence. *Community Mental Health Journal*, *42*(2), 121-130.

Appelbaum, P. S., & Rumpf, T. (1998). Civil commitment of the anorexic patient. *General Hospital Psychiatry*, *20*(4), 225-230.

Ashcraft, L., & Anthony, W. A. (2006). A treatment planning reality check. *Behavioral Healthcare, 26*(2) 7-8.

Astroff, R. E. (1997). Who lives, who dies, who decides?: Legal and ethical implications of advance directives. *Windsor Review of Legal and Social Issues, 7*, 1-33.

Atkinson, J. M. (2004). Ulysses' crew or circe? The implications of advance directives in mental health for psychiatrists. *Psychiatric Bulletin, 28,* 3-4.

Atkinson, J. M., Garner, H. C., & Gilmour, W. H. (2004). Models of advance directives in mental health care: Stakeholder views. *Social Psychiatry and Psychiatric Epidemiology, 39*(8), 673-680.

Backlar, P. (1998). Anticipatory planning for research participants with psychotic disorders like schizophrenia. *Psychology, Public Policy, and Law*, *4*(3), 829-853.

Backlar, P. (2004). Anticipatory planning for psychiatric treatment is not quite the same as planning for end-of-life care. *Community Mental Health Journal, 33*(4), 261-268.

Backlar, P., McFarland, B. H., Swanson, J. W., & Mahler, J. (2001). Consumer, provider, and informal caregiver opinions on psychiatric advance directives. *Administration and Policy in Mental Health, 28*(6), 427-441.

Barreira, P., Macias, C., Rodican, C., & Gold, P. B. (2008). Choice of service provider: How consumer self-determination shaped a psychiatric rehabilitation program. *Psychiatric Rehabilitation Journal 31*(2), 202-210.

Beaumont P., & Carney, T. (2004). Can psychiatric terminology be translated into legal regulation? The anorexia nervosa example. *Australian and New Zealand Journal of Psychiatry, 38*(10), 819-829.

Berg, J.W., Appelbaum, P.S., & Grisso, T. (1996). Constructing competence: Formulating standards of legal competence to make medical decisions. *Rutgers Law Review 48*(2), 345-396.

Berkson, G. (2006). Mental disabilities in western civilization from ancient Rome to the *Prerogativa Regis*. *Mental Retardation, 44*(1), 28-40.

Bilsker, D., Goldner, E. M., & Jones, E. (2007). Health service patterns indicate potential benefit of supported self-management for depression in primary care. *Canadian Journal of Psychiatry, 52*(2) 86-95.

Bisson, J. I., Hampton, V., Rosser, A., & Holm, S. (2009). Developing a care pathway for advance decisions and powers of attorney: Qualitative study. *British Journal of Psychiatry, 194*(1), 55-61.

Bogdanoski, T. (2009). Psychiatric advance directives: The new frontier in mental health law reform in Australia? *Journal of Law and Medicine, 16*(5), 891-904.

Botelho, R. J. (1992). A negotiation model for the doctor-patient relationship. *Family Practice, 9*(2), 210-218.

Bowling, A., & Rowe, G. (2005). “You decide doctor.” What do patient preference arms in clinical trials really mean? *Journal of Epidemiology Community Health, 59*(11), 914-915.

Bravo, G., Dubois, M. F., & Paquet, M. (2003). Advance directives for health care and research: Prevalence and correlates. *Alzheimer Disease and Associated Disorders, 17*(4), 215-222.

Bravo, G., Dubois, M. F., & Wagneur, B. (2008). Assessing the effectiveness of interventions to promote advance directives among older adults: A systematic review and multi-level analysis. *Social Science & Medicine, 67*(7), 1122-1132.

Bravo, G., Paquet, M., & Dubois, M. F. (2003). Knowledge of the legislation governing proxy consent to treatment and research. *Journal of Medical Ethics, 29*(1), 44-50.

Brock, D. W. (1991). Surrogate decision making for incompetent adults: An ethical framework. *The Mount Sinai Journal of Medicine*, *58*(5), 388-392, 398-402.

Brock, D. W. (2003). Precommitment in bioethics: Some theoretical issues. *Texas Law Review, 81*(7), 1805-1821.

Brock, D. W. (1993). A proposal for the use of advance directives in the treatment of incompetent mentally ill persons. *Bioethics, 7*(2-3), 247-256.

Brock, D. W. (1994). Advance directives: What is it reasonable to expect from them? *Journal of Clinical Ethics, 5*(1), 57-60.

Brooks, R. A. (2006). U.S. psychiatrists' beliefs and wants about involuntary civil commitment grounds. *International Journal of Law and Psychiatry, 29*(1), 13-21.

Brooks, R. A. (2007). Psychiatrists' opinions about involuntary civil commitment: Results of a national survey. *Journal of the American Academy Psychiatry and the Law, 35*(2), 219-228.

Brown, J. D. (2003). Is involuntary outpatient commitment a remedy for community mental health service failure? *Ethical Human Sciences and Services: an International Journal of Critical Inquiry, 5*(1), 7-20.

Brown, K., & Murphy, E. (2000). Falling through the cracks: The Québec mental health system. *McGill Law Journal, 45*, 107-1079.

Brown, M. (2003). The law and practice associated with advance directives in Canada and Australia: Similarities, differences and debates. *Journal of Law and Medicine, 11*(1), 59-76.

Browne A., & Sullivan, B. (2006). Advance directives in Canada. *Cambridge Quarterly of Healthcare Ethics, 15*(3), 256-260

Bryden, P. (2005). Section 7 of the Charter outside the criminal context. *University of British Columbia Law Review*, *38*, 507.

Burgess, T. J. W. (1905). Presidential address - The insane in Canada. *American Journal of Insanity*, LXII, 1, 1-36.

Calsyn, R. J., Winter, J. P., & Morse, G. A. (2000). Do consumers who have a choice of treatment have better outcomes? *Community Mental Health Journal*, *36*(2), 149-160.

Campbell J., Stefan S., & Loder, A. (1994). Putting violence in context. *Hospital and Community Psychiatry, 45*(7), 633-668.

Candilis, P. J., Fletcher, K. E., Geppert, C. M., Lidz, C. W., & Appelbaum, P. S. (2008). A direct comparison of research decision-making capacity: Schizophrenia/schizoaffective, medically ill, and non-ill subjects. *Schizophrenia Research, 99*(1-3), 350-358.

Cantor, N. L. (1992). Advance directives and the pursuit of death with dignity: New Jersey's new legislation. *Rutgers Law Review, 44*(2), 335-403.

Cantor, N. L. (1992). Prospective autonomy: On the limits of shaping one's postcompetence medical fate. *Journal of Contemporary Health Law Policy, 8*, 13-48.

Caracelli, V. J. & Greene, J. C. (1993). Data analysis strategies for mixed-method evaluation designs. *Educational Evalutation and Policy Analysis, 15*(2), 195-207.

Carlsmith, K. M., Monahan, J., & Evans, A. (2007). The function of punishment in the "civil" commitment of sexually violent predators. *Behavioral Sciences & the Law, 25*(4), 437-448.

Carver P., & Langlois-Klassen, C. (2006). The role and powers of forensic psychiatric review boards in Canada: Recent developments. *Health Law Journal*, 14, 1.

Castelein, S., Van der Gaag, M., Bruggeman, R., Van Busschbach, J. T., & Wiersma, D. (2008). Measuring empowerment among people with psychotic disorders: A comparison of three instruments. *Psychiatric Services, 59*(11), 1338-1342.

Chodoff, P., & Peele, R. (1983). The psychiatric will of Dr. Szasz. *The Hastings Center Report, 13*(2), 11-13.

Churchill, L. R. (1989). Trust, autonomy, and advance directives. *Journal of Religion and Health*, *28*(3), 175-183.

Climent, C. E., & Plutchik, R. (1977). Lunar madness: An empirical study. *Comprehensive Psychiatry*, *18*(2), 369-374.

Clough, E. (2006). A critique of advance directives and advance directives legislation. *Appeal: Review of Current Law and Law Reform*, *11*, 16-38.

Corrigan, P. W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal*, *35*(3), 231-239.

Corrigan, P. W., Salzer, M., Ralph, R. O., Sangster, Y., & Keck, L. (2004). Examining the factor structure of the recovery assessment scale. *Schizophrenia Bulletin, 30*(4), 1035-1041.

Corrigan, P. W., Watson, A. C., Heyrman, M. L., Warpinski, A., Gracia, G., Slopen, N. et al., (2005). Structural stigma in state legislation. *Psychiatric Services 56*(5), 557-563.

Crisanti A. S., & Love E. J. (2002). From one legal system to another? An examination of the relationship between involuntary hospitalization and arrest. *International Journal of Law and Psychiatry*, *25*(6) 581-597.

Crisanti, A. S., & Love, E. J. (2001). Characteristics of psychiatric in patients detained under civil commitment legislation: A Canadian study. *International Journal of Law and Psychiatry*, *24*(4-5), 399.

Cuca, R. (1993). Ulysses in Minnesota: First steps toward a self-binding psychiatric advance directive statute. *Cornell Law Review*, *78*(6), 1152-1186.

Davidson L., Ridgway P., Kidd, S., Topor, A., & Borg, M. (2008). Using qualitative research to inform mental health policy. *Canadian Journal of Psychiatry*, *53*(3), 137-44.

Davidson, L., (2006). What happened to civil rights? *Psychiatric Rehabilitation Journal*, *30*(1), 11-14;

Davidson, L., Tondora, J., O’Connell, M. J., Kirk, T., Jr., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23-31.

