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Perspective Piece

Advance healthcare directives in psychiatry in Ireland: legal provisions, clinical challenges, and ethical issues in relation to self-harm and suicide

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Abstract

Objectives: To explore current and potential upcoming legal provisions concerning advance healthcare directives in psychiatry in Ireland, with particular focus on clinical challenges and ethical issues (e.g., self-harm, suicide).

Methods: Review and analysis of selected relevant sections of the Assisted Decision-Making (Capacity) Act 2015, Assisted Decision-Making (Capacity) (Amendment) Act 2022, Mental Health Act 2001, Mental Health Bill 2024, and Criminal Law (Suicide) Act 1993, and relevant publications from Ireland's Medical Council and Decision Support Service.

Results: The Assisted Decision-Making (Capacity) Act 2015 outlined new procedures for advance healthcare directives. The Assisted Decision-Making (Capacity) (Amendment) Act 2022 specified that advance healthcare directives relating to mental health are binding for involuntary patients unless involuntary status is based on Section 3(1)(a) of the Mental Health Act 2001 (i.e., the 'risk' criteria). The Mental Health Bill 2024 proposes making advance healthcare directives binding for all involuntary patients. In relation to suicide and self-harm, the Criminal Law (Suicide) Act 1993 states that 'a person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence', and the Decision Support Service advises that healthcare professionals are exempted from criminal liability if complying with a valid and applicable advance healthcare directive that refuses life-sustaining treatment, even where the directive-maker has attempted suicide.

Conclusions: Considerable public and professional education are needed if advance healthcare directives are to be widely used. The ethical dimensions of certain advance directives require additional thought and, ideally, professional ethical guidance.

Keywords: Advance healthcare directives; mental capacity; mental health legislation; psychiatry; mental illness; suicide

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Introduction

Mental health legislation and mental capacity legislation are in a state of significant change in Ireland. The Assisted Decision-Making (Capacity) Act, 2015 was fully commenced in 2023, and was amended by the Assisted Decision-Making (Capacity) (Amendment) Act 2022. These pieces of legislation brought substantial changes to various aspects of mental capacity law in Ireland. More recently, the Mental Health Bill 2024 proposed similarly significant revisions to mental health legislation and is intended to replace the Mental Health Act 2001 in due course. It is, therefore, a time of considerable change.

Advance healthcare directives are one of the features of this programme of legislative reform. These are often seen as vital tools to support respect for the will and preferences of people with mental illness (O'Mahony 2024), but uptake is generally extremely limited, and can be as low as 0% (Redahan et al., 2024). Therefore, while advance healthcare directives (and advance care planning) existed in Ireland prior to the Assisted Decision-Making (Capacity) Act 2015, the new legislation sought to place advance healthcare directives on a clearer, firmer footing, and increase uptake.

Against this background, the objective of the present paper is to explore current and potential upcoming legal provisions concerning advance healthcare directives in psychiatry in Ireland, with particular focus on clinical challenges and ethical issues (e.g., self-harm and suicide).

Methods

This paper is based on review and consideration of selected, relevant sections of the Assisted Decision-Making (Capacity) Act 2015, the Assisted Decision-Making (Capacity) (Amendment) Act 2022, the Mental Health Act 2001, the Mental Health Bill 2024, and the Criminal Law (Suicide) Act 1993, augmented by consideration of selected relevant publications from Ireland's Medical Council and Decision Support Service. These documents were identified as

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being relevant to the objective of this paper, which is to explore current and potential upcoming legal provisions concerning advance healthcare directives in psychiatry in Ireland, with particular focus on specific ethical issues. Research ethical approval was not required for this paper which was based on legislation and published documents which are already in the public domain.

