PROFESSIONAL PERCEPTIONS OF PSYCHIATRIC ADVANCE DIRECTIVES: A VIEW OF MULTIPLE STAKEHOLDERS IN ONTARIO AND QUÉBEC

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ABSTRACT

Psychiatric advance directives (PADs) are legal documents allowing competent individuals to declare their treatment preferences in advance of a mental health crisis. The objective of this thesis is to examine psychosocial perceptions of legal and mental health professionals in Ontario and Québec regarding their knowledge and willingness to implement PADs. Two hundred professionals—psychiatrists, psychologists, lawyers and administrative tribunal members—participated in an Web-survey measuring psychosocial perceptions of clinical, ethical, legal and implementation factors of PADs. Results indicate Québec professionals are more willing to begin using PADs than Ontario professionals. Mental health professionals reported more concern than legal professionals for medical malpractice lawsuits for overriding PADs. Advantages of PADs most commonly reported are patients' ability to declare their clear wishes ahead of time, respect for autonomous choice, and establishing a collaborative treatment plan with physicians. Disadvantages included patients' lack of awareness, treatment refusal, and being self-bound to an earlier decision.

RÉSUMÉ

Les directives préalables en santé mentale (DPSM) sont des documents légaux qui permettent aux personnes compétentes de préciser leurs préférences quant à leurs futurs traitements dans l'éventualité d'une crise de santé mentale. L'objectif de cette thèse est d'examiner les perceptions psychosociales des professionnels juridiques et de la santé mentale en Ontario et au Québec quant à leur connaissance des DPSM et leur volonté de les mettre en application. Deux cents professionnels (psychiatres, psychologues, avocats et membres des tribunaux administratifs) ont participé à un sondage en ligne mesurant leurs perceptions psychosociales des facteurs cliniques, éthiques, juridiques et de mise en application associés aux DPSM. Les résultats indiquent que les professionnels du Québec sont plus enclins à utiliser les DPSM que ceux de l'Ontario. Les professionnels de la santé mentale rapportent davantage de soucis au sujet des poursuites pour faute médicale lorsque les DPSM sont outrepassées que les professionnels juridiques. Les avantages des DPSM rapportés le plus souvent sont la possibilité pour le patient de faire connaître ses préférences à l'avance, le respect de l'autonomie et l'élaboration d'un plan de traitement en collaboration avec les médecins. Les inconvénients comprennent le manque de sensibilisation des patients aux DPSM, le refus des traitements et le fait d'être lié à une décision antérieure.

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This thesis is dedicated to my two wonderful sisters, Claudia and Graziella.

INTRODUCTION

The objective of this research study is to examine familiarity, knowledge and willingness to start using psychiatric advance directives (PADs) among legal and mental health professionals in two Canadian provinces. PADs are legal documents allowing mentally ill individuals to declare treatment preferences before a mental health crisis occurs. After a review of the literature is provided, the results of a survey are presented in which statistical tests are carried out on predictive factors associated with familiarity and willingness to use PADs among psychiatrists, psychologists, lawyers, and administrative tribunal members. The thesis then examines advantages and disadvantages associated with PADs, along with ethical value judgments made by legal and mental professionals.

1. LITERATURE REVIEW

1.1 Background

Canadians place a high value on the right to make independent health care decisions and to have their voices heard regarding their treatment preferences. A major criticism of mental health services and supports in Canada has been that it is largely centered on the convenience of providers rather than patients/clients (Kirby, 2004). In an effort to find practical solutions that reduce discrimination and stigma of mentally ill individuals, the Government of Canada recently established the Canadian Mental Health Commission to "facilitate the exchange of research findings and best practices between governments and stakeholders" (Health Canada, 2005). As psychiatric inpatient care continues to decrease, community supports are being used to a greater extent (Latimer, 2005). One example being compulsory community treatment orders, a doctor's order for a

person to receive treatment or care and supervision in the community, which attempt to provide the least restrictive treatment alternative (Gray & O'Reilly, 2005). Making sound health care decisions that benefits mentally ill individuals involves an understanding of key professional stakeholders' perceptions from within legal, mental health, and governmental bodies. Implementing community-based psychiatric services for mentally ill individuals in Canada requires an understanding of geographical and regional disparities of deinstitutionalization (Sealy & Whitehead, 2004) and transparency in the level of coercion used for treatment compliance (O'Reilly, 2006).

When mental health consumers have a meaningful, collaborative and shared decision-making role in deciding treatment choices with their health-care providers, a middle ground is sought between hard medical paternalism, coercion, and informed patient choice (Schauer, Everett, del Vecchio, & Anderson, 2007). A model of shared-decision making involves teaching patients the importance of self-determination and how to self-manage their mental illness so that the road to recovery is quick (Mueser et al., 2002; Mueser et al., 2006). If, on the other hand, leverage is used on patients to make treatment choices in a coercive manner, without any autonomous choice, some degree of legitimacy and justification should be provided. At the same time, research does not support the idea that pressuring mentally ill individuals to make treatment-related decisions is related to that person's inability to make the decision for themselves (Appelbaum & Redlich, 2006). We must ask ourselves a moral and ethical question then: if the decision is made to restrict the liberty and free choice of a mentally ill individual, to what degree is that individual's self-determination, autonomy, and long-term recovery affected?

Mentally ill persons have run-ins in with the civil and criminal justice system for numerous reasons including disagreement of treatment decisions made on their behalf under a doctor's recommendation (Starson v. Swayze, 2003), denial of having a mental illness, and drug induced states or paranoia which can impair judgment (Roth, Appelbaum, Sallee, Reynolds, & Huber, 1982). Diversion practices encouraging appropriate medical treatment requires collaborative dialogue across medical and legal disciplines. For example, judges, lawyers and administrative tribunal members of Review Boards rely on the judgment of mental health professionals for current and up-to-date medical knowledge of mental disorders, along with personal, social, and psychological information of mentally ill individuals. Mental health professionals are called upon by lawyers and judges to provide expert testimony regarding a patient's mental capacity in cases of fitness to stand trial, involuntary civil commitment, and treatment refusal.

The influence mental health legislation can have on an individual's ability to assume personal responsibility for treatment choices should not be underestimated (Samele, Lawton-Smith, Warner, & Mariathasan, 2007), for legislation has the potential to shape professional attitudes which can then be translated into positive or negative policy decisions. For example, therapeutic jurisprudence is a relatively new approach to mental health law policy that envisions the construction of law as a therapeutic agent which positively impacts the emotional life and psychological well-being of individuals (Winick, 1991; Winick & Wexler, 2003). When mental health law policies are drafted in the context of a framework such as therapeutic jurisprudence, mental health consumers are more likely to assume an active and meaningful role in negotiating and designing treatment programs, collaborating with mental health and legal professionals, feeling

empowered, and having a more active role in their recovery process (O'Connell & Stein, 2005).

1.2 Psychiatric advance directives (PADs)

Psychiatric advance directives (PADs) are legal documents that allow competent individuals to declare their treatment preferences in advance of a mental health crisis, when they may lose capacity to make reliable health care decisions (Amering, Stastny, & Hopper, 2005; Appelbaum, 1991; Winick, 1996). A medical advance directive deals mainly, although not exclusively, with end-of-life decision-making, while PADs tend to apply to episodic and recurring mental health crisis (Backlar, 1997; Miller, 1998; Swanson, Tepper, Backlar, & Swartz, 2000). Advance statements, on the other hand, differ from advance directives in that they involve positively framed treatment choices, are not legally binding, and are generally open to interpretation. Advance directives are designed to deal with treatment refusal as legally binding documents when completed while an individual is considered mentally capable (Gallagher, 1998; Williams & Rigby, 2004). In the United Kingdom, patients can express their treatment preferences outside of the legal framework through 'crisis cards' (patients state their preferences without reference to the service provider) or 'joint crisis plans' (a discussion between the patient, service provider, friends, care coordinator and an independent facilitator regarding acceptable forms of treatment in the event of relapse) (Szmukler & Dawson, 2006). In the United States, the concept of making advance statements dates back to the 1960's 'right to die movement', which actually took root in the 1980's and 1990's due to some high-profile 'right to die' legal cases (Quinlan, 1976; Cruzan, 1990). In 1982, well-known psychiatrist Thomas Szasz proposed the concept of a 'psychiatric will' which was

intended to help psychiatrists deal with psychotic patients whose capacity may fluctuate (Szasz, 1982). PADs have since been named Ulysses contracts and opt-in provisions or directives (Atkinson, 2004; Cuca, 1993; Dresser, 1982; Joshi, 2003; Varekamp, 2004) to show their irrevocable nature as a self-binding document (Macklin, 1987), and as a means to protect an individual's autonomous choices (van Willigenburg & Delaere, 2005). More recently, there has been an increasing number of empirical studies and international research conducted on PADs (Atkinson, 2003) relating to their utility (Srebnik et al., 2005), clinical attitudes towards the documents (Elbogen et al., 2006), implementation barriers (Van Dorn et al., 2006), and whether they may be justifiably overridden (Swanson, Van McCrary, Swartz, Van Dorn, & Elbogen, 2007).

In one study involving two small communities in Ohio, United States it was found that 55% of individuals affiliated with either legal/law, health care, clergy, mental health, consumers or family member groups never heard of PADs, and only 11% of all group members considered themselves very familiar with the documents (O'Connell & Stein, 2005). Two-thirds of individuals with schizophrenia wished to have legal advance directives for mental health treatment, yet only 7% actually completed them (Srebnik, Russo, Sage, Peto, & Zick, 2003). Another study revealed that 83% of individuals with schizophrenia were judged to have the capacity to sign the documents (Valletto, Kamahele, Menon, & Ruskin, 2002), and 74% of patients who experienced an emergency psychiatric episode stated they would complete an advance directive if provided the opportunity (Allen, Carpenter, Sheets, Miccio, & Ross, 2003). Srebnik & Brodoff (2003) show that individuals most interested in completing PADs have no history of outpatient commitment, and that the documents may only be valuable to persons who perceive meaning in the treatment directed, particularly if a case manager or clinician actively

supports them (Moran, 2003). While a majority of consumers indicate they do not understand enough about PADs (Srebnik et al., 2003), one reason may be because mental health clinicians are unaware of them and therefore unable to help patients develop them (Papageorgiou, Janmohamed, King, Davidson, & Dawson, 2004).

Empirical studies assessing mental health professionals' views of PADs primarily stem from the United States, along with some research from the United Kingdom; however, there has to been no empirical research in Canada comparing legal and mental health professionals' perceptions of PADs. Before such documents can be incorporated into the Canadian legal or medical landscape, it is important for legal and mental health professionals to understand the sorts of declarations that can be included in PADs.

1.3 Content of PADs

PADs can be used to document very specific future contingencies including a patient's treatment preferences, choice of hospital, alternatives to hospitalization, who to notify in an emergency, previously ineffective treatment, who will care for children and pets in the event of an emergency, and use of seclusion or restraint in emergency response options (Srebnik et al., 2005; Vuckovich, 2003b). For example, patients with severe mental illness, when given the opportunity to state their treatment preferences, do not generally refuse all psychotropic medications but are selective in manifesting a preference for second-generation antipsychotic medications over first generation anti-psychotics (Srebnik et al., 2005). PADs can, therefore, be used to document virtually anything an individual wishes as long as the expressed wish does not contravene rules of public order.

Psychiatrists and clients agree that it is helpful to include both positive and negative instructions within PADs (Varekamp, 2004). Some patients, for example, may

permit treatment with certain medications but wish to exclude other treatment options they are less familiar with, such as electroconvulsive therapy (Anonymous, 2004). Any contingency included within a PAD must still be objectively rational for it to be upheld legally by the courts (Joshi, 2003). In one computer simulated study of PADs involving outpatients with severe mental illness it was found that, although more than 80% needed some type of technical and non-technical support to fill out the documents, they were nevertheless capable of completing the documents (Peto, Srebnik, Zick, & Russo, 2004).

1.4 Benefits of PADs

The major benefit of PADs, as a form of self-mandated treatment, is their ability to allow a broader concept of patient-centeredness (Monahan, Swartz, & Bonnie, 2003), whereby patients are given a greater autonomous and self-determinative voice in their decision-making abilities against involuntary treatment (Joshi, 2003; Schouten, 2006). PADs offer patients a sense of empowerment in their lives (Backlar, McFarland, Swanson, & Mahler, 2001; Kent & Read, 1998; Swanson et al., 2003), foster a positive therapeutic alliance between psychiatrists, patients and families to facilitate communication (Howe, 2000; Vuckovich, 2003b), decrease perceived coercion of involuntary interventions (Monahan et al., 2003; Swanson et al., 2003), and increase collaboration for motivation of treatment adherence (La Fond & Srebnik, 2002). PADs may also help decrease hospitalization time and the number of involuntary commitments (Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002; Sherman, 1998), reduce rates of relapse (Joshi, 2003), and allow individuals to control their own care which may lead to better clinical outcomes and recovery when patients have a choice in directing their treatment (Calsyn, Winter, & Morse, 2000; O'Connell & Stein, 2005). They also

play an important role in fostering collaborative decision-making power (Amering, Stastny, & Hopper, 2005). With greater understanding of how PADs operate, they offer the added benefit of making public mental health systems more accountable by working to improve clinical outcomes of patients (Bernstein, 2006), particularly when a cooperative model is used that encourages psychiatrists, mentally ill individuals, and families to come together to complete a PAD (Dion & Racine, 2007). Patients who may have previously had bad, negative experiences with mental health professionals regarding their willingness to accept certain forms of medical treatment is one important consideration that influences motivation and a high demand to complete PADs (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006).

Furthermore, PADs prevent costly, time consuming and potentially dangerous treatment errors (Vuckovich, 2003b) and reduce the likelihood of patients forcibly being administered medication or restrained unnecessarily. PADs can help avoid legal proceedings that involve treatment refusal if they serve as the best evidence of a patient's earlier wishes (McArdle, 2001) and generally increase confidence in the mental health system (Ritchie, Sklar, & Steiner, 1998). Most mental health professionals see the implementation of PADs as a positive support service for individuals with severe mental illness, although some have expressed less optimistic views regarding their implementation (Backlar, 2004; Papageorgiou et al., 2004). Srebnik et al. (2004) stress that for the benefit of PADs to be realized, empirical research is needed to foster dialogue with relevant stakeholders on values such as patient recovery, client autonomy, treatment choice, and self-management of illness. Perhaps the greatest benefit of PADs lies somewhere between the ethical bases for respecting one's personal autonomy and the

clinical benefits that can be realized from them (Szmukler, Henderson, & Sutherby, 1999).

1.5 Implementation barriers

Some of the barriers to implementing PADs include a lack of understanding and support in filling out the documents (Peto et al., 2004; Srebnik & Brodoff, 2003), a belief that PADs have no impact on treatment, and uncertainty about what types of decisions can be outlined in the documents (O'Connell & Stein, 2005). Structured training sessions on how to complete PADs are, however, being administered to patients and offering promising results to overcome such barriers (Swanson et al., 2006; Swartz, Swanson, Van Dorn, Elbogen, & Shumway, 2006). Other potential barriers include operational features of the work environment and clinical concerns related to characteristics of individuals with severe mental illness (Van Dorn et al., 2006). Psychiatrists are more inclined to report clinical barriers associated with implementing PADs than social workers and psychologists, particularly if the psychiatrist is managing heavy caseloads of patients with psychosis (Van Dorn et al., 2006).

Another implementation barrier of PADs has been the degree of 'legal defensiveness' manifested by mental health professionals. Legal defensiveness, a determinant for treatment decision-making, refers to clinician's concerns about potential civil and criminal malpractice lawsuits regarding their professional treatment decisions for seriously mentally ill patients (Van Dorn et al., 2006). The greater legal defensiveness manifested by a mental health professional the more likely they are to report clinical barriers (Van Dorn et al., 2006). Ultimately, clinicians' attitudes towards PADs will

determine the manner in which the documents are explained to patients and possibly influence their interest in completing them (Srebnik & Brodoff, 2003).

1.6 Problems in assessing competency

PADs are intended to address the problem where an individual has not indelibly recorded a prior competent wish regarding their treatment choices, so that after becoming incompetent, mental health professionals have no way of knowing with certainty whether a currently expressed wish is truly representative of an individual's previous wish and true personal identity (Buchanan, 1988; Winick, 1991). Although incapacity and incompetency are terms often used interchangeably in the literature, a more refined lexicology provided by Srebnik & Brodoff (2003) is 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" (pg. 253). Legal and medical definitions of incompetence and incapacity frequently differ depending on the law of the land, although the terms are often used interchangeably and both terms are limited in time.

Although a small number of patients may manifest continuous psychotic symptoms with no window-period to make competent treatment decisions, the majority of patients with psychotic disorders, even those with serious mental illnesses, suffer from intermittent and fluctuating periods of psychosis (Backlar, 1998; Stavis, 1999). Rationale for proposed change is that the majority of mental health patients suffer from anxiety and non-psychotic depression and only a small percentage of all the mentally ill experience psychosis. Although PADs are not a form of treatment, with each psychotic episode an individual experiences there is a risk of chronicity of the illness; another reason to discuss

PADs early in the process (Varma, 2005). A fundamental issue posed by PADs is how to determine when, and if, a patient reaches a mental state sufficient to establish competency (Ritchie et al., 1998; Vuckovich, 2003b). Saks (2002, 2004) makes a creative argument for a "one-free shot regime" where an individual who experiences a first psychotic experience may be civilly committed however, after stabilization of psychiatric symptoms from the first psychotic break the competent individual should be permitted to self-bind their wishes through a PAD. Others have argued that a patient's competence can be challenged on well-meaning paternalistic grounds that promote the patient's overall well-being and, therefore, competence assessments can be adjusted in light of possible harms and benefits (Buchanan, & Brock, 1990). Clinicians face the challenge of how to frame the true elements of a patient's wishes as objectively as possible while the person is in a psychotic or depressive state (Bean, Nishisato, Rector, & Glancy, 1996).

The concept of defining what mental competency is and identifying when an individual is truly competent to make a decision has been a particularly difficult challenge due to its multi-dimensional status, where there is a need for treatment providers to consider, among other factors, personal, cultural, and familial reasons. Clinical judgment used to assess decisional capacity of mentally ill individuals is frequently subjective and limited (Valletto et al., 2002), making a more objective tool to assess capacity-to-consent desirable (Zayas, Cabassa, & Perez, 2005). The MacArthur Research Network has identified four legally relevant abilities to make competent decisions: 1) stating or communicating a choice, 2) understanding relevant information, 3) appreciating the nature of one's situation and, 4) reasoning with that information (Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1995; Grisso, Appelbaum, Mulvey, & Fletcher, 1995). The CAT-PAD (Competency Assessment Tool- Psychiatric Advance Directive) is one such

competency tool that has been developed to assess an individual's *understanding* of relevant information, *appreciation* of its significance, *reasoning* ability to weigh risks and benefits, and *evidence* a choice (Srebnik, Appelbaum, & Russo, 2004). A shorter version of this tool, the D-CAT-PAD, also reveals fairly robust connections between decisional capacity and neuropsychological status (Elbogen et al., 2007).

The development of conceptual frameworks and psychological instruments used to measure competency require an understanding of both psychiatric disorders and legal standards, so that competency instruments can be aligned with legislative standards and upheld in courts of law. In order for psychiatric research to dovetail with legal standards, these four core components of decisional capacity (communicating a choice, understanding, appreciation, and reasoning ability) could be compared with legislative standards of competency to assess whether legal professionals value the same criteria as mental health professionals (Appelbaum, & Grisso, 1995; Berg, Appelbaum, & Grisso, 1996; Hotopf, 2005; Shulman, Cohen, & Hull, 2005). As noted by Berg et al. (1996), "cases and statutes generally lack sufficient analysis of competence and its different elements" (p. 347), and "legislatures, in drafting competence statutes, may determine what type and degree of clinically assessed incapacity will allow a judge to declare an individual legally "incompetent". Theories of competence in medical-decision making focus on various criteria, the most common of which and the ones adopted by law, are cognitive" (p. 349). In criminal cases of competency assessments, such as whether someone is fit to stand trial, psychological instruments have been used to assess cognitive aspects of understanding, appreciation, ability to communicate (Zapf, Roesch, & Viljoen, 2001). Berg et al. (1996) highlight that there are no uniform standards of what constitutes competence, although the law tends to focus on the cognitive elements of competency

assessments. The importance of knowing whether an individual was truly competent when a PAD was completed is reflected in the fact that 90% of psychiatrists are more likely to support instructions in a PAD if the clinician's signature on the form indicates that the patient was competent at the time of completion (Srebnik & Brodoff, 2003). It is possible that differences between legal and mental health professionals' views of PADs may be a function of which of the four competency criteria (understanding, appreciation, reasoning, and evidencing a choice) are valued most and whether these criteria are reflected in mental health legislation.

1.7 Mental health legislation

Laws are created to reflect the beliefs and attitudes individuals hold regarding specific conduct. The form and substance of policies found in mental health legislation can have major effects on the practice of psychiatry, the level of social control over the mentally ill (Gove, Tovo, & Hughes, 1985), and whether potential barriers to implementing PADs may be overcome (Fleischner, 1998). When legislation allows individuals to voluntarily and actively take part in their treatment choices and reduce potential coercion, attitudes can become a catalyst to legislative change (Wallsten & Kjellin, 2004). Although advance directive legislation is intended to facilitate participation in treatment decisions, with legitimate concern that legislation has the potential to prevent all treatment (Appelbaum, 2004), research indicates that most individuals who complete advance directives do not wish to decline all treatment but rather outline their preferred choices for alternative treatments (Appelbaum, 2004).

Canadian criminal law has followed the legal principle that the "least onerous and least restrictive" principle should be adopted when considering the mental condition of an

accused (Penetanguishene Mental Health Centre v. Ontario, 2004; Pinet v. St. Thomas Psychiatric Hospital, 2004). In Canada, the least restrictive principle is necessarily a touchstone principle for PADs to be implemented as it ensures that liberty rights regarding treatment choices will be respected. At the same time, PADs should avoid becoming overly legalistic so that individuals contemplating them do not consider hiring a lawyer to be a financial burden (Howe, 2000), even if insurance companies may consider subsidizing their coverage (Joshi, 2003).

In the US, more than 25 states have laws authorizing some form of PADs (Elbogen et al., 2006; Swanson, McCrary, Swartz, Elbogen, & Van Dorn, 2006), with a recent US appellate level court-decision (Hargrave v. Vermont, 2003) declaring that legislation should not discriminate against people with a mental illness when binding preferences for future treatment are in place (Appelbaum, 2004, 2006). Although medical advance directives appear to be honored only 20-50% of the time in the US (Srebnik & La Fond, 1999), it is unclear whether similar statistics would apply to PADs in Canada. One thing is almost certain—whether PADs would be honored in Canada greatly depends on provincial mental health legislation dealing with advance directives and the right to refuse medical treatment.

1.8 Canadian mental health legislation

1.8.1 Ontario law

There exist 10 provinces and 3 territories in Canada, making it beyond the scope of this study to examine mental health legislation within each jurisdiction. The justification for using the provinces of Ontario and Québec as comparisons is how uniquely they deal with decisions of right to refuse medical treatment. Ontario law

reflects a libertarian position that upholds patient choice to refuse treatment, unlike in Québec where the judge assumes an activist role as the final arbiter. Because legal standards of capacity vary depending on disparate laws, defining what it means to be capable to complete a PAD has been a patchwork effort with no gold standard in place (Srebnik & Kim, 2006). When legislation should permit a PAD to be justifiably overridden is not always clear (Appelbaum, 2006). In the case of Ontario legislation, consent and capacity laws are governed by three statutes which should be read together (Health Care Consent Act, 1996; Mental Health Act, 1990; Substitute Decisions Act, 1992; Hiltz & Szigeti, 2004). Although Ontario legislation does not specifically address PADs, when the three statutes are interpreted together, it would be difficult to find legal recourse to override a prior competently expressed wish. Compared to legislation from other provinces and countries, Ontario has adopted a distinctive libertarian position in going to great lengths to respect prior competent wishes (Ambrosini & Crocker, 2007). For example, the Health Care Consent Act (1996) states:

> "A person may, while capable, express wishes with respect to treatment... wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. Later wishes expressed while capable prevail over earlier wishes (section 5)...A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles: (1) If the person knows of a wish applicable to the circumstances that the incapable expressed while capable...the person shall give or refuse consent in accordance with the wish. (2) If the person does not know of a

> wish applicable to the circumstances…the person shall act in the incapable person's best interests (section 21)."