Davis, J. K. (2002). The concept of precedent autonomy. *Bioethics, 16*(2), 114-133.

Davis, J. K. (2004). Precedent autonomy and subsequent consent. *Ethical Theory and Moral Practice: An International Forum, 7*(3), 267-291.

Davis, J. K. (2008). How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. *Kennedy Institute of Ethics Journal*, *18*(1), 87-106.

Davis, K. (1968). Evolving models of organizational behaviour. *The Academy of Management Journal, 11*(1), 27-38.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Dessureault, D., Côté, G., & Lesage G., (2000). Impact of first contacts with the criminal justice or mental health systems on the subsequent orientation of mentally disordered persons toward either system. *International Journal of Law and Psychiatry, 23*(1) 79-90.

DeWolf Bosek, M. S., Ring, M. E., & Cady, R. F. (2008). Do psychiatric advance directives protect autonomy? *JONAS Healthcare, Law, Ethics, and Regulation*, *10*(1), 17-24; quiz 25-16.

Diamond, B. (1975). The psychiatric prediction of dangerousness. *Pennsylvania Law Review*, *123*, 439.

Dickens, B. (1993). A response to the papers by Molloy and colleagues (Canada) and Cranford (United States) on advance directives. *Humane Medicine, 9*(1), 78-84.

Ditto, P. H., Danks, J. H., Smucker, W. D., Bookwala, J., Coppola, K. M., Dresser, R. et al., (2001). Advance directives as acts of communication: A randomized controlled trial. *Archives of Internal Medicine, 161*(3), 421-430.

Ditto, P. H., Smucker, W. D., Danks, J. H., Jacobson, J. A., Houts, R. M., Fagerlin, A. et al., (2003). Stability of older adults' preferences for life-sustaining medical treatment. *Health Psychology, 22*(6), 605-615.

Downie, J. (1993). "Where there is a will, there may be a better way": Legislating advance directives. *Health Law in Canada, 12*(3), 73-80, 89.

Downie, J. & McEwen, K. (2009). The Manitoba College of Physicians and Surgeons position statement on withholding and withdrawal of life-sustaining treatment (2008): three problems and a solution. *Health Law Journal*, 17, 115-137.

Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal, 34*(1), 7-13.

Dresser, R. (1984). Bound to treatment: The Ulysses contract. *Hastings Center Report, 14*(3), 13-16

Dresser, R. (2003). Precommitment: A misguided strategy for securing death with dignity. *Texas Law Review, 81*(7), 1823-1847.

Dresser, R. S. (1982). Ulysses and the psychiatrists: A legal and policy analysis of the voluntary commitment contract. *Harvard Civil Rights-Civil Liberties Law Review, 16*(3), 777-854.

Dukoff, R., & Sunderland, T. (1997). Durable power of attorney and informed consent with Alzheimer's disease patients: A clinical study. *American Journal of Psychiatry, 154*(8), 1070-1075.

Dull, M. W. (2009). Starson v. Swayze, 2003-2008: Appreciating the judicial consequences. *Health Law Journal*, 17, 51.

Dupin, F. (2003). Être protégé malgré soi. *Le Journal du Barreau du Québec*, 182.

Duxbury, N. (1996). Liberalism, self-interest, and precommitment. *Canadian Journal of Law and Jurisprudence, 9*(2), 383-395.

Dworkin, R. (1986). Autonomy and the demented self. *The Millbank Quarterly, 64*(Suppl. 2), 4-16.

Dworkin, R. B. (2003). Getting what we should from doctors: Rethinking patient autonomy and the doctor-patient relationship. *Health Matrix: The Journal of Law-Medicine, 13*(2), 235-296.

Eisendrath S. J., & Jonsen, A. R. (1983). The living will. Help or hindrance? *Journal of American Medical Association, 249*(15), 2054-2058.

Elbogen, E. B., Swanson, J. W., Appelbaum, P. S., Swartz, M. S., Ferron, J., Van Dorn, R. A. et al., (2007). Competence to complete psychiatric advance directives: Effects of facilitated decision making. *Law and Human Behavior, 31*(3), 275-289.

Ells, C. (2001). Shifting the autonomy debate to theory as ideology. *The Journal of Medicine and Philosophy, 26*(4), 417-430.

Emanuel, L. (1993). Advance directives: What have we learned so far? *Journal of Clinical Ethics, 4*(1), 8-16.

Emanuel, L. L., Emanuel, E. J., Stoeckle, J. D., Hummel, L. R., & Barry, M. J. (1994). Advance directives. Stability of patients' treatment choices. *Archives of Internal Medicine, 154*(2), 209-217.

Ende, J., Kazis, L., Ash, A., & Moskowitz, M. A. (1989). Measuring patients' desire for autonomy: Decision making and information-seeking preferences among medical patients. *Journal of General of Internal Medicine, 4*(1), 23-30.

Enthoven, A. (2006). Connecting consumer choice to the healthcare system. *Journal of Health Law, 39*(3), 289-305

Fagerlin, A., & Schneider, C. E. (2004). Enough. The failure of the living will. *Hastings Center Report, 34*(2), 30-42.

Falkum, E., & Forde, R. (2001). Paternalism, patient autonomy, and moral deliberation in the physician-patient relationship. Attitudes among Norwegian physicians. *Social Science and Medicine, 52*(2), 239-248.

Fisher, M. S. (2009). Psychiatric advance directives and the right to be presumed competent. *Journal of Contemporary Health Law & Policy, 25*(2), 386-405.

Fistein, E. C., Holland, A. J., Clare, I. C., & Gunn, M. J. (2009). A comparison of mental health legislation from diverse commonwealth jurisdictions. *International Journal of Law and Psychiatry, 32*(3), 147-155.

Fleischner, R. D. (1998). Advance directives for mental health care: An analysis of state statutes. *Psychology, Public Policy, and Law, 4*(3), 788-804.

Foti, M. E., Bartels, S. J., Van Citters, A. D., Merriman, M. P., & Fletcher, K. E. (2005). End-of-life treatment preferences of persons with serious mental illness. *Psychiatric Services, 56*(5), 585-591.

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.

Ganzini, L., Volicer, L., Nelson, W. A., Fox, E., & Derse, A. R. (2004). Ten myths about decision-making capacity. *Journal of the American Medical Directors Association, 5*(4), 263-267.

Gardner, W., Hoge, S. K., Bennett, N., Roth, L. H., Lidz, C. W., Monahan, J. et al., (1993). Two scales for measuring patients' perceptions for coercion during mental hospital admission. *Behavioral Sciences & the Law, 11*(3), 307-321.

Geller, J. L. (1986). Rights, wrongs, and the dilemma of coerced community treatment. *The American Journal of Psychiatry, 143*(10), 1259-1264.

Geller, J. L. (1992). A historical perspective on the role of state hospitals viewed from the era of the "revolving door." *American Journal of Psychiatry, 149*(11) 1532-1533.

Geller, J. L. (2000). The use of advance directives by persons with serious mental illness for psychiatric treatment. *Psychiatric Quarterly, 71*(1), 1-13.

Gillick, M. R. (2006). The use of advance care planning to guide decisions about artificial nutrition and hydration. *Nutrition in Clinical Practice, 21*(2), 126-133.

Goss, C., Moretti, F., Mazzi, M. A., Del Piccolo, L., Rimondini, M., & Zimmermann, C. (2008). Involving patients in decisions during psychiatric consultations. *British Journal of Psychiatry, 193*(5), 416-421.

Gove, W. R., Tovo, M., & Hughes, M. (1985). Involuntary psychiatric hospitalization: A review of the statutes regulating the social control of the mentally ill. *Deviant Behavior, 6*(3), 287-318

Gray J. E. & O'Reilly, R. L. (2001). Clinically significant differences among Canadian mental health acts. *Canadian Journal of Psychiatry*, *46*(4), 315-321.

Gray J. E., & O'Reilly, R. L. (2009). Supreme Court of Canada's "Beautiful Mind" Case. *International Journal of Law and Psychiatry, 32*(5), 315-322.

Gray, K. G. (1937). The Mental Hospitals Act, 1935 (Ontario). *University of Toronto Law Journal*, *2*(1), 103-113.

Greco, P. J., Schulman, K. A., Lavizzo-Mourey, R., & Hansen-Flaschen, J. (1991). The Patient Self-Determination Act and the future of advance directives. *Annals of Internal Medicine, 115*(8), 639-643.

Greenberg W. M., Moore-Duncan L., & Herron R. (1996). Patients' attitudes toward having been forcibly medicated. *Bulletin of the American Academy of Psychiatry and the Law, 24*(4), 513-24.

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1-2), 135-144.

Gremmen, I., Widdershoven, G., Beekman, A., Zuijderhoudt, R., & Sevenhuijsen, S. (2008). Ulysses arrangements in psychiatry: A matter of good care? *Journal of Medical Ethics, 34*(2), 77-80.

Griener, G. G. (1991). Living wills/advance directives - an ethicist's view. *Health Law Review, 1*, 6-9.

Grisso T., & Appelbaum, P. S. (1995). The MacArthur treatment competence study. III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior, 19*(2), 149-174.

Grisso, T., Appelbaum, P. S., Mulvey, E. P., & Fletcher, K. (1995). The MacArthur treatment competence study. II: Measures of abilities related to competence to consent to treatment. *Law and Human Behavior, 19*(2), 127-148.

Grosse Holtforth, M., Reubi, I., Ruckstuhl, L., Berking, M., Grawe, K. (2004). The value of treatment-goal themes for treatment planning and outcome evaluation of psychiatric inpatients. *The International Journal of Social Psychiatry, 50*(1), 80-91.