Results

Assisted Decision-Making (Capacity) Act 2015

Among its many reforms, the Assisted Decision-Making (Capacity) Act 2015 outlined new procedures relating to 'advance healthcare directives' (Kelly 2017). Under these provisions, an advance healthcare directive is defined as 'an advance expression made by the person, in accordance with Section 84, of his or her will and preferences concerning treatment decisions that may arise in respect of him or her if he or she subsequently lacks capacity' (Section 82). The 2015 Act specifies that a 'refusal of treatment set out in an advance healthcare directive shall be complied with if the following 3 conditions are met: (a) at the time in question the directive-maker lacks capacity to give consent to the treatment; (b) the treatment to be refused is clearly identified in the directive; (c) the circumstances in which the refusal of treatment is intended to apply are clearly identified in the directive' (Section 84(2)).

By way of contrast, 'a request for a specific treatment set out in an advance healthcare directive is not legally binding but shall be taken into consideration during any decision-making process which relates to treatment for the directive-maker if that specific treatment is relevant to the medical condition for which the directive-maker may require treatment' (Section 84(3)(a)). Furthermore, 'an advance healthcare directive is not applicable to life-sustaining treatment unless this is substantiated by a statement in the directive by the directive-maker to the effect that the directive is to apply to that treatment even if his or her life is at risk' (Section 85(3)).

In addition, 'an advance healthcare directive is not valid if the directive-maker (a) did not make the directive voluntarily, or (b) while he or she had capacity to do so, has done anything clearly inconsistent with the relevant decisions outlined in the directive' (Section 85(1)). An advance healthcare directive is 'not applicable if (a) at the time in question the directive-maker still has capacity to give or refuse consent to the treatment in question, (b) the treatment in question is not materially the same as the specific treatment set out in the directive that is requested or refused, or (c) at the time in question the circumstances set out in the directive as to when the specific treatment is to be requested or refused, as the case may be, are absent or not materially the same' (Section 85(2)). Decisions about validity and applicability are made in the first instance by the treating clinician.

The situation differs somewhat in the context of mental health legislation. The Mental Health Act 2001 permits involuntary admission on the basis of 'mental disorder' which 'means mental illness, severe dementia or significant intellectual disability where' either:

(a) 'because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons' (Section 3(1)(a)), or

(b) '(i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent' (Section 3(1)(b)).

If the person's treatment is regulated under Part 4 of the 2001 Act (i.e., if they are an involuntary patient based on these criteria) or the person 'is the subject of a conditional discharge order' under Section 13A of the Criminal Law (Insanity) Act 2006, the 2015 Act specified that an advance healthcare directive was not legally binding, except 'where a refusal of treatment' related 'to the treatment of a physical illness not related to the amelioration of a mental disorder', in which case 'the refusal shall be complied with' (Section 85(7)). This was later amended and might change again (see below).

The 2015 Act states that the person who makes the advance healthcare directive can appoint 'a designated healthcare representative [who has] the power to ensure that the terms of the advance healthcare directive are complied with' (Section 88(1)(a)). This 'designated healthcare representative' has specific roles, and can 'advise and interpret what the directive-maker's will and preferences are regarding treatment' (on the basis of the advance healthcare directive) and 'consent to or refuse treatment, up to and including life-sustaining treatment, based on the known will and preferences of the directive-maker as determined by the representative by reference to the relevant advance healthcare directive' (Section 88(1)(b)).

Finally, 'an advance healthcare directive is not applicable to the administration of basic care to the directive-maker', where 'basic care' includes '(but is not limited to) warmth, shelter, oral nutrition, oral hydration and hygiene measures but does not include artificial nutrition or artificial hydration' (Section 85(4)).

Assisted Decision-Making (Capacity) (Amendment) Act 2022

The Assisted Decision-Making (Capacity) (Amendment) Act 2022 made specific amendments to the 2015 Act, including the position of advance healthcare directives in the context of the Mental Health Act 2001. The 2022 Act amended the 2015 Act to specify that:

> [. . .] an advance healthcare directive shall, insofar as provided for by this Part, be complied with unless, at the time when it is proposed to treat the directive-maker - (i) his or her treatment is regulated by Part 4 of the Act of 2001, other than where he or she is detained under that Act on the grounds that he or she is suffering from a mental disorder within the meaning of section 3(1)(b) of that Act, or (ii) he or she is the subject of a conditional discharge order under section 13A of the Criminal Law (Insanity) Act 2006 (Section 74).

