



**Mental Health Commission Response to the Public
Consultation on the Draft Scheme for Advance
Healthcare Directives**

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Introduction

The Mental Health Commission (the Commission) welcomes the publication of the Draft General Scheme for Advance Healthcare Directives (AHD) for incorporation into the Assisted Decision-Making (Capacity) Bill 2013 by the Department of Health. The Commission is of the view that the recognition of AHDs is a fundamental step towards a recovery-based approach. AHDs also represent an important means by which individuals can exercise their autonomy and capacity under the supported decision-making model in the UN Convention on the Rights of Persons with Disabilities (CRPD).

The Commission notes that the purpose of the proposed legislation is to promote autonomy; to enable persons to be treated according to their will and preferences and to provide healthcare professionals with important information about persons and their choices in relation to treatment. The Commission endorses autonomy and the right of persons to be treated with respect for their will and preferences. The concept of recovery endorsed by the Commission is described “in terms of the human right to autonomy and the self-fulfilment of the individual.”¹ The Commission welcomes the presumption of capacity for all adults to execute an AHD and the provision of a single legislative framework, which encompasses AHDs for general and mental healthcare. Under the proposed Scheme, an individual is entitled to make an AHD for mental healthcare treatment, but these decisions may be limited for individuals detained under the Mental Health Act, 2001 (2001 Act). In the submission on the Assisted Decision-Making (Capacity) Bill, the Commission stated that it fully supports the introduction of AHDs into Irish law and submits that they should equally apply to all persons including those detained under the 2001 Act. However, it recognises the need for compatibility between the AHD provisions and Part 4 of the 2001 Act. These may be addressed in the review of the Act. The Commission, in this submission, has addressed the specific issues raised in the public consultation by the Department of Health and additional areas relevant to the use of AHDs for individuals with mental health conditions.

Mental Health Commission

The Mental Health Commission is an independent statutory body, which was established under the provisions of the Mental Health Act, 2001. The principal functions of the Commission are to promote, encourage, and foster the establishment and maintenance of high

¹ Mental Health Commission, *Annual Report 2012 including Report of the Inspector of Mental Health Services* (Mental Health Commission 2012).

standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres. The strategic priorities of the Commission include safeguarding the human rights of service users, incorporating these rights into practice and involving service users and their families in treatment and care. Other priorities include promoting service user-centred and recovery-oriented services. AHDs are a key driver in the transition to person-centred services. The implementation of AHDs can assist the ‘paradigm shift’ towards the recovery and supported decision-making approaches in Irish mental healthcare. The introduction of progressive human rights legislation is important in achieving attitudinal change towards individuals with mental health conditions and how they are treated in Ireland.

1. What are your views on requiring an individual to obtain professional advice (e.g. clinical and/or legal) before preparing an advance healthcare directive?

While users should be encouraged to discuss their AHD preferences with treating clinicians, the requirement to obtain clinical or legal advice before preparing an AHD may act as a barrier to completion. Service users should be encouraged to discuss their AHD preferences with treating clinicians after the document is developed with an independent support person. The discussion of the AHD with the clinician can have significant benefits for the therapeutic relationship and the promotion of trust. The involvement of the treating clinician in the preparation of the directive can raise undue influence concerns due to the power imbalance in the relationship. Time may also be a barrier for clinician involvement in development. Clinicians may be involved in introducing AHDs to the person and referring them to an independent trained support person for facilitation e.g. peer facilitator. This may form part of the Code of Practice. The evidence indicates that the majority of AHDs contain clear and valuable information² and are consistent with clinical practice regardless of professional involvement.³

² Jacque Reilly and Jacqueline Atkinson, ‘The Content of Mental Health Advance Directives: Advance Statements in Scotland’ (2010) 33 *International Journal of Law and Psychiatry* 116.

³ Marvin Swartz and others, ‘Patient Preferences for Psychiatric Advance Directives’ (2006) 5 *International Journal of Forensic Mental Health* 67; Richard Van Dorn and others, ‘Clinicians’ Attitudes Regarding Barriers to the Implementation of Psychiatric Advance Directives’ (2006) 33 (4) *Administration and Policy in Mental Health* 449; Debra Srebnik and others, ‘The Content and Clinical Utility of Psychiatric Advance Directives’ (2005) 56 (5) *Psychiatric Services* 592.

