Received: 26 February 2019 | Accepted: 7 November 2019
DOI: 10.1111/appy.12374

BRIEF REPORT

Psychiatric Advance Directives and their relevance to improving psychiatric care in Asian countries

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Abstract

People with mental illness may be unable to provide critical input about the care they wish to receive during a psychiatric crisis because of altered mental states. It is therefore imperative that clinicians seek to understand service users' wishes for care while they are well and able to provide meaningful input into the discussion. Achieving such an end may be done by discussing and completing a psychiatric advance directive. However, very few Asian countries have legislation that supports such advance directives. The present article seeks to give physicians more information about advance psychiatric directives and the potential role they could play to improve the healthcare provided in Asia to people at risk of losing capacity due to a mental illness. The degree to which mental health legislation supports psychiatric advance directives is documented for each country of South East Asia and Eastern Asia.

KEYWORDS
Psychiatric advance directives, advance care plan, joint crisis plan

1 | BACKGROUND

People with severe mental illness may experience altered mental states during psychotic, depressive or manic episodes at any point in their life. During these episodes, they may be unable to take part in the shared decision making process. In such cases, clinicians are tasked with providing psychiatric care using the least restrictive methods with the service user's best interest in mind (Semple & Smyth, 2013). This may include life-saving treatments that can only be provided in an inpatient setting (Seo, Kim, & Rhee, 2013).

Several strategies exist to help clinicians serve the best interest of service users in crisis by sharing the responsibility of choosing a course of treatment. Given the legal implications of treating an individual who may resist treatment because of their altered mental state, many strategies are supported by protective legislation (Semple & Smyth, 2013). For example, in England and Wales, the process follows a structured framework that includes independent mental capacity advocates (Cowley & Lee, 2011). Courts and tribunals may appoint an independent advocate to oversee medical decisions on behalf of the individual if the individual is unable to complete a lasting power of attorney (Menon, 2013). Clinicians may encourage service users to complete psychiatric advance directives to plan the care they would hope to receive should they lose capacity again. These strategies challenge paternalistic practices and go beyond the principle of beneficence to strategies which truly involve the service user. Relying on one or more of these strategies protects the rights of all involved. Below we discuss psychiatric

Commentary

advance directives as an important direction for Asia as it moves toward enacting various legislations to support patient-centred care (Sarin, Murthy, & Chatterjee, 2012). By calling into focus psychiatric aspects of care, policymakers can build healthcare systems that put individuals with mental illness at the centre of treatment planning not only at the end of life, but during any stage of life when capacity may be lost.

2 | PSYCHIATRIC ADVANCE DIRECTIVES

The purpose of implementing psychiatric advance directives is to help clinicians better manage psychiatric conditions that may interfere with an individual's willingness to engage with beneficial treatment (Semple & Smyth, 2013). Generally, these directives intend to reduce the use of deceptive or coercive involuntary treatment methods, and reduce length of hospitalization (Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008; Ouliaris & Kealy-Bateman, 2017). Because psychiatric advance directives take into account fluctuating levels of capacity and are regularly revisited to adjust to the changing needs and wishes of service users, they go beyond advance medical directives. Therefore, certain health ministries, such as in Canada, have explicitly highlighted the potential added role of psychiatric advance directives (*Toward Recovery and Well-Being: A Framework for a Mental Health Strategy*, 2009).

Results of randomized controlled trials about the utility of psychiatric advance directives have been mixed (Barrett et al., 2013;

TABLE 1 South- Southeast- and East- Asian countries for which data is available, the presence of mental health legislation, the year of the legislation's most recent iteration, and notes whether the legislation includes provisions for advance directive in any form

Country *	Name of the mental health legislation and year of its most recent iteration	Note on the absence or presence of psychiatric advance directives
Cambodia (Olofsson, Sebastian, & Jegannathan, 2018)	No mental health legislation exists	
China (Chen et al., 2012)	Mental Health Law 2012	No provision for the registration of psychiatric advance directive
Hong Kong	Mental Health Ordinance, Cap 136 2012	No provision for the registration of psychiatric advance directive
India	Mental Health Care Act 2017	Has provision for recording advance directives and appointing a donee
Indonesia	Mental Health Act 2014	No provision for the registration of psychiatric advance directive
Japan	Law related to mental health and welfare of persons with mental disorders 2005 (law no 94)	No provision for the registration of psychiatric advance directive
Malaysia	Mental health Act 2001; Mental Health Regulations 2010	No provision for registering an executive of the estate or donee or psychiatric advance directive.
Mongolia	Mental Health Act 2000	No provision for the registration of psychiatric advance directive
Myanmar (*WHO-AIMS Report on Mental Health System in Myanmar*, 2006)	Mental Health Legislation Lunacy Act of 1912	
Philippines	Comprehensive Mental Health Act House Bill no 6452	Allows a person to designate a legal representative through the registration of an advance directive
Republic of Korea	Act on the improvement of mental health and the support for welfare services for mental patients 2017	No provision for the registration of psychiatric advance directive, or of a donee
Singapore	Mental Capacity Act; the Mental Health (Care and Treatment) Act 2008	No provision for the registration of psychiatric advance directive, but recognizes the individual's appointment of a donee
Taiwan (Wu & Cheng, 2017)	Mental Health Act, Amendment 2007	No provision for the registration of psychiatric advance directive
Thailand	Mental Health Act B.E. 2551(2008)	No provision for the registration of psychiatric advance directive
Vietnam (Vuong, Van Ginneken, Morris, Ha, & Busse, 2011)	No mental health law, only law on persons with disabilities	