Gutheil, T. G., & Appelbaum, P. S. (1985). The substituted judgment approach: Its difficulties and paradoxes in mental health settings. *Law Medicine & Health Care, 13*(2), 61-64.

Hansson, L., & Bjorkman, T. (2005). Empowerment in people with a mental illness: Reliability and validity of the Swedish version of an empowerment scale. *Scandinavian Journal of Caring Sciences, 19*(1), 32-38.

Harmon, S. H. E. (2010). Body blow: Mature minors and the Supreme Court of Canada's decision in *A.C. v. Manitoba*. *McGill Journal of Law and Health, 4*(1), 83-96.

Heinssen, R. K. (2002). Improving medication compliance of a patient with schizophrenia through collaborative behavioral therapy. *Psychiatric Services, 53*(3), 255-257.

Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services, 59*(1), 63-71.

Henry, Y. (2001). Psychiatric gating: Questioning the civil committal of convicted sex offenders. *University of Toronto Faculty of Law Review*, *59*(2), 229-250.

High, D. M. (1994). Families' roles in advance directives. *Hastings Center Reports, 24*(6), S16-8.

High, D. M. (2004). Surrogate decision making. Who will make decisions for me when I can't? *Clinics in Geriatric Medicine, 10*(3), 445-462.

Ho, A. (2008). Relational autonomy or undue pressure? Family's role in medical decision-making. *Scandinavian Journal of Caring Science, 22*(1), 128-135.

Hogan, T. P., Awad, A. G., & Eastwood, R. (1983). A self-report scale predictive of drug compliance in schizophrenics: Reliability and discriminative validity. *Psychological Medicine, 13*(1), 177-183.

Hoge, S. K. (1994). The patient self-determination act and psychiatric care. *Bulletin of American Academy of Psychiatry and the Law, 22*(4), 577-586.

Holm, S. (2001). Autonomy, authenticity, or best interest: Everyday decision-making and persons with dementia. *Medicine, Health Care and Philosophy, 4*(2), 153-159.

Hotopf, M. (2005). The assessment of mental capacity. *Clinical Medicine*, *5*(6), 580-584.

Howard, L., & Thornicroft, G. (2006). Patient preference randomised controlled trials in mental health research. *British Journal of Psychiatry, 188,* 303-304.

Hundert, E. M. (1987). A model for ethical problem solving in medicine, with practical applications. *American Journal of Psychiatry, 144*(7), 839-846.

Hunt, R. & Ells, C. (2010). Partners towards autonomy: Risky choices and relational autonomy in rehabilitation care. *Disability and Rehabilitation*, Early Online, 1-7.

Iosif, A., & Ballon B. (2005). Bad moon rising: The persistent belief in lunar connections to madness. *Canadian Medical Association Journal, 173*(12), 1498-1500.

Joshi, K. G. (2003). Psychiatric advance directives. *Journal of Psychiatric Practice*, 9(4), 303-306.

Kaiser, H. A. (2009). Canadian mental health law: The slow process of redirecting the ship of state. *Health Law Journal*, 17, 139.

Kalis, A., Mojzisch, A., Schweizer, T. S., & Kaiser, S. (2008). Weakness of will, akrasia, and the neuropsychiatry of decision making: An interdisciplinary perspective. *Cognitive, Affective & Behavioral Neuroscience, 8*(4), 402-417.

Kane R. J. (2002). Information is the key to patient empowerment. *Annals of Health Law*, *11*, 25-44.

Kartalova-O'Doherty, Y., & Doherty, D. T. (2008). Coping strategies and styles of family carers of persons with enduring mental illness: A mixed methods analysis. *Scandinavian Journal of Caring Sciences, 22*(1), 19-28.

Kennedy, D. (2000). From the will theory to the principle of private autonomy: Lon Fuller's "Consideration and Form." *Columbia Law Review*, *100*(1), 94-175.

Khazaal, Y., Richard, C., Matthieu-Darekar, S., Quement, B., Kramer, U., & Preisig, M. (2008). Advance directives in bipolar disorder, a cognitive behavioural conceptualization. *International Journal of Law and Psychiatry, 31*(1), 1-8.

Kielstein R., & Sass H. M. (1993). Using stories to assess values and establish medical directives. *Kennedy Institute of Ethics Journal*, *3*(3), 303-25.

Killaspy, H., Johnson, S., Pierce, B., Bebbington, P., Pilling, S., Nolan, F. et al., (2009). Successful engagement: A mixed methods study of the approaches of assertive community treatment and community mental health teams in the REACT trial. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 532-540.

Kim M. M., Van Dorn R. A., Scheyett A. M., Elbogen E. E., Swanson J. W., Swartz M. S. et al., (2007). Understanding the personal and clinical utility of psychiatric advance directives: A qualitative perspective. *Psychiatry, 70*(1), 19-29.

Kim, M. M., Scheyett, A. M., Elbogen, E. B., Van Dorn, R. A., McDaniel, L. A., Swartz, M. S. et al., (2008). Front line workers' attitudes towards psychiatric advance directives. *Community Mental Health Journal, 44*(1), 28-46.

King, N. M., & Davis, A. M. (1996). End-of-life decision-making. The patient's right to choose. *North Carolina Medical Journal, 57*(6), 381-384.

Kirschner, K. L. (2005). When written advance directives are not enough. *Clinics in Geriatriac Medicine, 21*(1), 193-209.

Kouri, R. (2010). Le mineur et les soins médicaux, *A.C. c. Manitoba*: de l’autonomie au meilleur intérêt, une limite bien floue. *McGill Journal of Law and Health, 4*(1), 65-81.

Kovnick, J. A., Appelbaum, P. S., Hoge, S. K., & Leadbetter, R. A. (2003). Competence to consent to research among long-stay inpatients with chronic schizophrenia. *Psychiatric Services, 54*(9), 1247-1252.

Kuroda, N., Sun, S., Lin, C. K., Morita, N., Kashiwase, H., Yang, F. et al., (2008). Attitudes toward taking medication among outpatients with schizophrenia: cross-national comparison between Tokyo and Beijing. *Environmental Health and Preventive Medicine, 13*(5), 288-295.

La Fond, J. Q. (2000). The future of involuntary civil commitment in the U.S.A. after *Kansas v. Hendricks*. *Behavioral Sciences & the Law, 18*(2-3), 153-167.

La Fond, J. Q., & Srebnik, D. (2002). The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions. *International Journal of Law and Psychiatry, 25*(6), 537-555.

La Guardia, J. G., & Ryan, R. M. (2007). Why identities fluctuate: Variability in traits as a function of situational variations in autonomy support. *Journal of Personality, 75*(6), 1205-1228.

Larson E. J., & Eaton, T. A. (1997). The limits of advance directives: A history and assessment of the Patient Self-Determination Act. *Wake Forest Law Review, 32*(2), 249-293.

Laugharne, R., & Priebe, S. (2006). Trust, choice and power in mental health: a literature review. *Social Psychiatry and Psychiatric Epidemiology, 41*(11), 843-852.

Lavin, M. (1986). Ulysses contracts. *Journal of Applied Philosophy, 3*(1), 89-101

Lemmens, T. (1996). Towards the right to be killed? Treatment refusal, assisted suicide and euthanasia in the United States and Canada. *British Medical Bulletin, 52*(2), 341-353.

Leo, R. J. (1999). Competency and the capacity to make treatment decisions: A primer for primary care physicians. *Primary Care Companion to the Journal of Clinical Psychiatry, 1*(5), 131-141.

Levine, J. M. (1996). Historical notes on restraint reduction: The legacy of Dr. Philippe Pinel. *Journal of the American Geriatrics Society, 44*(9), 1130-1134.

Lidz C. W., & Arnold, R. M. (1993). Rethinking autonomy in long term care. *University of Miami Law Review, 47*(3), 603-623.

Linhorst, D. M., Hamilton, G., Young, E., & Eckert, A. (2002). Opportunities and barriers to empowering people with severe mental illness through participation in treatment planning. *Social Work, 47*(4), 425-434.

Lukoff, D., Nuechterlein, K. H., & Ventura, J. (1986). Manual for the expanded BPRS. *Schizophrenia Bulletin, 12*(4), 594-602.

Lynn J. & Teno, J. M. (1993). After the Patient Self-Determination Act: The need for empirical research on formal advance directives. *The Hastings Center Report*, *23*(1), 20-24.

Macklin, A. (1987). Bound to freedom: The Ulysses contract and the psychiatric will. *University Toronto Faculty Law Review, 45*(1), 37-68

Margolin J., & Witztum, E. (2006). Mental health legislation: An unavoidable necessity or a harmful anachronism. *Israel Journal of Psychiatry and Related Sciences*, *43*(3), 219-227.

McEvoy, J. P., Applebaum, P. S., Apperson, L. J., Geller, J. L., & Freter, S. (1989). Why must some schizophrenic patients be involuntarily committed? The role of insight. *Comprehensive Psychiatry, 30*(1), 13-17.

McEvoy, J. P., Freter, S., Merritt, M., & Apperson, L. J. (1993). Insight about psychosis among outpatients with schizophrenia. *Hospital & Community Psychiatry, 44*(9), 883-884.

McKenna, B. G., Simpson A. I., & Coverdale, J. H. (2000). What is the role of procedural justice in civil commitment? *Australian and New Zealand Journal of Psychiatry*, 34(4) 671-676.

McLaren, C. (2009). Alberta creates electronic registry for personal directives. *Canadian Medical Association Journal, 180*(7), 708.