The Substitute Decisions Act (1992) also provides a statutory basis to the right of anticipatory treatment refusal in Ontario:

> "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 (section 47)."

Note that two of Ontario's legislative criteria, understanding and appreciation ability, overlap with the MacArthur Network Group's research findings of the four legally relevant abilities to competent decision-making (communicating a choice, understanding relevant information, appreciating the nature of ones situation and, reasoning with that information) (Appelbaum & Grisso, 1995). As another example, the Ontario Health Care Consent Act states:

> "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 (section 4)."

In a recent Supreme Court of Canada decision that continues to foster active debate (Starson v. Swayze, 2003), the majority of the court held it was not the role of the Ontario Consent and Capacity Board to equate the presence of a mental disorder with

incapacity. A judge's interpretation of Ontario legislation requires a patient to have the *ability* to appreciate the consequences of a decision, but it does not require *actual* appreciation of consequences for not agreeing with a doctor's diagnosis. In discussing the Starson decision, Sklar (2007) explains how the understanding requirement for capacity in the Health Care Consent Act (1996) may pose a potential constitutional challenge. The upshot is that Ontario patients cannot be found incapable by a Review Board because they deny suffering from a mental illness; they only require the ability to recognize the manifestations of their condition—a unique feature of Ontario law (Sklar, 2007).

It is possible that legal and mental health professionals' different perceptions of how to define what it means to be capable to consent creates a situation where legislation is drafted without fully incorporating how mental health professionals perceive such terms. Although judges are required to hear expert psychiatric testimony of whether someone has the requisite capacity to refuse treatment, judicial and medical perceptions of legislative criteria may not be aligned with current psychiatric research. This may become an important factor that influences whether PADs will be favorably received by different professional stakeholders.

1.8.2 Québec law

Mental health laws in Québec are governed and codified by civil law found in the Civil Code of Québec (CCQ) (1991), unlike the rest of Canadian common law provinces and the majority of the US (similar to the state of Louisiana which is also a civil law jurisdiction). Québec has adopted a 'functional approach' towards mental capacity where consent to treatment is a question of fact, based on a patient's ability to make the decision and not on one's legal status (Brown, 2000). Article 16 (CCQ, 1991) allows courts to

authorize involuntary psychiatric treatment when a legal substitute decision maker is not approved and a patient refuses to assent to treatment by a substitute decision maker. A functional approach to assessing mental capacity has likewise been incorporated in legislation from several European countries where if new assessment methods prove reliable, judges assume a more interventionist and active role (Nys, Welie, Garanis-Papadatos, & Ploumpidis, 2004). Québec law does not guarantee that treatment will not be imposed on patients who refuse; instead it places the onus on interested parties to convince courts that the individual's incapacity is well-founded and that the proposed treatment is necessary. Moreover, the primary role of psychiatrists is not considered simply to evaluate whether a particular decision of a mentally ill patient is rational or not, but to assess the patient's capacity and cognitive ability to make decisions more generally. This raises a question of whether Ontario and Québec judges may differ in the degree that they are willing to follow psychiatric recommendations regarding the right to refuse medical treatment.

Article 26 (CCQ, 1991) distinguishes the terms 'confinement in an institution' from 'legally mandated treatment', so that no one may be confined in a psychiatric institution without their consent or without authorization by law or the court. At the same time, where a reason exists to believe that a person is a danger to oneself or others, a physician or interested person, notwithstanding the absence of consent, can request the court to order an individual be confined temporarily for a psychiatric assessment (CCQ, 1991 article 27). The court can authorize any other medical examination that is necessary in such circumstances (CCQ, 1991 article 27). The general rule is that a person may not be made to undergo care of any nature without their consent, but if the individual is unable to give their consent a person authorized by law or mandate may do so (CCQ,

1991 article 11). Where an individual is unable to give their consent and has not mandated family members to act in their behalf (CCQ, 1991 article 15) legally mandated treatment can be sought through authorization of the court (CCQ, 1991 article 16). Legally mandated treatment is a form of 'assisted treatment' which could be considered a "soft version" of coercion.

Article 12 (CCQ, 1991) allows for an opening to accommodate PADs into Québec's legal framework where it states:

> "A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account, *as far as possible*, any wishes the latter may have expressed."

This phrase, *as far as possible*, would allow judges to consider evidence of a prior competent wish that may be expressed in a PAD. Compared to Ontario legislation where courts seldom override patient's prior competent wishes, Québec legislation fosters a protective set of rules allowing courts to act in an individual's best interests. Although the Starson ruling (2003) has been applied in subsequent lower level Québec cases (M.B. c. Centre Hospitalier Pierre-de-Gardeur, 2004), there is no legislative reference describing the four legally relevant abilities to assess competency outlined by the MacArthur Group (Appelbaum & Grisso, 1995). In fact, Québec law does not even have a legislative definition of capacity but has instead chosen to adopt the five criteria for capacity found in another province's legislation, the Nova Scotia Hospitals Act (Hospitals Act, 1989; Sklar, 2007). The five criteria within that common-law legislation are (i) understanding the condition for which the treatment is proposed, (ii) understanding the nature and purpose of the treatment, (iii) understanding the risks involved in undergoing the

treatment, (iv) understanding the risks involved in not undergoing the treatment, and (v) whether or not the ability to consent is affected by ones condition (Hospitals Act, 1989).

Given that much of mental health services depends on professionals' willingness to implement new interventions, processes and best practices (Kirby, 2004), it would be helpful to understand whether legal and mental health professionals' attitudes toward legislation affects their perceptions of PADs and the right to refuse medical treatment. It is possible medical and legal professionals may have different perceptions of what constitutes a "good outcome", whereby "the ethics of law emphasizes respect for autonomy and liberty, whereas medical ethics tend to privilege beneficence and healthy paternalism, where a 'good' outcome means 'what is good clinically'" (Sarkar & Adshead, 2005). Psychiatrists may be more inclined to consider a patient's best interests as the best 'medical interests' rather than lawyers who may focus on an individual's best 'social interests' (Sarkar & Adshead, 2005). The manner in which legislation is drafted may be a contributing factor to these divergent views. For example, the Mental Capacity Act in the United Kingdom (Mental Capacity Act, 2005) has adopted a definition of capacity that, for the most part, accords with the four legally relevant identified under Appelbaum's criteria (Appelbaum & Grisso, 1995) and as such, what is considered to be in the best interests of the patient is ultimately determined by courts (Hotopf, 2005).

To what extent has Canadian mental health policy aligned knowledge of psychiatric research with legislative standards? Do attitudes of legal and mental health professionals from Ontario and Québec correspond with legislation regarding what constitutes the best interest standard? Although US statutes authorizing some version of PADs have increased, there has been no research in Canada on whether clinical and legal judgments conform to treatment found in legislation (Swartz et al., 2005).

1.9 Professional stakeholders' perceptions

There has been a growing recognition of the importance to consider various stakeholders' perceptions of PADs including patients, family members and clinicians (Atkinson, Garner, & Gilmour, 2004; Buscemi, 2002; Srebnik & La Fond, 1999; Swanson et al., 2003; Van Dorn et al., 2006). If sound mental health law policies surrounding PADs are to be adopted, it is equally important to understand perceptions of whether such documents will be honored by different legal and mental health professionals (Lens & Pollack, 2000; Winick, 1998). In a study involving the mailing of a survey to law enforcement officers, clergy, and mental health professionals, it was found that 69% thought PADs were a good idea. Individuals who earned their highest degree in a helping profession (this would be considered care-giving professions such as psychology, social work, counseling, nursing, or medicine) seemed more familiar with PADs than individuals from a non-helping profession (legal/law enforcement) (O'Connell, 2002). Other studies indicate psychiatrists are less convinced of the need for advance directives than other groups such as voluntary organizations, social workers and nurses (Atkinson, 2004). Professionals who have been surveyed are primarily those who work directly with mentally ill individuals such as psychiatrists, psychologists, psychiatric nurses, and social workers, and less so among legal professionals such as lawyers, judges, and administrative tribunal members of Review Boards.

1.9.1 Psychiatrists

Psychiatrists working in hospitals, private clinics, and research centers are frequently called upon as expert witnesses and ethics-consultants by hospitals (Leeman, Blum, & Lederberg, 2001). As psychiatrists are, among other things, responsible for

prescribing medications to patients, they are critical to the long-term clinical outcomes mentally ill individuals will experience; yet, their views are not always congruent with those of other professionals. For example, psychiatric reports and clinical opinions are frequently relied upon by judges to decide whether someone has the requisite capacity to refuse medical treatment. Prior research indicates psychiatrists and judges differ in their perceptions of risks associated with antipsychotic medication and willingness to prescribe medications (Bursztajn et al., 1991). There is an expertise bias between psychiatrists and judges so that the two groups hold dissimilar frames of reference in determining whether patients should be classified as dangerous to the point of civil commitment (Poletiek, 2002). It is possible that similar expertise biases exist in other contexts such as the right to refuse treatment—a bias that could be related to perceptions of mental health legislation.

Research indicates that psychiatrists, as a group, are divided on their willingness to honor PADs so as to permit treatment refusal, with 47% reporting that they would override a valid, competently-executed PAD that refused hospitalization and medication (Swanson et al., 2007). Survey research from England indicates psychiatrists are more opposed to PADs than social workers and psychiatric nurses (Atkinson et al., 2004). In a US study, 53% of psychiatrists were willing to follow wishes expressed in a PAD, compared to 65% of psychologists and 64% of social workers (Elbogen et al., 2006). When psychiatrists become more knowledgeable of laws related to PADs they have more positive attitudes towards the documents (Elbogen et al., 2006). To what extent then do attitudes of mental health professions match legal standards found in mental health legislation regarding the right to refuse medical treatment or PADs (Roberts, 2002)?

Although psychiatrists differ in how much patient autonomy one should be able to exercise during admission and the kinds of treatment that should be administered,

evidence also suggests psychiatrists are not opposed to PADs (Varekamp, 2004). Many psychiatrists believe PADs have the potential to promote autonomy, empowerment, reassurance, patient responsibility, crises intervention, de-stigmatization and good clinical practice, but express reservations in how PADs may constrain their clinical judgment (Nys et al., 2004). Two-thirds of psychiatrists indicate they would honor a PAD, while others believe patients will use PADs to inscribe treatment refusal (Levin, 2005). Psychiatrists are more likely to report clinical and operational barriers to implementing PADs than psychologists or social workers (Van Dorn et al., 2006). Even between psychiatrists, there are varying views on the viability of PADs, where those working with patients who suffer from psychotic spectrum disorders, making capacity assessments more difficult, are less favorable to implementing PADs (Van Dorn et al., 2006). Likewise, public sector psychiatrists appear to hold less positive views of PADs than private sector psychiatrists (Swartz et al., 2005). Some recommend that a middle ground be adopted whereby psychiatrists should not simply overrule a patient's refusal in a PAD as irrelevant, but should instead allow the spirit of the legal document to be interpreted broadly (Widdershoven & Berghmans, 2001). Whether psychiatrists will deny or uphold a PAD will likely be influenced by knowledge of consent and capacity legislation and medical malpractice standards (Swartz et al., 2005).

1.9.2 Psychologists

Psychologists are often called upon to perform assessments of prior, present and future capacity judgments, where another person or agency is substituted for that individual's ability to make decisions (Drogin & Barrett, 2003). In certain US states psychologists perform emergency psychological examinations prior to civil commitment

(Droney, 1997). Irrespective of the ongoing debate about whether psychologists should have prescription privileges (St-Pierre & Melnyk, 2004), or even discuss medications with clients (Littrell & Ashford, 1995), psychologists are at times called upon to determine patients' cognitive capacity. Similarly, many of the researchers developing criteria and clinical instruments to effectively measure capacity and competency are trained as psychologists.

Psychologists may hold different perceptions than other professionals regarding long-term treatment adherence to medication, a view that could result from emphasizing psychosocial interventions and/or applying different ethical value judgments towards important values such as autonomy, self-determination, and stigmatization. Psychologists perceive the lack of access to PADs as a potential barrier to their implementation, are less concerned than psychiatrists regarding the extra documentation required, and less concerned than social workers with the lack of time to review the document (Van Dorn et al., 2006). In one study where an advance instruction documented a patient's treatment refusal, 65% of psychologists said they would honor treatment refusal, and 42% believed the benefits of PADs could be outweighed by patient's using them to refuse medication (Elbogen et al., 2006).

1.9.3 Psychiatric nurses

Psychiatric and mental health nurses face a unique ethical challenge in being sensitive to patients' autonomous choices while making sound decisions on their behalf (Lutzen & Schreiber, 1998), as they are often on the front lines of both medical and psychosocial treatment in virtually all hospitals offering mental health services. Psychiatric nurses can help make PADs widely available, assist patients in their

formation, ensure they are honored and implemented appropriately, work along with family members, and advocate for PAD legislation (Vuckovich, 2003a, 2003b). As part of their role to ensure that involuntary patients take their prescribed medications (Houlihan, 2005), some nurses may attempt to justify coercive measures so that legal procedures will not be instituted when patients refuse to follow prescribed treatment plans (Vuckovich, 2003a).

As psychiatric nurses have advanced knowledge of the effects of certain forms of treatment, and are in close contact with mentally ill patients, their views of PADs may be more closely related to the content and form of treatment refused by patients. For example, in a survey administered to psychiatric nurses and psychiatrists, three-quarters rejected specific methods of therapy such as neuroleptics which can have significant side-effects (Amering et al., 2005). When mentally ill patients and psychiatric nurses were asked about alternatives to forced medication, patients tended to seek more dialogue, coaxing, or waiting with psychiatrists and staff, whereas psychiatric nurses do not mention any alternatives and perceive coercive measures as necessary (Haglund, Von Knorring, & Von Essen, 2003). The degree of education, age, and work experience of psychiatric nurses also appear to affect their views of PADs (Lipson, Hausman, Higgins, & Burant, 2004).

1.9.4 Social workers

Social workers from the community, hospitals and nursing homes assist mentally ill individuals to understand their rights and how the legal system works (Odiah, 2004). In referring to advance directives Odiah (2004) states, "social workers do not always know how courts will deal with them, especially when it concerns a person with mental illness."

Part of the reason for social workers' uncertainty of advance directives may be due to a lack of familiarity with provincial legislation governing their use. However, research indicates that 82% of social workers in Ohio, US have moderate knowledge of policies surrounding advance directives and 98% hold positive attitudes regarding their use, particularly if they work in nursing homes and hospice settings (Baker, 2000). While older social workers are more knowledgeable of advance directives (Baker, 2000), they appear less concerned about possible clinical barriers than their younger counterparts (Van Dorn et al., 2006). Social workers also report that lack of communication between staff is a potential barrier to implementing PADs, and are particularly concerned about the lack of time to review the documents (Van Dorn et al., 2006). Social workers face the added challenge of assessing whether mentally ill individuals are capable to fill out advance directives while still accommodating views of other front-line workers such as psychiatric nurses (Kadushin & Egan, 2001). Social workers are more likely to believe involuntary treatment does not work than psychologists and psychiatrists, and are more inclined to endorse respect for patient autonomy than psychiatrists (Elbogen et al., 2006).

1.9.5 Lawyers

Research related to PADs has primarily been targeted towards perceptions of medical professionals, and there has been very little research documenting lawyers' attitudes. Perlin (2004) highlights how lawyers' attitudes in assessing competency are important in arriving at dispositions in right to refuse treatment cases. Lawyers who represent mentally ill individuals may present their case before judges as if they already know what is in the best interests of their mentally ill client (Perlin, 2004). For example, refusal of electroconvulsive therapy (ECT) is one form of treatment mentally ill

individuals could document within a PAD even if legal and medical professionals have very different perspectives regarding its efficacy (Guze, Baxter, Liston, & Roy-Byrne, 1988). In a Japanese based study exploring the concordance between psychiatrists' and lawyers' judgments of competency to refuse ECT, it was found that psychiatrists are more likely to judge mentally ill individuals as incompetent than lawyers (Kitamura, Kitamura, Ito et al., 1999; Kitamura, Kitamura, Mitsuhashi et al., 1999). Lawyers may not always zealously represent their mentally ill clients because they feel responsible as knowing what is in a client's or society's best interest (Perlin, Gould, & Dorfman, 1995). How lawyers interact with their mentally ill clients can have therapeutic or anti-therapeutic effects as a function of perceptions of legislative rules and procedures (Perlin, 2000). Lawyers may find themselves arguing "for their version of patient's needs rather than for patient's expressed wishes" (Bottomley, 1987). In order for treatment to be efficient and individuals to receive suitable quality care, legal and mental health professionals must adopt a collaborative and united front to deal with treatment refusal declarations (Gutheil, 1987).

1.9.6 Judges

The number of individuals who are involuntarily committed continues to increase each year in Canada (Legislative Assembly of Ontario, 2000), with contested cases appearing before Superior court judges. Systematic differences are created in the application of law when 'expertise biases' exist between judges and psychiatrists in determining whether a mentally ill individual should be civilly committed for dangerousness (Owens, Rosner, & Harmon, 1985; Poletiek, 2002). Judicial decisions and legislative policies supporting legally mandated treatment are frequently based on public

perceptions of perceived dangerousness (Watson, Corrigan, & Angell, 2005). Different perceptions also exist between judges themselves on how to assess competency, whether to uphold treatment choices, risk of dangerousness, which guiding ethical principles should prevail, and the application of legal rules (Owens, Rosner, & Harmon, 1987). Some judges are more activist than others in imposing their opinions of clinical and diagnostic treatment choices for the mentally ill (Miller, 2000b). Psychiatric information provided to judges by mental health professionals through clinical reports and evaluations undoubtedly influences their decisions of involuntary treatment. Miller (2000a) argues that just as patients cannot demand treatment by clinicians, so too judges should not be able to force doctors to provide improper treatment or impose their treatment decisions on clinicians.

Measuring judges' perceptions of PADs would offer insight into whether and why they believe that a patient should have the right to refuse treatment. Judges who have sat on the bench longer than some of their colleagues place more weight on the clinical presentation of patients, although many judges still feel insufficiently trained to make judicial decisions regarding mental health (Poyner, 2002). It is not surprising, therefore, that judges who report lack of confidence in deciding mental health cases also lack training in abnormal psychology and knowledge of mental health law (Poyner, 2002). Still, it is possible that the reason 90% of judges believe involuntary commitment decisions should be made by themselves is because mental health statutes are vague placing them in the best position to interpret the meaning behind such legislation (Poyner, 2002).

Judges may decide not to give sufficient attention to PADs because they wish to avoid undermining the clinical judgment of psychiatrists and question whether such

examinations have been completed ethically. O'Connell (2002) found general agreement among lawyers, judges, psychologists, psychiatrists and social workers that judges will uphold professional recommendations for treatment over directives. Bursztajn et al. (1991) provides evidence that when psychiatrists and judges are asked whether they would treat a psychotic patient with neuroleptics, aware that tardive dyskinesia is a side effect, psychiatrists choose to treat the patient while judges are inclined to forgo treatment. In this respect, clinicians tend to make treatment decisions prospectively to avoid potential danger or harm whereas judges tend to make decisions retrospectively after the harm has occurred (Bursztajn et al., 1991).

1.9.7 Administrative tribunal members

Professionals who sit as members of administrative tribunals of provincial Review Boards include judges, lawyers, psychiatrists, psychologists, nurses, and social workers, among others, and decide issues related to capacity and consent to treatment, hospital discharge and release, and treatment choices. In Québec, the Tribunal Administratif du Québec (TAQ) is a Review Board that allows Québec citizens to solve disputes and challenge governmental decisions when their freedom is restricted. One subgroup of the TAQ is the Commission D'Examen Des Troubles Mentaux (CETM) which makes decisions with respect to individuals who, after being accused of committing a crime, are judged to be unfit or not criminally responsible as a result of mental health problems.

The Consent and Capacity Board in Ontario is another Review Board that consists of psychiatrists, lawyers and community members who adjudicate on matters of consent, capacity, civil commitment and substitute decision making, with over 80% of the hearings related to a person's involuntary status in a psychiatric facility and capacity to consent to

or refuse treatment. The Ontario Review Board primarily hears cases involving criminal matters for someone found not criminally responsible on account of mental disorder or unfit to stand trial, although frequently many of these cases deal with mentally ill individuals who refuse to accept medical treatment. Professionals who sit on Review Boards are important professional stakeholders as they are frequently the first to hear legal aspects of cases involving the right to refuse medical treatment.

Mail questionnaires have been used to measure professional's perceptions of PADs in past studies (O'Connell, 2002). The advantage of administering an online Web-survey to professionals, rather than paper mailing, is the speed and convenience of response and lower cost (no mailing needed). Internet surveys also typically reduce costs associated with postage, data entry costs and paper (Granello & Wheaton, 2004). Individuals who complete Web-surveys do so typically right away with 50% of all completes being done within a few days (Czaja, 2005). An online Web-survey was specifically designed for this study because, although pre-existing surveys were consulted (Elbogen, 2006), they tended to focus exclusively on perceptions of mental health professionals and were therefore incompatible with the goal of this study—to measure perceptions of legal and mental health professionals from Ontario and Québec on relevant medico-legal issues.

Response rates among professional groups in PADs studies reveal there has been a paucity of data examining how psychiatrists respond to online Web-surveys, although mailed questionnaires of PADs surveys average between 25-41% in England (Atkinson et al., 2004), 32% in the US where a $50 gift certificate was awarded (Elbogen et al., 2006; Swartz et al., 2005), and 58% in Austria (Amering et al., 2005). Psychologists typically practice in hospitals, private clinics, and academic institutions (Gauthier, 2002). Response

rates from mailed questionnaires to psychologists generally hovers around 40% in Canada (Sladeczek, Madden, Illsley, Finn, & August, 2006) and 48% in the US (Elbogen et al., 2006). Response rates of mailed questionnaires to psychiatric nurses regarding knowledge and attitudes of advance directices generally varies between 24-58% (Amering, Denk, Griengl, Sibitz, & Stastny, 1999; Lipson et al., 2004). Response rates of mailed questionnaires to social workers generally fall between 57 to 67% (Baker, 2000). A similar study from North Carolina, US recruited 193 social workers through an online Web-survey (Elbogen et al., 2006), however the response rate of their survey was not available.

2. IMPORTANCE OF THE PRESENT RESEARCH STUDY

There is a dearth of literature on PADs in Canada. The importance of this research is to improve management of mental health crisis, to improve the working therapeutic alliance between patients and clinicians, and to align legal and health policies in a manner that improves patient services generally through advance treatment planning. This study is also important for exploring perceptions of autonomy, coercion and stigmatization among the mentally ill, particularly when such principles are at odds with medically necessary treatment (McArdle, 2001). How far do ethical principles of patient autonomy and self-determination extend when such principles conflict with governmental interests to protect third parties? Unlike legal professionals, mental health professionals face dual legal and ethical obligations to respect patient autonomy while also providing the best possible medical treatment. How treatment providers understand and interpret governing laws within each province affects their beliefs and best practices, and whether patients should be permitted to exercise their personal autonomy rights in deciding treatment

preferences. Furthermore, this research was important for adding an empirical dimension to a long-standing debate between doctors and lawyers on the utility and benefit of PADs and the right to refuse medical treatment. To my knowledge this is the first research study to explore this debate in Canada.