2. Is it necessary for the provisions to designate a specific, mandatory time period within which an advance healthcare directive must be reviewed?

The AHD should be reviewed periodically so changes in treatment preferences or personal circumstances are incorporated, but this should form part of the Code of Practice rather than a legislative requirement. The requirement for a specific, mandatory time period for review in the legislative provisions may impact on the validity and enforceability of the directive. The review of an AHD should occur on an annual basis, after each episode of illness or crisis or as the person requests. The Council of Europe recommends reviewing AHDs at regular intervals e.g. on a yearly basis.⁴

3. Should a standard format be developed for advance healthcare directives?

The Commission members support the development of a standard simplified form (s) for AHDs in the Code of Practice. However, the form should not be a legislative requirement for the AHD to be valid. Model forms should be provided in the Code of Practice, which capture the information in a clear and systematic manner. The form facilitates service provider recognition of the directive and provides a template for instructions. This decreases the likelihood of ambiguity or error.

4. If a standard format for advance healthcare directives was developed what information should it contain?

A standard integrated form should be developed to include all healthcare decisions i.e. physical and mental health decisions. A separate form should also be developed for individuals, who wish to document mental health decisions separately to protect confidentiality in other healthcare settings. The form for mental health decisions should include details of the person; any designated decision-making representative (s) or other support persons; the authority of the decision-maker; when the directive should be activated or deactivated; emergency contacts; details of treating doctors; treatment refusals/requests; reasons for preferences; Ulysses clause; preferences for life-sustaining treatment and life-saving emergency treatment; life management choices, hospitalisation preferences; relapse symptoms; organ donation and participation in research. The person should only be legally required to provide minimal details such as name, address, date of birth, witness signatures and the details of any designated representative (s) for the AHD to be valid. The details of

⁴ Council of Europe, Parliamentary Assembly Resolution 1859 (Council of Europe 2012).

any support person with whom the directive was developed with, may also be included. If the person appoints a representative, but does not provide specific instructions or limit his/her power, the representative will be bound to make decisions based on the persons will and preferences or to make every effort to identify these where they are unknown.

The Commission is of the view that a standard format should be developed, which includes decisions specific to mental health and life planning issues. Any intersectional information from the Assisted Decision-Making Capacity Bill should also be included, including who should be contacted if there is lack of clarity. The format adopted by the New Zealand Medical Association is one example for consideration.⁵

5. Where should advance healthcare directives be kept to ensure that their existence is known about and they can be readily accessed when required?

In the absence of electronic medical records, AHDs should be kept in a secure online registry with confidentiality safeguards. The central registry should be accessible by healthcare providers with the consent of the person or the designated decision-making representative. The person should specify whether they wish mental health information to be made available to general healthcare providers to protect privacy. The register for decision-making agreements proposed by the Office of the Public Guardian may also include AHDs. In order to protect confidentiality, the Mental Health Commission may assume responsibility for access, where the AHD includes mental health decisions. The legislation should not require submission to the registry for the AHD to be legally valid, but registration should be recommended in the Code of Practice. The registry should be easily accessible to enable all individuals to submit their directive with support if needed. Copies of the document should also be valid and distributed to relevant treatment providers, family members and other relevant persons.

6. What additional measures could be included in the provisions to ensure that healthcare professionals are made aware that an individual has prepared an advance healthcare directive?

There should be an obligation on clinicians to inquire whether a person has an AHD on admission to mental health services (community or inpatient settings) or as part of the

⁵ <http://www.nzma.org.nz/patients-guide/advance-directive>

clinical assessment. The existence of an AHD should be documented in a section on the person's medical record and in the online registry. Crisis cards (similar to organ donation cards) should also be made available to alert healthcare professionals of the existence of an AHD. Individuals should be encouraged to discuss their AHD preferences with treating healthcare professionals and distribute copies to providers and family at execution. The development of an AHD should also be documented in the individual care plan. This should form part of the Code of Practice in the legislation.

7. The provisions enable an individual to make a legally-binding refusal of treatment in an advance healthcare directive, however, requests for treatment in such directives will not be legally-binding. What should be done to ensure that such treatment requests, while not legally-binding, are adequately considered during the decision-making process?