McNaught, M., Caputi, P., Oades, L. G., & Deane, F. P. (2007). Testing the validity of the recovery assessment scale using an Australian sample. *Australian and New Zealand Journal of Psychiatry, 41*(5), 450-457.

Molloy, D. W., Guyatt, G. H., Russo, R., Goeree, R., O'Brien, B. J., Bedard, M. et al., (2000). Systematic implementation of an advance directive program in nursing homes: A randomized controlled trial. *Journal of the American Medical Association, 283*(11), 1437-1444.

Molloy, D. W., Guyatt, G., Alemayehu, E., & McIlroy, W. E. (1991). Treatment preferences, attitudes toward advance directives and concerns about health care. *Humane Medicine, 7*(4), 285-290.

Molloy, D. W., Harrison, C., Farrugia, M. C., & Cunje, A. (1993). The Canadian experience with advance treatment directives. *Humane Medicine, 9*(1), 70-77.

Monahan, J., Ruggiero M., & Friedlander, H. (1982). Stone-Roth model of civil commitment and the California dangerousness standard. *Archives of General Psychiatry, 39*(11), 1267-1271.

Mueser, K. T., McHugo, G. J., & Curran, P. J. (1997). Factor structure of the brief psychiatric rating scale in schizophrenia. *Psychological Assessment, 9*(3), 196-204.

Mueser, K. T., Corrigan, P. W., Hilton, D. W., Tanzman, B., Schaub, A., Gingerich, S. et al., (2002). Illness management and recovery: A review of the research. *Psychiatric Services, 53*(10), 1272-1284.

Mueser, K. T., Meyer, P. S., Penn, D. L., Clancy, R., Clancy, D. M., Salyers, M. P. (2006). The illness management and recovery program: Rationale, development, and preliminary findings. *Schizophrenia Bulletin, (32)* Suppl 1, S32-43.

Neilson, G. (2005). The role of mental health legislation. *Canadian Journal of Psychiatry, 50*(11), supp 1-2.

Nelson, W. A. (2007). The ethics of patient preferences. Autonomy has limitations when contrary to medical judgment, illegal or unethical. *Healthcare Executive, 22*(5), 34, 36-37.

O'Connell, M. J., & Stein, C. H. (2005). Psychiatric advance directives: perspectives of community stakeholders. *Administration and Policy Mental Health*, *32*(3), 241-265.

O'Reilly, R. (2004). Why are community treatment orders controversial? *Canadian Journal of Psychiatry*, *49*(9), 579-584.

O'Reilly, R. L. (2008). The capacity to execute an advance directive for psychiatric treatment. *International Journal of Law and Psychiatry, 31*(1), 66-71.

Papageorgiou, A., Janmohamed, A., King, M., Davidson, O., & Dawson, J. (2004). Advance directives for patients compulsorily admitted to hospital with serious mental disorders: Directive content and feedback from patients and professionals. *Journal of Mental Health, 13*(4), 379-388.

Patterson, C., Molloy, D. W., Guyatt, G. H., Bedard, M., North, J., Hassard, J. et al., (1997). Systematic implementation of an advance health care directive in the community. *Canadian Journal of Nursing Administration, 10*(2), 96-108.

Pearlman, R. A. (1994). Are we asking the right questions? *The Hastings Center Report*, *24*(6), S 24-27.

Peck, M. C., & Scheffler, R. M. (2002). An analysis of the definitions of mental illness used in state parity laws. *Psychiatric Services*, *53*(9), 1089-1095.

Pellegrino, E. D. (1992). Ethics. *Journal of the American Medical Association, 268*(3), 354-355.

Pellegrino, E. D. (1994). Patient and physician autonomy: Conflicting rights and obligations in the physician-patient relationship. *The Journal of Contemporary Health Law & Policy, 10*, 47-68.

Pellegrino, E. D., & Thomasma, D. C. (1987). The conflict between autonomy and beneficence in medical ethics: Proposal for a resolution. *The Journal of Contemporary Health Law and Policy, 3*, 23-46.

Perling, L. J. (1993). Health care advance directives: Implications for Florida mental health patients. University of Miami Law Review, 48, 193-228.

Peters, C., & Chiverton, P. (2003). Use of a values history in approaching medical advance directives with psychiatric patients. *Journal of Psychosocial Nursing & Mental Health Services, 41*(8), 28-36.

Poletiek F. H. (2002). How psychiatrists and judges assess the dangerousness of persons with mental illness: An 'expertise bias.' *Behavioural Sciences and Law*, *20*(1-2), 19-29.

Preference Collaborative Review Group. (2008). Patients' preferences within randomised trials: Systematic review and patient level meta-analysis, *British Medical Journal,* 337, a1864.

Pullman, D. (1999). The ethics of autonomy and dignity in long-term care. *Canadian Journal of Aging, 18*(1), 26-46.

Quante, M. (1999). Precedent autonomy and personal identity. *Kennedy Institute of Ethics Journal, 9*(4), 365-381.

Quill, T. E., & Brody, H. (1996). Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Annals of Internal Medicine, 125*(9), 763-769.

Radden, J. (1994). Second thoughts: Revoking decisions over one's own future. *Philosophy and Phenomenological Research*, *54*(4), 787-801.

Rain, S. D., Steadman, H. J., & Robbins, P. C. (2003). Perceived coercion and treatment adherence in an outpatient commitment program. *Psychiatric Services, 54*(3), 399-401.

Range, L. M., Campbell, C., Kovac, S. H., Marion-Jones, M., Aldridge, H., Kogos, S. et al., (2002). No-suicide contracts: An overview and recommendations. *Death Studies, 26*(1), 51-74.

Redman, B. K. (2003). Review of measurment instruments in clinical and research ethics. *Journal of Medical Ethics, 32*(3), 153-156.

Rhoden, N. K. (1982). Can a subject consent to a 'Ulysses Contract'? *The Hastings Center Report*, *12*(4), 26-28.

Rich, B. A. (2006). Medical paternalism v. respect for patient autonomy: The more things change the more they remain the same. *Michigan State University College of Law Journal of Medicine and Law, 10*, 87-124.

Riley, R., & Richman A. (1983). Involuntary hospitalization in Canadian psychiatric inpatient facilities. *Canadian Journal of Psychiatry*, *28*(7), 536-541.

Ritchie, J., Sklar, R., & Steiner, W. (1998). Advance directives in psychiatry. Resolving issues of autonomy and competence. *International Journal of Law and Psychiatry*, *21*(3), 245-260.

Robertson, G. B. (1991). Living wills/advance directives - A legal view. *Health Law Review*, *1*(1), 3-6.

Robertson, G. B. (1994). Ontario's new informed consent law: Codification or radical change? *Health Law Journal, 2,* 88-98.

Robertson, J. A. (1991). Second thoughts on living wills. *The Hastings Center Report*, *21*(6), 6-9.

Robertson, J. A. (2003). Precommitment issues in bioethics. *Texas Law Review, 81*(7), 1849-1876.

Robins, C. S., Ware, N. C., dosReis, S., Willging, C. E., Chung, J. Y., & Lewis-Fernandez, R. (2008). Dialogues on mixed-methods and mental health services research: Anticipating challenges, building solutions. *Psychiatric Services, 59*(7), 727-731.

Rogers, A., Day, J., Randall, F., & Bentall, R. P. (2003). Patients' understanding and participation in a trial designed to improve the management of anti-psychotic medication: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, *38*(12), 720-727.

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services, 48*(8), 1042-1047.

Rosen, B. (1978). Written treatment contracts: Their use in planning treatment programmes for in-patients. *British Journal of Psychiatry*, *133*, 410-415.

Rosenfeld, E. A. (2001). Mental health advance directives: A false sense of autonomy for the nation's aging population. *Elder Law Journal*, *9*, 53-81.

Rosenson, M. K., & Kasten, A. M. (1991). Another view of autonomy: Arranging for consent in advance. *Schizophrenia Bulletin, 17*(1), 1-7

Sam, M., & Singer, P. A. (1993). Canadian outpatients and advance directives: Poor knowledge and little experience but positive attitudes. *Canadian Medical Association Journal, 148*(9), 1497-1502.

Samanta, A., & Samanta, J. (2006). Advance directives, best interests and clinical judgement: Shifting sands at the end of life. *Clinical Medicine*, *6*(3), 274-278.

Sass, H. M. (2003). Advance directives for psychiatric patients? Balancing paternalism and autonomy. *Wien Med Wochenschr, 153*(17-18), 380-384.

Schalock R. L., Luckasson, R. A., & Shogren, K. A. (2007). The renaming of mental retardation: Understanding the change to the term intellectual disability. *Intellectual and Development Disabilities, 45*(2), 116-124.

Scheyett, A. (2008). Psychiatric advance directives: Benefits and barriers. *Current Psychiatry Reviews, 4*(3), 137-144.

Scheyett, A. (2009). Autonomy and the use of directive intervention in the treatment of individuals with serious mental illnesses: A survey of social work practitioners. *Social Work in Mental Health, 7*(4), 283-306.

Scheyett, A. Kim, M. M., Swanson, J. W., & Swartz, M. S. (2007). Psychiatric advance directives: A tool for consumer empowerment and recovery. *Psychiatric Rehabilitation Journal, 31*(1), 70-75.

Scheyett, A., Kim, M., Swanson, J., Swartz, M., Elbogen, E., Van dorn, R. et al., (2008). Social workers' familiarity with psychiatric advance directives: Implications for education, practice, and research. *Families in Society: The Journal of Contemporary Social Services, 89*(2), 228-236.

Schneider, R. (1995). Mental disorder and the courts: Psychiatric gating. *Criminal Lawyers' Association Newsletter*, *16*(2), 18-21.