With facilitated training about PADs, they are beginning to show promising results in countries such as the United States where active research is being conducted on their implementation (Elbogen et al., 2007). This study offers the benefit of understanding whether PADs are perceived to be useful legal documents in Canada and whether legal and mental health professionals may be willing to start using them as a form of mental health service. Furthermore, this study is distinctive in that it explores legal versus mental health professionals' perceptions rather than medical professionals' perceptions against each other. Knowledge about PADs obtained through this study, from the perspective of decision-making professionals, will benefit mentally ill individuals if translated into a practical service that increases therapeutic and clinical outcomes. The study will also be useful for legal and policy makers in future decision-making when contemplating capacity and consent laws as it relates to patient's treatment concerns. There has been little empirical data to inform legislative decision-making on issues such as advance directives, capacity and consent law, and the right to refuse medical treatment in Canada. The study also stands to benefit the international research community by providing a Canadian perspective on PADs and how they may interact with mental health legislation.

3. PURPOSE OF RESEARCH

The purpose of this study is to identify perceptions of PADs among various legal and mental health professionals in Canada that broadens our present understanding of

PADs and whether such documents may be favorably received. Before attempting to implement PADs, professional attitudes across clinical, legal, ethical and implementation factors need to be examined in relation to provincial mental health legislation. This research study focuses on professional stakeholders' views from Ontario and Québec where mental health legislation governing psychiatric care, capacity to consent to or refuse medical treatment differs considerably. This research also extends our body of knowledge surrounding the right to refuse medical treatment in two Canadian provinces. While there has been prolific research on PADs from other countries, empirical research on advance directives for the mentally ill in Canada has received less attention with the focus on specific medical disorders such as Alzheimer's (Bravo, Dubois, & Paquet, 2003; Bravo, Paquet, & Dubois, 2003). As Van Dorn states, "the generalizability of research on clinician attitudes from other countries, while useful, is still limited by its context," (Van Dorn et al., 2006). It is therefore necessary to explore the feasibility of implementing PADs from a Canadian perspective.

There have been several missing elements from previous research that justify the purpose for conducting this PADs study. For example, prior research has recommended that future studies should examine mental health professionals' opinions about advance directives in different US states to assess legislative differences (Elbogen et al., 2006). A perspective of two different Canadian provinces, where the laws differ substantially, of both legal and mental health professionals is provided. To address the paucity of empirical research on what constitutes justifiable criteria to override PADs (Swanson et al. 2006), this study extends our current knowledge by offering additional important factors. Another gap in the literature has been how to determine standards of decisional capacity used to revoke PADs (Srebnik & Kim, 2006), which is partly addressed in this

study by asking professionals their opinions of legally relevant criteria such as understanding and appreciating ability. While previous research has demonstrated a legitimate concern for medical malpractice lawsuits among psychiatrists, psychologists and social workers (van Dorn et al. 2005), this study also specifically asks legal and mental health professionals about their views on this important issue.

4. MAIN STUDY OBJECTIVES

There are three main objectives of this study. The first objective is to explore familiarity and knowledge with PADs between legal and mental health professionals and among Ontario and Québec professionals. It is necessary to first understand whether professionals have different levels of familiarity of PADs based on the type of professional practice and the jurisdiction in which they practice. For example, Ontario and Québec laws differ substantially from each other and it is possible that knowledge of PADs is associated with the jurisdiction where a professional practices.

Objective 1.1: To assess whether legal and mental health professionals differ in their familiarity with PADs.

Objective 1.2: To assess whether Ontario professionals differ from Québec professionals in their familiarity with PADs.

The second objective is intended to explore willingness to start using PADs between legal and mental health professionals and between Ontario and Québec professionals. It is possible that willingness to begin using PADs is associated with knowledge of how the documents are intended to work.

Objective 2.1: To assess whether legal and mental health professionals differ in their willingness to use PADs.

Objective 2.2: To assess whether Ontario professionals differ from Québec professionals in their willingness to use PADs.

The third objective is intended to identify predictive factors associated with familiarity and willingness to begin using PADs. Understanding the reasons why legal and mental health professionals are willing or reluctant to start using PADs is important so that we can better understand which factors contribute to possible implementation barriers.

Objective 3: To identify predictive factors of legal and mental health professionals' familiarity and willingness to start using PADs.

5. METHODOLOGY

5.1 Participants and recruitment

An online Web-survey was administered to 200 participants between January, 2007 and March, 2007. In this survey, attitudinal data was gathered from legal professionals (n=50) and mental health professionals (n=150) from two Canadian provinces, Québec and Ontario. The inclusion criteria for this study are that the participant is a legal or mental health professional (primarily psychologists, psychiatrists, lawyers, or administrative tribunal members of Review Boards) from Ontario or Québec. For the purposes of this study, a legal or mental health professional included students in training (i.e. psychiatric resident, law student), university professors, or mental health advocates. If a participant belonged to two professional groups (i.e. both legal and mental health professional) the participant was only assigned to one group. This was applied in one instance where a lawyer self-identified as a social worker however was included only as a legal professional because their role as social worker was selected in the survey

secondary. Where a participant was not licensed to practice in either Ontario or Québec (i.e. US, Europe, etc.) that individual's response was excluded for any statistical analyses involving provincial comparisons. Likewise, where a participant was licensed to practice in both Ontario and Québec, that individual was included in a "mixed" group for any statistical analyses involving provincial comparisons. For example, if a participant practiced in Ontario along with another foreign jurisdiction (i.e. US, Europe, Alberta) the participant was only assigned to Ontario.

The provinces of Ontario and Québec were selected primarily because the laws regarding treatment refusal are substantially different in these two provinces. The major population centers are Montreal, Québec and Toronto, Ontario. Professional associations and email listserv providers were contacted and asked to participate in the study by forwarding an email hyperlink to their professional members to access the online Web-survey. One major advantage of asking professional associations and listserv providers to forward the email with the survey link directly to their members was that there was no need for them to release any personal names or emails.

The sampling frame contained participants from two major categories: mental health professionals (psychiatrists, psychologists) and legal professionals (lawyers, administrative tribunal members of Review Boards). Flowchart 1 reveals that of the 26 organizations invited to participate in the study, 8 associations or groups forwarded the online Web-survey to their members. Those organizations agreeing to participate included psychiatric, psychological, legal, administrative tribunal, and psychiatric advocacy groups (Flowchart 1). Participants were originally intended to be recruited across four mental health professions (psychiatrists, psychologists, social workers, and psychiatric nurses) and three legal professions (lawyers, judges, administrative tribunal

members) in both Ontario and Québec. However, due to the administrative challenges posed in obtaining consent from organizations of social workers, psychiatric nurses, and judges these professional groups were omitted from the study (see Flowchart 1). A convenience sample was used.

The number of individuals who participated in this study was N=200. Flowchart 2 shows participants by professional group. When the category of administrative tribunal members was established as a separate group there was an overrepresentation of N=229. The reason 29 individuals are counted twice is because they belonged both to a professional group (i.e. psychiatrist, psychologist, lawyer) and were also a member of an administrative tribunal. This categorization was done to represent which participants sat on an administrative tribunal, however they were not counted twice in the analyses of the study. Likewise, some professionals practiced in two jurisdictions (i.e. Ontario and Québec) or had multiple types of practice (i.e. private and public sector), in which case the number of participants reflected in Flowchart 2 is N=235. In other words, 35 individuals practiced in two jurisdictions or had multiple types of practice. They were also not counted twice in the analyses. The total number of invited participants (N=4183) represented in Flowchart 2 refers to the number of individuals who received an email from their professional association or listserv.

Psychiatrists: In this Web-survey, 1271 psychiatrists from Ontario and Québec were invited to participate primarily through the Canadian Psychiatric Association (n=1237). To increase representation of Québec psychiatrists, a convenience sample of contacts was provided by the Psychiatrist-in-Chief at the Douglas Mental Health University Institute in Montreal (n=34). In total, n=98 psychiatrists responded to the survey, 71% from Ontario, 12 % from Québec, and 16% from a mixed jurisdiction.

Psychologists: Of the 1969 psychologists invited to participate, recruitment was primarily through the Ontario Psychological Association (n=400) and an online listserv of Québec psychologists hosted by Laval University in Québec City (n=1,569) (Flowchart 1). Among the 50 psychologists who responded, 59% practiced in Ontario, 31% practiced in Québec, and 5% were from a mixed jurisdiction (see Flowchart 2; Table 1).

Lawyers: Lawyers specializing in health or medical law were recruited through the Ontario division of the Canadian Bar Association's Health Law Section (n=310) and the Québec division 'Section droit de la sante' (n=190). A total of 30 lawyers responded to the survey with 67% from Ontario, 30% from Quebec, and 3% from a mixed jurisdiction (see Flowcharts 1 and 2; Table 1).

Administrative Tribunal Members: Administrative tribunal members of Review Boards conduct specialized judicial hearings related to psychiatric treatment issues. The Consent and Capacity Board, Ontario Review Board and Tribunal Administratif du Québec (TAQ) were each contacted to participate in this study. Administrative tribunal members included judges, lawyers, psychiatrists, psychologists, psychiatric nurses, and community members. A total of 29 administrative tribunal members responded to the survey, or 15% of the total sample population, primarily from the Ontario Consent and Capacity Board (n=25) (see Table 1).

Community members: Nineteen community members were recruited as individuals who did not belong to an identified professional group in the survey, and were members of the Psychiatric Patient Advocate Office, Consent and Capacity Board, or Ontario Review Board. For the purpose of this study, community members were classified as legal professionals due to their role as members of a judicial tribunal or active involvement in mental health advocacy (see Flowchart 1 and 2; Table 1).

Psychiatric Nurses: Although four nursing organizations were contacted to participate in this study (Flowchart 1), none agreed to participate because they could not release emails of their members for research purposes or the study did not fall within their professional mandate. Flowchart 2 shows that two psychiatric nurses from Ontario participated in the study because they were members of an administrative tribunal.

Social workers: Two social worker organizations were invited to participate in the study but both declined (Flowchart 1).

5.2 Study procedure

5.2.1 Online Web-survey

An online Web-survey was designed using software program (Remark Web Survey 3, 2003) and administered to legal and mental health professionals practicing in Ontario and Québec (Appendix B: survey). Prior to administering the survey it was pilot-tested with ten individuals (psychiatrists, psychologists, lawyers), after which changes were made to the substance, format, and time required to maximize response rates. The time to complete the survey during the pilot-training session was between 10-15 minutes. A maximum of 15 participants could access the survey at any given time. Once re-directed to the Website, participants who provided their consent could begin the survey.

5.2.2 Instruments and Measurements

The Web interface of our survey had the advantage of being visually appealing and of humanizing the survey-taking experience so that the participant maintained interest. Questions from clinical, ethical, legal, implementation, and demographic factors appeared on a separate colored screen allowing the responder to focus on a sub-area

before moving to the next screen and item. The survey and consent forms were translated and reviewed from English to French by the project coordinator of the Mental Health and Law Laboratory at the Douglas Hospital who is fluently bilingual.

The survey was designed to contain 41 questions: one qualitative question at the outset of the survey and one at the end, along with 39 4-point Likert-scale items to yield quantitative data. Qualitative methods have been used in previous research to assess how PADs can become a tool for empowerment, how service providers' knowledge of the documents can be increased, and difficulties posed in communicating PADs' potential benefits to inpatient staff members (Kim et al., 2007). Appendix B shows that the survey was divided into six main sections, along with the two qualitative questions. The first section examined clinical factors related to treatment preferences, clinical criteria used to assess capacity, along with the role of mental health professionals. The second section explored professional perceptions of ethical factors as they related to provincial mental health legislation and the ethical value judgments made by different groups. The third section dealt with legal factors such as knowledge of legal standards of competency, concern for medical malpractice, and how PADs might be incorporated into the current state of the law. The fourth section related to implementation of PADs, the role of family members, and willingness to start using PADs. The fifth section gathered demographic information of participants. The sixth section assessed the degree of contact professionals had with mentally ill individuals. Question 1 asked, 'In your view, what are the advantages and/or disadvantages of implementing PADs?' and question 41 was used as an alternate way to tap into willingness to begin using PADS by asking, 'Why are you willing or reluctant to implement PADs?'

5.3 Dependent and independent variables

The main dependent variables of interest in this study were: (i) knowledge and familiarity with PADs and (ii) willingness to implement PADs. However, in conducting logistic regression, other secondary dependent variables were examined such as concern for medical malpractice in overriding PADs, judicial power to override PADs, and whether mentally ill individuals should have the right to refuse medical treatment.

The primary independent variables explored in this study were: i) jurisdictions of Ontario and Québec and ii) legal and mental health professionals. Similarly, other independent variables were examined to assess whether they predicted familiarity and willingness to use PADs. These included age, gender, ethnic background, contact with the mentally ill, and length of time in professional practice. In conducting logistic regression, additional survey questions were also included as independent variables to assess familiarity and willingness to use PADs.

5.4 Data collection

This study relied on both quantitative and qualitative data collection. The data was collected and converted into a SPSS (2003) format data and syntax file, which facilitated the analysis stage. The website was fully encrypted so that when participants submitted their response, the data was immediately transferred to a secure hosting site into an Excel document. The program used to collect the data is hosted by the manufacturer of the survey technology (Remark Web Survey 3, 2003), and the only person able to access the data was a computer technician at the Douglas Hospital who held a special key (with code). The computer technician used a 128 bit encryption key to access the data. The benefit of using the program was that it facilitated collection of the data, was compatible

with the statistical program SPSS 11.5 (2003), and the data reduction process into usable file format was a rapid process. The qualitative data was collected through two open-ended questions and then coded, categorized, and analyzed with the software program QSR N6 (2000).

5.5 Statistical analysis

5.5.1 Quantitative analysis

Of the 41 items in the online Web-survey, 39 questions used a 4 point Likert-scale response format allowing participants to respond from 1 to 4, where 1= 'not at all' and 4= 'extremely'. The survey was designed as a forced-choice format with 4 response options, rather than 5, so that participants were unable to select a neutral, middle response value. For ease of statistical analyses, the measures from the 4 point Likert-scale were then divided into two categories: 1 & 2= 'No' and 3 & 4= 'Yes'. The reason for generating two response categories, Yes/No, from the four original categories was the ease of establishing a midpoint which facilitated statistically analyzing two discrete categories instead of four.

Descriptive statistics of informant demographics were generated. Chi-square tests for independence were then performed for: (i) legal and mental health professionals, (ii) administrative tribunal members, (iii) Ontario and Quèbec professionals and, (iv) psychiatrists, psychologists, lawyers, and community members. A Bonferroni correction was used to account for multiple testing (α value of .001 /number of tests performed within each theme of analysis).

To identify variables that could be entered into the multivariate logistic regression analyses, bivariate correlation analyses using SPSS 11.5 (2003) were performed to assess

which variables were significantly correlated at $p < 0.25$ level and could be included as candidate variables into the multivariable model (Hosmer & Lemeshow, 2000). Table 10 shows the bivariate correlation matrix of the variables included into the model. To find the most parsimonious model explaining the data, a $p < 0.25$ value was used rather a more traditional approach of $p < 0.05$, which often fails to identify variables known to be important. In this study, all of the variables included into the model were significant at $p < 0.05$, except for one (legal and mental health professionals correlated with familiarity with PADs) which was significant at $p < 0.25$. Given the large number of variables significant at the bivariate level, and in order to avoid over-fitting the model and producing potentially unstable estimates, a maximum of nine variables were included in the logistic regression model. The choice of the nine variables to include into the model was based on their theoretical relevance. A direct logistic regression was used to analyze the data because the outcome being studied was exploratory, the important covariates were unknown, and associations with the outcome were not well understood.

Five separate logistic regression analyses were performed using SPSS software (2003) to identify predictor variables for the following dependent outcome variables: (i) familiarity with PADs, (ii) willingness to use PADs, (iii) concern for medical malpractice in overriding PADs, (iv) judicial power to override PADs, and (v) whether mentally ill individuals should have the right to refuse medical treatment. Logistic regression is based on the odds ratio and used to measure how much more likely it is for an outcome to be present (i.e. familiarity with PADs) among those with a specific attitude (i.e. knowledge of ethical issues) than among those without a specific attitude (i.e. no knowledge of ethical issues).

5.5.2 Qualitative analysis

The first and last items of the survey were analyzed as open-ended qualitative data since the questions explored in these sections were intended to be subjective. Question 1 asked, "In your view, what are the advantages and/or disadvantages of implementing PADs?" and the last question (41) asked, "Why are you willing or reluctant to implement PADs". Every response given for both questions were read by two persons, the author of this thesis and a research assistant, and then classified into two major themes (advantages and disadvantages). The advantages and disadvantages were then categorized into several major sub-themes to produce frequencies with the use of a qualitative software program (QSR N6, 2000). For question 41, "Why are you willing or reluctant to implement PADs?" responses were further coded into three categories: (i) willing (a clear statement was made by the participant in favor of PADs), (ii) unwilling/reluctant (a clear statement was made by the participant not in favor of PADs), or (iii) neutral (either the participant made no definitive comment or specifically stated they were neutral towards PADs).

5.6 Ethical considerations

This study was submitted and approved by the McGill University Health Research Ethics Board and received expedited approval. The privacy and confidentiality of all participants remained anonymous at all times, and there was minimal risk inherent in this study as data collected was not identifiable and no secondary uses from the data were ever intended or used. The Web link to the Web-survey was forwarded to participants by professional organizations so that linking names and emails was never possible.

6. RESULTS

6.1 Descriptive statistics

Results were obtained for descriptive statistics of informant demographics by professional groups (Table 1), administrative tribunal members (Table 2), legal and mental health professionals (Table 3), and jurisdiction of Ontario and Québec (Table 4).

Table 1 indicates that 57% of the sample was male and 44% female. Among lawyers, 80% were specialized to practice in health law, while 72% of psychiatrists were in public practice. Participants provided their age in category intervals (i.e. 41-50; 51-60) so that age was statistically analyzed with chi-square tests. Table 2 reveals a tendency for administrative tribunal members to be older in age than non-administrative tribunal members (X^2 (2, N=200) = 31.77, $p < .001$). Administrative tribunal members also spent more time as a practicing member within their professional group than non-administrative tribunal members (X^2 (2, N=200) = 29.06, $p < .001$).

In Table 3, chi-square tests for independence were performed revealing that legal and mental health professionals and age is unrelated (X^2 (2, N=200) = 1.36, $p > .505$). Among the participants, 86% were from a Caucasian ethnic background. Thirty-two percent of legal professionals and 9% of mental health professionals sat as administrative tribunal members (X^2 (1, N=200) = 16.468, $p < .001$). As would be expected, 75% of mental health professionals reported working frequently with the mentally ill compared to 44% of legal professionals (X^2 (1, N=200) = 16.783, $p < .001$). Almost 70% of legal professionals and 75% of mental health professionals were never hospitalized nor had an immediate family member who was hospitalized for symptoms of severe mental illness.

Table 4 reveals that among professionals from Ontario (n=131), Québec (n=37), or a mixed jurisdiction (n=26), 65% of Ontario professionals were male and 68% of Québec professionals were female (X^2 (2, N=194) = 12.552, $p < .01$). There was a tendency for Ontario professionals to be older than Québec professionals (X^2 (4, N=194) = 31.051, $p < .001$), with only 9% of Québec professionals spending more than 30 years in professional practice in comparison with almost 25% of Ontario professionals (X^2 (4, N=194) = 26.314, $p < .01$). Among those who responded to the survey, Ontario professionals (71%) worked more frequently with the mentally ill than did Québec professionals (51%), X^2 (2, N=194) = 5.874, $p < .05$.

6.2 Results of study objectives

6.2.1 Objective 1.1: Familiarity with PADs (legal and mental professionals)

The results from this study indicate that familiarity with PADs was not associated with legal and mental health professionals (X^2 (1, N=200) = 2.23, $p > .135$). However, when examining individual professions, it was found that lawyers, psychiatrists, and community members were more familiar with PADs than psychologists (X^2 (3, N=197) = 11.85, $p < .01$).

When compared with other professionals, legal professionals in this study reported more knowledge of the law related to advance directives than mental health professionals, (X^2 (1, N=200) = 25.926, $p < .001$). Congruent with these findings, legal professionals (44%) reported more knowledge with the process of how to document advance directives than mental health professionals (23%) (X^2 (1, N=200) = 8.466, $p < .01$). Lawyers (57%) were more knowledgeable with documenting advance directives than psychiatrists (29%), psychologists (12%), and community members (26%) (X^2 (3,

N=197) = 18.433, $p < .001$). As would be expected, lawyers reported more knowledge compared with psychiatrists, psychologists, or community members of laws surrounding advance directives when compared with other mental health professionals (X^2 (3, N=197) = 15.450, $p < .001$), and when compared with other legal professionals (X^2 (3, N=197) = 43.748, $p < .001$). Almost 87% of lawyers and 80% of psychiatrists were more familiar with mental health legislation and the standard of legal competency in their province compared to 50% of psychologists and 58% of community members (X^2 (3, N=197) = 19.409, $p < .001$).

Reported below are other significant results associated with legal and mental health professionals. For example, regarding perceptions of clinical factors involving PADs, 95% of mental health professionals expressed concern for leaving the mentally ill untreated compared with 82% of legal professionals (X^2 (1, N=200) = 7.736, $p < .01$). Mental health professionals perceived the four criteria to assess clinical capacity for severe mental illness as more important than legal professionals (understanding ability, X^2 (1, N=200) = 8.274, $p < .01$; appreciating ability, X^2 (1, N=200) = 3.997, $p < .05$; reasoning ability, X^2 (1, N=200) = 4.773, $p < .05$; and evidencing a choice, X^2 (1, N=200) = 9.722, $p < .01$). Psychiatrists, psychologists, and lawyers each expressed more concerned with leaving the mentally ill untreated than community members (X^2 (3, N=197) = 10.715, $p < .05$). Psychiatrists were more likely to believe that the way legislative policies are drafted can affect clinical outcomes than psychologists, lawyers, or community members (X^2 (3, N=197) = 8.863, $p < .05$).

Regarding perceptions of ethical factors of PADs, a higher proportion of legal professionals (68%) than mental health professionals (52%) viewed decreasing stigmatization as an important ethical value for an individual's right to refuse treatment

(X^2 (1, N=200) = 4.552, $p < .05$). Mental health professionals were more concerned than legal professionals that when patients refuse medical advice they may be left untreated for lengthy periods of time (X^2 (1, N=200) = 3.990, $p < .05$). Psychiatrists and community members were more likely to believe than lawyers that PADs can have therapeutic value (X^2 (3, N=197) = 8.900, $p < .05$). Almost 77% of lawyers were inclined, when compared to 36% of psychiatrists and 32% of community members, to allow a patient the right to decline medical treatment even if the decision is not in an individual's best interest (X^2 (3, N=197) = 20.744, $p < .001$). All professions were strongly concerned that patients who refuse to follow medical advice would leave a mentally ill individual untreated. For example, 98% of psychiatrists were concerned when compared to psychologists (80%), lawyers (87%), and community members (79%) that refusing to follow medical advice may leave a patient untreated for lengthy periods of time (X^2 (3, N=197) = 15.192, $p < .01$).

A greater percentage of mental health professionals than legal professionals expressed concern with the possibility of medical malpractice lawsuits for overriding PADs (X^2 (1, N=200) = 3.804, $p < .05$). Psychiatrists (71%), psychologists (60%), and lawyers (67%) were more concerned compared to community members (32%), who are not generally responsible for treatment, that overriding a prior competent wish may lead to a medical malpractice lawsuit (X^2 (3, N=197) = 11.449, $p < .01$), however, there was no difference between psychiatrists, psychologists, and lawyers. When asked whether courts should protect prior competent wishes expressed in a PAD over clinical decisions made by mental health professionals, psychiatrists (43%) and psychologists (52%) responded affirmatively less often than lawyers (70%) and community members (74%) (X^2 (3, N=197) = 10.754, $p < .05$). Legal professionals (72%) believed more than mental

health professionals (47%) that courts should have an active role in protecting prior competent wishes expressed in PADs over clinical decisions made by mental health professionals (X^2 (1, N=200) = 9.661, $p < .01$). Legal professionals (98%) placed more importance on the criteria of appreciating ability to assess competency than mental health professionals (87%), (X^2 (1, N=200) = 5.125, $p < .05$).