An obligation should be placed on healthcare professionals to provide treatment requested in the directive where it is reasonably available and clinically appropriate. Treatment requests should also be discussed with healthcare professionals after the AHD is developed to ensure requests are respected. A duty should be placed on the healthcare professional to inform the person and/or the designated decision-making representative and the monitoring body of the reasons why the requested treatment could not be provided (e.g. the Mental Health Commission) and to document it on the medical record. If the treatment is available through another professional or provider, reasonable efforts should be made to transfer the person to another provider or professional who is able or willing to comply with the request. The Commission is of the view that there should be equivalence such that voluntary patients and patients subject to detention under the provision of the Mental Health Act 2001 have the same rights and access to the same system.

8. Given that advance healthcare directives relating to mental healthcare and treatment are intended to be used on a recurring basis, as opposed to advance healthcare directives for general healthcare which are predominantly used once, should a different format be used for both types of directive?

The provisions should include both integrated and separate formats for mental health and general healthcare so that the individual has a choice of forms. An integrated form should be made available for both physical and mental health decisions. Many individuals with mental health conditions also have physical illnesses, which they may want to document. Other

individuals may want to document mental health decisions separately to protect confidentiality in general health settings. The form for mental health decisions should include details of relapse symptoms, crisis responses, support persons, recovery strategies, treatment refusals/requests, reasons, hospitalisation preferences, ECT preferences, life-saving emergency treatment, review date and a Ulysses clause for individuals who want their AHD wishes to stand over his/own objections during crisis periods. The Ulysses clause should be signed by an independent support person to ensure it reflects the person's will and preferences. The form should also include life management choices when an individual is in crisis e.g. childcare, household finances.

9. What do you think the role of the patient-designated healthcare representative should be? Should the representative's role be limited to that of interpreting the individual's advance healthcare directive? Should the representative have a broader role to advise as to what the individual's will and preferences regarding treatment are likely to be?

The legislation should place a duty on the healthcare representative to follow the person's instructions or to make every effort to identify his/her will and preferences where instructions are not provided in line with the principles of the 2013 Bill and the AHD Scheme. The individual should specify the role of the designated healthcare representative in the terms of the directive at execution i.e. when they want the representative to be consulted and whether they wish them to have broad or limited decision-making authority, or respond to changes in treatment. The form should allow the person to specify whether the representative has a broad or limited decision-making role and the duration of such role. In certain circumstances, the person may wish to allow the representative to consent to hospitalisation for a limited period. This should be subject to independent review safeguards by a Mental Health Tribunal. The distinction between a representative's authority to make decisions about mental health treatment and the authority to consent to hospitalisation should be clarified and set out separately. The Commission recommends that Guidelines are developed regarding the role of the healthcare representative.

The legislation should allow individuals to have a choice of executing a stand-alone instructional directive; a directive where a representative is appointed to communicate the person's will and preferences or a hybrid directive where the person includes instructions and a representative. The research suggests that a significant proportion of mental health service users lack a trusted representative to act on their behalf so the option to execute a standalone

instructional directive and the development of support should be provided for in the legislation.⁶ The CRPD requires State Parties to facilitate the creation of supports, particularly for individuals who are isolated and may not have access to naturally-occurring supports in the community.⁷ Due to the conflict of interest, a healthcare professional should not act as a decision-making representative. The Scheme states that a provider of paid personal or healthcare services should not act as a representative. The importance of appointing a trusted representative with knowledge of the person's will and preferences should be stated in the Code of Practice. The involvement of an independent support person in the development of the directive can safeguard against undue influence.

Primarily, the role of the healthcare representative should be to ensure the person's directions are followed in the anticipated circumstances. However, this may not always be clear particularly where there are no instructions. There should be some enabling provisions in the legislation permitting the representative to have a more assertive role as anticipated in the 2013 Bill for supported decision-makers. The role of the healthcare representative may be context and person dependent and depend on the level of trust and knowledge in the relationship.

10. What additional safeguards may be required in relation to the provisions for the patient-designated healthcare representative to protect the individual who made the advance healthcare directive and to ensure that the representative carries out his/her wishes?