This means that an advance healthcare directive relating to mental healthcare does not need to be complied with if the patient's involuntary status is based on Section 3(1)(a) of the Mental Health Act 2001 (i.e., 'because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons'). The position of an advance healthcare directive relating to mental healthcare if the patient is detained under *both* Sections 3(1)(a) and 3(1)(b) of the 2001 Act is regrettably unclear.

Despite these new complexities, it remains the case that, 'where a refusal of treatment set out in an advance healthcare directive by a directive-maker relates to the treatment of a physical illness not related to the amelioration of a mental disorder of the directive-maker, the refusal shall be complied with' (Section 85(7)(b)).

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The Decision Support Service summarises the position in its *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* (Decision Support Service 2023). The 2015 Act states that 'the Director [of the Decision Support Service] may prepare and publish a code of practice, based (whether in whole or in part) on recommendations made to him or her by the working group as to the contents of the code, for the purposes of the guidance of designated healthcare representatives or healthcare professionals, or both, or with respect to such other matters concerned with this Part as the Director thinks appropriate' (Section 91(3)). In addition:

'A person concerned shall have regard to a code of practice published under *subsection (3)* when performing any function under this Act in respect of which the code provides guidance' (Section 91(13)); and

'Where it appears to a court, tribunal, or body concerned, conducting any proceedings that (a) a provision of a code of practice published under *subsection (3)*, or (b) a failure to comply with a code of practice published under *subsection (3)*, is relevant to a question arising in the proceedings, the provision or failure, as the case may be, shall be taken into account in deciding the question' (Section 91(14)).

The Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* adds that 'this code should be read in conjunction with the Assisted Decision-Making (Capacity) Act 2015 (as amended). For the avoidance of doubt, in the event of any conflict or inconsistency, the legislative provisions in the Act prevail' (Decision Support Service 2023; p. 2).

Against this background, the *Code of Practice* points out that 'the advance healthcare directive will not apply if the person is detained on what is commonly referred to as the risk ground of the Mental Health Acts', and/or 'the directive-maker is the subject of a conditional discharge order under the Criminal Law (Insanity) Act 2006':

> In these situations:
>
> - Where the treatment decision in question is in respect of treatment for a physical illness, the advance healthcare directive must be complied with in the same way as any other advance healthcare directive; and
> - Where the treatment decision in question is in respect of treatment for a mental disorder, the advance healthcare directive may still be taken into consideration as an important expression of the directive-maker's will and preferences.
>
> However, the relevant legislation specified above shall take priority' (Decision Support Service 2023; p. 14).

Mental Health Bill 2024

The Mental Health Bill 2024, which is still in the legislative process and therefore not yet law, presents revised criteria for involuntary admission (Section 12), among other proposed reforms. With regard to advance healthcare directives, it does not distinguish between involuntary patients admitted under different criteria (in contrast with the current position):

> Where there is a valid advance healthcare directive in respect of a person in relation to the specific treatment proposed, the specific treatment shall not be administered if the advance healthcare directive specified that there is no consent to the treatment concerned or the designated healthcare representative duly authorised under an advance healthcare directive, refuses to consent to its administration, as the case may be (Section 49(6)).

If carried through to the final Act, this would represent a shift from the current position. The treatment provisions in the 2024 Bill are, however, extraordinarily complex and self-contradictory, so other issues might well arise in relation to advance healthcare directives in this context (Kelly 2024). For example, the 2024 Bill specifies that an 'application to High Court for treatment order' for an involuntary patient may be made 'in certain circumstances' (Section 51). These circumstances include:

> [. . .] where treatment cannot be administered to an involuntarily admitted person because the person [. . .] has a relevant decision-making representative, or has a valid and relevant advance healthcare directive or a relevant designated healthcare representative appointed under an advance healthcare directive relevant to the treatment concerned and that representative refuses to consent to the treatment concerned or the advance healthcare directive specifies that there is not consent to the treatment concerned (Section 51(1)).