*References are given for countries where no legislation exists, or if the original acts were not reviewed by the authorship team.

Henderson et al., 2004; Lovell et al., 2018; Ruchlewska, Mulder, Van der Waal, Kamperman, & Van der Gaag, 2014). However, cohort and case-control studies provide encouraging evidence (Swanson et al., 2008). Some have proposed that length of stay and readmission rates are too distal from the impact of psychiatric advance directives to measure reliably in the context of experimental studies (Nicaise, Lorant, & Dubois, 2013). Rather the most important impact of psychiatric advance directives is on the therapeutic alliance, the integration of service providers, informal caregivers and service users, and enhanced autonomy (Nicaise et al., 2013). Other studies have shown impacts on intermediate outcomes, such as medication adherence, which significantly improves in groups that completed psychiatric advance directives (Wilder, Elbogen, Moser, Swanson, & Swartz, 2010).

3 | LEGISLATION

In Asia, the presence of legislation to support advance medical directives varies considerably. For example, Singapore passed the Advance Medical Directive Act in 1996 (Tee, Seet, Tan, & Choo, 1997) but in Hong Kong, advance directives are not yet supported with legislation (Chung et al., 2017). Taiwan was the first country in Southeast Asia to enact a Patient Self-Determination Act in 2015 (Chu et al., 2018) similar to that which exists in the United-States. This act is not specific to mental health but allows individuals with mental capacity to register an advance directive documenting their wishes for medical care (Chu et al., 2018). Unsurprisingly, systematic reviews of the effectiveness of advance medical directives in Asia are lacking, possibly because the service user demand for such services has been low due to limited awareness (Chu et al., 2018; Gowda et al., 2018; Lai, Mohd Mudri, Chinna, & Othman, 2016; Tay, Chia, & Sng, 2010).

However, the concept of psychiatric advance directive is absent in mental health legislation in most Asian countries, with the notable exception of India and the Philippines (Table 1). Both of these nations have been grappling with the issue of reconciling psychiatric directives with previous treatment ideologies for several years (Ratnam, Rudra, Chatterjee, & Das, 2015; Sarin et al., 2012). They have both recently enacted legislations that enable an individual to register their wishes for treatment in a way that is recognized by local laws.

Singapore enacted the Mental Capacity Act and the Mental Health (Care and Treatment) Act to safeguard the treatment of people who lack mental capacity but require immediate, available and appropriate treatment. The former act sought to protect service user autonomy by allowing them to appoint lasting power of attorney to a donee recognized by the Office of Public Guardian. However, neither act made formal provisions to allow people who may lose capacity to register their treatment preferences to guide their care. The legislation in Hong Kong, Japan and Malaysia include extensive details about the court appointment of guardians that are empowered to make decisions on behalf of the incapacitated individual, but do not clearly make provisions for the individual to provide input into the process. Legislation from the remaining countries include minimal mention of the process of appointing a guardian to people without capacity. Vietnam, Myanmar and Cambodia have yet to enact specific mental health legislation to address issues of autonomy, though overarching legislation on persons with disabilities may provide general direction.

While we have focused on legislation related specifically to mental health, it is necessary to mention that these pieces of legislation do not exist in isolation. Each country has some form of constitutional or legislative protection of the rights of persons with disabilities. This is generally understood to extend to people with mental illness. India has specifically formulated their 2017 Mental Health Act to bring it in line with the UN Convention on the Rights of Persons with Disabilities (Duffy & Kelly, 2019). This indicates that specific mental health legislation is necessary, even in places where legislation already exists to protect the rights of persons with disabilities.