In cases, where the person provides specific instructions, the representative should have a duty to follow these in treatment and other decisions. There should be some form of accountability mechanism where the representative does not follow the person's instructions. In the absence of instructions, the representative should have a duty to make decisions in accordance with the person's will and preferences and make every effort to identify them where they are unknown. The Code of Practice should emphasise the importance of appointing a trusted decision-making representative, who is familiar with the person's values. An obligation should be placed on providers to help build trusted support networks for

⁶ Marvin Swartz and others, 'Patient Preferences for Psychiatric Advance Directives' (2006) 5 International Journal of Forensic Mental Health 67.

⁷ Committee on the Rights of Persons with Disabilities, 'Draft General Comment on Article 12 of the Convention-Equal Recognition before the Law' GE 2013. Adopted by the Committee at its tenth session (2-13 September 2013) para 25(d).

individuals who lack a trusted person. A system of supervision should be established under which an independent authority is empowered to investigate, in cases of abuse by decision-making representatives. Education and training programmes should also be provided for individuals who are appointed healthcare decision-making representatives to safeguard against substitute decision-making and to ensure the person's wishes are reflected in decisions. The legislation should allow more than one representative to be appointed for different decisions e.g. mental health and other decisions.

The Commission is of the view that the role of the decision-making representative and the instructions should be clearly stated in writing and signed by the person and healthcare professional (or other independent support person) involved in helping the person complete the directive. The Code of Practice should provide clear requirements in relation to how professionals approach this process. Conflicts of interest should be dealt with as far as possible in the legislation. The role of the Public Guardian and awareness raising and training will be essential to ensure that the representative carries out the wishes of the person.

11. Are there any other issues relating to advance healthcare directives that should be included in the legislative provisions?

11.1. *Formalities for Execution*

The legislation should include minimal formalities to ensure AHDs are easily executable by all persons. This suggests the need to remove limitations on adult witnesses and requirements for advice from legal or health professionals to encourage participation. The limitations on witnesses from a person's family in the draft Scheme may also act as a barrier to AHD execution and should form part of the Code of Practice rather than a legal requirement. The involvement of independently trained support persons in the development of the AHD can help protect against undue influence. There should be some sanction in the legislation for coercing a person to execute or alter an AHD or intentionally misrepresenting his/her will and preferences. Limited provision should be provided for oral AHDs with independent witness safeguards and/or recorded evidence in circumstances, where the person is unable to communicate in writing.

11.2. Legal Status of AHDs during Involuntary Detention

AHDs should be legally binding for all healthcare decisions, including mental health decisions and equally applicable during periods of involuntary detention. In the submission on the Assisted Decision-Making (Capacity) Bill 2013, the Commission submitted that AHDs should apply equally to all persons including those detained under mental health legislation, but recognises the need to amend the provisions of Part 4 of the 2001 Act for treatment decisions to be binding.

The Commission is concerned with the provisions of Head 5(7), which state that AHDs will not be legally binding where treatment is regulated under the 2001 Act.

While non-legally binding AHDs with accountability mechanisms are ethically valuable, the use of differential standards for mental healthcare and general healthcare directives reinforces the notion that the rights of individuals with mental health conditions are not respected on an equal basis with others. The integration of AHDs for mental health decisions in the legislative framework on an equal basis with other treatment decisions is important symbolically in reducing stigma and discrimination. Stigma and discrimination have been identified as the greatest barriers to recovery.⁸ The use of differential standards for treatment decisions during involuntary detention conveys the message that the person is not respected and can act as a deterrent to seeking treatment.

The limitation on AHDs during involuntary detention in the Scheme is justified based on the State duty “to uphold the common good and to protect and maintain the rights and ‘best interests’ of its citizens ... and override the rights of a given individual to protect that individual and/or the general population.” However, the evidence indicates that in the absence of substance abuse, the risk of violence is no greater than the general population.⁹ Risk does not therefore justify the exclusion of legally binding AHDs during involuntary detention. Involuntary detention can be used where there is risk to others and an emergency exception in the legislation can address situations where treatment is required due to an imminent risk to the life of the person. The fear that individuals will refuse all treatment or be left untreated often forms the basis for limitations on AHDs during involuntary detention.

⁸ Office of Social Inclusion, *Joint Report on Social Inclusion* (Office of Social Inclusion 2004).

⁹ John Monahan and others, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (Oxford University Press 2001).