When participants were asked whether psychiatrists should be the authoritative decision-maker in determining whether a patient has made a competent wish, 88% of mental health professionals and 74% of legal professionals responded yes (X^2 (1, N=200) = 5.612, $p < .01$). When asked how much psychiatrists should be the authoritative decision-maker in determining when a competent wish is valid, 92% of psychiatrists believed they were the authoritative decision-maker compared to 80% of psychologists, 73% of lawyers, and 74% of community members (X^2 (3, N=197) = 9.231, $p < .05$). At the same time, when participants were asked how much psychologists were the authoritative decision-maker in determining when a competent wish is valid, 84% of psychologists believed they were the authoritative decision-maker compared to 64% of psychiatrists, 57% of lawyers, and 58% of community members (X^2 (3, N=197) = 9.072, $p < .05$). Among psychiatrists, 89% perceived that Review Boards should be the authoritative decision-maker in deciding competent wishes in comparison to 64% of psychologists, 77% of lawyers, and 84% of community members (X^2 (3, N=197) = 13.232, $p < .01$).

Mental health professionals were more likely to believe than legal professionals that family members should be involved in assisting competent individuals to complete a PAD (X^2 (1, N=200) = 5.962, $p < .01$). Lawyers, on the other hand, were less favorable than psychiatrists, psychologists, and community members to have family members

involved in assisting competent individuals who could possibly develop a mental illness in the future complete a PAD (X^2 (3, N=197) = 8.073, $p < .05$).

6.2.2 Objective 1.2: Familiarity with PADs (Ontario and Québec professionals)

The results from this study indicate that Québec professionals were less familiar with PADs than Ontario professionals (X^2 (1, N=181) = 6.850, $p < .01$). At the same time, Ontario professionals reported more knowledge of ethical issues surrounding PADs than Québec professionals (X^2 (1, N=181) = 4.36, $p < .05$). Ontario professionals were more familiar with mental health legislation and the standard of competency in their province than Québec professionals (X^2 (1, N=181) = 12.858, $p < .001$), and Ontario professionals (33%) reported more knowledge of how to document advance directives than Québec professionals (10%) (X^2 (1, N=181) = 7.977, $p < .01$).

Reported below are significant differences between Ontario and Québec professionals. For example, 80% of Ontario professionals saw PADs as having more therapeutic value for individuals with serious mental illness than did 50% of Québec professionals (X^2 (1, N=181) = 14.528, $p < .001$). Among Québec professionals, 70% viewed decreasing stigmatization as an important ethical value for an individual's right to refuse treatment in comparison to 53% of Ontario professionals (X^2 (1, N=181) = 3.60, $p < .05$). Québec professionals believed that psychiatric nurses should have more of a role as authoritative decision-maker in determining when a competent wish has been expressed than Ontario professionals (X^2 (1, N=181) = 11.634, $p < .001$). Québec professionals also believed social workers should have more of an authoritative decision-making role in determining when a competent wish has been expressed when compared with Ontario professionals (X^2 (1, N=181) = 3.958, $p < .05$). On the other hand, Ontario

professionals are more likely to believe than Québec professionals that Review Boards should have an authoritative decision-making role (X^2 (1, N=181) = 5.125, $p < .05$).

6.2.3 Objective 2.1: Willingness to use PADs (legal and mental professionals)

These results revealed that there was no significant association between legal and mental health professionals and their willingness to begin using PADs in their professional practice (X^2 (1, N=200) = .061, $p > .804$). Instead, 58% of mental health professionals and 56% of legal professionals reported that they would be willing to begin using the documents. Similarly, it was found that 61% of psychiatrists, 50% of psychologists, 57% of lawyers, and 58% of community members were willing to begin using PADs in their practice (X^2 (3, N=197) = 1.71, $p > .634$).

6.2.4 Objective 2.2: Willingness to use PADs (Ontario and Québec professionals)

These results indicate that Québec professionals (73%) expressed more willingness to start using PADs in their practice in comparison to Ontario professionals (52%) (X^2 (1, N=181) = 5.443, $p < .05$).

6.2.5 Objective 3: Factors predicting familiarity and willingness to use PADs

Familiarity with PADs: A direct logistic regression analysis was performed on familiarity with PADs as outcome variable and nine predictor variables. Most of the predictor variables selected for inclusion into the model dealt with issues of knowledge and would be expected to relate to familiarity with PADs. Table 5 shows the nine predictor variables, bivariate correlations, odds ratios, and 95% confidence intervals for odds ratios associated with familiarity of PADs. Overall, the model correctly classifies 68% of individuals.

Administrative tribunal members were in practice longer than non-administrative tribunals this was also included into the model. Table 5 displays the results of the multivariate analysis. According to the Wald criterion, four variables reliably predict familiarity with PADs: (1) knowledge of ethical issues related to PADs ($OR = 25.00$, $p < .001$); (2) knowledge of the law related to advance directives compared to mental health professionals ($OR = 3.44$, $p < .05$); (3) knowledge of how to document advance directives generally ($OR = 7.25$, $p < .001$) and; (4) being an administrative tribunal judge ($OR = 5.58$, $p < .01$).

Willingness to start using PADs: A direct logistic regression analysis was performed on willingness to start using PADs as outcome variable and four predictor variables. The predictor variables for inclusion into this model were selected on the basis of implementation barriers and ethical concerns expressed in earlier research. Table 6 shows the four predictor variables, bivariate correlations, odds ratios, and 95% confidence intervals for odds ratios for each associated with willingness to start using PADs. Overall, the model correctly classified 56.4% of individuals.

Table 6 displays the results of multivariate analysis. According to the Wald criterion, four variables reliably predict willingness to start using PADs: (1) PADs not undermining clinical judgment of mental health professionals ($OR = 3.52$, $p < .05$); (2) knowledge of ethical issues related to PADs ($OR = 2.94$, $p < .05$); (3) professional practice in Québec ($OR = 3.03$, $p < .05$ and; (4) PADs perceived to help reduce stigmatization ($OR = 2.43$, $p < .05$).

Medical malpractice concerns: A direct logistic regression analysis was performed on concern for medical malpractice in overriding a PAD as outcome variable and seven predictor variables. Again, past literature was reviewed for reasons of concern associated

with medical malpractice and legal defensiveness, and questions from the survey believed to tap into this construct were included into the model. Table 7 shows the seven predictor variables, bivariate correlations, odds ratios, and 95% confidence intervals for odds ratios associated with concern for medical practice for overriding a PAD. Overall, the model correctly classified 63.5% of the individuals.

Table 7 displays the results of multivariate analysis. According to the Wald criterion, four variables reliably predict concern with medical malpractice for overriding a PAD: (1) concern with leaving the mentally ill untreated (OR = 4.76, $p < .05$); (2) if PADs are perceived to undermine the clinical judgment of mental health professionals (OR = 2.38, $p < .05$); (3) the belief that a patient who refuses to follow medical advice will leave someone untreated for lengthy periods of time (OR = 3.03, $p < .05$) and; (4) the professional works regularly with mentally ill individuals (OR = 2.23, $p < .01$).

Judicial discretion to override PADs: A direct logistic regression analysis was performed on judicial discretion to override a prior competent wish expressed in a PAD as outcome and four predictor variables. Table 8 shows the four predictor variables, bivariate correlations, odds ratios, and 95% confidence intervals for odds ratios associated with judicial discretion to override a PAD. Overall, the model correctly classified 61% of individuals.

Table 8 displays the results of multivariate analysis. According to the Wald criterion, two variables reliably predict judicial discretion to override a PAD: (1) a belief that individuals have an absolute right to decline treatment (OR = 2.37, $p < .01$) and; (2) perceiving judges as the authoritative decision-maker in determining whether a competent wish is valid (OR = 5.26, $p < .01$).

Right to refuse medical treatment: A direct logistic regression analysis was performed on the right someone with serious mental illness has to refuse medical treatment as an outcome variable along with five predictor variables. Rationale for including predictor variables into this model were primarily based on the association between ethical values (i.e. autonomy, coercion, self-determination) and the right to refuse treatment, which is inherently an ethical decision. Table 9 shows the five predictor variables, bivariate correlations, odds ratios, and 95% confidence intervals for odds ratios associated with the right to refuse medical treatment. Two hundred cases were entered into SPSS for analysis. Overall, the model correctly classified 55% of individuals.

Table 9 displays the results of multivariate analysis. According to the Wald criterion, four variables reliably predict the perception that individuals with serious mental illness should have the right to refuse treatment: (1) perceiving self-determination as an important ethical value ($OR = 6.25$, $p < .001$); (2) the perception that patients have an absolute right to decline medical treatment even if not in their best interests ($OR = 7.69$, $p < .01$); (3) awareness of past abuses from their province ($OR = 2.13$, $p < .05$) and; (4) gender ($OR = 2.13$, $p < .05$).

Flowchart 3 was developed to demonstrate an overall Logistic Regression Model of Psychiatric Advance Directives based on predictive and outcome factors. The model is intended to show different stages of the process—from beliefs of whether a mentally ill individual should be permitted the right to refuse treatment, to familiarity with PADs, to medical malpractice and override concerns, to willingness to start using PADs. The links between the outcome variables are only intended to show a possible direction of how events may proceed in the formation of a professional's perception of PADs.

6.3 Qualitative results

Results from the qualitative part of this study revealed that when participants were asked two questions, "In your view what are the advantages and/or disadvantages of implementing PADs?" (#1), and "Why are you willing or reluctant to implement PADs?" (#41) several major themes emerged. These themes were grouped, with a sample of responses to illustrate sub-themes, into 12 advantages (see Table 10) and 18 disadvantages (see Table 11). Definitions of how advantages and disadvantages were coded are described in the Tables 10 and 11. Table 12 demonstrates a frequency distribution of responses by professional group and jurisdiction. Among the 200 participants, 97% (n=193) responded to question 1 and 95% (n=189) responded to question 41.

Among the 12 advantages most frequently reported were: clear wishes, autonomous choice, collaborative treatment, medical benefits, family/substitute decision-maker, protection, legal concerns, predictability, liberty rights, systemic policy changes, dignity, and empowerment (Table 10, Table 12). The 18 disadvantages most frequently reported were: lack of awareness, treatment refusal, better treatment, legal concerns, family/substitute decision-making, professional non-compliance, new/changed circumstances, perpetuates illness, non-comprehensiveness, self-bound, hospital detention, economics, bureaucratic challenges, overbroad, danger/safety, validity, more research, and restricts liberty (Table 11, Table 12). Results were categorized into trends by legal versus mental health professionals, individual professional groups (psychiatrists, psychologists, lawyers, community members), and jurisdiction (Ontario, Québec, mixed jurisdiction).

Legal versus mental health professionals: Graph 1 shows trends of the top five advantages of PADs reported by legal professionals to be clear wishes, collaborative treatment, autonomous choice, family/substitute decision-maker, and predictability. Graph 1 also shows that the top five advantages of PADs reported by mental health professionals were autonomous choice, clear wishes, medical benefits, collaborative treatment, and family/substitute decision-maker. Only 3% of legal professionals reported on the medical benefits of PADs compared to 13% of mental health professionals. When legal and mental health professionals were combined to assess the top five advantages, the themes that emerged were clear wishes, autonomous choices, collaborative treatment, medical benefits, and the role of family/substitute decision-maker.

Graph 2 shows trends of the top five disadvantages reported by legal professionals as new/changed circumstances, lack of awareness, treatment refusal, better treatment, legal concerns, and professional non-compliance. Mental health professionals, on the other hand, reported the top five disadvantages as lack of awareness, treatment refusal, legal concerns, family/substitute decision-maker, and better treatment. When legal and mental health professionals were combined to assess the top five disadvantages, they were lack of awareness, treatment refusal, legal concerns, better treatment, and family/ substitute decision-maker.

When legal and mental health professionals were asked, "Why are you willing or reluctant to implement PADs?" each of the responses were interpreted and categorized into yes, no, or neutral. The method of categorizing responses was done by coding each participant's response into whether they were inclined to implement PADs. Graph 3 shows that among legal professionals, 40% leaned toward willingness to implement PADs, 32% leaned towards no, and 29% were neutral. Mental health professionals were

slightly more favorable to implementing PADs than legal professionals with 47% being interpreted as yes, 25% as no, and 28% as neutral.

Individual professional groups: Graph 4 shows trends of perceived advantages reported by individual professional groups (psychiatrists, psychologists, lawyers, and community members. Psychiatrists saw clear wishes, autonomous choice, medical benefits, collaborative treatment, and family/substitute decision-maker as the five most significant advantages of PADs. Psychologists, on the other hand, reported that autonomous choice, clear wishes, collaborative treatment, family/ SDM, and medical benefits were important. Lawyers suggested that clear wishes, autonomous choice, collaborative treatment, predictability, and liberty rights as the most important advantages. Community members reported that clear wishes, collaborative treatment, autonomous choice, family/ SDM, and medical benefits were important advantages of PADs.

Graph 5 presents perceived disadvantages of PADs by individual profession. Psychiatrists viewed lack of awareness, treatment refusal, better treatment, legal concerns, and the role of family/ SDM as significant disadvantages. Psychologists, on the other hand, reported treatment refusal, lack of awareness, legal concerns, family/SDM, and being self-bound as the foremost disadvantages. Lawyers suggested the major disadvantages of PADs were new and changed circumstances, better treatment, lack of awareness, treatment refusal, and professional non-compliance. Community members saw treatment refusal, new and changed circumstances, lack of awareness, non-comprehensiveness, and validity of PADs as disadvantages.

Graph 6 provides trends of willingness and reluctance to implement PADs based on individual professions. Results revealed that 50% of psychiatrists were likely to say

yes compared to 40% of psychologists, 40% of lawyers, and 39% of community members. At the same time, 39% of lawyers and 36% of psychiatrists were definitely not willing to implement PADs compared to 10% of psychologists and 14% of community members. In the neutral category were 49% of psychologists and 47% of community members, as opposed to 14% of psychiatrists and 21% of lawyers.

Jurisdiction: Graph 7 shows perceived advantages of PADs among professionals practicing in Ontario, Québec, and a mixed jurisdiction. Ontario professionals reported the top five advantages of PADs to be autonomous choice, clear wishes, collaborative treatment, medical benefits, and family/substitute decision maker. Québec professionals stated the top five advantages were clear wishes, autonomous choice, collaborative treatment, legal concerns, and family/substitute decision-maker. Interestingly, 12% of Québec professionals saw PADs as offering legal advantages as opposed to only 1% of Ontario professionals. Furthermore, 13% of Ontario professionals reported PADs as having advantageous medical benefits, unlike only 5% of Quebec professionals.

Graph 8 shows trends among reported disadvantages of PADs. Ontario professionals reported lack of awareness, better treatment, treatment refusal, family /substitute decision-maker, and legal concerns as the top five disadvantages. Québec professionals, on the other hand, reported lack of awareness, new and changed circumstances, professional non-compliance, legal concerns, and treatment refusal as the major five disadvantages.

Graph 9 shows that Ontario and Québec professionals both hovered around 44-45% in their willingness to implement PADs, while 31% of professionals from Ontario, 20% from Québec, and 24% from a mixed jurisdiction stated they were not willing to implement PADs. In general, the 43% from Ontario and Québec who were willing to

implement PADs is similar to the 45% of legal and mental health professional comparisons who were similarly willing to implement PADs.

7. DISCUSSION

The issues that arise in deciding whether PADs may be implemented in different parts of Canada are complex and multi-faceted as they must necessarily consider clinical, ethical, legal and implementation factors regarding the right to refuse medical treatment—in itself a highly charged ethical issue. In this online Web-survey administered to 200 legal and mental health professionals from Ontario and Québec, it was found that although 60% of legal professionals and 71% of mental health professionals reported unfamiliarity with PADs, there is a high demand to learn more about how PADs work, with approximately 90% of legal and mental health professionals believing PADs merit further research before the documents are implemented. As familiarity and knowledge with how PADs operate increases, positive attitudes to empower mentally ill individuals and make the mental health system more accountable may follow.

This survey provides evidence that Ontario professionals are more familiar and knowledgeable with PADs than Québec professionals; not a surprising finding given the recent high-profile legal cases dealing with the right to refuse medical treatment out of Ontario (Starson v. Swayze, 2003). Only 12% of psychologists in our survey were familiar with PADs, compared to approximately 40% among psychiatrists, lawyers, and community members, a finding that could be explained by the greater obligation upon psychiatrists and legal professionals to remain informed and current of legal aspects involving consent and capacity law for mentally ill individuals. As the majority of legal

professionals recruited in this study were specialists in health law, it is expected that they would report more knowledge of advance directives than mental health professionals and other non-specialist legal professionals. In order to increase familiarity with PADs, legal and mental health professionals need to be informed of ethical issues surrounding PADs and become more knowledgeable with legal aspects of advance directives generally.

The findings of this study revealed no difference between legal and mental health professionals' willingness to begin using PADs, however this may be due to the small number of participants particularly among legal professionals. At the same time, it was particularly revealing that 73% of Québec professionals were willing to start using PADS in their practice, compared to 52% of professionals from Ontario—a finding that goes against the initial thought that Ontario professionals would be more willing to start using PADs. Although Québec professionals expressed more willingness to start using PADs compared with Ontario professionals, 80% of Ontario professionals saw PADs as having therapeutic value for individuals with serious mental illness. Furthermore, Ontario professionals reported more knowledge with ethical issues related to PADs and how to document advance directives. One might surmise from this finding that having more knowledge about PADs and their implications actually decreases, rather than increases, interest in their use. One explanation may be that with very little knowledge individuals are very interested in PADs, but as subtleties and nuances of clinical, ethical, and legal knowledge of the documents increases, professionals become more reluctant. Nonetheless, almost 90% of professionals in Ontario and Québec believed that PADs merit further research, which suggests that perceptions may change with greater awareness.

Among legal and mental health professionals, these results also suggest that a little more than half of participants were willing to begin using PADs in their practice. Furthermore, around 40-50% of legal and mental health professionals who responded in the qualitative data suggested that they are willing to start using PADs, but more telling was that psychiatrists and lawyers were less likely to be neutral in their responses compared to psychologists and community members. It appears that psychiatrists and lawyers have more definitive views in whether they are willing to use PADs than psychologists and community members.

To increase willingness to begin using the documents, evidence from our logistic regression suggests that PADs should be presented in a manner that avoids undermining the clinical judgment of psychiatrists and contextualized in a collaborative patient-physician framework. Our results show that increasing professionals' knowledge of ethical issues related to PADs and showing how the documents can reduce stigmatization against mentally ill individuals predicts greater willingness to implement PADs.

Given Ontario professionals' greater knowledge with PADs than Québec professionals, knowledge appears to be a key factor in explaining why 80% of Ontario professionals saw the documents as having more therapeutic value than the 50% of professionals from Québec. Lawyers are less likely to believe PADs can have therapeutic value than psychiatrists, a finding that corresponds with psychiatrists' views that legislative policies can significantly impact clinical outcomes. This delicate interplay between professionals' perceptions of clinical outcomes, therapeutic values associated with perceptions of PADs, and how mental health legislation is drafted should not be overlooked by mental health policy-makers.

Another important clinical finding was that approximately 95% of mental health professionals were concerned with leaving mentally ill individuals untreated, compared to 82% of legal professionals. Similarly, mental health professionals are more concerned than legal professionals that if patients refuse to follow medical advice they will be left untreated for lengthy periods of time. This appears to be a legitimate clinical concern, with 98% of psychiatrists who work with mentally ill individuals on a day-to-day basis reporting that refusing to follow medical advice leads to lengthy hospital detention times. Mental health professionals who work with mentally ill individuals on a regular basis have an added obligation to deal with providing patients a realistic prognosis of their future mental condition, thereby facing the reality of being unable to discharge patients if their condition has not improved. The logistic regression model showed that if legal and mental health professionals see increasing self-determination as an important ethical value, they will be more inclined to report that that an individual with serious mental illness should be permitted the right to refuse medical treatment. Similarly, if a legal and mental health professional believes that a patient has the right to decline treatment, even if that decision is not in the patient's best interests, they will be more likely to report that an individual with serious mental illness should be permitted the right to refuse medical treatment. These findings suggest that professionals need to receive greater education regarding ethical issues surrounding PADs, such as the importance of autonomy, coercion, self-determination, and how to handle prior competent wishes.

The MacArthur Treatment studies originally established four criteria to establish if an individual has made a competent wish (evidencing a choice, understanding, appreciating, and reasoning ability) (Appelbaum & Grisso, 1995). Two of these clinical criteria, understanding and appreciating ability, have found their way into Ontario mental

health legislation (Health Care Consent Act, (1996) as legal criteria for lawyers and judges to determine whether someone is competent in law to make a decision. It is noteworthy that this research demonstrates that significantly more legal professionals see appreciating ability as an important criterion than do mental health professionals. Furthermore, only 67% of lawyers saw evidencing a choice as an important criterion, unlike the 96% of psychologists and 86% of psychiatrists. Although 'evidencing a choice' is becoming an increasingly important factor in academic research circles (Samele et al., 2007), it is possible that lawyers have a tendency to focus on legal definitions of capacity as found in mental health legislation which they work with on a regular basis.

Results from the qualitative data suggest that legal professionals see more advantage in PADs' ability to capture an individual's clear wishes at the time of documentation, and that PADs offer a collaborative treatment patient-physician relationship, than do mental health professionals. It is possible that mental health professionals do not have sufficient knowledge about how PADs can provide a collaborative treatment alliance with mentally ill individuals, while legal professionals are more concerned with instances where the patient-physician relationship may become litigious. At the same time, mental health professionals perceive PADs as offering potential medical benefits to patients more so than legal professionals. It is not surprising that mental health professionals were primarily concerned with how PADs could perpetuate illness as opposed to legal professionals, who instead were concerned with how changing circumstances can affect earlier documentation in a PAD. These differences suggest that legal and mental health professionals may prioritize advantages and disadvantages of PADs along legal or clinical factors. This provides some support for the finding that the ethics of law emphasizes different values such as autonomy and

liberty than medical ethics which focuses on good medical outcomes (Sarkar, 2005). For example, it is interesting that 9% of lawyers suggested PADs offer the advantage of predictability in future decision-making—a somewhat expected finding given lawyers have a tendency to look for certainty and predictability in the formation of contracts. On the one hand, legal professionals may be more inclined to see PADs as a means of establishing predictability and certainty before a mental health crisis occurs, so as to avoid new and changing circumstances, than mental health professionals who, on the other hand, may seek more flexibility and discretion in being able to revoke PADs. This may be one explanation for why 70% of lawyers, as opposed to 43% of psychiatrists, in this study believed courts should be permitted to protect prior competent wishes in PADs over clinical decisions made by mental health professionals.

Approximately 43% of lawyers stated that an important advantage of PADs is their ability to capture an individual's clear wishes at the time of documentation. On the one hand, lawyers appear less concerned with how PADs may affect whether an illness is perpetuated or whether the documents offer medical benefits to patients while psychiatrists, on the other hand, seem more concerned with the importance of patients making clear wishes and holding strong beliefs that PADs can potentially offer medical benefits to patients. It is revealing that 16% of psychiatrists saw PADs as offering medical benefits to patients compared to only 1% of lawyers. It is also noteworthy that community members and psychologists placed relatively more emphasis on the importance of family members and substitute-decision makers than did psychiatrists and lawyers. Community members saw treatment refusal and new or changed circumstances as a more salient disadvantage than psychiatrists, psychologists, and lawyers.

One could have probably predicted that legal and mental health professionals would hold the view that psychiatrists should be the authoritative decision-maker in deciding when a valid competent is exercised. It was also not surprising that mental health professionals saw psychiatric nurses and social workers as having more of an authoritative decision-making role in deciding whether a wish was expressed while competent than legal professionals. Legal professionals, on the other hand, reported that Review Boards should play more of an authoritative decision-making role as opposed to mental health professionals. Interestingly, when psychiatrists were asked if they should be the authoritative decision-maker in determining whether a competent wish is valid they viewed their role as more significant than other professional groups (psychologists, lawyers, community members). Likewise, when psychologists were asked whether they should be the authoritative decision-maker in determining whether a competent wish was made they viewed their role as more significant than others. These findings suggest, as previous research has shown (Poletiek, 2002), that a modest expertise bias exists among professionals in the belief they are the authoritative decision-maker in deciding whether a mentally ill individual has made a truly competent wish or not.