4 | THE RELEVANCE OF PADS IN EVOLVING PSYCHIATRIC CARE IN ASIA

While the paucity of evidence supporting the implementation of psychiatric advance directives in Asia and their logistical challenges appear to detract from the merits of further investigation, several arguments can be made to justify its wider consideration in Asia (Gowda et al., 2018). First, the potential impact of psychiatric advance directives in an Asian population remains largely unknown. Dismissing its relevance on the grounds of inconclusive extant literature could therefore be premature. Second, the legislative systems supporting advance medical directives are currently being reconsidered or rewritten in places like Thailand and Cambodia. It is therefore a prime time to consider how to imbed care planning in the legislation. Thirdly, systems supporting electronic medical records, which could serve as shared accessible platforms for the psychiatric advance directives, are in their infancy and possess great potential. The tools necessary to execute directives, such as institutional alliances and cooperation, may be simpler to build into new electronic systems rather than retrofit into established ones. The standard of care could be greatly improved by methods that collaboratively determine treatment plans, and attempt to reduce deceptive or coercive treatment practices. Integrating some form of universal advance planning for mental and physical health in these new electronic systems is essential to achieving a *future-ready healthcare system*. Finally, the ability of psychiatric advance directives to reduce potentially coercive practices could improve the image of psychiatric care, reducing the stigma that surrounds involuntary admissions and psychiatry in general (Ghooi, Dhru, & Jaywant, 2016).

Several barriers noted in Western settings are likely to add to those that might be unique to the Asian setting. As Kemp enumerates, legal, institutional, and individual barriers can impede the implementation and execution of psychiatric advance directives (Kemp, Zelle, & Bonnie, 2015). As we have noted above, the legal framework that supports individual rights may not explicitly support their right to

advance determination. The administrative burdens of care plans (Simpson et al., 2016) may financially challenge nascent mental health systems. In settings where it is newly introduced, service providers' uncertainty of service users' mental capacity may jeopardize the initiation of psychiatric advance directives (Ratnam et al., 2015; Swanson et al., 2006). These barriers should be considered as legislators move to enact reforms.

Specifically in Asia, the establishment of psychiatric advance directives introduces tension when the wishes of the individual are incongruent with societal concerns. Family plays a significant role in determining the course of care, as with any medical decision (Chan, Peart, & Chin, 2014; Ratnam et al., 2015). In Singapore, this may be due to cultural norms of Confucianism, but also due to the structure of the market-oriented healthcare system, which places financial burden on the individual, and by extension, the family (Chan et al., 2014). Relying solely on the wishes of the individual to guide advance decisions may introduce barriers if the family is not consulted. Therefore legislators may need to consider how to reconcile the right to medical privacy with the needs of the family.

Additionally, paternalistic culture permeates local organisations, especially in the healthcare sector, under the idea that "Medical paternalism serves the patient best" (Lim, 2002). Principles of beneficence often drive the dynamics of healthcare provisions in Asia. This may lead service users to defer medical decisions to their doctor (Pathare, Shields, Nardodkar, Narasimhan, & Bunders, 2015; Poremski et al., 2016). Efforts to introduce advance psychiatric directives may therefore be impeded by low uptake, as in the case of medical directives (Tay et al., 2010).

Furthermore, cultural taboos for having to hypothetically speak about matters pertaining to one's deteriorating condition (Barnes, Jones, Tookman, & King, 2007) may discourage people from discussing advance psychiatric directives with their teams, especially under facilitated plans. This taboo is doubly challenging because it impedes discussion with professionals and with family.

Reconciling incongruences may be challenging, but the challenge must not be met by returning to the paternalism behind other treatment strategies. Enshrining the right to make a decision in legislation without making its decisions legally binding may represent a compromise that will lay a foundation for shifting practices.

5 | IMPLICATIONS

The ultimate goal of psychiatric advance directives is increased service user autonomy and improved recovery. This is likely accomplished through the dialogue between professionals and service users that advance planning necessitates while service users are well. To achieve this goal, it would be favorable to set a standard of practice that allows psychiatrists and service users to meet while he or she is well, for the sole purpose of planning. Ideally, establishing an advance care plan that addresses all domains of care would cover all instances where care decisions need to be made in the absence of mental capacity. Considering resource constraints, clinicians working with people with a psychiatric condition may wish to prioritize psychiatric care planning. This is because fluctuating mental capacity seen during relapses of psychiatric conditions may mean these people still retain the capacity to direct other physical or mental health aspects of their care (Chamberlain, Walsh, & Falkowski, 2015; Gowda et al., 2018). In the current state of affairs, the medical system depends on an immediate need for care to justify a meeting between a medical professional and service user. It therefore cannot accommodate preventative measures (as these measures are not directly related to an acute episode or treatment maintenance). This is especially problematic in mental health where prophylaxis is less available to psychiatrists. Furthermore, mental healthcare professionals continue to practice within their narrow band of services. This is to the detriment of the service users as inter-professional collaboration improves the quality of care. Problems related to this professional isolation will continue to challenge several Asian healthcare systems given their mixture of service provision models and market-oriented funding models that tend to reinforce this method of service organization.

ACKNOWLEDGEMENT

None

DISCLOSURE

The authors have no financial or personal conflicts of interest to disclose.

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How to cite this article: Poremski D, Alexander M, Fang T, et al. Psychiatric Advance Directives and their relevance to improving psychiatric care in Asian countries. *Asia-Pacific Psychiatry*. 2020;12:e12374. https://doi.org/10.1111/appy.12374