However, the international research suggests that AHDs are rarely used to refuse all treatment and are generally used to express a preference for particular treatments or to inform providers of concerns.¹⁰ The evidence suggests AHDs increase treatment adherence and engagement.¹¹

The features of the Irish mental health system suggest a need for legally binding AHDs with accountability and oversight mechanisms until a cultural shift towards respect for treatment preferences is established. Several Commission reports have identified concern in relation to the low level of service-user participation and compliance with individual care planning.¹² The research with service users suggests a need and demand for legally binding AHDs during involuntary detention to address specific treatment concerns and to instil confidence that preferences will be respected.¹³ The threat of coercion in the mental health system impacts on voluntary and involuntary patients. Even if the AHD is legally binding for voluntary patients, the threat of involuntary detention, limits the impact of mental health decisions. AHDs are also associated with a reduced need for hospital readmission and involuntary detention.¹⁴ This is particularly pertinent in view of the high readmission rates in the Irish mental health system.¹⁵ The establishment of a strong philosophical ethos of respect may be the most important aspect of AHDs for service users.

The Commission's strong view in this regard, is that the current review of the Mental Health Act 2001 needs to fully consider and address this issue.

¹⁰ Debra Srebnik and others, 'The Content and Utility of Psychiatric Advance Directives' (2005) 56 *Psychiatric Services* 592; Jacque Reilly and Jacqueline Atkinson, 'The Content of Mental Health Advance Directives: Advance Statements in Scotland' (2010) 33 *International Journal of Law and Psychiatry* 116.

¹¹ Christine Wilder and others, 'Medication Preferences and Adherence among Individuals with Severe Mental Illness and Psychiatric Advance Directives' (2010) 61 (4) *Psychiatric Services* 380.

¹² Inspectorate of Mental Health Services, 'National Overview of Service User Representatives, Carers/Family Representatives and Advocacy Groups 2010' (Mental Health Commission 2011); Mental Health Commission, *Annual Report 2012 including Report of the Inspector of Mental Health Services* (Mental Health Commission 2012) 54.

¹³ Fiona Morrissey, 'The Introduction of Advance Directives in Irish Mental Health Care: The Views of Service Users and Consultant Psychiatrists' Unpublished 2013.

¹⁴ Claire Henderson and others, 'Effect of Joint Crises Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial' (2004) 329 *British Medical Journal* 136; Jeffrey Swanson and others, 'Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions' (2008) 17 *Journal of Mental Health* 255; Chris Flood and others, 'Joint Crisis Plans for People with Psychosis: Economic Evaluation of a Randomised Controlled Trial' (2006) 333 *British Medical Journal* 729.

¹⁵ Readmissions accounted for 66 per cent of the 18,173 admissions to Irish psychiatric units and hospitals in 2012.

11.3. Revocability

The Scheme of heads states that “... enabling a person who lacks capacity to revoke or alter his or her directive would defeat the purpose of preparing the directive.”¹⁶ The AHD development process confers recovery and capacity building benefits even if it is never legally invoked. The evidence suggests that a significant proportion of users have change of mind concerns and prefer the AHD to be revocable at any time, even though few are fully revoked in practice.¹⁷ The revocability of the directive during crisis periods should be specified by the user. Several jurisdictions allow the person to change the directive during periods when decision-making capacity may be reduced.¹⁸ The inclusion of a Ulysses clause in the legislation can address situations where individuals clearly want their AHD wishes to be followed over any changes they may try to make during crisis periods. The clause caters for individuals who have prior experience of crisis and clearly want their AHD wishes to be followed. Some individuals want to use the Ulysses clause to avoid deterioration, damage to interpersonal relationships or the need for involuntary admission. The clause should be subject to additional executional safeguards by an independent witness and/or healthcare professional to ensure it reflects the will and preferences of the person.

The Council of Europe recommendations state that the AHD should be revocable at any time and reviewed at regular intervals.¹⁹

11.4. Support

The international research shows the need for support for AHD completion.²⁰ This should be stipulated in the Code of Practice. Trained facilitators should be provided in a range of settings to support individuals to develop AHDs. The support person should be independent of the treating healthcare professional. The role of peer support should be recognised in the Code of Practice. The CRPD requires State Parties to provide access to supports to exercise legal capacity.

¹⁶ Head 4(6).

¹⁷ Debra Srebnik and Scott Kim, ‘Competency for Creation Use and Revocation of Psychiatric Advance Directives’ (2006) 34 (4) *Journal of the American Academy of Psychiatry and the Law* 501.