Ontario professionals reported significantly more knowledge of ethical issues of PADs than Québec professionals. Psychosocial mental health research campaigns have highlighted the importance of decreasing stigmatization as an important goal in psychiatry (Myers, 2001). If, as this evidence suggests, legal professionals are more concerned with the importance of decreasing stigmatization as an important ethical value than mental health professionals, just as Québec professionals see decreasing stigmatization as more important than Ontario professionals, it would be interesting to discover whether anti-stigmatization campaigns across provinces and professions are

having disparate results. How exactly is the ethical value of decreasing stigmatization related to perceptions of PADs? One possibility is that subtle forms of stigma continue to exist in mental health legislation whereby laws are drafted in a manner that prohibits and restricts the liberties and choices rather than fostering autonomy and empowerment. Professionals may continue to hold deep-seated perceptions about stigma that is essentially rooted in mental health legislation.

In order for PADs to be realized it is important that they not become overly legalistic; at the same time, relevant legal issues cannot be ignored. This will involve mental health professionals deciding for each patient what level of 'soft coercion' will be tolerable. Lawyers and community members placed more emphasis on the role of courts to protect prior competent wishes over clinical decisions made by doctors. Holding the view that judges are the authoritative decision-maker in determining whether a competent wish was valid when executed predicts whether someone believes judges should have the discretion to override a PAD.

Ontario professionals also reported being more familiar with mental health legislation and the legal standard of competency in their province than Québec professionals. Approximately 87% of lawyers and 80% of psychiatrists were familiar with mental health legislation and the standard of competency for mentally ill individuals in their province. Still, two-thirds of mental health professionals expressed concern with being sued for medical malpractice in the event of leaving a mentally ill individual untreated. Psychiatrists, psychologists, and community members maintain strong views that by overriding a prior competent wish this could lead to a medical malpractice lawsuit. Prior research has already shown that 'legal defensiveness' is a real concern among mental health professionals (van Dorn et al., 2006). This study extends that

knowledge by suggesting that factors predicting concern with being sued for overriding a PAD include belief that the document undermines clinical judgment and concern that leaving someone untreated for a lengthy period of time exacerbates treatment refusal.

Previous research reveals that lawyers tend to advocate for the mentally ill as if they already know what is in the best interests of their client (Perlin, 2004). Although this attitudinal variable was not measured in this study, it is noteworthy that lawyers were less favorable than psychiatrists, psychologists, and community members to have family members involved in the process of allowing a competent individual to complete a PAD. Many reasons could be suggested for why lawyers see less value in having family members involved in completing PADs than other professionals. The fact that only 50% of lawyers would involve family members in the process of documenting a PAD is somewhat disconcerting, and the reasons for this view need to be explored further. It is possible lawyers may believe that allowing family members to be involved prevents patients from making their own independent decision. Another possibility is that lawyers think that if they will be involved in the process of completing PADs, they do not want to be restricted by third parties telling them how to conduct their work. A yet alternate explanation is that lawyers are concerned with respecting a patient's individual right of autonomous choice so that it is not influenced by others. PADs are, however, intended to work optimally in a shared decision-making framework, which would ideally involve including family members.

Limitations of study

Several limitations should be noted in our study. The first is that this exploratory research needed to resort to a convenience sample of legal and mental health professionals and therefore not representative of the whole profession. The sample of

legal professionals (n=50) and mental health professionals (n=150) were not well balanced, with one group less representative than the other. At the same time, the goal of this study was intended to be exploratory, and in the future it would be ideal to obtain a larger sample. On the other hand, one explanation for the larger participation of Ontario professionals over Québec professionals may be that it reflects a willingness and open-mindedness to the topic of PADs. It is nevertheless difficult to generalize the findings of this study to the entire professional body (i.e. all psychiatrists, psychologists, and lawyers) in Ontario or Québec. Furthermore, it was not possible to survey certain professional bodies and important stakeholders in this debate such as psychiatric nurses, social workers, and judges—all critical views which could have provided additional insight.

Another limitation is that it was not possible to compare this survey with pre-existing surveys from other researchers due to the specific legal, political and clinical culture of the right to refuse treatment in Canada. In hindsight, the qualitative questions would be framed less complex as a compound question (i.e. "Why are you willing or reluctant to start using PADs?" and "What are the advantages and/or disadvantages?").

Several variables in this survey are most likely subject to significant ceiling effects. For example, very high percentages of psychiatrists (98%), lawyers (87%), psychologists (80%), and community members (79%) revealed that if patients refuse medical advice they will be left untreated indefinitely. Being that these values among are near or above the maximum ceiling possible for certain questions, it may be difficult to distinguish between professions at the top of the test.

A further limitation of this study is the response bias from participants that can occur when internet surveys target certain groups. For example, professionals who do not

have email obviously could not be included in the survey which may reveal something about the response and interpretation obtained in this study. Although a generation effect was possible, where younger professionals who are more comfortable in using computers are inclined to complete surveys more so than older professionals (Kelly & Charness, 2005), very few online Web-surveys have been conducted among professional stakeholders to reveal whether this is the situation. Although previous response rates of internet surveys hovers around 40%, some research reveals that response rates in Web-surveys are actually higher than mail questionnaires (Czaja, 2005). A limitation of this study is that due to the manner in which participants were recruited, it was not possible to obtain accurate response rates for each professional group.

8. CONCLUSION

The success of PADs ultimately depends on professionals' familiarity, knowledge and willingness to use the documents. This research demonstrates a relatively high demand to learn more about PADs in certain parts of Canada, and that legal and mental health professionals wish to learn more about how PADs interact with clinical, ethical, and legal factors. Addressing the clinical realities of leaving an individual untreated or detained in a hospital for a lengthy period of time, the effects of overriding an individual's autonomous prior competent wish, and how to encourage collaborative treatment between medical personnel and patients should remain at the forefront of this discussion. Providing knowledge to legal and mental health professionals about PADs in the context of balancing and competing ethical values, such as decreasing stigmatization in the face of treatment refusal, predicts whether individuals are willing to use such documents. As previous research has shown (Van Dorn et al., 2006), we too found

support for concern with medical malpractice lawsuits against mental health professionals for overriding a prior competent wish in a PAD.

This research study has particular significance for mental health policy-makers in Ontario and Québec who are mandated to craft legislation regarding the right to refuse medical treatment in the least restrictive and onerous manner according to Canadian principles of law. PADs have the potential to offer many advantages such as capturing an individual's treatment wishes when one's thoughts are clear, they demonstrate respect for an individual's autonomous choices, and work to improve the physician-patient treatment relationship. Nevertheless, a good number of professionals are reluctant to use PADs because they continue to see disadvantages in PADs such as knowing whether someone has made a truly competent wish at the time of executing the document. Others appear more concerned with how circumstances can change from the time when the document is executed, and whether allowing someone to remain untreated, in the face of newer and better treatment, constitutes the best medical and ethical decision. Still, with greater education about PADs, these perceived obstacles are not insurmountable.

In the midst of heated debates surrounding the right to refuse medical treatment generated in recent legal cases out of Ontario, such as Starson v. Swayze (2003), these research findings provide a helpful starting point to take a fresh look at the right to refuse medical treatment in Canada through an empirical lens of how PADs operate. Given the recent mental health reform recommendations by the Government of Canada's Senate Committee to make available forms and information kits to mental health patients explaining how to complete advance directives, and to make available community-based legal services to assist in the documentation process, this research study provides some initial insight on where professional values lie regarding these important medical issues.

9. RECOMMENDATIONS

In light of the above results, several recommendations can be made regarding the future success and availability of PADs in Canada. The first is that legal and mental health professionals should receive more knowledge to satisfy the high demand to learn about how PADs operate. Information and training sessions should be provided to mental health professionals showing how a collaborative treatment plan can be established between psychiatrists and patients in the context of competing ethical values.

If PADs can more clearly be shown to have therapeutic value for patients, in the form of positive clinical outcomes, willingness to use PADs by professional stakeholders may increase. One way to address whether PADs will have positive clinical outcomes is to initiate a PADs pilot program within a psychiatric hospital setting that implements them in a collaborative arrangement with hospital providers, families, and patients as the primary mental health consumer. Measurable outcome measures could be obtained assessing whether PADs have positive long-term clinical outcomes in the form of reduced hospital stays and faster recovery, which may translate into reductions in the cost of burden of illness and treatment. If successful, PADs may fit in well with economic justifications to reduce financial burdens on society, maximize community level care and participation, and promote innovation and flexibility within legal, political and medical arenas.

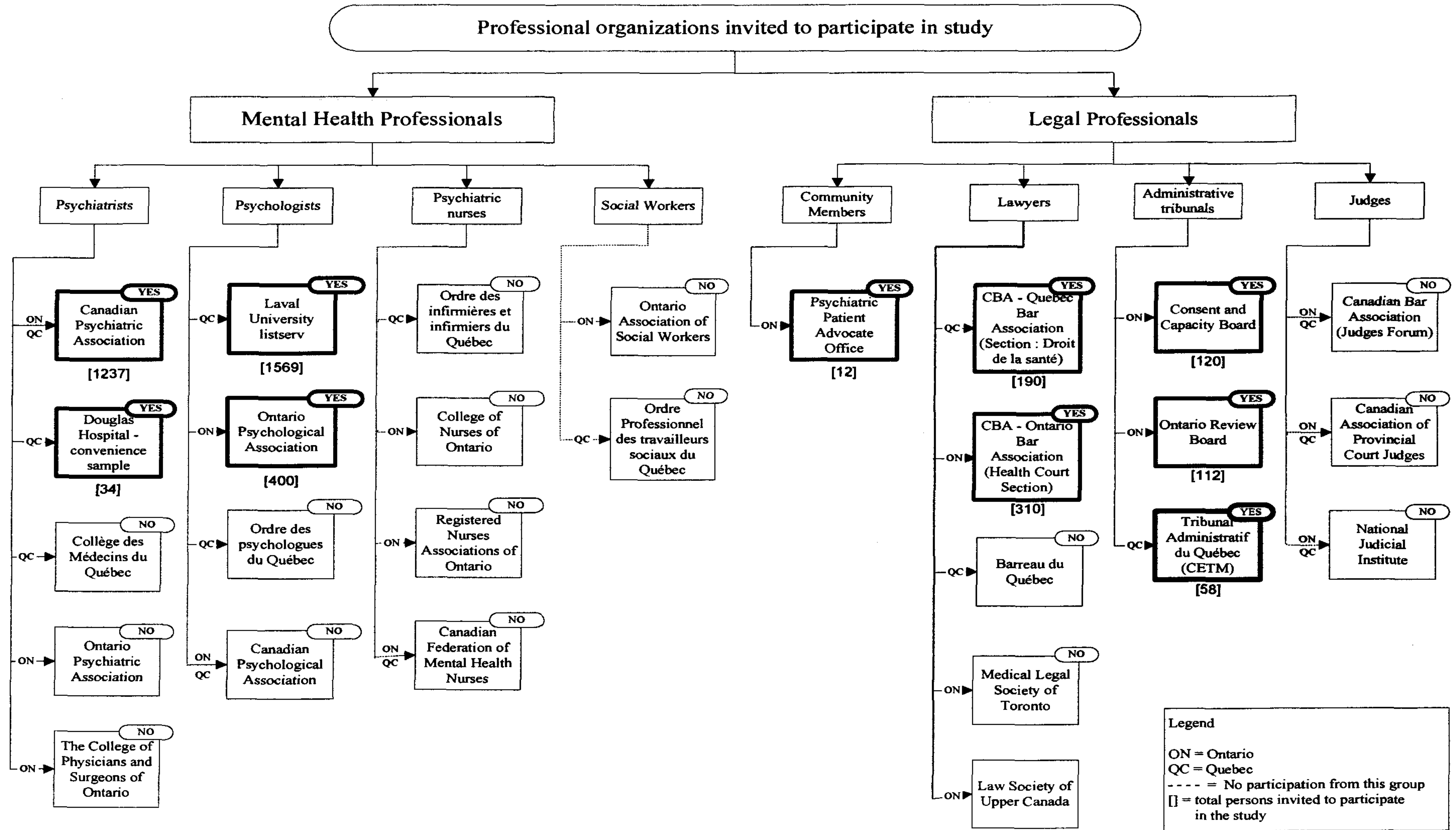
In Canada, where provinces have disparate mental health legislation, it is important to ensure that clinical research findings informing definitions of what being ‘clinically capable’ and ‘legally competent’ to make a prior competent wish signifies are conveyed uniformly. Given that our results indicate a strong emphasis to respect patients’

prior competent wishes and autonomous choices, it is recommended that any provisions found in mental health legislation barring individuals from making advance directives ought to be repealed, and public education campaigns continue to educate and empower patients and families about their right to take control of their treatment plans in collaboration with mental health professionals. As mental health professionals are clearly concerned with medical malpractice lawsuits for overriding PADs, it is also recommended that clearer guidelines and policies be developed to this effect.

As far as future investigations, it is recommended that an implementation study be conducted within a psychiatric hospital setting to assess how mental health professionals can use PADs to generate positive long-term clinical outcomes for mentally ill individuals. It would be useful in future research to discover how other professional groups, such as social workers, psychiatric nurses, hospital administrators, along with patients, their family members, and caregivers, feel about using PADs. By surveying patients, as PADs consumers, along with their close family members, the strength of their voices will not go unheard. More research is also needed on how to best educate clinicians about PADs, isolate the perceived ethical benefits of PADs among individuals suffering from mental illness, and find a valid and reliable method to boost competence to consent to the documents. Finding solutions to treatment concerns of mentally ill individuals through the use of psychiatric advance directives requires framing such mental health services in the most compassionate and caring manner that encourages long-time recovery.

TABLES, GRAPHS AND FLOWCHARTS

Flowchart 1
Professional organizations invited to participate in PADs study



Flowchart 2

Participants by professional group

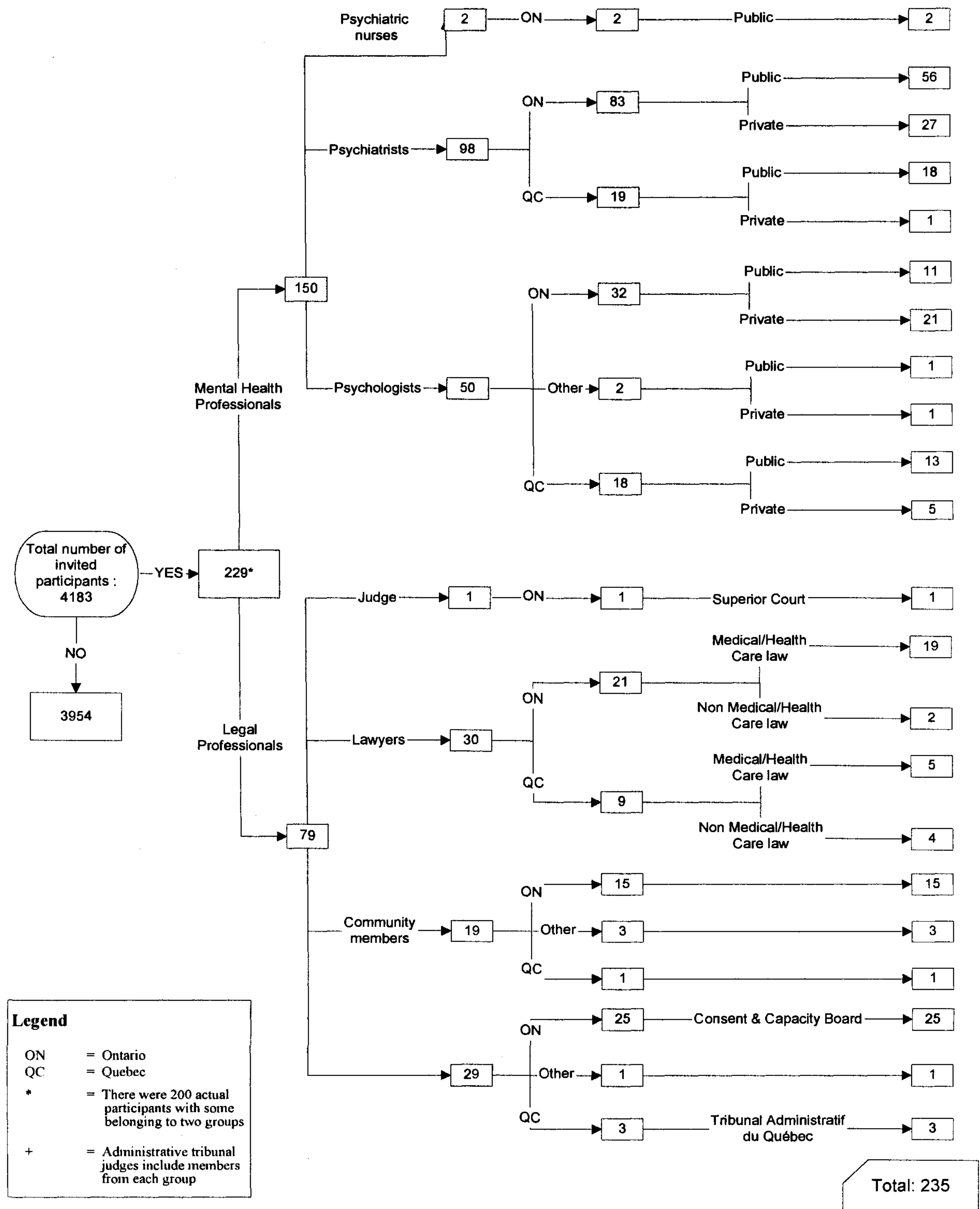


TABLE 1. Informant demographics of participants in original categories (N=200)

			Judge	Lawyer	Psychiatrist	Psychiatric Nurse	Psychologist	Community member
		N=200 n (%)	1 (.5) n (%)	30 (15) n (%)	98 (49) n (%)	2 (1) n (%)	50 (25) n (%)	19 (9.5) n (%)
Attributes								
Gender								
	Male	113 (56.5)	1 (100)	16 (53)	70 (71)		20 (40)	6 (32)
	Female	87 (43.5)		14 (47)	28 (29)	2 (100)	30 (60)	13 (68)
Age								
	20-30	20 (10)		2 (6.7)	7 (7.1)		9 (18)	2 (10.5)
	31-40	37 (18.5)		12 (40)	13 (13.3)		11 (22)	1 (5.3)
	41-50	41 (20.5)		6 (20)	22 (22.4)		10 (20)	3 (15.8)
	51-60	48 (24)		5 (16.7)	25 (25.5)		13 (26)	5 (26.3)
	61-70	29 (14.5)		3 (10)	13 (13.3)	2 (100)	5 (10)	6 (31.6)
	>71	25 (12.5)	1 (100)	2 (6.7)	18 (18.4)		2 (4)	2 (10.5)
Ethnicity								
	Caucasian	148 (74)	1 (100)	20 (66.7)	69 (70.4)	1 (50)	41 (82)	16 (84.2)
	European	24 (12)		7 (23.3)	13 (13.3)		3 (6)	1 (5.3)
	African American	1 (.5)					1 (2)	
	Asian	9 (4.5)			7 (7.1)	1 (50)		1 (5.3)
	American Indian	1 (.5)						
	South American	1 (.5)			1 (1)			
	Other	17 (8.5)		3 (10)	8 (8.2)		5 (10)	1 (5.3)
Jurisdiction								
	Ontario	139 (69.5)		20 (66.7)	70 (71.4)	2 (100)	32 (64)	15 (79)
	Québec	40 (20)		9 (30)	12 (12.2)		18 (36)	1 (5)
	Mixed*	23 (11.5)	1 (100)	1 (3.3)	16 (16.3)		2 (4)	3 (16)
	Unreported+	6 (3)						
Type of practice								
	Private	53 (29.4)			27 (27.6)		26 (52)	
	Public	97 (53.9)			71 (72.4)	2 (100)	24 (48)	
	Health law	24 (13.3)		24 (80)				
	Non-health law	6 (3.3)		6 (20)				
Years in practice								
	< 1	19 (9.5)		2 (6.7)	6 (6.1)		8 (16)	3 (15.8)
	2-5	38 (19)		5 (16.7)	14 (14.3)		13 (26)	6 (31.6)
	6-10	21 (10.5)		8 (26.7)	7 (7.1)		5 (10)	1 (5.3)
	11-30	75 (37.5)		9 (30)	44 (44.9)		17 (34)	5 (26.3)
	>30	47 (23.5)	1 (100)	6 (20)	27 (27.6)	2 (100)	7 (14)	4 (21.1)
Admin. tribunal								
	TAQ	1 (.5)						1 (5.3)
	CCB	25 (12.5)	1 (100)	7 (23.3)	10 (10.2)	2 (100)		5 (26.3)
	Other	3 (1.5)					1 (2)	2 (10.5)
	No			23 (76.7)	88 (89.8)		49 (98)	11 (57.9)

* Participants practicing in a mixed jurisdiction were licensed to practice in both Ontario and Québec. They were included in a separate category from participants who were exclusively licensed to practice in Ontario or Québec.

+ Unreported participants were not licensed to practice in either Ontario and Québec. They were not included in any statistical analysis involving jurisdictional comparisons.

TABLE 2. Informant demographics by administrative tribunal membership (N=200)

Attributes		Administrative tribunal member	Non-administrative tribunal member	
		29 (15)	171 (84)	
	n (%)	n (%)	n (%)	Chi-square statistics
Gender				
Male	113 (56.5)	18 (62.1)	95 (55.6)	
Female	87 (43.5)	11 (37.9)	76 (44.4)	X^2 (1, 200)= .428
Age				
20-40	57 (28.5)	1 (3.4)	56 (32.7)	
41-60	89 (44.5)	8 (27.6)	81 (47.4)	
> 60	54 (27)	20 (69)	34 (19.9)	X^2 (2, 200)= 31.773***+
Ethnicity				
Caucasian	172 (86)	25 (86.2)	147 (86)	
Other	28 (14)	4 (13.8)	24 (14)	X^2 (1, 200)= .001
Jurisdiction				
Ontario	133 (66.5)	25 (86.2)	108 (65.5)	
Quebec	40 (20)	3 (10.3)	37 (22.4)	
Mixed[#]	21 (10.5)	1 (3.5)	20 (12.1)	X^2 (2, 200)= 3.447
Unreported[##]	6 (3)			
Years in practice				
< 5 years	57 (28.5)	2 (6.9)	55 (32.2)	
5-30 years	96 (48)	9 (31)	87 (50.9)	
> 30 years	47 (23.5)	18 (62.1)	29 (17)	X^2 (2, 200)= 29.059***+
Work with MI				
Yes	135 (67.5)	19 (65.5)	116 (67.8)	
No	65 (32.5)	10 (34.5)	55 (32.2)	X^2 (1, 200)= .061
Self/family hospitalized for mental health				
Yes	53 (26.5)	7 (24.1)	46 (26.9)	
No	147 (73.5)	22 (75.9)	125 (73.1)	X^2 (1, 200)= .097

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

+ $p \leq .0001$ (Bonferroni correction performed for multiple comparisons)

[#] Participants from a mixed jurisdiction were licensed to practice in both Ontario and Québec. They were included in a separate category from participants who were exclusively licensed to practice in Ontario or Québec.

[##] Unreported participants were not licensed to practice in either Ontario and Québec. They were not included in any statistical analysis involving jurisdictional comparisons.