In other words, the psychiatrist can apply to the High Court to overrule the advance healthcare directive of an involuntary patient in certain circumstances. For this to occur, 'an application may be made by or on behalf of the responsible consultant psychiatrist to the High Court specifying the proposed treatment and seeking an order to administer the treatment concerned', and this can only happen if:

> (i) the treatment concerned is - (I) immediately necessary for the protection of life of another person or persons, or (II) necessary for protection from an immediate and serious threat to the health of another person or persons;
> (ii) the involuntarily admitted person requires the treatment concerned;
> (iii) there is no alternative safe and effective treatment available;
> (iv) it is likely that the condition of the involuntarily admitted person will benefit from such treatment (Section 51(1)).

Criminal Law (Suicide) Act 1993

The issue of a valid and applicable advance healthcare directive that specifies a refusal of treatment even if this results in death following self-harm presents a complex legal and ethical dilemma. From a legal perspective, the Criminal Law (Suicide) Act 1993 decriminalises suicide in Ireland, but adds:

> (2) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.
> (3) If, on the trial of an indictment for murder, murder to which section 3 of the Criminal Justice Act, 1990 applies or manslaughter, it is proved that the person charged aided, abetted, counselled or procured the suicide of the person alleged to have been killed, he may be found guilty of an offence under this section (Section 2).

The Assisted Decision-Making (Capacity) Act 2015, in its section on the 'Effect of advance healthcare directive', states that 'nothing in this Part shall be taken to affect - (a) the law relating to murder or manslaughter, or (b) the operation of section 2 of the Criminal Law (Suicide) Act 1993' (Section 86(5)).

The Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* addresses one aspect of this dilemma in a section titled 'Liability regarding attempted suicide':

> A healthcare professional is exempted from criminal liability when complying with an advance healthcare directive that refuses life-sustaining treatment, even in circumstances where the directive-maker has attempted suicide.
>
> While you must presume the directive-maker had capacity when making their advance healthcare directive, if in the circumstances, you have reason to believe the directive-maker may have lacked capacity when

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> making the directive, you may need to undertake further investigation, as set out in section 2.7 ['Resolving ambiguity'] (Decision Support Service 2023; p. 27).[1]

While this provision addresses the matter of legal liability, at least to an extent, other significant issues remain unresolved, including issues of professional ethics.

Ireland's Medical Council, in its 2019 *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Amended) (8th Edition)*, included a section devoted to 'End of life care' which stated, *inter alia*, that 'you must not take part in the deliberate killing of a patient' (Medical Council 2019; p. 34). This sentence was, however, removed from the most recent revision of this document in 2024, titled *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (9th Edition)* (Medical Council 2024). The new guidance states:

> You should involve patients (and/or persons with decision-making authority in relation to the patient) in decision-making about their end-of-life care, respecting their will, preference, any Advance Healthcare Directive and decision-making capacity. This may include discussions on potential organ donation, where appropriate (Medical Council 2024; p. 45).

The specific issue of an advance healthcare directive that refuses treatment even if this results in death following self-harm is not addressed. The matter is rendered more complex by the section on 'Conscientious objection' in the Medical Council's guidance, which states:

> You may refuse to provide, or to participate in carrying out, a lawful procedure, treatment or form of care which conflicts with your moral values, subject to compliance with the guidance set out below (Medical Council 2024; p. 42).

This and the rest of the section on 'Conscientious objection' refers only to conscientious objections to *providing* a specific treatment or 'form of care', as opposed to conscientious objections to *withholding* treatment and all 'forms of care' on the basis of an advance healthcare directive (or any other basis). It is arguable that palliative care following such a legally enforceable advance healthcare directive is a lawful form of care, albeit possibly more complex depending on the specific content of the advance healthcare directive.

Overall, and notwithstanding the section on 'Resolving ambiguity' in the Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* (Decision Support Service 2023), it remains the case that clinical and ethical dilemmas might well be further complicated by ambiguity about the advance healthcare directive, especially in cases of self-harm or apparent attempted suicide.