Schurhofer, M., & Peschl, M. (2005). Autonomy: Starting point and goal of personal and social change: A constructivist perspective on knowledge management in empowerment processes. *Kybernetes, 34*(1/2), 261.

Schwartz, H. I., Vingiano W., & Perez, C. B. (1998). Autonomy and the right to refuse treatment: Patients' attitudes after involuntary medication. *Hospital & Community Psychiatry: A Journal of the American Psychiatric Association*, 39(10), 1049-1054.

Segal, S. P., Laurie, T. A., & Segal, M. J. (2001). Factors in the use of coercive retention in civil commitment evaluations in psychiatric emergency services. *Psychiatric Services*, *52*(4), 514-520.

Shewchuk, T. R. (1998). Completing advance directives for health care decisions: Getting to yes. *Psychology, Public Policy, and Law, 4*(3), 703-718.

Shulman, K. I., Cohen, C. A., & Hull, I. (2005). Psychiatric issues in retrospective challenges of testamentary capacity. *International Journal of Geriatric Psychiatry, 20*(1), 63-69.

Silberfeld, M. (1995). Sacrificing patient autonomy? *Health Law in Canada, 16*(1), 14-16.

Silberfeld, M., Nash, C., & Singer, P. A. (1993). Capacity to complete an advance directive. *Journal of the American Geriatrics Society, 41*(10), 1141-1143.

Singer, P. A., Choudry S., & Armstrong, J. (1993). Public opinion regarding consent to treatment. *Journal of the American Geriatrics Society, 41*(2), 112-116

Singer, P.A., Choudry, S., Armstrong, J., Meslin, E.M., & Lowy, F.H. (1995). Public opinion regarding end-of-life decisions: Influence of prognosis, practice, and process. *Social Science & Medicine*, *41*(11), 1517-1521.

Singer, P. A., Robertson G., & Roy, D. J. (1996). Bioethics for clinicians: 6. Advance care planning. *Canadian Medical Association Journal, 155*(12), 1689-1692.

Sklar, R. (2007). Starson v. Swayze: The Supreme Court speaks out (not all that clearly) on the question of "capacity." *Canadian Journal of Psychiatry, 52*(6), 390-395

Slovenko, R. (2000). Civil commitment laws: An analysis and critique. *Cooley Law Review, 17*(1), 25-51.

Somerville, M. A. (1994). Labels versus contents: variance between philosophy, psychiatry and law in concepts governing decision-making. *McGill Law Journal, 39*(1), 179-199.

Spellecy, R. (2003). Reviving Ulysses contracts. *Kennedy Institute of Ethics Journal, 13*(4), 373-392

Srebnik, D., & La Fond, J. Q. (1999). Advance directives for mental health treatment. *Psychiatric Services, 50*(7), 919-925.

Srebnik D., & Brodoff, L. (2003). Implementing psychiatric advance directives: Service provider issues and answers. *Journal of Behavioral Health Services & Research, 30*(3), 253-268.

Srebnik, D., Appelbaum, P. S., & Russo, J. (2004). Assessing competence to complete psychiatric advance directives with the competence assessment tool for psychiatric advance directives. *Comprehensive Psychiatry, 45*(4), 239-245.

Srebnik, D., Rutherford, L. T., Peto, T., Russo, J., Zick, E., Jaffe, C. et al., (2005). The content and clinical utility of psychiatric advance directives. *Psychiatric Services, 56*(5), 592-598.

Srebnik, D., & Kim, S. Y. (2006). Competency for creation, use, and revocation of psychiatric advance directives. *The Journal of American Academy of Psychiatry and the Law, 34*(4), 501-510.

Srebnik, D., & Russo, J. (2007). Consistency of psychiatric crisis care with advance directive instructions. *Psychiatric Services, 58*(9), 1157-1163.

Srebnik, D., & Russo, J. (2008). Use of psychiatric advance directives during psychiatric crisis events. *Administration and Policy in Mental Health, 35*(4), 272-282.

Stiggelbout, A. M., Molewijk, A. C., Otten, W., Timmermans, D. R., van Bockel, J. H., & Kievit, J. (2004). Ideals of patient autonomy in clinical decision making: A study on the development of a scale to assess patients' and physicians' views. *Journal of Medical Ethics, 30*(3), 268-274.

Stiggelbout, A. M., Molewijk, A. C., Otten, W., Van Bockel, J. H., Bruijninckx, C. M., Van der Salm, I. et al., (2008). The impact of individualized evidence-based decision support on aneurysm patients' decision making, ideals of autonomy, and quality of life. *Medical Decision Making, 28*(5), 751-762.

Sugarman J., Powe, N. R., Brillantes, D., & Smith, M. K. (1993). The cost of ethics legislation: A look at the Patient Self-Determination Act. *Kennedy Institute of Ethics Journal, 3*(4), 387-399.

Sutherby, K., Szmukler, G.I., Halpern, A., Alexander, M., Thornicroft, G., Johnson, C. et al., (1999). A study of 'crisis cards' in a community psychiatric service. *Acta Psychiatra Scandinavica, 100*(1), 56-61.

Swanson, J. W., & Van McCrary, S. (1996). Medical futility decisions and physicians' legal defensiveness: The impact of anticipated conflict on thresholds for end-of-life treatment. *Social Science & Medicine, 42*(1), 125–132;

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., Swartz, M. S., Hannon, M. J., Elbogen, E. B., Wagner, H. R., McCauley, B. J., & Butterfield, M. I. (2003). Psychiatric advance directives: A survey of persons with schizophrenia, family members, and treatment providers. *International Journal of Forensic Mental Health, 2*(1), 73-86.

Swanson, J. W., McCrary, S. V., Swartz, M. S., Elbogen, E. B., & Van Dorn, R. A. (2006). Superseding psychiatric advance directives: Ethical and legal considerations. *The Journal of the American Academy of Psychiatry and the Law, 34*(3), 385-394.

Swanson, J., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Ferron, J., Wagner, H. R. et al., (2006). Facilitated psychiatric advance directives: A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *American Journal of Psychiatry, 163*(11), 1943-1951.

Swanson, J. W., Swartz, M., Ferron, J., Elbogen, E., & Van Dorn, R. (2006). Psychiatric advance directives among public mental health consumers in five U.S. cities: Prevalence, demand, and correlates. *Journal of the American Academy of Psychiatry and the Law, 34*(1), 43-57.

Swanson, J. W., Van McCrary, S., Swartz, M. S., Van Dorn, R. A., & Elbogen, E. B. (2007). Overriding psychiatric advance directives: Factors associated with psychiatrists' decisions to preempt patients' advance refusal of hospitalization and medication, *Law and Human Behavior, 31*(1), 77-90.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A. et al., (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*(3), 255-267.

Swartz, M. S., Swanson, J. W., Ferron, J., Elbogen, E. B., Van Dorn, R., Kim, M. et al., (2005). Psychiatrists' views and attitudes about psychiatric advance directives. *International Journal of Forensic Mental Health, 4*(2), 107-117.

Swartz, M. S. & Swanson, J. W. (2007). Commentary: Psychiatric advance directives and recovery-oriented care. *Psychiatric Services, 58*(9), 1164.

Szasz, T. S. (1982). The psychiatric will. A new mechanism for protecting persons against "psychosis" and psychiatry. *American Psychologist, 37*(7), 762-770.

Szasz, T. S. (1998). Parity for mental illness, disparity for the mental patient. *Lancet, 352*(9135), 1213-1215.

Szmukler, G., & Dawson, J. (2006). Commentary: Toward resolving some dilemmas concerning psychiatric advance directives. *Journal of the American Academy of Psychiatry and the Law, 34*(3), 398-401.

Tan J. O. A. & McMillan, J. R. (2004). The discrepancy between the legal definition of capacity and the British Medical Association's guidelines. *Journal of Medical Ethics, 30*(5), 427-429.

Tapp, A. (2006). Advance directives. *Canadian Nurse, 102*(2), 26.

Tauber, A. I. (2001). Historical and philosophical reflections on patient autonomy. *Health Care Analysis, 9*(3), 299-319.

Tauber, A. I. (2003). Sick autonomy. *Perspectives in Biology and Medicine, 46*(4), 484-495.

Templer D. I., & Veleber, D. M. (1980). The moon and madness: A comprehensive perspective. *Journal of Clinical Psychology, 36*(4), 865-868.

Tilbrook, H. (2008). Patients' preferences within randomised trials: Systematic review and patient level meta-analysis. *British Medical Journal, 337,* a1864.

Van Citters, A. D., Naidoo, U., & Foti, M. E. (2007). Using a hypothetical scenario to inform psychiatric advance directives. *Psychiatric Services, 58*(11), 1467-71.

Van Dorn, R. A., Swanson, J. W., Swartz, M. S., Elbogen, E., & Ferron, J. (2008). Reducing barriers to completing psychiatric advance directives. *Administration Policy Mental Health and Mental Health Services Research, 35*(6), 440-448.

Van Dorn, R. A., Swartz, M. S., Elbogen, E. B., Swanson, J. W., Kim, M., Ferron, J. et al., (2006). Clinicians' attitudes regarding barriers to the implementation of psychiatric advance directives. *Administration Policy Mental Health and Mental Health Services Research, 33*(4), 449-460.

Van McCrary, S., Swanson, J. W., Coulehan, J., Faber-Langendoen, K., Olick, R. S., & Belling, C. (2006). Physicians' legal defensiveness in end-of-life treatment decisions: Comparing attitudes and knowledge in states with different laws. *The Journal of Clinical Ethics, 17*(1), 15-26.

van Willigenburg, T., & Delaere, P. (2005). Protecting autonomy as authenticity using Ulysses contracts. *Journal of Medicine and Philosophy, 30*(4), 395-409.