TABLE 3. Informant demographics by legal and mental health professionals (N=200)

Attributes	n (%)	Legal Professionals N=50 n (%)	Mental Health Professionals N=150 n (%)	Chi-square statistics
Gender				
Male	113 (56.5)	23 (46)	90 (60)	
Female	87 (43.5)	27 (54)	60 (40)	X^2 (1, 200)= 2.991
Age				
20-40	57 (28.5)	17 (34)	40 (26.7)	
41-60	89 (44.5)	19 (38)	70 (46.7)	
> 60	54 (27)	14 (28)	40 (26.7)	X^2 (2, 200)= 1.365
Ethnicity				
Caucasian	172 (86)	45 (90)	127 (84.7)	
Other	28 (14)	5 (10)	23 (15.3)	X^2 (1, 200)= .886
Jurisdiction				
Ontario	131 (65.5)	30 (66.7)	101 (67.8)	
Quebec	37 (18.5)	10 (22.2)	27 (18.1)	
Mixed[#]	26 (13)	5 (11.1)	21 (14.1)	
Unreported[##]	6 (3)			X^2 (2, 194)= .541
Administrative judge				
Yes	29 (14.5)	16 (32)	13 (8.7)	
No	171 (85.5)	34 (68)	137 (91.3)	X^2 (1, 200)= 16.468***+
Type of practice				
Private/clinical	53 (26.5)		53 (35.3)	
Public/hospital	97 (48.5)		97 (64.7)	
Medical law	24 (12)	24 (80)		
Non-medical law	6 (3)	6 (20)		
Missing	20 (10)			X^2 (3, 180)= 180***+
Years in practice				
< 5 years	57 (28.5)	16 (32)	41 (27.3%)	
5-30 years	96 (48)	23 (46)	73 (48.7%)	
> 30 years	47 (23.5)	11 (22)	36 (24%)	X^2 (2, 200)= .406
Work with MI				
Yes	135 (67.5)	22 (44)	113 (75.3)	
No	65 (32.5)	28 (56)	37 (24.7)	X^2 (1, 200)= 16.783***+
Self/family hospitalized for mental health				
Yes	53 (26.5)	15 (30)	38 (25.3)	
No	147 (73.5)	35 (70)	112 (74.7)	X^2 (1, 200)= .419

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

+ $p \leq .0001$ (Bonferroni correction performed for multiple comparisons)

Participants practicing in a mixed jurisdiction were licensed to practice in both Ontario and Québec. They were included in a separate category from participants exclusively licensed to practice in Ontario or Québec.

Unreported participants were not licensed to practice in either Ontario and Québec. They were not included in any statistical analysis involving jurisdictional comparisons.

TABLE 4. Informant demographics by jurisdiction (N=194[#])

		Ontario	Québec	Mixed[#]	
Attributes	n (%)	N=131 n (%)	N=37 n (%)	N=26 n (26)	Chi-square statistics
Gender					
Male	111 (57.2)	85 (64.9)	12 (32.4)	14 (53.8)	
Female	83 (42.8)	46 (35.1)	25 (67.6)	12 (46.2)	X^2 (2, 194)= 12.552**
Age					
20-40	131 (67.5)	27 (20.6)	24 (64.9)	4 (15.4)	
41-60	37 (19.1)	64 (48.9)	10 (27)	13 (50)	
> 60	26 (13.4)	40 (30.5)	3 (5.8)	9 (34.6)	X^2 (4, 194)= 31.051***+
Ethnicity					
Caucasian	166 (85.6)	112 (67.5)	32 (19.3)	22 (13.3)	
Other	28 (14.4)	19 (67.9)	5 (17.9)	4 (14.3)	X^2 (2, 194)= .045
Administrative judge					
Yes	29 (14.9)	23 (79.3)		6 (20.7)	
No	165 (85.1)	108 (65.5)	37 (22.4)	20 (12.1)	X^2 (2, 194)= 8.555
Type of practice					
Private/clinical	53 (29.6)	43 (35.5)	4 (11.1)	6 (27.3)	
Public/hospital	96 (53.6)	58 (47.9)	23 (63.9)	15 (68.2)	
Medical law	24 (13.4)	18 (14.9)	5 (13.9)	1 (4.5)	
Non-medical law	6 (3.4)	2 (1.7)	4 (11.1)		
Missing					X^2 (6, 194)= 17.679**
Years in practice					
< 5 years	53 (27.3)	27 (20.6)	22 (59.5)	4 (15.4)	
5-30 years	95 (49)	72 (55)	11 (29.7)	12 (46.2)	
> 30 years	46 (23.7)	32 (24.4)	4 (8.7)	10 (38.5)	X^2 (4, 194)= 26.314**+
Work with MI					
Yes	132 (68)	94 (71.8)	19 (51.4)	19 (73.1)	
No	62 (32)	37 (28.2)	18 (48.6)	7 (26.9)	X^2 (2, 194)= 5.874*
Self/family hospitalized					
Yes	51 (26.3)	38 (29)	5 (13.5)	8 (30.8)	
No	143 (73.7)	93 (71)	32 (86.5)	18 (69.2)	X^2 (2, 194)= 3.885

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

+ $p \leq .0001$ (Bonferroni correction performed for multiple comparisons)

Participants practicing in a mixed jurisdiction were licensed to practice in both Ontario and Québec. They were included in a separate category from participants who were exclusively licensed to practice in Ontario or Québec.

Table 5. Logistic regression analysis of familiarity with PADs as a function of attitudinal and demographic variables

	Bivariate Correlations	Multivariate model	
		Odds Ratios	95% CI
Variable			
Knowledge of ethical issues related to PADs	0.64**	25.00***	(11.11-100.00)
Knowledge of how to document advance directives generally	0.51*	7.25***	(2.86-20.00)
Administrative tribunal judge	-0.18*	5.58**	(1.72-18.15)
Knowledge of law related to advance directives when all professionals were compared to mental health professionals	0.49**	3.44*	(1.11-11.11)
Awareness of past abuses towards mentally ill in province	0.15*		
Knowledge of law related to advance directives when all professionals were compared to legal professionals	0.39**		
Familiarity with legislation and standard of competency	0.36**		
Jurisdiction licensed to practice	-0.20**		
Legal or mental health professional	-0.11		

*p < .05 **p < .01 *** p < .001

Table 6. Logistic regression analysis of willingness to start using PADs as a function of attitudinal variables

	Bivariate Correlations	Multivariate model	
		Odds Ratios	95% CI
Variable			
PADs do not undermine clinical judgment	-0.32**	3.52***	(1.86-6.68)
Knowledge of ethical issues related to PADs	0.26**	2.94*	(1.52-5.88)
Jurisdiction licensed to practice	0.17*	3.03*	(1.30-7.14)
PADs help reduce stigmatization	0.25**	2.43*	(1.18-5.26)

*p < .05 **p < .01 ***p <.001

Table 7. Logistic regression analysis for concern of medical malpractice for overriding PAD as a function of attitudinal variables

	Bivariate Correlations	Multivariate model	
		Odds Ratios	95% CI
Variable			
Concern with mentally ill left untreated	0.22**	4.76**	(1.62-14.29)
PADs do not undermine clinical judgment	0.19**	2.38*	(1.22-4.55)
Treatment refusal leads to being left untreated	0.22**	3.03*	(1.08-8.33)
Courts should protect prior competent wishes over clinical decisions	-0.17*		
Knowledge of law regarding advance directives compared to mental health professionals	-0.24**		
Legal enforceability of PADs	0.144*		
Work with mentally ill	-0.14*	2.13*	(1.11-4.04)

*p < .05 **p < .01

Table 8. Logistic regression analysis for judicial discretion to override PAD as a function of attitudinal variables

	Bivariate Correlations	Multivariate model	
		Odds Ratios	95% CI
Variable			
PADs do not undermine clinical judgment	0.18*		
Absolute right to decline medical treatment	-0.17*	2.37**	(1.25-4.47)
Judge as authoritative decision-maker in determining competent wish is valid	0.37**	5.26**	(2.77-11.11)
Family involvement to assist mentally ill complete a PAD	0.15*	2.00	(1.00-4.00)

*p < .05 **p < .01

Table 9. Logistic regression analysis for whether SMI should be permitted right to refuse treatment as a function of attitudinal and demographic variables

	Bivariate Correlations	Multivariate model	
		Odds Ratios	95% CI
Variable			
Increasing autonomy as important ethical value	0.31**		
Decreasing coercion as important ethical value	0.22**		
Increasing self-determination as important ethical value	0.33**	6.25***	(3.45-11.11)
Absolute right to decline treatment even if not best interests	0.43**	7.69**	(2.13-25.00)
Prior competent wishes as important	0.20**		
Awareness of past abuses in province	0.19**	2.13*	(1.08-4.17)
Gender (female)	0.16*	2.13*	(1.10-4.17)

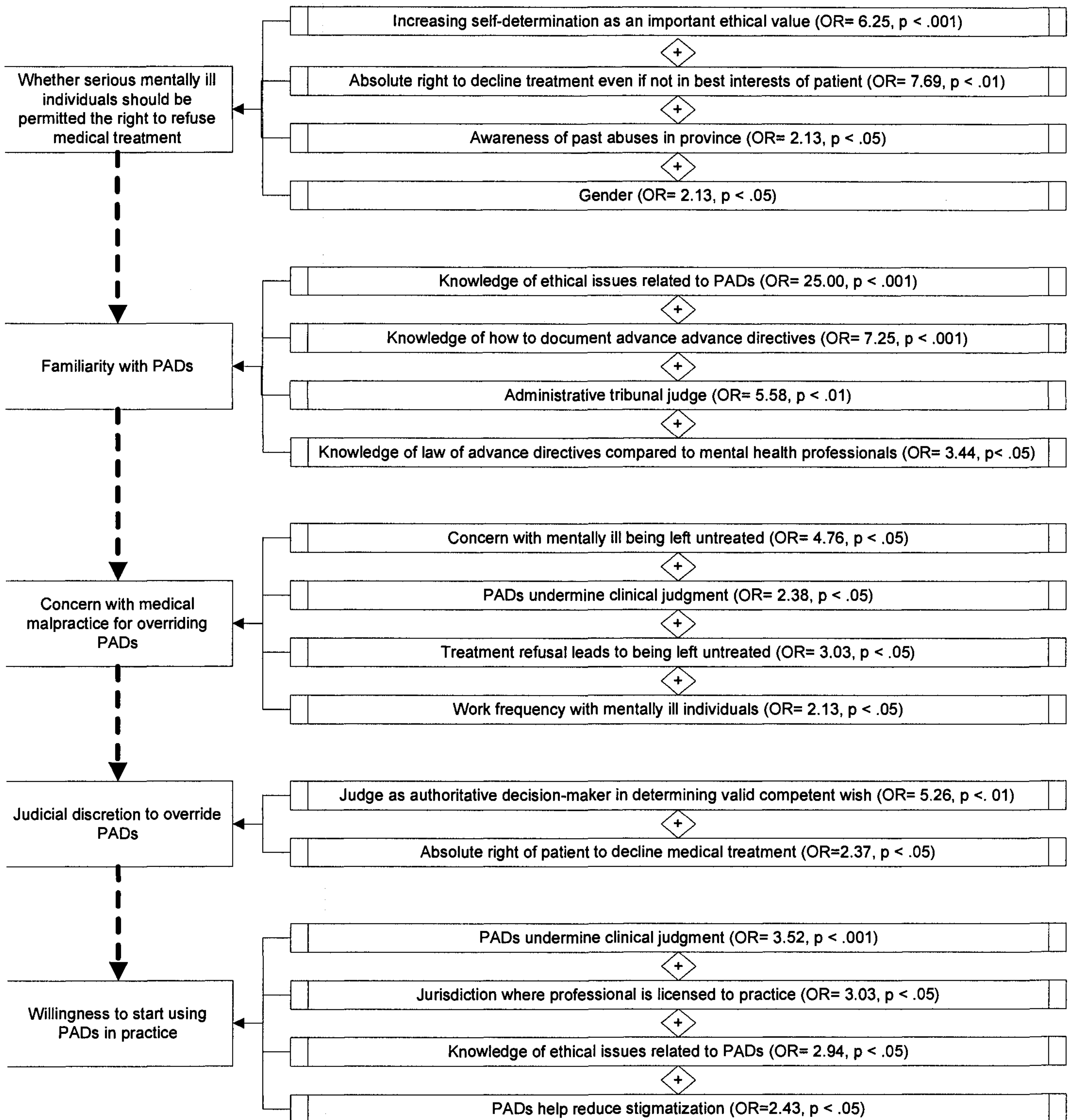
*p < .05 **p < .01 *** p <.001

Bivariate correlation matrix for variables included in logistic regression model

	Familiarity with PADs	Willingness to use PADs	Medical malpractice for overriding PADs	Judicial discretion to override PADs	Should SMI be permitted right to refuse treatment
Knowledge of ethical issues related to PADs	0.64**	0.26**			
Knowledge of how to document advance directives generally	0.51*				
Administrative tribunal judge	-0.18*				
Knowledge of law related to advance directives compared to mental health professionals	0.49**		-0.24**		
Awareness of past abuses towards mentally ill in province	0.15*				
Knowledge of law related to advance directives compared to legal professionals	0.39**				
Familiarity with legislation and standard of competency	0.36**		0.22*		
Jurisdiction licensed to practice	0.20**	0.17*			
Legal or mental health professional	-0.11				
PADs do not undermine clinical judgment		-0.32**	0.19**	0.18*	
PADs help reduce stigmatization		0.25**			
Concern with mentally ill left untreated			0.22**		
Treatment refusal leads to being left untreated			0.22**		
Courts should protect prior competent wishes over clinical decisions			-0.17*		
Legal enforceability of PADs			0.144*		
Work with mentally ill			-0.14*		
Absolute right to decline medical treatment				-0.17*	0.43**
Judge as authoritative decision-maker in determining competent wish is valid				0.37**	
Family involvement to assist mentally ill complete PAD				0.15*	
Increasing autonomy as important ethical value					0.31**
Decreasing coercion as important ethical value					0.22**
Increasing self-determination as important ethical value					0.33**
Prior competent wishes as important					0.20**
Awareness of past abuses in province					0.19**
Gender					0.16*

*$p < .05$ **$p < .01$

Logistic Regression model of Psychiatric Advance Directives



This flowchart shows how predictor variables have an effect on outcome variables. The thick, broken line arrows between the outcome variables indicate the order in which perceptions of the right to refuse medical treatment, beliefs of PADs, and willingness to start use the documents could occur.

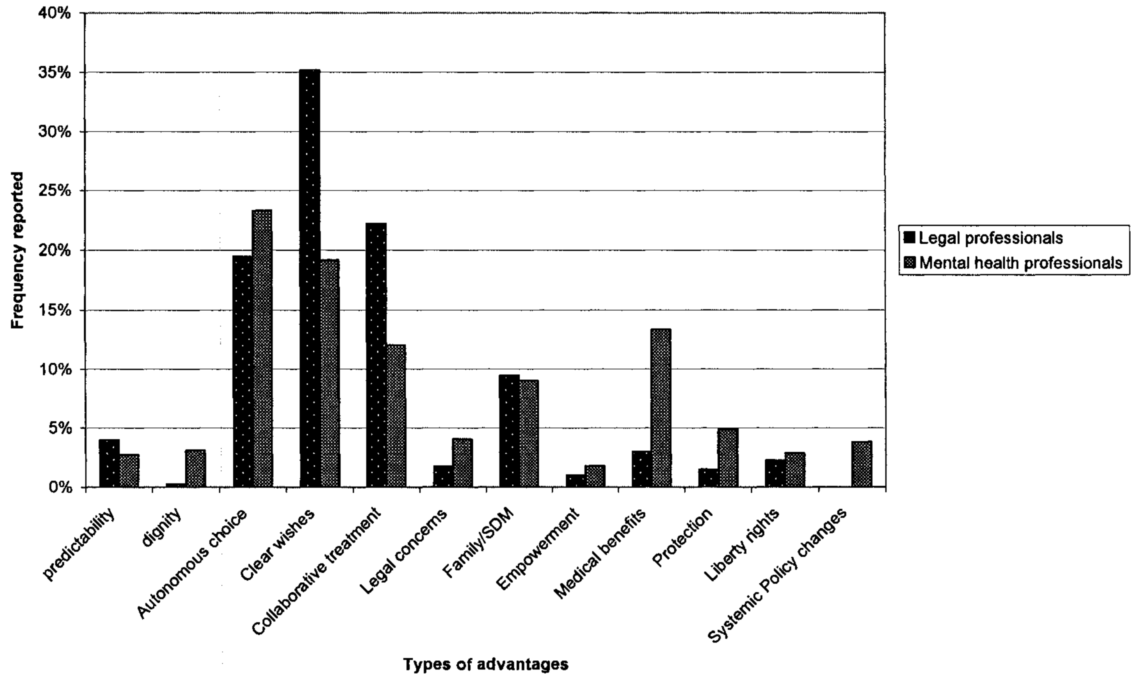
TABLE 10. Advantages associated with PADs	
Predictability	PADs provide a predictable and consistent approach to honoring wishes *"Advantages include certainty as to patient's wishes and consistency in approach"-Lawyer*
Dignity	PADs respect individual's dignity *"Allows the person to have the dignity and freedom to make their own medical decisions"-Lawyer*
Autonomous choice	PADs foster independence, autonomy, self-determination, and treatment choices which ultimately allow the individual to control decision-making *"I would welcome PAD's in order to promote autonomy and encourage self-esteem in the patient"- Psychiatric nurse*
Clear wishes	PADs help to identify, respect and uphold an individual's earlier stipulated clear wishes when they were in a competent frame of mind *"ensures that the individuals wishes and decisions valued and adhered to"-Psychiatrist*
Collaborative treatment	PADs foster collaboration between psychiatrists and/or treatment teams with the patient which reduces confusion *«Permettre une participation plus active du patient à ses soins»- Psychiatre*
Legal concerns	Any positive legal reference to PADs which works to uphold a prior competent wish *"I believe that PADs are very good if the person is competent and has had professional legal and psychiatric advice"-Psychiatrist*
Family/ SDM	Any reference to PADs as having a positive effect on families and/or substitute decision-makers *"this assists family members who might not be available at the time and so may not be able to make appropriate decisions in a timely manner"-Community member*
Empowerment	PADs empower the mentally ill *"PADs represent an extension of empowering individuals with mental illness"-Psychiatrist*
Medical benefits	PADS have a positive medical or psycho-medical benefit in the form of treatment *"Main advantage is the ability to access timely treatment in event of the client having a major breakdown"-Psychologist*
Protection	PADs protect the mentally ill from coercive influences which may appear paternalistic *« le DPSM est un facteur de protection pour l'individu atteint de maladie mentale »-psychologue*
Liberty rights	PADs foster libertarian rights of the mentally ill *"The advantage is respect for the rights of people with mental health problems, especially under section 7 and 15 of the Charter"-Lawyer*
Systemic policy change	PADs encourage positive governmental or hospital policy changes in the field of mental health *"Good step forward in getting public system more accountable"- Psychologist*

TABLE 11. Disadvantages associated with PADs	
Non-comprehensiveness	PADs are not comprehensive enough to deal with all possible contingencies which may arise *"PADs don't provide clarity as it's difficult to cover every possible situation"-Lawyer*
Lack awareness	Skepticism of PADs as not completed by mentally ill individuals while being full awareness, capable, or competent with their mental faculties in giving their informed consent *"The challenge is in knowing that the patient fully understands the context for which such consent might be required"-Psychiatrist*
Self-bound	PADs bind a mentally ill's prior competent wishes in the form of a self-binding contract which they cannot later decide to revoke *"they could implement a Ulysses clause, while they are well, which would preclude them from taking any action to prevent a doctor from treating them while ill"-Lawyer*
Better treatment	PADS do not account for better medical treatment becoming available in the future which has the effect of binding the individual to outdated treatment *"treatment decisions may be limited to what the patient wanted in the past, and may not take into account new information that might have led the patient to accept other options"-Psychologist*
Treatment refusal	PADs allow mentally ill individuals to refuse medical treatment which is negative *"Where would the benefit be if they have agreed, during a well" period of the mental health, to a particular treatment but can and most likely will, refuse the treatment when they become manic"-Community member*
Professional non-compliance	PADs discourage collaboration and compliance between mental health professionals and mentally ill individuals *"Disadvantage is that health care facilities and caregivers at times cannot and at times will not comply with wishes"- Lawyer*
Overbroad	PADs are overbroad in what they allow to be included in the documents *"may be problematic if not specific enough"-Lawyer*
Perpetuates illness	PADs allow refusal of treatment which translates into mental illness being perpetuated *"an opinion of the subject could have changed but remains 'frozen in time' as it were which could have its own detriment to the subject's well being or wishes"-Psychiatrist*
Economics	PADS have a negative costly or economic consideration *"From a business point of view, very lucrative for the legal profession"-Community member*
Restricts liberty	PADs actually work to restrict the rights and liberties of the mentally ill *"This may actually restrict liberty interests of the individual"- Lawyer*
New/changed circumstances	New or changed circumstances may arise which suggests that prior wishes should be revised *"not all circumstances can be foreseen, might confuse or hinder decision making when treatment is necessary"-Psychologist*
Legal concerns	Any reference to PADs as having a negative legal consequence *"The legal implications would be an obstacle to implement it"-Psychiatrist*
Validity	PADs will and should not be considered valid documents *"have some hesitancy with regard to the efficacy of them"- Psychiatrist*
Family/SDM	PADs discourage family and/or substitute decision-makers from collaborating *"A preferred option would be to consult (and if the patient is incapable, defer to) the opinion of a trusted family member assigned in advance"- Psychologist*
Hospital Detention	PADs keep the mentally ill detained in a hospital indefinitely *"The Starson case is a prime example, where the patient ended up in a secure locked ward for a long period of time because no treatment was undertaken"-Lawyer*
Bureaucratic challenges	PADs are perceived as bureaucratic *« bureaucratisation et empechement de traiter le malade »- Psychiatre*
Danger/safety concerns	Any reference to leaving the mentally ill untreated increasing dangerousness, threat, and safety concerns to the public *« le refus de traitement pose un problème puisque cela peut entraîner des situations de dangerosité pour soi et pour les autres par la suite »- Psychiatre*
More research	More research required regarding PADs before willing to make a definitive comment *"Need more debate and research"-Psychiatrist*

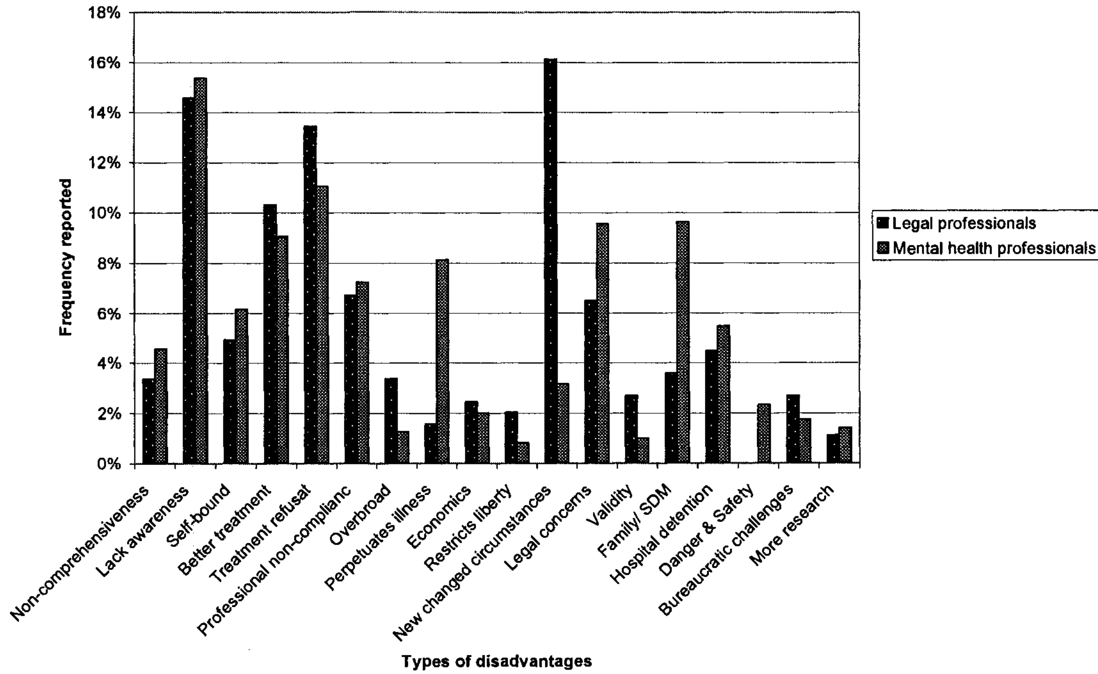
TABLE 12: Frequency distribution of qualitative comments towards PADs