¹⁸ Arizona, Washington, Virginia.

¹⁹ Council of Europe, Parliamentary Assembly Resolution 1859 (Council of Europe, 2012) Principle 7.6.

²⁰ Tracy Peto and others, ‘Support Needed to Create Psychiatric Advance Directives’ (2004) 31 (5) *Administration and Policy in Mental Health* 409.

11.5. AHD Completion

The Code of Practice should place a duty on healthcare professionals to offer individuals the opportunity to develop an AHD as part of the recovery and care planning process. Designated members of healthcare staff should be assigned responsibility for offering individuals the opportunity to develop an AHD as part of the care planning process and/or referring them to a trained facilitator for support to complete the document. The AHD should be integrated with individual care plans. The legislation should include some form of accountability mechanism e.g. requiring professionals to document when individuals were offered the opportunity to develop an AHD and the reason for not developing one in the medical record and/or the individual care plan. Healthcare providers should be required to return annual figures on how many AHDs were completed in the service. These figures should be returned to the monitoring body. The Mental Health Commission and the Office of Public Guardian should report on AHD completion figures in annual reports.

11.6. Capacity Determinations

The Scheme does not specify how the AHD will be activated and who will determine capacity for the purpose of invoking and revoking the directive. This is a major issue that needs to be addressed and should be subject to independent review safeguards. Head 3(2) specifies that a presumption of capacity shall exist unless there is evidence to the contrary, but does not specify who will make this decision. Consideration should also be given to how the AHD might be activated outside of hospital settings. The CRPD requires AHDs to be separated from legal frameworks that are based on mental capacity and incapacity.

11.7. Basic Care

Head 5(4) provides that AHDs are not to be applicable to the administration of basic care and clarifies that this is distinct from treatment. The definition of basic care includes, but is not limited to, warmth, shelter, oral nutrition and hydration. The legislation should provide a clear distinction between the refusal of life-sustaining treatment in end-of-life situations and the provision of life-saving emergency treatment in the mental health context. The ability to refuse artificial nutrition and hydration may be limited to persons with terminal conditions to alleviate concerns in relation to the refusal of life-sustaining treatment in cases such as anorexia nervosa.

11.8. *Litigation*

The healthcare decision-making representative should make the final decision in relation to the person's will and preferences. In cases of unresolved conflict between family members or other parties and the decision-making representative, the decision should be referred to the court or the monitoring body to adjudicate. The research shows AHDs may assist family understanding of the person's wishes and decrease decision-making burden rather than increase it. AHDs generally reduce the need for litigation due to increased communication between the person, professionals and family members.

11.9. *Accountability and Oversight*

The legislation should provide accountability and oversight mechanisms where treatment is provided in conflict with a valid AHD. The reasons for overriding the AHD should be submitted in writing to an independent body and documented in the person's medical record. The person and the decision-making representative should be informed of the decision and it should be reviewed by the monitoring body. The Mental Health Commission may provide oversight for AHDs in mental healthcare, while the Office of the Public Guardian may provide oversight for general AHDs. The implementation of the legislation on AHDs should be co-ordinated by these bodies. The use of AHDs should be incentivised and measured within the system.

11.10. *Education*

Stakeholder education and consensus building are critical for the effective implementation of the AHD legislation. The Office of the Public Guardian and the Mental Health Commission should monitor the implementation of AHDs, promote public awareness and provide education to professionals, families, representatives and services users. Legal compliance training should be provided for health professionals. Community education and public awareness will also be vital. Consideration should be given to piloting AHDs on mental health sites prior to implementation.

11.11. *Other Issues*

The provision in Head 5(1)(d), which states that an AHD is invalid if the person has "while he or she had capacity to do so, has done anything clearly inconsistent with the advance healthcare directive remaining his or her fixed decision" may create uncertainty in relation to the applicability of the directive and the duty of the healthcare provider to determine whether

this occurred. This could result in an implied revocation of the AHD and subjective interpretations of the person's will and preferences and delay key decisions. Users should be encouraged to communicate any changes to the directive as part of the review process.

The Expert Group currently reviewing the 2001 Act should give consideration to proposing amendment of the 2001 Act to allow AHDs to be considered by Mental Health Tribunals.