Varekamp, I. (2004). Ulysses directives in the Netherlands: Opinions of psychiatrists and clients. *Health Policy, 70*(3), 291-301

Velligan, D., Prihoda, T., Dennehy, E., Biggs, M., Shores-Wilson, K., Crismon, M. L. et al., (2005). Brief psychiatric rating scale expanded version: How do new items affect factor structure? *Psychiatry Research, 135*(3), 217-228.

Wagner, L. C., Fleck, M. P., Wagner, M., & Dias, M. T. (2006). Autonomy of long-stay psychiatric inpatients. *Revisita de Saude Publica, 40*(4), 699-705.

Weisstub D. N., & Moorhouse, A. (1996). Advance directives for research: Ethical guidelines. *Health Law in Canada, 17*(1), 3-10.

Wenger N. S. & Halpern, J. (1994). The physician's role in completing advance directives: Ensuring patients' capacity to make healthcare decisions in advance. *The Journal of Clinical Ethics, 5*(4), 320-323.

Werth, J.L. (2001). Involuntary mental health commitment statues: Requirements for persons perceived to be a potential harm to self. *Suicide and Life-Threatening Behavior, 31*(3), 348-357.

Wexler, D. B. (1996). Therapeutic jurisprudence in clinical practice. *American Journal of Psychiatry 153*(4), 453-455.

Whitley, R. & Crawford, M. (2005). Qualitative research in psychiatry. *Canadian Journal of Psychiatry, 50*(2), 108-114.

Widdershoven, G. & Berghams, R. (2001). Coercion and pressure in psychiatry: Lessons in psychiatry. *Journal of Medical Ethics, 33,* 560-563.

Widdershoven, G., & Berghmans, R. (2001). Advance directives in psychiatric care: A narrative approach. *Journal of Medical Ethics, 27*(2), 92-97.

Wilder, C. M., Elbogen, E. B., Swartz, M. S., Swanson, J. W., & Van Dorn, R. A. (2007). Effect of patients' reasons for refusing treatment on implementing psychiatric advance directives. *Psychiatric Services,* 58(10), 1348-1350.

Wilder, C. M., Elbogen, E. B., Moser, L. L., Swanson, J. W., & Swartz, M. S. (2010). Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. *Psychiatric Services, 61*(4), 380-385.

Williams, E. A. (2008). Gags, funnels and tubes: Forced feeding of the insane and of suffragettes. *Endeavour, 32*(4), 134-140.

Wilson, S. (1996). Consumer empowerment in the mental health field. *Canadian Journal of Community Mental Health, 15*(2), 69-85.

Winick, B. J. (1991). Competency to consent to treatment: The distinction between assent and objection. *Houston Law Review, 28*(1), 15-61.

Winick, B. J. (1996). Advance directive instruments for those with mental illness. *University of Miami Law Review, 51*(1), 7-95.

Winick, B. J. (1998). Foreword: Planning for the future through advance directive instruments. *Psychology, Public Policy, and Law, 4*(3), 579-609.

Winninger D. & Pineau, L. (1995). Incapacity and autonomy: Striking a balance. *Health Law in Canada, 15*(3), 59-64.

Winston, E., & Winston S. M. (1982). Can a subject consent to a 'Ulysses Contract'? *The Hastings Center Report*, *12*(4), 26-28.

Wolfe S. M., Boyle, P., Callahan, D., Fins, J. J., Jennings, B., Nelson, J. L., et al. (1991). Sources of concern about the Patient Self-Determination Act. *New England Journal of Medicine, 325*, 1666-1671.

Wowra, S. A., & McCarter, R. (1999). Validation of the empowerment scale with an outpatient mental health population. *Psychiatric Services, 50*(7), 959-961.

Books, Reports, Unpublished Materials, and Miscellaneous Media

Books

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Amering, M. & Schmolke, M. (2009). *Recovery in mental health: Reshaping scientific and clinical responsibilities*. Chichester, England; Hoboken, NJ: Wiley-Blackwell.

Appelbaum, P. S., & Grisso, T. (2001). *MacCAT-CR - MacArthur competence assessment tool for clinical research*. Sarasota: FL: Professional Resource Press.

Appelbaum, P. S., & Guteil, T.S. (2007). *Clinical handbook of psychiatry and the law* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Arboleda-Florez J. & Weisstub, D. N. Ethical research with vulnerable populations: The mentally disordered" in D. N. Weisstub (ed), *Research on human subjects: Ethics, law, and social policy* (Oxford: Pergamon, 1998).

Atkinson, J. M. (2007). *Advance directives in mental health: Theory, practice and ethics*. London: Jessica Kingsley Publishers.

Beauchamp, T. L. (2010). *Standing on principles: Collected essays*. New York: Oxford University Press.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.

Black, H. S. (2009). *Wills and estates cases, text, and materials*. Toronto: Emond Montgomery.

Cook, A. (1967). *The Odyssey*. New York: W.W. Norton & Company.

Creswell, J. W., & Plano-Clark, V. L. (2003). *Designing and conducting mixed methods research*. Thousand Islands: Sage Publications.

Deleury, E. & Goubau, D. (2002). *Le droit des personnes physiques* (3rd ed.). Cowansville, Québec: Les Éditions Yvon Blais.

Diesfeld, K. & Freckelton, I. (2003). Introduction. In K. Diesfeld & I. Freckelton (Eds.), *Involuntary detention and therapeutic Jurisprudence: International perspectives on civil commitment.* Aldershot, England; Burlington: Ashgate.

Elster, J. (2000). *Ulysses unbound*. Cambridge: Cambridge University Press.

Foucault, M. (2000). *Power: Essential works of Foucault, 1954-1984, Volume 3* (J. D. Faubion & R. H. Hurley, Trans.). New York: New Press.

Gauthier, S., Dupin, F., Panisset, M. (2001). Comment déterminer l'aptitude du mandant? In Formations permanente du Barreau du Québec (Ed.), *Les mandats en cas d'inaptitude : une panacée?* Cowansville: Les Éditions Yvon Blais.

Gray, J. E., Shone, M. A. & Liddle, P. F. (2008). *Canadian mental health law and policy* (3rd ed.). Markham, Ontario: LexisNexis.

Gribich, C. (2007). *Qualitative data analysis: An introduction*. London: Sage.

Gupta, M. (2003). All locked up with nowhere to go, treatment refusal in the involuntary hospitalized population of Canada, In K. Diesfeld & I. Freckelton (Eds.), *Involuntary detention and therapeutic jurisprudence: International perspectives on civil commitment.* Aldershot, England; Burlington: Ashgate.

Hosmer, D. C. & Lemeshow, S. (2000). *Applied logistic regression* (2nd ed.) New York: John Wiley & Sons.

Howell, T., Diamond, R. J., & Wikler, D. (1982). Is there a case for voluntary commitment? In T. Beauchamp et al., (Eds.), *Contemporary issues in bioethics*. Belmont, CA: Thomson/Wadsworth.

Iyengar, S. (2010). *The art of choosing*. New York, NY: Twelve.

MacNeil, I. (1980). *The new social contract: An inquiry into modern contractual relations*. New Haven: Yale University Press.

Miller, R. D. (1987). *Involuntary civil commitment of the mentally ill in the post-reform era*. Springfield, Illinois: Charles C Thomas.

Molloy, W. (1992). *Let me decide: The health care directive that speaks for you when you can't.* Toronto: Penguin Books.

Mulcahy, L. (2008). *Contract law in perspective* (5th ed.). London; New York: Routledge-Cavendish.

Pinel, P. (1806). *A treatise on insanity* (D. D. Davis, Trans.). Sheffield: Todd.

Radden, J. (1996). *Divided minds and successive selves: Ethical issues in disorders of identity and personality*. Cambridge, Mass.: MIT Press.

Schopp, R. F. (2001). *Competence, condemnation, and commitment*. Washington D.C.: American Psychological Association.

Slobogin, C. (2006). *Minding justice*. Cambridge, Mass.: Harvard University Press.

Smith, S.A., (2009). The limits of contract. In J. W. Neyers, R. Bronaugh, & S. G. A. Pitel (Eds.), *Exploring contract law*. Oxford; Portland, Or.: Hart Pub.

Stone, A. (1975). *Mental health and law: A system in transition*. Rockville, Md.: National Institute of Mental Health, Center for Studies of Crime and Delinquency.

Sweatman, M. J. (2002). *Guide to powers of attorney*. Aurora: Canada Law Book.

Vine, R. (2003). Decision-making by psychiatrists about involuntary detention, In K. Diesfeld & I. Freckelton (Eds.), *Involuntary detention and therapeutic jurisprudence: International perspectives on civil commitment.* Aldershot, England; Burlington: Ashgate.

Wexler, D. B., & Winick, B. J. (1991). *Essays in therapeutic jurisprudence*. Durham, NC: Carolina Academic Press.

Whitaker, R. (2010). *Anatomy of an epidemic: magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishers.

Widdershoven, G. (2007). *Empirical ethics in psychiatry*. Oxford; New York: Oxford University Press.

Winick B., (2003). A therapeutic jurisprudence model for civil commitment, In K. Diesfeld & I. Freckelton (Eds.), *Involuntary detention and therapeutic Jurisprudence: International perspectives on civil commitment.* Aldershot, England; Burlington: Ashgate.