In practice, it will be clinicians who must decide whether there is doubt if the person had capacity at the time the advance healthcare directive was made and, in the case of such doubt, what the correct course of action might be *now*. In this kind of ethically charged situation, the clinician will need to rely on (a) their best judgement in the circumstances; (b) the general principles of good medical practice (e.g., optimising information, prioritising emergency decisions, minimising nonconsensual interventions, consulting appropriately, reviewing decisions as situations evolve, etc.), and (c) formal guidance insofar as it addresses such dilemmas, including the Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* (Decision Support Service 2023), the *HSE National Consent Policy* (Health Service Executive 2024), and the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (9th Edition)* (Medical Council 2024). In these circumstances, the precise legal discretion open to clinicians is not clear, but the principles of good clinical practice are a solid, defensible basis for urgent decisions, along with consideration of appropriate formal guidance.

[1]Section 2.7 of the *Code of Practice* suggests a number of possible steps including consulting with the directive-maker's designated healthcare representative or trusted people close to the directive-maker and seeking the opinion of a second healthcare professional. These measures, although logical, are not always practicable if there is urgency such as a life-threatening overdose. The same applies to the advice that 'if there is an issue with regard to life-sustaining treatment a court application must be made to the High Court' (Decision Support Service 2023; p. 15).

Discussion

Summary of main findings

This paper sought to explore current and potential upcoming legal provisions concerning advance healthcare directives in psychiatry in Ireland, with particular focus on clinical challenges and ethical issues (e.g., self-harm and suicide). In summary, the Assisted Decision-Making (Capacity) Act 2015 outlined new procedures relating to advance healthcare directives including a provision that, for involuntary patients under the Mental Health Act 2001, an advance healthcare directive in relation to mental healthcare was not legally binding. This position was modified by the Assisted Decision-Making (Capacity) (Amendment) Act 2022 which specified that such a directive is binding unless the patient's involuntary status is based on Section 3(1)(a) of the Mental Health Act 2001 (i.e., the 'risk' criterion). The Mental Health Bill 2024 proposes making advance healthcare directives binding for all involuntary patients, although the 2024 Bill also introduces impenetrable complexity about involuntary treatment in general, which casts significant doubt on the coherence of its overall paradigm (Kelly 2024).

Advance healthcare directives, self-harm, and suicide

There are unresolved legal and ethical issues pertaining to advance healthcare directives that specify a refusal of treatment even if this results in death following self-harm. From a legal point of view, the 2015 Act introduced a relatively robust system of advance healthcare directives which are binding in certain circumstances (Part 8) but adds that 'nothing in this Part shall be taken to affect [. . .] the operation of section 2 of the Criminal Law (Suicide) Act 1993' (Section 86(5)). The 1993 Act, in turn, states that anyone 'who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years' (Section 2(2)). The Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* advises that 'a healthcare professional is exempted from criminal liability when complying with an advance healthcare directive that refuses life-sustaining treatment, even in circumstances where the directive-maker has attempted suicide' (Decision Support Service 2023; p. 27).

The situation becomes even more complex when ethical issues are added to the mix, in addition to legal ones. From a clinical ethical perspective, it is likely that many clinicians will have a tendency towards the preservation of life, especially when their patient lacks decision-making capacity owing to self-harm, even if the patient has a valid, applicable advance healthcare directive refusing treatment following self-harm, even if that refusal results in their death (e.g., an 18-year old with such an advance healthcare directive who is unconscious following an overdose).

Ethical guidance is needed in these situations, not least concerning the option of conscientious objection to non-provision

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of care when such non-provision will knowingly result in death following self-harm. As discussed above, the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (9th Edition)* refers only to conscientious objections to *providing* a specific treatment or 'form of care' (Medical Council 2024; p. 42), as opposed to conscientious objections to *withholding* treatment and all 'forms of care' on the basis of an advance healthcare directive. It is difficult to argue that withholding treatment and letting a patient die by suicide, even at their apparent request, is a 'form of care'. In consequence, it is not clear if a conscientious objection to such a course of action in this fraught ethical circumstance comes within the Medical Council's conscientious objection framework. It should.