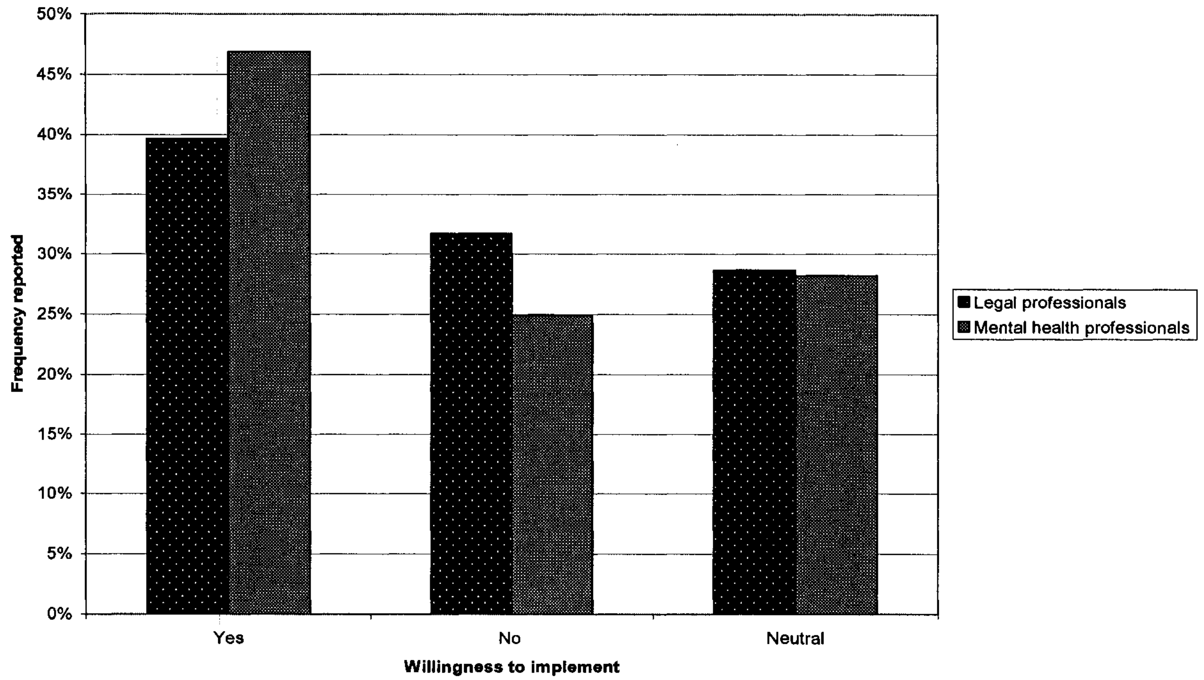
	Psychiatrists	Psychologists	Lawyers	Community Members	Legal Professionals	Mental Health Professionals	Ontario	Quebec	Other
ADVANTAGES									
Predictability	4%	2%	9%	0%	4%	3%	5%	1%	2%
Dignity	2%	4%	1%	0%	0%	3%	2%	5%	0%
Autonomous choice	20%	26%	16%	22%	19%	23%	23%	16%	19%
Clear wishes	24%	14%	43%	29%	35%	19%	23%	37%	15%
Collaborative treatment	11%	12%	14%	29%	22%	12%	16%	14%	9%
Legal concerns	5%	4%	4%	0%	2%	4%	1%	12%	2%
Family/ SDM	8%	11%	4%	14%	9%	9%	7%	5%	21%
Empowerment	2%	2%	0%	2%	1%	2%	2%	1%	2%
Medical benefits	16%	11%	1%	5%	3%	13%	13%	5%	9%
Protection	5%	5%	3%	0%	1%	5%	3%	1%	11%
Liberty rights	2%	4%	5%	0%	2%	3%	3%	3%	2%
Systemic policy change	2%	6%	0%	0%	0%	4%	1%	0%	10%
DISADVANTAGES									
Non-comprehensiveness	5%	3%	1%	9%	3%	5%	5%	4%	0%
Lack awareness	18%	11%	13%	18%	15%	15%	16%	21%	5%
Self-bound	5%	8%	7%	1%	5%	6%	4%	6%	13%
Better treatment	10%	6%	14%	3%	10%	9%	12%	6%	5%
Treatment refusal	11%	12%	9%	23%	13%	11%	11%	8%	15%
Professional non-compliance	7%	7%	8%	5%	7%	7%	5%	13%	10%
Overbroad	0%	3%	5%	0%	3%	1%	1%	5%	4%
Perpetuates illness	9%	7%	2%	0%	2%	8%	7%	2%	10%
Economics	0%	5%	2%	3%	2%	2%	0%	2%	8%
Restricts liberty	1%	0%	3%	0%	2%	1%	1%	3%	1%
New/changed circumstances	2%	6%	15%	20%	16%	3%	6%	14%	0%
Legal concerns	9%	10%	6%	7%	7%	10%	8%	11%	8%
Validity	1%	1%	1%	7%	3%	1%	1%	2%	0%
Family/SDM	9%	10%	5%	0%	4%	10%	9%	0%	12%
Hospital Detention	8%	0%	5%	4%	4%	5%	8%	0%	0%
Bureaucratic challenges	0%	7%	0%	0%	0%	2%	1%	1%	6%
Danger/safety concerns	2%	1%	4%	0%	3%	2%	3%	0%	2%
More research	1%	2%	1%	1%	1%	1%	2%	2%	0%

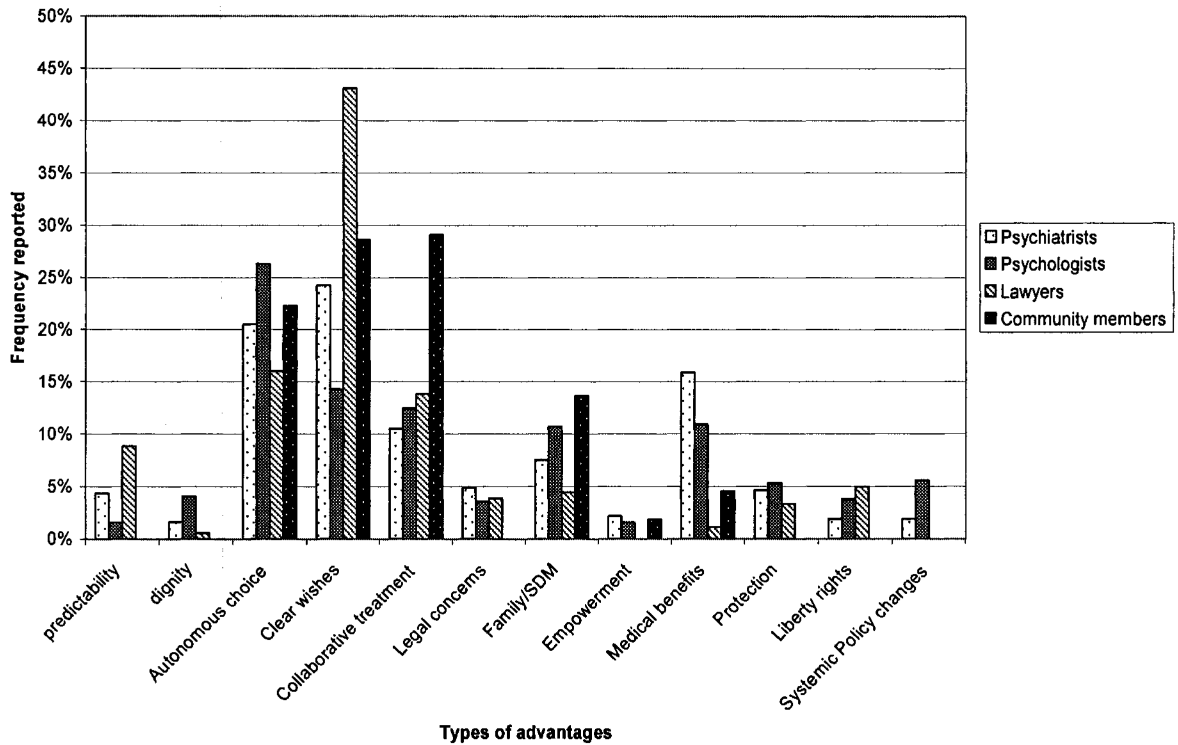
Graph 1. Advantages of PADs by profession

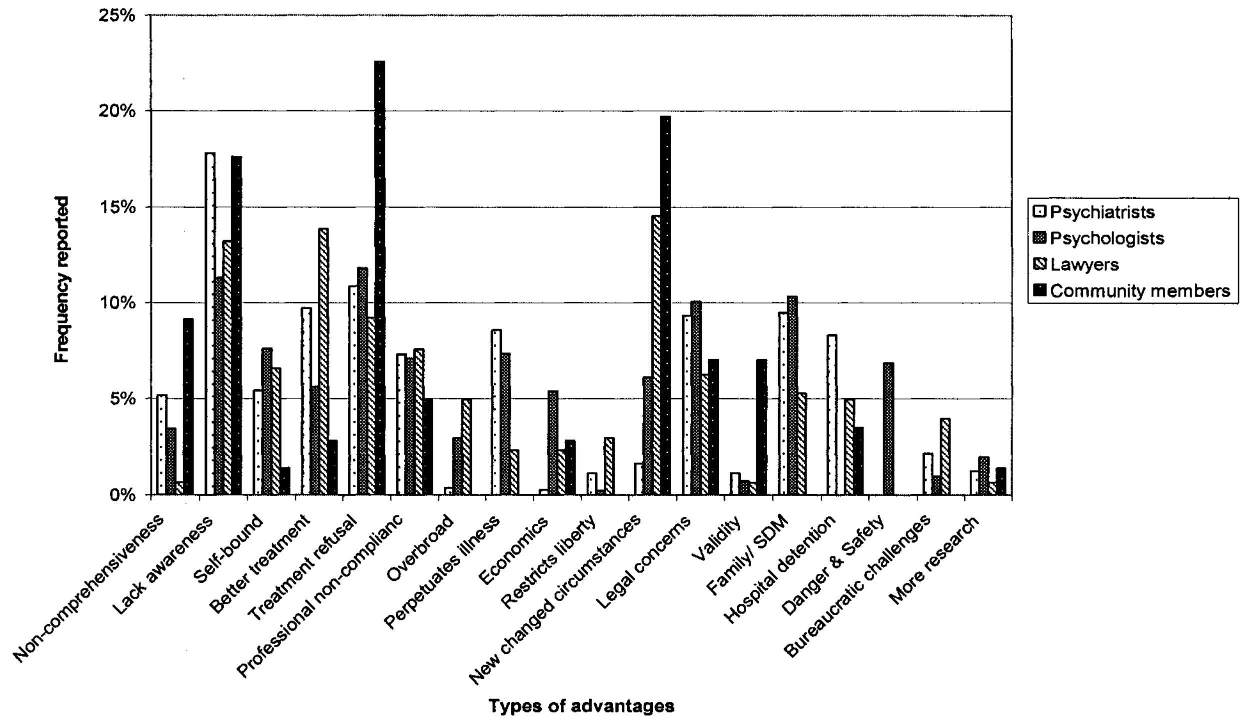


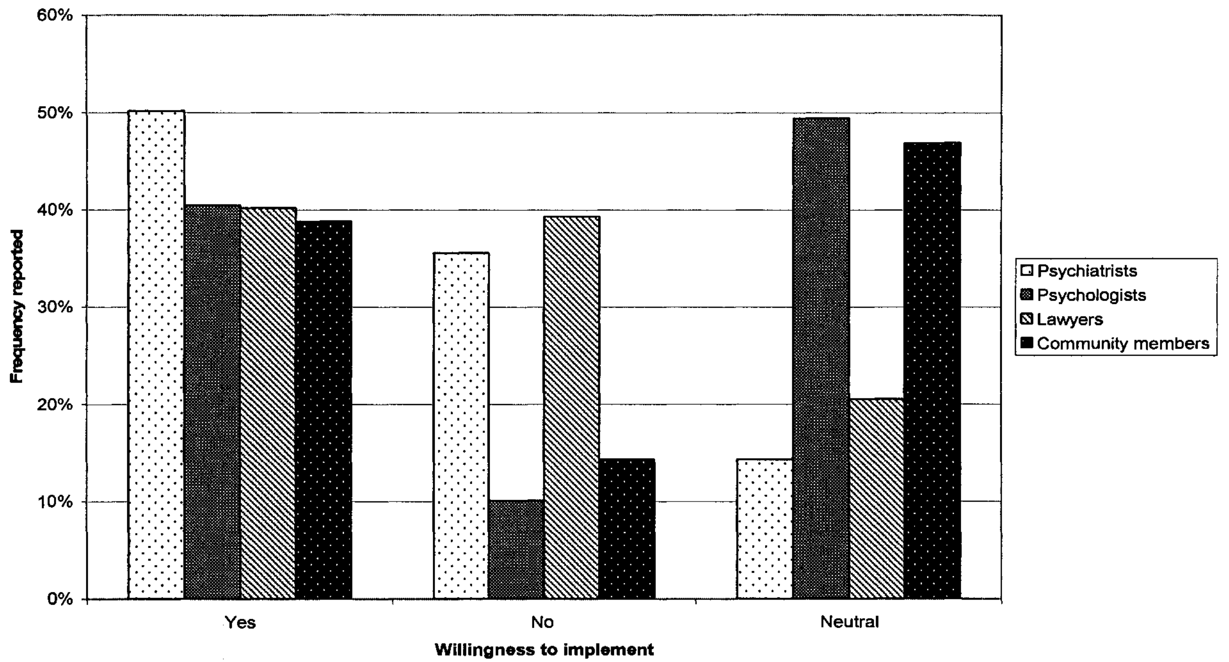
Graph 2. Disadvantages of PADs by profession



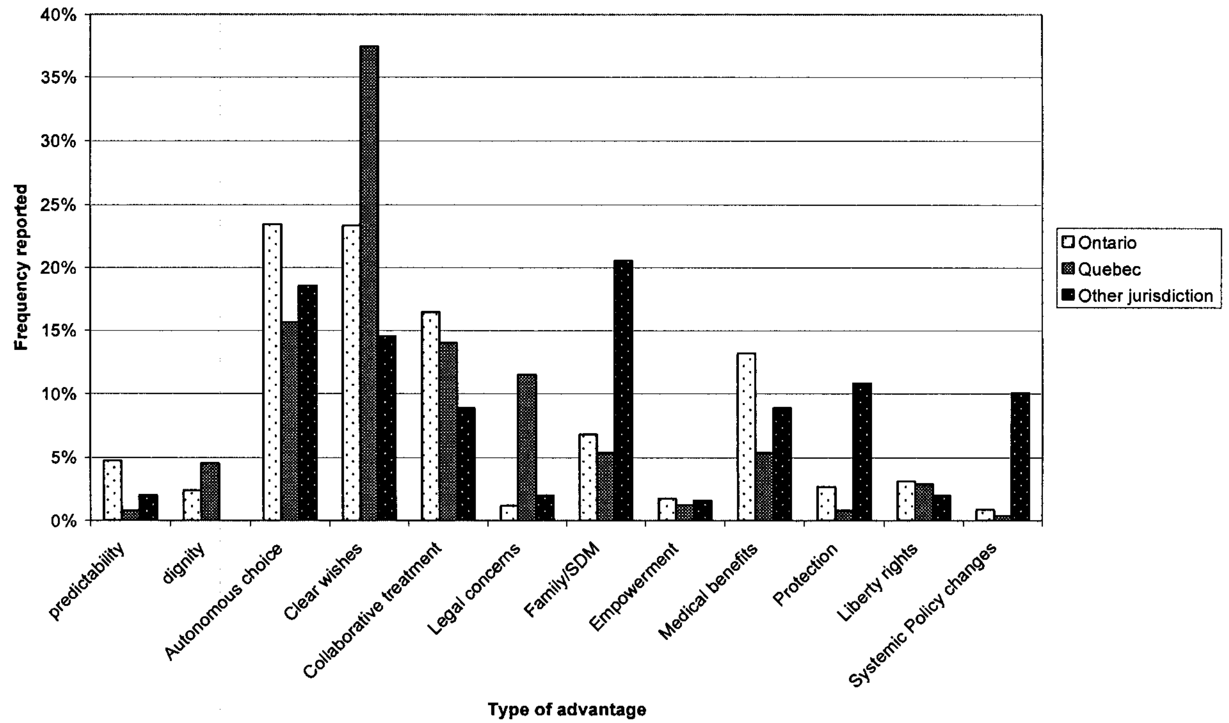

Graph 3. Willingness to implement PADs by profession
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Frequency reported
Yes
No
Neutral
Willingness to implement
Legal professionals
Mental health professionals


Graph 4. Advantages of PADs by profession
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Frequency reported
predictability
dignity
Autonomous choice
Clear wishes
Collaborative treatment
Legal concerns
Family/SDM
Empowerment
Medical benefits
Protection
Liberty rights
Systemic Policy changes
Types of advantages
Psychiatrists
Psychologists
Lawyers
Community members

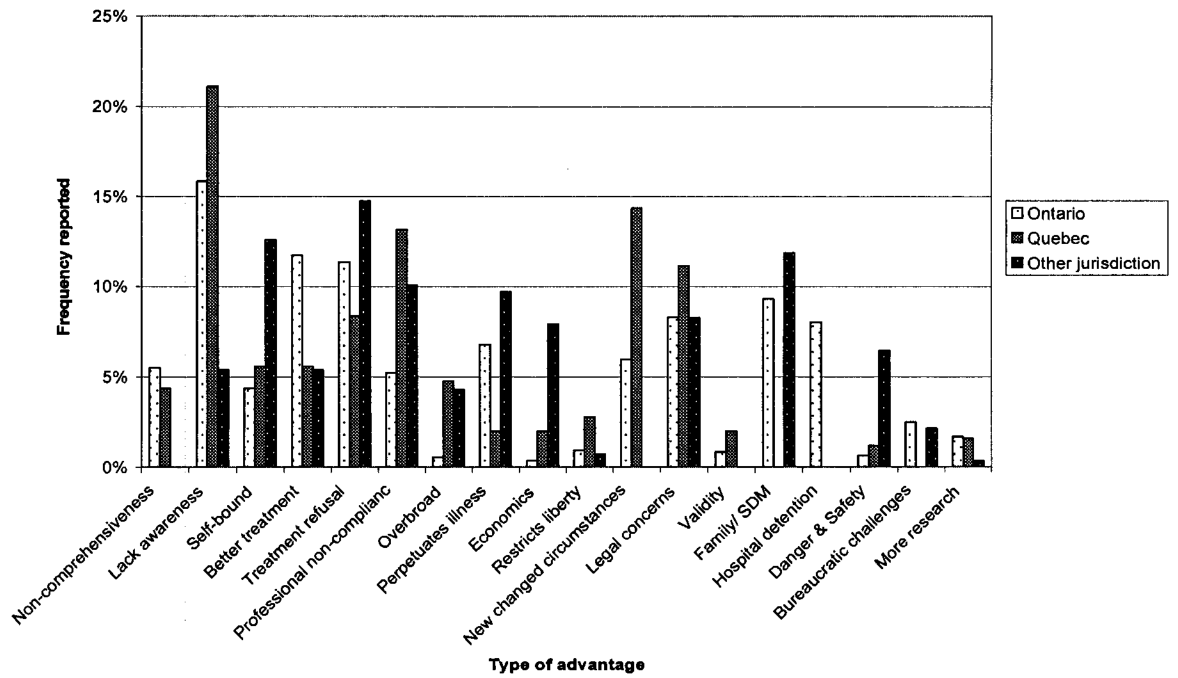

Graph 5. Disadvantages of PADs by profession
25%
20%
15%
10%
5%
0%
Frequency reported
Psychiatrists
Psychologists
Lawyers
Community members
Non-comprehensiveness
Lack awareness
Self-bound
Better treatment
Treatment refusal
Professional non-complianc
Overbroad
Perpetuates illness
Economics
Restricts liberty
New changed circumstances
Legal concerns
Validity
Family/ SDM
Hospital detention
Danger & Safety
Bureaucratic challenges
More research
Types of advantages

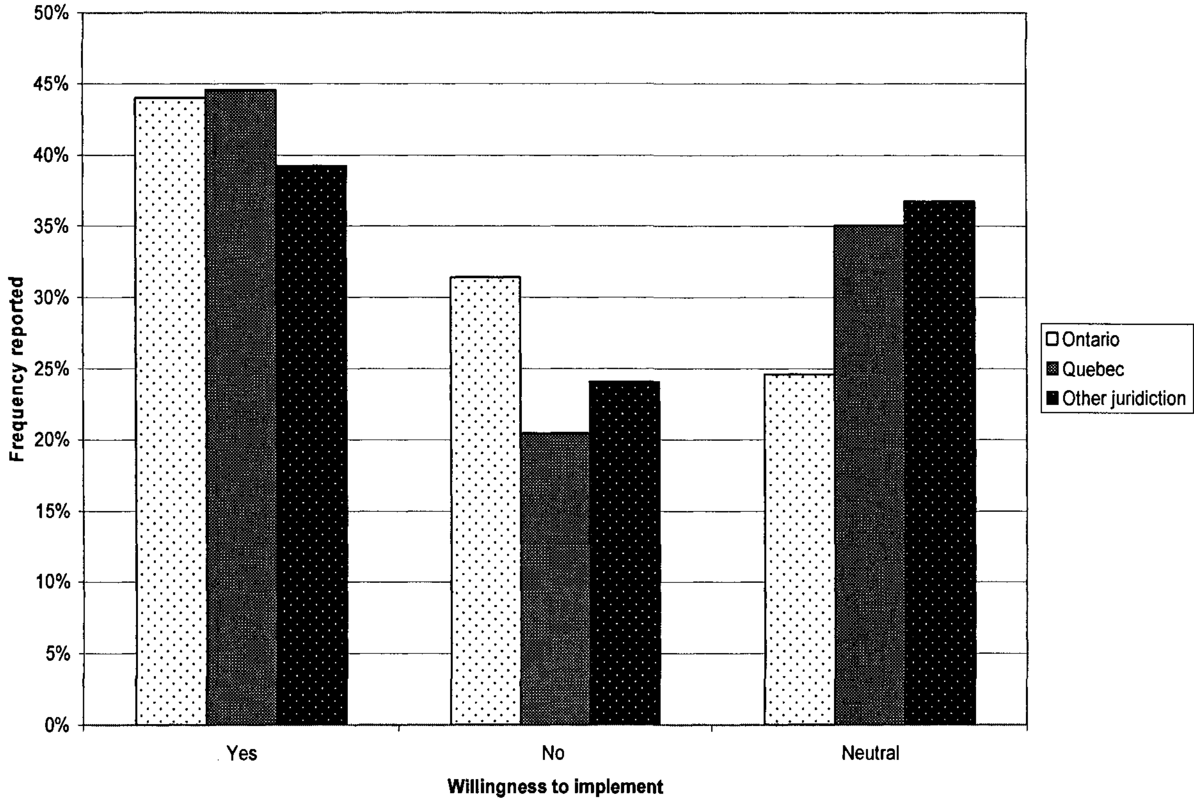

Graph 6. Willingness to implement PADs by profession
60%
50%
40%
30%
20%
10%
0%
Frequency reported
Psychiatrists
Psychologists
Lawyers
Community members
Yes
No
Neutral
Willingness to implement

Graph 7. Advantages of PADs by jurisdiction



Graph 8. Disadvantages of PADs by jurisdiction




Graph 9. Willingness to implement PADs by jurisdiction
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Frequency reported
Ontario
Quebec
Other juridiction
Yes
No
Neutral
Willingness to implement

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Appendix A: Contact information

1. Contact letter

Re: Request to participate in online Web-survey

Dear Mr/Mrs. XXX:

I am a law and psychiatry student in the Department of Psychiatry and Faculty of Law at McGill University. As part of my psychiatry thesis, I am requesting approval to have your organization forward members of your mailing list a short online Web-survey.