Winick, B. J. (2005). *Civil commitment: A therapeutic jurisprudence model*. Durham, NC: Carolina Academic Press.

Reports, Unpublished Materials, and Miscellaneous Materials

Albert Law Reform Institute & The Health Law Institute. (1993, March). *Advance directives and substitute decision-making in personal health care*. Retrieved February 1, 2011 from the Faculty of Law University of Alberta Website: http://www.law.ualberta.ca/alri/docs/fr064.pdf.

Alberta Justice and Alberta Seniors Community Supports. (2007, January). *Legislative review of the Dependents Adults Act and the Personal Directives Act: Stakeholder consultations summary*. Retrieved February 1, 2011 from the Government of Alberta Seniors and Community Supports Website: http://www.seniors.alberta.ca/services_resources/opg/leg_review/StakeholderConsultations.pdf

Attorney General of the Province of British Columbia. (2002). *Review of representation agreements and enduring powers of attorney*. British Columbia: A. J. McClean, Ministry of Attorney General. Retrieved February 1, 2011 from: http://www.ag.gov.bc.ca/public/McClean-Report.pdf.

Bach M., & Kerzner L. (2010). A new paradigm for protecting autonomy and the right to legal capacity. Ontario: Law Commission of Ontario.

Bazelon Center for Mental Health Law. (2010). Psychiatric advance directive. Retrieved February 1, 2011 from http://www.bazelon.org.

Campbell, L. A., & Kisely, S. R. (2009). Advance treatment directives for people with severe mental illness. *Cochrane Database of Systematic Reviews,* 2009(1), Article No.: CD005963. Retrieved January 18, 2011 from http://www.thecochranelibrary.com/view/0/index.html.

Canadian Hospice Palliative Care Association. (2010). *Advance care planning in Canada: National framework for consultation*. Ottawa: Canada Hospice Palliative Care Association. Retrieve February 1, 2011 from: http://www.chpca.net/advance_care_planning_index.

Canadian Institute Health Information. *Total patient days and average length of stay related to mental illness separations, 2005-2006*. Retrieved February 1, 2011 from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_topic_mentalhealth_e&cw_topic=Health%20Services&cw_subtopic=Hospital%20Mental%20Health%20Services.

Canadian Institute for Health Information. (2008, April). *Hospital length of stay and readmission for individuals diagnosed with schizophrenia: Are they related?* Retrieved February 1, 2011 from: http://secure.cihi.ca/cihiweb/products/aib_los_and_readmission08_e.pdf.

Canadian Institute for Health Information. (2009, March). *Analysis in brief, exploring hospital mental health service use in Ontario, 2007-2008*. Retrieved February 1, 2011 from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_2813_E.

Douglas Mental Health University Institute (DMHUI). (2005). *Code of ethics*. Montréal, QC: DMHUI. Retrieved February 1, 2011 from: http://www.douglas.qc.ca/publications/17/file_fr/code-ethique-en.pdf.

Dunbrack, J. (2006, August). *Advance care planning: the Glossary project*. Ottawa: Health Canada. Retrieved January 18, 2011 from: http://www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2006-proj-glos/index-eng.php.

Gagné, P., Joncas, L. & Carette, D. (1993, June). *The renaissance of custodial psychiatry*. Pater presented at the meeting of the International Academy of Law and Mental Health, Lisbon, Portugal.

Government of Alberta Seniors and Community Supports. (2010). *Personal directives registry*. Retrieved February 1, 2011 from: http://www.seniors.alberta.ca/opg/registry/.

Kirby, M. (2004). *Mental health, mental illness and addiction: Issues and options for Canada, Report 3*. Ottawa: Standing Senate Committee on Social Affairs. Retrieved February 1, 2011 from: http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report3/repintnov04vol3-e.pdf.

Manitoba Law Reform Commission. (1991). *Self-determination in health care (living wills and health care proxies).* Manitoba: Law Reform Commission.

Manitoba Law Reform Commission. (2004, October). *Substitute consent to health care*. Manitoba: Law Reform Commission, 2004) Retrieved February 1, 2011 from: http://www.gov.mb.ca/justice/mlrc/reports/110.pdf.

McLachlin, B., Chief Justice (2005). *Research views.* Alberta Heritage Foundation for Medical Research: Research News. From: http://www.ahfmr.ab.ca/publications.html

Mental Health Commission of Canada. (2009). *Toward recovery and well-being: A framework for a mental health strategy for Canada*. Ottawa: Canada. Retrieved February 1, 2001 from the Mental Health Commission of Canada Website: http://www.mentalhealthcommission.ca.

National Assembly of Québec (2010, May). *Dying with dignity*. Québec: Government of Québec. Retrieved January 18, 2011 from http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/actualite-21205.html.

Oxford English Dictionary (2011). Retrieved February 19, 2011 from: http://www.oed.com/.

Patton, L., & Simpson, D. (2002, July). *Psychiatrist charged*. Retrieved February 1, 2011 from the Psychiatrist Patient Advocate Office Website: http://www.ppao.gov.on.ca/med-pre-psy.html.

Provencher, C. & Hébert, A. (1999). *Quand la liberté ne tient qu'à…*". Étude de l'application de la loi, Région de Montréal Action Autonomie Le Collectif pour la défense des droits en santé mentale de Montréal.

Public Curator of Québec. (2009). *My mandate in case of incapacity*. Québec: Government of Québec. Retrieved January 18, 2011 from: http://www.curateur.gouv.qc.ca/cura/publications/mandatE.pdf.

Registres des dispositions testamentaires et des mandats du Québec. (2010). Retrieved January 18, 2011 from: http://www.rdtmq.org

Rush, J. (2005). *Stillborn autonomy: why the Representation Agreement Act of British Columbia fails as advance directive legislation*. Unpublished master's thesis, University of British Columbia.

SPSS Inc. (2008). SPSS Base 17.0 for Windows User's Guide. SPSS Inc., Chicago IL.

UK Mental Health Foundation. (2010). *Assessing mental capacity*. Retrieved February 1, 2011 from: http://www.amcat.org.uk

US Living Will Registry®. (2010). Retrieved February 1, 2011 from: http://www.uslivingwillregistry.com/.

World Health Organization. (2005). *WHO resource book on mental health, human rights and legislation*. Geneva: Switzerland. Retrieved February 1, 2011 from: http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf.

Case Law

Canadian Jurisprudence

A.B. v. C.D., [2009] B.C.J. No. 914 (B.C.C.A.).

A.C. v. Manitoba (Director of Child and Family Services), [2009] S.C.J. No. 30.

A.M. v. Benes, [1998] O.J. No. 4333. (Ont. S.C.).

Abrams v. Abrams, [2008] O.J. No. 5207 (Ont. S.C.).

Afemui v. Pearce, [2009] O.J. No. 2397.

Alberta v. Hutterian Brethren of Wilson Colony, [2009] 2 S.C.R. 567.

Allan v. Patterson, [2000] B.C.J. No. 2791; 2000 BCSC 1525.

Blencoe v. British Columbia (Human Rights Commission), [2000] 2 S.C.R. 307.

Bolt v. Popke, [2003] A.J. No. 613; 2003 ABCA 156.

C.B. v. Sawadsky, [2005] O.J. No. 3682.

C.B. v. Sawadsky, [2006] O.J. No. 4050.

C.B. v. Sawadsky, [2006] S.C.C.A. No. 479.

C.L. v. Hurdalek, [1997] O.J. No. 2572.

Canada (Minister of Citizenship and Immigration) v. Fast, [2001] F.C.J. No. 1730.

Chaoulli v. Québec (Attorney General), [2005], 1 S.C.R. 791

Conway v. Darby, [2008] O.J. No. 4205.

D.M. c. *Dr Prosper*, 22 décembre 2004, 500-09-015164-049 (Que. C.A.).

D'Almeida v. Barron, [2008] O.J. No. 2945.

Deacon v. Canada (Attorney General), [2006] F.C.J. No. 1153.

E v. Board of the Foothills General Hospital, [2003] A.J. No. 1563.

Eastern Regional Integrated Health Authority v. B.A.H. et al., [2007] N.J. No. 48; 2007 NLTD 30.

Fleming v. Reid, (1991), 4 O.R. (3d) 74 (Ont. C.A.).

Fraser (Re), [1911] O.J. No. 67.

Institut Philippe Pinel de Montréal c. *G.*, [1994] R.J.Q. 2523.

Institut Philippe Pinel de Montréal v. A.M., [2001] Q.J. No. 1554.

Institut Philippe Pinel de Montréal v. Gharavy, [1994] J.Q. no 837.

Kischer v. Kischer, [2009] O.J. No. 96 (Ont. S.C.).

L.P. c. F.H., [2009] J.Q. no 4771 (Que. C.A.).

Lajoie c. *Commission Québécoise d'examen et PGPQ*, [1994] R.J.Q. 607, 61 (Que. C.A.).

Landeryou v. Campbell Jr., [1952] S.C.J. No. 58.

Lavoie v. Canada, [2002] 1 S.C.R. 769.

M.B. v. Alberta (Minister of Health), [1997] A.J. No. 649; 149 D.L.R. (4th) 363.

Malette v. Shulman, [1990] O.J. No. 450; 72 O.R. (2d) 417 (Ont. C.A.).

Manitoba (Director of Child and Family Services) v. A.C., [2007] M.J. No. 26; 2007 MBCA 9 (Man. C.A.).

Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services) [2006] 1 S.C.R. 326.

Mullins v. Levy, [2009] B.C.J. No. 23 (B.C.C.A.).

Murphy v. McSorley, [1929] S.C.J. No. 36.

O'Neil v. Brown Estate, [1946] S.C.R. 622; S.C.J. No. 31.