Given these uncertainties, it appears likely that doctors, when managing a patient with an advance healthcare directive that specifies refusal of treatment even if this results in death following self-harm, will pay particular attention to the Decision Support Service's *Code of Practice on Advance Healthcare Directives for Healthcare Professionals'* further guidance on this point:

> While you must presume the directive-maker had capacity when making their advance healthcare directive, if in the circumstances, you have reason to believe the directive-maker may have lacked capacity when making the directive, you may need to undertake further investigation, as set out in section 2.7 ['Resolving ambiguity'] (Decision Support Service 2023; p. 27).

It is conceivable that healthcare professionals might regard the very writing of an advance healthcare directive that refuses treatment even if this refusal results in death following self-harm as evidence that the person might have lacked decision-making capacity when they wrote the directive (e.g., that they might have had severe depression which might have affected their decision-making capacity at that time). Following such a clinical judgement, and given the legal uncertainty and ethical questions surrounding this situation, it is possible that many doctors and other healthcare professionals will overrule such an advance healthcare directive owing to doubts about the patient's decision-making capacity when they wrote the directive, and proceed to treat the person for their self-harm despite the content of their directive.

It is also possible, however, that doctors and other healthcare professionals will be faced by cases where decision-making capacity at the time the advance healthcare directive was written might not reasonably be in question, and these cases could clearly present a deep ethical dilemma to certain practitioners.

Implementing advance healthcare directives

The complex issue of advance healthcare directives and self-harm, and the resultant legal and ethical dilemmas, should not distract attention from the great majority of advance healthcare directives which will *not* present such ethical issues, and which will promote the will and preferences of people who lack decision-making capacity. Realising the potential benefits of advance healthcare directives, however, depends on take-up by the public, which can be as low as 0% in some places (Redahan et al., 2024).

There are many reasons for the lack of enthusiasm for advance healthcare directives among the public. In Ireland, research conducted prior to the 2015 Act showed that perceived barriers to implementation of advance directives varied between stakeholder groups, with psychiatrists perceiving more barriers, and service-users primarily concerned about the possibility of advance directives being overridden or ignored (Morrissey 2015).

These issues are not new and are not limited to Ireland. In 2009, the Scottish Government published a *Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003* (Review Group 2009; Kelly 2016). The Review Group stated that, while advance statements were introduced in order 'to improve patient participation' in treatment decisions, 'take-up of them has not been as high as expected' (Review Group 2009; p. 8). Reasons included:

- 'Most persons have never heard of advance statements and, even if they have, they do not think they would ever be relevant to them';
- 'People do not know how to go about making one, who they can have as a witness and what to do with the document once they have drawn it up';
- 'Service users recognise that when they are unwell they need medical treatment and trust those who may provide this treatment to provide only appropriate treatment';
- 'When in recovery, many service users find it hard to contemplate being unwell again and are not ready to prepare for that eventuality'; and
- 'People do not believe that any regard will be had to their statement if the time comes when it may be needed. They stress that it can be overridden and feel it is therefore useless. In practice, however, figures from the Mental Welfare Commission show that the vast majority of advance statements are adhered to and very few overridden. (The Commission's Annual Report for 2007-08 recorded 13 actual overrides in the whole year)' (Review Group 2009; p. 8).

The Scottish Review Group suggested clarifying the possible content of advance statements; increasing awareness of advance statements; making 'it easier to make a valid advance statement'; extending the range of witnesses and clarifying their role; highlighting the low number of advance statements being overridden; and requiring 'responsible medical officers to review regularly any treatment in conflict with an advance statement and provide a written record of efforts made to address the person's stated wishes' (Review Group 2009; p. 9).