The research is being conducted from the Douglas Hospital, Montreal, under the supervision of Dr. Anne Crocker from McGill University, and has received ethical approval from McGill's Research Ethics Board. For the sake of confidentiality and privacy no personal information needs to be forwarded to anyone. We hope that you will find the practical value this research adds to the professional mental health community and mentally ill warrants sending out this online Web-survey. Allow me to provide you some background information.

This study examines perceptions of psychiatric advance directives (PADs) and the right to refuse treatment among professionals who deal with the mentally ill. Among these groups are psychiatrists, psychologists, psychiatric nurses, social workers, lawyers, judges and administrative tribunal members. While there has been some research among mental health and legal professionals in the US on this topic, similar research has yet to be conducted in Canada. It is possible that dissonant views among professional groups for treatment choices may be related to provincial legislation.

The online Web-survey is brief and takes only between 10-15 minutes and has been pilot-tested among a smaller number of representative participants. We are confident that with your sponsorship individuals will be more inclined to complete the survey and increase the response rate of this study. The information from this study not only provides valuable information regarding treatment choices; it also provides valuable information on the feasibility of future internet Web-surveys among professional groups.

For your perusal, please find enclosed an executive summary, paper version of the survey, consent forms and a copy of the Research Ethics Boards certification. Please do not hesitate to contact me should you have any questions or concerns about this research study. I look forward to hearing from you.

2. Email to participants (English)

RE: RESEARCH STUDY ON PSYCHIATRIC ADVANCE DIRECTIVES

Dear Sir/Madam:

We are conducting an important research study on professional perceptions of psychiatric advance directives (PADs) and the right to refuse treatment in Canada. You are invited to share your opinion by completing a simple 10-15 minute online Web-survey which will provide invaluable information to advancing research in mental health law.

PADs are new legal tools in mental health law that allows competent individuals to stipulate in writing their prior competent wishes should they lose their decision-making ability in the future. In order to assess the feasibility of implementing such documents this study examines the views of professional groups (lawyers, judges, psychiatrists, psychologists, social workers, psychiatric nurses, administrative tribunals) in Ontario and Quebec.

This study is being conducted under the supervision of Dr. Anne Crocker, of McGill University, Quebec and in accordance with ethical guidelines of the McGill University Research Ethics Board. All information will be kept strictly **CONFIDENTIAL**, private and completely anonymous. By connecting to the link in this email you will be directed to an online Web-survey that allows you to give your informed consent and participate in the study.

The knowledge obtained from this study will help policy and legal decision-makers make important decisions regarding treatment for the mentally ill, advance directives and consent and capacity law. Please do not hesitate to contact me should you have any questions or concerns about this research study. Thank you for your participation.

3. Consent form (English)

Participant Consent Form- Psychiatric Advance Directives (PADs)

Study title:
Professional perceptions of psychiatric advance directives: a view of multiple stakeholders in Ontario and Quebec

Study investigators and sponsor:
The study is directed by Daniel Ambrosini under the supervision of Dr. Anne Crocker, of the Douglas Hospital Research Centre and McGill University. The study is sponsored through the research funds of Dr. Crocker's research lab.

Introduction:
The purpose of this study is to measure psychosocial perceptions of legal and mental health professionals towards psychiatric advance directives (PADs) and the right to refuse medical treatment, and to explore how such views are affected by mental health legislation. This study examines perceptions of involuntary medical treatment, consent and capacity and the right to refuse to treatment. Due to your direct or indirect involvement with the mentally ill as a professional member of the public, you are being invited to participate in this study.

Study procedure:
By participating in this research study you will be asked to complete an online survey of approximately 10-15 minutes. You will be asked a few questions pertaining to your views of PADs, consent to medical treatment and professional demographic information.

Benefits:
There is no direct benefit in participating in this study, however, you will be helping legal and mental health professionals learn which important factors may affect attitudes and perceptions of the right to refuse treatment and the possibility of implementing PADs in Canada. This knowledge is useful for legal and policy decision-makers who draft legislation concerning mental illness and consent and capacity laws.

Foreseeable Risks and inconveniences:
Participation in this study does not carry any obvious or serious risks.

Your rights as a study participant:
Participation in this study is entirely voluntary. You can ask questions at any time, refuse to answer a question during the study or withdraw at any time by contacting the principal researcher of this study listed below.

Confidentiality:
You will never need to indicate your name in this questionnaire as all information is anonymous. If you voluntarily choose to identify yourself, your responses will still be kept strictly confidential. No information concerning your responses will be disclosed at

any time to anyone outside of the research team or laboratory. The answers to the survey will be temporarily stored in a computer file and destroyed at the end of the study.

Contact names:

If you have any questions about this research, you can call the principal researcher of this study, Daniel Ambrosini, at (514) 761-6131 ext. 3438. If you have questions about your rights as a study participant or have complaints about the research you can also contact the Institutional Review Board, of McGill University at (514) 398-2334 or by email at irb.med@mcgill.ca.

Thank you for participating in this research!

I agree and wish to participate in this study (click on this link to access the survey).

I do not wish to participate in this study.

4. Consent form (French)

Formulaire de consentement du participant
Directives préalables en santé mentale (DPSM)

Titre de l'étude
Les perceptions des professionnels sur les directives préalables en santé mentale : un regard sur différents groupes clés au Québec et en Ontario.

Les chercheurs et le financement de l'étude
Cette étude est dirigée par Daniel Ambrosini sous la supervision du Dr. Anne Crocker, du Centre de Recherche de l'Hôptal Douglas et de l'Université McGill. Cette étude est financée par les fonds de recherche du laboratoire de recherche du Dr. Crocker.

Introduction
Le but de cette étude est d'évaluer les perceptions psychosociales des professionnels du droit et de la santé mentale à propos des directives préalables en santé mentale (DPSM) et du droit de refuser un traitement médical, ainsi que de déterminer comment ces perceptions sont affectées par la législation en santé mentale. Cette étude s'intéresse aux perceptions à propos du traitement médical involontaire, du consentement et de l'aptitude, ainsi qu'au droit de refuser un traitement. À cause de votre implication directe ou indirecte avec les personnes souffrant de troubles mentaux dans le cadre de votre profession, vous êtes invité à participer à cette étude.

Procédure
En participant à cette étude, vous aurez à compléter un sondage en ligne d'une durée approximative de 10 à 15 minutes. Les questions porteront sur votre opinion à propos des DPSM, sur le consentement au traitement médical et sur votre parcours professionnel.

Avantages
Vous n'aurez aucun avantage direct en participant à cette étude. Cependant, vous aiderez les professionnels du droit et de la santé mentale à apprendre quels facteurs peuvent affecter les attitudes et les perceptions relatives au droit de refuser le traitement et si les DPSM peuvent être implantées au Canada. Cette information est particulièrement utile aux personnes qui rédigent la législation et les règlements concernant la santé mentale, les directives préalables et les lois sur le consentement et l'aptitude.

Risques et inconvénients prévisibles
La participation à cette étude ne présente aucun risque prévisible ni sérieux.

Vos droits en tant que participant à cette étude
La participation à cette recherche est entièrement volontaire. Vous pouvez poser des questions en tout temps, refuser de répondre à une question au courant du sondage ou vous retirez à tout moment en contactant le chercheur principal de cette étude dont les coordonnées apparaissent plus loin.

Confidentialité
Vous n'aurez jamais besoin d'indiquer votre nom dans ce questionnaire car toute

l'information est anonyme. Si vous choisissez de vous identifier volontairement, vos réponses seront gardées strictement confidentielles. Aucune information concernant vos réponses ne sera divulguée à aucun moment ni à quiconque en dehors de l'équipe de recherche. Les réponses au sondage seront détruites à la fin de l'étude.

Nom des personnes-ressources
Si vous avez des questions à propos de cette étude, vous pouvez contacter le chercheur principal de cette étude, Daniel Ambrosini, au (514) 761-6131 poste 3438. Si vous avez des questions concernant vos droits en tant que participant, vous pouvez contacter le comité d'éthique institutionnel de l'Université de McGill au (514) 398-2334 ou par courriel au irb.med@mcgill.ca

Merci de participer à cette recherche!

Je suis d'accord et je souhaite participer à cette étude (cliquez sur ce lien pour accéder au sondage).

Je ne souhaite pas participer à cette étude.

APPENDIX B: SURVEYS

1. PADs survey (English)

PSYCHIATRIC ADVANCE DIRECTIVE SURVEY

Instructions: Questions are divided into five page frames dealing with clinical, ethical, legal, implementation and demographic factors. This survey can be completed in 10-15 minutes. There is also an opportunity for you to provide comments. At the end of each page frame click NEXT PAGE to reach the following page and SUBMIT when the survey is complete. You must answer each question to reach the next page frame.

DEFINITION: Psychiatric advance directives (PADs) are legal documents allowing competent individuals to declare their treatment preferences in advance of a mental health crisis, in the event they lose mental capacity to make reliable health care decisions. They are self-binding legal documents allowing patients to be actively involved in their treatment, but at the same time may present ethical problems such as the right to refuse medical treatment and the extent to which prior competent wishes are respected. A PAD is most often used when the person who created the document experiences acute episodes of psychiatric illness and becomes unable to make or communicate decisions about treatment.

1. In your view, what are the advantages and/or disadvantages of implementing PADs?

I. CLINICAL FACTORS

Please respond to the following questions: *1= not at all, 4= extremely*

2. Are you familiar with PADs?

   1------2------3------4

3. Should individuals with severe mental illness be permitted the right to refuse medical treatment?

   1------2-------3-----4

4. Are you concerned with the effects of leaving someone with mental illness untreated?

   1------2-------3-----4

5. How important is it to have a mental health professional present when a PAD is documented?

   1------2-------3-----4

6. Can PADs have a therapeutic value for individuals with serious mental illness?

   1-----2--------3-----4

7. How much do PADs undermine the clinical judgment of mental health professionals?

   1------2-------3-----4

8. How much should mental health professionals be permitted to disregard instructions in PADs if evidence reveals better treatment exists?

   1------2-------3-----4

9. In your opinion, how much do legislative policies affect clinical outcomes of individuals with serious mental illness?

   1------2--------3-----4

10. How important are the following criteria to mental health professionals in assessing the clinical capacity of someone with severe mental illness?

    Understanding ability 1--------2--------3---------4
    Appreciating ability 1--------2--------3---------4
    Reasoning ability 1--------2--------3---------4
    Evidencing a choice 1--------2--------3---------4

II. ETHICAL FACTORS

11. How important are the following ethical values representing an individual's right to refuse treatment?

    Increasing autonomy 1-------2---------3---------4□
    Decreasing coercion 1-------2---------3---------4
    Increasing self-determination 1-------2---------3---------4
    Decreasing stigmatization 1-------2---------3---------4

12. How knowledgeable are you of ethical issues surrounding PADs for the mentally ill?

    1-----2------3-----4

13. How absolute should a patient's right be to decline medical treatment even if the decision is not in the patient's best interests?

    1-----2------3-----4

14. Do you think PADs can reduce stigmatization of mental illness?

    1-----2------3-----4

15. In your opinion, how important is it to consider someone's prior competent wishes before deciding their best interests?

    1-----2------3-----4

16. How concerned are you that if patients refuse to follow medical advice they may be left untreated for lengthy periods of time?

    1-----2------3-----4

17. Are you aware of past abuses against the mentally ill in your province?

    1-----2------3-----4

III. LEGAL FACTORS

18. Compared to mental health professionals how knowledgeable are you with the law related to advance directives for incompetent persons?

    1-----2------3-----4

19. Compared to legal professionals how knowledgeable are you with the law related to advance directives for the mentally ill?
    1-----2------3-----4
20. How much legal weight should PADs have as enforceable documents in court?
    1-----2------3-----4
21. Should a judge have the discretion to override a competent person's wish to refuse medical treatment?
    1-----2------3-----4
22. Would PADs assist judges in making accurate decisions about involuntary civil commitment?
    1-----2------3-----4
23. How much should the following individuals be the authoritative decision-maker in determining when a competent wish is valid?
    Psychiatrist 1-----2-----3------4
    Judge 1-----2-----3------4
    Psychiatric nurse 1-----2-----3------4
    Social Worker 1-----2-----3------4
    Review Board 1-----2-----3------4
    Family members 1-----2-----3------4

24. How concerned are you that if medical professionals override prior competent wishes in a patient's PAD it may lead to medical malpractice lawsuits?
    1-----2------3-----4
25. To what degree should courts protect prior competent wishes expressed in PADs over clinical decisions made by mental health professionals?
    1-----2------3-----4
26. In your opinion, how familiar are you with mental health legislation and the legal standard of competency in your province?
    1-----2------3-----4
27. How important are the following criteria to legal professionals in assessing legal competence of someone with severe mental illness?
    Understanding ability 1-----2-----3-----4
    Appreciating ability 1-----2-----3-----4
    Reasoning ability 1-----2----3------4
    Evidencing a choice 1-----2----3------4

IV. IMPLEMENTATION FACTORS

28. How knowledgeable are you with the process of documenting advance directives generally?
    1------2-----3----4
29. Should family members be involved in assisting competent individuals who may develop a mental illness in completing PADs?
    1------2-----3----4
30. Do PADs merit further research?
    1------2-----3----4
31. How willing are you to start using PADs in your practice?

1------2-----3----4

V. DEMOGRAPHICS & PROFESSIONAL EXPERIENCE

Please complete the following information pertaining to your profession:

32. Age

20-30 ☐
31-40 ☐
41-50 ☐
51-60 ☐
61-70
> 71

33. Gender:

Male ☐
Female ☐

34. Ethnic background

Caucasian ☐
European ☐
African-American ☐
Asian ☐
American Indian ☐
South American ☐
Other ☐

35. Which professional body do you belong to?

Judge- Superior Court
Judge- Other ☐
Lawyer/Attorney- Medical/health care law
Lawyer/ Attorney- Other
Psychiatrist- Hospital
Psychiatrist- Private practice ☐
Psychiatric nurse- Hospital
Psychiatric nurse- Private practice ☐
Psychologist- Hospital
Psychologist- Private practice ☐
Social worker- Hospital
Social worker- Private practice ☐
Other

If other (please specify):____________________
☐

36. Are you an administrative tribunal judge? (i.e. TAQ, Consent & Capacity)

Yes- Le Tribunal Administratif du Québec
Yes- Consent & Capacity Board (Ontario) ☐
Other ☐
No

☐

37. Where are you licensed to practice your profession? You may check more than one.
    - Ontario ☐
    - Quebec ☐
    - Another Canadian province ☐
    - United States ☐
    - Europe ☐
    - Other ☐

38. How long have you been a practicing member of your professional group?
    - < 1 year ☐
    - 2-5 years ☐
    - 6-10 years ☐
    - 11-30 years ☐
    - > 30 years ☐

VI. CONTACT WITH MENTALLY ILL

39. HOhOhow often do you work with individuals with severe mental illness who are not immediate family members?
    - Every day ☐
    - Once or twice a week ☐
    - Once a month ☐
    - Every few months ☐
    - Almost never ☐

40. Have you or someone in your immediate family ever been hospitalized for symptoms of severe mental illness?
    - Yes ☐
    - No ☐

VII. COMMENTS AND SUGGESTIONS

41. Why are you willing or reluctant to implement PADs?

2. PADs survey (French)

SONDAGE SUR LES DIRECTIVES PRÉALABLES EN SANTÉ MENTALE

INSTRUCTIONS: Les questions sont divisées en cinq sections se rapportant à des facteurs cliniques, éthiques, légaux et démographiques. Compléter ce sondage vous prendra environ 10-15 minutes. Il y a un endroit où vous pouver écrire vos commentaires. À la fin de chaque section, cliquer simplement sur PAGE SUIVANTE afin de passer à la section suivante et cliquer sur SOUMETTRE à la fin du sondage. Vous devez répondre à chaque question pour passer à la section suivante.

DÉFINITION : Les directives préalables en santé mentale (DPSM) sont des documents légaux permettant aux individus aptes de déclarer leurs préférences quant au traitement à suivre, advenant une crise en santé mentale durant laquelle ils perdraient leur capacité mentale à prendre des décisions éclairées à propos des soins de santé. Il s'agit de documents qui permettent aux patients d'être activement impliqués dans leur traitement, mais ces documents peuvent poser plusieurs problèmes au niveau éthique tels que le droit de refuser un traitement médical et jusque où les souhaits éclairés avant la crise de la personne sont respectés. Les DPSM sont utilisées le plus souvent lorsque la personne ayant remplie ces directives vit des épisodes de crise en santé mentale et devient inapte à prendre ou à communiquer ses décisions concernant le traitement.

1. Selon vous, quels sont les avantages et les désavantages d'implanter l'utilisation des DPSM?

I. FACTEURS CLINIQUES

1= pas du tout, 4= extrêmement

2. Êtes-vous familier avec les DSPM?

1------2------3------4

3. Croyez-vous que les individus ayant une maladie mentale sévère devraient avoir le droit de refuser un traitement médical?

1------2------3------4

4. Êtes-vous préoccupé par les conséquences de laisser quelqu'un souffrant de maladie mentale sans traitement?

1------2------3------4

5. La présence d'un professionnel de la santé mentale est-elle importante lorsque des DSPM sont rédigées?

1------2------3------4

6. Selon vous, les DSPM ont-elles une valeur thérapeutique pour les individus ayant un trouble mental sévère?

1------2------3------4

7. Les DSPM déprécient-elles le jugement clinique des professionnels de la santé mentale?

1------2------3------4

8. À quel point les professionnels de la santé mentale devraient-ils avoir la permission de ne pas tenir compte des instructions des DSPM s'il est démontré qu'un meilleur traitement existe?

1------2------3------4

9. Selon vous, à quel point les politiques législatives affectent-elles le pronostique clinique des individus ayant un trouble mentale grave?

1------2------3------4

10. À quel point les critères suivants sont-ils importants pour les professionnels de la santé mentale lors de l'évaluation clinique de l'aptitude d'un individu souffrant d'un trouble mental grave?

Habilités à comprendre 1------2------3------4
Habilités de jugement 1------2------3------4
Habilités de raisonnement 1------2------3------4
Habilités à faire un choix éclairé 1------2------3------4

II. FACTEURS ÉTHIQUES

11. Selon vous, quelle importance ont les valeurs éthiques suivantes dans la représentation des droits de l'individu à refuser un traitement?

Augmentation de l'autonomie 1------2------3------4
Diminution de la coercition 1------2------3------4
Augmentation de l'autodétermination 1------2------3------4
Diminution de la stigmatization 1------2------3------4

12. À quel point êtes-vous au courant de l'impact éthique que peuvent avoir les DSPM pour les individus souffrant de troubles mentaux?

1------2------3------4

13. Jusqu'à quel point les droits du patient devraient permettre de refuser un traitement médical même si cette décision n'est pas dans le meilleur intérêt du patient?

1------2------3------4

14. Croyez-vous que les DSPM peuvent diminuer la stigmatisation de la maladie mentale?

1------2------3------4

15. Selon vous, est-il important de prendre en considération les directives préalables en cas d'inaptitude avant de prendre la meilleure décision quant aux intérêts d'une personne?

1------2------3------4

16. À quel point vous sentez-vous concerné par le fait que si le patient refuse de suivre les conseils médicaux, il peut être laissé sans traitement pour une longue durée?

1------2------3------4

17. Êtes-vous au courant d'abus passés qui auraient été commis à l'égard d'individus souffrant de troubles mentaux dans votre province?

1------2------3------4

III. FACTEURS LÉGAUX

18. Par rapport à l'ensemble des professionnels de la santé mentale, à quel point êtes-vous au courant des lois relatives aux directives préalables pour les personnes souffrant de troubles mentaux?

1------2------3------4

19. Par rapport à l'ensemble des professionnels du domaine légal, à quel point êtes-vous au courant des lois relatives aux directives préalables pour les personnes souffrant de troubles mentaux?

1------2------3------4

20. À quel point les DSPM devraient-elles avoir un poids en tant que documents légaux?

1------2------3------4

21. À quel point les juges devrait-il avoir un pouvoir de décisions pour outrepasser les instructions d'un individu de refuser un traitement en cas d'inaptitude?

1------2------3------4

22. Les DSPM peuvent-elles aider les juges à rendre des décisions plus justes en regard de l'hospitalisation civile involontaire?

1------2------3------4

23. À quel point les individus suivants devraient-il être considérés comme des autorités en la matière pour déterminer de la validité des instructions en cas d'inaptitude d'un individu?

Psychiatre	1------2------3------4
Psychologue	1------2------3------4
Juge	1------2------3------4
Infirmière en psychiatrie	1------2------3------4
Travailleur social	1------2------3------4
Commission d'examen	1------2------3------4
Membres de famille	1------2------3------4

24. À quel point êtes-vous préoccupé par le fait que si le professionnel médical outrepasse les souhaits antérieurs du patient indiqués dans les DSMP, il peut avoir des poursuites pour faute professionnelle médicale?

1------2------3------4

25. En cas d'inaptitude, les cours devraient-elles prioriser les instructions exprimées dans un DSPM plutôt que les décisions cliniques prises par des professionnels de la santé mentale?

1------2------3------4

26. À quel point êtes-vous familier avec la législation relative à la santé mentale et avec le standard légal concernant l'aptitude dans votre province?

1------2------3------4

27. À quel point les critères suivants sont-ils importants pour les professionnels du droit lors de l'évaluation clinique de l'aptitude d'un individu souffrant d'un trouble mental grave?

Habilités à comprendre 1------2------3------4
Habilités de jugement 1------2------3------4
Habilités de raisonnement 1------2------3------4
Habileté à faire un choix éclairé 1------2------3------4

IV. FACTEURS D'IMPLANTATION

28. Connaissez-vous, de façon générale, la procédure pour rédiger les directives préalables en santé mentale?

1------2------3------4

29. Croyez-vous que les membres de la famille d'un individu apte pouvant développer un trouble mental devraient s'impliquer dans la rédaction des DSPM?

1------2------3------4

30. Les DSPM méritent-ils que la recherche s'y attarde davantage?

1------2------3------4

31. Seriez-vous disposé à introduire l'utilisation des DSPM dans votre pratique?

1------2------3------4

V. FACTEURS DÉMOGRAPHIQUES ET EXPÉRIENCE PROFESSIONNELLE

Veuillez compléter les informations suivantes :

32. Âge

    20-30
    31-40
    41-50
    51-60
    61-70
    >70

33. Sexe

    Homme
    Femme

34. Origine ethnique

    Caucasien
    Européen
    Afro-américain
    Aisatique
    Amérindien
    Sud-américain
    Autre

35. À quel corps professionnel appartenez-vous?

Juge- Cour Supérieure
Juge- autre
Avocat/Procureur- Droit médical/soin de santé
Avocat/ Procureur- Autre
Psychiatre- Hôpital
Psychiatre- Pratique privée
Infirmière en psychiatrie- Hôpital
Infirmière en psychiatrie- Pratique privée
Psychologue- Hôpital
Psychologue- Pratique privée
Travailleur social- Hôpital
Travailleur social- Pratique privée
Autre _______________

36. Êtes-vous membre d'un tribunal administratif?

Qui- Le Tribunal Administratif du Québec
Qui- Consent & Capacity Board (Ontario)
Autre
Non

37. Où détenez-vous un permis pour exercer votre profession? Vous pouvez cocher plus d'une case.

Ontario
Québec
Une autre province canadienne
États-Unis
Europe
Autre

38. Depuis combien de temps exercez-vous votre profession?

< 1 an
2-5 ans
6-10 ans
11-30 ans
> 31 ans

VI. Contact avec les individus ayant des troubles mentaux

39. À quelle fréquence travaillez-vous avec des individus ayant des troubles mentaux graves qui ne font pas partie de votre famille immédiate?

Tous les jours
Une ou deux fois par semaine
Une fois par mois
Quelques mois par année
Presque jamais

40. Est-ce que vous ou un membre de votre famille immédiate, avez déjà été hospitalisé pour des symptômes de troubles mentaux graves?

Oui
Non

VII Commentaires et suggestions

41. Pourquoi êtes-vous favorable ou défavorable à l'implantation des DSPM?