Ocean v. Economical Mutual Insurance Co., [2009] N.S.J. No. 332.

Ouderkirk v. Ouderkirk, [1936] S.C.R. 619; S.C.J. No. 42.

P.H. v. Eastern Regional Integrated Health Authority, [2010] N.J. No. 59.

Penetanguishene Mental Health Centre v. Ontario (Attorney General), [2004] 1 S.C.R. 498.

Petrowski v. Petrowski, [2009] A.J. No. 353.

Pike v. Stone, [1999] N.J. No. 217.

Pinet v. St. Thomas Psychiatric Hospital, [2004] 1 S.C.R. 528.

Professor Starson v. Dr. Mark Pearce, [2009] O.J. No. 21.

R. v. Demers, [2004] 2 S.C.R. 489.

R. v. Leach, [2007] O.J. No. 5092.

R. v. *Lenard*, (1998)123 C.C.C. (3d) 353.

R. v. Lenart, 39 O.R. (3d) 55.

R. v. Morgentaler, [1988] 1 S.C.R. 30.

R. v. Piamonte, [2006] O.J. No. 2814.

R. v. Rosete, [2006] O.J. No. 1608.

R. v. Rosete, [2007] O.J. No. 3273.

R. v. Simanek, [2001] O.J. No. 4187.

R. v. Swain, [1991] 1 S.C.R. 933; S.C.J. No. 32.

Rault v. Law Society of Saskatchewan, [2009] S.J. No. 436 (Sask. C.A.).

Re Weidenberger Estate (Re) [2002] A.J. No. 1157; 2002 ABQB 861.

Reference re: s. 94(2) of the Motor Vehicle Act (British Columbia), [1985] 2 S.C.R. 486.

Rodriguez v. British Columbia (Attorney General), [1993] 3 S.C.R. 519.

S.C. v. M.B., [2008] A.J. No. 1093; 2008 ABCA 336.

S.R. v. Hutchinson, [2009], O.J. No. 516.

Saskatoon Regional Health Authority v. A.B., [2005] S.J. No. 187.

Scardoni v. Hawryluck, [2004] O.J. No. 300.

Serdahely Estate (Re), [2005] A.J. No. 1620; 2005 ABQB 861.

Singh v. Canada (Minister of Employment and Immigration), [1985] 1 S.C.R. 177.

Starnaman v. Penetanguishene Mental Health Centre, [1995] O.J. 2130 (Ont. C.A.).

Starson v. Swayze, [2003] 1 S.C.R. 722; 2003 SCC 32.

Strong (Re), [1993] N.J. No. 83.

Sweiss v. Alberta Health Services, [2009] A.J. No. 1303; 2009 ABQB 691.

T and Board of Review for the Western Region et al., [1983] O.J. No. 3249.

Van Wijngaarden v. Tzalalis, [1997] O.J. No. 2408.

Villemure v. Turcot, [1973] S.C.R. 716.

Vout v. Hay, [1995] S.C.J. No. 58.

Wright v. Wright, [1951] S.C.R. 728.

American Jurisprudence

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).

Hargrave v. Vermont, 340 F.3d 27 (2d Cir 2003).

In the Matter of A.A., An Alleged Incapacitated Person, 381 N.J. Super. 334; 885 A.2d 974 (2005).

Matter of Kufeld, 51 A.D.3d 483, 859 N.Y.S.2d 119 (N.Y. App. Div. 1st Dep’t, 2008).

Prot. Advocacy v. City of Albuquerque, 2008 N.M. LEXIS 533 (N.M., Sept. 19, 2008).

Schloendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E. 92 (1914).

English Jurisprudence

Banks v. Goodfellows, (1870) L.R. 5 Q.B. 549.

re Bulger, (1911) 1 W.W.R. 248.

Re C (Adult: Refusal of Treatment), [1994] 1 WLR 290.

Re T (Adult: Refusal of Treatment) [1992] 3 W.L.R. 782.

Legislation and Regulations

Adult Guardianship Act, R.S.B.C. 1996, c. 6.

Adult Guardianship and Co-Decision-Making Act, S.S. 2000, c. A-5.3.

Adult Protection Act, R.S.N.S. 1989, c. 2.

Advance Health Care Directives Act, S.N.L. 1995, c. A-4.1.

An Act for the Better Management of the Provincial Lunatic Asylum at Toronto, (1854): Toronto: [s.n.], 1854. CIHM, microfiche, no. 53934.

An Act Respecting Health and Social Services, R.S.Q. 2002, c. S-4.2.

An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, R.S.Q. chapter P-38.001.

Canada Health Act, R.S.C, 1985, c. C-6.

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act*, *1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

Care Consent Act, S.Y. 2003, c. 21, Sch. B.

Civil Code of Québec, L.R.Q. c. C-1991.

Consent to Treatment and Health Care Directives Act, R.S.P.E.I. 1988, c. C-17.2.

Constitution Act, *1867* (U.K.), 30 & 31 Vict., c. 3 reprinted in R.S.C. 1985, App. II, No. 5.

Convention on the Rights of Persons with Disabilities, (New York: United Nations, 2006), Retrieved February 28, 2011 from: http://www.un.org/disabilities/convention/signature.shtml.

Criminal Code, R.S.C. 1985, c. C-46.

Decision-Making Support and Protection to Adults Act, S.Y. 2003, c. 21.

Eden Mental Health Centre Incorporation Act, R.S.M. 1990, c. 48.

Electronic Information and Documents Act, 2000, S.S. 2000, c. E-7.22.

Guardianship and Co-Decision-Making Act, S.S. 2000, c. A-5.3.

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181.

Health Care Consent Act, (1996), S.O. 1996, c. 2, Sch. A.

Health Care Directives and Substitute Health Care Decision Makers Act, S.S. 1997, c. H-0.001.

Health Care Directives and Substitute Health Care Decision Makers Regulations, R.R.S. c. H-0.001 Reg. 1.

Hospitals Act, R.S.N.S. 1989, c. 208.

Human Rights Code, R.S.O. 1990, c. H.19.

Incompetent Persons Act, R.S.N.S. 1989, c. 218.

Infirm Persons Act, R.S.N.B. 1973, c. I-8.

Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42.

Lunacy Act, 1845 (8 & 9 Vict.), c. 100.

Lunacy Act, 1890 (53 & 54 Vict.), c. 5.

Lunacy Act, R.S.M. 1940, c. 124.

Lunacy Act, R.S.O. 1914, ch. 68, s. 37.

Lunacy Act, S.O. 1909, ch. 37.

Medical Consent Act, R.S.N.S. 1989, c. 279.

Mental Health Act, R.S.N.B. 1973, c. M-10.

Mental Health Act, C.C.S.M. 2006, c. M110.

Mental Health Act, R.S.A. 2000, c. M-13.

Mental Health Act, R.S.B.C. 1996, c. 288.

Mental Health Act, R.S.N.W.T. 1988, c. M-10.

Mental Health Act, R.S.O. 1990, c. M. 7.

Mental Health Act, R.S.P.E.I. 1988, c. M-6.1.

Mental Health Act, R.S.Y, 2002, c. 150.

Mental Health Care and Treatment Act, S.N.L. 2006, c. M-9.1.

Mental Health Services Act, R.S.N.B. 1973, c. M-10.

Mental Health Services Act, S.N.B. 1997, c. M-10.2.

Mental Health Services Act, S.S. 1984-85-86, c. M-13.1.

Mental Health Services Act, S.S. 1984-85-86, c. M-15.1.

Mental Incompetency Act, R.S.O. 1937, c. 110.

Mentally Disabled Persons' Estates Act, R.S.N.L. 1990, c. M-10.

Ontario Disabilities Act, 2001, S.O. 2001, c. 32.

Patient Self-Determination Act of 1991 (PSDA), Pub. L. No. 101-508, 104 Stat. 1388-115, 1388-204 (1990) (codified as amended in scattered sections of 42 U.S.C.).

Personal Directives Act, R.S.A. 2000, c P-6.

Personal Directives Act, S.N.W.T. 2005, c.16.

Personal Directives Regulations, Alta Reg 99/2008.

Powers of Attorney Act, 2002, S.S. 2002, c. P-20.3.

Powers of Attorney Act, C.C.S.M. 2006, c. P97.

Powers of Attorney Act, R.S.A. 2000, c. P-20.

Powers of Attorney Act, S.N.W.T. 2001, c. 15.

Powers of Attorney Act, S.Nu 2005, c. 9.

Property Act, 1973, R.S.N.B., Chap – P 19.

Public Curator Act, R.S.Q. 1990, c. C-81.

Regulation Respecting the Application of Section 27 of the Mental Patients Protection Act, R.Q. 2003, c. P-41, r.1.

Regulation Respecting the Application of the Public Curator Act, R.R.Q. 2003, c. C-81, r. 1.

Rehabilitation of Disabled Persons Act, R.S.P.E.I. 1988, c. R-12.

Representation Agreement Act, R.S.B.C. 1996, c. 405.

Substitute Decisions Act, 1992, S.O. 1992, c.30.

The Health Care Directives Act, 1993, C.C.S.M. c. H27.

Uniform Mental Health Act, (Ottawa: Uniform Law Conference of Canada, 1987). Retrieved on February 1, 2011 from: http://www.chlc.ca/en/us/index.cfm?sec=1&sub=1m1.

Universal Declaration of Human Rights, GA Res 217 (III), UNGAOR, 3d Sess, UN Doc A/810, (1948).

Vulnerable Persons Living with a Mental Disability Act, 2004, C.C.S.M. c. V90.