Increasing awareness of advance healthcare directives is clearly important in Ireland too. One study conducted in 2016 found that while a majority (78.7%) of Irish consultant physicians who were surveyed agreed that advance healthcare directives are helpful when making treatment decisions concerning incapacitated persons, a minority (42.1%) were aware of the provisions of the 2015 Act in relation to such directives (Crowley and Doran 2022). In 2022, another survey showed that only 2% of doctors in one hospital had received any formal training about the 2015 Act, and 90% were unaware of what constituted a valid advance healthcare directive (Curtis et al., 2022).

It is worth noting that while both of these surveys predated commencement of the 2015 Act in 2023, comprehensive educational initiatives started prior to commencement. Since 2023, yet more extensive educational resources have been developed and provided by the Health Service Executive,[2] Decision Support Service,[3] and Citizens Information Board.[4] These resources continue to expand and evolve.

Clearly, the attitudes of doctors towards advance healthcare directives, and whether they will recommend them, is important. Broader attitudes also matter, and it is worth noting the existence of

[2]https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/assisted-decision-making-capacity-act/advance-healthcare-directive/ (accessed 25 January 2025).

[3]https://decisionsupportservice.ie/services/advance-healthcare-directives (accessed 25 January 2025).

[4]https://www.citizensinformation.ie/en/health/legal-matters-and-health/advance-care-directives/ (accessed 25 January 2025).

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long-standing, fundamental doubts about the idea that a person's exercise of autonomy can extend beyond their span of decision-making capacity. In 2004, Fagerlin and Schneider wrote about 'the failure of the living will' which, they argued, 'should be abandoned' owing to, among other factors, a marked lack of uptake, despite considerable encouragement (Fagerlin and Schneider 2004; p. 30). They described the persistent promotion of such instruments despite this widespread lack of interest in using them as 'the triumph of dogma over inquiry and hope over experience'.

Strengths and limitations of this paper

This paper addresses a complex issue (advance healthcare directives in mental healthcare) in a timely way, just two years after commencement of the Assisted Decision-Making (Capacity) Act 2015 and a year after publication of the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners (9th Edition)* (Medical Council 2024). The paper draws on several sources of information (legislation, ethical guidance, research surveys) and uses information from Scotland relating to 'advance statements' under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Review Group 2009).

Limitations of this paper include the lack of caselaw on the subject of advance healthcare directives in Ireland under the 2015 Act. At time of writing, there has not yet been adequate time for caselaw to accumulate to a significant degree in relation to advance healthcare directives in mental health, although caselaw in relation to advance healthcare directives is starting to emerge.[5] It is likely that further caselaw will provide an important source of information over the years ahead.

This paper also selected its sources purposively in order to examine specific themes and did not include an original quantitative component to provide new data in support of its arguments. It is hoped that research over future years will add more data-based evidence to discussions of these topics as advance healthcare directives come into wider use across the Irish health service.

Conclusions

Advance healthcare directives represent a significant change in Irish mental capacity law and could have a significant impact on mental healthcare. Sustained public and professional education are needed if advance healthcare directives are to be widely used. While evidence to date suggests that enthusiasm for advance healthcare directives is greater among legislators and legal academics than among the public, it is nevertheless important that information about advance healthcare directives is widely shared in order to facilitate those who wish to use them. In addition, the ethical dimensions of certain advance healthcare directives require additional thought and, ideally, professional ethical guidance (e.g., advance healthcare directives relating to self-harm and suicide).

In terms of legal reform, it is important that advance healthcare directives are integrated carefully into ongoing revisions of mental health legislation so that there is legal coherence across this field more generally (Kelly 2024). In terms of research, it would be helpful to focus more on potential uses of artificial intelligence in relation to decision-making capacity, mental capacity legislation, and advance healthcare directives, especially as this technology advances over the years ahead (Redahan and Kelly 2024). Finally, future research could also focus more on levels of awareness of advance healthcare directives among clinical professionals, patients, and families, along with examination of any other potential reasons for the low uptake in Ireland and elsewhere.

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Ethical standards. The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The author asserts that ethical approval for the publication of this paper was not required by their local ethics committee.

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